INVISIBLE BY DESIGN

DEVELOPMENTAL AND COGNITIVE DISABILITIES IN ALLEGHENY COUNTY'S CRIMINAL LEGAL SYSTEM

ALC — 2023

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Introduction

You don't really learn about interactions with cops growing up. CHOP [Children's Hospital of Philadelphia] has…VR headsets to run through simulations for autistic kids about how to interact with the police. It feels so dystopian…can you just teach cops not to shoot autistic people? - F.B. [1]

Many people believe that there is a direct line between the deinstitutionalization of people with psychiatric and intellectual disabilities and the rise in prison populations. Indeed, if we were to simply look at the numbers, that would seem to be the case. The era of mass incarceration began just as deinstitutionalization hit its peak. [2] In a 2014 report, the Bazelon Center for Mental Health Law and the ACLU of Southern California made the assertion that the "lack of community mental health services, coupled with mass incarceration of non-violent offenders, has resulted in three jails—the Los Angeles County Jails, Rikers Island Correctional Facility in New York City, and Cook County Jail in Chicago—having the distinction of being the nation's largest psychiatric institutions." [3] Statements like this thrive in the popular imagination, but without further explication and context carry the message that (1) individuals with disabilities are likely to commit crimes if not institutionalized in some capacity, and (2) jails and prisons provide psychiatric care to imprisoned citizens. Neither of these statements are true. The fact is not that people with disabilities are committing crimes, but that the construct of crime deliberately targets, imprisons, and enacts violence upon disabled people of color. Further, jails and prisons, like psychiatric institutions, are violent, deliberately traumatizing settings designed for further disablement.

The model for incarceration and disablement is this: a group of people is excluded from the community and oppressed with tools like imposed poverty and privatized health care; subsequently, their emotions, behaviors, and acts of survival in these conditions are criminalized, both constructing and furthering disablement.

1. Personal communication, April 2022
2. Perlin, Michael L. and Lynch, Alison, "Had to Be Held down by Big Police: A Therapeutic Jurisprudence Perspective on Interactions between Police and Persons with Mental Disabilities" (2016). Articles & Chapters. 1225. https://digitalcommons.nyls.edu/fac_articles_chapters/1225
3. Liebowitz et al. "A Way Forward: Diverting People with Mental Illness from Inhumane and Expensive Jails into Community-Based Treatment that Works." ACLU of Southern California and The Bazelon Center for Mental Health, July 2014. https://www.aclusocal.org/sites/default/files/wp-content/uploads/2014/06/MENTAL-HEALTH-JAILS-REPORT.pdf

Viewed in this context, disability is not necessarily someone's mental or physical state, but the barriers and cages built by society for the express purpose of ensuring that person's continued exclusion from the community. [4]

Poverty, for instance, a huge predictor of criminalization and incarceration, and disproportionately imposed on people of color, is also "a strong conduit to disablement and debilitation."[5] Housing deprivation and insecurity disables and criminalizes the people they are imposed upon. Liat Ben-Moshe asserts that "homelessness by itself disables...the constant noise, diesel fumes, cold/heat, lack of privacy, anxiety of not knowing where the next meal will come from, fear of attack, and fear of...police"[6] serve as stressors and drivers of criminalized behaviors or mental states, such as depression, agitation, anger, being uncooperative or unresponsive to police, self-medication with criminalized substances (leading at times to "public intoxication"), and atypical reactions to social cues (which may be interpreted as "disorderly conduct")[7] . Not only are these behaviors and mental states criminalized, they are pathologized as "mental illness." But these "[a]ltered states, anger and pain" are not illnesses. They are valid reactions to "a system of power and inequality that denies people their basic freedoms and needs." [8]

The manner in which someone is disabled by psychological/neural divergence, and whether their behaviors are criminalized or not, varies based on race, socioeconomic status, and gender. For instance, in *The Protest Psychosis,* Dr. Jonathan Metzl demonstrates that schizophrenia went from being considered a relatively "harmless" mental affliction in White patients to being one characterized by "aggression, violence, and delusional rage" as it became weaponized against Black Civil Rights activists at Ionia State Hospital, which became Ionia Correctional Facility as a result of this demographic change.[9]

While a great deal of research and advocacy focuses on the prevalence of serious mental illness and substance use disorders in jails and prisons, much less attention is paid to people with intellectual and developmental disabilities, autism, or cognitive impairments. These disabilities are often referred to as "invisible," as they tend to go unnoticed or undocumented by disabling systems. However, it is too often the case that what we call invisible is simply that which we choose not to see. Evidence suggests that intellectual and developmental disabilities are prevalent in jails and prisons, yet the experiences of people with these disabilities are hidden by a system designed for silence and suppression.

In January 2022, in response to this invisibilization the Abolitionist Law Center (ALC) began a research study to map out the intersection points between people with intellectual disabilities and the criminal punishment system in Allegheny County, with the goal of producing this report analyzing current practices, identifying information gaps,

4. Michael Oliver, The Politics of Disablement (London: Macmillan Education Ltd, 1990).
5. Ben-Moshe, Liat. Decarcerating Disability: Deinstitutionalization and Prison Abolition. Minneapolis: U of Minn. Press, 2020, 8.
6. Ibid 140.
7. Oberholtzer, Elliot. "Police, courts, jails, and prisons all fail disabled people." Prison Policy Initiative, 23 August 2017. https://www.prisonpolicy.org/blog/2017/08/23/disability/.
8. Ben-Moshe (n5) 140.
9. Metzl, Jonathan. The Protest Psychosis: How Schizophrenia Became a Black Disease. Beacon Press, 2011.

and making recommendations that will inform advocates, organizers, and government officials. Our objectives were to understand how best to integrate the needs and experiences of people with intellectual and cognitive disabilities into ALC's Allegheny County Jail and court-focused litigation, community organizing, public education, and media outreach. This included: exploring methods for modifying court and jail intake procedures to identify those with intellectual and cognitive disabilities and connect them with appropriate supports and interventions; expanding the focus of our Allegheny County Jail advocacy and our Court Watch program to begin to gather data regarding how many people with intellectual and cognitive disabilities come into contact with Allegheny County courts and ACJ, and what they experience; and consulting with experts, community members, and allied organizations to build advocacy and public support for meaningful reforms (especially early diversion processes) that reduce the instances of incarceration of people with disabilities in Allegheny County.

Our findings were not surprising: Allegheny County's criminal punishment system abuses, neglects, and unconstitutionally detains people with disabilities. Allegheny County, and Pennsylvania as a whole, has been sued multiple times for having the longest competency restoration waitlist times in the country, keeping people with disabilities imprisoned past constitutional limits (see section: Competency Waitlists), or even after they've been cleared to be released to the community. This is due to a failure of the county to provide appropriate housing and resources for disabled community members.

In all of our interviews with advocates, impacted individuals, and system professionals, the common thread was lack of community resources, especially appropriate housing options. Torrance State Hospital does not accept patients with intellectual or developmental disability diagnoses.[10] Staff in the public defender's office have told us that none of the placement options for system-involved youth are appropriate for children with intellectual/developmental disabilities. Often, staff at group homes or other congregate care settings call the police on residents because they do not have the experience or resources to address residents' needs.[11] Police, in turn, have little to no understanding of Intellectual and Developmental Disabilities (I/DD), Autism Spectrum Disorder) (ASD), and Cognitive Impairments (CI), and often cause more harm than good (see section: Crisis Response and Pre-Arrest Diversion and Services).

Post-arrest, screening for disabilities within Allegheny County's criminal punishment system is inadequate and often leads to further harm and discrimination (see section: Screening), and diversions like Mental Health Court are coercive, carceral, and often fail to differentiate between psychiatric disabilities, substance use disorders, and I/DD, ASD, or CI (see the ALC report on the Allegheny County Mental Health Court). All of these inadequacies and failures mean that people with disabilities in Allegheny County are suffering disproportionately at the hands of the criminal punishment system, leading to trauma,[12] loss of housing, extended and repeated incarcerations, further disablement, and death.

10. Personal Correspondence, Disability Justice Community Collaborative Initiative, May 2022.
11. Personal communications, Luciana Randall, Autism Connection of PA, September 2022, ODS Staff, January 2023.
12. In September 2022, Anthony Talotta, who was diagnosed with Austism and Intellectual Disability, was arrested at a residential facility and incarcerated in ACJ's mental health unit. He died 11 days later. https://pinjnews.org/hours-before-he-died-the-allegheny-county-jail-released-and-incarcerated-man-with-intellectual-disabilities-from-custody/

Definitions

*If **I had to describe my diagnosis to someone else…I would tell them it affects my social skills and that I notice some things that people don't usually pay attention to (sensory inputs, lights, tastes, sounds). Autism makes me feel very different from a neurotypical person. Sometimes I like that I think a little more "mechanically" than a neurotypical person. Sometimes it feels like an advantage. However, it can feel like a weakness, too. I don't like the challenges I face because of having autism. - E.S.***

As we move forward with discussions of disability in relation to the carceral system, we acknowledge that labels can be problematic and stigmatizing. We also recognize that they can be useful in discussing the specific forms of state violence and oppression a group of people with similar characteristics may experience. We will be looking specifically at the interactions of individuals with Intellectual and Developmental Disabilities (I/DD), Autism Spectrum Disorders (ASD) and Cognitive Impairments (CI). These "labels" refer not only to cognitive, intellectual, or neurological differences, but also to the ways that these differences are interpreted and addressed by an ableist society.

The definition and tracking[13] of disabilities in the criminal punishment system varies widely across the country. There is no uniform definition of I/DD, ASD, or CI, and most jails do not screen individuals for these. I/DD, ASD, and CI can present in a myriad of fashions, and many people have adopted a survival strategy known as the "cloak of competency," learning to mask any impairments so as not to show vulnerability and open themselves to discrimination and abuse. For all of these reasons, as well as the lack of training or attention paid to disabilities within the CLS, I/DD, ASD, and CI often go unidentified by law enforcement.

13. "Managing and Treating Justice-Involved Individuals with Intellectual Disabilities in Pennsylvania," Pennsylvania Mental Health and Justice Center of Excellence, 2014, http://www.pacenterofexcellence.pitt.edu/documents/ID%20and%20CJS%20in%20PA%2012%2013%2012%20-%20final%20copy%20sent%20to%20MHJAC.pdf.

It's important to note that there is no universal legal definition of I/DD, ASD, or CI. For the purposes of this discussion, we will begin with the ADA definition of disability, which states that a person with a disability is someone who "has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment."[14] It's important that the ADA acknowledges that the mere perception of impairment can be disabling for a person.

The Developmental Disabilities Assistance and Bill of Rights Act defines a developmental disability as:

> ...a severe, chronic disability of an individual that is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the individual attains age 22; is likely to continue indefinitely; [and] results in substantial functional limitations in 3 or more of the following areas of major life activity: Self-care; Receptive and expressive language; Mobility; Learning; Self-direction; Capacity for independent living; [and] Economic self-sufficiency.[15]

An intellectual disability is typically defined as a subtype of Developmental Disabilities and is typically characterized by the above functional limitations and an IQ score below 70. [16]

Autism Spectrum Disorder[17] refers to a range of developmental neurodivergence that, in general, impairs the ability to communicate and to interact "appropriately" in a neuro-normative social environment. While ASD is technically a developmental disability, many advocates tend to name it specifically, because it in itself umbrellas such a wide range of characteristics. Among many other characteristics, individuals with ASD may display: difficulty understanding emotions; an aversion to eye contact; a tendency to interpret abstract ideas literally; difficulty adjusting to small changes in routine; repetitive patterns of movement (stimming) or speech; sensory hypersensitivity; needing extra time to process new information or respond to questions; and leaving situations or "shutting down" to avoid confrontation. Signs and symptoms vary widely person to person, and may change over the course of a person's lifetime.

14. "Disability Demographics and Definitions." Disability Justice, 2022. https://disabilityjustice.org/justice-denied/disability-demographics/#cite-note-2
15. United States, Senate and House of Representatives, 30 Oct 2000, The Developmental Disabilities Assistance and Bill of Rights Act of 2000. 106th Congress, Public Law 106–402. https://acl.gov/sites/default/files/about-acl/2016-12/dd_act_2000.pdf
16. IQ scores are used in most assessments for ID and therefore indicate the above-cited disabling perception of impairment that leads to segregation and resource deprivation. A note here that IQ tests are tools of white supremacy tied to capitalist development, are not supported by wide scientific consensus, and reflect "a nexus of sociocognitive-affective factors determining individuals' relative preparedness for the demands of the IQ test" itself rather than a person's reasoning skills, emotional intelligence, or "real-life" abilities. Ken Richardson, "What IQ Tests Test," *Theory & Psychology* Vol. 12 Iss. 3, SAGE Publications, 282-314 at 287, 297 (2002). "Social context effects have masqueraded as group differences in research studies." Lawrence G. Weiss & Donald H. Saklofske, "Mediators of IQ test score differences across racial and ethnic groups: The case for environmental and social justice," *Personality and Individual Differences* Vol. 161 (July 2020), https://doi.org/10.1016/j.paid.2020.109962
17. We are using the language of "person with ASD" often in this paper as it is appearing in a list with I/DD and CI. However, we acknowledge that many in the Autistic community often choose to identify themselves without the use of diagnostic language (ie. Autistic Person v. Person with ASD). Each person has the right to choose the "label" or title that they feel most accurately identifies them, and we have made every effort to respect those choices.

Cognitive Impairments include conditions like Traumatic Brain Injury (TBI), Alzheimer's, Dementia, dyslexia, and ADHD. Among other things, these impairments can interfere with a person's memory, speech, concentration, task completion, problem-solving, response to verbal communication, and decision-making. Like other impairments and disabilities, signs and symptoms of cognitive impairments vary widely.

In addition to the criminal punishment system, this report will discuss the Department of Human Services' role in the lives of people with disabilities. The Pennsylvania Department of Human Services oversees the provision and administration of services and resources to Pennsylvania residents, such as subsidized healthcare, housing assistance, or supplemental nutrition assistance.[18] DHS is intertwined with the criminal punishment system, most clearly exemplified by its Office of Children, Youth, and Families, which oversees both the "child welfare" and "juvenile justice" systems. DHS also maintains a presence in Magisterial District Courts, assigning Resource Specialists tasked with "identifying human service resources when needed, as well as training and coaching the Magisterial District Judges (MDJ's) regarding important human service needs they see day-to-day in their courtrooms."[19]

The DHS offices most important in the context of disability and criminal punishment are the Office of Developmental Programs (ODP) and the Office of Mental Health and Substance Abuse (OMHSAS). The stated mission of the ODP is to "support Pennsylvanians with developmental disabilities to achieve greater independence, choice and opportunity in their lives." [20] In Allegheny County, these are in turn overseen by the Office of Behavioral Health (OBH) and the Office of Developmental Supports (ODS), which provides service coordination for individuals with I/DD and autism from age 9 through adulthood.

18. "About DHS." *Pennsylvania Department of Human Services.* https://www.dhs.pa.gov/about/DHS-Information/Pages/Learn-About-DHS.aspx. Accessed 1/2/2023.
19. *Department of Human Services Support Staff Directory 2021.*
https://www.alleghenycounty.us/Human-Services/Resources/Education/Child-Welfare-Support-Directory.aspx
20. "DHS Offices." *Pennsylvania Department of Human Services*. https://www.dhs.pa.gov/contact/DHS-Offices/Pages/DHS-Offices.aspx. Accessed 1/2/2023

Methodology: Disability Justice

Our approach to this project was ever evolving as we gained more understanding of the systems and processes contributing to state-sanctioned targeting and incarceration of individuals with disabilities. First, after consulting with experts in Disability Justice and on-the-ground advocates, we decided to expand our focus from Intellectual and Developmental disabilities (I/DD) to include Autism Spectrum Disorders (ASD) and Cognitive Impairments (CI) such as Traumatic Brain Injuries and Alzheimer's. As we will discuss later, Disability Justice prioritizes cross-disability organizing, and the labeling and separation of disabilities, while important when considering accessibility and person-centered planning, can also be limiting. Medical diagnoses are a flawed categorization system and often do not capture lived experience or acknowledge the variability and uniqueness of experience and identity for people with disabilities. Furthermore, they can exclude individuals who don't have access to medical diagnoses, who have chosen to abstain from interaction with the medical/psychiatric industrial complex, or who have been misdiagnosed. A broad range of individuals with developmental or cognitive divergences or disabilities/impairments encounter unique but similar issues when dealing with the criminal punishment system. In fact, the system generally does little to distinguish between psychiatric disabilities or neurodivergence and the above listed disabilities. The system tends toward one-size-fits-all policies, which of course is ineffective, inappropriate, and leads to further harm. It's also important to note that many of these disabilities can co-occur, as we will discuss later.

When examining disabilities and the criminal punishment system, it is also essential to understand the intersecting systems involved. The targeting and incarceration of persons with disabilities also involves the Psychiatric/Medical Industrial Complex, the Department of Human Services and other government entities (including assistance programs such as the "waiver" system), the public educational system, and institutions such as recovery centers and nursing homes.

Understanding how each of these systems connect and the failings within each system was a challenge, but essential to understanding how best to assist our comrades with disabilities targeted by the criminal legal system. Our work included interviews and meetings with disability rights advocates, officials from the Department of Human Services (DHS), particularly the Office of Developmental Supports (ODS), public defenders, Disability Justice organizers, individuals with I/DD, ASD, or CI (and family members) who have come into contact with the criminal punishment system in PA, ALC Court Watch volunteers, and other involved stakeholders. We were unsuccessful in our attempts to interview individuals at the ACJ Behavioral Assessment Unit, Mental Health Court administrators and staff, the Bail Investigations Unit, and Justice Related Services.

We attended and observed proceedings of the Disability Justice Community Collaborative Initiative, a collection of advocates, law enforcement, legal professionals, and concerned stakeholders who discussed and planned around the issues facing individuals with I/DD, ASD, and CI when pulled into the criminal punishment system.[21] We also attended court proceedings, both at preliminary arraignments and in Mental Health Court, to document accessibility gaps and develop new Court Watch monitoring techniques that might better support individuals with I/DD, ASD, and CI. Finally, we used public records, databases and Right to Know requests in an attempt to understand the scope of the problem in Allegheny County.

One of the greatest challenges of this project was that of finding models and creating recommendations for solutions to the incarceration of persons with I/DD, ASD, and CI that are abolitionist and rooted in the principles of Disability Justice.

Disability Justice was a shift in the Disability Rights movement from prioritizing equal access and integration to examining the social construction of disability and its intersection with race, gender, queerness, and other identities, and the ways that social disablement is built into existing systems and structures. The term itself was first introduced in 2005 by a collective of disabled queer women of color, including Patty Berne, Mia Mingus, and the late Stacey Milbern. Disability Justice confronts ableism head-on, rather than fighting for accommodations within an ableist framework. It centers the diverse social structures of access needed in order for everyone within a social system to thrive.[22] Patty Berne's "Working Draft for Disability Justice"[23] of 2015 established 10 core principles for disability justice:

21. See Appendix
22. One collective providing exceptional resources in this regard is the Abolition and Disability Justice Collective. Downloadable resources can be found at https://abolitionanddisabilityjustice.com/shareables/. Also see their Alternatives to Policing zine in Appendix.
23. Berne, Patty. "Disability Justice: A Working Draft." Sins Invalid, 10 June 2015. https://www.sinsinvalid.org/blog/disability-justice-a-working-draft-by-patty-berne

10 Core Principles for Disability Justice

Adapted from "Disability Justice: A Working Draft" by Patty Berne

Intersectionality: The Disability Justice movement asserts that Disability Rights is based on a single-issue identity, centering white experiences. It doesn't address the ways white disabled people can still wield privilege, nor does it acknowledge the intertwined histories of white supremacy, capitalism, and ableism. Patty Berne writes, "While a concrete and radical move forward toward justice, the disability rights movement simultaneously invisibilized the lives of peoples who lived at intersecting junctures of oppression." Thus, the principle of intersectionality states: "...each person has multiple community identifications, and...each identity can be a site of privilege or oppression. The fulcrums of oppression shift depending upon the characteristics of any given institutional or interpersonal interaction" [24]

Leadership of Those Most Impacted: Ensure that leadership, power, and opportunities are given to people most negatively impacted by the full spectrum of ableism (including white supremacy, heteropatriarchy, colonialism, and capitalism) to more effectively combat those issues.

