Good day, Chairperson Downey and members of the Assembly Human Services Committee. Thank you for the opportunity to testify on behalf of ABCD and in full support of A5565, “The Behavioral Health Crisis Mobile Response Act,” which would provide a crisis response tool for adults with intellectual or developmental disabilities who are undergoing a mental health or behavioral health crisis.

The incidence and prevalence of mental health conditions for individuals with intellectual and developmental disabilities is typically two to three times that of the general public. This supports the estimate that between 30-57% of people with intellectual and developmental disabilities also experience mental health challenges. Despite the frequency of individuals with intellectual and developmental disabilities having mental health conditions, this concurrence has often been misdiagnosed, understudied and undertreated leading one industry expert to name this population as “the last and the least served.” Possible explanations for this include:

- For years the common thought was that you had to have a certain intelligence level to have a mental illness; that individuals with intellectual and developmental disabilities didn’t have a high enough IQ to get depressed or to experience trauma.
- Behavioral issues in people with intellectual disabilities were most often viewed as a function of their cognitive impairment rather than a symptom of an underlying mental health problem. It did not occur to clinicians that there might be an additional diagnosis, so they did not think to look for other explanations for behaviors.
- A diagnosis of intellectual or developmental disability often overshadows the mental health issues so that the condition goes unrecognized.

3 Beasely, Overview of START.
4 Ibid.
• People with intellectual and developmental disabilities experience trauma, including abuse and neglect, at higher rates than the general population and are at increased risk of developing more severe post-traumatic stress symptoms than people without intellectual and developmental disabilities when exposed to the same traumatic event (Texas Health and Human Services). Trauma responses are often mistaken for willful noncompliance or lack of motivation.  

• Mental and substance use disorder treatment providers may underestimate the barriers of accessibility to their program or they may have specific exclusion criteria for some people with disabilities.  

“Immune,” unnoticed, overlooked, minimized and excluded; whatever the reason(s) the personal, familial and societal suffering and loss is immeasurable.

It is a great pleasure to support this bill in addition to actions being taken by the Division which together will help create a customized care model to prevent emergent and acute care crisis in our population. I’d like to take the opportunity to cast light on A5567 also sponsored by Assemblywoman Downey which would begin to treat demand and need further downstream, optimizing mental health/trauma prevention services in day and residential programs, where there are cheaper and many more options. Clearly the Assemblywoman understands the importance of a broad paradigm so that we can see the scope of the problem and enact meaningful solutions. We thank her for her leadership.

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7 Mental and Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities. (SAMSA Advisory, 2019). HHS Publication No. PEP19-02-00-002.
8 Ibid.