ORIGINAL

NEVADA ADVISORY COMMITTEE

to the

U.S. COMMISSION ON CIVIL RIGHTS

PUBLIC MEETING: THE IMPACT OF NEVADA POLICING PRACTICES ON THE ADMINISTRATION OF JUSTICE

Taken on Thursday, August 9, 2018

At 9:00 a.m.

At 4315 Swenson Street

Las Vegas, Nevada

Reported by: Janice David, CCR No. 405

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PANEL MEMBERS:

PANEL MEMBERS: (Continued)

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LAS VEGAS, NEVADA; AUGUST 9, 2018; 9:00 A.M.

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CHAIRPERSON BLAYLOCK: Well, before we begin today's meeting I would like to share a few housekeeping items.

The restrooms are located out of these doors and to the left. Please feel free to excuse yourself as needed. And in the event of an emergency, we have two exits in the back, and we have two exits in our front, just like a plane.

This meeting of the Nevada Advisory Committee to the U.S. Commission on Civil Rights shall come to order.

For the benefit of the audience, I will introduce my colleagues and myself. I'm Wendell Blaylock, the chair of the committee. Members of the committee are Sondra Cosgrove from Las Vegas; Carol Del Carlo from Incline -- Incline Village; David Fott from Las Vegas. Kara Jenkins will join us this afternoon in Las Vegas. Kay Kindred from Las Vegas, Theresa Navarro from Reno, Jon Ponder from Las Vegas, and Ed Williams from Las Vegas.

Also present are U.S. Commission on Civil Rights staff. Joining us from Reno is Commissioner David Kladney.

Commissioner, may I ask you to share your thoughts on today's hearing?

MR. KLADNEY: Yes. Since you told me I should be sharing my thoughts a few minutes ago, I've been thinking.

So, first of all, I would like to thank everyone on the committee, because these people volunteer their time for meetings and these types of briefings and with -- without compensation but for doing a good cause. And they come from all parts of the community.

So, I -- I think we should thank them very much. So, thank you.

CHAIRPERSON BLAYLOCK: Thank you.

MR. KLADNEY: Second of all, the subject that they're embarking on today, criminal justice and mental health, is a subject that I think is one of the three pillars of -- of the criminal justice system that have to be addressed along with fair sentencing and minimum mandatories and collateral consequences. But, interestingly enough, mental health and the criminal justice system, in my seven years on the commission I don't think anyone has specifically drilled down on this subject.

And I'm very excited, because we have 51 of

these committees. And they are throughout all the states and the District of Columbia. And as they start bringing up these subjects, they start gaining interest and traction within their communities. And I know my own personal thought -- not that of the commission or anything like that. It's my own personal thought. -- is that I don't know why we keep detailing the mental health crisis to the police. I don't think it's their job. I don't know if we equip them enough. They are not mental health professionals.

So, I think that this is a very important subject, and I thank the committee again for bringing it up, and I thank you all for doing this job. Thank you.

CHAIRPERSON BLAYLOCK: Thank you.

Also present from the civil rights commission we have Ana Victoria Fortes, civil rights analyst; Cynthia Fountaine, civil rights analyst; Angelica Trevino, support services specialist; Carolyn Allen, support services specialist; Josephine Tintera and Julian Valdes, law student research assistants.

The U.S. Commission on Civil Rights is an independent, bipartisan agency of the federal government charged with studying discrimination or

denial of equal protection of the laws because of race, color, religion, sex, age, disability, national origin, or in the administration of justice. In each of the 50 states and the District of Columbia an advisory committee to the commission has been established, and they're made up of bipartisan persons who serve without compensation to advice the commission on relevant information concerning their respective state.

At today's meeting it is our purpose to hear testimony, to exam and investigate police practices in Nevada, to understand and make recommendations regarding any disparate police practices or issues related to the use of excessive force. The committee will study issues related to police practices by focusing on implications for the administration of justice, of police practices as they relate to mental health and public health, with special emphasis on the impact on veterans and people of color.

The committee intends to view these issues through the lens of Pillar 4, community policing and crime reduction, of the Report of the President's Task Force on 21st Century Policing. The committee is to determine appropriate advice and recommendations to be shared with the U.S. Commission on Civil Rights

regarding the enforcement of the issues.

Please note: If speakers begin to veer away from the relevant questions at hand or go off topic, I will politely interrupt you and ask you to refrain from doing so. At the outset I want to remind everyone that this meeting is being transcribed by our court reporter from -- for the public record. I ask that you please state your name when speaking.

Today we are fortunate, very fortunate, and thankful to have a schedule of five panels, including fifteen speakers, who will share with us their expertise at this meeting. And I ask that you give them your undivided attention. Please note: We made several attempts to invite many other stakeholders, especially those who study these areas, have a unique perspective on community policing with emphasis on veterans or people of color, and other experts working in this area. But they were, unfortunately, unable to be with us today.

For those of you that use social media, we have a hashtag for today's event, and it is at -- not panel. Hashtag USCCR state committees, and the U.S. Commission on Civil Rights Twitter handle is at USCCR gov.

Is that gov period or just gov?

MS. FONTES: Just gov.

CHAIRPERSON BLAYLOCK: Just gov. Just gov. I would also like to present the ground rules for today's meeting.

This is a public meeting. It's open to the media and the general public. We have a full schedule of people who will be providing testimony within the limited time available. This will include a presentation by each panelist of approximately 10 to 15 minutes unless they're invited to speak longer. After the panelists have concluded their statements, committee members will engage them in questions and answers.

Panelists, please see that we're holding up time cards to ensure that you keep within your allotted time.

To accommodate persons who are not on the agenda but wish to make a statement, we have scheduled two open forums: one in the morning before the lunch break -- and that will be from twelve until 12:30. -- and one at the end of the briefing from 4:15 until 4:45. If you wish to speak, please add your name to the list at the registration table.

Please note: The open comment period is not an opportunity to ask questions of the panelists.

Rather, it's an opportunity for you to express your concerns and opinions relating to the topic of this briefing. In addition, written statements may be submitted by mail, so the U.S. Commission on Civil Rights at 300 North Los Angeles Street, Suite 2010, Los Angeles, California 90012, or by e-mail to afortes@usccr.gov. And that will be for 30 days after this hearing. You may also call area code (213) 894-3437 for more information.

Though some of the statements made today may be controversial, we want to ensure that all invited guests do not defame or degrade any person or organization. As a chair, I reserve the privilege to cut any statement short that defame, degrade, or do not pertain to the issue at hand.

In order to ensure that all aspects of the issues are represented, knowledgeable persons with a wide variety of experience and viewpoints have been invited to share information with us. Any person or organization that feels defamed or degraded by statements made in these proceedings may provide a public response during the open comment period. Alternatively, such persons or organizations can file written statements for inclusion in the proceedings. I urge all persons making presentations to be

judicious in their statement. The Nevada Advisory Committee appreciates the willingness of all our participants to share their views and experiences with this committee.

Finally, the rules for the question-and-answer portions of the panel are as follow: The committee may ask questions of the entire panel or individual members of the panel after all panelists have had an opportunity to provide their prepared statements. Committee members must be recognized by the chair before asking any question of the participants. In addition, in order to ensure all committee members have an opportunity to address the panel, each committee member will be limited to one question plus a follow-up. When five minutes are left in the session, I will announce that the last question may be asked.

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COMMUNITY POLICING AND CRIME REDUCTION PANEL

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WILLIAM SOUSA, Professor and Director, Center for Crime & Justice Policy, University of Nevada Las Vegas

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CHAIRPERSON BLAYLOCK: I would now like to begin our meeting by introducing the Community

Policing and Crime Reduction speaker, Mr. William Sousa, professor and director of the Center For Crime & Justice Policy with the University of Nevada Las Vegas. Mr. Sousa.

MR. SOUSA: Thank you for the introduction. William Sousa, for the record. I'm a professor at University of Nevada Las Vegas in the department of criminal justice, and I'm the director, Center For Crime & Justice Policy.

So, I have been asked today to talk a little bit about the idea of community policing and crime of -- crime reduction in general. And I should start by saying that I teach a course that's essentially titled the same, Community Policing and Crime Reduction. So, you're about to get 15 weeks in less than 15 minutes. So, keep those time cards handy for me.

I've had the opportunity in my career -- I've been very lucky in my career in some respects. First I've had the opportunity to work with a number of academics -- a great number of academics who are really the first to study and to write about community policing during its origin in the 1970s and 1980s. It is really interesting to hear about their insight regarding working with the police then versus working

with the police now.

Also, in addition to working with other academics, of course, I've had the opportunity to work with a number of police agencies, large police agencies, in the United States and also there on their community policing programs: Washington police; Newark, New Jersey police; NYPD; LAPD. And, of course, now that I'm here at UNLV, I've done quite a bit of work on Las Vegas Metro. And so I've been able to see community policing in practice in a number of places. And what's interesting about community policing is that the more places you see it, the more you realize that community policing is not all that well-defined.

The -- which raised question of, What is community policing? And the -- I heard it referred to as a specific project or a specific program. So, for example, if a police department is doing patrols every now and then, they can say that they're doing community policing. Maybe, but I'm not really sure about that. I've also heard it referred to as a model or a framework or a paradigm or a philosophy. And I think it's much more useful to think of it in that way, because when you think of it in terms of a paradigm, then you can think of it in terms of its

core principles. And the first core principle, I would argue, would be accountability to citizens.

Police have always been accountable to themselves, and they have been accountable to the law and legal processes. And the law still continues to be the main source of their legitimacy. But within the community policing framework, police are not just accountable to legal processes. They're also accountable to citizens. And especially as the citizens contribute more and more to identifying what community problems are and community -- and contributing more to a identification of solutions, police have become more accountable to those citizens, which leads me to Partnerships With the Public.

Since the start of community policing, there has been much more willingness on the part of police to work with citizens. We see police working with hospitals on violence reduction programs. We see them working with clergy and with schools on early intervention programs. We see police working with local businesses on crime prevention efforts. We see them working with universities on research. We almost take these things as a given now. But 25, 30, 35 years ago those types of partnerships would have been considered quite remarkable.

And the third core principle I would say, in terms of community policing, is the idea of proactive crime prevention. When it comes to addressing crime problems, everything that we've learned in the last 30 years of community policing is that policing efforts have to be proactive in order to be effective. But I'll return to that in just a minute.

To understand community policing, it's often helpful to contrast it with the -- the -- what I will call the traditional model.

CHAIRPERSON BLAYLOCK: Thank you.

MR. SOUSA: To understand community policing, it's often helpful to contrast it with what I will refer to as traditional policing, which is the model that was dominant during the '50s, '60s, and into the '70s. And now I'm speaking in very general terms. Police agencies -- we have 17,000 police agencies in the United States. And if you ask about their model of community policing, you'll get 17,000 different answers.

But during the '50s, '60s, and '70s it was a time when police were attempting to professionalize in a number of ways. And the form that that took was a very remote relationship with citizens. The idea was to be an impartial law enforcer. For those of you who

might be familiar with Sergeant Joe Friday of Dragnet and just the facts man, that was sort of the epitome of a good police officer, someone who could maintain that distance from citizens. Police sought to define themselves by how they addressed a serious crime. And other community problems: disorder, minor offenses, were essentially either ignored, or they were dismissed, or they were referred to as social work, and they were not considered proper police business. Police business was crime. And in that image, police were -- were basically the thin blue line in the war on crime. And police were essentially -- saw themselves in that way.

In this model citizens played very little role in crime prevention. Essentially citizens were to report crime if they saw it, and then they were to be a good witness later. But other than that, crime was police business. The tactics of the time to address serious crime were very reactive. This was the evolution of the 911 system. Citizen sees a crime. They report the crime. Police race to the scene. It's very reactive in nature. Police were essentially distributed randomly throughout cities, with the idea they could respond quickly to calls for service. But that response was a very reactive model.

Getting into the '60s and '70s, we find that there were a number of problems with this traditional model of policing. First, for all their efforts to call themselves crime fighters, crime's essentially spiraling out of control in many, many places. In addition to that, as a result of the remoteness that they have now achieved with citizens, relationships between police and citizens have really disintegrated, especially in poor communities and in many minority communities. And so because of these -- these issues, we see a reaction to it, which is the development of really the firs steps in community policing.

Now, again I speak very much in terms of generalities, because some community policing factors that I'm going to talk about, some of the agencies do better than others. And many agencies still struggle with being part of the traditional model of the police. But in any event, community policing is essentially associated with much more intimate relationship between police and citizens, the desire of citizens and police to work together, and not just on problems related to serious crime but also on other community problems, minor offenses, and quality-of-life concerns. We hear, instead of the warrior image, a shift to more of a guardian image.

And the wolf citizens in policing and crime reduction becomes much more active. Citizens are much more engaged in terms of identifying problems and in terms of developing solutions. Policing tactics that are associated with community policing are much more proactive.

Now, there are a number of terms that I'm going to associate with proactive tactics when it comes to community policing. A few would be, for example, problem-oriented policing. Problem-oriented policing stems from the idea that in the traditional model, police have fallen into a trap where they respond to incident after incident after incident, as if those incidents have no history or have no future. In fact, we know that it is often the case that incidents do have a history. And if they're not dealt with, they will have a future, which is to say that if we're able to identify those patterns, we have the opportunity to solve the problem that gives rise to the incidents.

You hear things like "pulling levers", we say, and sometimes referred to as focused deterrents, we say. Focused deterrents is based on the idea that roughly 5 percent of all offenders contribute to 50 percent of all criminal activity. The policy

implication there is, if we are able to identify that core 5 percent, then it will be the early intervention programs that can be done to reduce overall criminal activity. You hear about "hot spots" policing, which is a similar idea, the idea that 5 percent of all addresses generate about 50 percent of all calls for service to police. Again, the policy implication is that if we're somehow able to identify that 5 percent, there may be things that can be done at those locations to prevent repeat calls.

In "broken windows" policing, sometimes referred to as auto maintenance policing, which deals essentially with the management of minor offenses, with the goals of improving quality of life and preventing more serious crime -- has been demonstrated to be very effective in communities and can be very -- citizens, we know, support wholeheartedly policing when it's properly communicated to citizens.

Now, as a result of these -- these proactive tactics, we should -- and I really want to emphasize that these are -- this is a different philosophy than the 911 respond to calls for service. This is an actively going down to -- to attempt to prevent crime using these types of tactics.

What we can say over the last 30 years of

community policing is that, generally speaking, if you look at crime rates, they have decreased substantially. From 1992, which was sort of a height of the crime problem in the United States, to 2016, violent crime decreased in the nation by a nearly 50 percent. Now, there are differences in cities. And I'm always reluctant to talk about national trends, because cities are different from place to place. But we can say that when as -- there's been a steady decline. I know there have been blips up along the way in many cities in the nation. More recently we've seen minor blips up. But overall we find correlation between community policing programs and crime reduction.

What's also interest is when we look at citizen opinion of police. Citizen opinion of police is, generally speaking, very high. And that's across demographics. Now, there are some demographic differences, but, for the most part, when we do surveys of citizens, citizens rank police very high in terms of confidence in the profession. In fact, citizens routinely rate police among the highest, when it comes to professions, in terms of ethical standards. They rank right up there with the teachers, physicians, and college professors. They

rank far, far, far above attorneys. But it -- what we do know is that police, generally speaking, are thought of highly in the public relative to other professions. And we know that crime is down.

So, if crime is down associated with community policing -- and again there are -- we can't just associate cause with these things. There may be other factors. But if crime is down associated with community policing and citizen opinion of police is high associated with community policing, then why are we here, why the task force report, and why the discussions today? And it seems to me that's a very complicated question.

What I would say is that for us, just because things may appear to be getting better when it comes to crime trends and when it comes to opinions of police, just because things are getting better, that doesn't mean that there isn't room for improvement, whether it's managing crime, whether it's interacting with citizens, whether it's policy development. There can always be improvement.

The second thing I would say is that, in intro of the media now, and certainly social media, means that we are much more aware of policing practices than ever before, especially those practices

that involve interactions between police and citizens under the controversial circumstances. I don't think, and I think the evidence would generally suggest, that those interactions, the controversial interactions, have not gone up or that it doesn't appear they have gotten worse. But we are certainly more aware of them. And perception, of course, is important, because if there is perception that there is a problem, then much needs to be done to address it.

And so with that, I will say just a few final words. When it comes to police discretion and community policing, proactive policing, when done right, requires an enormous amount of police discretion; reactive policing doesn't. You get the call. You show up. There is discretion, depends on what you do at that point. But it's really the citizen that decided for that interaction. It wasn't the officer.

Proactive policing requires the officers to be much more engaged and much more proactive. Whether it's approaching youth, whether it's approaching citizens in need, whether it's approaching mentally ill, which is, of course, a more specific topic for today, discretion plays an important role. The difficulty traditionally, when it comes to police

policy manuals, is that police policy on discretion often describes what police can't do better than what it describes what police can do when it comes to discretion. And these are areas where we can see improvement regarding discretion in these proactive activities.

And, finally, what I would say is that, when it comes to community policing and these proactive tactics, it's very important to have citizen acceptance of those tactics. We know that when you're proactive, you're being a servant as police officers. When those tactics are not properly communicated to citizens, there can be what we call a backfire effect, which is to say that citizens don't understand why police are acting in these particular ways or doing these particular types of activities. And it becomes very important for -- for police to communicate with citizens in terms of those tactics. We know that when those tactics are properly communicated to citizens and citizens accept them, that they can indeed be effective not just in terms of reducing crime but in terms of citizen satisfaction.

With that, I will end.

CHAIRPERSON BLAYLOCK: Thank you.

Questions by the committee?

MR. WILLIAMS: Mr. Chair?

CHAIRPERSON BLAYLOCK: Mr. Williams.

MR. WILLIAMS: I -- so, for -- for those of us that are younger and may have not experienced traditional policing, thank you for making the contrast. Yeah. We might have a heart attack -- saw TV shows and remember what that was like.

But from a historic perspective, when there was a traditional police model as a primary model in place, historically what -- what sort of community organization would be taking up the slack of any non-policing activities, in your view?

MR. SOUSA: Well -- well, in many respects, when we talk about -- so, for example, minor offenses, things like graffiti, things like trash and litter, in many communities those types of disorders were virtually ignored. Police would be asking things about them, but they were -- would be dismissed and -- and there may be some interest to try to involve other city services, but certainly there wouldn't be much work done by police on that.

And really what we know is that when it comes to fear of crime in communities, when it comes to citizen concerns in communities, people are not just worried about a serious crime. They're worried about

minor offenses, because these are the types of things that they see on a daily basis. Even in very troubled neighborhoods in the United States, serious crimes are a relatively rare event. But what's much more common would be things like graffiti. It would be public drug use. It would be prostitution. These are the things that people see on a daily basis, and it contributes to a sense of fear, even though it's not a serious crime.

But the difficulty is, we put police in cars. It was very easy to separate from those minor disorders. And many of those minor disorders were virtually ignored by police, and it contributed -- I believe there is evidence to suggest that it contributed to the increase in crime in the United States through the '60s and '70s, because essentially no one was dealing with the minor offenses either.

CHAIRPERSON BLAYLOCK: Sondra Cosgrove.

MS. COSGROVE: Thank you very much for coming. So, if we're moving from the traditional model where the police are punishers, they're out there to react to a crime and then punish the people who have done the crime by taking them in, to more of a "we're there to help prevent crime; we're going to be more proactive," is there a sense within the police

department so that the professional development and the training that they're giving their officers is going to have to change?

Because I can see if -- if you're coming in as a police officer or we're teaching you just how to be an enforcer and a punisher, that's a different type of training than if I'm trying to maybe help you as a police officer understand mental illness or understand what's going on if there is graffiti happening.

Do you have a sense that the professional development or the training that's being offered to police officers is keeping up with the model shift?

MR. SOUSA: It seems to me -- essentially the question is, it seems to be that it varies quite a lot. And again I fall back on the fact that we have 17 -- roughly 17,000 police agencies, most of which have an extraordinary amount of autonomy when it comes to their own training techniques and their emphasis more than officers. So, it would seem to me that some of this type of training works better in some places than in others and some academies than in others.

But I should -- related to that, one of the difficulties that we have and where many police agencies struggle now is the recognition that proactive tactics can be effective, at least in terms

of reducing crime. But that it can be -- what happens is, police agencies are tied to the 911 system. And what has happened is, they can't stop responding to 911. But they really created a monster back in the '50s and '60s when 911 came along. They really created a monster, because it -- it brought this sort of sense, on the part of citizens, that for any little problem that occurs in life, what do you do? You call the police, and the police show up. Well, now the police are now tied to that.

And I talked to police around the country, and they will tell you, "Foot patrol is effective, because it engages citizens more. Working with businesses on crime prevention works better in the long run, but it's very difficult to do that, because we can't stop responding to 911." And -- and so police have to keep training on 911, because that's -- that's essentially the system that we've developed.

CHAIRPERSON BLAYLOCK: Kay Kindred.

MS. KINDRED: Dr. Sousa, thank you for being here. You mentioned that one of the obstacles to effectively implementing community policing is -- is a lack of communicating the objective to the -- to the affected communities well enough.

How might police better communicate their --

their goals and objectives of that program? And are there other things that you can think of that are -- are -- aside from resources, that might be a significant factor in impeding effectiveness of this model?

MR. SOUSA: Well, yes. So, I think that a number of agencies have dealt with this particular issue in -- in a number of ways.

It's often been the case in an agency, the way that these agencies are structured, that you have -- most of your precinct-level or local-level police are handling 911 calls. And then when there is proactive activity, you have a citywide unit or you have some sort of regional unit that goes in. But when that sort of thing happen, then you have people who are unfamiliar to the citizens. The police are unfamiliar with the neighborhoods, and the citizens are unfamiliar with those officers; right? And so what's happening is, you know, if you see police arresting your neighbor, you might, you know, even if you suspect your neighbor might have been up to no good -- you wonder why the police are there. And you see officers who you are not familiar with -- because they're not from that area. -- who are doing the enforcement.

However, if -- if you use officers who are familiar with the neighborhoods, who are familiar with the citizens, and through various mechanisms, whether it's community meetings, whether it's church meetings, you communicate the message of "here's the problem in the neighborhood," "here's how we know we can resolve it," and "here are the officers who will be doing it," that sort of message is much better received than just, you know, the, quote, old crackdown in areas.

CHAIRPERSON BLAYLOCK: Mr. Ponder.

MR. PONDER: Professor Sousa, you had made a statement that you have worked with other police departments across the country. And you had made mention of some: New York, LA.

As it relates to community policing, how well are we doing here in our local community compared to other community policing models across the country?

MR. SOUSA: I would say, generally speaking in terms of Las Vegas, Las Vegas is -- is considered a -- a progressive department relative to other cities. But what I -- I'm always very reluctant to compare, because the cities are just designed so differently.

In Boston -- Boston, for example, they take -- they use foot patrol and local police officers doing foot patrol, and they do that very effectively. But

here you put officers on foot in some of the neighborhoods here, and you could walk for days and not see too many people. And so, it's -- it's -- it -- it's -- it -- it -- the tactics are very different from place to place.

You know, the -- for years San Diego was known as the problem-oriented policing strategies, reducing crime in San Diego. New York City was known for auto maintenance and "broken windows" policing. And so different places have reputations for -- for different styles of community policing.

But it seems to me, the way that Las Vegas often communicates with residents, Las Vegas Metro certainly communicates with residents very often. There are a variety of mechanisms that they do to do that. And -- and it seems to me that -- that foot patrol, for example, is really a metaphor. It's a metaphor for citizen desire to communicate with police and police willingness to communicate with citizens. And while that can be accomplished in Boston via foot patrol, here it's being accomplished in other ways, through different types of meetings with citizens and outreach efforts that are going on really at the neighborhood level.

And it seems to me that a lot has been done in

terms of pushing authority down to the area command level, which is what we have here in Las Vegas, and giving authority to the captains in charge of area commands to communicate with the local areas, essentially being chiefs of their own areas.

MR. PONDER: Thank you.

CHAIRPERSON BLAYLOCK: Mr. Sousa, I have a question. And thank you for being here.

You had mentioned that, when it comes to public opinion of police, that they're rated relatively highly.

When you drill down into that data, whether it's by generations or community of color or the LGBTQ community or other diverse groups, is that information similar, or does it differ?

MR. SOUSA: So, again -- I'm sorry I didn't make that point a little more clear in my talk.

So, there is some variance by demographics. Youth minority citizens don't necessarily -- generally speaking, across demographics police rank pretty high relative to other, and the confidence in the police is relatively high. There is variance within demographics, even though, for the most part, citizens are -- have a lot of confidence in police and rate police very high in terms of ethical standards and

these types of things.

But, yes, to answer the question, there is variance there. Youth often don't rate -- rank police as high as older generations. Minority citizens often don't rank as high as whites.

So, there is some variance, but overall one of the remarkable findings that we have when we do research on -- in surveys of the police is, when you go out to the neighborhoods, for the most part citizens are very supportive of police. And, in fact, the response is usually, "Why aren't they here more often?" or "We don't see them enough."

And so it's -- it's -- it's across demographics, but, yes, there is some demographic variation.

CHAIRPERSON BLAYLOCK: Thank you.

Yes. David Fott.

MR. FOTT: Yes, sir. Thank you for being here.

Is it possible to make a general statement about the effect of -- of community policing on morale in the police department, or does it vary widely by location?

MR. SOUSA: That's an excellent question, and I would hazard to guess that it does vary quite a bit.

But I will say that what we find -- and a lot of this has been done through foot patrol programs. But what we find is that police who have the greatest job satisfaction, who are the most comfortable in the community and feel safer, are police who are on foot patrol. And there have been a number of studies over why that might be the case or -- or there has been a hypothesis of why that might be the case.

And one of -- some of the suggestions would be that the car is really a barrier. And the -- it prevents citizens -- police are only showing up when there is a -- tragedies occur. And, you know, researchers have asked foot patrol officers, "Well, why" -- you know, "Aren't you worried about backup?" or "Aren't you worried that, you know, you're not defended?" And the response is a question which is anecdotal. The responses are, "I have all the backup I need." And they're referring to the businesses, and they're referring to the residents that are around them. Because when push comes to shove, if someone is harassing the foot patrol officer, it's often the local businesses who come out; it's the residents who come out in defense of that foot patrol officer.

So -- so, what I would say to the question is that there is some suggestion that, at least in terms

of certain community policing tactics -- that they can be very effective in terms of morale, in terms of satisfaction with their job, in terms of feelings of safety on the officers themselves.

CHAIRPERSON BLAYLOCK: May I add some follow-up to that question?

It -- here in Las Vegas. So, it would be difficult to have a foot patrol in some areas of the city.

What would you suggest would be the most effective tactic here?

MR. SOUSA: Right. And so -- and again I -- I -- I'm -- I'm keying in on foot patrol, because that's the most visible tactic that's associated with community policing. But what I would say is that in certain parts of the valley you can do, you know, bike patrol. Foot patrol can work if you think about the tourist areas certainly.

When it comes to the residential areas, you know, as I said, these sorts of tactics are a little bit more difficult to -- to employ, but again foot patrol -- if you think of foot patrol as a metaphor for the desire of citizens to communicate with police and police to communicate with citizens, how can that be done? You can do this through a church group. You

can do it through community centers. You can do it through routine attempts by the area commands to communicate with business groups, with youth groups.

And so it seems to me that if you think of foot patrol as a metaphor for that desire for citizens to communicate with police and also police willingness to communicate with citizens, then there are other mechanisms for that to occur. And I think many of those mechanisms go on here in Las Vegas.

CHAIRPERSON BLAYLOCK: And would that be similar for northern Nevada as well and for rural areas throughout the state?

MR. SOUSA: Certainly. Now -- now, again, I -- most of my experience is here, and my experience tends to be more with larger urban environments than with more rural areas. But we can see the analogies, too. But, you know, rural policing is very, very different than -- than urban policing. There are -- you know, there are parts of Nevada where someone might be a couple hours away from a patrol car getting to you. And so how citizens there relate to police is much different.

However, in those areas it's often the case that there is a more personal connection between sheriffs' offices and people who live in those rural

areas, because they rely on them not just for -- for safety related to crime but for other emergency types of situations, and theirs is more of a personal connection.

CHAIRPERSON BLAYLOCK: Thank you. I appreciate your being here, and the information that you shared with us is very valuable.

Thank you for the comments from the committee. And this concludes our first panel of Community Policing and Crime Reduction. Thank you.

MR. SOUSA: Thank you.

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UNDERSTANDING MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM I

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LINDA MARIE BELL, Chief Judge, Eighth Judicial District Court
BITA YEAGER, Hearing Master, Eighth Judicial District Court
LISA ANN RASMUSSEN, Attorney
NITA SCHMIDT, Captain, Las Vegas Metropolitan Police Department

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CHAIRPERSON BLAYLOCK: The next panel will be Understanding Mental Illness and the Criminal Justice

System.

Thank you for coming. This panel is Understanding Mental Illness and the Criminal Justice System. The speakers are Linda Marie Bell, chief judge, Eighth Judicial District Court; Bita Yeager, hearing master, Eighth Judicial District Court; Lisa Ann Rasmussen, attorney; Nita Schmidt, captain, Las Vegas Metropolitan Police Department.

Thank you for being here. And if we can start with Linda Marie Bell...

MS. BELL: I put Hearing Master Yeager in charge of the PowerPoint here since she has been instrumental in putting all of this together. So...

Good morning. I'm Linda Bell. I'm the chief judge for Eighth Judicial District Court. I have had many years of being involved with our specialty court programs. I ran all of them at some point for about three years. And currently I handle our veterans treatment court in a program called open networks with youthful offenders as an alternative to prison.

