Maryland General Assembly
Public Safety and Policing Workgroup

AGENDA

Thursday, July 23, 2015
4:00 p.m.
Joint Hearing Room
Legislative Services Building
Annapolis, Maryland

I. Call to Order

II. Introductions

III. Presentations

STATEWIDE ADVOCATES:

- Rev. Todd Yeary, Senior Pastor, Douglas Memorial Community Church; Legislative Chair, Maryland State Conference of the NAACP
- David Rocah, ACLU
- Marion Gray Hopkins, survivor and leader of parents group in Prince George's County
- Garland Hopkins, university professor and specialist on training
- Michael Wood, Executive Director of LEAP
- Pastor Delman Coates, Mount Ennon Baptist Church
- Caryn Aslan, Job Opportunities Task Force

BALTIMORE PANEL:

- Ms. Inez Robb, Western District Community Relations Council
- Bishop Doug Miles, Koinonia Baptist Church; Co-Chair, Baltimoreans United in Leadership
- Tawanda Jones
- Ana Marquez
- Billy Murphy, Murphy, Falcon, & Murphy
- Darlene Cain

EASTERN SHORE PANEL:

- Rev. Mark Thompson, Director of EWC Adopt-A-Block (representing Wicomico)
- Dr. Kirkland J. Hall, Sr., Community Liaison to Law Enforcement for Somerset County
- Rev. Dr. Lewis N. Watson, Pastor of First Baptist Church & Lewis N. Watson Funeral Home (representing Wicomico)
- Rev. Dr. William T. Wallace, Pastor of Union United Methodist Church (Dorchester & Talbot Counties)
- Ms. Thelma Washington, Citizen (representing Kent County)
- Mary Ashanti, Wicomico County NAACP

ANNAPOLIS/ANNE ARUNDEL COUNTY PANEL:

- Reverend Stephen Tillett, Pastor, Asbury Broadneck United Methodist Church; Anne Arundel County NAACP President
- Archie Trader, Recreation and Facility Manager, Stanton Center
- Steve Cornette, Chief Executive Officer, Boys & Girls Clubs of Annapolis & Anne Arundel County
- Lea Green, Maryland CURE

IV. Discussion of Work Plans for Future Meetings

V. Adjournment

COMMUNITY MEDIATION MARYLAND

your conflict, your solutions

Community Mediation Maryland Testimony to the Public Safety and Policing Workgroup

July 23, 2015

Submitted by: Lorig Charkoudian, Ph.D., Executive Director
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Community Mediation Maryland is a nonprofit organization dedicated to advancing collaborative conflict resolution in Maryland through educating the public, providing training and quality assurance, conducting research, and creatively applying mediation to social challenges. CMM has 18 member centers throughout Maryland who provide free mediation to resolve a range of community conflicts. These centers work with local law enforcement. In some counties, this relationship is strong and in other counties, we hope to strengthen the relationship.

Community mediation centers can improve policing and police community mediation in two specific ways.
(1) Community mediation centers support resolution of disputes between community members (neighbors, family, businesses), at the community level. When law enforcement officers refer cases to community mediation, people involved can resolve their conflicts in a sustainable way that builds relationships. This enables law enforcement to connect people with community resources and be early intervention "problem-solvers" rather than just enforcers. Community mediation centers also offer training in communication and de-escalation skills for law enforcement officers and community mediators can ride along with officers, offering their skills on the spot in the middles of an escalated conflict.

(2) Community mediation centers can and do mediate complaints against police officers. Unlike the traditional method of addressing allegations of police misconduct, this resident—police mediation allows for community members and officers to build understanding around what happened in the situation, creating bridges between law enforcement and the community. Community mediation centers also offer dialogue circles with youth and police, to build broader understanding and offer a chance to change behaviors in future interactions.

Both forms of mediation (intra—community and resident—police) reduce community strife, increase mutual understanding, and prevent violence.

Below is a more in depth description of these approaches. CMM hopes to work with the Task Force and local law enforcement agencies to identify ways to increase the use of these strategies. While these strategies alone will not resolve all of the current challenges, they are an important component of the broader reforms that we believe are necessary and hope will be forthcoming.

Community Policing: Supporting Police as Problem-Solvers

Mediation for Community Conflicts:

Police can refer neighborhood, family, and business disputes to mediation when they

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Executive Director
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respond to these calls for service. Mediation brings together all participants in a dispute with two non-judgmental mediators. Mediators listen to everyone and support the conversation to build understanding. In mediation, participants develop their own solutions that meet the needs of everyone involved. Mediation services are free and provided in locations throughout the service area.

Research has found that mediation decreases repeat calls for service, thus saving public resources through resolution of the underlying issues of the dispute[1].

Conflict Management Skills and De-escalation Training:

Community Mediation Maryland provides training in Conflict Management and De-escalation Skills for Law Enforcement. These skills support verbal efforts to de-escalate situations and highlight the connection between de-escalation and officer safety. This training is certified by the Maryland Police and Corrections Training Commission for 6 hours of in-service credit.

Mediators Ride-along with Police Officers:

Mediators can participate in ride-alongs with police officers. In this capacity, they can help with making referrals to mediation or opening cases on the spot. They can also educate officers about mediation and learn more about police experiences.

Engaging Police in Dialogue with Community Members

Dialogue Circles

Dialogue circles between community members (youth and/or adults) and police support relationship building and humanize members of the circle to each other. The facilitated circles give everyone a chance to speak about their experiences and allow everyone to hear different perspectives on some divisive issues. The overall goal is to build a new understanding. Sometimes specific suggestions come out of these circles.

Police Complaint Mediation

Voluntary mediation between police and residents can be used in place of the traditional Internal Affairs investigation for complaints such as Harsh Language, Unprofessional Behavior, or Disrespect. Mediation gives both the resident and the officer a voice in a direct conversation where each can explain their experience of the situation. When appropriate, they can develop agreements for their future interactions. Police complaint mediation is available in some cities around the US and feedback is consistently positive from both officers and residents. In Maryland, Calvert County has had success with such a program, and Baltimore City is in the process of developing this program.

Facilitated Collaborative Policy Building

Community mediation programs can facilitate broader collaborative decision-making between multiple stake-holders, such as law enforcement, residents, elected officials, civil rights groups, and others. Through this dialogue, participants can identify specific challenges and collaboratively develop both policy and programmatic solutions to those challenges

[1] Charkoudian, Lorig. "Giving Police and Courts a Break: The Effect of Community Mediation on Decreasing the Use of Police and Court Resources." Conflict Resolution Quarterly, 2010, 28(2), 142-155. Charkoudian, Lorig. "A Quantitative Analysis of the Effectiveness of Community Mediation in Decreasing Repeat Police Calls for Service," Conflict Resolution Quarterly, 2005, 23 (1), 87-98.

EQUITYMATTERS

July 23, 2015

To Whom it May Concern within The Honorable Maryland State Legislative Committee and within the Larger Body Considering Matters of Police Reform and issues of Equity around Jobs, Safety and Justice :

As one of 24 national WK Kellogg Foundation Community Leadership Network Fellow in the Racial Equity and Healing Cohort (one of 2 in Maryland, the only in Baltimore, and one of a handful in the East Coast), I often find myself nationally defending our great State of Maryland often at National Conferences and Think tank gatherings around best and most promising practices.

In our defense of the state of Maryland, we at Equity Matters believe that we are at a place in our lifetime that innovation and bipartisan boldness are essential for Maryland to lead the nation in having challenging conversations regarding....law enforcement reform, community engagement, and reducing the sentiments of anger, fear, and hopeless in communities of color.

We at Equity Matters believe that as Texas has taken on the challenge to address the effects of racism within their state by having state agency complete training in Undoing Racism, we in Maryland can match and surpass the efforts needed to prevent the questionable deaths of Maryland residents and reduce the sentiments of abuse and brutality being raised against law enforcement officials.

We at Equity Matters believe that Maryland has the opportunity to lead in having hard conversations regarding the relationships that communities of color have with law enforcement and the important role and responsibility given to law enforcement to protect and serve all communities. But we have not yet displayed that in evidence.

We at Equity Matters defend the ability for the great state of Maryland to work beyond stark political beliefs on racism in Maryland to create communities that are beloved by its current residents that are equitable for safety, employment, education, and well-being.

Please Find attached some practices from Texas that I know we can meet and exceed here in MD.

We look forward to serving the State of Maryland Legislature as it continues to serve the citizens of the Great State of Maryland in "Promoting Equity-in-All Policy™

In Service,

Michael P. Scott
Chief Equity Officer, Founder
Equity Matters, Inc.

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THE INSTITUTE FOR URBAN POLICY RESEARCH & ANALYSIS
THE UNIVERSITY OF TEXAS AT AUSTIN

THE CENTER FOR ELIMINATION OF DISPROPORTIONALITY AND DISPARITIES:

Spearheading Texas's Ongoing Fight Against Institutional Racism and Other Causes of Inequity

June 1, 2015

Victor O. Obaseki, JD
Renée Hatcher, JD

EXECUTIVE SUMMARY

Institutional racism. It is a word that means many different things to different people. However, there is likely mainstream consensus on at least one thing concerning institutional racism: elimination. That is, right-minded people want to eliminate it wherever it exists, whatever it is.

This brief examines the Center for Elimination of Disproportionality and Disparities (CEDD), the institution that, over time, has become the primary mechanism for the elimination of institutional racism in Texas state agencies that serve families and children. In addition to providing the long history of CEDD and its predecessor institutions, this brief explores the meaning of institutional racism, particularly as it relates to CEDD's work to eliminate "disproportionality and disparities." Crucially, while assuming widespread goodwill amongst state agency employees, the brief uses various research and data to conclude—as the state's health equity efforts have, at least, strongly implied—that institutional racism, properly defined, exists in Texas state agencies. However, the brief also recognizes that institutional racism may not be the only cause of disproportionality or disparities.

Thus, this brief makes recommendations for CEDD to progress and succeed in its mission to eliminate disproportionality and disparities, whether caused by institutional racism or some other factor. Specifically, the recommendations call for Texas to 1) move CEDD from the Health and Human Services Commission (HHSC) to the Office of the Governor, with specific mandates for relevant state agencies to regularly report to CEDD and otherwise cooperate with CEDD; 2) pass legislation similar to House Bill (HB) 2038 (2013) in order to empower and require CEDD to address disproportionality across state systems; and 3) pass legislation to require CEDD and the Legislative Budget Board to conduct a comprehensive economic analysis of the impact disproportionality and disparities have on the state.

HISTORY OF THE CENTER FOR ELIMINATION OF DISPROPORTIONALITY AND DISPARITIES

Administratively established in 2010 and codified in 2011, CEDD aims to partner with health and human services agencies, other state systems, external stakeholders and communities to identify and eliminate disproportionality and disparities affecting children, families, and individuals (Center for Elimination of Disproportionality and Disparities [CEDD], n.d.). The Texas Department of Family and Protective Services (DFPS), within HHSC, defines "disproportionality" as the overrepresentation of a particular group of people in a particular program or system, and "disparity" as the unequal or inequitable treatment of one group as compared to another. CEDD has performed many training sessions and presentations, formed key partnerships, and generally informed Texans and others about combating disproportionality and disparities throughout this state and its governmental agencies. But Texas's official effort to fight against disproportionality and disparities affecting children and families is far older than CEDD; indeed, the effort is more than two decades old.

National Effort Becomes State Effort

In 1985, U.S. Secretary of Health and Human Services Margaret Heckler released a landmark task force report that called for the U.S. government and the public health community to address the significant health disparities the report had found affecting ethnic and racial minorities (Heckler, 1985). The report represented the first time the U.S. Department of Health and Human Services had consolidated racial minority health issues into one report. The U.S. Congress responded the next year by establishing the Office of Minority Health within the U.S. Department of Health and Human Services. During the next 20 years, as various research detailed disparities in health and other social service systems, 40 states followed the nation's lead by establishing state offices intended to work to eliminate health disparities affecting people of color (National Association of State Offices of Minority Health [NASMOH], 2006).