Anti-capitalist Politic: All people deserve to have their needs met, regardless of their ability to produce.

Cross-Movement Solidarity: In short, "Because every demographic of people includes people with disabilities, people with disabilities will not be liberated without the success of each movement seeking liberation." [25]

Recognizing Wholeness: An often repeated declaration in Disability Justice is: "All bodies are unique and essential. All bodies have strengths and needs that must be met. We are powerful, not despite the complexities of our bodies, but because of them." The principle of Wholeness reaffirms the intrinsic value of every person without condition.

Sustainability: The principle of sustainability is a call for DJ to take into account the needs and superpowers of the people within that movement. In order for the fight for liberation to continue long-term, Disabled activists and advocates need to be in tune with their bodies, minds, and lived experiences, and rest must be prioritized. The principle also asserts that "the sustainability of the movement is dependent on the community, and cannot be pushed forward by individuals alone." [26]

24. ibid.
25. Berne, Patty. "Disability Justice: A Working Draft." Sins Invalid, 10 June 2015. https://www.sinsinvalid.org/blog/disability-justice-a-working-draft-by-patty-berne.
26. ibid.

10 Core Principles for Disability Justice

Adapted from "Disability Justice: A Working Draft" by Patty Berne

Commitment to Cross Disability Solidarity: There is no hierarchy of disability. Anyone who experiences the oppression of ableism is included in DJ: "Isolation ultimately undermines collective liberation.." [27]

Interdependence: In relation to the above statement, the principle of interdependence acknowledges that the idea of independence is one born from a Western Colonial domination. We do not achieve anything alone. Instead of the Disability Rights movement's focus on independent living, DJ focuses on mutual aid and community care.

Collective Access: The Collective Access Principle acknowledges that "there is no neutral body from which our bodies deviate." We all have various capacities which function differently in various environments. Therefore, all access needs have equal importance. Collective access means that we must create new ways of doing things outside of ableist supremacist norms, and that "we can share responsibility for our access needs without shame." [28]

Collective Liberation: Finally, the principle of collective liberation encompasses all of the previous principles with the statement, "We move together, with no body left behind." [29]

Building on the pillars of Disability Justice, the Abolition and Disability Justice coalition developed a framework for forming and analyzing anti-carceral initiatives. These include: Rejecting coercive reforms that mandate social services, sobriety, medication, or psychiatrization, or which include registries, monitoring, or surveillance; resisting the movement of funds from jails and prisons to psychiatric institutions or nursing homes; and, most importantly, placing "Neurodivergent and/or Disabled people's needs, desires, experiences and leadership over those of professionals."[30] The questions we asked ourselves about each recommendation were:

27. ibid
28. ibid
29. ibid
30. "Guiding Principles Based in Disability Justice" – *The Abolition and Disability Justice Coalition*, 2022. https://abolitionanddisabilityjustice.com/guiding-principles/

- Is this in line with Disability Justice?
- Is this inadvertently promoting the logic of carceral ableism (the paternal assertion that people with disabilities need special/extra protections because of their inherent vulnerability "in ways that often expand and legitimate further marginalization and incarceration")? [31]
- Is this a recommendation that furthers the cause of abolition? Often, efforts to decarcerate individuals with disabilities directly or indirectly imply that prisons are appropriate for some people, by stating that they are not appropriate for a specific population (such as individuals with mental illness).
- Does this center the needs of individuals and allow space for person-centered planning rather than a one-size-fits-all solution?
- Is this centered on consent and free of coercion?
- Do those most impacted in our community think this is a good idea?

The final question was perhaps the most difficult for us to answer confidently. Our efforts to consult with individuals with disabilities who have been impacted by the Criminal Punishment System in Allegheny County were not always fruitful. We reached out to disability justice organizers, mutual aid groups, solidarity networks, and nonprofit advocacy organizations to find impacted individuals, conscious that we would need to center self-determination and leadership of those most impacted in our community without asking for limitless unpaid labor. While we were able to have meaningful conversations with some of our impacted community members and disability justice organizers, we did not achieve the scope and depth of engagement we had hoped for. Plans to remedy this shortcoming are included in our "Next Steps" section. For now, we have relied on our initial conversations, the written work of Disabled organizers and abolitionists, and models for decarceration and decriminalization led by people with disabilities.

This report takes a harm reduction approach to the criminalization of disability. While we envision a future in which no one is incarcerated or subjected to state violence, we acknowledge this cannot happen immediately. Our recommendations will include practical modifications to existing systems that can keep more people physically out of jails and prisons, provide material improvements for the people suffering within these systems today, and center disability justice and collective access in our advocacy. The abolitionist and disability justice contributions of this project are:

31. Ben-Moshe (n5) 17.

- Prioritizing the voices, opinions, and empowerment of those most impacted. The quotes throughout this report come from both in-person interviews and mail correspondences with people who identify as Disabled and who have been confronted by police, arrested, or incarcerated in the state of Pennsylvania.

- Focusing on collective access by recommending whole-system reforms rather than accommodations based on disability labeling/identification (particularly in our recommendation for universal counsel at first appearance);

- Recommendations for grassroots community efforts that increase solidarity and build sustainable alternatives to current systems, such as harm reduction and Know Your Rights trainings;

- Recommendations for targeted harm reduction.

- Recommendations that promote the leadership of those most impacted.

- Expanding our lens of carceral abolition to include other secured facilities, such as psychiatric hospitals and alternative housing units.

We want to clarify that this is not a comprehensive review of all aspects of the targeting of individuals with disability by the criminal punishment system, and we do not purport to be experts in Disability Justice nor on the individual needs and experiences of every person with disabilities. What we present here are our findings within a limited scope based on our own understandings of carceralism, DJ, and abolition. As we present these findings, we are acutely aware of the fact that when we discuss disability we are not only discussing "the variations that exist in human behavior, appearance, functioning, sensory acuity, and cognitive processing but, more crucially, the meaning we make of those variations" [32] We acknowledge the inevitable influence of our own biases and blind spots, and of the limitations and bias inherent in data and statistics. We remain open to critique and input, and are always willing to expand our understanding of this issue, engage in dialogue with stakeholders, and change our findings and recommendations to more accurately align with the wants and needs of those most affected by the criminal punishment system's targeting of people with disabilities.

32. Linton, Simi. *Claiming Disability: Knowledge and Identity*. New York: NYU Press, 1998, 2.

Scope

In school, I had it hard to comprehend things….The court, police system treated me wrong. [They] took advantage of me. **- P.S.** [33]

According to a Department of Justice study, 32-40% of state and federal prisoners self-reported having a disability, the most common of which was cognitive disability (23%). Twenty-four percent reported that they had been in special education classes at some point in their childhood. In the general population during the same time period, 11% of people reported having a disability.[34] The Center for American Progress has asserted that prison inmates are four times as likely, and jail inmates more than six times as likely, to report a cognitive disability than the general population.[35] A 2017 study found that individuals with disabilities have a cumulative probability of arrest by age 28 that is 12.97% higher than those without disabilities. (42.65 % vs. 29.68 %). [36]

According to the PA Mental Health and Justice Center of Excellence, approximately 1 percent of individuals served by the Allegheny County DHS Office of Developmental Supports spent one or more days in jail between 2006-2012.[37] This approximation was confirmed for us by ODS, who stated that around 60 out of 6000 individuals were booked at ACJ between 2019–2022.[38] This is an extremely limited data point, as it only applies to individuals served by ODS. Nationally, only about 17-20% of individuals with I/DD typically receive services from state human service agencies.[39] This means the above statistics are a gross underrepresentation of the actual numbers. Note that this also only includes jail bookings, not bench warrants, arrests that do not result in booking/charges, and other interactions with the criminal punishment system.

33. Personal Correspondence, January 2023.
34. Maruschak, Laura et al., "Survey of Prison Inmates, 2016: Disabilities Reported by Prisoners." U.S. Bureau of Justice Statistics, 2021, https://bjs.ojp.gov/content/pub/pdf/drpspi16st.pdf.
35. Vallas, Rebecca. "Disabled Behind Bars: The Mass Incarceration of People With Disabilities in America's Jails and Prisons." Center for American Progress, July 2016. https://cdn.americanprogress.org/wp-content/uploads/2016/07/15103130/CriminalJusticeDisability-report.pdf.
36. McCauley, Erin J. "The Cumulative Probability of Arrest by Age 28 Years in the United States by Disability Status, Race/Ethnicity, and Gender." American Journal of Public Health vol. 107,12 (2017): 1977-1981. doi:10.2105/AJPH.2017.304095
37. "Managing and Treating Justice-Involved Individuals with Intellectual Disabilities in Pennsylvania," Pennsylvania Mental Health and Justice Center of Excellence, 2014, http://www.pacenterofexcellence.pitt.edu/documents/ID%20and%20CJS%20in%20PA%2012%2013%2012%20-%20final%20copy%20sent%20to%20MHJAC.pdf.
38. Personal Correspondence, ODS Staff, May 2022
39. Residential Information Systems Project (2020). Minneapolis: University of Minnesota, RISP, Research and Training Center on Community Living, Institute on Community Integration. Retreived from: https://publications.ici.umn.edu/risp/2017/infographics/people-with-idd-in-the-united-states-and-the-proportion-who-receive-services

In 2021, out of 8273 individuals booked at ACJ/alternative housing, 118 were documented as either having received supports from ODS (38) or as having "Alzheimer's or related disorders or senile dementia" (80). An additional 62 people were documented as having been CCBH/Allegheny County Behavioral Health Clients and as having I/DD, ASD, or cognitive impairments such as dementia or TBI. In total, this amounts to 2.2% of bookings and, again, is most likely a significant underrepresentation. Of those who had received services from ODS, 37 had a documented co-occurring health condition, and 31 had a documented co-occurring behavioral health condition (22 of which were classified as "Serious Mental Illness"). Twenty-five of the 37 (67.6%) were booked more than once in the same year.

In that same time period, out of 36,673 active criminal cases, 373 had received services from ODS (112) or were documented as having "Alzheimer's or related disorders or senile dementia" (261). An additional 155 people were documented as having been CCBH/Allegheny County Behavioral Health Clients and as having I/DD, ASD, or cognitive impairments such as dementia or TBI. Of the 112 who had received support from ODS, 108 had documented co-occurring health disorders, and 77 had a documented co-occurring behavioral health disorder.[40] This accounts for 1.4% of active criminal cases for 2021. In both of these groups, the majority of individuals were Black men aged 20-29.

Imprisonment at ACJ and/or criminal charges were not the only forms of incarceration for individuals with I/DD, ASD, or CI. In 2021, out of 4918 involuntary commitment petitions, 156 had received ODS I/DD services and 271 had Alzheimer's or related disorders. An additional 242 individuals were listed as having been CCBH/Allegheny County Behavioral Health Clients and as having I/DD, ASD, or cognitive impairments such as dementia or TBI. That amounts to 13.6 percent of all petitions. Of those who had received ODS services, 147 had co-occurring health disorders, and 147 had co-occurring behavioral health disorders. Further, 27 individuals who had received ODS I/DD services and had involuntarily commitment petitions were under 20 years old, demonstrating that children and youth with disabilities are also suffering at the hands of the criminal punishment system. Again, we should note that these numbers are primarily looking at individuals receiving services from DHS.

When investigating I/DD, ASD, and CI in the criminal punishment system, it is often useful to examine documentation on individuals identified as having psychiatric disabilities, substance use disorders, or who have received behavioral health services. While there are no solid statistics, I/DD, ASD, and CI are known risk factors for psychiatric disabilities. Estimates for individuals with co-occurring I/DD and psychiatric disability nationally, for example, range from 20-39%. The above statistics from Allegheny County DHS indicate that the majority of ODS clients interacting with the criminal punishment system had co-occurring behavioral health disorders.

40. https://quickcount.alleghenycounty.us/

While still seriously under-documented and poorly addressed, Substance Use Disorders (SUD) and psychiatric disabilities tend to be more commonly identified by the criminal punishment system. Further, there is evidence that the criminal punishment system often fails to make a distinction between psychiatric disabilities and I/DD, ASD, or CI, housing all of them in the same units and attempting to funnel them through the same systemic processes. [41]

In a 2020 study, researchers from the University of Pittsburgh found that individuals with a history of receiving behavioral health services in Allegheny County were, for five of the seven most common charges, more likely to be given monetary bail at preliminary arraignments. Bail amounts were also consistently higher for individuals with BH service histories than for those without these histories, despite the cases themselves having identical dispositions, meaning that individuals with documented behavioral health needs in Allegheny County are "at greater risk to spend time in jail prior to their preliminary hearing."[42] It is safe to assume that the same is true for individuals with I/DD, ASD, and CI, given the aforementioned co-occurence of disabilities and the conflation of behavioral/psychiatric health issues and other types of disabilities by law enforcement and judges. For instance, ODS staff shared observations that traumatic brain injuries seem to be grossly overrepresented in Allegheny County's criminal punishment system but are very rarely discussed or documented.

41. "Managing and Treating Justice-Involved Individuals with Intellectual Disabilities in Pennsylvania," Pennsylvania Mental Health and Justice Center of Excellence, 2014, http://www.pacenterofexcellence.pitt.edu/documents/ID%20and%20CJS%20in%20PA%2012%2013%2012%20-%20final%20copy%20sent%20to%20MHJAC.pdf.
42. Mulvey, Edward P. and Carol A. Schubert. "A Behavioral Health and Criminal Justice Cross-System Evaluation in Allegheny County." University of Pittsburgh and Allegheny County DHS, 7 March 2019. https://www.alleghenycountyanalytics.us/wp-content/uploads/2020/09/Cross-Systems-Evaluation-Intercepts-_final-report_9-24-20.pdf. (42).

Disproportionate Targeting and Harm

I was crying a lot, screaming, hyperventilating, shaking. Basically, I was being inappropriately autistic for the situation, [so] the cops threatened me with commitment. **– E.K.**

Like individuals with psychiatric disabilities, individuals with I/DD, ASD, and CI are disproportionately subjected to the violence of the criminal punishment system. Much of the problem begins with "the decision making processes 'on the street' by police officers who choose to apprehend and arrest certain cohorts of persons… rather than working with them."[43] Police Officers have little to no training on I/DD, ASD, and CI, and yet are given "substantial discretion" [44] as to how to handle interactions with the people they are purported to serve. Individuals with I/DD, ASD, and CI are more likely to misunderstand social cues and stressful situations and are often the last people to leave the scene of crimes, leading to increased arrests of witnesses. Further, behaviors like strong reactions to external stimuli like sirens, difficulty responding to verbal commands or rapid questioning, and extreme sensitivity to physical touch are inappropriately handled by police,[45] who often categorize these behaviors as "disorderly conduct" or "resisting arrest." Police also misinterpret behaviors like stimming, perseverating, or yelling and lashing out physically as a result of being overwhelmed as "aggression" and respond with escalation and violence. F.B., who has been diagnosed with Bipolar I, Borderline Personality Disorder, and Autism Spectrum Disorder, described her experiences with police for us:

43. Perlin, Michael L. and Lynch, Alison, "Had to Be Held down by Big Police: A Therapeutic Jurisprudence Perspective on Interactions between Police and Persons with Mental Disabilities" (2016). Articles & Chapters. 687.
https://digitalcommons.nyls.edu/fac_articles_chapters/1225.
44. Ibid. 688
45. "Pathways to Justice™: Get the Facts," The Arc of the United States, 2015.
https://thearc.org/wp-content/uploads/2019/07/NCCJDFactSheet_Autism-Copyright--BJA.pdf

I was just really distraught. I hadn't been diagnosed with Bipolar or BPD yet. These are just stressful things that are happening to me I'm not tolerating. And I feel like, whatever the interaction, these are armed police officers showing up and I feel like, the way I was treated, I could notice the disparity right there…not being well-spoken or coherent because I'm Autistic and I'm on drugs and I don't think I'm a very eloquent communicator. Normal interactions feel like they have a lot of pressure to me, so one like that, I feel like I couldn't make my words very well, and I think at least the officer was saying my incoherence was [evidence of] me abusing so many drugs and I was some kind of reprobate…

…I feel like sometimes that made it difficult for me to process or regulate my emotions because sometimes something as small as making plans with friends, going on a date, or ordering food can be this really high-stakes interaction that I think about the rest of the day. So when it's a cop – when it's literally life or death – I just freeze. I don't know what's the correct words to say. It created this thing in me where I [thought]…you're gonna die, not by suicide or from infection from self-harm, but because a cop is going to shoot you. [46]

As a survival adaptation, then, individuals with these disabilities often pretend to understand more than they do in order to avoid conflict or violence. This "cloak of competency" can also manifest as an eagerness to please and increased compliance and agreeability. Therefore, "a growing body of evidence shows that mental disabilities impair the ability of [affected individuals] to withstand the pressures of interrogation, as well as understand and invoke their constitutional rights during questioning," [47] leading to "compliant false confessions," "internalized false confessions" (cases in which interrogation convinces a person of their own culpability even if they do not themselves remember the crime), or individuals agreeing to plea bargains without proper information and legal advice. [48] Further, important stages of arrest like Miranda warnings are not collectively accessible for all levels of cognitive functioning, leading to a cascading set of disproportionate impacts for people with disabilities in the courts.

46. Personal correspondence, April 2022
47. Rogal, Lauren, "Protecting Persons with Mental Disabilities from Making False Confessions: The Americans with Disabilities Act as a Safeguard," 47 N.M. L. Rev. 64 (2017). http://digitalrepository.unm.edu/nmlr/vol47/iss1/4. 64.
48. Ibid. 69.

Courts

When it came to the court system, it always felt like a fever dream; it's kind of hard to picture that happening to the same person sometimes… You're just in a line with a bunch of people, you're just watching other people get charged with crimes like it's a fucking fast food line. – **F.B.**[50]

While the waiving of one's own *Miranda* rights and right to counsel under the 6th and 14th Amendments should "technically be knowing, intelligent, and voluntary, the court inquiry tends to focus on the voluntariness and only superficially address the person's comprehension." [51] While it's believed that the majority of individuals with I/DD, ASD, and CI are deemed competent to stand trial, without significant accommodations (which are not provided), many people with I/DD, ASD, and CI struggle to understand the proceedings and assist in their own defense. In *Atkins v Virgina,* the Supreme Court ruling noted "multiple factors that increase the risk that an innocent person with intellectual disability may be convicted: they are more likely to confess falsely to a crime they did not commit; they often have difficulty communicating favorable information to their attorneys; they typically make poor witnesses (and thus rarely are able to testify, or testify persuasively, in their own defense); and, their demeanor can convey a false sense of lack of remorse." [52]

I/DD, ASD, and CI can co-occur with each other and with psychiatric disabilities, and individuals with disabilities are more likely to have experienced physical/sexual violence and abuse in their lives, leading to post-traumatic reactions and even further complicating interactions with police and the court system. F.B. explained:

> I *feel like you're supposed to talk and have a certain decorum in a courtroom setting…and I feel like especially my body language, I fidget and stim a lot when I'm very nervous, and I feel like I devote so much mental energy into not doing that that it sometimes makes it hard to concentrate on what I'm saying or what I'm supposed to be doing. It's like the sensation of being at the DMV and trying not to be weird turned up to the max.* [53]

As a result of these complications, individuals with I/DD, ASD, and CI tend to receive harsher punishments, higher cash bail amounts, and are more often subjected to pretrial incarceration. [54]

49. Ibid. 71-74.
50. Personal correspondence, April 2022.
51. Rogal (n46) 75.
52. *Atkins v. Virginia*, 536 U.S. 304 (2002). Justia Law. https://supreme.justia.com/cases/federal/us/536/304/#tab-opinion-1961117.
53. Personal communication, April 2022
54. Mulvey & Schubert (n41) 41.