We -- I think that specialty courts are the best example of what we can accomplish when we come together as a community. It's a fabulous partnership with probation in the courts to ensure that people have every opportunity to succeed on probation.

Sometimes it's a diversion program so the person ends up not having a felony on their record, so that they can be successful and not reenter into the criminal justice system. In fact, we have a few of our excellent probation officers here from veterans treatment court and mental health court who are really the backbone of these programs.

The specialty courts help increase public safety, keep a very close eye on all of our participants. We have specially-trained probation officers that are very dedicated to these programs, reduces criminal recidivism. The NACD (phonetic) numbers are 10 to 15 percent reduction in recidivism -- obviously improves the quality of people's lives. We understand that the increase in substance use over someone who's not involved in a specialty court program is about 20 percent. And it saves money. It's less expensive, are less expensive than having somebody in jail.

The mental health court that Hearing Master Yeager runs cost about $51 a day as compared to a hundred and $55 a day to house somebody in jail. So, it's a huge savings -- and then obviously the ongoing savings of having people not reenter into the criminal justice system.

I recall we had one participant, when I was running the mental health court, who had been arrested something like 35 times in the two years or so before she came into mental health court. In the time she was in mental health court, she was arrested three times, and they were all for violations in the program basically that we -- we had. Her probation officers had taken her into custody, because she was having issues in the program. And we see those huge differences consistently in these programs.

MS. YEAGER: Okay. So, just to give you a overview of -- Bita Yeager. I run the mental health court for the Eighth Judicial District Court.

So, our mental health court was created by statute. So, a defendant with a serious mental illness can enter mental health court either, as Judge Bell said, through the diversionary process where they enter into a guilty plea and are placed on probation but, if they successfully complete their probation with mental health court, then the case gets dismissed, or as a condition of probation. Currently the majority of our mental health participants are coming through as a condition of probation.

So, mental health court has been concentrating on the severely seriously mentally ill. So, just to

give you a -- an example of what I'm talking about, when we're talking about serious mental illness, we're talking about conditions that can be treated with medication. So, the majority of the people that we have in mental health court has schizophrenia, schizoaffective disorder, bipolar disorder, some PTSD, major depressive disorder with psychotic features, those kinds of things. So, we're really concentrating on not just the seriously mentally ill -- because that is certainly overrepresented in our criminal justice system. -- but the severe part of that. Those are the people that we've found, without the specialized probation officers that we have, without those additional supportive treatments in place, would fail miserably on probation. So, that's why we've concentrated on that.

There is some confusion sometimes about the people that are -- that should be in mental health court. We get some referrals for personality disorders, which is not something that we can treat with medication. Sometimes people look like they're mentally ill, because it's a substance-induced psychosis or traumatic brain injury, that kind of thing. But what we've done is, we have licensed clinical social workers who are coordinators who meet

with the participant, make sure that they have that serious mental illness and that it's on the severe side before we decide whether or not they can enter mental health court.

So, to be eligible for mental health court, you have to have a serious mental illness. Like I said, we're concentrating on the people that have frequent hospitalizations. Also, I would say that the majority of our participants also have co-occurring disorder, meaning that they also have a substance abuse issue. They have to be involved in the criminal justice system.

There are some challenges. Eighty-six percent of our applicants who come in to us come in homeless, which means that they have to live in supported living arrangements. If someone has a sex offense or is an arson, there is an arson crime, it's more difficult to be able to house them in those supported living arrangements. So, that's one of the challenges that we have. But each of those applicants are considered on a case-by-case basis. So, we look -- you know, violence -- violent crimes do not preclude someone from being in mental health court. It just depends on, you know -- was it during a manic episode? Were they on their medications? So, we look at all those

kinds of things to see if we believe they would be a good candidate for mental health court.

So, for the process to be in mental health court, there is a special court application that goes to our court system that gets funneled to our coordinators. Our coordinators then meet with each of the potential applicants in person. They have an interview from like an hour to an hour and a half. They review all the medical records that look at the history of serious mental illness. And then our -- our mental health court team meets and invites the defense attorney to come, and then we talk about whether or not that person would be appropriate for mental health court.

So, we recently changed our mission statement, because we recognized that the individuals that come through our mental health court are not going to be with us forever. So, as part of our process, we are making sure that we're teaching them about their mental illness.. Some of them come in with very, very little insight to their mental illness -- so, about medication management, coping skills, also substance abuse to make sure that they have the supports in place to support their sobriety. And we're also working on ways to address their antisocial criminal

thinking parts. That's -- that's more of a challenge, because there are fewer resources available in the community to address that. But that's something that we're currently working on. But we want to make sure that the individual is taking ownership and responsibility of their individualized treatment plan.

So, that's how we've shifted our mental health court mission statement to make sure that it's on the individual to be able to make those choices and to also participate in their individualized treatment plan.

So, some of the benefits of mental health court is that we work as a full team. It's coordinated. When we talk in our treatment team meetings, we get information from the therapists to make sure that our -- our participants are on track. We get information from our probation officers and our case managers and our court coordinators so we can talk and see the individual as a whole, you know, what's going on with them, if there has been some behavior issues, is there something else that's going on. So, it's really truly a partnership between all of our criminal justice partners.

I also want to recognize Captain Schmidt who's here with the Clark County Detention Center. They

have a third-party provider, NaphCare, which does the psychiatric services. So, if, for example, in mental health court, because a participant needs to be taken into custody as a sanction -- our court coordinators communicate with the NaphCare CCDC provider to make sure that that person continues to have their medication while they're in custody, because certainly not having their medication would have very bad results.

So, what we also have as far as benefits, we have case management services. And we continuously monitor their treatment. So, we want to make sure that we address any therapeutic interventions that is necessary for the participant.

So, the -- for mental health court our average participant on a felony or gross misdemeanor is there for about 25 months. For a misdemeanor, a participant, it's about 15 months. While they're in mental health court they cannot have any alcohol, illicit drugs, marijuana, because that interferes with their medication. And the -- the -- those who are starting out earlier, I see them weekly -- I mean -- yeah, weekly. And then as they progress, then they -- then the time between court monitoring increases. So, we also monitor -- make sure that they're going to all

their treatment and that they constantly communicate with their case manager. They're required to check in with their case manager every Monday.

So, our goals for our mental health court participant is that we are teaching them the psychiatric goals to understand and have insight into their mental illness, understand what their diagnosis is, to be able to know what symptoms that their diagnosis are, what medication they're taking, what that medication actually treats, so that way once they are done with our mental health court, you know, when they're in the community -- that they can advocate on their behalf and with their doctors and -- and -- and make sure that they are constantly making sure that they're addressing those mental health needs.

In addition with substance abuse, we -- you know, we teach them and get them into the interventions that they need to as far as treatment. And then they -- they can work on supportive services once they're done with mental health court. We also have life skills, the -- the BST workers, and other interventions that are in place to help them become more independent.

So, we have our -- our mental health court is divided into four phases. I'm not going to go through

all of those phases, since you have that available in your -- in your paperwork. But that gives you kind of an idea of what our strategic goals are when we're talking about how we treat and work with our mental health court participants.

On graduation I give my mental health court participants a hug. It makes my marshals a little twitchy, but it's very important to -- to -- to recognize their accomplishments. And, you know, it -- it is very important, I think, for each of the mental health court participants to know that we care about them, that we want them to succeed, that we're invested in their success. So, I think that when we treat them that way in our mental health court, it really makes a difference.

So, just to give you some of our current challenges: Due to monetary issues, we currently have about 50 people on our wait list, which equates to about six to seven months that they need to wait while they're in -- or until they're able to be in mental health court. There are long wait times for residential treatment and especially for female residential treatment. That's a current challenge right now. We also have challenges with housing for the supported living arrangements. And, of course,

our caseloads are always growing.

You know, I have to recognize my probation officers -- I have a couple of them right here. -- who are with mental health court. You know, I would say that for those police entities that are having that constant contact with people who are mentally ill, there is no one more experienced than one of my four probation officers. They really are up to the challenge and do a wonderful job.

And I just wanted to point out a new program that started. So, assisted outpatient treatment is not a new program, but it's just that in our last legislative session they have allowed for people who are on probation, as a condition of probation, to do assisted outpatient treatment. It's actually a civil process. So, if you've heard of a mental health commitment, then what happens with assisted outpatient treatment is that they are committed to a lesser restrictive community program, which is the assistant outpatient treatment which we've had in our valley since -- since 2014. These are the people who are really, really -- I mean, when I say mental health court is this mentally ill, like our assisted outpatient treatment, you know, really has the frequent hospitalizations. And the one additional

aspect of assisted outpatient treatment, because it actually is a civil commitment, if they are not taking their medication, they can come on in court for a motion for medication against their will, so that they make sure that they're taking their medication. So, these are the people that are treatment resistant.

So, just to give you some statistics: Since the start of AOT, which has been more on the civil side this entire time -- this kind of gives you how many people have been in AOT. Currently there are 75 participants. Fifteen of those currently are probationers.

And then I'll turn it over to Judge Bell for mental treatment. All right.

MS. BELL: All right. So, the veterans treatment court is a wonderful program to help our members of the military and veterans who struggle because of issues related to their service. The statute allows veterans to come into the program -- and I say veterans. We also have active members of the military, but, truthfully, our program primarily has veterans. So, I'm just going to use that term.

But the veteran can come in either as a diversion, so that if they complete the program successfully, they end up with no conviction on their

record, which is a decision that's made generally by the DA's office in agreement with the defense lawyer, or as a condition of probation. Those are the options. Sometimes it's an alternative to prison if the case is fairly serious. That may be an option that the sentencing judge feels more comfortable with than putting somebody on general supervision probation, because we have more -- there is a little more supervision and more resources that can be focused particularly on the veteran.

The requirements for the court is that the person has to be a veteran or active member of the armed forces, and they have to have an issue related to their military service. So, mental illness, substance abuse, posttraumatic stress, traumatic brain injury, or military sexual trauma -- so, that's the psychological issues that come from sexual harassment or sexual assault while serving in the military, which, unfortunately, is something that we see.

Veterans are ineligible if they have a dishonorable discharge or they have previously gone through the veterans treatment court program. The application process is similar for all of our specialty courts. So, there is an application. We have a coordinator who is a licensed mental health

professional who goes over and meets with the veteran, sees what their needs are and sees if they would be a good fit for our program.

The benefits of the program really -- this is the great thing about the veterans treatment court, is the community partnership. We have people from the veterans administration, from the vet center, which is a counseling agency separate from the VA that provides services for combat veterans primarily and victims of military sexual trauma. Our probation officer and the team all gets -- and then other treatment providers -- and we all get together and meet before court to talk about the participants, what we can do to make sure that they are successful, what services they need, if they're going to treatment. And -- and that coordination allows us to provide the best possible services and the most options to the person who is participating in the program, so that if they fail in the program, it's because they didn't make good decisions. It's not because they didn't have the resources that they needed to be successful.

Our veterans court also has phases, which I am not going to go through. But we -- you know, I see the vets more frequently. It's every two weeks, and then it goes to every four weeks as they move through

the phases and they're being successful. With our goal of graduation day, we have an amazing community partner called Quilts of Valor. And you can see in the pictures. So, every vet who graduates gets a quilt that's specially made for them, and we wrap them. So, it's very -- it's very emotional actually, the graduations, and it's really quite an honor to work with that organization. They put in so much time. And then we had as many -- we have -- I think we had six graduates, and they had a quilt for every single one of them. And we do think it's important, as Hearing Master Yeager said, to recognize the success of our participants in -- in moving forward. And they work so hard. We require so much of them, you know: drug testing and counseling and coming to court. And to get through one of these programs is a true accomplishment for -- for every participant, whether they're in mental health court or veterans court or any of our specialty courts.

Some of our challenges, of course, are dealing with veterans who have other than not just honorable but other than honorable discharges who don't necessarily have eligibility for all of the benefits that the veterans administration offers. Then we have to try to find other resources for those people. We

don't want to turn them away, but sometimes it's difficult to find other resources for them, including, you know, medical, mental health. Housing is a big -- a big issue. We have a lot of vets who come to us homeless. We have great resources through the VA. If we don't have those resources available, then that can be a little bit of a struggle.

And then if we have people who have really serious mental health issues, sometimes inpatient counseling for serious substance abuse issues, that could be a bit of a challenge for us, too. Transportation is always a huge issue for veterans treatment court and for all of our other specialty courts, because if we have people who are not financially -- you know, they don't have a car. Some people don't have a license. We have some of our vets that are disabled and not able to drive. So, to get to all of the many places we require them to go can be a struggle. It takes you two hours to get to do your drug tests on the bus and two hours to get back, which doesn't leave a whole lot of time in the day to do other things.

And then finally, we have a mentor program. It's a little bit of a fledgling program. We've -- and so finding folks who will come and mentor the

vets, sometimes they can help fill in a few of those gaps, you know, take somebody to get their driver's license or provide moral support for our vets. It's the best practice. And so finding, identifying people who are willing to make the time and commitment to help out the people in our veterans treatment court is another challenge that we have.

And that's all I have on veterans treatment court.

MS. RASMUSSEN: Hi, I'm -- I'm Lisa Rasmussen. I'm an attorney practicing here in Las Vegas. I have -- oh, I think I've got this on my slide.

So, the origin of my cases are a combination of retained clients, appointed clients. I represent people in state court and in federal court. I -- really glad I get to talk to you today, because I think I'm kind of the only one here who brings to the table what it actually looks like to have clients with serious mental illness and mental health issues.

So, in -- in kind of getting ready for today, I was looking through my caseload and trying to figure out, you know, how much of an issue is this. It's a substantial issue. I -- I estimated, just in going through my felony kind of serious cases -- and that tends to be more the kind of cases that I get. --

probably 25 percent of my clients who were involved in the criminal justice system have mental health, mental illness issues. Of those -- and the majority of them are the kind of people who qualify for -- for Hearing Master Yeager's program. So, there are serious mental illness issues. They're bipolar, or they're schizoaffective, schizophrenic with, you know, depression, with psychotic features. It's a high number, and it's a surprisingly high number.

But in -- on the other hand, it's also not, because here they are. They're involved in the criminal justice system, and now I am -- you know, they have to have a lawyer to represent them.

In talking with some of my colleagues who do kind of lower level misdemeanor type crimes, who have tracks where they represent clients in municipal court, it's even higher for them. Their caseloads -- they're looking at probably 30 to 35 percent of their caseloads represent people with mental health issues. So, these programs that we're talking about are important. It's unfortunate that they're underfunded. I think we need, you know, at least twice the capacity, frankly. And that -- that ought to be some of the goals that we're looking at in the state of Nevada.

So, I wanted to just show you and give you some examples of what it looks like. This is one of my clients from Carson City. I practice all over Nevada. And I'll also say, I think the problems with mental health overlap with the criminal justice system are even worse in the rurals (phonetic). And I -- I don't know why that is, but I have -- you know, in my -- my -- if I looked just at my caseload in Pahrump, probably 50 percent of my clients there have mental health issues.

This particular case is from Carson City. Michael is a Native American. He is -- I guess we would call him homeless, but he sort of lives up in the mountains in the forest. So, he seems more like a homeless mountain man, what we could call an urban homeless. And that works for him. He has contact with his mom. She helps him when he needs some money and resources. She makes sure he has money for food. He works in the logging industry intermittently. But he is mentally ill and doesn't really like the noise of society as we understand it.

So, on this particular occasion how he became my client is, he took a shuttle down from Lake Tahoe to Carson City to see his grandmother who's 95. And he got off the shuttle and basically sat down his

backpack, pulled out his cigarette pack to have a cigarette, and an officer came up to him and started asking him questions. And he felt offended by it. And after really several minutes of conversation, he just turned and ran. And then the officer, of course, chased him and tackled him, and they kind of wrestled. And then he got up, and he pulled out a pocketknife and, you know, went like this to the officer and actually scraped the officer on the head. And the officer shot him five times.

He's lucky to be alive. He was seriously wounded. He has basically -- was shot in both hands and in the abdomen. He doesn't have really opposing thumbs that work anymore. And he -- nobody really recognized -- and I use this as an example, because nobody recognized that he was mentally ill. He -- finally the jail at Carson City realized that something was going on when he, after he -- well, the hospital kind of realized things were problematic, but once he got pulled up to -- the jail said, yeah, this guy is psychotic. So, he went to Lakes Crossing, which is where we send people for restoration of competency. And they recognized the serious mental illness.

But, you know, the initial contact with the

police, there wasn't a recognition that something wasn't right with him. And instead it turned into, you know, a lengthy conversation with a guy who really wasn't doing anything wrong. And I feel like, you know, these are the examples of where we could perhaps be a little bit better at identifying that some people aren't committing a crime; they're just mentally ill; and when somebody seems off, it's not because they're trying to hide -- hide some criminal behavior. There was no, you know, crime reported. The officer even said he was just patrolling the community and decided to talk to him.

So, there -- there are many instances where I think we could be better at identifying, in the street with community policing, mental illness issues and -- and then deciding, you know, how to react. It goes to what Professor Sousa was saying earlier: How are we going to react? How are we going to identify these issues in the street?

He -- this is him after being taken to the local hospital before he was Care Flighted into Reno. This is what happened to the officer. And the officer was injured. And I'm not suggesting that there wasn't -- that there was an inappropriate use of force. I just think that the whole thing didn't have

to happen if someone were just understanding what they're dealing with in talking to him in the initial conversation.

What you see here -- and this is very common with mentally ill people involved in the criminal justice system. The -- and I pulled these notes from -- from some of his paperwork. His previous legal involvement is arrests in Nevada and California for trespassing, disorderly conduct, unlawful use of 911, possession of a firearm, under the influence of drugs or alcohol, and a domestic battery. He's never served a prison sentence. He has no serious prior criminal record. And this -- these are very common crimes that you see with mental health issues in the criminal justice system. It's this disorderly conduct, trespassing, you know, something looks out of place. And what's out of place is, they're mentally ill, you know, not that they're really -- if it were me, you know, in the same location at the same time, it wouldn't be odd. It -- and officers pick up on the fact that something seems odd, but what's odd is, they have a mental illness; they're just off. So, it's the kind of minor, petty, ongoing involvement that's typical of clients with mental health issues.

Here is how he was exhibiting at the time that

he was in the hospital: He was making grandiose-sounding statements. He exhibited mood lability with frequent irritability and anger, again all common symptoms of people with mental health issues.

The second case is Patrick. Patrick was -- is a college graduate. He is a bright kid. He's in his -- he's 24 years old. He had his first diagnosis of bipolar disorder in Chicago when he was visiting his parents in December. They got him stabilized on medication. He has worked for national parks throughout his college career and wanted to go to Death Valley before starting a job for the summer up at Olympic National Park where he was going to work for the U.S. Forest Service there. He told his parents he was going to go to Death Valley first. This is in March. Then he was going to head up to Washington to start his job in May. They were a little worried about it, wanted to make sure he stayed on meds. He came to Las Vegas. He didn't stay on meds.

He ended up hitchhiking after all of his things were stolen from him. He had only a pair of shorts on. He ends up hitchhiking to Goodsprings, Nevada and basically walked in some lady's back yard

and asked if he could have her phone. And she said no, and she called the police. He ended up going in her house and falling asleep. SWAT came. And SWAT, to their credit, recognized that something wasn't right. And they were able to arrest him without incident. I think SWAT probably has training with dealing with mental health issues more than the common -- common -- you know, just officers in the street.

But when I got his records, you know, he had been taken to -- I realize he had been taken to Sunrise Hospital the day before by ambulance, and Sunrise released him. They just released him, didn't do anything. He was in the middle of a psychotic episode. His incident occurred in Goodsprings. Like I said, he was wearing shorts. It was very cold. Everyone commented how cold it was. He had a blanket wrapped around him. That ought to have been an indication that there was a mental health issue.

SWAT did a good job. The officers who later took him to CCDC for booking -- he was booked for basically battery, because he got into a little wrestling match with this lady when he wanted her phone. They started asking him -- when I look at this transcript, they're like, "What are you, 25? You just

like to beat up 70-year-old women for no apparent reason at all? What are you, a rapist? A murderer?" And they keep trying to get him to engage in conversation. And then the officer finally says, "Ah, he's playing games. We don't have time for this." And they book him, with no recognition really that he's in the middle of a psychotic episode. No normal person would hitchhike to Goodsprings, Nevada, which is in the middle of nowhere, I think for, you know, some of you who may not know. But it's in the middle of nowhere. There is a bar and some homes out there.

CCDC recognized it, and they realized it right away, and they put him in what they call C2, their psyche ward. And he devolved further from there. He started eating his own feces in his little cell. And, you know, finally, because the parents found out from the park service that he was actually in custody, I got involved, got him to Stein Hospital. We got, you know, medication going, and medicated he's fine.

This is what it looks like to have these clients. This is how it looks on the inside. They have, you know, these kinds of issues. And now he's fine and we're able to resolve the case. I actually wanted a disposition that involved mental health court, but the prosecutor wasn't interested in it.

So, we are doing our own mental health program, and I have him -- he's out of custody. He's back in Chicago. I have him enrolled in an early psychosis recovery program at Northwestern University. So, we're kind of self-creating, because I'm fortunate in this case to have parents with resources, our own program to help him rehabilitate so that he doesn't become involved ever again in the criminal justice system.

I, you know, kind of wanted to sum up by saying, these are -- this is what I think is needed: We need law enforcement to have training that -- where they can recognize the issues, where they realize early on what they're dealing with in a conversation with someone. Sometimes people could appear sketchy, an officer could think, That's because they are hiding something or they're committing a crime and they don't want me to know. But oftentimes it's really just a mental health issue. First responders need -- I -- I frankly find that I think the ambulance and EMTs, they seem to cue into the mental health issues a little bit more easily than officers do.

I was, you know, pretty horrified, in Patrick's case, that Sunrise Hospital released him. He should never have been released. He was clearly

psychotic. He was saying things there like, what they said, you know, where -- "Do you have a phone?" And then he said, "Elvis Presley arrested me at the bus station and took my phone." You know, that was clearly an indication that he was having a mental health episode.

So -- and then finally, you know, I -- I find -- I'm very proactive on -- with my clients in making sure that I don't want them back in the criminal justice system. So, I'm often going to prosecutors and saying, "I would like to resolve this with a mental health component, either mental health court or treatment in the community. This is my proposal." And, for the most part, they're amenable to it, but it almost doesn't occur enough. They wouldn't come to me and say, "Hey, you know, we think your client has mental health issues. Let's see if we can get them into mental health court." It's always me suggesting it.

And I know that we also lack resource. I -- her -- Hearing Master Yeager's program is awesome. It's wonderful. And we just need 10 times the funding, I think. So...These are the challenges we face. This is what it looks like to have clients actually involved in the system.

MS. SCHMIDT: Hi, everybody. I am Captain Nita Schmidt. I am the bureau commander of the south tower bureau of the Clark County Detention Center. And I am over the medical and mental health contract. It is currently provided -- services are provided by NaphCare. I also want to note that I am over the largest mental health facility in the state of Nevada. And, yes, you heard that correctly. The Clark County Detention Center is the largest mental health facility in the state of Nevada. And that is common in many other states in the U.S. where the local jail and detention centers have become the mental health providers for those that are seriously and chronically mentally ill. I also have the privilege of being the first law enforcement officer to come and speak to you today and talk to you about the great proactive things that the Las Vegas Metropolitan Police Department are doing in order to address some of these very, very important issues.

And so, first off, I'll talk a little bit about the detention center side and kind of what we're experiencing. And I know that Judge Bell discussed this a little bit earlier. The cost of incarceration is significant. The -- the quote that she gave of a hundred and $55 a day, that's for an inmate that is

healthy. Many times people that come into our system are -- have neglected their health care, require -- require frequent trips to the hospital, additional medications, things like that. So, those costs are going to exponentially rise.

Right now about 20 to 25 percent of our inmate population are actively taking psychotropic medications. Those are the ones that we know about. So -- and those are also the ones that are compliant with the medications. Unlike a mental health facility that's like a state mental health facility where people are sent for competency restoration, we cannot force people to take their medications. They have the choice to take medications if they choose to. Many times they have had reactions to medications or side effects that they don't like. So, they're adverse to taking those medications. And it's a long process in order to gain that trust from people so that they will then be able to -- to see our providers as being true treatment providers, to be able to give them the care that they need.

One of the things that is unique about law enforcement response -- and the commissioner kind of discussed this a little bit. -- is that we've had to have a big paradigm shift in our -- the way that we

deal with citizens with mental health issues. Law enforcement officers are much more like social workers now than they ever have been before. I see the corrections officers that work in the jail where we have had this huge paradigm shift where it's teaching them on higher rates of communication skills and dealing with people. Currently our agency, about 80 percent of our commissioned officers are trained in crisis intervention. They receive 40 hours of training and then a refresher course every two years to keep them abreast, but they're not mental health care providers, and they're never meant to be. However, that has fallen onto law enforcement to address that issue. And we've seen that here in our department. Statistics show, since we had our crisis intervention team since 2003, that since we've been tracking in 2012, we're on track to double our response calls for people in crisis and double our commitments for a legal 2000 process.

My partner this afternoon, he's going to give you a little bit more discussion on community policing and things that we've done to address those issues. But for this year we're on track to outpace our number of about 34,000 calls for police service involving people in crisis. And approximately 11,000 legal 2000

holds for those are emergency mental health commitments. Hearing Master Yeager discussed this a little bit earlier, about how there is some significant issues with the legal 2000 hold process, and many times people aren't getting the treatment that -- that they're needing. Sometimes they are getting released relatively early without treatment. That is something that has been recognized by Nevada legislature, and as a result of that, there was a regional southern -- regional behavior health policy board that was created, and there is members of all the different areas that affect mental health in the community. I sit on that board as a member. And we have the ability to write a legislative note to be able to try to affect some of this significant change.

One of the biggest issues that we have is that we have this cycle. It goes around; right? You have somebody in crisis. The police are called. Police respond. There are no places for them to go. We don't have beds. We don't have large crisis units. With only about 8 percent of Nevadans not having health insurance, because Nevada is a Medicaid expansion state, they cannot go to our public health entities, so our Rawson-Neal psychiatric facility. They need to go to private facilities in order to have

their -- their medical and mental health care addressed over there.

So, arrest. They come into the jail. This cycle starts where we see them in the booking process, can identify them as being -- having mental health issues. Many, many, many times these are people that have come in and out through our system. And because they have come to us so many times, we have more medical records and mental health records than many other community providers do, and so they're able to start the treatment right away. Through our collaboration with the courts and with other community programs that are offering services, we're able to provide those avenues to be able to refer -- that's something that we just recently started with the mental health court process, is making referrals in-house to people who we think could be fit for some of these programs.

The average length of stay at the Clark County Detention Center is about 22 days. That's not a lot of time for us to affect real meaningful change. So, getting them through this process and trying to get them stable so that we can get them released back out into the community -- but if there is not that warm hand-off, if there -- if there isn't that community

support, if there aren't those areas out there that are able to get them the support that they need to address things like housing and medication and transportation and getting them to their appointments, that cycle is going to turn back around again and again and again.

And so the Las Vegas Metropolitan Police Department is committed to making some meaningful change to this. Earlier this year the sheriff assembled a team to -- for -- a mental health committee. And I also sit on that team as well as one of my officers who's in the back who runs the crisis intervention team program. And we're taking a look at -- it's several different things that our agency can do in order to address some of these issues -- recently took a team to Houston Police Department to take a look at their mental health unit that they developed, that they are pairing law enforcement officers and mental health providers out in a police car that go out to calls, that can then see people, follow up with people, kind of track things that way. We're looking at a model like that. We're looking at perhaps having our own mental health unit to address some of these significant issues.

Just as an example of some of the costs and

some of the things that we're experiencing: In 2017 there were over -- almost 11,000 legal 2000 calls. That's a cost of almost $77 million when you take a look at the costs for the call takers and the dispatchers and the patrol officers to respond, the ambulance to transport, the cost for the hospital fees, even for them to just see somebody. And that's on a good case. Last year the number-one consumer or the number-one super user of this resource was placed on a legal 2000 39 times, at a cost of almost $300,000.

So, with very little to go from, I think that we're doing -- we're making amazing gains in order to address some of these issues and to continue to take the pulse of this, to continue to have these relationships with other members of the criminal justice system as well as community members, and to be able to discuss these things and see what's truly needed in the community and try to provide these resources on our way out. But we can't do it alone. This has kind of been something that's been shouldered by the police department. And with a number of other different law enforcement issues to address, this is a big one for us, but we need help. Thank you.

CHAIRPERSON BLAYLOCK: Thank you. I'd like to

open it up to the committee members for questions, this panel. Carol Del Carlo.

MS. DEL CARLO: Thank you. And thank you so much for the work you're doing, all four of you. Wow.

We have a legislative session coming up next year. And I'm a native Nevadan, not that that matters, but, I mean, we have never put enough resources in the state into mental health. And I think mental health issues that we have in our state affect so many areas.

So, what would you suggest that we do in this upcoming session?

And I really think the economics have been really darn good, and I think we're going to have a little more money in the budgets next year.

So, what do you guys suggest, and who do you go to for all of this? And what's been successful or not in the past?

MS. RASMUSSEN: My number-one wish list would be more funding for mental health court. And I know, for example, in Nye County there is nothing. So, I've had people transferred to Hearing Master Yeager's program. So, they have got nothing there. You know, I think we -- someone needs to at least identify what resources are in the rurals (phonetic). Carson City,

I think, might have mental health court, but I'm not sure if they use Reno's.