Texas was one of those states, establishing its Office of Minority Health via legislation in 1993 (HB 1510, 1993). Eight years later, Representative Garnet Coleman authored a bill that established a Health Disparities Task Force to help the state "eliminate health and health access disparities in Texas among multicultural, disadvantaged, and regional populations" (HB 757, 2001). The legislation required the task force to investigate and report on disparities issues, develop strategies to eliminate the disparities, and reorganize state health programs as necessary to strive for that elimination. The legislature also required the task force to consult with the renamed Office of Minority Health and Cultural Competency and the women's health office. The task force was required to report to the governor and legislative leaders, first annually and later biennially.

Next, in 2003, Representative Arlene Wohlgemuth authored a bill that consolidated the state's health and human services system under the oversight of HHSC and its executive commissioner (HB 2292, 2003). The bill laid the groundwork for Representatives Dawnna Dukes and Garnet Coleman to further the state's health equity aims with 2007 legislation (HB 1396, 2007). The 2007 legislation officially gave the Office of Minority Health a more apt statutory title: Office for the Elimination of Health Disparities. However, the Office of Minority Health continued administratively and today serves within CEDD as a grant-receiving information resource. The 2007 legislation moved the newly named office from the Department of State Health Services to the parent HHSC agency, so that the office could carry

out its mission across all of the state's health and human services system. The bill also specified that the five-year-old Health Disparities Task Force should focus on race and ethnicity, in addition to other, more generally termed demographics.

State of Texas Timeline: Addressing Racial Disproportionality and Disparities

1990s

- 1993 - Texas establishes state Office of Minority Health (House Bill [HB] 1510, 73rd Regular Legislative Session)

2000s

- 2001 - Texas establishes state Health Disparities Task Force (HB 757, 77th Regular Legislative Session)
- 2003 - Texas consolidates state health and human services system into five agencies, including parent agency, Health and Human Services Commission (HHSC), headed by executive commissioner (HB 2292, 78th Regular Legislative Session)
- 2005 - In the midst of a Child Protective Services (CPS) crisis, Texas requires CPS data analysis on racial disproportionality (Senate Bill [SB] 6, 79th Regular Legislative Session)
- 2005 - Texas requires cultural competency training for CPS's child welfare staff and recruitment of appropriate foster and adoptive families and diverse child welfare staff (SB 6, 79th Regular Legislative Session)
- 2006 - CPS reports that it takes disproportionate action, particularly against Black or African American and Native American children, and that it has started remediation, including "Undoing Racism" training

2010 - Present

- 2010 - CPS reports that, since 2005, it has moderately reduced disproportionate action against children of color and racially diversified its staff
- 2010 - HHSC executive commissioner administratively establishes Center for Elimination of Disproportionality and Disparities (CEDD), citing successes during CPS disproportionality reform
- 2011 - Texas codifies CEDD, establishes Interagency Council for Addressing Disproportionality (IC), and eliminates decade-old Health Disparities Task Force (SB 501, 82nd Regular Legislative Session)
- 2012 - IC releases legislative report, adopting Texas Model for addressing disproportionality and disparities and making policy recommendations
- 2013 - HB 2038, 83rd Regular Legislative Session, aims to implement IC recommendations and continue IC, but bill fails in Senate
- 2013 - HHSC Rider 87, SB 1, 83rd Regular Legislative Session, calls for CEDD to spearhead steps to address disproportionality and disparities across state systems and report to legislature
- 2013 - IC officially expires
- 2015 - HHSC and CEDD release Rider 87 report that identifies new Texas Model and highlights the lack of formal legislative mandate to address disproportionality and disparities, except in Department of Family and Protective Services
- 2015 - New State Budget expected to be signed into law (HB 1, 84th Regular Legislative Session) retreats from previous legislative sessions' efforts to make CEDD truly cross-systems and largely limits CEDD's role to health and human services

Meanwhile and relatedly, the Texas Legislature in 2005 took another key step to addressing health and human services equity by passing Senator Jane Nelson's Senate Bill (SB) 6 (2005), coauthored by Kyle Janek, the current HHSC executive commissioner who was then a state senator. The bill was a response to then-Governor Rick Perry, who had sought systemic reforms of the state's troubled child and adult protective services with executive orders and a declaration of an emergency legislative item. The governor's actions came after several news reports on injuries to and deaths of children involved in Texas Child Protective Services (CPS), overseen by DFPS (Mann, 2007).

In relevant part, SB 6 required HHSC and DFPS to analyze 2004 and 2005 data on child removals and other child protection enforcement actions to determine whether such actions, when accounting for all relevant factors, were taken disproportionately against any racial or ethnic group. If the agencies found such disproportionate action, the legislation required the agencies to 1) evaluate policies and procedures on child protection enforcement actions, 2) develop and implement a remediation plan to prevent disproportionate action based on race and ethnicity, and 3) report back to the legislature.

Furthermore, the bill added a cultural awareness section to the child welfare chapter of the Texas Family Code, which applies to CPS. The section—unamended since—requires DFPS to 1) develop and deliver cultural competency training for service delivery staff; 2) target recruitment efforts for appropriate foster and adoptive families and diverse staff; and 3) partner with community organizations "to provide culturally competent services to children and families of every race and ethnicity."

After conducting SB 6's mandated analysis, HHSC and DFPS did find disproportionate child protection enforcement actions that affected children of color, particularly Black or African American and Native American children (Texas Health and Human Services Commission & Department of Family Protective Services [HHSC & DFPS], 2006). In the resulting 2006 remediation plan and report to the legislature, HHSC and DFPS listed the first major remedial achievement as staff training, including "Undoing Racism" training for CPS management and later DFPS staff. In 2007, with CPS still mired in controversy because of more child deaths, Senator Nelson's SB 758 furthered the reform process of DFPS, particularly CPS, by calling for an overall improvement plan (Department of Family and Protective Services [DFPS], 2007). The December 2007 improvement plan report to the legislature noted that DFPS was in the process of establishing a statewide network of disproportionality specialists to serve the community and CPS staff. The report mentioned that the legislature funded the specialists network, in addition to "undoing racism" training.

During the five years after SB 6's 2005 passage, several thousand Texas CPS staff, other agencies' staff and community members throughout the state participated in undoing racism and other cultural competency training, as DFPS implemented its remediation and improvement plans. Meanwhile, CPS slightly reduced disproportionate child protective actions while making the CPS staff more racially diverse (DFPS, 2011).

In September 2010, then-HHSC Executive Commissioner Tom Suehs administratively created CEDD, appointing Joyce James to head the institution (HHSC, 2010). James, who had provided testimony regarding CPS disproportionality during hearings on 2005's

SB 6, worked in CPS as an assistant and deputy DFPS commissioner from 2004 till taking over CEDD. Part of the announcement of CEDD quoted Suehs: "At the heart of all our programs and services, we're about people. And we want to make sure that every person is treated with respect and dignity. Joyce has been a pioneer in helping improve equity in our protective services programs, and we want to put that same focus on all our services."

Cross-Systems Elimination of Disproportionality and Disparities

With passage of Senator Royce West's SB 501 (2011), the legislature made CEDD official in law during its 2011 regular legislative session. The bill officially replaced the Office for Elimination of Health Disparities with CEDD, which now encompasses the state Office of Minority Health and Health Equity, the Office of Border Affairs, and the statewide network of regional equity specialists first established in CPS.

The legislation also created an Interagency Council for Addressing Disproportionality (IC) and eliminated the decade-old Health Disparities Task Force statute. In a move to a more cross-systems approach to the problem, the legislation required the IC to include agency and community representatives from various education, health and human services, juvenile justice, and criminal justice backgrounds. The bill named CEDD's representative presiding officer of the IC. SB 501 explained that the IC was to examine, investigate, and then report to the legislature on any disproportionality or disparities affecting racial or ethnic minorities in the state's juvenile justice, child welfare, mental health, education or health system.

Just ahead of the December 2012 deadline, the IC, led by James, released a 222-page report that found that disproportionality and disparities affected racial and ethnic minorities in all of the systems examined (Interagency Council for Addressing Disproportionality, Texas Health and Human Services Commission, Center for Elimination of Disproportionality and Disparities, 2012). The report outlined components of a "Texas model" for addressing the disproportionality and disparities. The model had been used during the CPS disproportionality remediation and guided CEDD's work. In addition to a focus on data-driven strategies, community engagement, and cross-systems collaboration, two elements featured prominently in the model: 1) "anti-racist" training and principles and 2) "an understanding of the history of institutional racism and the impact on poor communities and communities of color" to "develop common analysis of racism and history that led to current outcomes."

The report, in relevant part, recommended to the legislature that: 1) CEDD assist HHSC in developing cross-systems performance measures based on the Texas model; 2) the state implement the Texas model in all of the systems examined in the report; 3) the IC continue till December 2015 and submit a status report on the implementation of the Texas model to the legislature in December 2014; and 4) CEDD monitor and report to HHSC executive commissioner on implementation plans to address disparities in health and human services agencies.

Center for Elimination of Disproportionality and Disparities: 2013 to Present

During the 2013 regular legislative session, Representative Dawnna Dukes authored HB 2038 (2013) to implement the IC's recommendations. The bill passed in the House with bipartisan support, but only after it was amended to give the HHSC executive commissioner more control over CEDD's contract-based partnerships and the substance of the Texas model. The legislation died in the Senate, leaving the

IC to officially expire in December 2013. HHSC Rider 87 of the state budget, however, contained some key provisions from HB 2038, including a requirement that CEDD advise various state systems on cultural competency training and partner with community to help deliver culturally competent services to children and families (SB 1, 2013). The rider also called for CEDD and the IC to develop and recommend to the HHSC executive commissioner policies for addressing disproportionality and disparities across several state systems, and to report back to the legislature on implementation of those policies (assuming the executive commissioner's approval).

Since the 2013 regular legislative session, at least five key things have occurred in the story of CEDD. First, leadership at CEDD changed hands, with Sheila Sturgis Craig taking over from James. Second, the IC officially dissolved in December 2013. Third, on January 6, 2015, HHSC and CEDD released to the Institute for Urban Policy Research & Analysis a report in response to Rider 87 (R. Patterson, personal communication, January 6, 2015). The Rider 87 report was 17 pages and contained no information regarding whether any of the state systems examined by the December 2012 report had made any progress in eliminating disproportionality or disparities; instead, the report highlighted that "only the Department of Family and Protective [*sic*] has a formal legislative mandate to address disproportionality and disparities within their agency." Fourth, CEDD has altered the Texas model, which was approved by the IC and reported to the legislature in 2012. While the Rider 87 report indicates that CEDD continues to refine the Texas model, which includes "[p]romoting anti-racist or race equity principles … ," CEDD's website explanation of the Texas model, as of the publication of this brief, includes no mention of anti-racist work. Furthermore, neither the Rider 87 report nor the website uses the term "institutional racism." Fifth, HHSC Rider 64 of the new state budget expected to be signed into law retreats from the legislative effort of the two previous regular sessions to carry out CEDD's mission across systems (HB 1, 2015). Instead, Rider 64 limits CEDD's advice on cultural competency training and development of and recommendation on policies to health and human services agencies, excluding key systems that 2013's Rider 87 included. Also, Rider 64 makes the first legislative mention of the "CEDD and the HHS Statewide Coalition on Addressing Disproportionality and Disparities." CEDD officials have said this coalition is intended to replace the IC. However, the names of the two groups tell the fundamental difference—the IC or *Interagency* Council was a cross-systems entity, while the "CEDD and the HHS Statewide Coalition" is limited to health and human services. As legislation on CEDD moves away from a cross-systems effort, the Center seems to be moving away from explicitly addressing "institutional racism."