Incarceration

In the prison setting, having ASD has been very challenging. I was just starting to get comfortable with life in my community (after 23 years of being alive), to be forcibly placed in confinement where the rules are very different. I have a very difficult time grasping social situations in prison, and in this unnatural environment that can be a very hazardous handicap…Living in prison, where there are many unspoken "rules" and unique social settings (sometimes even dangerous ones) makes living in this situation very difficult, maybe even impossible for certain individuals. – **E.S.**[55]

In a report on Traumatic Brain Injuries in jails and prisons, the CDC outlines the following potential complications for individuals with TBI who are incarcerated:

- Attention deficits may make it difficult for the prisoner with TBI to focus on a required task or respond to directions given by a correctional officer. Either situation may be misinterpreted, thus leading to an impression of deliberate defiance on the part of the prisoner.

- Memory deficits can make it difficult to understand or remember rules or directions, which can lead to disciplinary actions by jail or prison staff

- Irritability or anger might be difficult to control and can lead to an incident with another prisoner or correctional officer and to further injury for the person and others.

- Slowed verbal and physical responses[56] may be interpreted by correctional officers as uncooperative behavior.

55. Personal correspondence, December 2022
56. "Traumatic Brain Injury in Prisons and Jails: An Unrecognized Problem." National Center for Injury Prevention and Control (U.S.). Division of Injury Response, 2007. https://stacks.cdc.gov/view/cdc/11668.

Jails and prisons are debilitating and disabling for anyone, but this disablement is compounded for individuals with I/DD, ASD, and CI, who often become targets both for correctional officers and other incarcerated individuals because of their inability to understand social cues or rules, and are more likely to experience physical or sexual violence. J.B., who identifies as Autistic and is currently incarcerated, told us that jail in particular was a dangerous environment:

> *My experiences throughout my two year battle in county jail were harsh to say the least. I was bullied, harassed, extorted, threatened, beaten, and sexually harassed by inmates and officers alike. My family was verbally harassed at the institution when they tried to advocate on my behalf to protect me. The county jail I was in was not suited to hold individuals like myself with ASD or any mental health issues. Access to trauma therapy or psychiatric therapy was almost nonexistent once staff learned I was not suicidal, which was their only real concern. This transition to jail would be hard for any Autistic, but especially combined with the trauma of my case...the two years in county jail were especially traumatizing.* [57]

Correctional Officers often segregate people with disabilities from the general population, placing them in solitary confinement "for their own protection." [58] They are more likely to be denied medical treatment due to inability to fill out forms and lose parole opportunities because re-entry programs are not universally accessible. [59] As the Prison Policy Initiative explains, "Already in a position of deeply unequal power simply by being incarcerated, disabled people in prison are then further disadvantaged by systemic ableism." [60]

Suicide is the leading cause of death in jails. [61] This cannot simply be attributed to lack of treatment; carceral settings exacerbate underlying conditions as the state violently forces individuals already under stress into an unlivable environment. E.S. explained:

> *Prison is not a safe place to heal, so if rehabilitation is one of the goals of corrections, I don't understand how it can take place for me here...it seems that they don't have the proper resources to treat me so I can be better than what I was. I had a very difficult time with life before all of this, and now, the letter of the law has made it so much more difficult.* [62]

57. Personal correspondence, November 2022.
58. Vallas, Rebecca. "Disabled Behind Bars: The Mass Incarceration of People With Disabilities in America's Jails and Prisons." Center for American Progress, July 2016. (3). https://cdn.americanprogress.org/wp-content/uploads/2016/07/15103130/CriminalJusticeDisability-report.pdf
59. Ibid. (3).
60. Oberholtzer (n7).
61. Wang, Leah. "Rise in Jail Deaths is Especially Troubling as Jail Populations Become More Rural and More Female," Prison Policy Initiative, June 23, 2021. https://www.prisonpolicy.org/blog/2021/06/23/jail_mortality/
62. Personal correspondence, November 2022.

Allegheny County

Crisis Response and Pre-Arrest Diversion and Services

I have nightmares about being arrested all the time. They're very realistic. I have to do a double take and make sure I'm still here. – **F.B.**[63]

Because I/DD, ASD, and CI often co-occur with psychiatric disabilities, crisis response is an essential diversionary strategy for this population. However, most crisis response services, whether or not they are associated with police, tend to be structured around psychiatric disabilities with little to no attention paid to the specific needs of individuals with I/DD, ASD, and CI.[64] Many advocates in Allegheny County and surrounding areas described to us the insufficiency of crisis response for this population, as most responders are not familiar with these disabilities.

Currently, a portion of Pittsburgh police officers are offered Crisis Intervention Training, but 911 dispatchers have no way to match CIT-trained officers to behavioral health calls, although an officer on scene can request a CIT-trained officer or a mobile crisis unit.[65] We found no evidence that this training includes information on I/DD, ASD, or CI, and "there are limited assessments of this training on officer attitudes or behaviors. In addition, there is little systematic assessment of the Allegheny County CIT program in terms of the number of people with BH problems who have been diverted from arrest or the proportion of individuals under court supervision who have been in contact with these services." [66]

63. Personal correspondence, April 2022.
64. For an overview of sequential intercepts for people with I/DD in Allegheny County, see ODP's "Justice Process & Intervention Opportunities Map" in Appendix.
65. Mulvey (n41) 15-22.
66. Ibid. 20.

In July 2021, The City of Pittsburgh's Office of Community Health and Safety (OCHS) and Bureau of Police were awarded a grant from the Bureau of Justice Administration to expand its CIT research and training "to further develop an effective model for police to identify what co-responders can best help in emergency situations" and "expand relationships [of the police] with support services and community based resources." [67] The model includes training and resources both for behavioral health issues and "developmental disabilities." This grant makes Pittsburgh one of 3 pilot cities for the Academic Training to Inform Police Responses (ATIPR).

According to the overview of the ATIPR, the training will be created by & for police (based on the Memphis Model).[68] This means that police will have the vast majority of the control over implementation and data outputs, as well as which community resources are used to implement this program, and how. This sets up a pathway for community services to become more integrated into the carceral system, as we have seen with many psychiatric care resources (like reSolve and Western Psych) or used as tools of surveillance.

In Allegheny County, there are several crisis response and case management teams, involved to different degrees with policing agencies, either in operation or in preparation to launch in the near future, including reSolve Crisis Services with UPMC, four Community Treatment Teams through UPMC's Western Psychiatric Institute and Clinic, Mercy Behavioral Health, and Residential Care,[69] and START services from ODS.[70] Of these, the START model is the only one we know of with response for I/DD, ASD, and CI built into its model. As part of a national initiative, Allegheny County also launched its 988 crisis hotline in summer of 2022. This hotline is handled by Western Psych and reSolve, and there are concerns about staffing as well as surveillance/law enforcement involvement. [71] All of these teams need more transparency and monitoring in order for the community to determine whether or not they are more beneficial than harmful. Another issue is that, for those who have already experienced violence and abuse at the hands of emergency responders, even a nonviolent encounter carries trauma, like for F.B.:

> *I started getting nightly seizures, not being able to talk when it happened, and having a roommate call the paramedics in Penn Hills, and the paramedics show up and they're wearing Kevlar and they're in blue, so when they were approaching, I was having a seizure, I don't know what they told the paramedics, I don't know how they've interpreted the "friend's having a seizure" or if they asked "does your friend have mental health problems?" and if they've sent cops just in case. I was terrified. I shouldn't get more nervous when the paramedics are approaching my house.*[72]

67. "Pittsburgh Police and Office of Community Health and Safety Selected to Develop Crisis Response and Intervention Team Co-Response Model," City of Pittsburgh, July 2021, https://pittsburghpa.gov/press-releases/press-releases/5094.
68. "Academic Training to Inform Police Responses: A National Initiative to Enhance Police Engagement with People with Behavioral Health Conditions and Developmental Disabilities." IACP, https://www.theiacp.org/projects/academic-training-to-inform-police-responses.
69. "Community Treatment Teams in Allegheny County: Service Use and Outcomes." Allegheny HealthChoices, Inc., October 2005, https://www.ahci.org/Reporting/QualityFocusReports/CTTReportFinal10-12.pdf.
70. Personal Communication, ODS, employee. https://centerforstartservices.org/sites/www.centerforstartservices.org/files/AnnualReports/ncss_annualreport_2021.pdf
71. Personal communication, Disability Justice Organizers.
72. Personal communication, April 2022.

A promising pre-arrest diversion program recently launched in Allegheny County is LEAD (Law Enforcement Assisted Diversion) through University of Pittsburgh's CONNECT (Congress of Neighboring Communities) Program.[73] LEAD is a consent-based harm reduction model for people who are repeatedly arrested or otherwise targeted by the criminal legal system due to issues like behavioral health needs, psychiatric disabilities, or substance use. Currently, policing agencies refer individuals to LEAD, but eventually the program will expand to accept referrals from the community as well. Policing agencies can refer someone they interact with frequently, or refer someone rather than arresting or charging them. In the latter case, the only requirement is for the individual to participate in an intake appointment with a LEAD case manager in order to have their charges dropped; any further services are completely voluntary. A LEAD case manager might help someone navigate healthcare, mental healthcare, substance use treatment, housing services, and other resources, as well as help the person to build and strengthen their own networks of support. Further, case managers meet every two weeks with an "Operations Workgroup," which includes representatives from the courts and policing agencies, in order to ensure that the person is protected from the harms of the criminal legal system and deal with further issues that may arise.

LEAD's first pilot program began in the Etna-Millvale-Shaler area in late 2022 and has received 40 referrals and is currently working with ten active participants, as well as a Community Leadership Team of five community members who provide ongoing input and feedback from the community as well as help to ensure program accountability. Participants include individuals with mental health needs and substance use disorders, and many have a long history of hospitalizations/institutionalizations. While LEAD does not currently have training or evaluations in place for I/DD, ASD, or CI, case managers have noted participants with reading difficulties or who seem to struggle with executive functioning.

This program, though still in its early stages, is promising in its consent-based approach to harm reduction and diversion, its investment in community leadership, and its attention to capacity (caseloads are capped at 25). There is movement toward beginning programming in the city of Pittsburgh and elsewhere in Allegheny County, and ensuring that advocates for individuals with I/DD, ASD, and CI are included in further consultation and expansion will be vital.

73. https://www.connect.pitt.edu/LEAD.

Screening

As demonstrated above, the gathering of data regarding I/DD, ASD, and CI in the Criminal Punishment System is almost nonexistent, presenting a challenge to advocates. One of the most common requests we heard in our conversations with advocacy organizations and DHS employees was for more effective and consistent disability screenings at jail and prison intakes. There are many ways in which screening might be useful to advocates and individuals who are arrested. First and foremost, there is the idea that screening would provide advocates with concrete data about the prevalence of I/DD, ASD, and CI within the criminal punishment system. One might also assume that, once someone is identified as having a disability, they would be able to receive the accommodations they may need, including a court advocate or diversion programs. However, this seemingly common sense recommendation has complex implications and may indeed be impractical, unhelpful, and even harmful, to individuals with disabilities.

Any kind of screening or gathering of data results in increased government surveillance of vulnerable individuals. Surveillance done in the name of safety and improved services usually ends in further punishment and carceral interactions, as we can see with Child Protective Services or the Psychiatric Industrial Complex. We can also see that current screening methods do not necessarily result in improved outcomes for individuals. Mental health screenings result in involuntary commitments, increased solitary confinement, chemical restraints (involuntary injection of antipsychotic or sedative medications like Haloperidol, Ativan, etc.),[74] increased uses of force, and other forms of brutality and discrimination. At best, an individual may end up in a diversionary program like Allegheny County's Mental Health Court, which does not necessarily lead to decarceration, only a movement from incarceration in jails and prisons to "treatment" institutions, chemical incarceration (mandated medication), and long-term probation, much of which can be understood as "carceral sanism…forms of carcerality that contribute to the oppression of the mad or 'mentally ill' populations under the guise of treatment."[75]

74. Kowalski, J Michael. "Physical and Chemical Restraint." Roberts and Hedges' Clinical Procedures in Emergency Medicine and Acute Care, 7th ed. Edited by James. R Roberts. Elsevier, 2018. Pp 1481-1498.
75. Ben-Moshe (n5) 58.

That said, the argument can be made that even options like "specialty" diversion courts make a difference on an individual level, and that the opportunity to return to the community as opposed to incarceration in jail or prison can make a life or death difference for some, and that screening may help facilitate that return.

The barriers to "proper" screening for I/DD, ASD, and CI are many. As discussed, there is no uniform legal definition for these disabilities. Second, there is no one test that adequately identifies I/DD, ASD, or CI. A formal I/DD diagnosis requires an IQ test, an adaptive functioning test, and a review of records to show deficits developed before age 22. As discussed, IQ tests are incredibly biased, and trauma and stress lower scores, so the likelihood of getting an accurate IQ test in a carceral setting is very low. No adaptive functioning tests have been developed to be used in a carceral environment. Furthermore, these tests were designed to be performed by a licensed psychologist. There are some short screening instruments available that might be able to be administered by prison staff, but there is contention about their reliability and vulnerability to interviewer bias. Beyond that, we know that the screening already required at intake is not currently being properly performed, information is not being consistently transmitted between staff, and environmental factors like crowding and noise would make it even more difficult for a person with I/DD, ASD, or CI to fully engage in any kind of screening.[76] A report on ACJ from NCCHC states that "staff interviewed reported that due to the busy intake process they encounter times when they do not have enough time for gathering sufficient information on inmate health. and "lack of privacy and interview space conducive to effective health screening is a concern throughout the facility, especially at intake."[77] One stark example of improper screening was documented as follows:

> *We observed the booking observation questions being asked by officers sitting at their station with a computer. The inmate is in front of the officer on the other side of the podium. The questions were asked quickly, loudly, and robotically, with the officer looking at the computer screen rather than observing the inmate for affect or critical red flag behaviors. The series of questions takes about half a minute.*
>
> *We observed a female being queried. She was crying and had remarked earlier that she was in withdrawal from fentanyl. She appeared to be ill and was shaking. The officer asked the questions without attention to her behavior. We stood approximately 10 feet from the officer and heard the questions and the answers clearly. Due to the speedy nature of the process, it seemed like the purpose of the questions was being overlooked.* [78]

76. National Commission on Correctional Health Care, Inc. "Suicide Prevention Program Assessment." Allegheny County Bureau of Corrections, October 2019. https://www.alleghenycourts.us/downloads/administration/ncchcsuicidereview.pdf.
77. Ibid. 1.
78. National Commission on Correctional Health Care, Inc. "Suicide Prevention Program Assessment." Allegheny County Bureau of Corrections, October 2019. https://www.alleghenycounty.us/uploadedFiles/Allegheny_Home/Dept_-_Content/Jail/Docs/NCCHC%20Suicide%20Review_Redacted.pdf.

The current screening process at Allegheny County Jail is documented as including the following steps:

1. ACJ Sally Port Screening[79] – This is the first screening to occur when someone is brought to ACJ by law enforcement. According to ACJ, this screening includes: [80]

- Self-Report Screenings at several "Intake Stations" to identify urgent health needs, language issues, gender identity, sexual orientation, incarceration history, chronic conditions, current medications/treatments, hospitalizations, mental health history, substance use, and insurance coverage.
- A medical examination conducted by a medical assistant or nurse to determine whether an individual needs to be treated at a medical facility before being incarcerated in ACJ. Signs of florid psychosis (e.g., active hallucinations), intoxication, and suicidal thoughts are assessed.
- No questions or assessments about I/DD, ASD, brain injuries, or cognitive impairments are included.

2. JRS Diversion Specialists – A diversion specialist from Justice-Related Services (JRS) is purported to be present in the intake area Monday through Friday during daylight hours.[81] This individual checks three databases (eVOLVE, OnBase and CIPS) to see if the individual is currently or has been a client of JRS. If the person is an active client of JRS, the service is notified. Note that this search is particularly looking for involvement in mental health systems/mental health diversion, not I/DD or other disabilities.

3. Booking Questionnaire [82] – If the outcome of a preliminary arraignment results in further incarceration at ACJ, a correctional officer administers a booking observation questionnaire. The questionnaire consists of 28 "yes/no" questions, some of which ask about suicidal thoughts, history of self-harm, substance use and hospitalization for "emotional problems." We requested a copy of this questionnaire from the jail and received a redacted version. [83]

4. RN Assessment and Screening[84]– After booking, a more in-depth physical assessment is to be completed by a registered nurse and a "qualified mental health professional" conducts a screening to identify serious mental health needs, deficits in intellectual functioning and/or need for immediate further assessment. The screening covers a wide range of topics and is used to determine whether an individual should be assessed in greater depth and/or housed in a specialized unit. The assessment does not employ a scoring system and is a subjective indicator of need for further assessment. There is also no sound method for carrying this data through the system so that the information follows the individual to ensure consistent treatment.[85] This screening includes three questions about I/DD or brain injuries:

79. Mulvey & Schubert (n41) 35.
80. See appendix.
81. Mulvey & Schubert (n41) 44.
82. See appendix.
83. See appendix.
84. See appendix.
85. Mulvey & Schubert (n41) 103.

- Does the individual have a history of special education classes in school?
- Does the individual have any form of serious developmental or learning disability, or does the interviewer believe the inmate has such a disability?
- Does the individual have a history of a serious head injury or seizure?

These questions are inadequate and flawed. They rely on self-report and an observer's subjective assessment of an ill-defined "serious developmental or learning disability." Many people are reluctant to disclose disabilities because they know it can make them targets for both correctional officers and other incarcerated individuals, and it might lead to segregated housing, isolation, or coercion into medical or psychiatric treatment. It is unclear what "serious" means in this context and there is no way for a medical professional to make an accurate judgment about someone's intellectual/cognitive functioning simply by observing them. A common saying in ASD advocacy is, "If you've met one person with autism, you've met one person with autism." The same can be said for I/DD and CI. There is a wide range of how these disabilities manifest in each person and how effectively or deliberately someone masks their disability. This method assumes that you can tell by looking whether someone has a developmental disability, a common assumption that is completely untrue. This entire assessment is open to bias, stereotypes, and places all the power in the hands of a medical professional who meets briefly with someone entering the criminal punishment system.

There are plans to implement a short screening for ASD at ACJ in the near future.[86] This screening is known as the Ritvo Autism and Asperger Diagnostic Scale (RAADS14) and includes 14 questions related to ASD.[87] This screening is not meant to be diagnostic. Advocates hope that it will flag a person as in need of further evaluation if/when they are sentenced to further incarceration at an SCI.

Screening is not helpful if there are not supports in place for those with I/DD. There would need to be advocates readily available, as having the assistance of an advocate during police interrogation is one of the most essential supports for those with I/DD, ASD, and CI. There is also little to no evidence that current "accessibility" measures within ACJ would help someone identified as having I/DD, ASD, or CI. In fact, a data brief from DHS found that ACJ's Behavioral Health Programming "exclud[es] particularly vulnerable individuals (e.g., those with intellectual disability, or who are non-ambulatory or non-English-speaking individuals)."[88] There are also no diversion programs in Allegheny County specifically for individuals with these disabilities, and even when advocates or DHS staff work to divert individuals to community care, staffing shortages in community care programs and lack of housing options often keep them stuck waiting in jail.