MS. YEAGER: It's a muni court.

MS. RASMUSSEN: It's only muni court. Yeah. So, that is actually another common problem, is, we only have it in the lower-level courts, not for more serious felonies that happen in district court. So, you know, that would be on my number-one wish list.

And -- and also, you know, I think setting up something that could be done through the detention centers would also be incredibly helpful. And I don't know what their, you know, thoughts are or thinking on that, because there are a lot of people that have these overlapping. Like she said, without a warm hand-off, where do you send them? If we're going to release them, where are they going to go? Some of my clients have resources, but a lot of them don't.

MS. SCHMIDT: And as part of that legislative committee that I'm on, we do have the ability to have a bill draft, and that's been something that's been something that we've talked about in our last couple of meetings. And a couple of topics that we're taking a look at is a legal 2000 reform and kind of making it to be real meaningful treatment and not just having people -- I mean, as an example: We will have people

who are placed on a legal 2000 by our police department officers twice in a shift. And so obviously this is somebody who's still unstable when they're released.

And, you know, one of the things that I didn't -- I didn't bring up is that we live in this community, too. You know, we as law enforcement officers and as officers of the court -- you know, we have a vested interest. You know, my children go to school with many other citizens' children. And so as a citizen in this community, I think that we have the ability -- this is a community with a lot of needs and a lot of wants, and I think that we -- to -- to be able to get everybody on the same page, I think we're getting a heck of a lot closer, seen a lot of growth in this discussion points in the last couple of years. So, I think that we have the ability to put some real good legislation there in -- in the books.

MS. DEL CARLO: Thank you.

CHAIRPERSON BLAYLOCK: Theresa Navarro.

MS. NAVARRO: Thank you. Thank you all for being here. Thank you so much. I've been very educated today, which is very important for me as a -- I've been a community activist for 45 years in the North, so very involved on the community level.

So, I have an individual question for each of you that I'd just like -- for Judge Bell.

I just wanted to ask you, all the information that you gave on your veterans court, many people of the community don't even know about your veterans court.

And so I guess my question would be, Do you have like a community outreach, or do you have -- are there people that can actually go out into the community to talk about your veterans court? Because I think it's a very important issue.

MS. BELL: We do do some community outreach. We try to partner with veterans organizations, time permitting. We have -- like everybody, we're stretched in terms of time and resources. So, I have one coordinator that works with me on the vets program. And so when we have the ability to do that, we do try to go out into the community. And, in fact, we've been -- the first service event from the -- the Vietnam Vets of America gave all of the veterans courts in our county a small amount of money that we use -- they donated. We use it for bus passes and, you know, to try to fill in some of the gaps that we have. So, we do try to do that. We could do more.

MS. NAVARRO: Thank you.

Bita, my question for you is, you made a comment about -- that you work with all mental health issues except for personality disorder.

Can you tell me what that is?

MS. YEAGER: Yes. So, personality disorders are what would have been traditionally considered the axis 2 diagnoses under the DSM-IV. So, those are disorders -- it's called personality pathology, like narcissism. That's a narcissistic personality disorder. Borderline personality disorders are -- you know, usually their symptoms are that they are self -- what's the word? They hurt themselves; they're about drama. Those are kinds of things that can be treated with therapy but not medication.

And a large percentage of our mental health court participants also have a personality pathology along with a mental illness. So, you know, for those people we also try and get them -- you know, address those issues in therapy as well. But if someone just has a personality disorder, it's not something that's necessarily appropriate for mental health court.

MS. NAVARRO: Okay. That makes sense. Thank you.

And, Lisa, I think I -- I think you addressed what I was going to ask about an officer's training

and so forth and what is needed more for our community officers and so forth. And I know up in the North I'm on a committee with the police department, outreach committee, and that's one thing that we're really looking at. So, you did answer my question on that, and thank you.

Nita, I have a question for you. You made a comment about -- when you were talking about some of the issues that are some of the problems that you have. You talked about a Medicaid expansion, that that was an issue.

Can you explain to me what you mean by -- that you say that we're medicated -- we're a Medicaid -- Medicaid expansion state, which, you know, is one thing that we fight for in our community as activists. And I'm trying to find out why you made that statement that you feel that that was a problem.

MS. SCHMIDT: Yeah. Absolutely. So, one of the things that we did about two years ago is, I started a program at the jail where we were able to collaborate with the state, and we have the ability to have a Medicaid enrollment person in our jail facility. And now I have two. And so every single person that is sentenced or has an out date that we're able to do that discharge planning process with, every

single person gets seen for Medicaid, welfare, food stamps, whatever it is that they -- they may possibly need. So, those are all great things to have. However, in our state, one of our biggest issues is that we have a significant shortage of mental health workers in our state. And that's been something that's kind of exacerbated now.

I -- just my medical and mental health contractor, NaphCare, I've had three positions that have been unable to be filled now for several months, because there just aren't a lot out there. And there is positions that are open both with the state and the county as well. That's some of the things that I think that, with UNLV having their school of medicine now -- that that will kind of help to repair some of that, but there is a significant shortage all across the state. And if we're experiencing it down here, I know that they're probably experiencing it much more significantly in the rural areas and up North.

So, one of the things with the Medicaid expansion is that if somebody has insurance, they cannot go to a lot of these facilities that have -- that provide care for the uninsured, because those are things -- there is bed limitations. There is size limitations. They can't have, you know, crisis beds.

There is a lot of different limitations. So, it's kind of a double-edged sword there. It's great that we have Medicaid that we can offer people, and it's great that they have the services. But with having a shortage and not having a lot of bed space and a lot of places for people to go, sometimes the only place for them to go is jail. And -- and that is often not the best place for them to be.

MS. NAVARRO: Thank you.

CHAIRPERSON BLAYLOCK: Thank you. I have a clarifying question for Bita Yeager.

MS. YEAGER: Yes.

CHAIRPERSON BLAYLOCK: The DSM-IV, is that the Diagnostic and Statistical Manual of Social Sciences?

MS. YEAGER: That's correct, but it's now the DSM-5. So, they don't have it under the axes anymore, but just for -- for ease of purposes, you know, we refer to that as the axis 1 under the DSM-IV so that people know.

CHAIRPERSON BLAYLOCK: Great. Thank you. I think we have time for one more question.

MS. COSGROVE: Question.

CHAIRPERSON BLAYLOCK: Sondra Cosgrove.

MS. COSGROVE: I really appreciate everything you all do. I'm in another organization, and we've

been looking at behavioral mental health issues since the last legislative session, because we really feel like we don't get very good outcomes when it comes to behavioral mental health. And then we do a lot of crisis triaging and trying to put out fires, as opposed to doing early interventions and helping people when it's less expensive and you can get better outcomes. And this is such a huge issue, though. It seems like there -- a huge puzzle that you're putting together. And when you put the puzzle together, you -- the piece that you guys represent is a big piece. And there is a lot of resources and money that are required to go into that piece, but I really don't feel it's the place where you get the best outcomes for the least amount of money.

But, yet, when I say, okay, this is something that's really important, the CCSD is missing 18 school psychologists. And they feel like they're saving money by not filling those 18 positions. But then when you're looking at the puzzle, you're like, You're spending $77 million on legal 2000s, but you're saving how much money by leaving open the 18 school psychologist positions. When we get to that point in the discussion, then usually I'm asked for data.

Can you provide me data that -- that this

would actually save money?

Then we wouldn't need to make the extra money, that we can maybe start moving money around if you caught somebody earlier.

Have you all thought maybe that there would be ways -- and I like what Lisa did where you gave an example where you can see the real people, people that are maybe coming through your systems, where you could get a life story on them, that maybe they could have been caught at the community college or they could have been caught at the elementary school or their family could have gotten social services. Because I think that's the data piece that we're missing, that we could possibly shift money around or use it better or invest more money and get better outcomes.

But because the puzzle pieces sometimes are in silos and creating their own data and not sharing, we're not creating debt that's useful, it makes it hard to go from where we're at to where we need to be.

Are you guys keeping data? I mean, are you thinking about the -- the qualitative narrative that goes along with your data?

MS. BELL: I think we would all agree that the criminal justice system is not the best place to solve all of these problems. We're just the end of the

road, and we are tasked with solving a lot of problems that don't get caught somewhere else.

You know, the average educational level somebody that comes through the criminal justice system -- they will say 11th grade, but it's probably more like 7th or 8th grade. We have high rates of illiteracy, all of the mental health issues that we see. It would be far better if those problems were solved ahead of time. How you capture that exactly, I -- I think is really complicated, because each person is so -- each person and each story is fairly unique.

So, I think it is a challenge, but I think we would all tell you that we all have stories of, you know, how the people that we see slipped through the cracks, sometimes repeatedly, to get to the point where we see them.

MS. YEAGER: I can tell you -- so, in addition to mental health court, I also do civil commitments. So, the legal 2000s, you know, the 11,000 funnel down to -- if they're -- if they are certified to be a danger to themselves or others within 72 hours, then it's set for a hearing with a petition. There are about 500 a week that are set, which trickle down to about between a hundred and 50 to a hundred and -- or

to 200 hearings a week that I hear.

I have -- I have asked, from just our case perspective, to be able to figure out who our highest number of petitions are. Because what I would like to do is then try and refer those people to the AOT program. So, we're looking at that.

We have started collecting data on -- or we're starting a process where we're going to start collecting data on the participants' perception of mental health court and what was most effective and what wasn't. So, at the beginning, at the middle, at the end they're going to be filling out surveys on that.

The issue with collecting data is, it costs money. It costs money to collect it. It costs money to analyze it. And, you know, we're already so stretched in our resources as it is that it's very difficult to be able to do that. You know, we've applied for grants that would allow for that, and we are still waiting to hear back on that, but I think that's one of the challenges that we have, is that it also costs money to be able to collect and -- you know, certainly if we can show our legislature, this is the efficacy, your dollars are much better spent here than they are other places, they would certainly

fund us more. The problem is getting the money to be able to show that data.

MS. COSGROVE: So, looking at the next legislative session, if there was an organization that went to legislatures and said, "You would be spending money wisely to provide system analysts for organizations to help them gather data, analyze data, and produce reports, that would give you a better way of knowing what outcomes are good and how you could be more efficient with the money you're spending," would that be something you would agree with?

MS. YEAGER: Oh, absolutely.

MS. SCHMIDT: Yes.

CHAIRPERSON BLAYLOCK: We're at the end of our -- we're at the end of our time. I would like to thank each of our panelists for sharing this information with us. I've -- I've learned a lot this morning. So, thank you very much.

We're going to take a 10-minute break. We will reconvene at approximately 11:10. So, thank you.

(Recess taken.)

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UNDERSTANDING MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM II

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DR. AARON E. BOMER, Director of Inpatient Social Services Department & Mobile Crises Team, Nevada Department of Health and Human Services
DR. JASON SCHWARTZ, Director of Community Support, University of Nevada Las Vegas, Medicine
SARA GORDON, Professor of Law, University of Nevada Las Vegas William S. Boyd School of Law

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CHAIRPERSON BLAYLOCK: Thank you. We'd now -- now like to introduce the Understanding Mental Illness and the Criminal Justice System II panel. We have Aaron E. Bomer, director of inpatient social services department and mobile crises team, Nevada Department of Health and Human Services; Jason Schwartz, Dr. Jason Schwartz, director of community support, University of Nevada Las Vegas Medicine; and Sara Gordon, professor of law, University of Las Vegas -- University of Nevada Las Vegas William S. Boyd School of Law.

So, thank you all for being here. And I will turn the panel over to Dr. Bomer.

DR. BOMER: Good afternoon. It's truly a --

I'm on? Okay.

Good afternoon. It's truly a honor to -- to be here and to address such a distinguished group of individuals, community partners on a topic that's near and dear to -- to my heart and have an opportunity to make comment. I'd just like to start by discussing the mental health crisis as it relates to the intersection with law enforcement.

I've worked in the mental health field for about 20 years. And I've worked with our local crisis response team. And I've seen the lack of collaboration with respect to law enforcement and mental health professionals. And I've also noticed that there is an opportunity to expand in these efforts for the benefit of mentally ill clients in our community.

And just to expand on that comment, I was looking at a really startling statistic that indicated that over two million individuals that are booked every year in our jails suffer from mental illness. That's a little less than the size of city of -- the state of Nevada. So, when I looked at that, I said, well, wow. Could we perhaps look at a better course as a community, in terms of our capacity to address and treat this extremely vulnerable population? So, I

went on to do some additional research, because I wanted the latest statistics. And it indicated also that 55 percent of women in prison suffer from a mental illness, a actual DSM diagnosis, 55 percent. I said, wow. That's just -- that's startling. And I said, well, as a community there are efforts, such as CIT training, diversion court. But there is a community effort, but I always wonder if perhaps we could do a better job, in terms of working together, working collaboratively, with respect to mental health professionals and law enforcement, to make sure that there is a -- an appropriate disposition for folks that perhaps should not be incarcerated but rather part of a rehabilitative model.

So, when we look at -- from a historical context in terms of how we got here, we notice that in the 1970s there was a de-institutionalization of mental health facilities, and folks were turned out to the streets. The medication got better, which it was a great thing. People are -- the quality of life, therefore, should improve and -- but one would have to spend the rest of their lives in a mental institution. But the community capacity did not grow with those initiatives. We did not provide adequate funding and training for officers who essentially are the first

responders, in terms of mental health providers. Those are the first points of contact, not -- not clinicians like myself. It's those officers. And one would have to wonder in terms of the toolbox to address some of these mental health disorders such as schizophrenia, PTSD, bipolar disorder, schizoaffective disorder and the like, and how does that impact those interactions with law enforcement and what could we do, from a mental health side, to expand -- help expand the toolbox and work with local law enforcement in that respect.

So, I'm really honored to be here and provide some incites from the mental health perspective on how we can do that. Thank you.

CHAIRPERSON BLAYLOCK: Thank you.

DR. SCHWARTZ: Hi. I'm Jason Schwartz, director of community support at UNLV Medicine, Mojave clinic. This is the behavioral health practice plan of the school of medicine. So, we're not actually part of UNLV the school, but along with all of the medical practice plans, Mojave is the behavioral health clinic.

Mojave originally was affiliated with University of Nevada, Reno School of Medicine. As you know, just last July, 2017 we added a second school in

Nevada. All of the practice places in the South re-affiliated to the South, to the UNLV School of Medicine, and the practice place in the North stayed with UNR.

I wanted to tell you a little bit about the history of Mojave, a little bit about the -- the population that we serve, what makes our SMI population relatively unique, our police relationships and involvement in community policing from the mental health side, and how our interactions with the police have grown and -- and then looking forward to issues that may be of import and assist in the future.

So, 1992, Bob Miller was the governor. The state had a huge fiscal crisis. And in order to resolve the budget crisis, Governor Miller closed all of the satellite mental health clinics in Las Vegas, only keeping open the West Charleston campus. Dozens of employees were laid off, and hundreds of clients lost services. That was the Valentine's Day Massacre on Friday. That weekend the director of human services for the State of Nevada, the dean of the school of medicine, and Mojave's founder got together, and on Monday the 17th Mojave opened to serve the SMI population who had Medicaid. And Mojave billed Medicaid underneath NSHE's provider number, which met

the federal requirements for CMS for how to build targeted case management for the SMI population.

Mojave grew from there. We're now serving over a thousand clients in targeted case management for severe and persistent mental illness. That's more targeted case management for that population than Southern Nevada Adult Mental Health Services. And the state and Mojave and the schools of medicine are the only sanctioned providers of targeted case management for the SMI population because of CMS rules.

So, that population, the folks that live with serious and persistent mental illness, our folks had to have Medicaid. And until the Affordable Care Act, that meant they had to have SSI. In order to qualify for SSI, you have to have had no appreciable work history in your life. What this means is that these folks had earlier onset and more profound symptoms than even other SMI populations. Otherwise, they would have SSDI, disability insurance. And typically disability insurance would raise their income above the SSI level, making them disqualified for Medicaid, although they would have Medicare insurance, two different things. Medicare doesn't pay for case management. So, they wouldn't be eligible for case management services.

So, Mojave now became a provider of services for the most profoundly ill SMI folks in the state. The state took folks who either didn't have insurance or who had Medicare. Mojave took the Medicaid clients.

I personally, as a case manager and a director of community support -- I always felt that it was important, as an administrator, to keep my hands in direct services with clients. I find in some institutional settings or treatment provision settings that the administration forget what it's like to actually do the service, and all of a sudden you get all of these mounds of paperwork that everybody has got to do, and they don't remember what that's like, that it interferes with services. So, I at least kept a small caseload.

I remember one time we had one gentleman come in. He was intoxicated. He stated that he had a gun and he was going to shoot the place up. We took it seriously, called police. The police came out. And he was kind of a dapper, older guy, very well coifed. I wasn't wearing a suit. I didn't have my badge on. The police immediately went to me and started to cuff me. And -- and I said, "No. No. No. It was not me." And we resolved that. It was no problem.

But another time I took a client to the bank to cash a check. And -- and we were walking out. There was a gentleman in a very big hurry. I held the door for him. And I go out and take the client home in my truck, go to pick up my daughter -- it's the end of the day. -- at day care. I walk out of the day care with my two-and-a-half-year-old daughter, and there are seven men with guns pointed at me, only one in uniform. I turn around. I said, "Would you please turn your hand back to the side, please?" I come out. Apparently the man that had robbed the bank took off running. The only car they saw leaving the parking lot was mine. They traced my license plate to my house, and my gun law wife gave me up. And so they -- but again, we resolved that pretty quickly. It was not a problem. Everybody had a good laugh about it.

Formerly Mojave started doing CIT training. We experienced very positive results of that pretty much immediately. When we call for a legal 2000 at Mojave because someone is either a danger to themselves or to others or on the verge of being so, we do the legal 2000. So, all those numbers you heard before don't even count, the ones that we do. The police are called to provide support in case the client becomes more riskful (phonetic) or acts out

with the ambulance there not able to -- the ambulance personnel not able to control the situation. But we -- a hundred percent of the time if we're calling for support for a legal 2000, we conduct the legal 2000.

There was often a response from officers earlier in our existence where they would come in, they would be angry with us, they would be angry with the client, they wouldn't understand the abhorrent behavior that was being demonstrated, they'd expect them to obey. And you could see the disconnect and the escalation of behavior on the result -- as a result of some of the lack of understanding. After CIT, I would say it's 90 percent of the officers that we come in contact with have a much calmer understanding. Now, when they come to our agency, they already know what they're working with. They know it's a mental health. It's got to be a lot more difficult for them in the community where there is nobody -- no mental health professional to assist with the process. But still that CIT training is critical.

We haven't been doing it for a little while now. It became a little bit overwhelming for some of our clients. They escalated the -- the time line in terms of, every three weeks we were doing CIT. And so

we stopped. We're planning on re-engaging that process if they're still doing it. And I believe they are, from what we just heard.

One of the issues that has created -- I don't know if you know about the Tashii Brown case. He wasn't necessarily mentally ill, but he was tased seven times. He was at the Venetian, and he got chased by a police. He came up to police with this apparent ideation "people are after me", chased, tased seven times, put into a choke hold, and died. Some of the procedural elements of that arrest weren't proper. When it went to court, Steve Wolfson, the DA, called in Force Science, which is a company that teaches procedural elements to police forces. In fact, they have a six-figure budget with Henderson Police Department. But in all of the times that they have been called in to do expert testimony, they have never found against a police officer.

So, that kind of a decision interferes -- and again that's not the police. That was the DA's office -- interferes with the perception of community-based services from the police department, because here you have conflict of interest. They get money to teach the police. They don't want to find against the police in an expert testimony situation.

Looking ahead, there are a couple of things that I would like to see from the legislature. You guys asked. To me, if we can intervene with clients before they come in contact with the police and with mental health court -- Mojave provides mental health court services for Eighth District Court. For 50 percent of their clients they come to us if they have Medicaid. The ones that don't have Medicaid go to the state -- love that program. But that's after they have already been engaged multiple times in the justice forensic situation. One minute and -- okay.

So, what we need -- what destabilizes clients? People in targeted case management have a full wrap-around component to their program, and they do much better than folks who are unsupported in the community. There is a huge reduction in hospitalization, huge reduction in arrest rate. But what mostly destabilizes these folks is lack of housing, lack of affordable housing. They get $750 a month. Apartments in Las Vegas are $900 a month -- can't do it.

We get no legislative funds. UNLV gets no legislative funds for supported housing. That would be huge assistance. Basically anyone who has Medicaid is denied housing assistance, because the only housing

assistance goes to the state. It's almost a homestead decision violation, fear -- the worst-served client or the client with the highest symptoms in the state, you're the one that doesn't get any support services. So, we would like to see housing assistance to UNLV.

And then, secondly, if you have a substance use disorder and you live in a group living situation, the house provider is allowed to hold your EBT card, your food stamp card, and you're allowed to eat together. If you're in a mental health situation, you're not allowed to. The client has to have their own card. You're not allowed to hold it for them. They're not allowed to eat together. They have to eat as a separate domicile. That's a very simple change to the Medicaid manual, because our clients, they lose their cards, they trade them 50 cents on the dollar for money, or they go to the 7-Eleven and eat junk food for way too high price, and so then they don't have food at the end of the month. And food insufficiency, another big destabilizing factor that leads to forensic involvement. Thank you very much.

MS. GORDON: All right. Okay. Can you hear me?

All right. So, I have slides, because I always have slides. So...All right. And actually I

think if you have a printout of my slides, I have updated them. So, they're similar but not exactly the same to what you have in front of you.

So, good morning. I'm really happy to have been invited here today. I'm Sara Gordon. I teach at the law school at UNLV. I teach -- I teach and write about mental health law and criminal laws. So, this is sort of right up my alley. And I'm grateful to be here. I'm going to talk to you a little bit today about research that I have done on mental health and specialty courts. And I caught the tail end of the last panel. And so I'm going to try to make sure I'm not redundant and -- and maybe add a little bit to what they already said, although I didn't hear the whole thing. So, I will do my best.

As I think everybody here knows, a good number of -- sorry, my glasses these days -- a good number of people in Nevada who are arrested or become involved in the criminal justice system are diverted into specialty courts or problem-solving courts. And I've done quite a bit of work with problem-solving courts and specialty courts, and a lot of what I try to do is educate judges, court personnel, and also law enforcement, all of whom are involved in -- in one way or another within the specialty court system, about

the course of the disease of addiction. My work primarily focuses on addiction. And I hopefully get to raise awareness a little bit about best treatment options. So, I'm going to try to do a little bit about that today.

And I want to say at the outset that I think, unlike the earlier panel, a lot of my -- my research isn't focused on any particular court or any particular Nevada court, although I am going to give you a little bit more information about the types of specialty courts that we have in Nevada. And while specialty courts definitely do share common characteristics, they are all quite distinct from one another. There is a -- actually a great quote I read somewhere that said, "If you've seen one drug court, you have seen one drug court." But with that said, what I want to do is talk to you about two -- what I see as two sort of shortcomings of the specialty court system.

The first is the -- the reluctance of many courts to use evidence-based treatments for substance use disorder, in particular pharmacological treatment for substance use disorder, and, second, the fact that the specialty court system as it is currently organized or structured doesn't in many cases allow

for the treatment of co-occurring disorders, which is where an individual is suffering from both a substance use disorder and an additional mental health condition or mental health disorder. So...All right.

I don't think any of this is going to be especially new information to this group, but my work focuses on, like I said, addiction and substance use disorder, which I think, as everyone here knows, is a type of mental health diagnosis and a very common form of mental illness. So, just to give you a couple of numbers to sort of situate this: This is actually from a study that was published last year, but the numbers were collected from the calendar year of 2014. So, about 21.5 million Americans over the age of 12 had a substance use disorder in 2014. The most common were additions involving alcohol and nicotine, followed by those involving illicit drugs, marijuana, controlled prescription drugs.

Just as a point of reference -- so, remember that's 21.5 million Americans with a substance use disorder. In this country 27 million people have heart disease, 26 million have diabetes, 19 million have cancer, 21.5 million have substance use disorder. So, I say that just to emphasize that we are talking about what is a major public health concern in

addition to being, you know, a policing or a criminal justice issue. And there is more.

Many people with a substance use disorder also have an additional mental health diagnosis. So, when we say co-occurring disorder, what we mean is that the individual meets diagnostic criteria for two or more conditions. Those can actually be physical and mental conditions. In this context what I'm talking about is an individual meets diagnostic criteria for both a substance use disorder and an additional mental health condition.

And when we talk about addiction these days, we talk a lot about opioids. So, I thought I would use an example from opioids. About 40 percent of opioid-dependent individuals have a co-occurring psychiatric disorder. As you can see here, the most common are things like depression and anxiety disorders, bipolar disorders, but it sort of spans the spectrum. And it goes beyond just opioids obviously. We hear a lot about opioids, but rates of co-occurring mental health and substance use disorders, although they can vary somewhat based on type of substance, type of mental illness, or population, they are high and consistent among all of those categories.

So, just as a couple of examples:

Co-occurring substance use disorder, rates of -- of co-occurring disorders are high, regardless of whether you're talking about something like an anxiety disorder or you're talking something about -- like depression or mood disorder. Similarly, individuals with behavioral addictions or non-substance-related additions also have high rates of co-occurring disorders. So, for example and particularly relevant to our state, a study of problem gamblers found that 57 percent of those individuals also met criteria for at least one additional mental health disorder or substance use disorder.

And then, finally, studies that look at specific populations also find very, very high and consistent rates of co-occurring disorders. So, of particular relevance to I think what you all are looking at, a study of veterans from 2007 looked at a hundred thousand users of VA services who were coming back from wars in Iraq and Afghanistan. Of those hundred thousand studied participants, about 25 percent sought services for mental health conditions. So, it was narrowed down to that 25 percent. Of that 25 percent, 44 percent had one mental health diagnosis, but 39 percent had two, and 27 percent had three or more.

Not surprisingly -- just a little bit more on veterans. Not surprisingly, veterans most often sought services for PTSD. There is a whole body of research study rates co-occurring disorders among veterans, but estimates are that among individuals with PTSD, the rates of co-occurring depression are as high as 60 percent, and rates of substance use disorder of all sorts of various types range anywhere from 34 to 88 percent. So, the takeaway here on that front is that if you've got somebody with PTSD, it's more likely than not that that individual also meets diagnostic criteria for an additional psychiatric disorder, in many cases a substance use disorder.

One sort of obvious thing is that individuals with co-occurring disorders have much higher mortality and morbidity rates. Treatment can be difficult to integrate and coordinate. But the research shows -- consistently show that integrated treatment or -- and what I mean by that is treatment that's delivered by a single clinical team or a clinician -- is much more effective and has better outcomes for patients than programs that focus on one disorder at a time.

So, hold on to -- hold on to that idea of co-occurring disorders, and I'm going to circle back to that in just a second.

And then so how does all this relate to the criminal justice system? I think you all have a good guess. So, as most of us know, addiction, mental illness, and involvement in the criminal justice system often go hand in hand. So, just another few numbers for you: Adolescents age 12 to 17 who have ever been arrested are five and a half times as likely to meet diagnostic criteria for addiction. The rates are slightly lower for adults who are arrested, who are three times more likely to meet diagnostic criteria.

And, in fact, one of the primary sources of referral for individuals with substance use disorder into publicly funded treatment is the criminal justice system. And a huge reason for that is the specialty court system. So, yeah -- is the specialty court system. So, you can see here that the criminal justice system is responsible for about 44 percent of referrals into publicly funded addiction treatment, and a big part of the reason for that are drug courts or problem-solving courts, diversion courts.

I think you talked quite a bit about specialty courts in the last panel. So, I don't want to repeat all of that too much, but drug courts originated in 1989 in Miami County -- or Dade County, Miami. It is

a way for people whose criminal justice involvement is seen to be due to an underlying addiction. The idea quickly caught on. We started seeing all sorts of other types of specialty courts. And the basic idea is that these courts are meant to divert offenders out of the typical criminal justice system and into a program where they can receive treatment.

Although drug courts remain the most common and best known type of specialty courts, they have formed the basis for all of these different kinds of courts up here. And one point I'll come back to in a minute is that these courts are traditionally siloed. So, individuals are often referred into a particular court based on the crime that led to their arrest. If you're arrested for a DWI or you're arrested for a drug charge, you're often diverted into drug court, into DWI court. If you have a diagnosed mental illness or you're a veteran, for instance, you might then be diverted into a mental health court or a veterans court.

There are a ton of these courts. This is just drug courts, and it's about five years old. There are even more at this point. The most recent numbers I found are that in the U.S. and its territories there are more than 3,000 drug treatment courts.

Can I go like three minutes? Are we short on time? I'll go fast. Okay.

There are more than -- there are more than 3,000 drug courts, about a thousand other problem-solving courts. Here are all the ones that we have in Nevada. People mentioned this earlier. We've got a lot more in the urban areas, fewer in the rurals (phonetic). We -- the majority of them are drug courts, although we have a variety of other types of courts.

Really quickly, I'm just going to answer this question for you so I don't spend too much time on this. What most people think about when they think about treatment for addiction is AA; people think about mutual support programs. I've talked a lot about this in other places, but while AA is a -- an effective resource for people with substance use disorder, it is not, in fact, considered an evidence-based type of treatment.

If you are treating the disease of addiction in the same way that you would treat any other crime, disease, something like diabetes or heart disease, best practices for the effective treatment and management of the disease should be consistent with the causes and courses of the -- the disease. I don't

want to spend too much time on best practices at all, because I'm now over time, but I want to focus for one second on that acute care portion.