As legislation on CEDD moves away from a cross-systems effort, the Center seems to be moving away from explicitly addressing "institutional racism."

INSTITUTIONAL RACISM

Institutional racism has been defined as those established laws, customs, and practices that systematically reflect and produce racial inequities in American society (Jones, 1972; see also Knowles & Prewitt, 1970). While the practice of institutional racism has a long-standing history in the United States, the term was coined in 1967 by Kwame Ture and Charles Hamilton in the book Black Power: The Politics of Liberation (Ture & Hamilton, 1967). Institutional racism is different from individual racism, or the prejudice acts and attitudes of individuals against a member or members of an oppressed minority (Sears, Henry, & Kosterman, 2000). Institutional racism is "less overt, more subtle, less identifiable in terms of individuals committing the acts. But it is no less destructive to human life" (Ture & Hamilton, 1967).

It is important to understand that institutional racism does not necessarily result from intent. It can occur even when the institution or its agents—individuals—do not intend to make distinctions on the basis of race. Often, institutional racism occurs without any awareness that it is happening (Schafer, 2000). Cultural bias in standardized testing is an example of unintentional institutional racism. The results of such biases contribute to the "Black White test score gap" and have a wide-ranging effect on the educational opportunities of African American children. (Hilliard, 1979; Jencks & Philips, 1998).

Institutional racism looks beyond the maliciously motivated model of individual racism. In doing so, it stresses how past policies result in current inequalities and focuses on outcomes, as opposed to actions (Lopez, 2014). For example, the infant mortality rate for African American mothers is more than twice that of their White counterparts (Centers for Disease Control and Prevention, 2014). Maternal health, nutrition, and access to prenatal care contribute to pregnancy and childbirth outcomes (Centers for Disease Control and Prevention, 2014). African American women are more likely to live in a food desert and receive lower quality medical care than their White counterparts (Trehaft & Karpyn, 2010; IOM Unequal Treatment, 2002). Another example is the wealth gap. In 2013, the median wealth of Black households was $11,000, compared to $141,000 of White households (and $13,000 for Hispanic households) (Kochhar & Fry, 2014). Researchers have identified possible factors including, intergenerational inheritance, differing unemployment rates, differing rates of and policies on homeownership (including redlining, race covenants, and housing segregation), and college education (Desilver, 2013).

The policies and practices of institutions operate in a way that produces systemic and ongoing advantages and disadvantages based on race (Zatz & Mann, 1998). As a result, it creates and maintains racial and socioeconomic inequalities in communities across the United States (Fong, Dettlaff, James, & Rodriguez [Eds.], 2015, pp. 21-22). Institutional racism is reflective of the dominant group's cultural assumptions and leads to the systematic disadvantage of minorities (Anderson & Taylor, 2006; Knowles & Prewitt, 1970). As a result, minorities face overrepresentation in adverse outcomes (disproportionality) and unequal treatment or services as compared to the dominant group (disparity). Disproportionality and disparities exist across systems, in every societal sector that individuals have contact with, including health, education, criminal justice, and employment (Fong et. al. [Eds.], 2015).

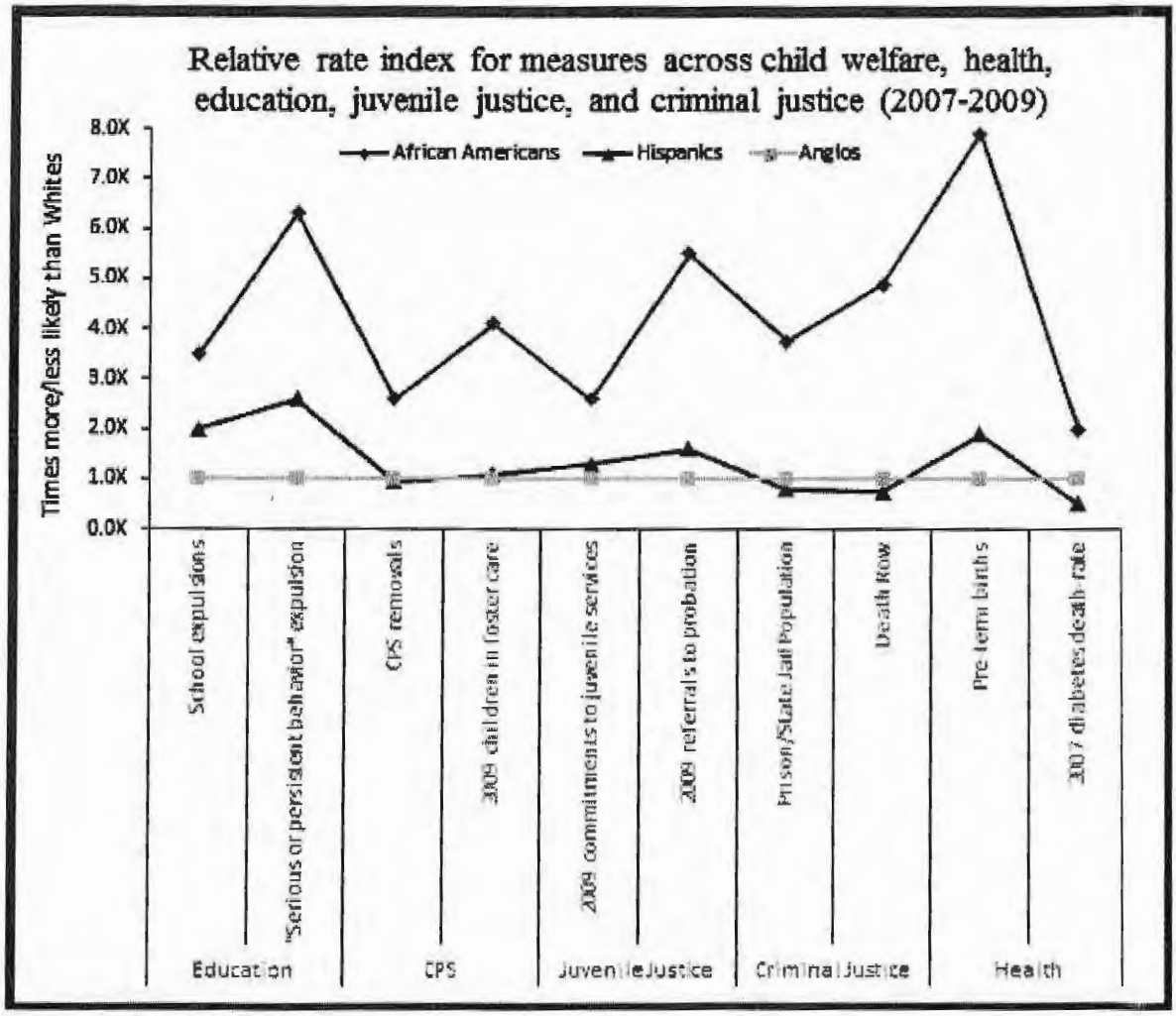
Key Terminology		
Term	**Definition**	**Most commonly used in:**
Disproportionality	The overrepresentation or underrepresentation of a particular race or cultural group in a program or system	Child welfare
Health Disparity	Preventable differences in the burden of disease or disability or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.	Health
Disproportionate minority contact (DMC)	The disproportionate number of minority youth that come into contact with the juvenile justice system	Juvenile justice
Achievement gap	The observed disparity on a number of educational measures between the performance of groups of students	Education
Equality	The concept that everyone should be treated in exactly the same way	Systems
Equity	The concept that everyone should be treated in a way that meets their specific needs so they have a fair opportunity to attain their potential	Systems

Source: Myers, S. L. (2010). Definitional Clarity. Presented at the Alliance for Racial Equity in Child Welfare Research Symposium on Racial Disparities in Child Welfare: What Does the Research Tell Us about Racial and Ethnic Disproportionality and Disparities in the Child Welfare System? Baltimore: MD. July 27-28, 2010.

Well-established empirical research has confirmed the pervasive existence of institutional racism, as well as the resulting disproportionality and disparities. African American and, to a lesser extent, Hispanic children are more likely to be taken out of the home and placed into foster care than Whites, even when families have the same characteristics and problems. (Department of Health and Human Service [DHHS], 1997; Fluke, Harden, Jenkins, & Ruehrdanz, 2010). For example, a child welfare study found that hospitalized Black and Hispanic children were five times more likely to be evaluated for child abuse and three times more likely to be reported than White children hospitalized for similar injuries (Lane, Rubin, Monteith, & Christian, 2002). Racial and ethnic minorities tend to receive lower quality health care and are less likely to receive needed care than Whites, even when controlling for access-related factors (IOM Unequal Treatment, 2002). Nationally, Black students are suspended and expelled three times more than White students and represent 31% of school-related arrests (Dept. of Education, 2013). Black men are given, on average, nearly 20% longer sentences than those served by White men for similar crimes (U.S. Sentencing Commission, 2013). The Texas populace is no exception to the widespread documented disproportionality and disparities.

Disproportionality and Disparities in Texas

Patterns of inequity are prevalent in the Texas health, child welfare, education, juvenile justice, and criminal justice systems. That is to say, disproportionality and disparities exist across systems. These systems are intertwined and often compound negative outcomes for people of color.



Source: (James & Love, 2013)

In 2007, the HIV infection rates for Texas adolescents were 0.8% for Whites, 1.4% for Hispanics, and 7.1% for African Americans. In 2009, the infant mortality rate of African Americans in Texas was twice that of Whites and Hispanics in the state. African American Texans, on average, live four years less than the state's average life expectancy (Lakey, 2013). African American and Hispanic Texans are five times more likely to die from diabetes. African Americans Texans are also more likely to die from heart disease, cancer, and stroke (James & Love, 2013).

African American children in Texas are twice as likely to be removed from their families and four times as likely to be placed in foster care when compared to their White and Hispanic counterparts

(James & Love, 2013). Hispanic children are twice as likely as their White counterparts to be expelled from school, while African American children are three times as likely as White children to be expelled (Governments Justice Center [CSGJC], 2011). Controlling for other variables, African American students have been found to be 31% more likely to receive discretionary disciplinary action when compared to otherwise identical White and Hispanic students (CSGJC, 2011). These systems are interconnected and have many points of overlap (Nicholson-Crotty, Birchmeier, & Valentine, 2009). Students suspended for a discretionary violation are nearly three times more likely to be in contact with the juvenile justice system (CSGJC, 2011). African American children are twice as likely to be committed to a juvenile detention center in Texas (James & Love, 2013). This pattern of disproportionate detention is carried throughout the larger criminal justice system in Texas. While African Americans make up only 12% of the Texas population, they account for roughly 36% of the prison population in Texas (Texas Department of Criminal Justice, 2012).

All of these statistics illustrate racial disproportionality and disparities that exist because of institutional racism in Texas. Arguably, the most clear and comprehensive research implicating institutional racism in this state came in 2011's "Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Student's Success and Juvenile Justice Involvement." The Council of State Governments Justice Center and the Public Policy Research Institute at Texas A&M University produced the study. Remarkably, the study followed all students in Texas public schools who began seventh grade in academic years 2000, 2001, or 2002 (CSGJC, 2011). Of the nearly one million students whose records were reviewed, 14% were African American, 40% were Hispanic, and 43% were non-Hispanic White.