86. Personal Communication, Luciana Randall, Autism Connection of PA.
87. See Appendix
88. *DATA BRIEF: Behavioral Health Services in the Allegheny County Jail.* The Allegheny County Department of Human Services, January 2014. https://www.alleghenycountyanalytics.us/wp-content/uploads/2016/09/BHServicesJail.pdf

Competency Waitlists

The label of "incompetent" means that someone does not meet the legal requirements for ability to assist in their own defense. A person cannot be tried while declared incompetent. Competency constitutes that someone 1) Understands the charges against them and their seriousness in terms of punishment, and 2) Understands the purpose and nature of a trial and the role of its principal actors and is able to assist the attorney in their own defense.[89] Someone can either be declared "incompetent and restorable" or "incompetent, not restorable" meaning that the person's ability to assist in their own defense is unlikely to change. It's important to note that not every person with I/DD, ASD, CI, or psychiatric disabilities are declared incompetent to stand trial, and that having a disability of course does not equate to an inability to understand court proceedings. The vast majority of individuals with disabilities are either not assessed for competency or are declared competent. Around twelve to 36 percent of individuals with an intellectual disability who undergo evaluations are determined to be incompetent.[90] Of that group, about ⅓ to ½ of individuals are "restored" to competency.[91] However, the Allegheny Office of Developmental Supports estimates that nine out of ten of the clients they serve who are booked into Allegheny County Jail end up being declared "incompetent, non-restorable" by the courts.[92] We know, however, that this population is a small percentage of the total number of individuals with I/DD incarcerated. As discussed, many individuals have co-occurring psychiatric disabilities, and may not even have a diagnosis of I/DD. Therefore, it's reasonable to assume that some of the people who are being singled out for competency evaluation have both psychiatric and intellectual/developmental disabilities, autism, or cognitive disabilities, some of which are not diagnosed.

89. https://psychology-tools.com/test/raads-14
90. Douglas Mossman, et al., AAPL Practice Guidelines for the Forensic Psychiatric Evaluation of Competence to Stand Trial, 35 J. of Am. Acad. of Psychiatry and L. (Supplement) S3, S44 (2007).
91. Debra A. Pinals, Where Two Roads Meet: Restoration of Competence to Stand Trial from a Clinical Perspective, 31 NEW. ENG. J. CRIM. & CIVIL CONFINEMENT 81, 104 (2005).
92. Personal Communication, ODS Staff, May 2022.

The labels of "incompetent" or "competent" both have positive and negative implications for individuals with I/DD, ASD, or CI. Someone declared "incompetent and non-restorable" cannot be prosecuted. However, this label may lead to involuntary institutionalization or prolonged incarceration due to lack of community housing and supports. Like criminal records, incompetency labels can follow people into their lives, affecting their ability to enter into contracts or give informed consent. Further, someone found to be legally "competent" may still require supports or accommodations that are not provided to them. And, as we will discuss, the finding of "competent and restorable" can lead to prolonged incarceration, involuntary institutionalization, and forced medication. Further, competency restoration is a "treatment" designed to move someone through the criminal punishment system, not provide them with the treatment, care, and support they want or need. Competency restoration is for the benefit of the court, not the individual. [93]

The competency evaluation process itself is not designed for individuals with I/DD, ASD, or CI. A report from the National Center on Criminal Justice & Disability (NCCJD) states:

> Competency is a critical issue in nearly every stage of a criminal case, from the investigation to initial charges, through adjudication and sentencing, through incarceration and reentry, and in some instances where the sentence is death, at execution. At each of these stages, the system is not designed to address competency of individuals with I/DD, as exemplified by the lack of I/DD-specific evaluations, restoration programs, resources, and expertise.

The Behavior Assessment Unit at Allegheny County Jail does not have a separate competency evaluation process for individuals with I/DD. Every person is administered a uniform evaluation. [94]

In Pennsylvania, individuals declared incompetent to stand trial are sent to one of only two state-run hospitals with beds for competency restoration in Pennsylvania. In Allegheny County, individuals are typically sent to Torrance State Hospital to be involuntarily committed and administered "treatment" for competency restoration. This "treatment" may include forcible administration of medications (chemical restraint). [95] We have been told that those formally diagnosed with I/DD are not admissible to TSH.

93. The Arc's National Center on Criminal Justice and Disability (NCCJD), Competency of Individuals with Intellectual and Developmental Disabilities in the Criminal Justice System: A Call to Action for the Criminal Justice Community (Washington, D.C.: The Arc, 2017). http://thearc.org/wp-content/uploads/2019/07/16-089-NCCJD-Competency-White-Paper-v5.pdf.
94. Personal Communication, BAU employee.
95. Steadman, Henry and Lisa Callahan. Reducing the Pennsylvania Incompetency to Stand Trial Restoration Waitlist: More than Just Beds. New York, Policy Research Associates, 2017, https://www.dhs.pa.gov/docs/Documents/OMHSAS/c_269519.pdf.

However, many people are not even reaching Torrance State Hospital in any reasonable amount of time. In Allegheny County, many people found incompetent and needing restoration, and some found non-restorable but in need of supportive living, are stuck in ACJ waiting for a bed. This has been confirmed by multiple advocacy organizations. According to the Allegheny County Pretrial Services 2019 report, The BAU psychiatrists completed 1,030 court-ordered competency evaluations, including 885 new evaluations and 145 rechecks. They recommended 128 involuntary commitments to Torrance State Hospital. The BAU social workers completed 130 social histories associated with these mental health evaluations. The report explicitly states:

> We continued to explore alternatives to jail for defendants who are deemed incompetent, working with both the state and county Departments of Human Services. The lack of resources available at both the state and county levels for mental health and drug/alcohol beds has severely hindered the ability to move these defendants from jail to a therapeutic setting in a timely manner. [96]

This is in direct violation of the ruling in *Jackson v Indiana*, which states:

> ...a person charged by a state with a criminal offense and who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the State must either institute the customary civil commitment proceedings that would be required to commit indefinitely any other citizen, or release the defendant. [97]

In 2015 the ACLU sued Pennsylvania DHS for having the longest wait times for defendants deemed incompetent to be transferred to treatment facilities in the country. They've since sued the state multiple times. In 2016, ACLU and the PA DHS entered into a settlement agreement to reduce the Pennsylvania competency-to-stand-trial waitlists. Between January 2016 and April 2017, however, the number of people on the waitlists increased from 215 to 258.[98] In 2019, the ACLU filed a motion for the federal district court to mandate a seven day wait time limit for defendants deemed incompetent. [99]

Not only are individuals stuck waiting in jail for a bed at TSH to become available, they are also incarcerated in TSH for unreasonable amounts of time. In 2017, the average amount of time a defendant had been incarcerated at TSH for competency restoration was 514 days. [100] An assessment by medical professionals on July 1, 2017 found that 21 percent of the individuals at NSH and TSH committed for competency restoration were competent and ready to return to court, but were instead still incarcerated at the state hospital.

96. *2019 Annual Report. ALLEGHENY COUNTY PRETRIAL SERVICES*. https://www.alleghenycourts.us/annual_reports/default.aspx?show=hO2hY1wXYvomWuS74lU/65bIEC8nFYsi
97. Jackson v. Indiana :: 406 U.S. 715 (1972) :: Justia US Supreme Court Center. Justia Law, https://supreme.justia.com/cases/federal/us/406/715/.
98. Steadman & Callahan (n94) 1.
99. "ACLU-PA Goes Back To Court On Behalf Of People Who Are Too Ill To Stand Trial." ACLU PA, 19 March 2019. https://www.aclupa.org/en/press-releases/aclu-pa-goes-back-court-behalf-people-who-are-too-ill-stand-trial, Accessed 31 January 2023.
100. Steadman & Callahan (n94) 3.

Further, 51 percent were found to be "non-restorable," meaning they were unable to stand trial and therefore, according to *Jackson*, should be released into the community unless the court went through the legal process of commitment. However, there are few to no community living options for individuals deemed incompetent and non-restorable; therefore, they are kept incarcerated in state institutions.[101] We believe this is in direct violation of the ADA and the Supreme Court ruling in *Olmstead v LC*, which requires public entities to provide services to people with disabilities in the least restrictive setting possible. See more below in our recommendations for increasing access-centered housing in Allegheny County.

The Allegheny County Jail issued a Request for Proposals in 2018 for a Jail-Based competency restoration program.[102] While no motion toward this program has happened since then, it is concerning. ACJ currently does not provide adequate mental health care for individuals imprisoned there. There is no reason to believe that a competency restoration program would be any different. Further, the jail environment is traumatizing and disabling, and will only prolong any "restoration" efforts, leading to even longer incarceration periods for individuals with disabilities.

In October 2022, Allegheny County issued an RFP for a mobile competency restoration program that could be provided to individuals in a variety of settings.[103] In its press release announcing this RFP, the county stated, "Currently, there are 25 individuals who are awaiting transfer" to Torrance State Hospital for competency restoration. Six of them have been waiting 60 days or more for transfer, well past the seven day wait time dictated by the consent decree. It is essential that these wait times be addressed and that there be an end to this unconstitutional prolonged imprisonment of people with disabilities at Allegheny County Jail.

101. Steadman & Callahan (n94) 3.
102. "Request for Proposals: Jail-Based Competency Restoration Program." Allegheny County Department of Human Services, 18 August 2018. https://www.alleghenycounty.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=6442464928
103. See Appendix

DHS/ODS

The Office of Developmental Supports at DHS has been working to add additional supports for individuals receiving services who become involved in the Criminal Punishment System. One important recent development is the addition of the LeCSI program (Legal Connection, Support, and Intervention) in January 2023. This program involves individualized case management for individuals registered with ODS who become involved in the Criminal Punishment System, including tracking cases through the system, attending all court proceedings, communicating with police, lawyers, judges, and service providers, and visiting or communicating with clients while incarcerated and ensuring their access needs are being met.

The LeCSI Program expands the ODS' role as "boundary spanner," a program or person who serves as a bridge between people with disabilities and the legal system, translating disability, access, and care provision to system professionals, and translating the legal system to clients. Often, advocates report that once judges and ADAs are aware that a person has support services in place and a team surrounding them, they are prepared to compromise or drop charges. The LeCSI advocate provides this information to system professionals, and explains behaviors related to disability. In its first month, the LeCSI Program has assisted in getting four cases withdrawn or dismissed. As stated above, the group of people receiving services through ODS represents only a small fraction of the I/DD, ASD, and CI community, but it is a strong start to increasing support and advocacy in the court system. It's also a message to judges and legal professionals that their actions in response to disability are being monitored.

Recommendations

Housing

The 1999 *Olmstead v. L.C*. was perhaps the most consequential case for contemporary anti-carceral litigation for I/DD. Two women had been confined in a psychiatric institution for years even after medical professionals said they could be moved to a community-based setting. The state of Georgia claimed there were no community placements available and kept them confined. The plaintiffs in the case used Title II of the ADA, known as the integration mandate, which states that public entities must "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." According to this argument, denying these women access to community living was discriminatory. The Supreme Court agreed, ruling that Title II prohibits the unjustified segregation of individuals with I/DD and that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, and institutional confinement severely diminishes individuals' everyday life activities."[104] Since *Olmstead*, public entities are required to provide community-based services to persons with disabilities when such services are appropriate, the affected persons do not oppose community-based treatment, and community-based services can be reasonably accommodated.[105]

One important aspect of the *Olmstead* ruling is the question of funding. The state of Georgia claimed that the failure to place the women in community living conditions was not due to discrimination but to lack of funding.[106] The Court rejected this argument, stating that financial constraints could not be used to justify unnecessary institutionalization, though they "might be significant if the state can show that allocation of resources to one patient will cause harm to others."[107] Thus, the goal of *Olmstead*-based litigation since then has often been to force states to expand their budgets for community-based services in order to be in compliance with the ruling, though there is still a good deal of disagreement about what exactly *Olmstead* mandates concerning funding.

104. *Olmstead v. L. C. ::* 527 U.S. 581 (1999) :: Justia US Supreme Court Center, https://supreme.justia.com/cases/federal/us/527/581/#:~:text=%22A%20public%20entity%20shall%20make,of%20the%20service%2C%20program%2C%20or
105. https://www.alleghenycounty.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=6442480963
106. https://www.alleghenycounty.us/News/2022/6442479488.aspx
107. "Olmstead v. L. C." *Oyez*, www.oyez.org/cases/1998/98-536.

In 2009, President Obama declared a "Year of Community Living," and the DOJ created additional guidance for *Olmstead* compliance and began a series of *Olmstead* investigations, specifically stating that state and local governments must "divert people with these disabilities from the criminal justice system and serve them in their communities."[108] It also further defined integrated settings as ones which "are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with nondisabled persons to the fullest extent possible."[109] The DOJ has brought cases and created consent decrees or settlements in several states or locales, mandating creation of diversion programs, crisis service alternatives to law enforcement, re-entry services, and disruption points in the school-to-prison pipeline.[110] Since then, several important cases have used *Olmstead* to expand beyond large institutions to include nursing homes, sheltered workshops, and to challenge incarceration of persons with disabilities in jails and prisons. [111]

While these methods of deinstitutionalization/decarceration of individuals with disabilities can and should, to differing extents, be criticized as ableist or reformist,[112] they are potential tools for the dismantling of the Criminal Punishment System and for ensuring the freedom of as many people as possible while on the path to ensuring freedom for all. Advocates should consider using this type of litigation to push for appropriate and accessible community housing options. Ideally, housing should be non-restrictive and cross-disability peer-supported. Housing should not be contingent on sobriety, medication compliance, or other medicalized requirements.

108. "Examples and Resources to Support Criminal Justice Entities in Compliance with Title II of the Americans with Disabilities Act." *US Department of Justice Civil Rights Division*, January 2017, https://www.ada.gov/cjta.html
109. Dinerstein & Wakschlag (n105) 930.
110. ibid.
111. In *Seth v. District of Columbia*, a man found to be "unrestorable to competency" and able to safely receive services in a community setting remained incarcerated. In *U.S. v. Nino*, a man with I/DD was confined in a locked facility for competency restoration. In *People v. McCollum*, a man with autism was deemed by the Court to have a "dangerous mental disorder" and confined in an institution. In all of these cases, an *Olmstead-style* appeal was made using the ADA integration mandate and, although they were ultimately unsuccessful, they began to build momentum for applying the integration mandate to prison settings. *M.G. v. Cuomo* challenges New York State's failure to provide community-based housing and supportive services to people with serious mental illness upon discharge, leaving unhoused individuals in prison even after their release date, or releasing them to the shelter system without the necessary supports, increasing the likelihood of future arrest. It again relies on both Section 504 and the ADA Integration Mandate. In 2021, the court found the argument to be plausible and further action is pending.
112. Ben-Moshe (n5) 263-268.

Community Crisis Response, Pre-Arrest Diversion, and Harm Reduction Training

There's basically a series of times people called the cops on me when I was having a mental health episode or a meltdown…and [cops] doing "wellness checks," they're always "wellness checks." It's scary because I do drugs, I'm Black, calling the cops on me is the most stressful interaction I can handle. **- F.B.**

Beyond behavioral/psychiatric health crises, inappropriate police response to behaviors typical of those with I/DD, ASD, or CI can escalate a non-crisis situation into life or death situations for the very community members police purport to serve. No matter how well-meaning or well trained a police officer may be, the mere presence of police escalates already tense situations. Using 911 data from eight cities, a report from the Center for American Progress and Law Enforcement Action Partnership states that "between 33 and 68 percent of police calls for service could be handled without sending an armed officer to the scene;[113] between 21 and 38 percent could be addressed by Community Responders; and an additional 13 to 33 percent could be dealt with administratively without sending an armed officer to the scene." Gathering information and monitoring current crisis response services, as well as promoting non-police-involved civilian response teams both for behavioral health situations and non-urgent 911 calls, is an essential step in protecting community members with disabilities from the criminal punishment system.

Non-police Community Responder models have been shown to be incredibly effective. One example is Toronto's Indigenous-led crisis response unit, Kamaamwizme wii Naagidiwendiiying (coming together to heal/look after/take care of each other). This unit is aimed at helping Indigenous communities with psychiatric or substance use crises, or for non-emergency wellness checks. Teams consist of crisis response workers and community resource specialists trained in suicide intervention, harm reduction, CPR, first aid, and Naloxone administration.

113. Irwin, Amos and Betsy Pearl. "The Community Responder Model: How Cities Can Send the Right Responder to Every 911 Call." The Center for American Progress, October 2020. https://www.americanprogress.org/article/community-responder-model/

Services are based on consent and collaboration.[114] Another well-known example is CAHOOTS (Crisis Assistance Helping Out On The Streets) which has provided 24-hour crisis response in Oregon's Eugene-Springfield metro area since 1989. Teams consist of a medic and a civilian crisis worker, and they can be contacted through police non-emergency lines. Again, services are voluntary and confidential.[115] Best practices indicate that community response teams should "include peer responders who have lived experience with the concerns they are responding to" in order to be trusted and effective.[116] We believe this remains true not only for mental health and substance use crises, but for individuals with I/DD, ASD, and CI. Peer responders, or "credible messengers... individuals with strong ties to the community, oftentimes with a personal history of overcoming violence or justice system involvement, who are able to connect to community residents based on their shared background and experiences" can also be incredibly effective when responding to non-emergency conflict and quality-of-life calls.[117] These teams can prevent violence between community members, as well as the violence of police response to non-urgent situations. One example is Man Up! Inc. in Brooklyn's East New York Neighborhood, who respond not only to interpersonal conflict but to problems like shoplifting (another common charge for individuals with I/DD) with nonviolent, non-carceral solutions.[118]

As discussed, the LEAD program is showing promise. Efforts should be made to ensure that its program incorporates more extensive knowledge of and accessibility to people with I/DD, ASD, and CI. Case managers should be trained and knowledgeable about these disabilities and about resources for diagnosis and assistance. Another important aspect of the LEAD program is the community training component. Many police encounters with disabled people begin because community members call the police when they perceive someone to be either in crisis or threatening in some way. LEAD staff have noted observations from data collection and police ride-alongs indicating that community members are often making calls regarding what they believe to be psychiatric crises, but which are actually behaviors related to I/DD, ASD, or CI.

As we transition from centralized, militarized crisis response to community crisis response and mutual aid, it is vital that all community members have an understanding of disability and access needs. Like LEAD, it will be important for multiple organizations to continue developing community trainings on ableism and bias, crisis response, conflict de-escalation, mental illness, I/DD, and access-centered care. These trainings should be developed and led by people with disabilities.

114. Sachdeva, Rhythm. "New Indigenous-led crisis team offers targeted mental health support," CTV News, 2 August 2022, https://www.ctvnews.ca/canada/new-indigenous-led-crisis-team-offers-targeted-mental-health-support-1.6011307.
115. CAHOOTS.https://whitebirdclinic.org/cahoots/.
116. Irwin & Pearl (n112).
117. ibid.
118. ibid.

Know Your Rights Trainings For Disability Community

Every time one of these things happened, I didn't know my rights, I didn't know what was happening, I was just scared every single time and I just feel like I didn't have the literacy not only about how to navigate my own mental health but also how to navigate an interaction with the police while [also] being visibly Black and sometimes visibly trans… **– F.B.**

In addition to community trainings on disability and crisis response, advocates emphasized the need for "Know Your Systems/Know Your Rights" trainings for community members with disabilities. These could be developed and presented as written materials, webinars, and/or in-person sessions. There are examples of this kind of programming both nationally and in local settings.[119] Training teams should include legal professionals, people with lived experience, and/or disability justice advocates.

119. See: https://thearc.org/resource/know-your-rights-as-a-person-with-a-disability-in-the-criminal-justice-system/. https://www.aclu.org/know-your-rights/disability-rights#im-in-prison-and-have-a-disability, https://adanc.org/wp-content/uploads/2018/08/Interacting-with-Law-Enforcement.pdf, https://www.disabilityrightsca.org/publications/your-rights-people-with-disabilities-and-law-enforcement.