Here are some of the common evidence-based treatments for acute care in the treatment of addiction. I have pharmacological therapies up there in red, because that is a type of treatment that has not been widely embraced by drug courts. Most specialty courts provide and require various types of inpatient and outpatient counseling, but if you dig a little deeper into the research, what you'll see is that the majority of that treatment that is provided in most of those settings is based, at least in part if not primarily, on a 12-step model of treatment.

What is less common in drug courts, to sort of summarize this, are pharmacological-based treatments. These numbers are a little bit old, but they still apply in a lot of cases. You'll notice one thing on there, that the use of methadone is about the -- methadone maintenance rather is used at about the same rate as the use of acupuncture. This is changing. More courts are becoming receptive to medication-based treatment and pharmacological treatments. In fact, Nevada, I recently learned, has two medication-assisted treatment courts. Both of those

are in northern Nevada.

And I think it's also true that a big problem is, we just don't have the resources and communities to provide these sorts of treatments. Courts are limited in the treatment they can order participants to undergo based on what's available in the communities, and many communities just don't have those resources.

And just quickly, another big part of the problem, like I mentioned earlier, is that these courts tend to be traditionally siloed; right? You're just sort of shuttled into one, depending on your arrest. The problem is -- is that they're quite different. In addition to differences based on individual judges, drug courts in particular tend to have a punitive focus, focused solely on the individual's addiction, compliance with treatment. There are a lot of repercussions if you fail urine tests, for example. Courts like mental health court, veterans court tend to have the stated goal of connecting individuals to available community resources.

So, it's a little bit of a luck of the draw, depending on where you end up, the type of treatment and the sort of court philosophy that you end up

encountering. And what this also means is that judges and court personnel often don't have the experience to screening and treating individuals with co-occurring disorders who might end up in their courts. They might not be aware of available community resources to treat this population.

And then one last point and I'll -- I'll conclude. I didn't touch on this, but I -- I think I have to mention it.

I think by segregating courts in this way, by saying, okay, if you have a diagnosed mental illness, we're going to put you in mental health court but if you were arrested for a drug crime, we're going to put you in drug court -- a pretty obvious effect of that is that we're further stigmatizing addiction; we're not really acknowledging that drug and alcohol use disorders are simply one subset of mental health disorders that are recognized by the medical community.

So, just two quick takeaways from this: My work does tend to focus on this gap between what we know about appropriate addiction treatment and the types of treatment courts are providing. And I think that a lot of courts are a little bit behind the ball, especially in regards to evidence-based treatment and

in particular medication-assisted treatment. And, similarly, these really enormously high rates of co-occurring disorders suggest that anyone involved with this population, from law enforcement to specialty court judges, really needs more training in the inappropriate screening and treatment of individuals who present with co-occurring substance use and mental health disorders. Thank you.

CHAIRPERSON BLAYLOCK: Thank you. We have about 10 minutes for questions. I would like to open it up to the committee for questions. Kay Kindred.

MS. KINDRED: We heard a lot this morning and I think we all know that if we had more funding, that would address many things. But aside from additional funding to address some of the lack of resources that we have, you each sort of touched on -- and I would like to just hear this from the panel in general, your thoughts about how we might better utilize the resources that we have to address some of these issues earlier on before -- as you all suggested, before these folks who have mental illness, drug additions, so forth, get involved with the court system or get involved with law enforcement.

Do you have any thoughts on that, of how we might better collaborate as -- with the resources that

we have?

DR. BOMER: I think that, as you mentioned, there are resources that are available. And -- and there is an emphasis on even expanding those resources. But I think what we need to look at is making sure that no opportunity goes to waste, in terms of an opportunity to train, an opportunity to collaborate between organizations, an opportunity to let the public become aware of just how -- how dire some of these -- some of the most vulnerable members of our community, how dire their -- their existence can be without proper support, without a support apparatus that will make sure that they're not placed in our criminal justice system but rather receiving the -- the treatment that is needed.

For example, if one -- if one would put a person in jail if they were diabetic and -- and we say, well, if you're diabetic and you exhibit some of the acute symptomatology associated with diabetes, then we're going to criminalize that, it would be a public outcry. But when we look at mental illness, you look at a person, and you can't really appreciate clinically how sick the person might be. So, we may have expectations that are unrealistic in terms of how that person should act. And -- and when the person

is -- is exhibiting symptoms of psychosis, we may say, well, the person is under the influence or they -- they should still be responsible for their behavior.

So, to answer your question, we need to expand the community's understanding and consensus in terms of what mental illness is, how it needs to be treated, and making sure the appropriate mental health professionals are included in the discussion.

As I mentioned earlier, law enforcement, they're the first responders, not to suggest that there is not training there, but I believe, in my opinion, that mental health professionals should be there; right?

My background is -- I'm a psychologist. My background is in mental health. You probably -- you wouldn't want me to -- to make a cake, to bake your wedding cake. That probably wouldn't work out. You wouldn't want me to respond to a robbery in progress. That's not my area of expertise.

So, we need to include the mental health professionals in the conversation and work collaboratively with the resources that we have at our disposal. When we look at the statistics, it's -- one could determine that we have not done a good job in terms of getting that message out. And it's not -- as

you know, with respect to the media, it does not take a lot of effort to get a story out.

As a matter of fact, I -- I recall hearing a news feed in terms of -- it said -- it's sad. It said, "Outside of the -- we were outside of a police headquarters, and protesters are gathered, demanding answers after an unarmed mentally ill black man is shot by police. And back to you, Sally. Let's talk about the Raiders." That was it. It was that -- that callousness, that -- it was just reduced to a -- a sound bite, if you will, a sound bite. And -- and when we can look at that and somebody's life is destroyed -- that officer's life, that -- that person's life, it's destroyed. And we've become so callus in our society where we can't appreciate just how dire of a situation this is.

So, I think it's important to use every venue possible at our disposal to get the message out. And that should not -- that -- that should not cost a lot of funds in that respect, but it's just a matter of re-engaging our priorities as a society and making sure that we advocate for those who are struggling with mental illness. Thank you.

DR. SCHWARTZ: Two things: Getting people into wrap-around services, like Mojave, like the

state, is critically important. That is extremely effective. When you're talking about Mojave, there is no legislative funds involved. It's, "We kill what we eat. We bill Medicaid." So -- and Medicaid funds are shifted from state costs to federal for the most part. So, it's a very effective way to provide services for people that need them and reduce their incidence of being involved forensically in the system.

The other thing that the legislature could do would be policies that encourage affordable housing, regardless of whether they fund it or not, just policies that encourage affordable housing. You have Siegel Suites coming in here, buying up dozens of our low-income apartment settings that we could afford to put people in, raising the rent to the weekly rate our clients can't even live there anymore. They can't afford $200 a week for Budget Suites. And that's their model. They're coming in. They're buying the cheap -- not motels, the apartments, Charleston Wood on Charleston, $450 a month for a studio. Now it's 200 a week for Budget Suites.

So, we need some affordable housing initiatives, even if they don't get funded by the legislature.

MS. GORDON: So, I think I'll keep focusing on

the addiction piece. I think that one thing that -- that this state and most states need is better access to pharmacological treatments before the person is arrested and becomes involved in the criminal justice system. I'll piggyback also on what Dr. Bomer said a little bit.

You know, if we were talking about somebody with diabetes, there would be no question that they would receive medication for their disease. And I think a lot of the problem is that much of the treatment provider community was sort of -- sort of came up in a 12-step ideology, and there is a big resistance to using pharmacological treatments, out of a fear that, you know, what we're really doing here is replacing one addiction for another; we're just going to give you drugs to get off the drugs. And that's not a long-term solution.

It's also true that there is a big difference in people's access to these types of treatments, based on socioeconomic status. If you can afford it and you have a primary care physician or you have accurately -- or you can afford pretty expensive monthly payments, you can go to a private doctor's office; you can get a prescription for Suboxone or Buprenorphine and be on your way and -- and sort of

deal with that privately. If you can't afford it, your option is typically a methadone clinic or some other sort of public and much more visible process.

So, I think that one thing that I try to do is -- is -- and it really does take convincing -- is try to convince people that, you know, substance use is already a disease; this is something like heart disease; this is something like diabetes. And if we are ever going to actually come to terms with -- with what the mental health community has said substance use disorder is, we need to start providing appropriate treatment beforehand, before someone is assigned to a drug court or before they find their way into a mental health court. So...

And then, of course, that raises the issues of resources and funding and -- and it comes back to all of the points that everyone has been making but...

CHAIRPERSON BLAYLOCK: Thank you. I think we have time for one more question.

MR. PONDER: I have one.

CHAIRPERSON BLAYLOCK: Jon Ponder.

MR. PONDER: We had spoken about better ways for mental health professionals to work with law enforcement. And I'm a big believer in collaboration. We get more done collaboratively.

So, outside the parameters of what's already being done, what would be some of the ways that we could, mental health professionals, work more closely with law enforcement in getting the work done?

DR. BOMER: I think at this current juncture in our community it's -- it's more of a courtesy than a mandate. I think what we need to look at, making it a mandate in some respects, that, given the enormity of the issue and how it encapsulates so many different variables as it relates to mental -- access to appropriate mental health care, the disparities in terms of access for minorities and veterans -- when we look at training for law enforcement, it -- there is so many different variables. I think that it deserves more of a mandate than a courtesy.

And with respect to my experience, it's always that, "okay, well, we'll agree to work with you." It's not that these are the parameters set out how we will work together. We must work together. Because this issue affects all of us as a community. It affects every last one of us in this community, in terms of the importance of making sure that some of the most vulnerable among us receive the services that -- that they need.

MR. PONDER: Okay.

DR. SCHWARTZ: One program that seems like it has a positive future is ride-alongs, mental health professional riding along with the police for selected shifts. Of course, if an emergency situation happens that isn't mental health related, the social worker would stay in the car and an officer would respond. But -- but a lot of the -- the Corridor of Hope areas stuff would have mental health.

I -- I laugh, because the name doesn't seem to fit what it feels like down there. It's a really tough area. I don't know if you know Las Vegas at all. The Corridor of Hope is the homeless corridor. It's really rough. It's sad to see.

Anyways (phonetic) I think ride-alongs is a particularly specific thing that probably wouldn't cost very much and could be beneficial to both sides, I would think.

MS. GORDON: Yeah. I think -- I think that my comments will reflect both of those. You know, I think we need more training for people on the ground, for people who are among the first people to come into contact, certainly law enforcement.

I -- I teach mental health law at the law school, and UNLV actually at the Lincy Institute provide something called expert training, which is

screening, brief, intervention, referral to treatment, which can be used in a variety of contexts. But one -- I used it in one of my classes once, and one of the interesting -- one of the good benefits of it was that -- you know, I think a lot of people are really sort of -- on the addiction front are open to hearing, you know, what sort of the more recent science tells us about what addiction means and how it's best treated. But that's not what the general public tends to think of when they think of addiction treatment.

So, you know, programs like that for the people who are sort of first responders, who are on the ground, who are interacting with these folks is -- is an important first step at the very least.

CHAIRPERSON BLAYLOCK: I would like to thank you, each of the panelists, for this information, again very, very helpful.

This concludes our Understanding Mental Illness and the Criminal Justice System, session 1. So, thank you very much. We appreciate that.

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OPEN PUBLIC COMMENT

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KENIA LEON, WIZ ROUZARD, ROBERT STRAWDER, MICHAEL MCDONALD, WESLEY JUHL

CHAIRPERSON BLAYLOCK: We're going to move into the public comment period. So, if you'll give us just a moment, I understand we have three individuals that would like to provide public comment.

So, would Michael McDonald, Robert Strawder, and Wiz Rouzard please come forward and have a seat, and Kenia Leon?

So, thank you for making time in your very busy day to come and share your experiences -- your experiences and -- and your thoughts on this topic. You will each have three to five minutes to share with us.

And if we can start -- well, let's start with you. If you would, please give your name for the court reporter.

MS. LEON: Sure. My name is Kenia Leon. That's K-e-n-i-a, just to be different. I'm a licensed marriage and family therapist and a licensed clinical alcohol and drug counselor here in the community, also a Las Vegas native. We're liking our corns here. So...And I also work as a psychologist in the department of corrections, so a wide variety of experience in mental health care in our community.

And one of the things -- also a local activist, so kind of both sides of the rails here.

So, one of the things I think that's important to recognize is, in marginalized communities, in communities of color, the perception of police and mental health are both stig -- are both things of stigma. So, I think understanding that is first and foremost. So, having cultural competence, number one, about that, I think, is going to be important, along with understanding what mental health looks like in crisis, so CIT-trained officers, but also officers understanding what that may look like in the community, that it may not be discussed. So, a lot of this may be undiagnosed. So, having that combination of, also important, I think, as well. So, I think that's something that hasn't necessarily been brought to light, of that cultural aspect in these communities.

So, on top of that, the prevention piece is definitely important, to Ms. Cosgrove's comment about not having those additional resources. We know that black and brown students are diagnosed more than other students; they get direct filed more than other juveniles in our criminal justice system. So, there is a lot of systematic issues, both criminal justice-wise and mental health-wise, that if we were to chart them, we would kind of see them going up

equally. So, I don't think it's something we can separate.

So, to the comment earlier about kind of, "well, that's not something we should necessarily know about," I would wholeheartedly disagree, not again to the psychologist point, not to be an expert, but it's definitely something -- that it's come to the point where we do have to have some education on at least enough to do our job professionally. If I were a police officer, I would need to know that effectively in order to know, do I need to go to the hospital first, or do I need to go to CCDC first? Where are we making these decisions, and at what point are we taking action on them correctly? For all our community sake, we all live here. And then that would help, I think, education-wise, and it would help in just the relationship with the community. I think it's very important, also.

And the separation of mental health from medical care, I think, is a huge paradigm shift we need to make as a society. They're not separate. Mental health care is medical care. And I think if we were to make that culture shift, that would also help. It's not seen as something different. It's often, even within professionals -- we have a hierarchy

issue: "Are you a therapist?" "Are you a psychologist?" "Are you a social worker?" "Oh, you're the psychiatrist" or "You're on the medical side or over there and we won't talk to you," so just even within the separation itself. It might cause some issues, but if we start taking a wholistic look that it is part of health care and it's an issue and the systemic issues that are a part of access and health care itself also impact the issues of mental health care -- so, that's all I wanted to mention. Thank you so much for your time.

CHAIRPERSON BLAYLOCK: Thank you.

MR. STRAWDER: Hello. My name is Robert Strawder. I'm a libertarian. I'm running for congress. And I just -- my nephew -- I wanted to talk about my nephew. He's -- he has autism. And so he stays in a African American community. And he's walking with his friends, and the police come by, stop him. And, you know -- you know, autism, he -- he has -- he's special.

So, I seen him the next day or whatnot. He calls me: "Yo, Uncle, the police, they pulled me over." I was like, "What for? You don't got a car." And he like, "Yeah, but they just stopped me and my friends. And they was frisking us. What do you think

about the police?" And I'm like, you know, just like, "Did you tell them that you have autism and this and that?" He says, "No. I -- I just was around some dudes and they in a gang." And I'm -- you know. So, I was like, "Well, why -- why the police pull you over?" And he -- he didn't even have any explanation.

But with that being said, I'm here to talk about what's going on in the African American community with the police when they pull you over with aggressive like, say, for instance, driving. I just spoke with a female the other day. She was at a stoplight. She put her phone, you know, on the holder. And then a police pulled her over. And then she was like, "What for?" And then he said, "Because you were on your phone." She said, "I just put -- picked the phone up and put it, you know, on the phone holder." He said, "That was too much. You wasn't supposed to do that." She said, "I was at a stop sign and did that" -- pulled her out of the car and handcuffed her and did whatever. So, that was another incident.

An incident that happened to me with my daughter, she -- she was graduating from Spelman, out here on a summer break. And I'm going to get some chicken and, you know, in -- in the urban

neighborhood. And -- oh, I -- I tell her, "You have it good. You don't have it like me. I grew up in North Las Vegas on Donna. It was horrible: drugs, gangs, whatnot. And you need to look where I came from," show her the gates. And the police pulled me over. I'm like, "What are you pulling me over for?" And they said, "Because you made a right turn 300 feet instead of 500 feet." I'm giving an estimation. But I was like, "Oh, so, you have to -- I have to know how many feet that I'm supposed to turn right before anything happens?"

And so I just feel like, with that being said, we -- I wanted to -- I hope we can implement something in the police department dealing with diversity and dealing with African Americans around with relations. Because I have a police officer, some friends, and they said, "The reason that we react like that, because we scared." And I said, "We're scared, too." So, both of us scared. And you -- you know, it's both of us are fearful for each other.

So, can we like build a relationship to where you understand why we act the way we do and we can understand why you act the way you do and so we can get together and build a better relationship and have -- you know, I just -- I just feel like if the

police officers were more diversified in training at the beginning -- because, you know, some police officers never been around a African American. So, they see TV, what's on TV. And then they just think everyone is like that. And that's not true, you know. And I understand them being fearful of an African American, us, me, a black man. But I'm fearful of them, too, now, even though I'm running for congress. If I get pulled over, you know, I'll be, you know, nervous myself still.

So, I just feel like if we could create a diversity program from training from the beginning, I think it will be better for the communities. Thank you.

CHAIRPERSON BLAYLOCK: Thank you.

MR. MCDONALD: Hi. My name is Michael McDonald. I'm the assembly -- Nevada Assembly District 20 candidate, president of the family and criminal law reform -- committee for family and criminal law reform, the Nevada's Families Civil Liberties Union, Restoring Freedom, Reform Family Courts, and the director of a nonprofit, Positive Minds Global, restoring families.

There is a complete upsert (phonetic) of our civil rights that's being -- or that's going on in our

family courts and people that are going through -- through family courts. The constitution is not applied when one goes through family court. There is no right to an attorney, their Fifth and Sixth Amendment rights to due process, to an attorney, no jury.

We have 24 million American children being alienated from at least one parent. And it's a root cause of so many social issues, such as anxiety, depression, mental illness, criminal history, drug use, sex trafficking, mass shootings, all occurring because of the breakdown of our family.

Now, one of the root causes of all of this is the -- or one of the ways to fix and address this issue is to -- to take out the monetization of the family courts, such as Title 4D and Title 4E, which is -- is causing complete havoc among so many Americans. Right now the family court is a $70 billion district. There is more money in family court than all the courts combined.

It was -- I've -- let me tell you, I've been personally affected by the family and our criminal courts out here. I haven't seen my own kids in almost two years, zero contact. I have never been proven unfit. I have -- I'm a good father. I used to work

for the city, never had any criminal record, nothing. I spent six months in jail for trying to call my own children. I had a contract and order saying that I could.

There is such -- such nepotism going on in our courts. There is complete discretion just from a judge that plays god in people's lives. I'm telling you that -- that there is a study called the A study, the Adverse Childhood Experience Study {sic}. And this is the root cause of why we have so much mental illness and homelessness, is when you're -- it stems from the childhood. When you don't have -- you're a part of two wholes: a mother and a father. And when you have one as a pathogenic parent or one that's alienating due to vindictiveness or whatever, it is a root concern of all this.

And growing up, I was also a child of divorce. When I was 5, I was alienated from my father. He was smoking marijuana. And my mom sides with all judges and attorneys. And it caused me to have anxiety and depression growing up, and I faced all kinds of adversities.

I'm telling you that if we don't address this concern, our society is going to have a complete ripple effect for -- for the rest of society. And

that's why we have this presently. Let's attack the root issue, set -- a set standard of equal parenting.

I lobbied in congress last year for a bill called HJ 121, SB 48, which is a constitutional amendment for equal parenting, which is in place right now. If it's passed, it will decrease 70 percent of litigation. It will keep families together. And -- which is the forefront of our society. We have 3,000 -- I mean immigrant children being affected, but we don't want to address the amount of children that are being affected right now.

And if you go and address those concerns of the prisoners or the people going through the mental health, ask them did they have their father growing up, did they have their mother growing up, how was your childhood. And we don't address that concern. That -- that is the root. That's the heart of the issue. So, that's what I advocate for, and I really would like the committee to address those -- those set standards of equal parenting. I also have a lot of incites into the family court, which is the plea deals, the bail amounts, which I'll talk later on in public comments.

So, I thank you for your time and thank you all for being here and addressing these major

concerns. And I hope that the family court issue will be at the forefront of you guys' issue. Thank you.

CHAIRPERSON BLAYLOCK: Thank you.

MR. ROUZARD: Thank you all for giving me this opportunity. My name is Wiz Rouzard. I'm a field director for America For Prosperity, a graduate of UNLV, played football there for four years, have been in the community since 2005.

But criminal justice reform is a huge thing when it comes to freedom, liberties, and economic prosperity. We're taking on criminal justice reform, because we see that there is huge disparities in every component that you can consider.

I know, Sondra, you mentioned the key component of trying to catch it at the start of the river rather than the end of the river, which I totally agree. Michael touched here on the family component, which is the most influential component there is, that a human being can be encountered with.

Just some statistics: 66 percent of individuals currently incarcerated today are under the age of 30. Okay? Our recidivism rate right now is about 65 percent within three years, so then returning back to prison. Jon T. Ponder and his organization, Hope for Prisoners, is doing an amazing job in helping

reduce that with their success rate, but it's not just one organization, two organizations that's going to help get this done. It's going to require a community. So, we built grassroots communities throughout the Las Vegas areas to push criminal justice reform.

A couple things that we touch on is, you know, reform, which is the issuance of warrants that we have to reassess. Right now bails are more on a cost base rather than a risk base. A lot of individuals who are jailed typically live below the poverty line. One, two are in jail for victimless, non-violent crimes, and two typically have families, single parents. And what that does is, when they're arrested, in jail, you're leaving kids at home by themselves. So, then now government gets involved. Then the person might be in jail for two to three weeks, because they don't have the family network of wealth to get them out. So, it perpetuates the cycle, and then eventually they take a plea deal, even though the charges are something they can fight and not be found guilty. They don't know the laws. And, therefore, they take plea deals and take whatever they can get to just try to get out the situation as easy as possible. And this becomes a cyclical effect.

It definitely -- when you look at the incarceration system, I first initially always allocate for Black Lives Matter, because they originated in the criminal justice system, meaning 40 -- over 40 percent of African Americans are incarcerated in the prison population, which holds the majority. And that's where it originated. And the point is really -- and Rand Paul and Kamala Harris, both legislators in the federal level, pointed out that this wasn't really a race issue; it was more of a economic means issue starting with the bail bonds system. Most African Americans do not have the economic means to bail themselves out. So, therefore, they take plea deals. And I believe here in Nevada it's about 90 percent rate. That's bad. And, therefore, you have a disparity when it comes to certain minority groups being found in the criminal justice system.

Mentuary (phonetic) reform touches on the mental aspect. I totally agree. Michael's case that Lisa brought up was a very, very strange case. You know, there is individuals who don't intend on breaking the law. Matter of fact, they don't even know what the laws are. There is a book out there called Three Felonies a Day, and that means each and

every one of us in this room actually wake up breaking three felonies, and we just don't know it. That's how these laws are on the books. And we don't take in consideration the -- the mindset, the mental approach, the intention of the individual who was engaging. And a lot of times in minority communities you have individuals who are -- they -- they make contact with the police. They didn't break the law, and all of a sudden, because of the contact and conversation with the police, they become a criminal, and they're taken to jail.

So, when it comes to policing practices, I feel that we have to re-engage. This is a great step where your board is actually, you know, opening up discussions and looking for sound solutions, because we're strong advocates, that we need the police department as well. The job that they do in protecting our freedom and liberties is huge. I have a lot of friends who are police officers. But even they themselves, when they have to enforce the laws, they even say it's discriminatorily, like it puts them in some hard places. And that's tough.

So, we have to review the laws that we do have on the book and take into consideration, are we pulling some of them and changing or giving a little

bit more descriptive approach as to how you apply it? A Yale -- a law -- a Yale law professor recently had a article where he basically said that all laws are inherently violent. And you have to consider that. Michael is a prime example. Patrick is a prime example where, when the law is being enforced, there is a legal -- legal grounds in which this can be enforced but -- so, with that said, in the economic aspect, we take on occupational licensing reform.

Currently in California -- currently in California there is a fire going on, but most of you don't know. There is a program in the prison system where -- there is a -- there is a -- a program in the jail system where individuals are actually right now helping put out that fire. But here's the biggest problem: After they serve their time and get reactivated back into society, they can't even apply to be a firefighter. So, if we're going to talk about reducing the recidivism rate, we have to address occupational licensing.

And, yes, doctors need it. Yes, those fields that need it are very important. But we have to reconsider. The fields -- there is over 8,000 licenses requirements to go into the field of work. So, when these individuals are coming out of prison,

they have paid their debt to society; they have given their time. What do we as a society say to them? Are we going to stigmatize them for the rest of their lives and say, "You were a felon when you were 18, and now for the rest of your life you can't apply for a license."? How is the individual going to provide for themselves, yet alone for their family?

I feel that once we address occupational licensing, we will reduce the homelessness rate, and more importantly, we'll reduce the recidivism rate by allowing individuals to have the ability to have the economic means to provide for themselves and the family and not have an inherent alternative, which is typically violence, to breaking the crime to provide for themselves and their family. So, I thank you for your time.

CHAIRPERSON BLAYLOCK: Thank you. I would like to thank all of you for making -- oh, I -- I apologize. We have one more person. Wesley Juhl, Juhl.

MR. JUHL: Juhl.

CHAIRPERSON BLAYLOCK: Juhl.

MR. JUHL: Hello. Thank you guys. My name is Wesley Juhl. I do communications for the ACLU of Nevada. I just wanted to start by thanking you for

picking such a important topic. It's regretful that the ACLU of Nevada was not invited to present today, because we definitely have a lot to say on the issue.

And then just real quickly, we're going to submit written testimony to you guys. Our policy and legal team are going to work something up for you, but I wanted to address a couple things I heard this morning. One of them was that one of the presenters brought up the Tashii Brown case and said that was not a mental illness. And I just wanted to set the record straight. I've spoken to his family, and I've been told that in the months before his death he was diagnosed as a schizophrenic. And then, two, Captain Schmidt mentioned during her presentation that members of the crisis intervention team are given 40 hours of CIT training. I would personally love to see how that stacks up against how officers -- how much time officers are given training in guns and other use-of-force techniques, because I think it should be closer together. That's it. Thank you.

CHAIRPERSON BLAYLOCK: Thank you. I would like to thank all of you for -- I know this was -- it took a lot of courage and that you were all very passionate about this topic. So, for you to take time from your day to come and meet with us and share your

thoughts and feelings about this particular topic is very important. And I want to thank you for coming forward to share your thoughts with us.

MR. MCDONALD: I'm going to also state one thing, one more thing for the record.

I submitted some legislative reports that I would like you guys to review that are the statistics on the fatherless, motherless homes that's going on right now. I'd also like you guys to address the TPO issues, the protective orders, the domestic violence law. A lot of people -- Nevada being the number-one state for domestic violence. It swung so far in the opposite direction that even the neighbors call the cops now, they have to take somebody to jail. The state will pick it up and prosecute those people. It's -- it's causing a lot of -- a lot of fines, a lot of people getting thrown in jail, a lot of family devastation. So, I would like you guys to address the TPOs, the domestic violence laws.

There is also a lot of people getting put on ankle bracelets for -- for -- for all kinds of reasons. A person I know, their bitter spouse says, "Oh, he's just drinking alcohol around the child. Put an ankle bracelet on him, monitor his alcohol." They put -- charge people $12 a day. And they have got --

upsert (phonetic) their Fourth Amendment right to searches and seizures. And a lot of people are being affected by that. We're getting put as a -- a -- tracking these -- these individuals. It's not -- it's causing a lot of devastation.

The recidivism, the stay-out-of-trouble orders, no judicial oversight -- there is a lot that really needs to be addressed, and I could commend this commission to really look into the heart of the issues and present that to the United States commission. Thank you.

CHAIRPERSON BLAYLOCK: Thank you. And you can provide written comment to the committee for up to 30 days.

We are going to break for lunch, and we will reconvene at 1:30 -- 1:45.

(Recess taken.)

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POTENTIAL SOLUTIONS I

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DAMON D'AMATO, Founder, Qi United

WILL SCOTT, Captain, Las Vegas Metropolitan Police Department

LAKEISHA OLIVER, National Alliance on Mental Illness

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CHAIRPERSON BLAYLOCK: Good afternoon. I hope everyone had a good lunch. So, welcome to the Nevada Advisory Committee to the U.S. Commission on Civil Rights for our afternoon session. And for those of you that are new, what I would like to do is re-introduce the committee members.

So, I'm Wendell Blaylock, the chair of the Nevada committee. We also have Sondra Cosgrove from Las Vegas, Carol Del Carlo from Incline Village, David Fott from Las Vegas. Kara Jenkins will be joining us a little bit later from Las Vegas. Kay Kindred from Las Vegas, Theresa Navarro from Reno, Jon Ponder from Las Vegas, and Ed Williams from Las Vegas. So, thank you for joining us this afternoon.

This afternoon we will continue our discussion on the focus of community policing and mental health. If you are interested in sharing public comment, please see Angie in the back of the room so we can announce your name when the open comment period begins. And if any of you have additional information, additional slides, or would like to submit additional written format material to the committee, you can do so within the next 30 days. Please send that to Ana Fortes at usccr.gov.