Generally, the study found mandatory discipline for serious violations was relatively rare and nearly equal across racial groups during the secondary school years overall. However, when controlling for 83 factors—including sex, low-income status, special education status, at-risk status, attendance rate, limited English proficiency, immigrant or migrant status, campus teacher racial demographics, and a variety of academic performance factors—race was still a predictive factor for whether a student would be disciplined, especially for discretionary disciplinary actions. African Americans suffered the most from disproportionate discretionary disciplinary actions of school officials. In fact, in ninth grade, African American students were 23% *less likely* than White students to commit serious offenses that required *mandatory* discipline, yet school officials were 31% *more likely* to subject African American ninth-graders to *discretionary* discipline when compared with their White counterparts. The authors found this astounding disproportionality even after factoring in all other measurable student and campus attributes; race still dictated.

DISCUSSION

Nearly 22 years after Texas began formally striving for racial equity in its health and human services system, the Rider 87 and December 2012 IC reports make absolutely clear that there is still much work to do. Disproportionality and disparities in Texas, as throughout the country, are pervasive. They profoundly affect not just the children and families served by Texas's health or child welfare services and systems, but also the state's education, mental health, and juvenile justice systems. Black or African American children and families face particularly dire disproportionality and disparities, though many other Texas residents of color also suffer from disproportionate outcomes or disparate service or treatment.

Research shows that institutional racism—regardless of the intention of those working in the relevant institutions—has caused and continues to cause disproportionality and disparities in this country and this state. Understanding this fact requires that, amongst other things, one appreciates the differences between institutional and individual racism. A recent book on addressing disproportionality and disparities in human services quotes a White scholar in this regard: "I was taught to recognize racism only in individual acts of meanness by members of my group, never in individual systems conferring unsought racial dominance on my group from birth" (Fong et al. [Eds.], 2014, p. 251).

The main reason CEDD—and institutions like it—must train, present, and discuss institutional racism is not to place blame on any individuals within the relevant institutions; rather, it is because the opportunity to eliminate something within an institution is obviously greater when all stakeholders have a robust and common understanding of exactly what they seek to eliminate. That fact is why the Texas model formerly referred to "an understanding of the history of institutional racism." The former model was used for years, with some success during the CPS disproportionality remediation (Interagency Council for Addressing Disproportionality, Texas Health and Human Services Commission, Center for Elimination of Disproportionality and Disparities, 2012).

It is important to recognize that disproportionality and disparities likely can exist without institutional racism being the cause. Most researchers believe that the causes of disproportionality and disparities are complex and multiple. Thus, the best way to approach an effort to eliminate disproportionality and disparities is to appropriately address all causes to the fullest extent possible (Fong et al. [Eds.], 2014). This brief focuses on institutional racism because it is *one* widely misunderstood and profoundly pervasive factor that causes immense disproportionality and disparities.

CONCLUSION & RECOMMENDATIONS

Texas has been fighting to eliminate disproportionality and disparities affecting children and families for nearly a quarter-century, but they stubbornly persist across state systems. The state must make a concerted, robust, cross-systems effort to eliminate or, at least, minimize institutional racism, because research shows that it is a widespread cause of disproportionality and disparities. The Center for Elimination of Disproportionality and Disparities—an institution Texas should be applauded for creating—is the state institution best positioned to do that as part of its effort to rid this diverse state of inequity. Therefore, Texas should do three things to support and grow CEDD in the most efficient and effective way:

Recommendation #1: Transfer the Center for the Elimination of Disproportionality and Disparities from the Health and Human Services Commission to the Office of the Governor, while requiring relevant agencies within state systems—including health, mental health, juvenile justice, education, and child welfare—to regularly provide data to and otherwise cooperate with CEDD in identifying, tracking, and eliminating disproportionality and disparities.

Rationale: Instead of having each system address disproportionality and disparities issues in its own way, without a legislative mandate, CEDD can more comprehensively, efficiently, and consistently work with these interconnected systems to carry out its mission wherever it is necessary. This cross-systems approach was the reason SB 501 (2011) established the Interagency Council for Addressing

Disproportionality, in addition to codifying CEDD. It makes sense that an effort involving so many different state agencies comes from the Office of the Governor.

Recommendation #2: Pass legislation similar to HB 2038 (2013) reestablishing a statutory, cross-systems body similar to the IC and requiring each relevant agency to address disproportionality and disparities together with CEDD. The legislation should establish new duties for CEDD regarding a) officially adopting a Texas model to achieve equity and address disproportionality and disparities and all of their causes, b) implementing the Texas model in HHSC and other relevant state systems, and c) advising relevant state agencies regarding cultural competency training for staff and partnering with community to deliver culturally competent services.

Rationale: The December 2012 legislative report produced by CEDD and the IC indicated that significant disproportionality and disparities exist in every examined state system (Interagency Council for Addressing Disproportionality, Texas Health and Human Services Commission, Center for Elimination of Disproportionality and Disparities, 2012). The CEDD and IC report produced in response to HHSC Rider 87 of SB 1 (2013) gave no indication whatsoever as to whether any improvement had been made in any of the state systems examined by the December 2012 report (R. Patterson, personal communication, January 6, 2015). In fact, the report required by Rider 87 points out that "only the Department of Family and Protective [*sic*] has a formal legislative mandate to address disproportionality and disparities within their agency." Presumably, the "mandate" the report refers to is Section 265.004 or Section 264.2041, Texas Family Code. Recommendation #2, together with Recommendation #1, would ensure that all relevant agencies address disproportionality and disparities with the guidance of CEDD.

Recommendation #3: Pass legislation to require CEDD and the Legislative Budget Board to collaboratively produce an economic analysis on the cost of disproportionality and disparities to the State of Texas.

Rationale: The issue of disproportionality and disparities is a moral issue concerning equity for the future and foundation of the state—children and families; however, it is also an economic issue. For example, research indicates that dropping out of the education system is linked to a greater likelihood of involvement in the juvenile justice system, and, in turn, is linked to greater likelihood of involvement in the criminal justice system, which, of course, costs Texas taxpayers dramatically (Texas Appleseed, 2007). Similarly, the impact of health disparities comes at a substantial cost to the State of Texas. The years of potential life lost, time or days away from work, and additional costs to the health care system all contribute to an excess cost or loss of economic value for Texans. A number of states have developed a method of measurement for health disparities using one or more of these metrics (HCUP, 2011). In Texas, these costs will likely increase given the state's growing population of color. It would be hugely beneficial to understand just how economically impactful disproportionality and disparities are to Texas.

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The Institute for Urban Policy Research & Analysis
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Vision

To become the major policy research organization that identifies, proposes, and measures solutions to social justice problems that disproportionately affect populations of color and their communities.

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Report to the 83rd Legislature

The Interagency Council for Addressing Disproportionality

Texas Health and Human Services Commission, Center for Elimination of Disproportionality and Disparities

December 1, 2012

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Acknowledgements

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Executive Summary

Senate Bill (S.B.) 501, 82nd Legislature, Regular Session, 2011 was enacted in May 2011 to address the disproportionality of certain groups in the juvenile justice, child welfare, health, and mental health systems and the disproportionate delivery of certain services in the education system. *Disproportionality* refers to a comparison between the percent of persons of a certain race or ethnicity in a target population to the percentage of the same group in a reference (or base) population.

S.B. 501 directed the Texas Health and Human Services Commission (HHSC) to establish the Interagency Council for Addressing Disproportionality (Interagency Council) to review the delivery of services to children who are members of a racial or ethnic minority group in the child welfare, education, health, juvenile justice, and mental health systems for disproportionality; examine best practices, training, and the availability of funding related to addressing disproportionality; and to make recommendations on methods to improve the use of available public and private funds to address disproportionality and the long-term elimination of disproportionality.

Additionally, the legislation required the Interagency Council is to report on the implementation plan to address health and health access disparities. *Disparity* is the comparison of the ratio of one race or ethnic group in an event to the representation of another race or ethnic group who experience the same event. A disparity exists when the ratios are not equal. The report is due December 1, 2012.

Statewide Data Collection

Data collection for this legislative report took place from December 2011 through August 2012 and involved Fiscal Year 2010 quantitative data on racial or ethnic groups and qualitative information on disproportionality funding and cultural competency training. The Interagency Council representative on juvenile justice from the Governor's Office provided statewide data from the Texas Juvenile Justice Department (TJJD. The Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), the Texas Education Agency (TEA), and the Department of Assistive and Rehabilitative Services (DARS) also provided available statewide data for children who are members of a racial or ethnic minority group at points of entry, decision points, and outcomes. Ages differ for these children and youth across agencies. Thus comparisons within agencies, rather than across agencies, are used in this report.

A relative rate comparing racial and ethnic groups to one another was constructed from almost all the data collected (see footnote 4). The resulting statewide data used in this report is used to determine whether or not disproportionality and disparities exist within Texas systems, not how or why they exist. Additionally, the statewide relative rate data are not compared to national prevalence or incidence rates as this was beyond the scope of the report.

Statewide Data Findings

Juvenile Justice

- Disproportionality and disparities exist for Texas children and youth in juvenile justice, child welfare, mental health and education systems at points of entry, decision points, and outcomes.
- When systems have an entry and exit point; and those entries are disparate and/or the exits from those systems are disparate, the result is more children and youth of racial and ethnic minorities in the system.
- At the juvenile justice point of entry, referrals are more disproportionate for African American youth and somewhat less so for Hispanic youth. Following that, the groups are equal until the next major decision point: the courts. At this decision point, the likelihood of being confined as a juvenile or being tried as an adult is higher for African American youth than Hispanic or Anglo youth, though Hispanic youth are confined at a higher rate than Anglos.

Child Welfare

- Child abuse and neglect reports of African American and Native American youth are higher than Anglo or Hispanic youth. Once reported, however, there is no disparity with respect to CPS initial investigation actions. African American and Native American children are more likely to be placed into foster care and custody, and following that decision, African American children are less likely to be reunified with their families. These two decision points, placement and reunification, are related to a disproportionate number of African American children in foster care.

Mental Health

- The rate of referrals for children and youth of different races and ethnicities to DSHS inpatient mental health services varies as do diagnostic categories. Once hospitalized, the use of restraints is higher for African Americans than Hispanics or Anglos. Outcomes are similar for all groups with "no change" reported for around 90 percent of inpatients.
- African American children and youth are more likely to be newly admitted to DSHS mental health outpatient services and served, while a lower rate of Hispanics are served, relative to Anglos. Outpatient diagnoses vary by race and ethnicity. Hispanic children and youth are more likely, and African Americans less likely, to have completed outpatient services than Anglo children and youth. Levels of functioning and problem severity scores at discharge are similar for all groups (over one-third show improvement), and re-arrest rates are low for all groups. Improvement in school is lowest for African American children and youth (60 percent), relative to other groups (approximately 70 percent).

Education

- African American and Hispanic children and youth are less likely than Anglo children and youth to be in educational programs for the gifted. They are more likely to be considered at

risk and economically disadvantaged. They are also more likely to drop out of school than Anglo youth. In addition, the "Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Students' Success and Juvenile Justice Involvement" report indicates that, "African American students and those with particular educational disabilities were disproportionately likely to be removed from the classroom for disciplinary reasons."

Interagency Council Recommendations

- Recommend that the Center for Elimination of Disproportionality and Disparities assume a leadership role in identifying and reporting on the social determinants and health conditions in most need of high impact response to address disproportionality and disparities across health and human services agencies.
- Recommend that the Center for Elimination of Disproportionality and Disparities assist the Health and Human Services Commission in developing cross systems performance measures aligned with the components of the Texas model for addressing disproportionality and disparities.
- Recommend that the Interagency Council continue through December 1, 2015.
- Recommend that the Interagency Council prepare and submit by December 1, 2014 to the lieutenant governor, the speaker of the house of representatives, and the legislature a report on the status of implementation of the Texas model for addressing disproportionality and disparities and the Interagency Council's recommendation as to whether to continue the Interagency Council.
- Recommend that the Center for Elimination of Disproportionality and Disparities monitor and report to the Executive Commissioner of HHSC on implementation plans to address health disparities across HHS agencies.
- Recommend implementation of the Texas model for addressing disproportionality and disparities in the juvenile justice, child welfare, health, education, and mental health systems.