Mandatory Presence of Counsel or Other Professional Advocate During Interrogation

My disability made it more difficult to understand the process that I was going through. I chose to remain silent during my interactions with police, but that left me with unanswered questions…Advocates, either peer-based or professionally assigned would make a big difference in understanding… ***- E.S.***

Studies show that individuals with I/DD should have an advocate with them as soon as they are arrested, and should not be interrogated without a lawyer or advocate present.[120] Individuals at Allegheny County's Office of Developmental Supports and other advocates have reiterated the need for representation during any police interrogations.[121] Common interrogation tactics like isolation, confrontation, presenting false evidence, "minimization" or normalization of the crime, or requiring that someone listen or concentrate for an extended period of time without a break all have disproportionate impact on people with I/DD, ASD, and CI.[122] Additionally, the same behaviors police and court officials misinterpret in the street and court settings are misinterpreted during interrogations. Stimming or rocking might be judged as guilt, or flat affect as lack of remorse. And, as discussed, the desire to either hide one's disability or please or ingratiate oneself to authority figures, or simple difficulty separating memory from what one is told, can lead someone with an intellectual disability to confess to a crime they did not commit. The presence of a lawyer, mental health professional, or another professional advocate, can help mitigate these harms.

As we've discussed, screening for disabilities is a complicated process. Currently, there is not a reliable model for screening before police interrogations. The principle of collective access, then, would suggest that, instead of having to determine whether someone has a disability in order to make this accommodation, courts should provide advocates or lawyers during interrogation for **every single person**. In short, interrogations should never be performed without representation.

120. *Competency of Individuals with Intellectual and Developmental Disabilities in the Criminal Justice System:* A Call to Action for the Criminal Justice Community. National Center on Criminal Justice and Disability (The Arc), 2017, https://thearc.org/wp-content/uploads/2019/07/16-089-NCCJD-Competency-White-Paper-v5.pdf.
121. Personal Communication, DJCCI, April 2022.
122. Rogal, Lauren. "Protecting Persons with Mental Disabilities from Making False Confessions: The Americans with Disabilities Act as a Safeguard." *New Mexico Law Review,* Vol. 47, Winter 2017. https://digitalrepository.unm.edu/nmlr/vol47/iss1

Beginning in 1995, Chicago's First Defense Legal Aid operated a 24-hour hotline to provide free counsel and representation at police stations to anyone in custody.[123] However, Chicago Police Departments routinely denied individuals they arrested access to phone calls or counsel, referred to as *incommunicado* detention. In 2020, this issue was magnified during the Movement for Black Lives, and the FDLA, the Office of the Public Defender, and several community groups and individual plaintiffs filed a lawsuit against the Chicago Police Department: *#Letusbreathe Collective, et al. v. City of Chicago*.[124] That lawsuit resulted in a historic consent decree from the Chief Judge of Cook County Circuit Court that a Public Defender be appointed immediately upon request by an arrested individual.[125] The decree also dictated that phones be installed in all interrogation rooms, information about obtaining free representation be posted in detention areas, and all individuals be allowed to call family and counsel within three hours of arrest.[126] Counsel is now available to individuals after arrest 24 hours a day by the Public Defender's Police Station Representation Division, and has been implemented successfully despite a lack of buy-in from the police department itself (and, in fact, active resistance).[127]

One day in jail can have significant impacts on mental and physical health, employment, housing, the well-being of a person's family and children and, in some cases, constitutes the difference between life and death.[128]All of these impacts are felt even more acutely for a person with disabilities, as they are already fighting to survive within ableist systems of employment, health care, etc. We believe that counsel immediately after arrest is an issue of collective access and should be universally guaranteed. Allegheny County should look to implement its own Public Defender's Police Station Representation Division. The Chicago Public Defender's Office was able to survey 1468 people in bail hearings, and found that 23 percent were never offered access to a phone at the police station. Local advocates might look to work similarly with the Allegheny County Public Defender to determine whether representation is being offered in a meaningful and accessible manner to people upon arrest.[129] Especially when discussing I/DD, ASD, or CI, it is not enough for police to say representation was available had it been asked for; individuals must be made aware of the opportunity for counsel and given instruction as to how to obtain that counsel.

123. *Access to Counsel at First Appearance:* A Key Component of Pretrial Justice. National Legal Aid and Defender Association, February 2020, https://www.nlada.org/sites/default/files/NLADA%20CAFA.pdf.
124. First Defense Legal Aid. "Chicagoans in Custody Now Have Guaranteed Access to Attorneys and Family Calls." https://www.first-defense.org/advocacy/chicagoans-in-custody-now-have-guaranteed-access-to-attorneys-and-family-calls
125. National Legal Aid and Defender Association, Access to Counsel at First Appearance: A Key Component of Pretrial Justice, February 2020, https://www.nlada.org/sites/default/files/NLADA%20CAFA.pdf.
126. Kalven, Jamie. "Chicago Could Be a Model for the Future of Miranda Rights." The Atlantic. 30 September, 2022. https://www.theatlantic.com/ideas/archive/2022/09/chicago-consent-decree-miranda-rights-model/671610/.
127. ibid.
128. Wang, Leah, Rise in jail deaths is especially troubling, Prison Policy Initiative, June 23, 2021, https://www.prisonpolicy.org/blog/2021/06/23/jail_mortality/#:~:text=Dying%20in%20jail%20often%20happens%20within%20days%20or%20weeks&text=Someone%20in%20jail%20is%20more,ethnicity%20to%20match%20jail%20populations).
129. MacArthur Justice Center. #LetUsBreathe Collective v. City of Chicago. 23 June, 2020. https://www.macarthurjustice.org/case/letusbreathe-collective-v-city-of-chicago/

Counsel at First Appearance

Going through the court system was absolutely terrifying…it felt like a life or death situation. – E.S.

The first court appearance required of people accused of crimes in Allegheny County is a preliminary arraignment, where defendants are informed of criminal charges against them and a magistrate makes an initial decision regarding bail. Defendants are currently not afforded a lawyer at these hearings.[130] Without representation, judges make decisions regarding pretrial incarceration based solely on the criminal charge and a standardized risk assessment algorithm.[131] The risk assessment tool considers age at arrest, whether the defendant is accused of a violent offense, and a variety of ostensible risk factors including prior arrests, convictions, and failures to appear.[132] Important considerations for the defendant's own welfare - mental health conditions, housing insecurity, employment obligations, children and dependents, and, crucially, the risk that incarceration itself poses to the individual - are not included.

Representation at preliminary arraignments, or Counsel at First Appearance (CAFA), is necessary to disrupt the machine-like dehumanization of algorithmic risk assessment and the unchallenged authority of a judge. Provision of counsel allows for consideration of individual circumstances and mitigating factors that would otherwise go unmentioned. Defense counsel can interview clients prior to preliminary arraignments and ask about any disabilities, including I/DD, ASD, or CI, that should affect decisions regarding incarceration.

130. While Supreme Court precedent from Rothgery v. Gillespie County, 554 U.S. 191 (2008), mandates counsel at "any critical stage before trial," jurisdictions vary in their definitions of a "critical stage" and often exclude first-appearance hearings where bail determinations are made.
131. Allegheny County Pretrial Services Annual Report, 2019, https://www.alleghenycourts.us/wp-content/uploads/2022/06/Pretrial_AR_2019.pdf
132. Public Safety Assessment: Risk Factors and Formula, Laura and John Arnold Foundation, 2016, https://craftmediabucket.s3.amazonaws.com/uploads/PDFs/PSA-Risk-Factors-and-Formula.pdf

Jurisdictions that have implemented CAFA have seen significant decreases in pretrial incarceration[133] and bail amounts set.[134] Allegheny County's own pilot study found that representation at first appearance decreased cash bail, increased pretrial releases, decreased jail bookings, and decreased racial disparities in bookings and bail, all without a change in re-arrest or failures to appear.[135]

CAFA also works to combat the terror and disorientation of criminal processing alluded to by E.S. in the quote above. Having counsel to explain criminal procedure and serve as an advocate can help to alleviate the anxiety of facing a hostile courtroom.[136]

The central barrier to providing CAFA is the work required of resource-strapped public defender's offices. As Pennsylvania is currently the only state that does not provide state-level funding to public defense,[137] legislation providing for state-wide funding would make CAFA implementation more readily feasible.

133. Defendants provided CAFA in Baltimore, MD were 2.5 times more likely to be released without bail (15); those in various counties in upstate New York were between 1 and 20.8% more likely to be released after initial appearance (17). Access to Counsel at First Appearance: A Key Component of Pretrial Justice. National Legal Aid and Defender Association, February 2020, https://www.nlada.org/sites/default/files/NLADA%20CAFA.pdf;
Representation prior to arraignment in San Francisco doubled the likelihood of release at arraignment from 14% to 28%. The Impact of Early Representation: An Analysis of the San Francisco Public Defender's Pre-Trial Release Unit, California Policy Lab, June 2018, https://www.capolicylab.org/wp-content/uploads/2018/06/Policy-Brief-Early-Representation-Alena-Yarmosky.pdf;
Implementation of CAFA in Alameda County, CA increased the proportion of cases with motions for release from virtually 0 to 27% of cases, most of which were granted. Danielle Soto & Mark Lipkin, Representation at Arraignment: The Impact of "Smart Defense" on Due Process and Justice in Alameda County, Impact Justice Research & Action Center, 2018, https://impactjustice.org/wp-content/uploads/Smart-Defense-Report-2019.pdf.
134. Defendants provided CAFA in Baltimore, MD were 4 times more likely than others to have bail reduced. Access to Counsel, National Legal Aid at 3. Implementation of CAFA in three upstate New York counties significantly increased the likelihood of having bail set under $1,000. Andrew L.B. Davies, Reveka V. Shteynberg, Kirstin A. Morgan & Alissa Pollitz Worden, Guaranteeing Representation at First Court Appearances May Be Better for Defendants and Cheapter for Local Governments, London School of Economics U.S. Centre: U.S. Politics & Policy (Aug. 2018), https://blogs.lse.ac.uk/usappblog/2018/08/28/guaranteeing-representation-at-first-court-appearances-may-be-better-for-defendants-and-cheaper-for-local-governments/
135. Allegheny County Department of Human Services, October 2020, Public Defense at Preliminary Arraignments Associated with Reduced Jail Bookings and Decreased Disparities, https://www.alleghenycountyanalytics.us/wp-content/uploads/2020/10/20-ACDHS-06-Public-Defense-Brief_v5.pdf; Anwar, Shamena, Shawn D. Bushway, and John Engberg, The Impact of Defense Counsel at Bail Hearings. Santa Monica, CA: RAND Corporation, 2022, https://www.rand.org/pubs/working_papers/WRA1960-1.html
136. Access to Counsel, National Legal Aid at 16. See also: "[Clients provided CAFA] are more comfortable, les nervous, and better prepared for not only the arraignment but also when and if they move ahead in the court process," The Huron County District Court's Counsel at First Appearance Pilot Program, Michigan Indigent Defense Commission, Summer 2017 at 5, https://michiganidc.gov/wp-content/uploads/2015/04/Huron-County-Counsel-at-First-Appearance-Report.pdf
137. Christopher Welsh, Pennsylvania is the only state that doesn't fund public defenders, Philadelphia Inquirer, Oct. 11, 2021, https://www.inquirer.com/opinion/commentary/public-defenders-funding-pennsylvania-20211011.html

Vertical Representation

Best practice models for individuals with I/DD involved with the criminal legal system recommend continuity of services wherever possible.[138] It is beneficial for any person to have as few variations as possible while navigating the incredibly confusing and overwhelming system, and this applies especially to their lawyer. However, the Allegheny County Public Defender's Office provides defense "horizontally," which means that someone going through the system encounters a different attorney for each step.[139] This is disorienting for anyone dealing with the punishment system, and is only amplified for those with I/DD, ASD, and CI. For someone with high social anxiety, as is often the case with ASD for example, this constant re-introduction to strangers might be especially stressful.

The American Bar Association explains that horizontal representation raises the risk of substandard defense, decreases trust between a defendant and counsel, prevents relationship building, and increases a person's feeling that they are merely being "processed" by the system.[140] For a person with a disability, this can add the increased burden of repeatedly explaining that disability and any individual access needs.

The National Legal Aid and Defender Association and the American Bar Association both recommend "vertical representation," where one lawyer represents a person throughout their case.[141] Again, this would require an influx of resources to public defenders, most likely following a legislative shift to state-wide public defense funding, as horizontal representation is less costly and requires fewer employees.

138. Glaser, W., & Florio, D. (2004). Beyond specialist programmes: A study of the needs of offenders with intellectual disability requiring psychiatric attention. Journal of Intellectual Disability Research, 48(6),591-602. doi: 10.1111/j.1365-2788.2004.00628.x

139. Rebecca Nuttal, "The Allegheny County Public Defender's Office is in Better Shape Than it Was Three Years Ago but 'A Lot Remains to be Done," Pittsburgh City Paper, June 24, 2015, https://www.pghcitypaper.com/pittsburgh/the-allegheny-county-public-defenders-office-is-in-better-shape-than-it-was-three-years-ago-but-a-lot-remains-to-be-done/Content?oid=1835795&storyPage=2

140. "Continuous representation of the defendant by the same attorney – ABA Principle 7." Sixth Amendment Center, accessed 28 January 2023. https://sixthamendment.org/the-right-to-counsel/national-standards-for-providing-the-right-to-counsel/continuous-representation-of-the-defendant-by-the-same-attorney-aba-principle-7/#

141. Rebecca Nuttal, "The Allegheny County Public Defender's Office is in Better Shape Than it Was Three Years Ago but 'A Lot Remains to be Done," Pittsburgh City Paper, June 24, 2015, https://www.pghcitypaper.com/pittsburgh/the-allegheny-county-public-defenders-office-is-in-better-shape-than-it-was-three-years-ago-but-a-lot-remains-to-be-done/Content?oid=1835795&storyPage=2

Public Defender Training

My own lawyer was not concerned that I had a disability. – E.S. [142]

The Supreme Court has repeatedly ruled that indigent defense must include competent, independently supervised representation with adequate time, training, and resources.[143] Without these elements the system is "presumptively providing ineffective assistance of counsel, resulting in…the 'constructive' denial of counsel." [144] In addition to early and consistent representation, then, people with disabilities should be represented by lawyers who understand disability and access. Without this understanding, they are lacking in the resources and skills necessary to competently and effectively communicate with and defend their clients. As J.B. explained:

> *My lawyer was unfamiliar with ASD but was willing to learn and hire experts to learn about Autism, which was a huge advantage over a public defender or another lawyer. We hired an Autism expert later to testify at my sentencing…overall, the financial cost of my representation was $32,000… for the many families who cannot afford these extremely expensive legal costs, the legal system becomes tremendously unfair to the Autistic defendant.*

Public defenders, therefore, should be offered regular, specialized training on working with individuals with I/DD, ASD, and CI. There is precedent for providing training to public defenders/indigent defense counsel to both assess clients for disabilities and more effectively represent individuals with I/DD, ASD, and CI, such as the guide for attorneys created by The Arc of New Jersey and the New Jersey Bar Foundation. [145]

142. Personal Correspondence, November 2022.
143. Jaffe, Samantha. "It's Not You; It's Your Caseload: Using Cronic to Solve Indigent Defense Underfunding." Michigan Law Review, vol 116, Iss 8, 2018. https://repository.law.umich.edu/cgi/viewcontent.cgi?article=1779&context=mlr.
144. "The Right to Counsel in America Today." Sixth Amendment Center, accessed 28 January 2023. https://sixthamendment.org/the-right-to-counsel-in-america-today/.
145. The Criminal Justice Advocacy Program and the New Jersey Bar Foundation, 2014, Individuals with Intellectual and Developmental Disabilities Who Become Involved in the Criminal Justice System: A Guide for Attorneys, https://njsbf.org/wp-content/uploads/2018/11/CJAP-Attorney-Guide.pdf

Community Based Competency Restoration

Allegheny County's struggle to maintain constitutional competency wait times reveals two key issues for individuals with disabilities: 1. Lack of community living options, and 2. Lack of state capacity for inpatient competency restoration. As stated by Henry Steadman and Lisa Callahan, more beds at TSH is clearly not the answer:

> There are too many people in TSH and NSH who should not be there… There are too many people on the Waitlist who should not be. The IST system in Pennsylvania is broken…Just building more beds is little more than a band aid for a body that is mortally wounded. [146]

One approach to this issue is community-based competency restoration. For individuals who are not labeled as posing a risk to the community, there is no reason they cannot receive competency restoration services on an outpatient basis. Currently, at least 35 states have allowed outpatient competency restoration services to be considered as alternatives to inpatient restoration programs, and at least 16 of those have developed formal competency restoration programs that are based outside of an institutional or other hospital setting. [147] Pennsylvania has no law prohibiting outpatient competency restoration, and some PA counties have implemented these programs.[148] We should note that competency restoration programs sometimes still entail mandatory social/health services, professionalized mental health treatment, and medications, but we believe that moving these processes out of state hospitals and into the community is an important harm reduction measure.

Allegheny County's plan for a mobile competency restoration program is a promising pathway to offering community-based competency restoration, but it also states that services may be provided in the jail, leaving the door open for jail-based restoration services and lengthy confinements. ALC should monitor the situation as it develops, and maintain contact with DHS and ACLU.

146. Ibid.
147. Wik, Amanda. "Alternatives to Inpatient Competency Restoration Programs: Community-Based Competency Restoration Programs." NRI-Inc, 31 October 2018. https://www.nri-inc.org/media/1508/ocr_website-format_oct2018.pdf.
148. Steadman & Callahan (n94).

As part of any community-based restoration effort, the county also needs to provide adequate supportive housing for individuals undergoing competency restoration, and connect them with further community supports that are intended to provide a maximum benefit to them as individuals rather than push them through the legal system regardless of personal well-being. We believe any community-based competency restoration program must have the following elements:

1. The provision of a forensic support specialist, peer navigator, or advocate as soon as someone is referred for competency evaluation. This person helps the individual understand the process and can advocate for diversion, additional support, or outpatient restoration. Further, even if the individual is declared competent, their advocate can push the courts to provide the supports and accommodations they may need to adequately assist in their own defense. Washington State's Forensic Navigator Program is a strong model for this kind of service.[149] While these navigators and specialists have traditionally been focused on mental illness/psychiatric disabilities, it would be equally beneficial to individuals with I/DD, ASD, and CI. We should note that these programs are not without flaws and controversy, as they are still professionalized services and remain part of the system we ultimately seek to dismantle. They should be seen as a transitional model between carceral and community response.

2. Non-restricted supportive housing/independent living/peer-managed housing.

3. Outpatient competency restoration services that are provided in conjunction with traditional case management services to find care and support for individuals, and explore diversion options while undergoing restoration programming.

Funds for this program should be diverted from the criminal punishment system. This can be achieved through litigation and/or advocacy for legislation that diverts funds in order for a locality to comply with the ADA and the *Olmstead* ruling.

There should also be a push for public access to the competency waitlist numbers and timelines on an ongoing basis, including tracking people once they are incarcerated at TSH (how long they stay, if they are declared competent or not restorable, and if they are released to the community or courts in a timely manner).

149. https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/forensic-navigator-program.

Pre-Plea Diversion

There are no current diversion processes or specialty courts in Allegheny County designated for I/DD, ASD, or CI. Diversion is a complicated subject when addressed from the starting point of Disability Justice and abolition. For instance, the Abolition and Disability Justice Coalition outlines the following reforms to avoid, among others:

1. Reforms that replace policing and criminalization with mandatory social or health services, including those that replace imprisonment with other forms of incarceration, such as in a group home, nursing home, drug treatment facility, or hospital, including seemingly benign ones like check-ups that are used to surveil and gate-keep people from getting other services (like education and housing).