We shall continue our agenda. And this

afternoon we have Potential Solutions. The first panel, we'll hear from Damon D'Amato, who is a founder of Qi United; Will Scott, captain, Las Vegas Metropolitan Police Department; and Lakeisha Oliver, National Alliance on Mental Illness.

I'll turn the floor over to Damon D'Amato.

MR. D'AMATO: Thank you, Wendell. Again my name is Damon D'Amato. I'm the founder of Qi United. Thank you for having me here today.

We are a nonprofit, a 501(c)(3) company and -- there we are. Thank you.

And our -- our focus is working with first responders, veterans, and law enforcement, helping them dealing with PTSD-related issues and the triggers that may set them off in -- in harsh circumstances. And so the focus is to teach breathing techniques so they can become less like stressed, less -- less fear, depression, things that set in, they don't know how to handle maybe what might be setting in in regards to things that are out of their control. You can get in control by learning how to breathe, randomly breath all day long, but it's how do we -- how do we spend the time. The only time that we really focus on breathing is if maybe we're exercising. Otherwise, we breathe rather rapid or kind of shallow.

So, we focus on breathe -- breathing deep and intentional, focused, and spending time in the depth of -- and so that it relaxes the nerves. So, we get into what they call the parasympathetic mode in the mind so it's breathing into a relaxed form, overdominating the sympathetic mode, which is in the stress mode. When we're stressed, it causes inflammation, it causes disease, it causes all kinds of things. And inflammation is known to be pretty much the cause of all -- all disease. So, if we can use the breath and override the switch to the stress response, we can get into a relaxed state, and we can do it on command; we can do it quickly. It's not like meditation where it takes a lot of time, a lot of practice. What we share, we can get to the core of everything in less than a minute once I teach how to -- how to manage the breath, how do we do this.

We literally can take the individual and get them under control, which really we don't have time to take back our lives. So, it's easy to kind of put up a shield and everything is okay and masking what's happening, especially with veterans, which, you know, if -- seeing so much, how can you unsee what you've been through -- or law enforcement especially, with 10/1, you know. I think a lot of people, we medicate,

or we self-medicate. We can talk about it all day long, but we need to kind of get to the core of the problem, which is deep inside.

In getting to the breath and to -- to deep cellular breathing is -- is a unique experience, but it gets to the core where you can find the peace and the tranquility, into relaxation mode that you really need to get to. And you can do it so fast in so many different ways. So, there are many techniques that we share with the different individuals.

And I'm going to share -- there we are. So, this is an example of a blood test that was taken -- there is a microscope on the left. -- and from a very healthy individual. Their cells, as you can see, there is maybe some bacteria. They're all kind of clumped together. That is -- that is a normal person's blood cells that was taken by -- at one of our studios. They did a technique that took -- it was nine breaths; take three steps, one minute. So, I pretty much articulate that to individuals: Listen, nine breaths, three steps, one minute, and it's done. That's easily digestible in your mind. Okay? So, they do this technique. And, as you see on the far right, the cells are like these gigantic blueberries. They're free of -- you know, fully oxygenated, you

know. And if we -- and that's just one round that took like one minute to change the cellular structure within the body. Imagine if you spent even longer or a whole session.

So, you're healing the body from within, but you're also -- it's the mind-body chemistry that begins to change. We can get into the depth of the cell, get into the depth of what's going neurologically, an override switch to your stress response, so when you feel the trigger of what is happening to you and you know -- it's almost like a vibration. You kind of see it coming. And a lot of times people I work with have maybe anger issues, or it could be depression or whatever it is. You kind of feel it coming on. And as you do, we give them the tools -- like kind of like a tool belt. We give them different tools to be able to utilize so when you know what you feel, like almost like that vibration coming on, you know exactly what to do. And, you know, it's -- it's filling yourself up and taking back control to -- the art really is called Qigong, which is the -- the master of internal martial arts. So, it's not like from food, from the outside. We are fighting internally from the inside out, so taking offense from the inside out, taking control of your

life when stress happens.

I know when navy SEALs -- many times they will -- they will learn how to sync their breath in time so that their breath rate is then connected to the heart rate, which creates like this, you know, field, energy field, and then the brain states, so they're all in the same -- in the same place so that they all work together as one. They have to do that so -- but we can do the same thing as well individually or with other people as a team.

So, I've even gone to, you know, corporate businesses, and instead of now them taking, say, a coffee break or a cigarette break, they go take an oxygen break. Because they, you know, go out, and they will breathe together in sync and get back into the game so that they can, you know, handle the task at -- you know, at hand.

But -- but it's important to understand that this has been highly effective. So, it's an alternative to, say, medication. Because it's, you know, taking a problem with like opioid addiction or pain medication, something that's symptomatic rather than getting to the core, so it's like a -- like a Band-Aid or a bullet wound. We're really not dealing with the root cause. We're just kicking the can down

the road. And we want to do something that is outside the realm. And the breath; right, is free of charge and abundant in nature. And it seems so simple; right, but you can alter what is happening, especially people dealing with depression or the folk that are -- have problems in regards to addiction, drug addition. Half the people I work with are veterans, and the other half are just regular folk. But either way, it is a way for them to kind of find that peace and rely on that rather than -- and using that instead of maybe medication.

You know, that -- in severe situations -- you know, maybe other people could speak more specifically on, say, opiates, but I believe that we can do something different and -- as far as pain. So, when we breathe in and tap into the autonomic system, which is tied to strengthening your immune system, when you breath in the way that I teach, basically you tap into your endocrine system, which balances out all the hormones. And that's where you can draw in and control the adrenaline in your body. And naturally the key is being able to -- getting control of your hormones and oxytocin and serotonin and dopamine, all of those wonderful hormones that we have inside, but we're not tapping into it, because we don't breathe,

kind of just take it for granted and -- like I said, we're very -- kind of mouth breathers, but we're not taking advantage of what's around us.

So, if we were more conscious, if we ultimately want to be healthier and happier, stronger for ourselves, the people that we're working with that need -- that need help and guidance, and for our children -- you know, we want them -- ultimately the next generation to be happier, healthier, stronger, not have mental health issues. If we just tie -- you know, we don't teach -- you know, we teach math and science and literature. We teach many things. But we don't teach the simplicity of maybe just breathing and spending time -- and this again is mindfulness. This is not meditation. We're not lighting candles and, you know, trying to get into a vibe. We're trying to be right here, right now. We can actually tap into the core of the cells and be able to change what you feel inside directly.

And anybody -- there is actually some people in this room that have experienced the breath techniques that I share and that we share at Qi United. And it's highly effective and is a simple relief.

And this next one, last one, I work with --

well, I'm a community partner with the VA, but I also work with about six other veterans affiliations throughout Las Vegas and Henderson. This is one. Actually there is Michael. Oh, my gosh. I didn't know he was in the picture.

So, nonetheless, this is with a group called Merging Veterans With Players {sic}, MVP. And so this is a great organization that -- that we kind of co -- co-sponsor and co-work with. And we'll get in the ring. These are for people with all abilities or disabilities, whatever it is. It's about kind of just getting it done but working together as a team, getting in the ring, and then breathing it out at that point so we're kind of using exertion, you know, adrenaline. Then we shift into breath mode, and so we're able to, you know, get the -- get it out. Sometimes we need to get it out in a different way other than just speaking about it.

But once we achieve that goal, then we breathe it out. And then the guard is down, the shield is down, and we don't have all of this -- you know, we put up the fight, and the honesty comes out, and then we can share at a roundtable about what's going on and come up with real solutions and get to the core of stuff, because we don't have anything left to fight;

we've let it all out. And -- and it really is highly effective.

So, you know, working with them, they're all brothers, but this works in -- in -- it's about mental health. So, whether they be veterans, law enforcement, first responders, in -- pretty much anybody in this room needs to -- to breathe more and -- and -- I can simply show you how to go about doing so to enrich the quality of your life, not just the longevity but the quality of life in the -- in the long run. So...Let's go to some questions.

CHAIRPERSON BLAYLOCK: So, after all of the individuals on the panel -- and I apologize. I should have shared this earlier.

After everyone on the panel has spoken, then the committee will ask questions of -- of the panel. So, thank you.

MR. D'AMATO: Thank you.

MR. SCOTT: All righty. First of all, thank you for inviting me to speak for you today. I think as you saw this morning with my peer, Captain Schmidt -- I think the Las Vegas Metropolitan Police Department is really innovative and creative in some of the things that we're finally starting to do. And I'm going to give you an example of another thing that

we've done. I think our leadership within our agency is really pushing us, as captains and leaders within the organization, to develop strategies that are different from the old policing methodology of "you break the law, we arrest."

So, back in 2015 I was approached by one of my assistant sheriffs, and he was looking for some ideas on alternatives to incarceration. He wanted me to do some research in that area, because we were seeing the increase in individuals who really didn't belong in jail, but they were in jail, and they were spending a lot of time in jail. The average cost of a person that's incarcerated in the jail is a hundred and $50 a day. And the average non-violent, low-level offender spends probably around anywhere between 32 and 33 days in jail. So, you can see that's a staggering cost to the -- to the citizens.

So, I went to Atlanta and went to this opioid conference. And I'm sitting at this conference, and I'm like, man, am I at the right conference? I'm thinking I'm at the wrong conference. I called my secretary. I'm like, "Deb, am I at the right conference?" I say, "I'm here with these pharmacists and these doctors and -- and I'm a cop in this place." And she was like, "No. This is the one they sent you

to." So, I sat back and started listening to the words of harm reduction and listening to diversion, and then the lights started coming on. I'm like, "Oh, okay. That's why they sent me here."

So, I got back, and I really started hitting the ground running and started reaching out to some folk in the community who I knew that could actually help me with this process. So, I reached out to a -- a group of folks and -- I guess I need to use this slide here.

And we established this substance abuse advisory council. And the mission of council -- or the mission of the advisory council is to develop a systems-level response to the southern Nevada opioid crisis through evidence-based strategies and unique community collaborations and to decrease the number of people who are incarcerated for low-level, non-violent narcotic offenses.

And this really -- this process really works with mentally ill individuals, too, because -- and I'll talk later about how we added that mental health component into -- an illness component into this process.

Here are some of the partners that we actually started with when we first launched this. And this is

probably about 2015 to '16 when we really started getting this collective group together to just discuss this opioid crisis that we're seeing. Out of that group became -- we developed some subcommittees. And as you can see, those subcommittees up there -- advocacy, education, public awareness, legislation of policy, infrastructure, community leadership panel, and enforcement.

So, on the very bottom of that enforcement -- I know you've seen an increase in UC, which is undercover and confidential informant buys. And you're probably saying, "Well, wait a minute. You're talking about diverting an individual, but now you're talking about incarcerating individuals. What it has to be within law enforcement, there has to be that balance of enforcement and that -- wrap-around services that we offer in our community. There needs to be some amount of balance. But when you look at that and what we are talking about, there is those mid-level to high-level drug traffickers, are the ones that we're really trying to focus on, because they're the ones that bring the drugs in, and it trickles down to the streets.

So, the goal of the actual council is to, number one, save lives and rebuild families. That's

why I highlighted that and bolded that, because I think that, out of everything, is the most important thing, is to save lives and rebuild families.

Reduce the inmate population in the jail, I already gave you the cost of one person being incarcerated inside of the Clark County Detention Center. And that jail holds around 4,000 individuals. And last time I looked at data on that, there were 36 people incarcerated that day, just in a single day, who met a -- this criteria that I'll show you a little later on in the slides. It's also to reduce the number of lab requests submitted for narcotics.

When I was over at the -- met with the mid-violation narcotics section, within one year we had 6,000 requests for drugs and testing. And also it's going to decrease the caseload at the district attorney's office. A lot of these individuals who go to jail for these low-level narcotics offenses, they don't get prosecuted. So, it's almost like a vicious cycle that we're in, and we need to get out of that cycle. And then it reduces the time that the officers are in the street, and those officers now focus on violent crime.

So, what is Law Enforcement Assisted Diversion, LEAD? Law Enforcement Assisted Diversion

is a pre-booking diversion pilot program developed with the community to address low-level drug and prosecution crimes. The program allows law enforcement officers to redirect low-level offenders engaged in drug or prostitution activity to community-based services instead of jail and prosecution. By diverting eligible individuals to services, LEAD is committed to improving public safety and public order and reducing the criminal behavior of people who participate in the program.

So, how does LEAD work? This is an example of how LEAD works: So, we in law enforcement have three ways that we can encounter somebody. That's through a Terry stop, which is a probable cause or a reasonable suspicion stop, or through a consensual encounter stop. So, an officer really can go out on the street, see that there is probably a crime that's about to take place or a crime that has taken place, and he stop an individual. Or he can just merely go up to that individual and just have a consensual encounter with that person.

So, the way this works is, the officer is out there doing his normal patrol activity, he sees somebody. And the person doesn't necessarily have to commit a crime, but he really wants to engage in that

individual. I think we've all seen an increase in individuals who are on the medians with signs saying that they need some type of service. So, basically they can go out and do an encounter with that individual. And then they approach that individual. They find out what that person needs, what's going on with that individual. And then they could actually get them some type of service if that person hasn't committed a crime. There is the criteria right there. That's on the left.

You got to forgive me. I'm nervous, and I feel like I'm in a senate hearing. So, excuse me. I've been watching too much CNN lately, and I feel like I'm in a senate hearing here. So, I apologize. Yeah. You guys look really serious up there. So...Okay.

So, those are the offenses that we look at. So, if a person has a possession of controlled substance, whether it's cocaine, marijuana -- and the marijuana is for the juveniles since we've legalized marijuana and we have medical marijuana. So, if the officer encounters that person and the person meets that criteria, now the officer can do this. This is a decision point. We didn't want to take that discretion away from the officer, because once you

take discretion away from the officer and you handcuffed him from actually doing their job, then they're not going to buy into the actual program. So, we wanted to give the officer some type of discretion. So, it's a decision point.

But I think we in law enforcement need to educate our officers on "this is the best alternative versus incarceration." And it's going to be a cultural change within law enforcement, because the officers go through a 27-week academy, and what are they taught? You break the law, you go to jail. You break the law, you go to jail. So, that cultural mindset, the paradigm shift, is going to have to be brought down from the top-down leadership down to the boots on the ground.

So, what the officer does now, he initiates the department's "alternative to incarceration" process. But you still need some type of stick, and you still need some type of leverage over that person that you're dealing with, because you just can't give individuals a free pass, because that word will get out: "Oh, just say you want to get into this law enforcement diversion program, and Metro just let you go." Well, no. The officer is still going to do everything that he or she is supposed to do. They're

going to impound evidence. They're going to do an officer's report on how they came in contact with you. And what we want to do is, we really want to encourage those individuals that "We don't want to incarcerate you, but what we're going to do is get you some peer support on the right, and we're going to get you some clinical support on the left so that you can be successful within the program." And we do understand that some of those people are going to relapse. But that's when that peer support comes in, when a peer mentor can now come in and talk to that person and call that individual and say, "Hey, John, you know you're falling off your program. We need to get you back engaged in the program."

So, we haven't really set a standard of what we want to -- 30, 60, 90 days and then submit it for a warrant. My thing is, let's use that peer support and that clinical -- those clinical folks to actually work with those folks the best way they know how. And if they say, "Hey, we've tried. John is not going to be successful in the program," then that's when we submit it for a warrant. Then what you have is the -- so, again he's going to do everything that he needs to do.

This is where the hand-off is going to be. We're missing a -- a piece in there. So, where the

officer comes in contact with that individual and where we do the actual -- what we call that soft hand-off or warm hand-off, whatever way you want to say it, we're missing that case management, because you have to have a case management system in the middle. And that's where we're suffering.

We started this program June 29th. Today we've contacted or made contact with a hundred and 48 individuals. Thirty people -- 30 individuals are in this program now, which is roughly about 20 percent of those individuals on the program. But we're still missing that case management component, and that's the most important part of this.

So, I know it's going to say questions up here, but one thing I really wanted to hit on, because I think it's very important, I discuss another project or initiative that our department is really trying to take on. It's called the mental health unit. We haven't approached the sheriff on this. So, I'm really kind of bolstering this program, because I feel he is the one that -- that was a part of his platform, was mental health. That was part of his platform when he ran for election this year, was mental health and -- and violent crime.

But I think if you look at years past, we've

had a number of individuals who have been legal 2000. They either had a threat to themselves or threats to others where we had to do a legal 2000 on those individuals. But what we really want to do is identify those crime users of that, because there is individuals who are legal 2000 two and three times a day. So, there is a disconnect between our mental health providers or the hospitals and then law enforcement, because an individual shouldn't be legal 2000 two and three times a day. Because what does that result in? That results in law enforcement now having to use force on those individuals, or worse, we have to kill those individuals.

One of the officer-involved shootings that we had this year, we had 22 contacts with an individual, 22. And on the -- 22, and on the 22nd time is when we had to, unfortunately, shoot and kill that individual. But why didn't we catch it on the first or second time? We should have caught that.

So, my idea is to really stand up a mental health unit within the officer community engagement, to really work with our mental health providers, to actually get in front of that, to really give that information to the mental health providers and say, "Hey, use your expertise and all of the knowledge and

skills and abilities that you have and go out with us to make contact with these individuals so that we don't have to use force on these individuals." So, that's what we're -- we're hoping to stand up.

And that's about it for my presentation. So, thank you.

CHAIRPERSON BLAYLOCK: Thank you.

MS. CLIVER: Good afternoon, ladies and gentlemen. My name is Lakeisha Oliver, and I am one of the program coordinators, volunteer program coordinators, for the National Alliance on Mental Illness here in southern Nevada.

NAMI or the National Alliance of Mental Illness, otherwise called NAMI, is one of the largest grassroots organizations that help individuals dealing with mental illnesses across the nation. We are currently in most states within the United States, and we offer programs that includes support, education, and additional resources for individuals who are dealing with mental illness.

Please excuse me and my nervousness today, because I am actually sitting in for someone. So, bear with me.

Some of the things that I want to talk about, actually piggyback off of some of the things that

Mr. Scott had talked about, during a crisis people with mental illnesses are more likely to encounter police than to get medical attention. Nearly two million people with mental illnesses, including many veterans -- which myself, I am one, a retired air force veteran -- individuals with PTSD, or other mental health conditions are booked into jails each year, resulting in people with mental illnesses being disproportionately represented in jails or prisons. When in jail, people with mental illness stay almost twice as long as other individuals facing similar charges.

The rate of recidivism among people with co-occurring mental illness and substance abuse is 68 percent. Often people with mental illness who would be better served in a psychiatric hospital setting rather than jail face additional difficulties and exacerbated symptoms within the criminal justice system. Many people with mental illness in jails are non-violent offenders who have minor offenses such as trespassing. Correctional systems are not equipped to provide comprehensive mental health treatment, and correctional officers are often not trained to deal with these situations effectively.

In many cases -- in many cases these people

with mental health conditions are segregated and isolated, which research shows only triggers and worsens the psychiatric symptoms. The National Alliance on Mental Illness adamantly believes that it's time to stop using our jails and prisons as a default mental health facility. Rather than working in a silo -- and this is a term that I'm sure you guys have heard a lot here in Las Vegas, because, getting here in December, I found out very quickly that it's really difficult to make connections between organizations here.

So, instead of working in silos, mental health and law enforcement need to continue to collaborate on these issues to ensure that our individuals who are suffering with mental illness are really receiving the services that they deserve. Once we streamline these services, we give the individual an opportunity to address their mental illness and not maybe the small criminal offense that they have had.

As a person who has severe anxiety, I find it difficult in some situations when dealing with law enforcement. It's not the idea that I feel like I've done something wrong but more so the idea that I'm so nervous that it's difficult for me to be able to explain that, "Oh, this was just what happened" or

"This is the situation that I happen to be in." So, I think that when we think about individuals who suffer with mental illness and the way that our minds process information and interactions with other people, you start to understand a little bit more how important it is to determine what a person is dealing with, to effectively treat them in the necessary way.

Additionally, supporting and initializing -- I'm sorry, supporting and utilizing community-based programs such as assisted outpatient treatment, mental health courts, ACT -- ACT teams, and NAMI can yield positive results and reduce recidivism as well as save taxpayer dollars. NAMI's peer-led support groups are being held in jails in northern Nevada, and we're hoping that we will be able to start those programs here in southern Nevada as well.

So, there are additional -- there are additional places that we feel like attention can be paid to. When you utilize those program, it's been shown across the United States that those programs effectively assist individuals in dealing with not only the criminal justice system but functionality in general. There are specific things that we feel like the -- there are specific programs that we feel can help.

We have currently been working with a couple of the officers on the Crisis Intervention -- Crisis Intervention Team with the Metro police department, dealing with information that specifically targets the idea, like you said, with the legal 2000s. We were told that in the year 2017, that there was one individual who was actually legal 2000'd 38 times. And when Scott talks about the difficulty that that causes, not only for the individual and their family and community -- but also for the justice system as a whole. We really get to see how one person who is struggling with a mental illness can fall into a system that turns into a cycle.

States and communities that have invested in programs such as the aforementioned programs have seen dramatic drops in deaths, serious injuries, and other costly and tragic outcomes. NAMI Southern Nevada is willing to continue our partnership with Metro law enforcement in an effort to expand the training for officers and also for the community in general.

Another thing that's extremely important to the National Alliance on Mental Illness is early intervention for youth. There is a lack of intervention that shows you how to utilize mental health services, how to recognize the signs and

symptoms of mental illness, and what measures should be taken when they do recognize them.

It was reported in 2013 that information from third-grade standardized tests was being used to predict the prison populations. We feel like if you utilize assessments for third-graders, their knowledge on mental health, their precursors that support the idea that they're potentially in danger of suffering from mental illness in the future -- that that information can be better used to facilitate programs that show them the way when it comes to intervention, recognizing themselves the issues that are associated with mental illness, and then also asking for help. Because, unfortunately, sometimes the families of these individuals are also in the same predicament where they don't understand what mental health is. Mental health and mental illness can be implemented into schools in the same way -- I'm sorry. I'm so nervous. I'm so sorry.

MS. COSGROVE: We're your friends. We're your friends.

MS. OLIVER: I appreciate it. It's just --

MS. COSGROVE: I really want to hear what you have to say. I'm intrigued. I'm intrigued.

MS. OLIVER: I appreciate it. I'm just --

as -- as I said --

MS. COSGROVE: See, I'm having the urge to go over there and hug her.

MS. OLIVER: Oh, no. No. No. No. It's not that bad.

As I said -- I don't need a hug yet. I don't need breathing assistance yet.

But -- but as I said, I am an individual who suffers with extreme anxiety. And this has been one of the things that I've dealt with for a long time. Understanding how that affects an individual really motivated me to be a change agent.

MS. NAVARRO: Well, you're doing a great job.

MS. OLIVER: Thank you. I appreciate you.

So, what I was saying is that if we use assessments in third grade, if we're using third grade as a target, to ask questions to children who may have, you know, issues at home, that -- we know that a lot of mental illnesses and the issues associated with mental health start in the home, because we're learning those behaviors from the people who are, you know, based as our caregivers. So, it's important to think about implementing programs that not only give information and education about mental illness to be used, but also engage them in the idea that they can

also help their families and communities understand the importance of mental health.

So, there are three things that I want to touch on that are a part of NAMI's call to action. So, we're asking that people continue to advocate for increased funding towards the Mentally Ill Offender Treatment and Crime Reduction Act, which provides grants to state, local, and tribal governments to support collaborative efforts to reduce incarceration on non-violent offenders with mental illness and establish community-based programs to reduce incarceration since its inception. Funding for the year 2019 is $30 million and an $18 million -- that's $18 million increase from 2017.

We also ask for the support of the $403 million funding for the Edward Byrne Memorial Justice Assistance Grant Program which provides grants to state and local jurisdictions to support a wide range of initiatives in many states. And that includes crisis -- crisis intervention teams and veterans treatment courts. Funding in the fiscal year of 2017 was 300 and 70 -- 375.3 million but has been in danger of experiencing cuts.

The cost of mass incarceration of people living with mental illness is not only a physical one

but a human cost as well. As advocates, policy makers, professionals in the criminal justice system, and behavioral health field experts, we must band together to expound upon these recommended solutions and continue to create additional innovative action plans locally to do our part in fixing this broken system.

Thank you so much for bearing with me.

CHAIRPERSON BLAYLOCK: Thank you. I'm going to open the session up for questions from the committee. Carol Del Carlo.

MS. DEL CARLO: Thank you. And, Lakeisha, you had quoted $30 million in 2019.

Is that in Nevada, or is this a -- the national.

MS. OLIVER: I believe that's nationally.

MS. DEL CARLO: Okay. Because if -- if it was just Nevada, wow, yes, great. But nationally, that's not very much money.

MS. OLIVER: Exactly.

MS. DEL CARLO: Thank you.

CHAIRPERSON BLAYLOCK: Thank you. Ed Williams.

MR. WILLIAMS: My question is for Captain Scott. So, I'm looking at this program, this program

that you presented. It's an interesting program, but I notice that your -- your criteria for an officer to consider someone for a diversion under this program are drug-related offenses.

So, in a situation of an officer coming across someone for trespassing or one of the other offenses that's very common amongst the mentally ill in our communities, is there a diversion program for mental services, or is there -- is there an impediment to having a program like that, something along those lines?

MR. SCOTT: Yes. So, we kind of carved out some room for those. I didn't mention -- I talked about it early on when I was speaking, is that what you have is, you have the Law Enforcement Assisted Diversion at the top. Then when you go over to this corner, you'll have that low-level, non-violent offenders. But what we've actually done since this mental health committee that the sheriff has stood up, we saw how important it was, because I think both of those things kind of go hand in hand, whether it's homelessness, some drug -- drug addiction. It kind of go hand in hand.

So, on the other spectrum we have a mental health component, and that's added to that. And

that's part of that process of going out and doing early intervention on those frequent L2K users. And if the officer comes across -- so, right now we don't have this thing open department-wide. Out of officers' community engagement, we only have two officers that are assigned to do LEAD. So, they go out two times a week, four hours a day and actually identify the individual. So, they understand the process. And we're trying to figure out what hurdles and barriers that we have to overcome, whether it's with our providers or whether it's within our internal processes. And that's one thing that they're recognizing, is something that you just mentioned, is that that mental health component is almost everybody that they're running into.

And they're not doctors. So, they can't diagnose anybody as being mentally ill, but they could really understand that the way some of these folks are talking and some of the mannerisms that they're exhibiting, really they have some type of mental illness. And we're really adding that mental health component into the national LEAD program.

MR. WILLIAMS: So, this is a pilot program?

MR. SCOTT: So, this is a pilot program. Yes, sir. Yeah. So, we were going to see if there is

funding room for that -- that mental health -- those mental health sufferers, that they need to come into the LEAD program as well. I think Seattle really has a robust LEAD program. Albany, New York has that. They're experiencing the same thing. So, it's Albany, New York is the -- one of the leaders there and Seattle. But we do a monthly call where everybody talks about that. And that's resonated through all those monthly calls. We hear mental health, mental health, mental health.

So, you're going to see that paradigm shift to a lot of the drug and prostitution, to a bigger flow of mental health, focusing on it, too.

CHAIRPERSON BLAYLOCK: Other questions? Jon Ponder.

MR. PONDER: And I -- I got to tell you I'm really, really excited. This has been a great day. You know, having this level of conversation, there's been a lot of common ground, like one theme.

And one of the things that we had talked about, a question that I'm -- posed to Dr. Bomer earlier today -- because he expressed -- stressed the importance of mental health professionals working more closely with -- with law enforcement, as law enforcement are the -- the first points of contact,

the boots on the ground, and how we need to partner with the mental health professionals.

So, Captain Scott, first of all, I want to applaud the mental health unit out of the office of community engagements. I think that's going to be a major, major home run.

With standing that up, what are some ways that you think that you -- your office could partner or work closely with mental health professionals?

One of the doctors had said -- made a comment today about more ride-alongs with the mental health professionals so that they could be out and about, but maybe we can -- outside the parameters of what we're currently dealing with, what are some of the out-of-the-box ways that we could -- law enforcement can work more closely with mental health professionals?

MR. SCOTT: I know it's not going to be any easy fix, but I think, like Lakeisha said -- I think there needs to be a lot more communication. There needs to be a lot more communication, a lot more honesty with not only the service providers but with law enforcement, too.

And what I mean by that is that we see in this program -- like it took almost three years just to

stand this program up. And that's only in the infancy stages right now. But you see a lot of providers that say they'll do a certain thing for you. And then when you get to the table, they can't do it; they don't have the capacity to do what they say they can do. There is no fault of their own. I think they really are truthful in what they're saying. They think they can do. But then when the boots come through the door, it's like, "Oh, my god, we're getting overran with this, and we really don't have the capacity."

So, I think there really needs to be a collaborative effort of everybody coming together. Because there is dollars for everybody that's there. There is people that need help everywhere. And if we can get to the mindset -- that's why I said that honest conversation and creative conversations that -- if we can get out of that comfort zone of what we normally do on a daily basis and say we're coming together as a collective group and we're going to all do X, Y, and X, and make sure that they stick to doing what they say they're going to actually do -- because we do it in law enforcement, too. You know, we'll start a program, and the program is going good for, you know, a month or two and it's all bright and shiny and at the beginning, and all of a sudden it just --

that -- that -- that spark will -- just kind of fades.

So, when you're talking about out of the box, things that we can do is, we really have to educate the folks with the boots on the ground to say that, yeah, what you're being told in the academy is fine, but we really need to teach a lot of this mental health component, how to divert the things you're dealing with, Hope for Prisoners. We need to -- that needs to be implemented at the first day of the academy and -- and all the way through. We're talking about cultural awareness change -- I mean cultural awareness training and mental health training. We get probably about an hour of that within the 27-week academy. And then you may get a refresher course, if you want to take it or not, later on down in your career. I'm coming on my 28th year doing this job, and I can tell you I've never had any type of mental health training at all, in 20 -- in 28 years.