Implementation Plan to Address Disproportionality and Health and Health Access Disparities

The Interagency Council adopted the Texas model for addressing disproportionality and disparities as the implementation plan to address disproportionality and health and health access disparities across HHS agencies.

Model Components

- *Data driven strategies*: All data collection, research, evaluation, and reporting includes a breakdown by race and ethnicity. Data is compared to the racial and ethnic populations of a defined area. Data is examined from a systemic and cross systems perspective and shared transparently with systems and the communities affected by the data outcomes.
- *Leadership development*: Develop both systems and community leaders grounded in training defined by anti-racist principles and are willing to support internally and externally individuals within the same leadership framework.

- *Culturally competent workforce*: Develop workforce that reviews and examines its work through an anti-racist and humanistic lens.
- *Community engagement*: Recognize strengths of grass roots community, hear its ideas, and include community throughout process.
- *Cross systems collaborations*: Share data, training, and dialogue with systems, institutions, and agencies that serve the same vulnerable populations.
- *Training defined by anti-racist principles*: Train staff and partners in principles that ensure work at culturally, linguistically, and institutionally appropriate levels.
- *An understanding of the history of institutional racism and the impact on poor communities and communities of color*: Develop common analysis of racism and history that led to current outcomes.

The Four Stages of the Community Engagement Model

Stage 1: Community awareness and engagement:

This stage involves three discrete, but interdependent processes. The first of these includes making the problem visible by sharing the data with communities and internal organizational systems that serve families and youth. The facts about disproportionality are described.

The second process involves anecdotal stories told through the voices of constituents – alumni of foster care, birth parents, kinship caregivers, and foster and adoptive parents – who know firsthand what disproportionality is from their own experiences.

The third process involves engaging community leaders who are willing to be accountable with systems to effect sustainable change through anti-racist strategies. This process involves organizing efforts to develop informed advocates and allies who will become partners with systems to identify community strengths and needs.

Stage 2: Community Leadership:

This stage involves key processes that build leadership in communities for systems improvement and result in community leaders who are empowered to hold systems accountable for sustainable change.

A second related process relies on a shared leadership in which community leaders and members make use of their knowledge of community strengths and resilience to address the problem.[i] As implemented in the Texas child welfare system, community advisory committees provide leadership in partnership with systems and organizations. Leadership development has been achieved through cultural competency training focused on history, race, and culture and through understanding the impact of systems on poor communities.

Stage 3: Community Organization:

This stage involves a process that elevates the importance of collaborative efforts where community and systems leaders guide the work. The role of community members in this process

must be legitimized and the value of their contributions applied in the selection and analysis of strategies for sustainable change.

This process is guided by anti-racist principles (The People's Institute for Survival and Beyond, 2011) that are defined by learning from and understanding the history of racism; understanding its manifestations in our systems; understanding, sharing, and celebrating our cultures; networking; maintaining accountability; developing new leadership; reshaping gate keeping; and making a commitment to undoing racism and internalized racial oppression. The overall process provides a foundation that positions community leaders to gain a sense of their own power. It results in holding systems to a higher level of accountability while remaining accountable to their community constituents.

Stage 4: Community Accountability:

This stage involves mutual and reciprocal accountability, and a full investment by community and systems leaders in identifying, developing, and achieving desired and measurable outcomes.

The processes that define this stage are ensuring transparency in community and systems partnership; the belief that communities are the owners of their solution; and realizing these solutions require building genuine relationships between communities and systems that lead to achieving safety, permanency, and well-being for children and families. The constant referencing back to the data and feedback from constituents provide a context to evaluate desired outcomes.

The success of this stage is the realization that communities are their own best resource, they hold systems accountable; and they advocate with systems leaders for equitable access to resources, supports, and programs that bring about transformational change.

The four stages in practice outline the importance and role of community in the development of strategies to bring about true systemic change. The stages convey the belief that improved outcomes are possible and disproportionality can be eliminated.

The stages support the importance of conveying a transparent message that is key to developing trust between communities and systems. This message is delivered and reinforced by state and regional level management to communities, constituents, and front line staff by sharing data online and in unit and regional meetings. It is also presented to community groups and at community and town hall meetings.

Finally, evaluation reports are provided and presentations via power point are made at local, statewide, and national conferences.

Interagency Council Findings and Recommendations

Background

The HHSC established the Interagency Council pursuant to S.B. 501. The purpose of the Interagency Council is to "examine issues and make recommendations relating to the disproportionality of children who are members of a racial or ethnic minority group in the juvenile justice, child welfare, health, and mental health systems and the disproportionality of the delivery of certain services in the education system."

Consistent with the requirements of S.B. 501, Interagency Council membership is composed of appointed representatives from:

- the Texas Education Agency (TEA);
- the Center for Elimination of Disproportionality and Disparities (Center) within the HHSC (see Appendix A for the mission and vision of the Center);
- the DARS;
- the DSHS;
- the DFPS;
- the DADS;
- the TJJD (formerly the Texas Youth Commission and the Texas Juvenile Probation Commission);
- the HHSC;
- the Office of Court Administration (OCA) of the Texas Judicial System;
- the Office of the Attorney General (OAG);
- the Supreme Court Permanent Judicial Commission for Children, Youth and Families;
- the criminal justice division of the Governor's Office;
- one representative of a community-based organization that works with child welfare, juvenile justice, education, or children's mental health issues;
- one representative of a faith-based community organization; and
- one person who is a former foster care youth; and two representatives of the medical community (see Appendix B for a list of Interagency Council representatives).

The faith-based community organization representative and one representative of the medical community appointed to the Interagency Council were former members of the statewide disproportionality task force that was administratively created by DFPS and the statutorily mandated Health Disparities Task Force (HDTF) repealed under S.B. 501, respectively. These appointments reflect the HHSC commitment to ensuring the historical context of previous efforts to address disproportionality and disparities.

Additionally, the Interagency Council is charged with the preparation and submission of a report by December 1, 2012; to the lieutenant governor, the speaker of the House of Representatives, and the legislature containing the findings and recommendations, including a recommendation as to whether to continue the Interagency Council.

The Interagency Council conducted its first meeting on November 30, 2011. Subsequent quarterly meetings took place on February 28, 2012; May 31, 2012; August 30, 2012; and October 8, 2012 (see Appendix C for Interagency Council meeting minutes).

Methodology

Pursuant to S.B. 501, the Interagency Council's charge is to:

- Review the delivery of public and private child welfare, juvenile justice, and mental health services to evaluate the rates of disproportionality. These are to include: (1) points of entry, (2) treatment decisions, and (3) outcomes.
- Review the public education services to identify disproportionality in the delivery of services
- Review federal, state, and local funds appropriated to address the disproportionate use of children's services
- Examine the qualifications and training of children's services providers
- Review information concerning identified unmet children service needs
- Review information on issues related to health and health disparities

The Interagency Council representative on juvenile justice from the Governor's Office provided statewide data from the Texas Juvenile Justice Department (TJJD). The Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), the Texas Education Agency (TEA), and the Department of Assistive and Rehabilitative Services (DARS) also provided available statewide data for children who are members of a racial or ethnic minority group at points of entry, decision points, and outcomes. To help address the health and health access disparities requirements of S.B. 501; additional contacts within the DSHS were identified along with contacts in the DARS. Once these contacts were made, two types of information from Fiscal Year 2010 were provided by the above agencies.[1]

The quantitative data provided represent population data on racial or ethnic groups to address the requirements of S.B. 501. Data are provided on children of a racial or ethnic minority group in the juvenile justice, child welfare, mental health, and educational systems in a comparative context (see Appendix D for figures).[2] One way of doing this is to use data from these systems in comparison to data from the general or specific population of children of a similar age and racial or ethnic group. This involves comparing data between those at different points as a single rate.[3] This way the likelihood of a particular racial or ethnic group experiencing an event such as a referral can be compared to another group. In the present report relevant "base rate' comparisons will be to Anglos. To both represent comparative difference between groups, and to

[1] This year was chosen because (1) at the time the data were obtained, not all agencies had 2011 data available and (2) consistency of years was considered desirable. Not all of the data from 2010 was available so there are a few variations in the years. Additionally, not all data from private services were available to be analyzed.

[2] When this is not done, percentages or averages for each racial or ethnic group will be provided. In almost all cases, the racial and ethnic categories are African American, Hispanic, Anglo and Other (Asians, Native American and mixed races).

[3] Rates can involve a comparison between those in the population, those within a system, or both.

be able to more directly estimate the magnitude of the differences between rates, a relative rate index is provided[4].

Furthermore, the population data analyzed for this report represent whether or not disproportionality and disparities exist and, if possible, their location in the system. The population data did not indicate how disproportionality and disparities operate or *why* they exist. It is expected that disproportionality and disparities found in the report will be addressed by more in-depth multivariate analyses by agencies to answer questions related to how they operate and why they exist. Additionally, the statewide relative rate data are not compared to national prevalence or incidence rates as this was beyond the scope of the report.

The second was qualitative information on funding and cultural competency training that is also required by S.B. 501 to address disproportionality and disparities. This was addressed by having the agency contacts fill out and return an electronic template concerning these issues. Though some data has been gathered thus far, this task requires further data collection. Additionally, information needed to address unmet needs will also require further data collection and analysis.

The Interagency Council also reviewed information from the former HHSC HDTF related to the elimination of health and health access disparities in Texas among multicultural, disadvantaged, and regional populations.

Initial Findings: Juvenile Justice, Child Welfare, Children's Mental Health and Education

Juvenile Justice

Although their arrest rates are low, African American youth are more than two and one half times (2.78) as likely and Hispanic youth slightly over one and one half times (1.56) as likely to be referred to juvenile justice as Anglo youth[5]. African American youth are less likely to be assigned to detention. All groups are about equally as likely to receive probation. However, African American youth are more likely than Anglo youth to experience confinement (1.29 times) and be transferred to an adult court (1.89 times). Hispanic youth are also more likely to be transferred to an adult court (1.21 times)[6] (see Appendix E for an earlier report on juvenile justice in Texas).

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[4] The actual calculation is the rate of the racial or ethnic group of interest on a given measure divided by their rate in a particular population whose division (quotient) is then divided by the Anglo rate of interest divided by their rate in a particular population (in this case, youth 10 to 16 (inclusive). This formula is typically referred to as a measure of disparity and is one preferred metric for assessing differences between racial and ethnic groups (Myers, 2010).

[5] Referrals can happen separately from arrests (e.g., a referral from a school)

[6] The baserate for arrests is the general population, for events early in the system (e.g. detention) it is a referral. The baserate comparison for probation, confinement and being transferred to an adult court is filing a petition.

Child Welfare

Similar to the juvenile justice system, the child protective system has cases flowing in and out of it and important decisions are made along the way. Some of these decisions affect entry into the system and some affect whether children and youth of different races and ethnicities remain in the system of care. Child abuse and neglect reporting differences by race and ethnicity contribute to African Americans, Hispanics (slightly), Native Americans, and members of other races and ethnicities being more likely to be reported to the DFPS system; relative to Anglos. African Americans and Native Americans are about two times more likely be reported to DFPS as are Anglos.[7] Once they are reported, however, children of all races and ethnicities are assigned to an investigation and identified as an alleged or confirmed victim at rates similar to Anglos.

