The Milwaukee Mental Health Task Force is committed to being a leader in identifying issues faced by all people affected by mental illness, facilitating improvements in mental health services, giving consumers and families a strong voice, reducing stigma, and implementing recovery principles.

Milwaukee Mental Health Task Force Recommendations Regarding the Life and Death of Dontre Hamilton
7/8/2014

The Milwaukee Mental Health Task Force (MMHTF) mourns Dontre Hamilton and honors his life. We are gravely concerned by the circumstances of his death, which raise many questions about the response of the Milwaukee Police Department (MPD). We are also concerned about the challenges Dontre and his family experienced navigating the mental health and housing service delivery system, and accessing medication and other services. The recommendations in this document grew out of dialogue with Task Force members and heartfelt discussion with Mr. Hamilton's family, and our fervent conviction that the system must change to ensure other community members get needed services and additional lives must not be lost. We must take action as a community to ensure that this never happens again.

The MMHTF was formed in 2004, in response to a crisis in inpatient psychiatric services that exposed major gaps in Milwaukee's system of mental health care. The task force includes participants from over 40 organizations who work collaboratively to identify issues faced by people affected by mental illness, facilitate improvements in services, give consumers and families a strong voice, reduce stigma, and implement recovery principles. There was then and remains now, an urgent need to improve every aspect of our response to individuals experiencing mental illness.

Despite an unprecedented amount of organization and advocacy by the MMHTF and many other collaborative efforts, these very ambitious goals seem very far from realization. It is possible to identify some progress, but the recent death of Dontre Hamilton in Red Arrow Park in the middle of a spring afternoon as a consequence of his contact with an officer of the Milwaukee Police Department calls into question whether we have adequate commitment from our community and its key institutions to provide the services that our most vulnerable community members deserve.

We are determined that Dontre Hamilton's death be seen as a critical turning point – as the moment in which our community awakened to the still urgent need to change the way vulnerable people are treated on our streets and in our parks, in housing and their neighborhoods, when they are receiving treatment, and when they have contact with law enforcement officers or are in jail. First and foremost, there must be a formal process to investigate the decisions made by the police officer involved. But this event raises broad issues regarding the actions of law enforcement as well as the response of the mental health service delivery system which Dontre and his family tried to navigate. These require that we ask difficult and uncomfortable questions and commit to real change until tragedies like this become the extremely rare events that they must be in a healthy community.

6737 W. Washington Street, #3230 Milwaukee, WI 53214 Voice 414/773-4646 FAX 414/773-4647

RECOMMENDATIONS REGARDING LAW ENFORCEMENT SERVICES

To advance to Mayor Tom Barrett, Milwaukee Police Chief Edward Flynn, City of Milwaukee Public Safety Committee, Board of Fire and Police Commissioners

1. Increase the capacity of the Milwaukee Police Department to provide CIT officers for critical situations requiring this expertise

- Expand the number of Milwaukee Police Department officers and other key staff who are trained in CIT - Crisis Intervention Team Training.

    - MPD should develop a timeline for expanding and funding CIT training with the ultimate goal of having 100% of officers get CIT training.
    - Priority should be given to supervisors, to new officers and to officers in districts where there has been a history of high percentage of calls related to mental health crises.
    - There should be periodic refresher training for all CIT officers and appropriate advanced training for select officers, including some supervisors and command staff.
    - Specialized training is also needed for MPD staff who take calls and dispatch officers to ensure they are asking the rights questions and appropriately deploying CIT trained officers, etc. There should also be a review of the current protocols for dispatch staff when responding to a situation where there is a possible mental health component.
    - Ensure that CIT can serve outside of their district if needed.
    - Establish a CIT Community Advisory Committee including individuals with lived experience, family members, advocates, and mental health professionals.
    - MPD should establish a new position, a Police Academy trained Certified Peer Support Specialist, to assist officers in Mental Health Specific calls, crimes and investigations. (this was suggested by one of our survey respondents).
    - We recommend exploring establishment of a specialized CIT Team made up of officers who have advanced training and a strong commitment to the values and mission of CIT.

2. Conduct a thorough community based review of the Dontre Hamilton incident with the goal of identifying key patterns, gaps and improvements using one or more of the suggested strategies.

- The City of Milwaukee should create a structured review process for any police interaction with an individual with mental illness which results in death or serious injury to an officer or the individual involved. This should be added to the mandate for the Homicide Review Commission or be built on the same type of model. Because these after-incident reviews would seek to understand what has gone wrong in the community mental health interventions for the individual affected, Milwaukee County must be an active partner in providing information and data to support the work of the review commission. Once established, this review commission should be expanded to include other municipalities in Milwaukee County as resources permit. The goal of these reviews is to identify critical gaps in services available to affected individuals, officer training needs, and other steps necessary to minimize the likelihood of such events.