2. Reforms like Assisted Outpatient Treatment that require compliance with medication, or any kind of forced drugging to avoid incarceration/hospitalization or in order to get other services (like housing or Social Security benefits). This is also sometimes referred to as chemical incarceration. [150]

3. Reforms that expand funding for mandatory services like psych hospitals or psychiatrization more broadly, or mandatory check-ups (by medical professionals, Child Protective Services, etc.).

4. Reforms that require registries, monitoring, or surveillance.

5. Reforms that base eligibility for housing or other services on sobriety, medication compliance, not engaging in self-harm, or other restrictive criteria.

6. Reforms that further isolate and segregate people…Separating and isolating people as a way of "treating" them or addressing crises is a common approach that endangers vulnerable people and worsens the harms they face. [151]

150. Erick Fabris, *Tranquil Prisons*: Chemical Incarceration Under Community Treatment Orders, Toronto: University of Toronto Press, 2011. Chapter 6: "Bioincarceration," pages 114-131.
151. "Reforms to Avoid." The Abolition and Disability Justice Coalition, 2022, https://abolitionanddisabilityjustice.com/reforms-to-oppose/

The county should explore diversion courts that, like the LEAD program, involve services that are largely based on consent. Diversion should also be pre-plea, meaning that a person does not have to plead guilty in order to participate, and their charges may be dropped if the diversion program is completed. Usually, participants are released on bond to the diversion court for a specified amount of time and monitored by the court and pretrial services.[152] It is likely, however, that even a pre-plea diversion court would contain some elements listed above, especially for more serious charges. Again, this court should be considered a harm reduction step on the road to decarceration and, ultimately, abolition. In that vein, the court itself should focus on harm reduction, [153] trauma-informed care, and relationship-based care.[154] The formation of a specialty court for I/DD, ASD, and CI should of course involve a team of advisors with lived experience.

152. Amanda B. Cissner, Ashmini Kerodal, & Karen Otis, "The Allegheny County Mental Health Court Evaluation: Process and Impact Findings," Center for Court Innovation and Bureau of Justice Statistics, 2018, https://www.courtinnovation.org/sites/default/files/media/documents/2019-01/allegheny_county_mhc_evaluation.pdf.
153. See: "Bridging the Gap: A Practitioner's Guide to Harm Reduction in Drug Courts" by by Alejandra Garcia and Dave Lucas, Center for Court Innovation, August 2021, https://www.innovatingjustice.org/sites/default/files/media/document/2021/Guide_TA_BridgingtheGap_08102021.pdf.
154. See: "A Relationship-Based Care Model for Jail Diversion" by Rafael A. Rivas-Vazquez Psy.D. et al., Psychiatric Services, Vol. 60, Iss. 6, 1 June 2009. https://doi.org/10.1176/ps.2009.60.6.766.

Screening in Specialty Courts

As discussed in earlier sections, screening at the point of entry into the criminal legal system is logistically problematic; however, it seems appropriate to introduce voluntary screenings and diagnostic processes in Allegheny County's "specialty courts." While individuals who enter the Mental Health Court already have mental/behavioral health diagnoses, these diagnoses may or may not be correct, or may not encompass all of what someone is experiencing. As discussed above, disabilities often co-occur, and it's likely that some individuals in Mental Health Court, Drug Court, Veterans Court, and Sex Offenders Court have more than one disability, some of which may be unaddressed or ignored. F.B. explained:

> *My Autism diagnosis was early. A lot of the problems I had were delegated to being symptomatic of that and I was also being given a lot of the wrong medication. I thought I had depression and really I had bipolar and it just made my manic episodes really, really long and contributed to that…I got at least two of [my] diagnoses later in life and some of these interactions with police ended up happening before I got those diagnoses. It wasn't like I wasn't being adamant about trying to fix things with my health. The symptoms, the life-altering things that were happening were happening, I just couldn't get access to mental health services that I needed because I was on Medicaid or I didn't have health insurance.*[155]

Specialty Courts, perhaps beginning with Mental Health Court, should contract with providers to offer participants complete neuropsychiatric and medical evaluations to screen for I/DD, ASD, TBI, other cognitive impairments, and any psychiatric disorders or mental health needs. These should be optional and the results confidential. Providers should walk participants through what evaluation results mean, how certain impairments may be affecting their lives, and choices they have moving forward, including whether or not to share new diagnoses with courts and probation.

155. Personal communication, April 2022

Another option for participants, outside of medical/psychiatric diagnostic diagnoses and labeling, would be to establish more thorough evaluation in these specialty courts of individuals' functional challenges. The Supports Intensity Scale was developed by the American Association on Intellectual and Developmental Disabilities in 2004 and is the standard scale used by the PA DHS.[156] The SIS focuses on strengths-based, person-centered planning, and evaluates the types and intensity of supports needed in work, home, or social settings. It is a "collaborative and participative process [that] provides information on current and needed supports including... Identification of the activities that are important to the individual [and] amount of supports needed to enable participation in daily activities and community involvement."[157] The SIS is specific to I/DD, so would not be appropriate to apply to all mental health or substance use disorder needs assessments, but is an example of the type of functional assessments that could be used in lieu of diagnostics both as a way to provide evidence-based care and collect/distribute data about disability in the criminal punishment system.

156. https://www.dhs.pa.gov/Services/Disabilities-Aging/Pages/SIS.aspx
157. "Supports Intensity Scale® Implementation Manual." Michigan Department of Health and Human Services, v 2.2, June 2021, https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/BH-DD/MDHHS_SIS_Manual_Version22_727728_7.pdf?rev=282bf6548ce5437aab643f6a49aea149&hash=439FAEA552AD3ED62C5F494D04EBFDDA.

Obtain RN Screening Data

We attempted, through a Right to Know request, to obtain anonymized data regarding the number of “yes” answers to the three questions about I/DD and TBI in ACJ’s RN screening, but the request was denied, citing a need for confidentiality. These numbers may get closer to capturing the numbers of individuals with I/DD or TBI that are booked at ACJ, and if anonymized would not be a violation of confidentiality. ALC and other advocates might consider appealing the request or working with DHS, the JOB, or a Protection and Advocacy organization like Disability Rights Pennsylvania to obtain this data, as it is currently the best available data regarding prevalence of these disabilities at ACJ.

Survey and Investigation of all Carceral Institutions in Allegheny County

I had broken up with my girlfriend and I told her to just leave me the fuck alone, I was feeling really bad, and then she called the cops on me…and they put me in a mental health hospital where I was sexually assaulted. They didn't give me an option when I came there, they were like, you can go for a short time, or if I have to make you go, it's going to be for a long time. And that felt like an impossible decision to make.

I felt pretty upset, because it felt like somebody seeing me in this very vulnerable state, not even being suicidal per se, just self-harming, and that's why I'm being forced to go to the hospital, when I feel like other people just get away with self-harming and just going about their natural days and I feel like I wasn't allowed to be vulnerable or allowed to have mental health problems. **- F.B.**

The Independent Living movement, the establishment of Medicare and Medicaid, and a series of documentaries and exposés of horrific conditions in state institutions, accelerated the release of confined individuals out of large institutions and into the community, often into community-based outpatient facilities. However, Medicaid still incentivised, and continues to incentivise, other forms of institutionalization. Liat Ben-Moshe notes that while "the number of people with I/DD labels living in institutions decreased by 80 percent[158] from 1977 to 2015…the number of people living in small residencies (six or fewer people) increased by greater than 1900 percent over this same time period."[159] Disability waivers and benefits are paid directly to nursing homes, group homes, etc. rather than individuals, so people are often not able to choose living situations outside of government-ordained institutions. The quality and carceral logics of these institutions vary, from secured facilities to group homes.

158. Ben-Moshe (n5) 3.
159. Ben-Moshe(n5) 44.

Many Disability Justice organizers describe some of these facilities as "mini-institutions," simply smaller versions of large, state-run hospitals. Marta Russell states:

> the forces of incarceration of disabled people should be understood under the growth of both the prison-industrial complex and the institution-industrial complex, in a growing private industry of nursing homes, boarding homes, for-profit psychiatric hospitals, and group homes. People with disabilities are profitable to the capitalist system when they are incarcerated within any of these spaces.[160]

Many people are mandated by courts to be institutionalized or incarcerated at alternative housing. Too often, individuals with I/DD, ASD, and CI are grouped into alternative housing units and programming designed for serious mental illness while, at other times, "community-based programs often actively seek to exclude individuals with ID."[161] Even if someone is deemed incompetent to stand trial and charges are dropped, they may still then be committed to a hospital or nursing home. We need more public information about the practices and conditions in these carceral spaces.

A reasonable place to begin is with increased investigation into, and monitoring of, the alternative housing sites for Allegheny County Jail, including Renewal, Inc., Passages to Recovery Pittsburgh (downtown), and Passages to Recovery West Homestead. These operate as large, independent nonprofit organizations (Renewal had an operating budget of twenty million dollars for FY 2020-21)[162] who contract with the county to provide beds and services for incarcerated community members. It's important to note that they are seldom the focal point for anti-carceral advocacy efforts, despite the fact that the population incarcerated there likely represents a high concentration of people with disabilities. Further, it is less common for investigative reporting or academic research to focus on these facilities, resulting in diminished community oversight. They do, however, fall under the purview of the Jail Oversight Board, and are paid with taxpayer dollars, and the public could therefore pressure the Board to increase its monitoring of these sites. A 2018 Allegheny County Controller's Office audit (the most recent we could find), for instance, reported that Renewal did not have documentation of a satisfactory grievance process, failed to consistently provide prescription medication, and retained funds that belonged to returning community members,[163] and a 2018 survey of alternative housing and inpatient facilities utilized by the Mental Health Court revealed a high degree of variability in the utilization of evidence-based treatment practices.[164] Issues like these and others need to be investigated and made public, current and former residents should be consulted, and policies and practices around I/DD, ASD, and CI should be examined.

160. Ben-Moshe (n5) 13.
161. "Managing and Treating Justice-Involved Individuals with Intellectual Disabilities in Pennsylvania." Pennsylvania Mental Health and Justice Center of Excellence, 14 December 2012.
162. "202-2021 Annual Report." Renewal, Inc. https://www.renewalinc.com/wp-content/uploads/2022/02/2020_2021-Renewal-Inc-Annual-Report.pdf
163. Allegheny County Office of the Controller, Performance Audit Report, 10 May, 2018. https://alleghenycontroller.com/wp-content/uploads/2020/03/89724b271f2dbfb76808dff8992c2e222018JunWed1407241528898844d3d9446802a44259755d38e6d163e82046a465a6d11659aa1ad87a51d4eae347A-1FINALRenewalPerformanceAuditReport-b.pdf
164. Cissner, Kerodal, & Otis, "The Allegheny County Mental Health Court," (n21).

Disability Representation in Oversight and Access

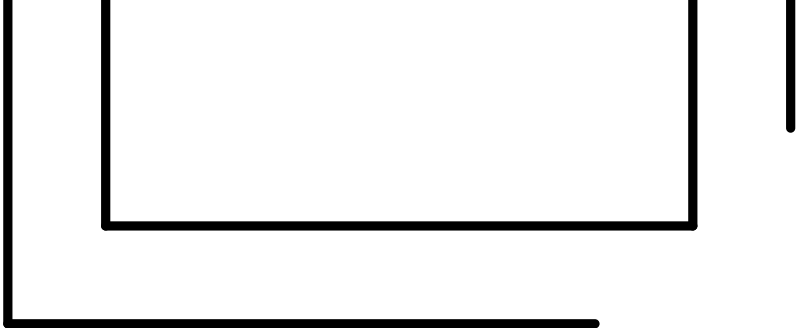
Allegheny County should convene a multi-disciplinary, cross-disability policy committee to advise on these recommendations and:

1. Perform a collaborative assessment of resources and services available in the community and identify what types of services and enhancements should be implemented to prevent the interaction of individuals with disabilities and policing agencies.

2. Inspect and make recommendations for harm reduction, accessibility, and population reduction at ACJ and its alternative housing sites.

3. Provide recommendations for harm reduction and accessibility in court practices and processes in Allegheny County.

Conclusion



I earned punishment, but I don't feel I earned imprisonment. **- E.S.**

It is long past time to stop criminalizing disability in the United States, to understand that "the level of independence someone is capable of, regardless of age, should not be a reason to grant or deny them respect, trust, and autonomy." [165] The decarceration of people with disabilities begins with the nurturing of Disability Justice and access culture in our communities. It begins with independent and interdependent living and housing options, a movement away from congregate care and locked facilities. It begins with community education and crisis response. It begins with the de-stigmatization of neurodivergence so that community members and policing agencies stop responding to natural human behaviors with fear and violence. It begins with robust pre-arrest diversion services, and thorough, informed counsel immediately upon arrest for every single person. Above all, it begins with the leadership of our most impacted community members, a recognition that even advocates and abolitionists have long overlooked the voices of our neighbors with intellectual/developmental disabilities, autism, and cognitive impairments, and that we are ready to stand in solidarity, listen, and follow.

165. Desmarais, Idzie. "Anarchy Begins at Home." Trust Kids! Stories on Youth Autonomy and Confronting Adult Supremacy. Carla Joy Bergman, ed. AK Press, 2022.

Appendix

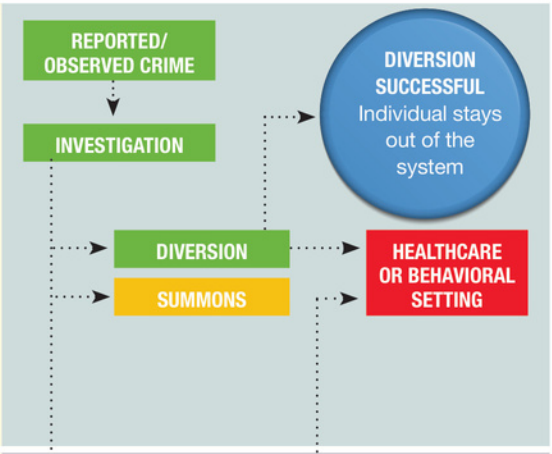
Justice Process & Intervention Opportunities Map

Developed by the Office of Developmental Programs (ODP)
in collaboration with William F. Ward, Retired Judge, Allegheny County, PA

COMMUNITY SERVICES/ PRE- SYSTEM ENTRY

POINTS OF INTERVENTION:

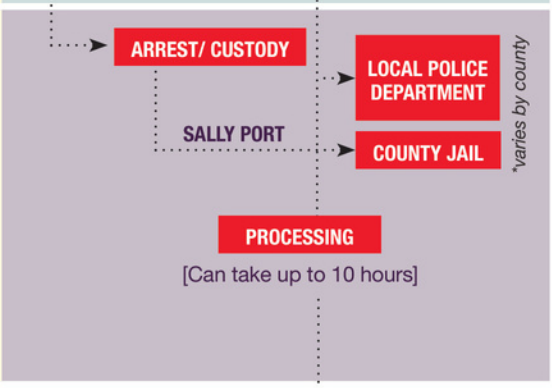
- Offer evidence-based trainings to prepare law enforcement to interact and engage with individuals with Autism, I/DD or MH diagnoses
- Introduce individual to police and local crisis staff
- Assess individual for potential risk and develop strategies to mitigate
- Prepare card with emergency contacts and numbers to keep in wallet
- Ensure they understand the meanings of, "you have the right to remain silent" and "you have the right to an attorney"
- Reduce rates of recidivism with supports for housing and employment
- Teach the importance of sharing diagnoses and self disclosure
- Utilize social stories as a strategy to assist in preparing for justice scenarios



ENTRY INTO THE SYSTEM

POINTS OF INTERVENTION:

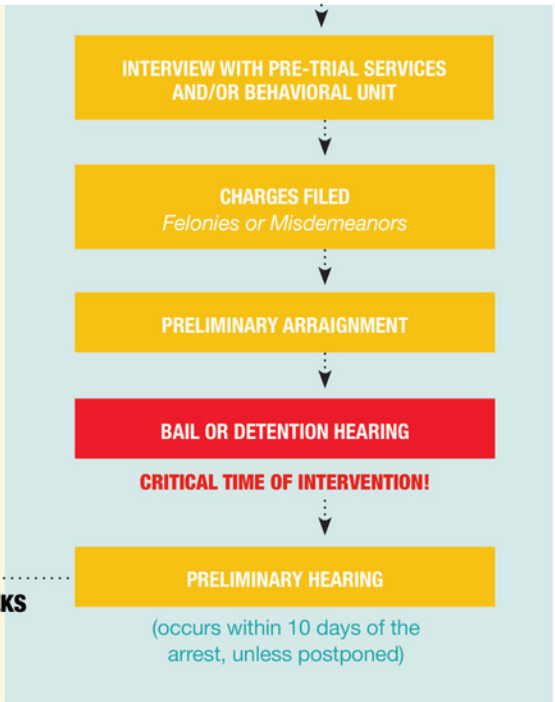
- Respond to crisis and/or police department
- Contact emergency diversion unit, mobile crisis, or peer specialist
- Encourage police to take individual to stabilization unit, walk-in service or respite instead of jail
- Prep individual for processing phase
- Contact the jail and ask them for their process for how you can stay up to date on the current status of the individual (website, phone number, etc.)



PRE-TRIAL SERVICES & PROSECUTION

POINTS OF INTERVENTION:

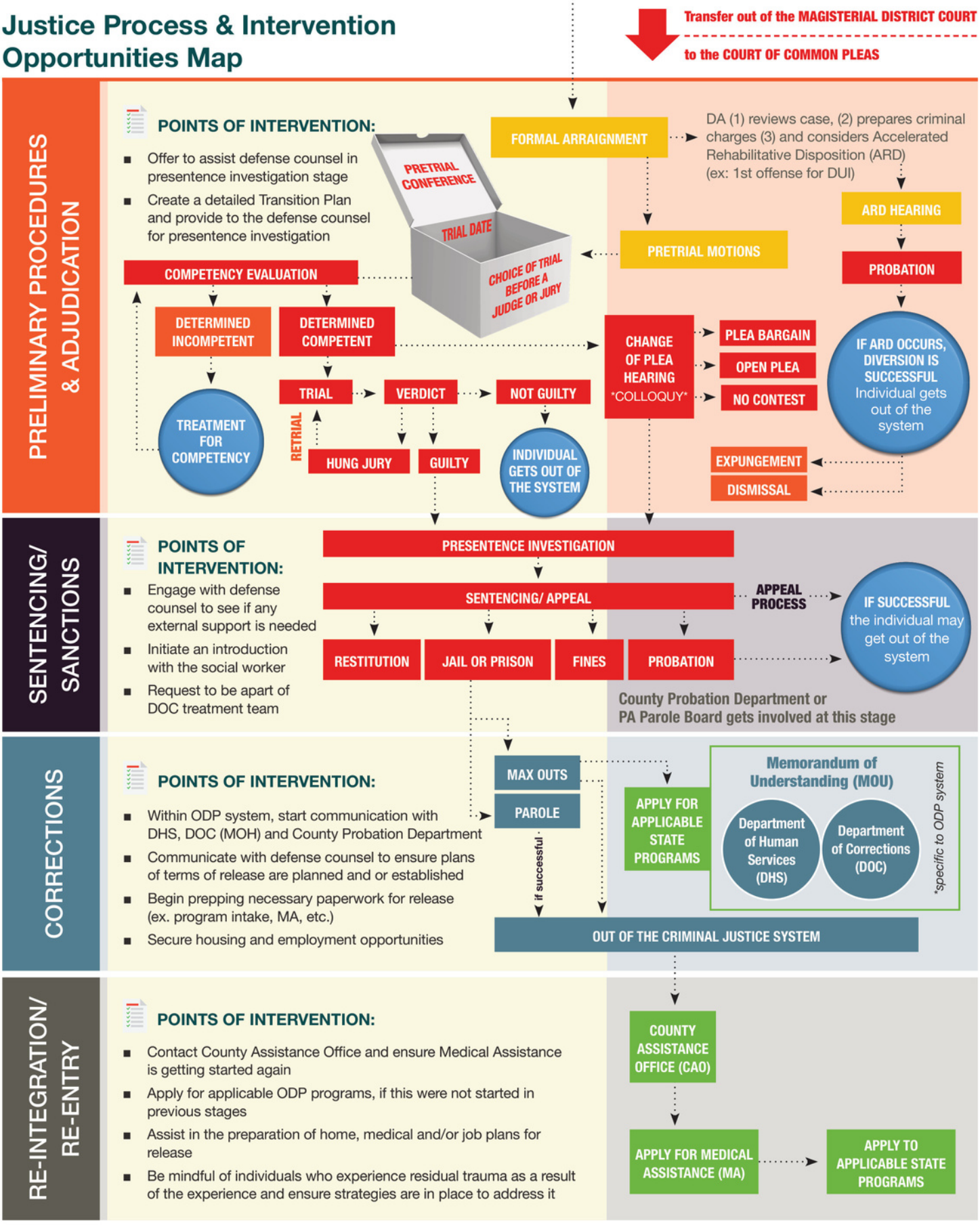
- If State supports are not involved, they need to be at this level. Contact defense counsel so they have the appropriate contact information and request that you (and anyone else identified) be added to the individual's visitor list
- Review updates to case, including information about the defense counsel by locating the docket sheet: **https://ujsportal.pacourts.us/DocketSheets/CP.aspx**
  **De-identify: name, MJ#, and MDJ# for consults*
- Engage the public defender or private defense counsel in (1) identifying necessary medication the individual may need and (2) offering helpful information for the interview with the Behavioral Unit and (3) explain the importance of utilizing social stories as a strategy to assist in preparing for justice scenarios (provide resources, if necessary)
- Identify if a competency evaluation is needed or already occurring
- Inform defense counsel of services being put into place and discuss what progress the participant is able to make in order for a dismissal or a withdrawal to occur
- Discuss completion of a Petition of Competency Evaluation and ARD with the defense before the Adjudication phase



6 WEEKS

Transfer out of the MAGISTERIAL DISTRICT COURT to the COURT OF COMMON PLEAS

Justice Process & Intervention Opportunities Map



ASERT bringing autism resources together. PAautism.org

Pennsylvania's leading source of autism-related resources and information.