CPS can remove a child and seek legal custody from an investigation or from family preservation. African American and Native American children are more likely than Anglo children to be removed both from an investigation and from family preservation while Hispanic and other children are less likely than Anglos to be removed. [8]

Somewhat more complicated is the three way choice following investigation to close the case, open the case for services, or place the child into care. Two studies have considered this, and in both cases, the odds of a placement for African American children are greater than providing family preservation services in lieu of a removal, with the risk of future maltreatment statistically controlled (DFPS March 2010 and August 2011). Both the risk of future maltreatment and actual repeated maltreatment by families of African American children is lower than that of Anglo and Hispanic families. The 2010 risk of future maltreatment as rated by the investigator on an average of the sum of seven scales (1 to 5 point scales) is lower for African American families (24.2 points) than all groups but Asian families (a low of 23.6 points).

Once placed into care, there are a number of decisions made. Among these are decisions to attempt reunification with the family, have a relative take legal custody as a permanent managing conservator, or to permanently place the child in an adoptive home with either a relative or non-relative. Failing these outcomes, the child remains in the care of the state (though there are public and private providers) and emancipates or ages out of care. In 2010, as compared to Anglo children, African American children were less likely to reunify while Hispanic children were more likely to reunify and other children were equally likely to reunify. For those children who do not reunify, African American and Hispanic children are slightly less likely to have a relative become a permanent managing conservator but more likely to be adopted (either by a

[7] The base rate (denominator) for reports is the child population, the base rate (dominator) for screening is children in reports, the base rate (denominator) for alleged victims is children investigation and the base rate (denominator) for confirmed victims is alleged victims.

[8] The base rate (dominator) for all children removed is children in investigation and some children removed from FPS may not have a 2010 investigation, the base rate (denominator) for children removed from investigation is alleged victims, and the base rate (denominator) for children removed from Family Preservation is children in an open Family Preservation case in 2010.

relative or non-relative).[9] When combined with the data on the removals of African American children, the reunification data show why more African American children in 2010 (and historically) are in the care of DFPS than Anglo children. As compared to Anglos, other children who do not reunify are more likely to have a relative take permanent managing conservatorship or be adopted and are much less likely to age out (see Appendix F for a link to the DFPS 2010 Report).

Children's Mental Health[10]

Children's Inpatient Mental Health

Referrals to the DSHS state hospitals serving eight regions vary for children of different racial and ethnic groups. Although the highest number of referrals for all groups comes from the courts/law enforcement, clinic referrals have a higher rate for African American children and youth (1.4 times) than Hispanic and Anglo children and youth. Hispanic children and youth, relative to African American children and youth, are more likely to be referred from mental health centers (2.2 times) and Anglo children and youth are more likely than the other groups to be referred by physicians (5 times more than Hispanics and 1.5 times more than African Americans).

The most common admission single diagnosis[11] among all groups is affective disorder, though; this diagnosis has a higher relative rate among Hispanic children and youth. Developmental and behavioral disorders have a higher relative rate for African American youth than Anglo youth, and Hispanic youth are less likely to be diagnosed with this disorder than other groups. Factitious personality and impulse disorders are relatively less likely to be diagnosed for both African American and Hispanic children and youth, relative to Anglo children and youth (see Appendix G for DSHS Diagnositc Groupings). No comparisons are made to statewide or national rates. There are three types of restraints that can be used by state hospital staff: personal, mechanical, and seclusion. The rate at which each type of restraint is used is higher for inpatient African American children and youth than Anglo children and youth. Seclusion has the highest rate, followed by personal and mechanical. Individuals of other races and ethnicities have a high rate of mechanical restraints.

The outcome measure provided by DSHS for inpatients is change on the Global Assessment Functioning Scale. This scale is used on Axis V of the Diagnostic and Statistical Manual (DSMIVR) as a measure of functioning. The vast majority of individuals' outcome scores on this measure (over 85 percent) do not change from initial measurement to discharge.

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[9] The base rate (denominator) for all exits is the children in conservatorship; the base rate for reunification is all exits. The base rate (denominator) for placement with relatives, adoption, aging out and other are exits other than reunification. Individual level data were not available to conduct cohort analyses which are needed to determine those who exit and remain in care over time.

[10] As indicated at the outset of this report, only DSHS inpatient and outpatient data were included.

[11] Dual diagnose are not included. Additionally, the comparative racial and ethnic baserate used for the relative rates indices for the diagnoses are the inpatient or outpatient population admitted (respectively). These groups are unlikely to be representative of the general population. Thus, statewide or national prevalence and/or incidence rates do not apply.

Furthermore, the slight change that does occur from initial measurement to discharge is negative with little difference between children and youth of different racial and ethnic groups.

Children's Outpatient Mental Health

There were 44,916 children and youth served as outpatients. African American children and youth are more likely than Anglos (1.95 times) to be newly admitted to outpatient services while Hispanics (1.25 times) and other (1.14 times) races and ethnicities are very similar to Anglos. When children and youth of these groups actually served in 2010 are compared against the base rate of the groups admitted in a full service package, the pattern changes slightly: a higher rate of African American children and youth are served than Anglo youth (1.42 times) while the comparative rate is slightly lower for Hispanic children and youth (.91 times) and those of other races and ethnicities (.97 times).

Developmental disorders are diagnosed more than half the time (58 percent) for children and youth of all racial and ethnic groups, though the rate of this diagnosis among those admitted is higher for African American children and youth than Anglos (1.78 times), Hispanics and others. Both affective and adjustment disorders have higher rates of diagnosis for African Americans than Anglo children and youth (1.22 and 1.27 times higher). Hispanic children and youth also have slightly higher rates of adjustment disorders (1.17 times). All groups, especially Hispanic children and youth (.46 percent lower), have lower rates of the diagnosis of bipolar disorder than Anglo children and youth. Major depression is less likely for African American children and youth (.74 percent) and slightly higher for Hispanic children and youth (1.12 percent) than Anglo children and youth.

African American children and youth have a higher rate of discharge from services, relative to Anglo children and youth (1.36 times).[12] Hispanic children and youth of other races and ethnicities are discharged at a slightly lower rate than Anglo children and youth. African American children and youth are less likely to have completed services (.92 times), mostly due to changing providers (.86 times). Hispanic children and youth are more likely to have completed services than Anglos (1.25 times) and are also more likely than Anglos to change providers (.78 times). Children of other races and ethnicities have the lowest completion rate (.60 times).[13]

There are four categories of outcomes available for children and youth who are served on an outpatient basis: (1) change in level of functioning on the Global Assessment of Functioning Scale, (2) change in problem severity, (3) re-arrests, and (4) school improvement. Results indicate a fairly similar pattern for all groups on the first two measures. Only 37 percent of children and youth of all races and ethnicities improve at acceptable levels of functioning and problem severity, 45-50 percent experience no change in functioning or severity and 13 to 17 percent worsen. African American and Hispanic children and youth have slightly lower

[12] The base rate (denominator) is 2010 admissions

[13] The base rate is the race and ethnicity distribution of the population of Texas children and youth admitted in 2010. Discharges are those in 2010 and not unique clients.

improvement and acceptable levels of functioning and problem solving than Anglo children and youth. Re-arrest rates are both low and similar for all groups (8.1 percent overall).

Over three fourths of all outpatients improve in school (66 percent) or remain the same (25 percent). However, the percentage of improvement for African American children and youth is lower than other groups (60 percent versus approximately 70 percent).

Children and Youth Self-Reported Mental Health and Substance Abuse Problems, Treatment and Outcomes

African American youth tend to have higher rates of self-reported problems that could be considered mental health problems.[14] They are approximately three times more likely than Anglo or Hispanic youth to report feeling sad or hopeless and to consider attempting or planning suicide. They are over five times more likely to attempt suicide.

Data indicate that 62 percent of all youth improve following treatment. When this is added to the 18 percent whose scores are acceptable, 80 percent of all children and youth appear to have benefited from treatment. The noticeable areas where there are slight differences by race and ethnicity are that African American youth have slightly lower percentages of acceptable change (15 percent), slightly higher percentages of improvement (64 percent), a lower percent of change that is regarded as worse than the other groups (9 percent versus 11 percent) and a higher percentage of no change (12 percent versus 9 to 10 percent).

Initial Findings: The TEA and DARS

Education (1)

Each year data on student characteristics by race and ethnicity are provided to DFPS that compares characteristics of children in DFPS care to the general population of school children of the same age in Texas. TEA supplied that same information to the Interagency Council broken down by race and ethnicity.

African American youth are around two times, and Hispanic youth are slightly over two times, more likely to be considered at risk[15] by school officials than Anglo students and less likely to be identified as gifted. More striking are the economic data for these two groups: Both African American and Hispanic children are more than two and ½ times as likely as Anglo children to be identified as economically disadvantaged. African American youth are slightly more likely to be

[14] The data from the Texas Youth Risk Behavioral Surveillance System survey is administered to students in Texas and converted to relative rates for this report. The data are used in planning by both DSHS and TEA. The base rate is the population of Texas youth in school of the same age as those responding to the survey.

[15] The term 'at-risk' refers to a school-aged individual who is at-risk of academic failure, has a drug or alcohol problem, is pregnant or is a parent, has come into contact with the juvenile justice system in the past, is at least one year behind the expected grade level for the age of the individual, has limited English proficiency, is a gang member, has dropped out of school in the past, or has a high absenteeism rate at school.

in special educational classes[16]. Furthermore, Hispanic youth are far more likely than African American or Anglo children and youth to be of immigrant status and have limited English proficiency. They are also more likely to drop out of school than Anglo youth.

TEA also records dropout and graduation rates both annually and longitudinally.[17] Longitudinal dropout rates for Anglo youth are 3.5 percent, while African American youth are 11.8 percent, and Hispanic youth, 9.5 percent. Relative rates are for the class of 2010 beginning longitudinally in Grade 9. African American youth are approximately three and one half times more likely to drop out of school, and Hispanic youth two and one half times more likely than Anglo youth when compared to the base rate of youth in school.

In addition, the "Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Students' Success and Juvenile Justice Involvement" report indicates that, "African-American students and those with particular educational disabilities were disproportionately likely to be removed from the classroom for discretionary [as opposed to mandatory] disciplinary reasons."

The "Breaking Schools' Rules" data also indicates that:

- Eighty-three (83) percent of African American male students had at least one discretionary violation (83 percent), compared to 74 percent for Hispanic male students, and 59 percent for white male students.
- Seventy (70) percent of African American female students had at least one discretionary violation, compared to 58 percent of Hispanic female students and 37 percent of white female students (see Appendix H for a report on school disciplinary actions).

Education (2)

The DARS provides early intervention services to children from birth to three years old. Data from Early Childhood Intervention indicate that the percentage of African American children receiving services is 11 percent, Hispanic children 52 percent, Anglo children 31 percent and other racial and ethnic groups 3 percent. These numbers are consistent with the statewide child population rates.

Interagency Council Recommendations

- Recommend that the Center for Elimination of Disproportionality and Disparities assume a leadership role in identifying and reporting on the social determinants and health conditions in most need of high impact response to address disproportionality and disparities across health and human services agencies.

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[16] This category covers children identified by school officials as having any one or more of a number of disabilities that include emotional disturbances, intellectual disabilities and learning disabilities. It might be noted that the Texas Department of Rehabilitative Services offers Early Intervention Services to children through age 3, that include fifty two percent Hispanic, thirty five percent Anglo, eleven percent African American, and three percent Asian children.

[17] The annual rates can be located at http://ritter.tea.state.tx.us/acctres/drop_annual/0910/state_demo.html, and the longitudinal rates at http://ritter.tea.state.tx.us/acctres/completion/2010/state_demo.html. Both are for 2010.

- Recommend that the Center for Elimination of Disproportionality and Disparities assist the Health and Human Services Commission in developing cross systems performance measures aligned with the components of the Texas model for addressing disproportionality and disparities.
- Recommend that the Interagency Council continue through December 1, 2015.
- Recommend that the Interagency Council prepare and submit by December 1, 2014 to the lieutenant governor, the speaker of the house of representatives, and the legislature a report on the status of implementation of the Texas model for addressing disproportionality and disparities and the Interagency Council's recommendation as to whether to continue the Interagency Council.
- Recommend that the Center for Elimination of Disproportionality and Disparities monitor and report to the executive commissioner of HHSC on implementation plans to address health disparities across HHSC agencies.
- Recommend implementation of the Texas model for addressing disproportionality and disparities in the juvenile justice, child welfare, health, education, and mental health systems.