So, just think about the workforce that's coming in now. If we don't educate the workforce that's coming on now, they're going to be like me, that they're not going to be educated, and they're going to be coming into their 28th, 29th year, getting ready to retire, and we're still in the same vicious cycle. So, we need to -- I'm thinking of what your --

to answer your question is -- really implement a lot of this stuff on the front end of the officers' training where they really could understand that, yeah, you're a civil servant, is what you really are, and understand what a civil servant is. And it's not about hooking and booking and arresting people and using force and red lights and sirens. It's a totally different thing. And it took me 28 -- about 25 years to really realize that. So...

CHAIRPERSON BLAYLOCK: Thank you.

MS. OLIVER: So, I just also wanted to add that even though we're talking about training, which is extremely important, there also is a gap that needs to be addressed. One thing that we've noticed here locally is that, when individuals are arrested and they have a mental health issue, they go to the hospital, but the hospital can't keep them. So, when they're released, you can give them a list of services that might help them, but it's not guaranteed that they ever follow up with those services. And so then again you fall into the problem of them being arrested over and over again in that cycle.

So, there is really a gap there that needs to be filled in where there is an organization that looks at the needs of individuals being released from the

hospital after being arrested and make sure that they're getting appropriate referrals and following up with that.

MR. SCOTT: It is a gap if you have not been -- I think there is just a actual gap I'm seeing in the legal 2000 process with the hospitals. So -- so, we in law enforcement are -- have the ability to -- to recommend somebody be legal 2000 where they're going to go in and see a psychiatrist and be evaluated; right? We have that ability really to take somebody's freedom away from them with a signature of a pen.

But then when they get down to that facility, I think that's where the -- the gap happens, is that there is no process in place to hold that person accountable for sane, number one, ensuring that they do get the services that they need and making sure that person stays there until that.

So, an example, an officer legal 2000 an individual. He takes that person -- they call the AMR, the hospital, whatever transport and provider that we have. They come and pick that person up. They take them down to Rawson-Neal. If Rawson-Neal is full, they will take them down to UMC. If UMC is full, they take them down to Valley Hospital. It's

almost like, "We're just going to put you on a gurney and put you in the hallway somewhere, and the perception is, you're getting assistance." But the perception is not the reality, because you're not getting any type of assistance at all. And -- and it's no -- I think that the -- the -- the problem is so huge now that, when I'm speaking earlier about the capacity -- just don't have the capacity to do it.

But, like I said earlier, too, is that they have to have honest conversation with themselves and say, "Hey, this is the business that we chose to be in." So, I need to make sure that there is some checks and balances on my end to ensure that when the police bring that individual in, that we detain that individual, because we've really taken away that person's freedom. We have to detain that individual and make sure that he or she gets the evaluation that they need.

And like Ms. Oliver just said, is that we're so used to giving out a flyer and telling the person to do that. No. Those wrap-around services need to be immediate and right there in that person's face right when they're incarcerated. So, that's the idea that we have within the Las Vegas Metropolitan Police Department, is that we're not just going out as police

officers to confront these individuals, we're bringing them all the wrap-around services, whether it's going to be veteran services, whether it's going to be homeless services, whether it's going -- those individuals are going to go out -- and it's called Operation Safe Median, Operation Safe Median. It's going to be once a month. Those folks are standing on the median, and they're saying, "I need X, Y, and Z." Well, if you're saying you need X, Y, and Z, I'm going to bring you X, Y, and Z.

Now, if you're service resistant, now we have to look at the law enforcement part of it to say, "We'll give you a warning citation. You can't be out on the median, because, number one, we have a lot of fatalities out in the valley. It's dangerous for you. We'll give you a warning citation, but we want you to be not service resistant. You're asking for this help. So, we want to give you this help."

So, it's going to be -- it's going to be interesting to see how that's going to play out.

MR. PONDER: Okay.

CHAIRPERSON BLAYLOCK: Theresa Navarro.

MS. NAVARRO: Yes. Thank you for being here and -- really educated again. Every panel that we were listening to, we've heard a lot of good

information and are really honored to be sitting here listening to all of you.

You know, to me it's like I keep hearing kind of like the same thing, like there is this gap between all of this and the mental health, with the mental health professionals, with your law enforcement, with your judicial system, with your nonprofit organizations that are trying to be involved in all that. And, you know, what bothers me is that earlier today the -- the lady, Nita, from the prison system, she made a comment, and that really bothered me, because she said that even a mental health person gets into the system and they are in jail; they can't force them to take the medication. And, yet, all I keep hearing from -- from the officers, from non-profits, from everybody is that they get -- they come into -- 30, 40 times for the same thing, but, yet, there is no enforcement once they're in -- in the system they can't force them to take the medication. They can only say, "This is your medication." But you can't force them. Well, obviously that's not going to help them.

So, you know, what I keep hearing is that there has to be some type of -- whether it be a mandatory thing that all of these organizations, all

of the people that are here and talking to us become altogether really as one force and say, "This is the process. This is what we need to do." You know, that's just what I keep hearing.

But thank you so much for the education, because it really helps to go out into the community and explain what's going on.

CHAIRPERSON BLAYLOCK: Thank you. Other questions from the committee? Sondra. Sondra Cosgrove.

MS. COSGROVE: So, looking into the future, Mr. Scott -- so, let's say your pilot program works and then you're able to get more of your officers that can go out and they decide either someone needs to be incarcerated or they're going to get services.

How -- how are people in the community going to know that the police officer I'm looking at now has that discretion?

Because, I mean, most of us, you know, we see the lights in the rearview mirror, the cop coming at us, and we think, oh, we're in trouble.

So, would there be a way to partner with other, you know, community or organizations and groups that are out there working, to get the word out that the police officer now that's maybe -- you're

encountering someone that's there to help you and they can give you services and has -- you know? How do we make that shift out in the community?

MR. SCOTT: So, the first thing -- excellent question. So, the first thing we really wanted to do was work through the bugs ourselves, because the last thing we wanted to do was bring a program to the community and there is still flaws in it. Because I've learned from going to these opioid summits and mental health summits -- is that if you promise somebody that you're going to do something and you don't do it, that really kind of stiffens your program and people don't believe in your program.

So, the first thing we want to do -- that's why we only have a core group of individuals who are doing it, first of all. Those officers are some of the hardest-working officers on our agency who really believe in the actual program. So, that way we use those senior officers who really can buy into the process of this, find the hurdles and barriers that we need to overcome to make this -- the program successful. And now you launch it out to the other area commands at -- at the same time while you're doing public awareness and -- and educating our workforce on how to actually get this done.

Because -- because a lot of officers, they only see this. They have blinders on. They don't really see anything else but the way they want to do things. So, what we want to do is educate them on, "Well, if you don't want to take the time to do this, here's a number that you can call, and we'll come out and get those individuals, and we'll do it for you."

But what we're also doing is adding a component to this: When they go to jail or if they do go to jail, the jail is going to recognize that, "Hey, this person is a -- maybe a good candidate for the LEAD program. Stop at the gates right here. We're not going to take you through the gates or the door. We're going to contact an officer that's involved in LEAD" and into that transition right then and there instead of taking them in.

So, it's going to be -- it's going to take a while just like with anything that we do. I remember back when I was a young patrol officer, we didn't even have domestic violence laws. We would go on tons of calls where these women were beat up, and we would sit there and beg this woman to try to -- you know, she's bloodied and battered, and we're trying to beg this woman. And now we have the legislature to get some teeth behind mandatory arrests with domestic violence.

And that process when we had to fill out those forms, all the officers complained: "No, I don't want to fill out this form, this, this, and this, and I don't want to do this." But as time grew on, they just learned this is a natural process. And that's what I'm hoping, that this is going to be a natural process.

And why I said at the early part of my statement -- is that this needs to be taught in the academy. So, it's -- it doesn't have to be force fed at the very end of your career. It's going to be a natural transition to what policing has already done. You're going to have to -- so -- so, I hope I answered your question.

CHAIRPERSON BLAYLOCK: Okay. Carol Del Carlo.

MS. DEL CARLO: Thank you. My question is to you, Captain Scott, too, because you went to this training, and you saw value in it, and you brought it back to Clark County. So, we have 17 counties total in the state.

Is there a statewide agency where you guys ever get together as counties and -- and you share best practices, that all the other 16 counties ought to get on this program or -- or what, because --

MR. SCOTT: The chiefs of police do. They

have a -- chiefs of police. All of them come together to actually discuss what is going to be trends in crime, or they talk about new and upcoming, innovative ideas, that their departments are actually bringing on a -- programs that they're -- bring on. So, they have a chance to hear this.

I know Reno right now is very interested in the LEAD program. There is a ex-captain. His name is Brendan Cox. He's out of Albany, New York. He's the director right now of the national LEAD program. He actually is responsible for looking at police agencies, whether it's in Las Vegas or around the country, to bring all of those individuals together to educate them on LEAD. And then we're pushing it out to all of our partners out in the state, too, as well.

But it really is a -- it's a hard lift. It's a heavy lift. If you don't have a dedicated personnel that have the compassion to actually lift that heavy weight, it's going to be a failure. And then what you do as a law enforcement agency, you've tarnished your agency who has a reputation, because you're saying that you could provide something and you're going to do it, and now you can't do it, just like Hope For Prisoners. That's why Jon is so successful with Hope for Prisoners, because when he says he can do

something and he's going to be able to get those individuals something and he does it, his program, it's going to be successful. And that's what we're kind of modeling ours after, is that if you're telling folks you're going to be able to do something, well, I'd better be able to come clean on that promise.

Because what does everybody think law enforcement does? We do everything. The firefighters, they go rescue kitty cats out of the tree. What do we do when we stop your car? We give you a citation. We come to your house, we're going to take you to jail. It's really -- the perception of police work is really negative. It's really nothing positive. So, it -- to transition and get that mindset from the perception of the public to be a positive perception, it's going to take a long time, because policing has been around since the 1800s, and that's just going to take a long time. So...

MS. DEL CARLO: Thank you.

CHAIRPERSON BLAYLOCK: Thank you. Other questions from the committee?

All right. I have a general question for all three of you. Earlier today we heard from someone who mentioned that mental health has a stigma within the community. And so we've heard a lot about mental

health resources and about mental health being appropriate for some individuals who come in contact with law enforcement.

So, I'm wondering, number one, What can be done to reduce the stigma of mental health? And, number two, with law enforcement -- it's my understanding that law enforcement would have the same sort of anxiety, stress, depression, PTSD as a result of issues within the community.

So, what sort of resources are available for law enforcement as well? So, I guess that's two questions.

MR. SCOTT: So, we have an internal process called police employee --

CHAIRPERSON BLAYLOCK: Right. And it's for all three of you.

MR. SCOTT: So, we have -- internally what we have -- so, you're really addressing now what we as law enforcement has to deal with -- with -- Damon was talking about with inner stress or inner-agency stress that we have to deal with on a daily basis and what programs are there for us.

We have a Police Employee Assistance Program called PEAP. We have a director over PEAP. We have a number of employees that work in that arena. And it's

confidential. Any employee on our agency could go to the assistance program and seek -- whether it's counseling. Whatever -- whatever issues they have going on, that director and her staff is responsible for getting you that assistance.

Me as a bureau commander, my job, too, is to -- I do what I call managing by walking around. So, I really have to have my 3,000-foot elevation eyes on in identifying employees who may be going through some type of crisis. They might not be aware, but I see it because of just the way mannerisms are, their dress, their -- just -- just certain things about them. And me and my staff, my lieutenants and my sergeant, have to really keep an a eye out for that.

And then what we do is, we do an anonymous recommendation to PEAP, what we call PEAP, and say, "Hey, I need you to make contact with Officer Such and Such. I think he's going through maybe a divorce." or "He's going through some stress in his life." -- strictly confidential. They can't even tell me what the results are. That employee could -- they could say, "Hey, we need to take this person out of work for a period of time." And they can't tell me where this person is at or anything about it. So, it's completely confidential.

So, that's one thing that we have within our agency, and it works fantastic if the employees take advantage of it.

MR. D'AMATO: Yeah. That's really it right there, like, you know, are they going to take advantage of what's offered to them. Because there is a -- that stigma that's attached to it that if I am considered having issue and I -- there is a certain amount of pride, there is a certain amount -- like you don't want to seem weak. You don't want to seem like there is anything that bothers you. But when we did the six-month anniversary for 10/1, and we had Captain McCahill -- spoke -- Captain McCahill spoke. And she was telling us what she had gone through and what she was dealing with and the fact that she's not dealing with it at all. And she expressed that to everybody in the room, like "I've just been working through it."

But, you know, at some point -- we're only so strong, and we're going to break. And we have got to use the resources in the community within -- program that's, you know, available, all -- anything that's available and deal with it, because we can only -- mental health is all over the place, and there are different levels, no matter what you do.

In -- for law enforcement, you know, that is a

lot of stress. They're regular people. They take the, you know, suit off and -- and we're just like everybody else. Everybody has got to face what's going on and so that we can, you know, get through this life together. But it's -- it's -- like what we share specifically is working with law enforcement or working with first responders and veterans specifically. Those is who we're really diving deep into to -- to come face to face with their value, like a breath is like -- it's a mirror, a reflection of what's going on with you. And when we're fearful, when we're -- get shutting down and we're not -- you know, we're not ourselves and then we begin to second-guess ourselves, that second guess could get you shot. It could get you hurt, because, you know, you're not completely like, you know, in the face of it all.

So, treating and sharing how to breathe, how we do that is allowing you to face your fears, obstacles in your life so you can get past anything that's going on, that internal strike. And that improves your mental health, you know, the endorphins that are going on, the neuroreceptors in the brain. You function at a different level. So, you can rise to the occasion.

So -- but as far as mental health, we offer those services as far as -- you know, we typically have to go to you. It's not often they end up like at the dojo or the studio or anything. I have to outsource. So, a lot of times I'll just show up at meetings or go knocking on, you know, the firehouse or, I mean -- so, it's getting into the trenches and just saying, "Hey, there is somebody that is here. There is an organization that is here, that we care about you." So, it's daily in the trenches, face to face with individuals whenever we can.

If they show up to my studio, great. If they don't, whatever it takes to -- to -- if it's just one person that were able to help them, that's all that matters. One soul at a time, one person at a time is how we go, but we want to branch out to expose it to more, you know, creative a program so if you're -- you know, have these services within, you know, the -- law enforcement, we can make it available and do a whole program and share simple stuff that would make a big difference.

And we look forward to growing Qi United and -- and I actually go speaking around the country. We share throughout -- doing 18-city tour, and we actually are sharing food healing, food science,

breath work, and, you know, utilizing that in a effective way. And -- but we're here. This non-profit is focused here in Nevada and sharing with those that are in need that serve us. And, you know, we're just grateful to be of service to them. So...

MS. OLIVER: So, I actually do a stigma training with the Nevada Statewide Recovery Project, and we talk specifically about stigma and how it affects us as a society. If you allow it, if I'll have a couple of minutes, I want to do a really quick exercise about stigma.

One of the main things associated with stigma is people's fear to speak about it in the moment. So, you guys saw me pretty much have a panic attack; right? So, I am a individual who was in the air force for eight years. So, I operated under high stress. I have been married for 14 years. So, I operate under high stress. I have an 11-year-old son. So, I operate under high stress. But the idea is that I'm also a student. I'm four months away from completing my master's in clinical mental health counseling. I'm currently a student counselor at a local counseling agency, and I've seen great success with a lot of clients. But the idea is that we associate mental illness with the inability to be able to do things

like that. We -- we look at the illness instead of the individual. And so when we speak about it in the moment, if I tell you, hi, yes, this is who I am and I have severe anxiety but I also am a successful person in my own right, doing things to be a productive person within our society, we start to look at it differently.

So, stigma is -- we can minimize and reduce stigma by just talking about mental illness, and we can do that in any place. You can do it by your water cooler in your office. You can do it, you know, in a panel like this. You can do it at work. There is so many places where you can cut down the stigma associated with mental illness.

CHAIRPERSON BLAYLOCK: Thank you. We have time for one more question.

MR. PONDER: I got a comment.

CHAIRPERSON BLAYLOCK: Jon Ponder.

MR. PONDER: Mr. D'Amato, when you got done giving your presentation -- first of all, it was a wonderful presentation. I just wanted to go over in the corner and just breathe. That was really, really good. Thank you for sharing.

CHAIRPERSON BLAYLOCK: Thank you. Any other comments or questions from the Nevada committee?

MS. DEL CARLO: I have one question.

CHAIRPERSON BLAYLOCK: Yes. Carol Del Carlo.

MS. DEL CARLO: Damon, what motivated you to start Qi United?

I mean, you must have benefited from it and knew you could help others.

MR. D'AMATO: Yes. Qi United is an extension of another company called Qi Revolution. And we saw the benefits, that it had a lot of healing properties to individuals throughout the country. And we felt like, you know, how can we truly give back in a meaningful way for those who sacrificed everything? Right? And we really felt that -- that the breath and -- and, you know, the food, science and food healing, you know, just from the earth, you know, no -- nothing else other than just what's natural that comes to us but -- you know, have specific foods for specific illnesses and -- and learning how to do deep, cellular breathing.

And I saw the transition in regular folk. And I said, we got to make this available to them but for free. Like -- so, when we tour, it's for free all over the country, and they're like three-day events. It's like 30 hours of breathing, which is crazy. But I go, but, you know, we need to start a nonprofit

and -- because I -- this is home. I said, let's begin. And, you know, I didn't -- I'm not a veteran, but, you know, it's like, how can I -- what do I have in my life that I can be able to contribute? What do I know? Anything? And I sound like, okay. Okay. I know something. So, let me just share something beautiful with -- with other individuals and see if we can make a difference in, you know, classes, start with one, two people and then more and more become, you know, involved.

And then I said, "Okay. But they're not going to come to class. I have to come to you." And so I'll be waiting after a meeting, you know, like an oxygen junky. You know what I'm saying, you know? And, you know, there will be, you know, the veterans helping -- sorry -- veterans helping veterans or MVP or, you know, vet center in Henderson, you know, anyplace I can go. I'm like hanging out -- but I got to breathe. So -- you know.

And so any -- but it's effective, and it really is a beautiful thing. So, I -- we made it like a mission to just continue to pour into people and love on them no matter -- even if they don't want to breathe. I have people that -- maybe for 10 years they haven't breathed, and, you know, they're --

they're -- right? They're just so spun out of control. But, you know, it's -- but once I get you there, it is like this -- this relief.

And when I see it happening in realtime, it's not like, you know, some medications when they take about 30 days and everybody is -- you're -- got Zoloft and Xanax and everybody's -- you know, it's like you can tap into this beautiful relaxation mode and to simplify it all and find the peace.

So, being able to give especially somebody in law enforcement or a veteran like 20 seconds of peace -- and I can show you how to get there. When you -- you're just -- you know, you're -- you got nothing left, and you're just so spun out. And you go, "Wait a minute. I just follow -- just do this." And for them to find the peace and all of a sudden it's gone and they can reset, refrain, realign, that is gold. That's -- that's a beautiful thing. And they know what to do. So, that -- that's it in a nutshell.

MR. PONDER: Did you ever think about bringing that training into prisons?

MR. D'AMATO: I've -- I haven't done that. I've worked with children with -- to a certain degree, probably like junior high kids for stress relief.

I've worked with a sober living -- it's that organization place that's called Holistic House for people. They're like -- some of these people are like four days off of heroin. I mean, they're really, you know, trying to straighten themselves out and get it together. I worked with people that -- and so they have been in and out of, you know, prison, obviously a lot of issues and so on, but not specifically indirectly, but it would certainly be something that would be beneficial, to learn how to cope, to deal with stress, because I guarantee all of them are having anger issues, anxiety issues, depression, you know, any -- all of those, like a rainbow of -- you know, kind of hell for them. You know, how do they come together to find the center in finding peace and -- and calmness in the storm? And they can be the calm in the storm, realize that they, you know, are not just whipped all around but finding calm. They are just that.

So, we can certainly discuss that further and in any which way.

MR. PONDER: Love to.

CHAIRPERSON BLAYLOCK: Any other questions? So, I would like to thank you for taking part of your afternoon to share with us potential solutions. And

this has been very informative, very educational for me and, from the questions from the committee, for all of us. So, thank you for coming.

Let's see. We have time for a 10-minute break, and then we will have our second solutions panel.

(Off the record.)

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POTENTIAL SOLUTIONS II

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JEFF DETRICK, University of Nevada Las Vegas Military and Veteran Services Center

DANIEL SOLOW, Lt. Col., Nevada Highway Patrol

ANNE CARPENTER, Deputy Chief, Nevada Parole and Probation Department

ROBERTA PIKE OATES, Senior Master Sergeant, Retired U.S. Air Force; President, Thunderbird Chapter, Air Force Association; Vice President, Women Veterans of Nevada

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CHAIRPERSON BLAYLOCK: I now would like to introduce the Potential Solutions II panel. On the panel are Jeff Detrick, University of Nevada Las Vegas Military and Veteran Services Center; Daniel Solow, lieutenant colonel, Nevada Highway Patrol; Anne

Carpenter, deputy chief, Nevada Parole and Probation Department; Roberta Pike Oates, senior master sergeant, retired, U.S. Air Force, president of the Thunderbird Chapter of Air Force Association and vice president of Women Veterans of Nevada.

And I will turn the floor over to Roberta Oates.

MS. OATES: I'm glad you were the last one. I thought I would be the last one to speak.

As stated, my name is Roberta Oates, O-a-t-e-s. In addition to the Thunderbird Chapter for Air Force Association and the Women Veterans of Nevada, I'm also on the governor's women veterans advisory committee.

Several years ago, about 2014, the governor declared it would recognize women for that year, and they set an advisory committee for us to assist the governor in addressing women veterans issues. Well, our first meeting, we were made up of two women from Las Vegas, two from Reno, and one from one of the rural areas. And it's actually somebody form Elko. The first meeting we had, we decided that a year was not enough. So, we took it before the legislature to put us into statute. And it was passed through the legislature. So, we are in statute as a permanent

committee. That was our first objective.

This is my third term on the committee. I've been on it since the beginning. And our goal was to assist the Nevada Department of Veterans Services in reaching our women veterans. Because what we had found is that a lot of women don't identify as veterans, especially our older women vets. Most people they -- the thought is, if you have served in combat, then you are a veteran. Most of our older women have not served in combat as our present women are doing. So, therefore, they do not feel they are a veteran.

Also, we found that reservists also face that same problem. They don't consider themselves as veterans, or the general public doesn't consider themselves as veterans. We are also finding that a lot of our women veterans are just kind of disappearing, in the fact that they may have had a negative experience in the military, be it military sexual trauma, MST; PTSD, or some other problem. And they just kind of fade away. So, therefore, they don't realize that they're eligible for benefits just as our men are eligible for benefits.

Another problem that women veterans, if they do try to reach out for services -- find that they may

lose their children. Because you'll find a lot of women veterans are single parents. So, therefore, like a lot of women, vets may become homeless, because if -- they figure if they go for assistance, their children will be taken away from them. So, therefore, they won't go for the assistance.

Our VA center, we have a very active women programs manager, Jenny Childress. She is really working hard to help our women veterans. And at one of our previous VA institutions she was at, they offered child care for our people for when they come for their doctors' appointments. And we in discussions have found that that might be more positive, and more women might come out to get services if they had someplace to bring their children. Because, like I said -- and it's a lot of those single parents. They don't have anybody to take care of their children. So, therefore, they don't come out for services for themselves.

The population of our women veterans is getting younger. There is some studies that have said that "Women represent a growing population of American veterans. Of post 9/11, 20 percent are women, a largest minority group in today's military. Nevada's number is nearer this trend. As one of the

fastest-growing subgroups, women veterans are signing up for USVA health care and benefits at a higher rate than ever in history. VA studies indicate that the female military and veteran population will continue to grow. By 2014, report showed women veterans made up less than 10 percent of total veterans in the U.S. By 2043 they will account for 16 percent, an increase of 50 percent of all veterans.

"To keep pace with the growth of the women veterans population, the U.S. Department of Veterans Affairs, DVA, has developed a new program and services. It will take time for that to change decades-old systems. In the meantime, women veterans face challenges to myriads of services and care to women. Of the estimated 24,000 women veterans of Nevada, only about 6500 or 27 percent have sought VA benefits and services. And of that, Nevada Department of Veterans Services has only been able to identify by name and contact information of about 300 women -- 3,000 women veterans."

And that's another problem, is because of the HIPAA laws, we have women that are registering with the VA and going to the VA clinics in Reno and in Las Vegas, but we cannot share the information with our department of Nevada Department of Veterans

Services. So, the way we kind of get around that is, sometimes we'll hold joint events so that we can get people to sign up. But because of the federal laws, we can't go say, "Hey, you know, can you give us who the women veterans are so we can come out and find them?"

One of the -- our veterans advisory committee, it was initially established by executive order. But we were established to support and assist in locating, educating, and advocating for all women veterans in the state. We will assist with outreach through various means, including the organizations of state women veterans events, promotion of benefits of superior health care for women vets, development of programs that inform the community about the important role women have played in the American armed forces.

We'll also assist to advocate on behalf of women veterans to ensure that programs and policies, the state of Nevada, and the department of veterans services remain open to women, ensure that these programs and policies remain mindful of those elements of women -- veterans experience that are unique to women.

Another thing that has been talked about a lot today has been the prisons. And we do know that there

are women veterans that are in the jail system. But as with most veterans, be they male or female, they may not self-identify as a veteran within the prison system because of the fact that there is a stigma that they may get special treatment, or the other inmates may feel that they're getting special treatment, and there may be retribution against the veterans for doing that.

So -- and I -- aware that in some states they're trying to set up like this special PAWS that are just made up of veterans so that they make sure that they do get the services that they need. And I know Nevada Department of Veterans Services is reaching out to the prisons to help the prisoners that are incarcerated to -- to let them know the benefits available to them.

Nevada is trying to be the most veteran-friendly state in the union in the past several years that I have been working with the committee. We're slowly gaining ground. People are recognizing that women are out there, that we have served, that we do contribute as much as men have done. Our main goal is to make sure that we won't always be having, you know, this woman accomplish this, the first woman to do this. We want to get that

"being the first" gone, that we're just veterans.

We happen to be female. And, yes, we are unique. We have special problems. We may have, you know, MST. Some men may have that problem, too. But with the MST may be with the PTSD, and the PTSD may be with the MST. It's just an education of letting people know what's -- what's going on and that, you know, we did serve, we served proudly.

And one fact, in the '60s when they were talking about doing away with the draft, a person up in congress made the remark, "Well, if we do away with the draft, nobody will show up to fight if we have a conflict." Women have been fighting since the American Revolutionary War, and we had been volunteers in every conflict that has gone on. And over -- almost 300 million women have served in our services since -- since the beginning of our country.

And that's all I have for right now. Thank you.

CHAIRPERSON BLAYLOCK: Thank you.

MS. CARPENTER: Good afternoon. My name is Anne Carpenter. I'm the deputy chief for the department of public safety, division of parole and probation, and I have been personally impacted with loss both on the mental illness side and veterans with

PTSD. So, this is very -- I'm passionate. This is very important to me as well. I also have some of my team here from my mental health court and veterans court in case you have questions later on.

As an overview, the -- the division has a few specialty court programs, but I would like to just discuss the mental health court and veterans treatment court. And we can also talk about the AOT court.

So, the mental health court at the division, who participates in mental health court? The court is available to probation offenders only, so just probationers, and those probationers who have been clinically diagnosed with serious mental illness. We also have those probationers that have co-occurring mental health and substance abuse. So, they're in there as well. And the criteria for this program is outlined in the Nevada Revised Statutes. And if you want the statutes, I have them here.

Our treatment goals and objectives: Well, we want to modify their behavior. We want to make sure that we're monitoring them through treatment and medication. We want to reduce recidivism, like the other panelists have talked about. We don't want people to come back over and over and over again. So, we want to make sure their treatment plan is working

for them. And we want to alleviate incarceration. Like the captain of Metro said, it costs so much money to incarcerate people, and we want to keep them out of jail as much as possible.

Our program structure: Our probationers are required to -- to complete a two-year program, and this is at a minimum, and these programs are extremely intense. Our probationers can be placed in the mental health program either at the time of sentencing by the district court judge or at revocation in lieu of sending them to prison or incarceration. Our probationers in mental health court are provided treatment through our community partners, and we work very closely with Southern Nevada Mental Health.

And after reading some of the information that the committee put out, they wanted to know about the demographics. So, I included that as well, so 43 percent Caucasian and 57 percent persons of color.

So, the supervision of our mental health cases -- just a little bit of background. The way our division is structured, the legislature funds us, our -- our officers by our caseload, how many people we have on these types of caseloads versus the officer. So, with these types of cases we'll get one officer per every 30 cases, is how they -- how we're

funded. So, currently about 45 cases to one officer, which is high -- and our goal is 30. So, hopefully we'll get some more officers in the next session.

But with our team they have weekly staff meetings, and it's a team approach with the public defender, district attorney, judge, and the treatment staff and our probation officers. They discuss the treatment options and discuss appropriate ways to treat these people. And I've talked to my team, and I think this is a really great way to handle the mentally ill offenders that we have. And they determine the appropriate levels of care. I think this is really great, because everybody is at the table, and they can explain what's going on with these people, and then every single person has a voice at the table.