877-231-4244

The ASERT Collaborative is funded by the Office of Developmental Programs, PA Department of Human Services.

Allegheny County Jail
950 2nd Ave
Pittsburgh, PA 15219

6/23/2022 12:29:55 PM EDT

RECEIVING SCREENING - Created on 6/23/2022 12:29:55 PM EDT

Patient:	NCCHC, ZZTEST	**#:**	234342313334d3e193b0534bb18646 (T54691)	**Lang:**	
DOB:	8/22/1966 (Age=55)	**Sex:**	Female	**Race:**	
Housing:	LEVG	**SSN#:**	**HIDDEN**	**Type:**	
Status:	NOT ACTIVE				

PICTURE NOT AVAILABLE

☐ **Patient Refused**

BP	Temp	Pulse	Resp	SaO2	BS	Pain	Height(ft)	Height(in)
/							0	0
Weight	**BMI**	**MAP**						

Review Med Clearance

Current Allergies

Pediazole

Transferring from another facility

☐ Yes
☐ No
Which facility?

Records Received?

☐ Yes
☐ No

Interpreter Used?

☐ Yes
☐ No
Name and Service

Special Needs

☐ Blind	☐ Visually Impaired	☐ Deaf
☐ Hard of Hearing	☐ Limited English Proficiency	☐ Limited Reading Skills
☐ Other	☐ None Reported or Observed	

Describe

- [ ] Signs of developmental disability (slow speech, appearance, or history)
- [ ] None Observed

Details

- [ ] Impaired mobility from casts, bandages, injury, body deformity
- [ ] None Reported

Findings

- [ ] Special medical requirements (adaptive devices, hearing aids, visual aids)
- [ ] None Reported

Details

Receiving Screening Refused?

- [ ] Yes
- [ ] No

How does the individual identify:

- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Intersex

- ◯ Male to Female (MTF)
- ◯ Female to Male (FTM)

How do you identify your sexual orientation?

- [ ] Straight/Heterosexual
- [ ] Bisexual
- [ ] Gay
- [ ] Lesbian
- [ ] Asexual
- [ ] Pansexual
- [ ] Other

Describe

Have you ever been incarcerated in the Allegheny County Jail?

- ◯ Yes
- ◯ No
- ◯ Refused to Answer

Have you ever been incarcerated in any other correctional facility?

- ◯ Yes
- ◯ No
- ◯ Refused to Answer

CHRONIC CONDITIONS–Select and Document all that apply

Neurological

- ☐ Seizure Disorder
- ☐ Migraines/Chronic Headaches
- ☐ Stroke
- ☐ Dementia
- ☐ CNS Impairment
- ☐ None

Respiratory

- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ None

Cardiovascular

- ☐ CAD
- ☐ CHF
- ☐ Valvular Disease
- ☐ Hypertension
- ☐ Arrhythmia
- ☐ Dyslipidemia
- ☐ PVD
- ☐ Endocarditis
- ☐ None

Gastrointestinal/Hepatic

- ☐ Cirrhosis
- ☐ Alcohol Liver Disease
- ☐ Inflammatory Bowel Disease
- ☐ None

Endocrine

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Adrenal Disease
- ☐ None

- ◯ Blood Sugar less than 70
- ◯ Blood Sugar greater than 400

Hematology/Oncology

- ☐ Anemia
- ☐ Cancer
- ☐ Bleeding or Coagulation Disorders
- ☐ Sickle Cell Disease
- ☐ None

Cancer Details

Infectious Disease

- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ None

Chronic Care - Other/Miscellaneous

- [ ] Kidney Disease
- [ ] Transplant
- [ ] Chronic Pain
- [ ] Other Chronic Care
- [ ] None

Other

GENERAL MEDICAL ASSESSMENTS--Select and Document all that apply

Click the SureScripts button to run the medication verification report

SureScripts

SureScripts report reviewed?

- [ ] Yes
- [ ] No
- [ ] NA

Additional Medications or Treatments not documented with SureScripts

- [ ] Yes
- [ ] No

Medication	Strength	Filling Pharmacy	Address	Phone Number	Frequency	Last Dose	Last Fill Date

Current Treatments:

- [ ] Recent medical hospitalizations
- [ ] None Reported

List location, time and reason for each

- [ ] Active infections, contagious illnesses or STDs
- [ ] None Reported

Describe

- [ ] General-fever, lethargy, weight loss, loss of appetite, night sweats
- [ ] Skin-Lesions, needle marks, abscesses, bruises, rash, jaundice, lice, trauma, scars, tattoos, MRSA, Varicella (chicken pox), Herpes Zoster (Shingles)
- [ ] Pulmonary-Persistent cough, coughing up blood
- [ ] None Reported

- [ ] Urgent dental issues requiring Dentist Sick Call appointment
- [ ] None Reported

Describe

- [ ] Head injuries or fainting/passing out in the last 72 hours
- [ ] None Reported

Please provide details of injury and/or symptoms below

GENERAL MENTAL HEALTH ASSESSMENTS--Select and Document all that apply

---

Mental Health History

☐ Current or Past Treatment for mental health issues ☐ None Reported

List diagnosis, location, when it occurred, and what treatments below

☐ Mental health hospitalizations in the past year ☐ None Reported

Please provide location, when and reason below

☐ Past suicide attempts, strong plans, or treatment for attempts ☐ None Reported

List when occurred, what method, and where treated below

Do you believe you are more vulnerable to sexual assault, rape, physical assault or other forms of violence because of any part of your identity?

☐ Yes

☐ No

What do you believe makes you vulnerable?

Do you have thoughts about what would make you feel safer?

Where would you feel safest being housed?

☐ History of sexual abuse, sexually abusing another, or conviction of a sex crime; or according to the interviewer, at risk of victimization or victimizing another inmate ☐ None Reported

Details

☐ Military service ☐ None Reported

List when, how long, and any combat exposure below

SUBSTANCE USE ASSESSMENTS--Select and Document all that apply

---

☐ History or risk of alcohol or drug withdrawal ☐ None Reported

Provide details of type of drug, symptoms, and when withdrawal occurred:

Are you an opioid user or have been in the recent past? (e.g. heroin, oxy, Lortab, methadone)

- ☐ Yes
- ☐ No

Are you an injection drug user or have you been in the past?

- ☐ Yes
- ☐ No

Are you a survivor of an overdose?

- ☐ Yes
- ☐ No

☐ Recent use of illegal drugs or prescription pain medications ☐ None Reported

Provide details of drug, frequency, amount, route, and last use below

☐ Most recent alcohol, sedative (e.g. Xanax, Klonopin, Valium, Ativan), or opioid (e.g. heroin, oxy, Lortab, methadone) ☐ None Reported

Provide details below--amount per day, number of days per week, last time sober for greater than 1 week

Most recent alcohol, sedative, or opiate use:

- ◯ 5 days or less
- ◯ 6 days or greater

FEMALE ONLY ASSESSMENT–Select and Document all that apply

☐ History of gynecologic problems ☐ None Reported

☐ History of Hysterectomy or Menopause or Tubal Ligation ☐ None Reported

Last known menstrual cycle Date: ☐ N/A

☐ Current use of contraception ☐ None Reported

Please provide name, dose, frequency, duration and last time taken below

☐ Recent delivery, miscarriage or abortion ☐ None Reported

☐ Patient reports that she is or could be pregnant ☐ Patient denies that she is or could be pregnant

****

MISCELLANEOUS ASSESSMENTS–Select and Document all that apply

Does the inmate have Medicaid?

☐ Yes

☐ No

Does the inmate have Medicare?

☐ Yes

☐ No

Does the inmate have private insurance?

☐ Yes

☐ No

Additional Comments:

Allegheny County Jail
950 2nd Ave
Pittsburgh, PA 15219

6/23/2022 12:25:57 PM EDT

MEDICAL CLEARANCE - Created on 6/23/2022 12:25:57 PM EDT

Patient:	NCCHC, ZZTEST	**#:**	234342313334d3e193b0534bb18646 (T54691)	**Lang:**	
DOB:	8/22/1966 (Age=55)	**Sex:**	Female	**Race:**	
Housing:	LEVG	**SSN#:**	**HIDDEN**	**Type:**	
Status:	NOT ACTIVE				

PICTURE NOT AVAILABLE

☐ **Patient Refused**

BP	Temp	Pulse	Resp	SaO2	BS	Pain	Height(ft)	Height(in)
/							0	0

Weight	BMI	MAP

Current Allergies

Pediazole

How does the individual identify:

- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Intersex

URGENT SCREEN - Select and document all that apply

Does the screener observe, or is the individual demonstrating any of the following?:

In need of Emergency Medical Treatment due to injury, excessive bleeding, extreme pain, or unconsciouness? If yes, select all that apply.

- ☐ Yes
- ☐ No

- ☐ Injury
- ☐ Excessive bleeding
- ☐ Extreme pain
- ☐ Unconsciousness

In need of assistance to transfer from chair-to-chair, or chair-to-bed?

- [ ] Yes
- [ ] No

Hallucinating, delusional, nonsensical, unresponsive, confused, paranoid, altered mental status, or inappropriate conduct?

- [ ] Yes
- [ ] No

Intoxicated, in withdrawal, slurred speech, unsteady gait, stupor, tremulous, sweating, anxious, abnormal breathing, or hyperventilating? If yes, select all that apply.

- [ ] Yes
- [ ] No

- [ ] Intoxicated
- [ ] In withdrawal
- [ ] Slurred speech
- [ ] Unsteady gait
- [ ] Stupor
- [ ] Tremulous
- [ ] Sweating
- [ ] Anxious
- [ ] Abnormal breathing
- [ ] Hyperventilating

Pregnant and detoxing, or a risk for detoxing?

- [ ] Yes
- [ ] No

- ◯ Positive hCG
- ◯ Negative hCG

Voicing current or very recent suicidal thoughts?

- [ ] Yes
- [ ] No

Disoriented to person, place, time, and/or situation?

- [ ] Yes
- [ ] No

- ◯ Medically Cleared for Incarceration
- ◯ NOT Medically Cleared for Incarceration

SUPPLEMENTAL INTAKE SCREENING FORM

Open

The following is a sample of ACJ's Booking Observation Questions form provided upon our request. Aside from the headings visible on the three pages that follow, the contents of the entire 14-page form were redacted. Transparency is essential and the public has a right to the information gathered and used to assess people who enter ACJ.

ALLEGHENY COUNTY BUREAU OF CORRECTIONS	APPLICABILITY: All Authorized Personnel
	POLICY NUMBER: #217 — EFEFCTIVE: 4/1/14 REVIEWED: 3/12/20
	TITLE: BOOKING OBSERVATION QUESTIONS
	AUTHORIZED BY: ORLANDO L. HARPER SIGNATURE: Orlando L Harper

POLICY

[redacted]

APPLICABLE POPULATIONS

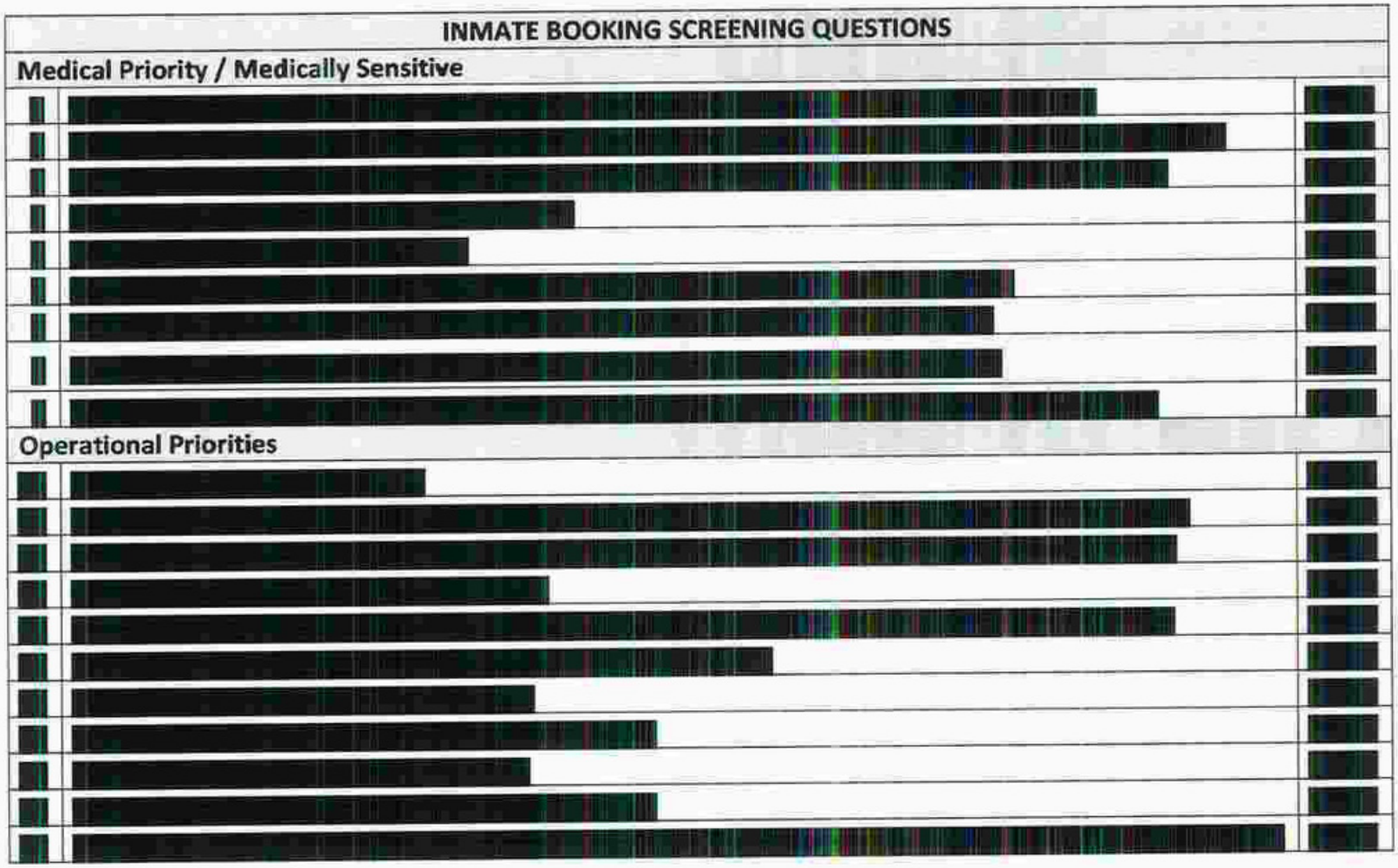
[redacted]

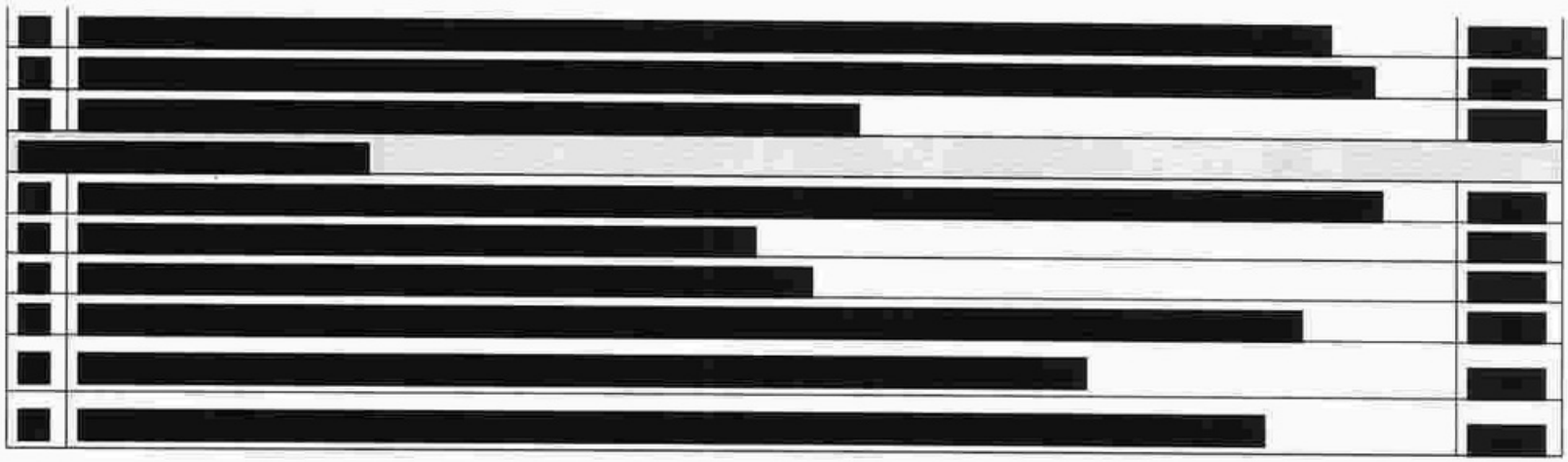
PROCEDURAL GUIDELINES

- [redacted]
- [redacted]
- [redacted]
  - [redacted]

Addendum 1

BOOKING OBSERVATION QUESTIONS





Allegheny County Jail
950 2nd Ave
Pittsburgh, PA 15219

6/23/2022 12:32:32 PM EDT

MENTAL HEALTH SCREENING - Created on 6/23/2022 12:32:33 PM EDT

Patient:	TEST, OMS	**#:**	194811 (2020-07232)	**Lang:**	
DOB:	1/1/1900 (Age=122)	**Sex:**	M	**Race:**	W
Housing:		**SSN#:**	**HIDDEN**	**Type:**	
Status:	NOT ACTIVE				

PICTURE NOT AVAILABLE

☐ **Patient Refused**

BP	Temp	Pulse	Resp	SaO2	BS	Pain	Height(ft)	Height(in)
/	Weight	BMI	MAP					

Current Allergies

Allergy History Not Known

SUICIDE RISK ASSESSMENT - Select and document all that apply

Does/Has the inmate: (Select all that apply)

1) Currently feel depressed?