With respect to the Interagency Council recommendations on training, the availability of funding to address disproportionality, and identified unmet children's service needs; the Interagency Council gathered preliminary information concerning these issues. However, additional data collection and analysis is necessary prior to the development of recommendations. Information needed to address unmet needs will also require further data collection and analysis.

Implementation Plan to Address Disproportionality and Mental Health and Health Access Disparities

Background

The legislative charge to the Interagency Council includes reporting on an implementation plan to address disproportionality and mental health and health access disparities. The plan adopted for use across the HHS agencies is the Texas model that was developed in response to disproportionality in child welfare.

In 2004, a state-level child welfare workgroup was formed in response to high-profile child death incidents and media attention that emphasized the need for the examination of CPS policies and practices, which resulted in S.B. 6., 79th Legislature, Regular Session, 2005.

The legislative analysis of S.B. 6 said that S.B. 6 strengthened the state's ability to protect society's most vulnerable citizens including abused and neglected children. The bill responded to the Governor's executive orders calling for the systematic reforms of CPS. These orders came in response to numerous cases in which children and elderly persons were left in states of abuse or neglect, despite agency involvement, resulting in severe harm or even death.

Provisions of S.B. 6 included requirements to:

- Develop and deliver cultural competency training to all service delivery staff;
- Increase targeted recruitment efforts for foster and adoptive families who can meet the needs of children and youth who are waiting for permanent homes;
- Target recruitment efforts to ensure diversity among department staff; and
- Develop collaborative partnerships with community groups, agencies, faith-based organizations, and other community organizations to provide culturally competent services to children and families of every race and ethnicity.

S.B. 6 also required the HHSC and DFPS to analyze data regarding child removals and other enforcement actions taken by the department during state fiscal years 2004 and 2005; and based on that analysis, determine whether enforcement actions were disproportionately initiated against any racial or ethnic group, in any area of the state, taking into account other relevant factors, including poverty, single-parent families, young-parent families, and any additional factor determined by other research to be statistically correlated with child abuse or child neglect. Then not later than January 1, 2006, the HHSC was to report the results of the analysis to the lieutenant governor, the speaker of the House of Representatives, the presiding officer of each house and senate standing committee having jurisdiction over child protective services, and the Parental Advisory Committee created under Section 40.073, Human Resources Code.

If the results of the analysis indicated that CPS enforcement actions were initiated disproportionately against any racial or ethnic group, S.B. 6 directed the HHSC to:

- Evaluate the policies and procedures the department uses in deciding to take enforcement actions to determine why racial or ethnic disparities exist; and

- Develop and implement a remediation plan to prevent racial or ethnic disparities not justified by other external factors from affecting the decision to initiate enforcement actions.

S.B. 6 also provided CPS with resources to address disproportionality in Texas. An initial and follow up report (HHSC and DFPS January, 2006; DFPS July 2006) found that high rates of African American child placements into care, in lieu of services to prevent such placements, combined with a lower likelihood of exiting care generally and through reunification, relative care and adoption. This left more of these children to remain in the care of the state until they were of age to leave care.[18]

S.B. 758, 80th Legislature, Regular Session, 2007; expanded the Texas model to address disproportionality and disparities and its seven core principles statewide. In 2010, a report on the effectiveness of the model indicated it was effective in reducing disparate African American entries into care, improving exits from care generally, and specifically to reunification and relative care. The latter was also true of Hispanic children. This reduction in disproportionality was shown statewide and in the four of the five DFPS regions of the state where the Texas model was fully implemented. Additionally, the diversity of the DFPS workforce increased, kinship care placements for children in care increased from 26 percent to 30 percent, and Family Group Conferences were found to improve not only exits from care for African American and Hispanic children but for all children as well. The report and resulting journal articles also documented some of the causes of disproportionality (Baumann, et. al., 2010, Rivaux et. al., 2008; Dettlaff, et, al., 2011).

In May 2011, S.B. 501 established the Center in statute and created the Interagency Council. The Center's mission is to partner with HHSC agencies and external stakeholders; other systems and communities to identify and eliminate disproportionality and disparities impacting children, families, and vulnerable citizens. The Center also serves as a leader in addressing the systemic factors and identifying practice improvements that address the disproportionate representation and disparate outcomes for children, their families, and other vulnerable citizens within Texas Health and Human Services systems.

The duties of the Interagency Council include the responsibilities of the former HDTF that was abolished by S.B. 501 (see Appendix I for the Health Disparities Task Force Strategic Plan). Regional committees administratively created by DFPS that previously focused on expansion of work to address disproportionality and disparities continue to partner with the Center. Disproportionality and Disparities Specialists across the state serve as the liaison between the Center and regional committees to ensure the timely and effective communication which informs the Center's work.

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[18] Hispanic children were also less likely to be permanently placed with relatives or to be adopted, though not less likely to be placed into care or exit from care.

Model Components

- *Data driven strategies*: All data collection, research, evaluation, and reporting includes a breakdown by race and ethnicity. Data is compared to the racial and ethnic populations of a defined area. Data is examined from a systemic and cross-systems perspective and shared transparently with systems and the communities affected by the data outcomes.
- *Leadership development*: Develop both systems and community leaders grounded in training defined by anti-racist principles and are willing to support internally and externally individuals within the same leadership framework.
- *Culturally competent workforce*: Develop workforce that reviews and examines its work through an anti-racist and humanistic lens.
- *Community engagement*: Recognize strengths of grass roots community, hear its ideas, and include it throughout process.
- *Cross systems collaborations*: Share data, training, and dialogue with systems, institutions, and agencies that serve same vulnerable populations.
- *Training defined by anti-racist principles*: Train staff and partners in principles that ensure work at culturally, linguistically, and institutionally appropriate levels.
- *An understanding of the history of institutional racism and the impact on poor communities and communities of color*: Develop common analysis of racism and history that led to current outcomes.

The Four Stages of the Community Engagement Model

Stage 1: Community awareness and engagement:

This stage involves three discrete, but interdependent processes. The first of these includes making the problem visible by sharing the data with communities and internal organizational systems that serve families and youth. The facts about disproportionality are described.

The second process involves anecdotal stories told through the voices of constituents – alumni of foster care, birth parents, kinship caregivers, and foster and adoptive parents – who know firsthand what disproportionality is from their own experiences.

The third process involves engaging community leaders who are willing to be accountable with systems to effect sustainable change through anti-racist strategies. This process involves organizing efforts to develop informed advocates and allies who will become partners with systems to identify community strengths and needs.

Stage 2: Community Leadership:

This stage involves key processes that build leadership in communities for systems improvement and result in community leaders who are empowered to hold systems accountable for sustainable change.

A second related process relies on a shared leadership in which community leaders and members make use of their knowledge of community strengths and resilience to address the problem.[ii] As implemented in the Texas child welfare system, community advisory committees provide leadership in partnership with systems and organizations. Leadership development has been achieved through cultural competency training focused on history, race and culture and through understanding the impact of systems on poor communities.

Stage 3: Community Organization:

This stage involves a process that elevates the importance of collaborative efforts where community and systems leaders guide the work. The role of community members in this process must be legitimized and the value of their contributions applied in the selection and analysis of strategies for sustainable change.

This process is guided by anti-racist principles (The People's Institute for Survival and Beyond, 2011) that are defined by learning from and understanding the history of racism; understanding its manifestations in our systems; understanding, sharing and celebrating our cultures; networking; maintaining accountability; developing new leadership; reshaping gate keeping; and making a commitment to undoing racism and internalized racial oppression. The overall process provides a foundation that positions community leaders to gain a sense of their own power. It results in holding systems to a higher level of accountability while remaining accountable to their community constituents.

Stage 4: Community Accountability:

This stage involves mutual and reciprocal accountability, and a full investment by community and systems leaders in identifying, development and achieving desired and measurable outcomes.

The processes that define this stage are ensuring transparency in the community/systems partnership; the belief that communities are the owners of their solutions; and, realizing these solutions require building genuine relationships between communities and systems that lead to achieving safety, permanency and well-being for children and families. The constant referencing back to the data and feedback from constituent stories provide a context to evaluate desired outcomes.

The success of this stage is the realization that communities are their own best resource, they hold systems accountable and they advocate with systems leaders for equitable access to resources, supports and programs that bring about transformational change.

The Four Stages in Practice:

The stages outline the importance and role of community in the development of strategies to bring about true systemic change. The stages convey the belief that improved outcomes are possible and that disproportionality can be eliminated. The stages support the importance of conveying a transparent message that is key to developing trust between communities and systems. This message is delivered and reinforced by state and regional level management to communities and front line staff by sharing data on-line and in unit and regional meetings. It is

also presented at advisory group and town hall meetings. Finally, evaluation reports are provided and presentations via power point are made at local, statewide, and national conferences.

Conclusion

The findings related to the cross systems data gathered for this report shows that African American children experience the worst outcomes in Texas' child welfare, education, juvenile justice, and mental health systems. Numerous studies and nearly all available statistical evidence documents this fact, but the reasons behind the statistics are much more complex.

The Interagency Council's cross systems data collection did not include information or analysis of the specific reasons for the racial disparities. However, there is consensus among the members that identifying the root causes of racial disproportionality and disparities will require a deeper analysis and understanding of the role of race in the delivery of services since the outcomes in every one of the systems examined reflect poor outcomes for the same population of children.

In at least one of the reports reviewed by the Interagency Council, the "Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Students' Success and Juvenile Justice Involvement" report; it is clear that when other factors are held constant, race is a determinate factor in the disproportionate number of disciplinary referrals received by African American youth.

HHSC and the Interagency Council are committed to examining opportunities to review all policies and procedures that may affect disproportionality and disparities, to develop remediation plans to address the problems identified in this report, and to support systems efforts to implement the Texas model. For example, in its forthcoming report, the HHSC Council on Children and Families has moved to support the implementation of the Texas model in coordination with the Interagency Council.

If the Interagency Council continues beyond 2013, a follow-up legislative report will be provided in December 2014 on the steps the Interagency Council has taken to use the Texas model to reduce disproportionality and disparities in systems whose data is reflected in this report.

With the submission of this report, much of the initial charge is complete. The Interagency Council's work in 2013 will include efforts to gather additional data on the availability of culturally competent training and funding to address disproportionality and disparities and to identify unmet needs of children served by the agencies named in SB 501. The Interagency Council will seek to implement strategies that promote positive systemic change that is sustainable and has the potential to ultimately eliminate racial disproportionality and disparities and to improve outcomes for all children.

THE INSTITUTE FOR URBAN POLICY RESEARCH & ANALYSIS
THE UNIVERSITY OF TEXAS AT AUSTIN

THE CENTER FOR ELIMINATION OF DISPROPORTIONALITY AND DISPARITIES:

Spearheading Texas's Ongoing Fight Against Institutional Racism and Other Causes of Inequity

June 1, 2015

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EXECUTIVE SUMMARY

Institutional racism. It is a word that means many different things to different people. However, there is likely mainstream consensus on at least one thing concerning institutional racism: elimination. That is, right-minded people want to eliminate it wherever it exists, whatever it is.

This brief examines the Center for Elimination of Disproportionality and Disparities (CEDD), the institution that, over time, has become the primary mechanism for the elimination of institutional racism in Texas state agencies that serve families and children. In addition to providing the long history of CEDD and its predecessor institutions, this brief explores the meaning of institutional racism, particularly as it relates to CEDD's work to eliminate "disproportionality and disparities." Crucially, while assuming widespread goodwill amongst state agency employees, the brief uses various research and data to conclude—as the state's health equity efforts have, at least, strongly implied—that institutional racism, properly defined, exists in Texas state agencies. However, the brief also recognizes that institutional racism may not be the only cause of disproportionality or disparities.