What I thought was really interesting is that Nevada, especially Las Vegas, it's a sin city; right? So, whatever happens here stays here, but I guess not for mentally ill. So, what they do is, on every Monday they have these conference calls, and the team gets together to find out exactly what happened over the weekend, because the weekend seems to be a period of crisis for people. So, that's wonderful that they try to get ahead of it.

And court work and intermediate sanctions, we address these infractions by meeting. They meet again, and they see if they have any failed or missed drug tests and that sort of thing. So, I try to give them intermediate sanctions instead of just throwing them in jail.

The waiting list for mental health court -- okay. Let's see here. Okay. So, the numbers fluctuate, but there are approximately 40 -- 40 misdemeanants and/or probationers awaiting space, and there is at least a six- to nine-month waiting list for people. So, that's a big problem and one of our challenges. Another thing, the judge must order mental health court as a specific probation special condition. So, for somebody to be in mental health court or even waiting mental health court, they have to have the judge order that. Let's see.

Having mentally ill probationers wait for mental health court is problematic. This population will either have to remain incarcerated until there is an opening, or these probationers will be assigned to a mental health caseload. But until the probationer is accepted into the mental health program, the probationer will not have a treatment plan in place, and that's a huge issue. Another issue is that the

mental health officer may not have appropriate amounts of time to devote to this type of probationer. So, they don't have a treatment plan, and if there is no plan in place, the officer is left with them just waiting for this opportunity to get into mental health court.

Usually they have to remain in custody, waiting for mental health court. I said, "Why? Why are they doing that?" Well, they said many are homeless. And if they're homeless, that could be an issue. They're a liability to the community. They could be a liability to themselves. And if they have no treatment and plan in place, sometimes the best place is incarceration. And that's what I would love to fix to see something different.

I think Hearing Master Bita Yeager spoke about this as the out-treatment program in a previous panel. I do want to talk about how -- in the last panel you talked about forced medication. One of the panel members said something about forced medication. Well, this is the only program that they -- it's a civil commitment, and they can force medication through this program.

All right. So, the veterans program overview -- so, who are -- who participates in

veterans -- veterans treatment court? Again it's those probationers who are diagnosed with mental health or substance abuse directly attributed to military services. Our probationers are admitted to veterans court at the time of sentencing and/or revocation, same as mental health. And once that probationer is accepted, we transport them to the VA for services.

Now, veterans court is different from the mental health court simply because this population of probationers has a myriad of resources through the VA, and mentally ill don't. So, it's very different. Oh, and the current demographics, it's -- it's almost flip-flopped for mentally ill, for veterans.

We have two supervising officers, and again the ratio is 30 to 1. And they're a one-year minimum program, and my team tells me that this program is extremely intense. So, some people don't want to go into this program. But the VA and the officer work together to stabilize the offender. They have staff meetings as well twice -- twice monthly. And they also discuss the treatment options and determine their appropriate level of care.

Interesting -- interestingly, there is space available for our veterans, and the reason why is that

sometimes there is a lack of education or communication between probation, maybe the legal system, the attorneys. And so we're trying to get more knowledge out there about the program. And per statute, in some instances veterans don't qualify for the program.

Some of our challenges: Different treatment providers may offer different treatment plans. For example, if a veteran is incarcerated in the county jail, they might have a treatment plan. And then if they get released and go to the VA, they might get a different treatment plan. And that could be problematic, because they might be at odds with each other.

Our potential solutions -- and I -- I'll go quickly. The big one is a long-term secured facility for those who are too mentally ill and cannot be supervised by the division or the courts. This is huge. And I think the other panel members had talked about this, if there could be one place with wrap-around services. The population of mentally ill and then veterans, it's very difficult for people to be transported to different places to get different things. We really have to have one place where they can come in and get everything they need, especially

that gap we talked about about 30 minutes ago. That, I think, would be wonderful.

Training: There is training out there, but we don't have enough. I wish that we had re-occurring training for our staff. The captain at Metro said for 28 years, 29 years he didn't have much training. So, I would love to see more training offered and then continuing training.

And then, lastly, the funding: It is not solely about the money but ensuring that the right amounts of money are in the right areas. It's about putting the right people in the right places and having oversight over the funding and the programs, because in the end we all want the same things: persons with mental illness to get the help that they need; the veterans, after serving our country, get the help that they need; and that our community is safe and liveable. That's all I have.

CHAIRPERSON BLAYLOCK: Thank you.

MR. SOLOW: Good afternoon, distinguished committee members. I'm Lieutenant Colonel Daniel Solow, the assistant chief of the Nevada Highway Patrol.

The Nevada Highway Patrol is the primary law enforcement agency for the state of Nevada, is a

division within the department of public safety. The duties of the Nevada Highway Patrol include, without limitation, to police the public highways in the state, to enforce and to aid in enforcing thereon all traffic laws of the state of Nevada, and to enforce all of the laws of the state. This statutory guidance leads to our primary mission of providing traffic safety and service to the motoring public as they use the state's highway transportation system, over 40,000 lane miles of road, and protection of the system that transports over a hundred and $60 billion worth of commerce annually.

The mission of highway patrol is to promote safety on Nevada highways by engaging and educating the community, by providing law enforcement and traffic services. The mission is met through five goals: to prevent the loss of life, injuries, and property damage; to maximize service to the public and assistance to allied agencies; to optimize traffic and emergency incident management; to protect public assets; and to improve divisional efficiency.

As a public agency, the highway patrol is committed to treating all persons with respect and to provide impartial, non-biased, professional, and fiscally responsible service to the public. The

highway patrol does this through a number of organizational values, which include the protection and respect of human life; loyalty to the standards of law enforcement; the courage to make the right decisions in the face of physical danger and/or moral dilemma; professional conduct, excellence of performance, and innovative public safety leadership; unprejudiced service and compassion for those in need; collaboration and teamwork among fellow employees, allied agencies and our communities; and accountability for our actions, performance, and reputation.

The highway patrol is a diverse workforce reflective of the population that we serve. A recent informal study revealed that almost 30 percent of our staff identified as a non-white, while just over 10 percent are veterans of the United States armed forces. By comparison, non-whites compose 25.4 percent of the population in Nevada, while veterans were just over 7 percent at the last census.

For the department of public safety as a whole, training in our values starts right at the beginning in the basic academy. With course of instruction that include crisis intervention, cultural awareness, and handling persons with mental illness,

newly commissioned DPS officers or troopers receive over 25 hours of values-related training, not counting what is instilled tangentially in other coursework. During mandatory annual "use of force" recertification training for sworn staff, both classroom and scenario-based training includes a module on mental illness awareness. Additionally, all employees are required to complete annual training in valuing diversity.

In early 2001 the Nevada legislature commissioned a study by the University of Nevada Las Vegas to collect data related to the perceptions of racial profiling among the Nevada law enforcement agencies particularly when it comes to traffic stops. The study's results published in 2003 showed that for the highway patrol, our organizational values were embraced by our troopers. Just for comparison, where non-white persons accounted for 34.8 percent of the state's population in 2000, minority drivers only accounted for 25.3 percent of all persons stopped by the highway patrol. This empirical data demonstrated the highway patrol's commitment to its primary mission of traffic safety where our troopers focus on driving behaviors which lead to crashes, regardless of any characteristic of the driver operating the vehicle.

One of the most common areas where highway patrol troopers encounter the mentally ill is through the issue of homelessness. The on and off ramps in major intersections along the highway corridors are common locations where homeless people congregate to panhandle due to their natural proximity to many of the locations where homeless can live relatively undisturbed along highway right of way. Many of these persons have misdemeanor warrants for crime such as panhandling, trespassing, vagrancy, and/or other pedestrian-related crimes. Additionally, a high percentage of these persons suffer from mental illness. With their safety in mind as a traffic issue, the highway patrol is vigilant about patrolling these areas and contacting these people. Instead of simply issuing citations or taking them to jail for their warrants, troopers are directed to provide contacts to community-based groups who can assist the homeless. Provided these persons do not pose a threat to themselves or others, troopers do not arrest except as a last resort if the subject is not cooperative and no other options exist. This is just one area where the highway patrol adheres to the recommendation for seeking least-harm resolutions pursuant to the 21st Century Policing report. Detention for evaluation,

pursuant to NRS 433A.150, is rare for troopers and requires supervisory approval prior to release to a mental health facility.

Today in southern Nevada the highway patrol has been particularly innovative and dedicated to not just enforcing laws but to work on actually helping people to make our communities a better place to live and work. In partnership with the Las Vegas Metropolitan Police Department, the highway patrol has adopted the Memphis model in regards to handling persons with mental illness or otherwise in crisis. In southern command, which is made up of the urban Las Vegas Valley, Pahrump, Beatty, Alamo, Pioche, Mesquite, Overton, Laughlin, Searchlight, Primm, and Sandy Valley, the highway patrol has 15 currently trained, certified crisis intervention team troopers, accounting for approximately 1 out of every 12 sworn officers. In addition, we currently have a waiting list of another 16 troopers who have been found to be qualified and are awaiting the training. While not quite the same in numbers, the northern command of the highway patrol is also involved in the CIT program.

The highway patrol is the lead partner with LVMPD in the "take back the strip" program. This program involves weekly patrolling of the Las Vegas

strip corridor area by specially-trained officers with a particular emphasis on community-based solutions to crime and related issues in this high-profile area. All of the highway patrol's urban Las Vegas graveyard has been trained as safe tourism action response squad officers and fully participate in the program. What sets this program apart is the involvement of many community-based groups, such as the Salvation Army, the American Red Cross, Seeds of Hope, Free International, faith-based groups, and HELP of Southern Nevada, who all share the goal of helping those in need. Any homeless encounter during these patrols are immediately put in contact with one of these organizations to assess and assist them. Additionally, should someone who identifies with a mental illness be arrested for a misdemeanor crime, their case is directed through the community impact court, which offers a number of diversionary services and assistance, including veterans assistance, should the person be a military veteran. Since January this program has been responsible for many drug, firearm, and other vice-related arrests, while providing assistance for countless homeless or destitute persons who live on or near the Las Vegas Boulevard strip corridor. This has included medical care, mental

health services, temporary housing, transportation, food, benefit assistance, education, and job skills.

Community engagement has been a focus of both our current leadership team and its predecessor dating back many years. It is clearly recognized among the executive levels of the highway patrol that positive interactions with the public are essential not only for the public to gain an understanding of our mission and identify with our goals, but these interactions also provide a benefit to our troopers as they gain an appreciation for those that they serve. The highway patrol has been involved in organizations such as Special Olympics, Pediatric Brain Tumor Foundation, and many others for years now. One area where the highway patrol has been historically involved in the community, which falls in line with the recommendations of the 21st Century Policing report, is involvement with youth in our schools. Every shift within the urban areas and nearly every rural substation participates in events with the local school district, ranging from reading hours and public-safety fairs, to full-on "adopt a school" events. One example, the Las Vegas urban graveyard shift has adopted the Ira J. Earl Elementary School for nearly 10 years now. The participation with this

predominantly disadvantaged community school includes donation drives every holiday seasons to provide meals, clothing, and gifts to families that otherwise might not have had anything, to participation in nearly every school-wide event during the year. This has become a model for many of the other squads to follow providing a positive police community interaction.

While not specific to persons with mental illness or veterans, one other way that the highway patrol has engaged the community in a unique fashion of community policing comes through the Nevada System of Higher Education. The 2017 Nevada legislature authorized the need-based Nevada Promise Scholarship program in all community colleges in the state. This program is designed to provide last-dollar funding to complete a community college education, therefore predominantly assisting those with lower incomes. One of the requirements of this program is that all high school and young adult participants who enroll in this program meet with adult mentors who help guide them through their first two years of college. Seeing an opportunity to be involved with the next generation in our community, the highway patrol had partnered with both the College of Southern Nevada and Truckee

Meadows Community College, providing over 50 trained, volunteer mentors statewide to work with these students and help lead them to success.

In conclusion, the Nevada Highway Patrol continues to embrace the community as a partner and seeks out any opportunity to serve and enhance our role in protecting the citizens and visitors to our great state.

MR. DETRICK: Good afternoon, everyone. My name is Jeff Detrick, and I'm humbled by my presence here. Thank you.

CHAIRPERSON BLAYLOCK: Jeff, excuse me one moment.

MR. WILLIAMS: Actually I want to make sure you have a good working mic there.

MR. DETRICK: Oh, yes, sir. It's good to go. All right. Good.

CHAIRPERSON BLAYLOCK: Are we good to go on this?

MR. DETRICK: All right. Thank you. So, thank you for asking me to speak before you today. You incredibly humble me. So, I want to make a quick correction. Hold on. Let me back this up.

So, I do not work for the military veterans service center at UNLV, although I do work for UNLV

as an academic counselor. I work for an adult education program that falls under the purview of the U.S. Department of Education. However, I'm closely tied in to the office. When I was in my undergraduate studies, I worked as a VA work study. I was the president of student vet org for two years. And I ran a mentoring program that's still in place on campus.

So, my position allows me a pretty cool job, as I get to sit -- one of my responsibilities is, I sit with veterans that are transitioning out of the military. So, we all know that that's a big conversation we're having in this country, is transition of veterans that are coming out of these team environments, going into employment, going into higher education. So, I sit with a plethora of different type of veterans and individuals as a whole, on top of people coming out of parole and probation. I work closely with both veteran and -- excuse me, Henderson and Las Vegas courts. So, they know about our program. So, they will send for veterans to me to talk about their education.

So, what I want to talk about is the transition in which obviously mental health has been a huge topic today. And so my apologies for not being able to be here this morning to listen to the dialog

that was going on.

So, one of the things that I found was -- sitting with veterans and through my work is, the transition process is, they are coming out of the military and they're having -- not all of them but a big deal of them are kind of in this "what do I do?", "do I go to school?", "do I go find a job?", "if I go to school, I kind of feel like an imposter, kind of Billy Madison return to school", because that's how I felt when I transitioned out of the military, 37-year-old man, and I'm in the classroom with 18-year-old, 19-year-old children, not children but young adults that are pursuing their education. And so what I found out real fast is, they really do not care how old it was. And I had to make experiences with that. So, I think that's kind of a -- an issue with some older adults that feel that way. And on top of that, a lot of them are not necessarily wanting to commit the four-year time frame to get a bachelor's. So, they could use their GI Bill benefits for vocational or technical schools. So -- and then that's been a challenge.

For the most part, all of them that I sit with know where they went to go. Man, there is a lot of feedback. Sorry about that, everybody.

So, for the most part, a lot of them know what they want to do, but they do have some challenges. I had one here a couple weeks ago that, for lack of better term, got a little excited when I told him that getting his vocational degree was going to take a little bit longer than a month that he wanted. Because he needed something right now. So -- and that goes into the employment prospect.

So, if you're X rank coming out of whatever service and you are -- I think -- no? No. There is -- yeah -- we're good now? Is this better? Okay. Fantastic. Sorry about that.

So -- and let me backtrack a little bit. When I got into this when I was on campus, that's when I started really figuring out the transition process, because one of my responsibilities, when I was working in the office, is, if Wendell got out of the air force and he was coming into the office for the first time, wanted to use his GI Bill education benefits, say, "Wendell, glad you're here. What can we do for you?" "Yeah. I just got out of the air force. I want to use my education benefits." But Wendell didn't know that he had to apply to UNLV. So, Wendell doesn't know that there is standards to get into the institution. And so that would be incredibly

frustrating for veterans, not knowing that process and stuff. And so that's when I started looking at this transition issue.

And then the program I ran after I was the president was initially developed out at the University of Michigan called Peer Advisors for Veterans' Education. So, UNLV is one of the first 13 schools that piloted this program. So, as -- my responsibility was, I had 10 different peer advisors under me.

So, Wendell came, and he's using his education benefits. We cold call him: "Glad you're here. If you need anything, this is the stuff we have on campus for you." Mental health challenges, problems paying bills, VA problems -- so -- and that's all data collected, because it gets sent back to the University of Michigan, and it gets sent to the big VA.

And so a lot of the issues I saw -- and we weren't counselors, but if you needed to come and see somebody, we could provide that tool for you, because they don't know where to turn. So, one of the things was I've -- you know, sit down with veterans, say, "Hey, I just need to blow off some steam, because I'm about to kind of lose my mind while I'm trying to learn and there is somebody playing a game on Facebook

while I'm trying to learn a lecture. So, it was little things like that.

However, we would have some veterans that come in, and it's like, "Yeah. I just blew $5,000 at the gambling table last night in an hour." Okay. We need to sit down. So, obviously they're bringing in challenges with this transition, because they're leaving a team and now no one is on them, no one is pushing them to tell them they have to do this. This is all on them. And so they kind of feel like they're not valued anymore. And so they're struggling with those things.

My transition itself was less than enjoyable. And I had planned on it. And so I didn't think it was going to be that difficult, and I still -- everybody else handles stuff differently. With that being said, I think a lot of veterans, when they are transitioning out of the military, are not expecting to have -- run across the challenges that they have. And to piggyback off Ms. Oates with the women vets, when I was initially there, we couldn't get anybody, no one to -- female veterans. And so that was a big challenge: How could we pull in more female veterans? Because we have so many of them now. We don't want them excluded from the activities we're doing and what

we're doing on campus. And so we actually started the female veteran club on campus. Through some leadership challenges, that's not really there right now. However, our president and vice president right now are both female veterans. So, that's -- we're happy about that.

And another issue that they're having -- and this is -- issue I had, too. I was a medic when I was in the army. So, I was initially doing pre-med. So, if they're going into an institution -- if you're coming out of there an eight, mean you're a nuke working on nuclear reactors. When you go to an institution, for the most part, that's not playing into your degree plan. So, one of the other challenges is like, okay, how can we -- that's another frustration veterans are having. So, how are they going to be able to apply what they did in the military to either higher education or getting employment? Because languages are different in the civilian sector compared to military sector, compared to the police and first responders, you know, sector. So, how is that transition working? So, those are some other challenges that are still ongoing.

But with my experience at UNLV, those are the solutions to the problems: implementing a Rebel vet

organization, because that helped with my transition with getting back involved. Having a peer advisor's education, you know, mentors on campus, a mentoring program to reach out to these veterans, with student veterans that had already been in school for a couple semesters and reaching out to them saying, "What are challenges you" -- "You know what? I had the same challenge. This is what I did to overcome it."

So, at UNLV as a whole it's a fantastic program, and a lot of the problems that initially when we first started this back in 2013 -- these were the solutions we implemented. So -- so, you guys have an understanding on the local level, at least at the university level here at UNLV, and across nationally, too, because you have Student Veterans of America. And if no one knows about that, it's a national organization that follows -- the regular veteran clubs that are at different institutions follow, and it's kind of like the big commission, U.S. Commission of Civil Rights. It's the same thing. We teach veteran club. So, they're dealing with an advocacy. So, a lot of these veteran clubs that are showing up at these universities across campus now -- there is over 1400 now. And so they're implementing a lot of these same solutions. Because there is -- we have a yearly

conference where we get together and talk about these things and these solutions that we can bring on campus.

And then -- yeah. Sorry about that. I kind of lost my train of thought on this one. So -- so -- and then that leads into employment. So, what can we do to help with the transition process as employment? Now, with mental health issues we see a lot of it, but we have solutions in place. We have had four suicides with veterans on campus since I've been there since 2013. So, every semester the Nevada Department of Suicide Prevention {sic} comes in and gives suicide prevention classes for the students there. So, we try and mitigate these situations as they come up and try and get the solutions to them really quick.

So -- and then another thing is, I'm intern president of the alumni club. We just started it. So, with that initiative, going back into transition pieces, setting up in the 20 programs for professional -- professional veterans going back into the workforce -- and that's one way I've met a lot of veterans in the community, was having monthly breakfasts for veterans to come out and just to kind of get together and say, "Okay. What kind of challenge are you having on the local level as far as

employment is concerned? What can we do to help each other out?" So, we implemented that a lot on the -- on the local level.

And so with that being said, we've had some great success, but then we had some -- you know, obviously some push-backs on that. But with the stuff that we have implemented here at the university level and locally -- because what I've -- really enjoy about the community here in Vegas is, it's a big city, but it feels like that small-town feel. So, when we're working with veteran service organizations within the community on the local level, I've run into people -- I run into Ms. Oates all the time. I run into Mr. Blaylock all the time, because we've wound up at these different veteran and community events. And that's what's great, is because if I don't have a solution, I can reach out to Mr. Blaylock or I can reach out to Ms. Oates or I can reach out to somebody else that we're tied into, that if I don't have it, then maybe they have the solution for me.

And I get that a lot as well. I have individuals call me up saying, "I'm having this challenge as a veteran. I don't know anybody." "Okay. I don't know anybody either, but let me see if I can find you somebody." So, that's what's been

really great about this community here, coming back. And it has helped immensely, because when I first started at UNLV, we had about 800 students, right, close to 1900 now almost. So, it's grown exponentially. So, we have really strong programs on there.

And other than that, that's been pretty much the biggest challenges we've come across in the biggest discussions we had on the local level as far as coming out of the UNLV, CSN, and stuff like that, is the transition piece that are concerning veterans. And I would argue, too, with -- well, there is no argument actually.

I work a lot with parole and probation. I've gone out and sat with veterans out in High Desert and Southern Desert as well. But that's another piece that obviously has been brought up, is, veterans have awesome transition programs out there for them right now. Persons of incarceration that are coming out do not, and that's something I've learned really quick, and that's been a real challenge of mine when I sit with these individuals, is trying to find them the resources, if I don't have them, on how we can better serve them.

So, that's what I have. Thank you very much

for allowing me to speak.

CHAIRPERSON BLAYLOCK: Thank you. I -- I apologize for the challenges with the mic.

MR. DETRICK: Oh, that's okay.

CHAIRPERSON BLAYLOCK: And, Roberta, did you have a question before I open it up to the committee?

MS. OATES: Actually -- actually -- actually I just did, one more comment, that one of the things with our -- our women veterans advisory committee -- another thing -- one of the biggest challenges is, when you ask a person, "Are you a veteran," a lot of people won't answer. So, our thing that -- one of the suggestions we gave to the governor in -- it will take effect as things -- over time -- is, instead of asking the question "Are you a veteran," ask "Have you ever served?" By asking the question "Have you ever served," that gets a discussion going. So, then maybe the person will go, "Well, yeah, I did a couple years here" or, you know, "I did a year here, three years."

But if -- so, they don't consider themselves veterans, but if you change the question, you'll find out they're a veteran. And that's one thing that they're working as they update forms and everything, is to change that question. And I think that's going nationwide where a lot of veterans organizations are

working to get that terminology changed. And that's a big thing.

CHAIRPERSON BLAYLOCK: Great. Thank you. I would like to open the floor up to the committee for questions for this panel. Ed Williams.

MR. WILLIAMS: So, my question is for Ms. Carpenter.

One of our previous panelists had made the suggestion of a possibility of consolidating some of our judicial court programs for efficiency and because of the -- the co-occurrence of a lot of these conditions. And we've seen earlier today about how people get separated into silos based on funding sources. So, you know, one group of people has medical insurance and gets treated a certain way. Another group of people has another set of medical insurance, and they don't get treated by this group; there is another group for them, and they get a different set of resources, even though they may be similarly situated.

Do you see any challenges in -- or opportunities in consolidating our specialty courts when there is so much crossover between the bridge programs?

MS. CARPENTER: When you say consolidation of

specialty courts, are you talking people that are under parole and probation, or are you talking about everyone in the community?

MR. WILLIAMS: Probably say in your case it would be people that are on parole and probation. So, that applies to the community.

MS. CARPENTER: Right. So, I guess it would have to go back to statute, because we have probationers in these -- in these treatment programs.

So, when people come out on parole, if we -- yes. I mean, the answer is, yes, you could do that. But we need to expand it. And right now, as you see with the RB sources not having enough funding, not having enough space in the program, having a wait lists -- so, I think if we can expand those programs, the simple answer is yes. We just have to get there.

MR. WILLIAMS: All right. Do you see opportunities to consolidate those, there is some efficiency there potentially?

MS. CARPENTER: Again, yes. But it takes the legal community. It takes our division. It takes legislators. It takes NDOC. It takes everybody, for us to work together, which is not impossible. They're just challenging.

MR. WILLIAMS: Great. Thank you.

CHAIRPERSON BLAYLOCK: Sandra Cosgrove.

MS. COSGROVE: So, I work at the College of Southern Nevada, and I do a lot of work with our diversity office. And we've had challenges where there is kind of an old way of looking at diversity, we define it cultural diversity. And they'll say, "Well, what do our Latinos students see?" and "What do our African Americans students see?" And we've -- as a faculty member, I can say, "So, when I'm looking at my students, I see a huge community of veterans. I see a mental health community." And so we need to be better when we're talking about diversity, make sure that we're defining -- there is all types of communities, and people belong to multiple communities.

And I agree with you. Oftentimes it's hard to sometimes know that someone is a veteran and that they probably need some extra services and that you need to be kind of maybe looking at them. But over time that I have tried to be more purposeful, when a student has identified as having served, to talk with them, see if they need help -- and I -- I found that I have become more aware that there is a veteran culture, that there this is a military culture that I need to be aware of as a faculty member so that -- that veteran is really

not challenging me as a faculty member. That's just the way the military is. And they want to engage with me. But it's not -- might come across as aggressive. That -- they think they -- that's the way the military is.

And so I think we need to do a better job, when it comes to communicating out to the education community, when it comes to workforce development, making sure that people are aware that there is a veteran culture; there is a military culture that other military people know and see and understand but those of us who are really now interfacing with them don't know about it.

MR. DETRICK: Okay. So, the answer -- so, the answer to that question, ma'am, is, the director of veterans services or military and veterans services at UNLV, Ross Ryan, has incorporated that training, called it SERV Training, S-E-R-V. And I have assisted him numerous times when I was an undergraduate. And what that training does is stuff he's developed on his own, that he presents to the administrative and faculty staff of UNLV to train them on -- exactly on what you were just stating, ma'am.

So, again that was another challenge that we had found, specifically him, when he was there. And

he like, "Hey, we got to, you know, inform the faculty and administration of the use -- institution of the challenges and," like you said, "the culture of coming out of the military and what to expect." So -- so, yes, ma'am, that is in place there as well at the university level.

I would have -- I would be remiss to say that if you need his contact information, he would be more than happy to come to CSN to -- to at least start that dialogue with you, to maybe talk about that up there at CSN, because it is in place there, and it's very popular. As a matter of fact, when faculty staff or departments or colleges attend the training, they get a sticker, says SERV. Much like when they attend LBGT -- LBGTQ training, you have the -- the symbol itself, the sticker. They have the same thing there at UNLV so when they -- when an individual goes to that department or that office, they can see the SERV sticker, and they can see the LBGTQ sticker, and that individual knows that, yes, okay, they have been trained on, you know, these particular things that have taken -- an hour-long session on that.

MS. OATES: Another thing is, in the -- Nevada Department of Veterans Services is doing a program. They call it Bravo Zulu. And what that program does

is, it teaches our health care providers, especially like our assisted-living people -- because, you know, we have a lot of veterans in the homes, and they have done -- they have found a lot more, through their Veterans in Care program, that there is veterans out there. But to educate the health care people -- yes, veterans do have that different culture. We look at things differently. We approach things differently. And so we're -- especially with the folks with dementia and Alzheimer's that -- to explain why they may be doing this, because they're reverting back to their military career, and that's how things were done. So, it's to also educate the health care providers why this person may be acting like that and so that they can interact more on the veterans level. Because, yes, veterans, we do have a different culture, and we approach things differently.

So, even near the end of life they're working on trying to educate our community about that, too.

CHAIRPERSON BLAYLOCK: David Fott.

MR. FOTT: Can you hear me okay?

MR. DETRICK: Yes, sir.

MR. FOTT: Well, given that there are military ways of doing things, Mr. Detrick, to what extent is it possible to integrate veterans into the larger, the

fuller life of the university, student organizations and so on?

MR. DETRICK: Yes, sir. So, that was -- so, that was one of the things, when I would sit down with veterans when they were coming into the office using their education benefits, is that I was letting them know how the benefits are utilized. And I do that as well, especially now with my current position, as academic counselor. When I'm sitting with veterans that are transitioning in, that's one of the things I give them. I tell them. I say, "Look, if" -- and I -- everybody is going to handle transition differently, but I don't even approach it from that. I just say, "Hey, look, a bit of advice for you: What helped me was getting involved again."

Because what we also found, it was a challenge. It's like every VSO is having now, is trying to pull in memberships. And so that was one of my greatest frustrations when I got the -- because when I came in, the student veteran organization was defunct. It had been defunct for about three years, and I came in and started it again. And so that was one of my great frustrations, like how can I pull in more people, more veterans, more female veterans to these organizations. So, we started revamping events.

So, let's call USAA Bank and do a financial class.

So, leading into that, when I sit with the veterans now that are transitioning, I tell them, "Get involved on campus." I say, "It doesn't even have to be with the student organization. Just get involved with whatever your college organization is. Start building that professional network for yourself. Start developing these relationships, because it enriches -- one, it enriches your education experience, as far as I'm concerned, because that's what it did for me. Two" -- my biggest challenge when I was coming out was, now I didn't have a mission. I didn't look at going to school as a mission, because I was like, "That's a selfish thing to do. I'm going to school for myself." So, I was kind of looking at it -- "That's a little selfish, man." So, like I know it was pushing that side. So, I need something to do, that I don't have a mission anymore with what I was doing.