☐ Yes
☐ No

Rate current feeling of depression on a scale of 1-10, with 10 being the most severe:

◯ 1 - 3
◯ 4 - 6
◯ 7 - 10

2) Currently or previously been diagnosed with any mental health disorder?

☐ Yes
☐ No

3) Currently or previously experienced any of the following symptoms? Inability to experience pleasure from previously enjoyable activities, impulsivity, hopelessness, anxiety/panic, insomnia, or command hallucinations

- [ ] Yes
- [ ] No

4) Currently have thoughts of self harm or suicide?

- [ ] Yes
- [ ] No

Current self-harm or suicidal ideation:

Receiving screen response:

5) Strongly considered or attempted suicide in the past?

- [ ] Yes
- [ ] No

When and what method:

Receiving screen response:

6) Feel that he/she has nothing positive to look forward to?

- [ ] Yes
- [ ] No

Comments inmate makes:

7) Have any family history of attempted or committed suicide?

- [ ] Yes
- [ ] No

List relatives:

8) Had any recent emotional losses or emotional charged events?

- [ ] Yes
- [ ] No

List recent losses:

9) Had any treatment for mental health issues or suicide risk during any previous incarceration?

- [ ] Yes
- [ ] No

When and where was the inmate incarcerated and what were the risk:

10) Recently been discharged from a doctor's treatment?

- [ ] Yes
- [ ] No

11) Exhibit any disorientation to person, place, time, and/or situation?

- [ ] Yes
- [ ] No

Record Deficit(s):

12) Feels capable of dealing with stress?

- [ ] Yes
- [ ] No

13) Appears to speak about their responsibilities and social supports?

- [ ] Yes
- [ ] No

14) Is the individual experiencing any suicidal ideation?

- ☐ Yes
- ☐ No

15) Is there indication of a plan?

- ☐ Yes
- ☐ No

16) Is the individual displaying or speaking about behaviors of concern?

- ☐ Yes
- ☐ No

---

17) How does the inmate feel about the current situation?

18) Does the interviewer feel the inmate is a suicide risk and/or should be on suicide watch?

- ☐ Yes
- ☐ No

GENERAL MENTAL HEALTH ASSESSMENTS - Select and document all that apply

---

Has the inmate:

19) Received treatment for mental health issues?

- ☐ Yes
- ☐ No

List diagnosis, when, what medication, location of treatment, and provider name:

Receiving screen response:

20) Had any psychiatric hospitalizations?

- ☐ Yes
- ☐ No

When and where:

Receiving screen response:

21) Intentionally injured himself/herself (aside from suicide attempts)?

- ☐ Yes
- ☐ No

What type of behavior when was it last done:

22) Had hallucinations (auditory, visual, or other)?

- ☐ Yes
- ☐ No

Type and content of hallucinations, and when they were last experienced:

23) Had delusional thought processes or psychosis?

- ☐ Yes
- ☐ No

Describe abnormal thoughts and when they were last experienced:

24) Experienced a life-threatening traumatic event?

- ☐ Yes
- ☐ No

Describe event and when:

25) Used illegal drugs or abused prescription drugs?

- [ ] Yes
- [ ] No

What drugs, how much, how often, route, and when last used:

Receiving screen response:

26) Abused alcohol or sedatives?

- [ ] Yes
- [ ] No

How many days per week, how many drinks per day:

Receiving screen response:

27) Experienced significant alcohol or drug withdrawal?

- [ ] Yes
- [ ] No

When, what drugs, what were the symptoms:

Receiving screen response:

28) Been in inpatient or outpatient detoxification or had any hospitalizations related to substance abuse?

- [ ] Yes
- [ ] No

When, where, and what substances:

GENERAL ASSESSMENTS - Select and document all that apply

---

29) Inmate Appearance:

- ◯ Clean/well groomed
- ◯ Mildly unkempt
- ◯ Dirty/disheveled
- ◯ Other

Describe appearance:

30) Inmate behavior:

- ◯ Cooperative
- ◯ Depressed/sad
- ◯ Hostile/angry
- ◯ Paranoid/psychotic
- ◯ Other

Describe behavior:

Does the inmate:

31) Voice any anxiety?

- ☐ Yes
- ☐ No

Describe:

32) Have a history of physical, sexual, or emotional abuse as a child or adult, in any setting including incarceration?

- ☐ Yes
- ☐ No

Form of abuse, age, setting:

Receiving screen response:

33) Have any charges or convictions of a sex crime or violent crime?

- [ ] Yes
- [ ] No

Describe charge and when:

34) Have a history of special education classes in school?

- [ ] Yes
- [ ] No

Report what grade:

35) Have any form of serious developmental or learning disability, or does the interviewer believe in the inmate has such a disability?

- [ ] Yes
- [ ] No

Describe reasons:

Receiving screen response:

36) Have a history of a serious head injury or seizure?

- [ ] Yes
- [ ] No

Describe injury or seizure history including age of onset an last event:

37) Family history of Diabetes?

- [ ] Yes
- [ ] No

Blood Relatives?

- [ ] Mother
- [ ] Father
- [ ] Brother
- [ ] Sister
- [ ] Maternal Grandfather
- [ ] Maternal Grandmother
- [ ] Paternal Grandfather
- [ ] Paternal Grandmother
- [ ] Maternal Aunt
- [ ] Maternal Uncle
- [ ] Paternal Aunt
- [ ] Paternal Uncle

DISPOSITION/TREATMENT PLAN - Select and document all that apply

---

Mental Health Evaluation required?

- [ ] Yes
- [ ] No

Mental Health PREA evaluation needed?

- [ ] Yes
- [ ] No

Psychiatric Evaluation needed?

- [ ] Yes
- [ ] No

Housing Assignment:

Does the patient require housing other than general population and/or other housing accomodations?

- [ ] Yes
- [ ] No

Discharge Planning:

- [ ] Outpatient Mental Health
- [ ] Drug/Alcohol Treatment
- [ ] Housing Assistance
- [ ] SSI/SSDI Assistance
- [ ] Resource Info Packet
- [ ] Other

Discharge needs reviewed with inmate?

- [ ] Yes
- [ ] No

Reason:

Allegheny County Jail
950 2nd Ave
Pittsburgh, PA 15219

6/23/2022 12:31:38 PM EDT

PHYSICAL ASSESSMENT - Created on 6/23/2022 12:31:38 PM EDT

Patient:	TEST, OMS	**#:**	194811 (2020-07232)	**Lang:**	
DOB:	1/1/1900 (Age=122)	**Sex:**	M	**Race:**	W
Housing:		**SSN#:**	**HIDDEN**	**Type:**	
Status:	NOT ACTIVE				

PICTURE NOT AVAILABLE

☐ COVID VACCINATION HISTORY

☐ Initial ☐ Annual ☐ Refused

Initial Receiving Screening Reviewed:

○ Yes
○ No
○ N/A

If No, explain why:

Initial Mental Health Screening Reviewed:

○ Yes
○ No
○ N/A

If No, explain why:

☐ **Patient Refused**

BP	Temp	Pulse	Resp	SaO2	BS	Pain	Height(ft)	Height(in)
/	Weight	BMI	MAP					

Are you currently receiving Medication Assisted Treatment/Medication for Opioid Use Disorder (MAT/MOUD)?

☐ Yes
☐ No

If yes, please specify medication:

- ◯ Methadone
- ◯ Naltrexone
- ◯ Sublocade
- ◯ Suboxone
- ◯ Subutex
- ◯ Vivitrol
- ◯ Other

Please specify:

CLINICIAN'S OBSERVATIONS:

ORIENTED TO:

Person:

- ☐ Yes
- ☐ No
- ☐ NA

Place:

- ☐ Yes
- ☐ No
- ☐ NA

Time:

- ☐ Yes
- ☐ No
- ☐ NA

Situation:

- ☐ Yes
- ☐ No
- ☐ NA

APPEARANCE:

- ☐ Appropriate
- ☐ Bizarre
- ☐ Disheveled
- ☐ Sweating
- ☐ Tremors

Other

BEHAVIOR:

- ☐ Appropriate
- ☐ Disorderly
- ☐ Insensible

Other

PERCEPTION:

- ☐ Appropriate
- ☐ Delusional
- ☐ Hallucinating
- ☐ Paranoid

Other

STATE OF CONSCIOUSNESS:

- ☐ Alert
- ☐ Lethargic
- ☐ Responsive

Other

AFFECT:

- ☐ Appropriate
- ☐ Afraid
- ☐ Angry
- ☐ Depressed
- ☐ Flat
- ☐ Happy

Other

OVERALL DEMEANOR:

- ☐ Agitated
- ☐ Cooperative
- ☐ Guarded
- ☐ Uncooperative

Other

PHYSICAL EXAM

NEW INJURIES:

- ☐ None
- ☐ Abrasions
- ☐ Abscess
- ☐ Burn Wounds
- ☐ Contusions
- ☐ Lacerations
- ☐ Puncture Wounds
- ☐ Sutures/staples

Other

HEENT: (Complete all)

- ☐ PERRLA
- ☐ No trauma to head, face, or neck
- ☐ External canals normal
- ☐ Pharynx normal
- ☐ Neck supple, normal range of motion

Abnormal Findings:

DENTAL:

Mouth Pain

- [ ] Yes
- [ ] No
- [ ] NA

Infection/Abscess

- [ ] Yes
- [ ] No
- [ ] NA

Describe

Bad Taste

- [ ] Yes
- [ ] No
- [ ] NA

Fever

- [ ] Yes
- [ ] No
- [ ] NA

Refer abnormal exams to Dentist.

- [ ] Yes
- [ ] No
- [ ] NA

Educational material provided to inmate

- [ ] Yes
- [ ] No
- [ ] NA

Other dental notes:

CARDIOVASCULAR: (Complete all)

- [ ] Regular rate, normal s1 and s2
- [ ] Peripheral pulses are normal

Abnormal findings:

RESPIRATORY: (Complete all)

- [ ] Respirations even, unlabored, and normal rate
- [ ] Lung sounds clear and equal in all lung fields

Abnormal findings:

Does the patient have asthma?

- [ ] Yes
- [ ] No

ABDOMINAL: (Complete all)

- [ ] Abdomen soft, nontender, nondistended
- [ ] No masses palpated
- [ ] Bowel sounds active and normally pitched

Abnormal findings:

MUSCULOSKELETAL/SKIN: (Complete all)

- [ ] Grossly normal strength and function of all extremities
- [ ] Gait normal with no limitations for ADL's
- [ ] No injuries or infections on extremities

Abnormal findings:

CENTRAL NERVOUS SYSTEM: (Complete all)

- [ ] Reflexes are normal
- [ ] CNS normal

Abnormal findings:

GENITOURINARY: (Complete all)

- [ ] Costovertebral angle (CVA) tenderness absent
- [ ] Urethral discharge none reported

Abnormal findings:

LABS:

PLEASE READ TO INMATE: All inmates who are admitted to the ACJ are tested for STDs as part of the routine health screening for individuals in your age category. A urine specimen is obtained to test for gonorrhea and chlamydia and will be collected now. A blood specimen is used to test for HIV and syphilis. You will be scheduled to go to the clinic for the blood test. All inmates with a positive result on these tests will receive treatment.

Chlamydia and Gonorrhea:

Is the patient between the ages of 18-34?

- [ ] Yes
- [ ] No

Lab Specimen Obtained?

- [ ] Yes
- [ ] No

HIV and Syphilis:

Is the patient between the ages of 18-50?

- [ ] Yes
- [ ] No

TUBERCULOSIS SYMPTOMS:

Chronic Cough Longer than 4 weeks, night sweats, blood in sputum?

- [ ] Yes
- [ ] No
- [ ] NA

Ever been tested for TB?

- [ ] Yes
- [ ] No
- [ ] NA

Results:

- [ ] Positive
- [ ] Negative
- [ ] N/A

Date or size if known:

CXR done?

- [ ] Yes
- [ ] No
- [ ] NA

Any clinically significant findings?

- [ ] Yes
- [ ] No

Does the patient's age, medical or sexual history past or present indicate the need for a provider to complete a pelvic, rectal, genitalia or prostate examination?

- ☐ Yes
- ☐ No

Do you believe you are more vulnerable to sexual assault, rape, physical assault or other forms of violence because of any part of your identity?

- ☐ Yes
- ☐ No

What do you believe makes you vulnerable?

Do you have thoughts about what would make you feel safer?

Where would you feel safest being housed?

Release signed to obtain all medical records, pharmacy records, substance abuse records?

- ☐ Yes
- ☐ No

Inmate Educated on Access to Care Procedures?

- ☐ Yes
- ☐ No

MEDICATION RECONCILIATION

Patient on any medication?

- ☐ Yes
- ☐ No

Review Medication Verification Report?

- ☐ Yes
- ☐ No

Explain:

Local Pharmacy contacted?

- ☐ Yes
- ☐ No

Explain:

Notify providers for orders?

- ☐ Yes
- ☐ No
- ☐ NA

Explain:

Complete Medication Reconciliation queue?

- [ ] Yes
- [ ] No

Explain:

HOUSING ASSIGNMENT & SPECIAL NEEDS

- [ ] Blind
- [ ] Visually Impaired
- [ ] Deaf
- [ ] Hard of Hearing
- [ ] Limited English Proficiency
- [ ] Limited Reading Skills
- [ ] Other
- [ ] None Reported or Observed

Describe

- [ ] Signs of developmental disability (slow speech, appearance, or history)
- [ ] None Observed

Details

- [ ] Impaired mobility from casts, bandages, injury, body deformity
- [ ] None Reported

Findings

- [ ] Special medical requirements (adaptive devices, hearing aids, visual aids)
- [ ] None Reported

Details

Does the patient require housing other than general population and/or other housing accommodations?

- [ ] Yes
- [ ] No

Is patient less than 18 years of age?

- [ ] Yes
- [ ] No

CONSENT

I have answered all questions on the Comprehensive Nurse Exam forms truthfully to the best of my knowledge and ability. I have been told and shown how to obtain medical and mental health services. I have been instructed on and understand oral hygiene and preventative oral care practices. I hereby give consent for professional services to be provided to me by and through Allegheny County Jail.

Alternatives to Policing Based in Disability Justice

By the Abolition and Disability Justice Collective

Plain Language Version

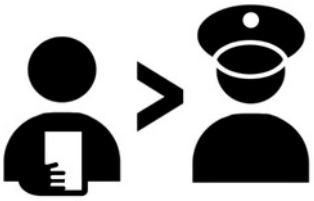
Designed by Euree Kim

Cripping Abolition

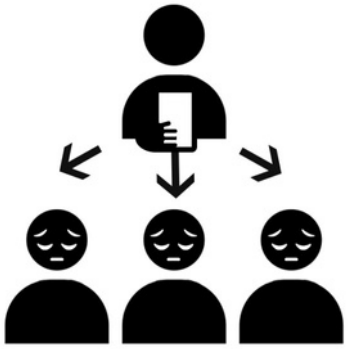
Abolition is not just about getting rid of cops and jails. It is about new ways of doing things.

We can deal with problems in other ways.

We can stop problems before they start.



Sometimes people say social workers are better than cops.



But social workers and other mental health providers can cause harm, too.

People may lock us up to “treat” us.

They may keep us from making choices about our lives.

These systems treat disabled and neurodivergent people as if we are less than others.

The problem isn't just jails. And the problem isn't just mental health providers.

It is the way people make money from jails and hospitals. Our economy uses cops, jails, and medicine to make a few people rich. Capitalism is part of the problem.

When we solve problems, we must try not to cause problems.

We must build the world we want to live in.

To do that, we have to listen to the people hurt most now. That includes disabled and neurodivergent people who also face racism, poverty, sexism, and other types of bias.

No one should be treated as if they don't matter.

Why does it seem normal to neglect some people?

Who does it seem normal to?

Let's take resources away from systems that treat some like trash.

Let's make a world where everyone has what they need.

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Let's make a world where everyone has what they need.

Why can't everyone have housing, food, water, and education? Why can't accessibility be normal? Why can't we have the health care we want? Why can't health care be peer-run and anti-racist?

We do not live in the world we deserve. We do not live in a world where each of us is valued for who we are. We deserve a world where we are celebrated and supported.

We fight for that world.

People are rising up to say no more cops or jails. We honor the work that has brought us to this point.

Our leaders are Black, Indigenous, and people of color.

Our leaders are queer, trans, intersex, and gender nonconforming.

Our leaders are migrants and refugees.

Our leaders are disabled and neurodivergent.

Our leaders are women and femmes.

Our leaders are youth and elders.

It is time to defund the police and invest in Black communities.

People are asking questions about what makes us safe. How should we deal with the things people usually call the cops about?

Some people say that people who are disabled or neurodivergent are a threat.

They want us drugged or locked up to keep others safe.

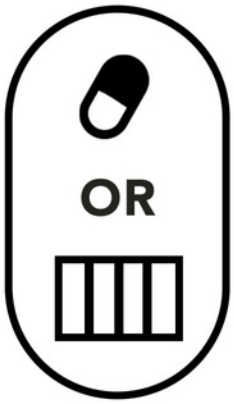
That is not the answer. These ideas are ableist and sanist. They are a part of the problem. They are part of the system that needs to change. This system hurts all of us.

We can't mend it. We have to end it.

Reforms to Avoid

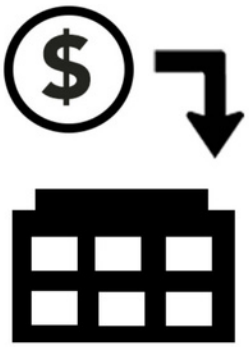
1. Forced social or health services.

No one should be locked up anywhere. That includes in group homes, nursing homes, drug treatment, or hospitals. Forced checkups are not okay either. We should get to go to school and have housing even if we don't want checkups.



2. Forced drugging.

Neurodivergent and disabled people should get to make our own choices. It is not okay to drug us against our will. It is also not okay to threaten us with jail or losing our kids if we don't take meds.



3. Money for forced services.

Money should get taken away from cops and jails. But that money shouldn't go to other places that do the same thing! Money should not go to psych hospitals or forced checkups.

4. Forced restraint or pain.

No one should be kept from moving their own body. And no one should be punished or controlled through pain. That includes disabled and neurodivergent people. It is ableist to say we might hurt others because of who we are. And it is ableist to say it is okay to hurt us.

5. Spying.

Sometimes, people think they are helping us by keeping track of us. But then we get punished if we don't do what others think we should. Spying does not help.

6. Mandated Reporting.

Some people have to tell the government if they think someone is hurting us. They also have to say if they think we might hurt ourselves. This makes things worse. It takes away our choice. It makes it more likely we will get hurt.

7. Protective Services.

Sometimes bad things happen in families, but it is not okay to take people away from their families against their will. What happens after being taken away may be worse. Some families are more likely to get torn apart than others. Disabled families get targeted. Black and Indigeneous families and other Families of Color get targeted. Queer and trans families get targeted. Migrant and refugee families get targeted. Poor families get targeted.

8. Ableist rules for services.

Services should go to those who want and need them. It is not okay to make rules that will keep

people out for other reasons. Some of us drink. Some of us self harm. Some of us don't take our meds. Some of us skip checkups. Some of us say or do things that seem weird. We still need services. We still deserve services. Rules that keep us out are not okay.

9. Isolation.

People need other people. Disabled people are not a problem. Forcing us to be alone is not okay. It is not "treatment." It leads to more harm.

THIS REPORT WAS MADE POSSIBLE BY GENEROUS SUPPORT FROM THE FISA FOUNDATION.