- The Milwaukee Police Department Standard Operating Procedure 455 – Critical Incident Review Board sets forth the purpose and procedures for an advisory body the the Chief of Police. The Chief of Police may call upon the CIRB to review incidents involving Department members which results in great bodily harm or death. SOP 455.05 includes provisions for consultation with" appropriate certified unified tactics experts" If such experts do not include experts on police encounters with persons with mental illness, then the SOP should be amended to require it. Furthermore, The Critical Incident Review Board is to submit a written report and recommendations to the Chief of Police. The Chief of Police will make all final determinations with regard to any training, policy changes, safety issues or any other issues of importance that may arise from the review. The CIRB process needs to be more transparent. Currently the Fire and Police Commission is copied on the CIRB report and follow up reports. These documents should be make available to the full Board, the Public Safety Committee and the public.

Days before an MPD officer shot Mr. Hamilton, 2013 Wisconsin Act 348 became effective. Act 348 relates to investigations of deaths involving a law enforcement officer. The law requires law enforcement agencies to have a written policy requiring that an investigation into the officer-involved deaths is conducted by at least two investigators neither of whom is employed by the law enforcement agency that employs the law enforcement officer involved in the officer-involved death. Investigators from the Wisconsin Department of Justice are conducting the investigation into Mr. Hamilton's death. Under Act 348 the investigators submit their report to the district attorney of the county in which the death occurred. If the district attorney determines there is no basis to prosecute the officer, the investigators must release the report to the general public. When MPD and the FPC considers amending or creating police or standard operating procedures to comply with Act 348, they should specific that in officer-involved deaths outside investigators must have expertise or consult with experts on law enforcement encounters with persons with mental illness.

- The City of Milwaukee, in collaboration with Milwaukee County, should work to create reliable measures to document its overall law enforcement capacity to respond to individuals whose mental health symptoms require emergency intervention. These measures might include the number of CIT officers, the number of EDs and arrests, as well as criminal justice and municipal court system data on incarcerated individuals with mental health diagnoses. These data allow the creation of a baseline against which performance and progress can be measured.

- A gap analysis should be conducted related to Mobile Crisis Team capacity. How many calls occur where deploying Mobile Crisis would be appropriate? How many times is Mobile Crisis deployed? Why is there a gap and what should be a strategy for addressing it and adding capacity as well as training law enforcement on use of Mobile Crisis?
- Urge a review and reconsideration of the MPD "shoot to kill" protocol. Why were 10 shots fired and why with the intent to kill? What are alternative protocols used in other communities?
- Support the requests by ACLU in 5/21/14 letter to the Public Safety Committee (attached) regarding analysis of the 9600 calls to MPD in 2013 about individuals who were in mental health crisis.

    - Of the 9,600 calls in 2013 how many were responded to by at least one officer having received crisis intervention training? How many were responded to by other responders, such as mental health professionals or EMTs?
    - How were the calls resolved? For example, citations issued – on site mental health intervention – transport to a mental health crisis facility.
    - Of the 9,600 calls in 2013 how many involved the use of force as defined in MPD SOP 460?
    - Consider requesting analysis of MPD response and use of force broken out by race. Historically, and in the case of Mr. Hamilton's death, there have been concerns raised regarding racial profiling and to what extent the law enforcement's response may be impacted by the race.

RECOMMENDATIONS REGARDING SERVICES FOR CONSUMERS & FAMILIES

To advance to Milwaukee County Executive Chris Abele, Milwaukee County Behavioral Health Division leadership, and the Milwaukee County Mental Health Board

Mr. Hamilton received a variety of Milwaukee County services including Access Clinic and other outpatient services through BHD contracted agencies, inpatient care at the Complex, peer support, assistance with benefits, case management, housing through Pathways, and possibly other assistance with housing. Both Mr. Hamilton and his family experienced some difficulties in navigating the system. One specific area of concern at the time of his passing, relates to the repeated difficulties he had obtaining prescribed medication. Therefore we recommend:

1. Milwaukee County should conduct a thorough review of Mr. Hamilton's experience with county services,. Including input from the family members he had asked to assist him, to determine if there are lessons learned that can be used to make systemic improvements for the future.
2. The experience of Dontre and his family reinforces the need for designated resources to assist consumers and their families in navigating the mental health system and overcoming barriers to needed services such as the factors which made it impossible for him to get the prescribed medication he needed and was voluntarily seeking. .The following should be considered:

    - Milwaukee County BHD should establish community based Mental Health Resource Centers to provide outreach and assistance to consumers and family members. This should include a 24-7 community helpline staffed by county funded independent advocates who can provide information about county programs and other community resources, as well as assist consumers and family members who are experiencing difficulties accessing services or overcoming barriers, such as Dontre and his family did, and assist individuals with their rights. This could be a similar model to the county Aging and Disability Resource Centers (ADRCs) but with the added mission of an independent advocate role to provide support for those experiencing difficulties. We have also identified the need for an advocate to help consumers and families better understand the legal process and their rights.
    - These new Resource Centers could be co-located at Mental Health Access Clinics. Initial establishment of the County Access Clinic has been a positive step, but the needs continue to greatly outpace the available resources. We urge establishment of additional strategically located Access Clinics, with a priority being given to those areas of the county that have a high percentage of mental health related calls to law enforcement and or to BHD. Mobile Crisis Teams could be co-located at the Resource Centers

3. A review should be done of current protocols regarding communication with family members to ensure that consumers are able to have family members and others in their circle of support, as allies and resources, <u>if they choose to do so</u>. One outcome could be the establishment of a family advocate