And so how I even got into that, the -- Ross was like, "Hey, man, so the student vet org is not working, you know. We don't have anything. Do you want to do the president?" I said, "Yeah, I'll do it." So -- and I just went into it not knowing, but I'm glad I made that leap, because that helped get me

on the path to, quite frankly, what I am today. If I -- I will sit here and tell you that I wholeheartedly believe that if I did not go that path and just focused on my education at UNLV, I would not have the job I have, because I got the job I have because of my professional network on campus. Because my director is retired air force, and she wanted a veteran to sit into the position that I have. And it just so happened, the position opened as I was graduating and going into my master's for public administration.

So -- and that's one thing that I really let them know. I'm like, "Get involved with something. If it's not the veteran organization on campus, fine. Get involved with your -- with your college education. Get involved with some kind of club. UNLV has over 300 clubs on campus. Get involved with something to ease that transition situation if you're having an issue. And then you're also helping yourself, but you're helping the university. You're helping the institution that you're going to school at. You know, you're representing them, and you're being a part of the culture as a whole at UNLV."

And as far as I'm concerned, that's one of the greatest things I like about UNLV. It's the most

diverse campus on -- on -- in the States. The military is the most diverse organization. So, to me it was just a great lead-in, because, okay, I'm coming out of -- of an incredibly diverse organization, and I'm going into another incredibly diversion organization. So, I'm used to working with those different dynamics and stuff.

So, that's one of the things I really try to push on other people, is get involved with the university itself, regardless of what institution you're going into.

CHAIRPERSON BLAYLOCK: We have time for another question. Kay Kindred.

MS. KINDRED: My question is for Lieutenant Colonel Solow. I believe you mentioned that in the training that the highway patrol receive, they get right from the very beginning diversity training, cultural competency training, and training with respect to diversionary practices.

Could you elaborate a little bit more on that, please, talk about what -- what that entails?

MR. SOLOW: Well, basically it's -- it's to make our officers aware that, you know, everybody is in a different situation so that we don't just treat every situation as an identical situation. It's

particularly stressed in our "use of force" position, training, because we realize that every -- every encounter we have doesn't always require the same level of force. You have to treat every situation individually. And we want to make sure that that's instilled in our officers and their mindsets so that we don't resort automatically to a higher level of force than might be necessary. Somebody that's in crisis could be in crisis for something that's not going to jeopardize my life or somebody else's life around them. So, it's not necessarily always the best course of action to just rush in and apply force to take care of the situation.

So, that's -- that's a lot of what our training is based around when I -- when I spoke about that.

MS. KINDRED: Thank you.

MR. PONDER: In -- just as a follow-up to that question -- love the level of training. Captain Scott had indicated that, as far as like LVMPD was concerned, that they were steering towards the -- the mental health training.

Is that something you see that's an opportunity for the highway patrol?

MR. SOLOW: Yes. As I spoke about, we do have

a CIT program already in southern Nevada, and it's been expand up into the North as well. But, to be honest, aside from certain areas, we don't encounter as many people that seem to be in distress with mental illness. You know, we're stopping people for traffic violations, for -- for things that jeopardize people's safety on the roadway, but it's not necessarily a crisis situation. So, it's a little harder for us, when we're looking at these type of trainings and where we spend our resources. But that's why we focus primarily right now in the "use of force" realm, so that in those really critical instances where it could be life or death or injury for somebody, we're making sure that we're taking the best approach possible.

Unfortunately, as -- as I'm sure many other community organizations and groups have told you, you know, our funding is very slim. So, our resource pie gets sliced many ways. But that is where we really focus our -- our focus for the mentally ill and those that are in distress.

MR. PONDER: Okay.

MS. NAVARRO: Yeah. I'm sorry. I just wanted to ask you that -- we all -- following on you.

Do you -- and I know that chief spoke earlier about how chiefs have a meeting with all the chiefs

for all of the 17 counties in Nevada.

MR. SOLOW: Correct.

MS. NAVARRO: Do -- do you get involved with those chiefs for the counties --

MR. SOLOW: Yes.

MS. NAVARRO: -- also? And so are you involved in those meetings, also?

MR. SOLOW: Absolutely.

MS. NAVARRO: So, do you actually see what is going on, like what -- what you were talking about, that -- with what they're trying to do with the mental health services and everything? So, you are aware of that?

MR. SOLOW: Correct. Yes. The Nevada Sheriffs' and Chiefs' Association meets quarterly. As a matter of fact, we just had our last meeting about two weeks ago up in Ely. And there is a very good representation. I am one of the representatives for the department of public safety at these meetings.

In addition to that, with my unique position being the assistant chief, of being stationed here in southern Nevada, I interact with all the local agencies quite frequently. I meet with the sheriff, the chiefs of police, any other commanders on a fairly regular basis. We have a law enforcement breakfast

here for southern Nevada monthly where most -- mostly it's the chiefs and me. We discuss issues and topics such as this that are relevant to our communities.

MS. NAVARRO: Okay. Because, you know, just as an activist and out in the community, you know, they always ask me that. And I don't -- I didn't really know, but I just wanted to be sure that you're all working in the same area of all the issues that we have going on in our -- in our community here.

MR. SOLOW: Absolutely. And I'm proud to say, in southern Nevada all of our law enforcement agencies have a very good working relationship together. I know that's not true in other areas of the country, but here in southern Nevada we have a very active, robust, cooperative law enforcement community. We work very well together.

10/1 was a perfect example of that. There were so many agencies represented. And nobody was stepping on anybody's toes. We all just -- we knew we had a job to do, and we all got down to doing what we could do to help, and we all did our best in our areas. You know, the highway patrol might not be necessarily the tactical entry team, but we have an important job: diverting traffic, protecting the scene from people getting into it, things like that.

So, we have a very good community when it comes to that.

CHAIRPERSON BLAYLOCK: I would like to thank all of you for making time to come and share your information with us. This entire day has been very informative. And, quite honestly, I have learned so much. And I think the members of the committee have learned so much and -- and thank you for all that you do for our state and for our communities as well. So, thank you very much for being here.

We're going to take five minutes to transition for the open comment period. So, we'll take five minutes.

(Recess taken.)

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OPEN PUBLIC COMMENT

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JANNAE SYKES, DR. ROBERT MEDOFF, KENIA LEON, MICHAEL MCDONALD

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CHAIRPERSON BLAYLOCK: This is our public comment period. And I understand that Michael requests to go first because of a personal situation. So, let me open up the floor for Michael McDonald. You will each have three to five minutes.

MR. MCDONALD: Thank you, Chairman. Thanks for -- you guys for the whole day of listening to all the issues and solutions that -- regarding this civil rights.

My name is Michael McDonald. I'm the assembly district 20 candidate. I'm also the president for the family -- the committee for family criminal law reform. I do a lot of activism, other issues affecting Nevada and especially in regards to the family and criminal courts.

As you can see, there is a lot of issues that need to be addressed, and a lot of those issues I would like to bring up is the -- the plea deals, the bail amounts, the "guilty until proven innocent" mentality, the -- the -- the actual fish tank where people are getting put into as -- and traffic violations, a little of the drug crimes where you have to sit in a room full of 20 and 30 people, have to sleep on the concrete floors or on a bench, where people have to go -- it's complete -- it's a -- completely against -- it's unhumanitarian what they put people through. A lot of these people have medical issues and have to sleep on a bench all night, up to 48 hours, awaiting trial. A lot of the people that don't take the plea deal, they will -- they will

be forced to -- to take it to trial. And they can't afford bail. They have to wait 21 days and sit in jail the whole time, when most of those people should be OR'd, own recognizance -- recognizance -- sorry -- release.

So, a lot of those people that are awaiting trial, they can't afford bail. And no -- that high bail amount constitutes no bail. And that's -- a lot of times these -- these are low-level crimes; they're nonviolent. And a lot of the judges have no empathy towards people, people begging them, "Hey, I'm going to lose my children, my house, my job." And the judge has no -- no empathy.

In my opinion, I think we need to -- to set a -- a -- set up a -- a institution or a program where that people that -- that sentence people to jail, prison, that kind of time, can actually experience that, experience the fish tank, the strip search, the -- the -- going into the -- the cells and see what they're sentencing people to, they can have them -- going and doing a tour of the jails or prisons isn't enough. You experience the food, the starvation they do. Then you have to -- they're forced to buy commissary where it's a dollar twenty a Ramen soup, 25 cents a minute, where they're "for profiting",

they're profiting off of the -- the -- the people through -- through certain vendors, through Cafe Network or -- or IC Solutions where people have to call their loved ones at 25 cents a minute, they spend thousands, or have no -- no contact.

People's children are being completely separated. When they get out, they become homeless, they become jobless, they can't follow the -- the guidelines or conditions that -- that they get on release. Some of these people are put on ankle bracelets or curfews that are just on complete -- complete low-level crimes. Even when -- say, for marijuana example -- for example, we -- in the state of Nevada it's legal. We still -- we do a lot of courts everywhere. They say no drugs. They go back to court, and they get drug-tested, and then they have marijuana or THC in their system. They get remanded. They get sent back to jail even for -- for a drug offense.

Why are we filling up the jails and prisons to -- to go set up that -- that budgetary requirement and say, "Oh, we -- we have this many people. That's why we need more money," which we just -- we just granted, through city council and the commission, millions of dollars for to -- to help build out the

prison or the jail that's over there in the north -- North Las -- NVC, North Visitor Complex way over by Nellis. The jails are completely full. You have six people to a little -- a little cell. They -- they -- such horrible living conditions. You have people on the streets that -- homelessness, low-level crime, drug dealers. These people should be -- should be about reformation, not punishment of all these people.

So, I would like you guys to look into those issues and why it's causing the -- the training for officers, that was a great example, the NHP going and doing those use of force when you have aggressive situation. I have people having a bad day or an emotional situation or have mental illness. It -- it escalates from there. It causes these shootings or -- or needless deaths that are occurring every day.

The profiling, the civil asset forfeiture, the -- the officer quotas is another big thing. Like, why do we have -- have a system where we have police officers that all go out and go find these people to go put them in jail? That's not what our system was made for. It's to -- to protect people, to serve people, to make sure that -- that -- that those offenses aren't causing them to go and slay the people and look for things. Attempted jaywalking, you put

your foot over a -- over the curb, you can go to jail for it.

I mean, there is -- there is so many law -- antiquated laws that need to be addressed. I mean, I've seen -- I've seen hundreds of people and talked to hundreds of people about what's going on. The -- with the people that are being enslaved with our own laws, which we fought this country to be free. We have 25 percent of the world's incarcerated rate. Well, there is a problem there, and I really hope that we can fix that and fix our -- our civil rights and make sure to keep people out of jails. And, like I said, it should be reformation and not punishment.

One more thing, too, is the -- address the root causes, the breakdown of our family. I -- I bet if you talk to any of these inmates, you'll see they didn't have their dad growing up. There is a fatherless crisis going on. A lot of even mothers, too, they -- we don't have a generation of parents that are at the home. They're all -- we're out working, and other people are raising their kids. It's causing a lot of emotional issues. And we don't have that love for one parent. It's the root cause of all this. So, I would ask that you guys address that and do -- like the officer said there, mentorship

programs are a huge -- in getting the parental involvement.

We have a system, which I would -- I really ask that this commission advocate for abolishing Title 4D and Title 4E which monetizes separating children from there own parents. Title 4E puts a dollar sign on children's heads to separate them and put them in the foster system. There is law called -- called Title 42, Section 666, which is a child support enforcement act, which -- which puts people in -- in jail, debtor's prison, which was eliminated in 1833. Why put people in jail, take away their license, take away their passport? How are they supposed to take care of their children? And then it's caused a ripple effect of -- of just fatherlessness and people that are -- are just -- commit these crimes.

I'd make a realistic program, more -- more training for officers, judicial oversight. Like I said, these judges have -- they have no bounds. So, please look into that. I would ask for -- to submit a -- ask for a committee or a commission to review cases of wrongfully incarcerated or people's -- low-level cases or nonviolent offenders, why are they -- we spending money to -- to imprison these people when we should let them out, give them a path

to reformation or give them the programs that -- such as Jon Ponder's programs that he put them through, get them work training, get those felonies off their record? You have a death sentence almost, trying to find work or trying to find somebody that will take or employ you when you have that label of felon or criminal.

So, I also would ask that -- jail and prison reformation, for full -- like I said, the full experience, and different diversion programs and addressing the people for housing and getting those people coming out and those programs and having that community, such as the new homeless community that we're -- we're also building out, the $10.1 million over on Foremaster, and do training and help people to overcome those issues and be productive members of society.

Thank you for all your -- your help and your issue -- addressing these issues. And I hope that you guys will report to -- to the United States commission and everything, we can actually address these root concerns. Thank you.

CHAIRPERSON BLAYLOCK: Thank you. Jannae Sykes.

MS. SYKES: Okay. Good afternoon, esteemed

committee. It's a pleasure to be here this afternoon. I've been with you all day.

My name is Jannae Sykes, J-a-n-n-a-e, and I am just a plain vanilla member of the community. I'm a concerned member of the community.

I currently work for the Clark County School District as a substitute teacher. I go all over the Clark County School District. I've taught long term, short term, and day-to-day assignments in all areas of this great city. I -- no matter what the color, no matter the ethnicity, no matter if it's a affluent or less affluent area, I've done them all. And the one thing that I found is that when a child is allowed to disrespect his mother and father, then he will or she will disrespect anyone. And this is one of the problems that I find in the school system, which to me is a precursor to the problems that have been being addressed today with respect to mental health issues, drug problems in the older person, because they have to start somewhere.

And to me, my experience firsthand, not word of mouth, what I have experienced, what I am continuing to -- continuing to experience is that many of our children are being forced to live lives as adults in their households, because either the parent

isn't there either through incarceration or having to work. And then when they come -- and they may have younger brothers and sisters that they have to feed, that they have to make sure take baths, go to sleep, get up, take them to school. And then when they come to school -- so, at home they have been functioning as these adults. And then when they come to school, we as teachers are expecting them to conduct themselves as children, which there is a tilt. To me that's like schizophrenic: What am I? I'm either an adult or I'm a child, but I can't be both at the same time.

And so I find and I have found that we have a lot of angry children. Okay? And many of their problems ultimately manifest themselves into these mental issues. We have children who are self-medicating themselves through the use of drugs and alcohol, because, just like the adults, they have to get through it. And they don't have anyone to talk to. Heaven forbid that they should tell someone outside their family, because then they will be separated.

I've had students whose parents -- who was being raised by a single parent, whose mother was mentally disturbed. And when she would go off, she would attack her child. And it would get to the

point -- thank God he had enough respect for her honor, for her that he would not physically attack her. But she would physically attack him. But it would be called in, and then they would have to come and get her and put him into -- I think it's child haven. So, he ended up missing lots of school time, because he was in child haven. And -- good student. But when he would come back, he would be so far behind, and he would struggle.

We've had students who are angry and can't read. And this seems to be more prevalent among the males than the females. So, we have these children who couldn't read in elementary school, can't read in middle school. And that's the age -- I deal with middle school: 6th graders through 12th graders. And they end up being passed on into high school and still can't read. And they are behavior problems, which are the ones you probably end up seeing in the institutions, because there is no place else for them to go. They're doing what they know how to do best, which is survive.

And so I think that -- and also another observation, especially when I've done the long terms, when we have parent night, it's difficult to tell who the parent is from the child, especially when that

child is a girl. I've got women coming in. The -- the mothers are maybe a little bit more than twice the age of their child: middle school, 12 years old. So, the mother is maybe 25. And they look alike. And as a matter of fact, the child may look more mature than the mother. So, here we have problems, because that adult-looking child is not acting like a child. She's acting like an adult.

The mothers want to be the good girlfriend. So, when they come to school, they think -- and many of them are -- are so grown in all aspects that they feel they don't have to listen to an adult. And the school system, many of them, many, many areas, are afraid to say something to these children, because they're afraid of the parents. And it's sad, because we have the children now governing, ruling everything. And the -- I believe that they're crying out, in their disorderliness, for someone to be in charge. Someone has got to be in charge, because they're going crazy. And I don't mean that in a derogatory way. But they need someone to rein them in, because they're just going wild. And they're getting worse and worse and worse, and that's being reflected in the schools -- in the school's force.

And these schools can say whatever they want

to say. There are some schools that are doing very well, but the ones who aren't, they're doing even worse. And it's because the standards are being lowered and lowered and lowered to help them have a sense of success, which ultimately when they become of the age when they're no longer in school, they find out they can't do anything. And they're just purely in that survival mode. They will do whatever they need to do to put food on the table, at least in their mouths, and clothes on their backs.

And for too many times I have had gang families where mother and father were members of gangs. And so what is the opportunity for the child to get out of that? It's difficult.

So, we need to begin to look at the things from a family perspective and start dealing with the family. And I think that we can begin to make a dent in at least no longer getting -- having to deal with them as adults. Because we can kind of nip it in the bud or at least begin to at the cradle level. Thank you.

CHAIRPERSON BLAYLOCK: Thank you. Kenia Leon.

MS. LEON: Thank you. You're speaking my language, girl, MFT. Kenia, K-e-n-i-a, Leon.

A couple of things -- I'm going to try and

keep it within the five minutes. As a marriage and family therapist and a licensed drug counselor, I also work for the department of corrections as a psychologist. I want to address a couple of things that were mentioned throughout the day.

First to the question of forced medication, that was brought up a few times. At High Desert State Prison we do have a forced medication panel. Since we're here to talk about civil rights, let's talk about the lack of civil rights that are present in our prison system here in Nevada; that when you are going to take away the rights of someone to make -- to make their decision whether they want to take medication or not, they need to have an advocate, they need to be aware of what medication they are taking. That does not happen. They need to have certain humanities present that usually are not. So, that has been an issue that was cited in the Bira (phonetic) study, that was cited in Aspus (phonetic) study, that NDOC was investigated for. So, all that is public record already.

But the issue when we talk about mental health in general, Mental Health America does a study every year and ranks all the states in terms of access to mental health care, quality of mental health care, all

those things. Nevada is consistently last on the list. Nevada is fifty-first in mental health care, quality and services. So, yay for consistency, if we're trying to be positive.

In the department of corrections, if you take a system that's already overloaded, being part of the biggest mental health care provider, you're going to also see then some deficiencies as well. So, with that being said, they are losing their one and only psychiatrist by mid August. So, what does that leave for the entire state of Nevada? That leaves the psychiatric nurse to do the only prescribing for the entire state of Nevada. So, that leaves obviously some deficiencies. So, we have a lot of things to work on. Our Intellimedicine isn't up and running. So, legislative actions happen. They don't follow through.

So, when we talk about potential solutions, that's wonderful. But we don't have the capacity to then carry it out. So, when we talk about that within our community, I think one of the major things is allocation of current resources. How can we use that more effectively? And I think, as working for the state, for example, there is a lot of redundancy in state positions. So, for example, as a psychologist,

there is also three other positions that require the exact same qualifications, although they will pay you a lot, lot less. So, those resources could possibly be utilized in different ways, maybe maximizing different positions or thing likes that. But those are also legislatively set, so again maybe ways to utilize existing resources.

One of the biggest things, in terms of being a mental health provider in the community, is, the reason people don't want to work here, in my opinion, is lack of reciprocity for mental health licensing. And if I could just stand on a soapbox all day and yell this across the world -- is this: You can be a practicing professional, whether that's an MFT, a licensed clinical social worker, mental health counselor, psychologist, be ethical, be licensed for 20 years, you move 20 miles into a new state, and you have to do hours again for free, you have to pay dues, and you have to get licensed in that state.

Nevada does not have reciprocity. That is a huge barrier. It prevents access to care. When you're an intern, it also blocks you from being able to provide certain services to certain parts of the population. So, it causes a problem. So, I think that's a huge barrier.

And supervision is also an issue, because, as a clinical supervisor, you can only carry a limited caseload. And we don't have a lot of supervisors because again of the liability of being the fifty-first state for mental health care. So, that leads into a question of quality of service: Are you getting the -- the access to care that you need? Is someone practicing within their scope of -- of competency, number one? Are you getting the help from the person that you need to get help from? And I also think that's a huge issue with hospitals during the pump and dump, not assessing the person who's there in crisis. Number one, it doesn't pay well with Medicaid and Medicare and things like that. So, we're also facing that issue. And that needs to be said. It needs to be addressed as a payment issue, especially if you don't have insurance. So, that's something that I think we need to be realistic about and have a plan in place, as mental health professionals and as the community, to come together to be able to assess that.

And public supports like NAMI, really being able to support them as providers -- when you apply to have slot machines in your establishment, per legislative -- per NRS, you have to have that problem

gaming brochure right next to that. Why can't we have that for mental health: Here are the signs and symptoms for depression or suicide. Again that stigma piece, not wanting to talk about it and not having it as part of health care, again that's kind of my activist piece coming out. We need to have that -- drill that in every single day. Let's not suffer from health care. That's something that should be and part of our everyday conversation.

So, with that, I won't take any more time. Thank you so much for allowing me to speak.

CHAIRPERSON BLAYLOCK: Thank you. Robert Medoff.

DR. MEDOFF: Yeah. First -- first of all, thank -- I want to -- yeah. First of all, my name is Dr. Robert Medoff. I'm a retired criminal court psychologist. I've lived in this community for -- for 35 years. I believe in putting back into the community. I've done two things here: I started the ice hockey program for school, Paul Lowden and me as a volunteer to open it up. But my main concern over the last 10 or 15 years, I've been helping litigants in -- that have fallen through the judicial cracks in all courts.

And recently in the last -- six months ago I

was contacted by initially one African American litigant in family court. Now it's grown up to -- I'm working with a hundred and 75 African American litigants that have had a judge specifically in this -- in family court. These aren't allegations or hearsay. These are -- it's cold, hard evidence.

I used to do some work for the FBI back in the '80s. I can lie and say the 2000s, but it was in the '80. And they made arrangements for me and a dozen African American litigants to go down to the FBI headquarters on West Lake Mead. And that was -- I believe that was about three and a half months ago. And if you know how the FBI works, it will take them 19 months to -- 18 to 19 months to actually resolve issue. They subpoenaed this judge's records over hate crimes.

Now, more specifically -- and I know I've only got a limited amount of time. The news media here has suppressed this, although there has been an article in the Review Journal on June 11, 2018 in the city page. This specific judge asked this specific litigant, a 35-year-old African American, to -- to take her daughter -- 3-year-old daughter, the grandmother, and herself and go to a hairdresser to get the nappiness (phonetic) out of their hair. She doubled down by

saying it in a southern accent. There is a court video that's posted on YouTube. And I have to give the judge's name to -- to locate that on YouTube. It's Judge Sandra Pomrenze, slash, nappy hair.

The -- unfortunately, that has been edited somewhat. Believe me, it has, because there is other racials -- charged comments: "your kind of people", "By the time your 3-year-old daughter is 12, she'll be pregnant." And these are cold, hard facts. We have the transcripts, the court videos, witnesses, and the Review Journal article above Ms. Mitchell. And she's public domain record. So, it's -- so, it's -- I'm not having a problem with confidentiality here. They -- and we saw the hard copy that Mike Shoro, the investigative reporter, did. And because of certain political ties -- let's put it that way. -- with the owner of the newspaper, it was -- became a puff piece.

We've contacted numerous television stations here and radio stations, very interested, and then all of a sudden they don't want to do it. So, I have a -- an associate of mine that I knew back in the '80s and '90s. It's a nationally syndicated columnist based in -- it's based out of Connecticut. And she does a lot of research before she even takes on the case. She's written, I believe, 11 articles so far that --

that have been in the paper. And it's all about individual cases. I'll give you one example, and I'll be -- I'll be brief with the examples, because there is two or three things I want to get into.

An African American gentleman married to a Caucasian woman -- the mother was charged and convicted initially with manslaughter of their two-and-a-half-year-old son Israel. Long story short, it was pleaded down to substantial bodily harm with -- with the cause of death. The gentleman's name is Burke Hall. It's public domain record. At -- in one of the hearings in one of the articles this Judge Sandra Pomrenze gave full custody to the mother. Burke Hall, I -- I know him well. I've got to know all my people that I've been assisting over the last five months -- hard-working man, no criminal charges, military vet. And this judge has a specific difficulty with African Amer -- with interracial relationships.

And as far as going through the legal procedures, I can easily answer that. In terms of going through the discipline committee of Nevada, Ms. Mitchell did that. And basically the -- Ms. Mitchell submitted, one, to have this specific judge recused, and the other was up to the discipline

committee. Both replies were -- and I quote. And I'm going to paraphrase a little bit.

And I have to apologize. I -- when I found out about this committee, I was at Southern Hills Hospital getting a procedure done, and I rushed down to the -- just now in the last two hours or so. So...

"Yes, there were racially charged statements but not sufficient or enough of them to cause" -- what is enough? I don't understand that terminology. I mean, do you have to call everybody the "N" word? I mean -- or just one time. One time a judge -- and especially a judge -- a sitting judge in a position of power, of trust.

With this specific judge and of the numerous cases that I've done research on -- and I've also with the -- also the FBI has done as well. This judge renders decisions on -- on the color of a person's skin, biases, and -- and total incompetence. She's had her nails wrapped a few times, but again the -- and I apologize if any of you people are attorneys. I have the greatest amount of respect for attorneys and for the court system. I worked in the court system for 30 years. I believe in what it actually stands for: for truth, you know, justice, you know, and honesty, to get that -- facts.

This specific judge basically renders her decisions on -- on a person's skin, biases, and incompetence, not on cold, hard facts and evidence.

And here's the problem that keeps me up at night practically all the time: With most of the cases obviously in family court, it's a guardianship case, custody, or even divorce or -- it's the children. Ycu know, basically what I wanted to say, I -- and I'm sorry I wasn't here earlier, because Judge Bell was here. She's the new chief justice. I've sent her office transcripts, court videos, witness statements, news articles. And her law clerk sent me back an e-mail yesterday night indicating -- indicating, "As stated before, these e-mails will not be forwarded to Judge Bell, and I will not be making any notations about the actual receipt of these -- this information." That's incredible. It's incredible. I don't have a case before her. So, it's not an ex parte communication. This is a concerned citizen that's writing -- writing to the judge. And she, you know, I -- I can understand just took over.

But what really keeps me up at night is that this is exactly what people are dealing with with not only this Judge Sandra Pomrenze but other judges. This -- you know, they're burying the issue and

continuing to harm the children of Las Vegas. That's exactly what they have been doing, is harming the -- our children of Las Vegas. And it's -- it's going to continue on and on and on unless there is something done about it.

You know, we -- there has been -- we've contacted numerous politicians and -- and about three-quarters of them have told me that, "You know what? I got an election to win. I can't get involved in something like this." But there has been some politicians -- this gentleman behind us right here is -- he's -- he's running to be a congressman. He's getting involved, Mr. Wes Duncan. I -- I took him down to the Pearson Community Center, and he spoke before a largely African American group. And I guess Mister -- this is not a political endorsement in any way, shape, or form, but Mr. Duncan actually came with -- with me -- I'm sorry. I'm running a little -- I do apologize.

But that's -- that's my personal feeling. And if there is anybody in this room that can facilitate some change, I challenge them to do that. Thank you very much.

CHAIRPERSON BLAYLOCK: Thank you. And -- and thank you to all of you for -- and I can tell you're

very passionate. -- for making time to share with us. All of this information will become part of the transcript, and all of it will be forwarded to the civil rights commission and will be part of our report.

DR. MEDOFF: Thank you very much. We appreciate it.

CHAIRPERSON BLAYLOCK: So, thank you very much. Thank you.

So, in conclusion, the transcript and other materials will be made available within 30 days following the meeting. If you have provided your e-mail address when you signed in this morning, we will send you the follow-up information regarding how to access those materials. We will also notify you when the committee is meeting for follow-up discussion and when the report will be available.

The record will remain open through September the 6th, 2018. If anyone would like to submit written comment, please send your written comments to the U.S. Commission on Civil Rights at 300 North Los Angeles Street, Suite 2010, Los Angeles, California 90012 or by e-mail to afortes@usccr.gov.

I would like to thank everyone for your time and consideration and thank all the members of the

Nevada committee for their engagement. This meeting is adjourned. Thank you.

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(Whereupon, the proceedings concluded at 5:00 p.m.)

CERTIFICATE OF REPORTER

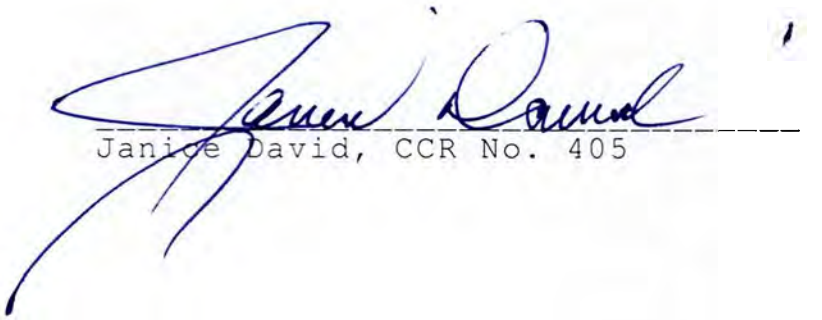
I, Janice David, a Certified Court Reporter licensed by the State of Nevada, do hereby certify:

That I reported the foregoing proceedings commencing on August 9, 2018, at the hour of 9:00 a.m.;

That I thereafter transcribed my related shorthand notes into typewriting and that the typewritten transcript of said proceedings is a complete, true, and accurate transcription of my said shorthand notes taken at said time.

I further certify (1) that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this 30th day of August, 2018.



Janice David, CCR No. 405