Thus, this brief makes recommendations for CEDD to progress and succeed in its mission to eliminate disproportionality and disparities, whether caused by institutional racism or some other factor. Specifically, the recommendations call for Texas to 1) move CEDD from the Health and Human Services Commission (HHSC) to the Office of the Governor, with specific mandates for relevant state agencies to regularly report to CEDD and otherwise cooperate with CEDD; 2) pass legislation similar to House Bill (HB) 2038 (2013) in order to empower and require CEDD to address disproportionality across state systems; and 3) pass legislation to require CEDD and the Legislative Budget Board to conduct a comprehensive economic analysis of the impact disproportionality and disparities have on the state.

HISTORY OF THE CENTER FOR ELIMINATION OF DISPROPORTIONALITY AND DISPARITIES

Administratively established in 2010 and codified in 2011, CEDD aims to partner with health and human services agencies, other state systems, external stakeholders and communities to identify and eliminate disproportionality and disparities affecting children, families, and individuals (Center for Elimination of Disproportionality and Disparities [CEDD], n.d.). The Texas Department of Family and Protective Services (DFPS), within HHSC, defines "disproportionality" as the overrepresentation of a particular group of people in a particular program or system, and "disparity" as the unequal or inequitable treatment of one group as compared to another. CEDD has performed many training sessions and presentations, formed key partnerships, and generally informed Texans and others about combating disproportionality and disparities throughout this state and its governmental agencies. But Texas's official effort to fight against disproportionality and disparities affecting children and families is far older than CEDD; indeed, the effort is more than two decades old.

National Effort Becomes State Effort

In 1985, U.S. Secretary of Health and Human Services Margaret Heckler released a landmark task force report that called for the U.S. government and the public health community to address the significant health disparities the report had found affecting ethnic and racial minorities (Heckler, 1985). The report represented the first time the U.S. Department of Health and Human Services had consolidated racial minority health issues into one report. The U.S. Congress responded the next year by establishing the Office of Minority Health within the U.S. Department of Health and Human Services. During the next 20 years, as various research detailed disparities in health and other social service systems, 40 states followed the nation's lead by establishing state offices intended to work to eliminate health disparities affecting people of color (National Association of State Offices of Minority Health [NASMOH], 2006).

Texas was one of those states, establishing its Office of Minority Health via legislation in 1993 (HB 1510, 1993). Eight years later, Representative Garnet Coleman authored a bill that established a Health Disparities Task Force to help the state "eliminate health and health access disparities in Texas among multicultural, disadvantaged, and regional populations" (HB 757, 2001). The legislation required the task force to investigate and report on disparities issues, develop strategies to eliminate the disparities, and reorganize state health programs as necessary to strive for that elimination. The legislature also required the task force to consult with the renamed Office of Minority Health and Cultural Competency and the women's health office. The task force was required to report to the governor and legislative leaders, first annually and later biennially.

Next, in 2003, Representative Arlene Wohlgemuth authored a bill that consolidated the state's health and human services system under the oversight of HHSC and its executive commissioner (HB 2292, 2003). The bill laid the groundwork for Representatives Dawnna Dukes and Garnet Coleman to further the state's health equity aims with 2007 legislation (HB 1396, 2007). The 2007 legislation officially gave the Office of Minority Health a more apt statutory title: Office for the Elimination of Health Disparities. However, the Office of Minority Health continued administratively and today serves within CEDD as a grant-receiving information resource. The 2007 legislation moved the newly named office from the Department of State Health Services to the parent HHSC agency, so that the office could carry

out its mission across all of the state's health and human services system. The bill also specified that the five-year-old Health Disparities Task Force should focus on race and ethnicity, in addition to other, more generally termed demographics.

State of Texas Timeline: Addressing Racial Disproportionality and Disparities

1990s

- 1993 - Texas establishes state Office of Minority Health (House Bill [HB] 1510, 73rd Regular Legislative Session)

2000s

- 2001 - Texas establishes state Health Disparities Task Force (HB 757, 77th Regular Legislative Session)
- 2003 - Texas consolidates state health and human services system into five agencies, including parent agency, Health and Human Services Commission (HHSC), headed by executive commissioner (HB 2292, 78th Regular Legislative Session)
- 2005 - In the midst of a Child Protective Services (CPS) crisis, Texas requires CPS data analysis on racial disproportionality (Senate Bill [SB] 6, 79th Regular Legislative Session)
- 2005 - Texas requires cultural competency training for CPS's child welfare staff and recruitment of appropriate foster and adoptive families and diverse child welfare staff (SB 6, 79th Regular Legislative Session)
- 2006 - CPS reports that it takes disproportionate action, particularly against Black or African American and Native American children, and that it has started remediation, including "Undoing Racism" training

2010 - Present

- 2010 - CPS reports that, since 2005, it has moderately reduced disproportionate action against children of color and racially diversified its staff
- 2010 - HHSC executive commissioner administratively establishes Center for Elimination of Disproportionality and Disparities (CEDD), citing successes during CPS disproportionality reform
- 2011 - Texas codifies CEDD, establishes Interagency Council for Addressing Disproportionality (IC), and eliminates decade-old Health Disparities Task Force (SB 501, 82nd Reglar Legislative Session)
- 2012 - IC releases legislative report, adopting Texas Model for addressing disproportionality and disparities and making policy recommendations
- 2013 - HB 2038, 83rd Regular Legislative Session, aims to implement IC recommendations and continue IC, but bill fails in Senate
- 2013 - HHSC Rider 87, SB 1, 83rd Regular Legislative Session, calls for CEDD to spearhead steps to address disproportionality and disparities across state systems and report to legislature
- 2013 - IC officially expires
- 2015 - HHSC and CEDD release Rider 87 report that identifies new Texas Model and highlights the lack of formal legislative mandate to address disproportionality and disparities, except in Department of Family and Protective Services
- 2015 - New State Budget expected to be signed into law (HB 1, 84th Regular Legislative Session) retreats from previous legislative sessions' efforts to make CEDD truly cross-systems and largely limits CEDD's role to health and human services

Meanwhile and relatedly, the Texas Legislature in 2005 took another key step to addressing health and human services equity by passing Senator Jane Nelson's Senate Bill (SB) 6 (2005), coauthored by Kyle Janek, the current HHSC executive commissioner who was then a state senator. The bill was a response to then-Governor Rick Perry, who had sought systemic reforms of the state's troubled child and adult protective services with executive orders and a declaration of an emergency legislative item. The governor's actions came after several news reports on injuries to and deaths of children involved in Texas Child Protective Services (CPS), overseen by DFPS (Mann, 2007).

In relevant part, SB 6 required HHSC and DFPS to analyze 2004 and 2005 data on child removals and other child protection enforcement actions to determine whether such actions, when accounting for all relevant factors, were taken disproportionately against any racial or ethnic group. If the agencies found such disproportionate action, the legislation required the agencies to 1) evaluate policies and procedures on child protection enforcement actions, 2) develop and implement a remediation plan to prevent disproportionate action based on race and ethnicity, and 3) report back to the legislature.

Furthermore, the bill added a cultural awareness section to the child welfare chapter of the Texas Family Code, which applies to CPS. The section—unamended since—requires DFPS to 1) develop and deliver cultural competency training for service delivery staff; 2) target recruitment efforts for appropriate foster and adoptive families and diverse staff; and 3) partner with community organizations "to provide culturally competent services to children and families of every race and ethnicity."

After conducting SB 6's mandated analysis, HHSC and DFPS did find disproportionate child protection enforcement actions that affected children of color, particularly Black or African American and Native American children (Texas Health and Human Services Commission & Department of Family Protective Services [HHSC & DFPS], 2006). In the resulting 2006 remediation plan and report to the legislature, HHSC and DFPS listed the first major remedial achievement as staff training, including "Undoing Racism" training for CPS management and later DFPS staff. In 2007, with CPS still mired in controversy because of more child deaths, Senator Nelson's SB 758 furthered the reform process of DFPS, particularly CPS, by calling for an overall improvement plan (Department of Family and Protective Services [DFPS], 2007). The December 2007 improvement plan report to the legislature noted that DFPS was in the process of establishing a statewide network of disproportionality specialists to serve the community and CPS staff. The report mentioned that the legislature funded the specialists network, in addition to "undoing racism" training.

During the five years after SB 6's 2005 passage, several thousand Texas CPS staff, other agencies' staff and community members throughout the state participated in undoing racism and other cultural competency training, as DFPS implemented its remediation and improvement plans. Meanwhile, CPS slightly reduced disproportionate child protective actions while making the CPS staff more racially diverse (DFPS, 2011).

In September 2010, then-HHSC Executive Commissioner Tom Suehs administratively created CEDD, appointing Joyce James to head the institution (HHSC, 2010). James, who had provided testimony regarding CPS disproportionality during hearings on 2005's

SB 6, worked in CPS as an assistant and deputy DFPS commissioner from 2004 till taking over CEDD. Part of the announcement of CEDD quoted Suehs: "At the heart of all our programs and services, we're about people. And we want to make sure that every person is treated with respect and dignity. Joyce has been a pioneer in helping improve equity in our protective services programs, and we want to put that same focus on all our services."

Cross-Systems Elimination of Disproportionality and Disparities

With passage of Senator Royce West's SB 501 (2011), the legislature made CEDD official in law during its 20ll regular legislative session. The bill officially replaced the Office for Elimination of Health Disparities with CEDD, which now encompasses the state Office of Minority Health and Health Equity, the Office of Border Affairs, and the statewide network of regional equity specialists first established in CPS.

The legislation also created an Interagency Council for Addressing Disproportionality (IC) and eliminated the decade-old Health Disparities Task Force statute. In a move to a more cross-systems approach to the problem, the legislation required the IC to include agency and community representatives from various education, health and human services, juvenile justice, and criminal justice backgrounds. The bill named CEDD's representative presiding officer of the IC. SB 501 explained that the IC was to examine, investigate, and then report to the legislature on any disproportionality or disparities affecting racial or ethnic minorities in the state's juvenile justice, child welfare, mental health, education or health system.

Just ahead of the December 2012 deadline, the IC, led by James, released a 222-page report that found that disproportionality and disparities affected racial and ethnic minorities in all of the systems examined (Interagency Council for Addressing Disproportionality, Texas Health and Human Services Commission, Center for Elimination of Disproportionality and Disparities, 2012). The report outlined components of a "Texas model" for addressing the disproportionality and disparities. The model had been used during the CPS disproportionality remediation and guided CEDD's work. In addition to a focus on data-driven strategies, community engagement, and cross-systems collaboration, two elements featured prominently in the model: 1) "anti-racist" training and principles and 2) "an understanding of the history of institutional racism and the impact on poor communities and communities of color" to "develop common analysis of racism and history that led to current outcomes."

The report, in relevant part, recommended to the legislature that: 1) CEDD assist HHSC in developing cross-systems performance measures based on the Texas model; 2) the state implement the Texas model in all of the systems examined in the report; 3) the IC continue till December 2015 and submit a status report on the implementation of the Texas model to the legislature in December 2014; and 4) CEDD monitor and report to HHSC executive commissioner on implementation plans to address disparities in health and human services agencies.

Center for Elimination of Disproportionality and Disparities: 2013 to Present

During the 2013 regular legislative session, Representative Dawnna Dukes authored HB 2038 (2013) to implement the IC's recommendations. The bill passed in the House with bipartisan support, but only after it was amended to give the HHSC executive commissioner more control over CEDD's contract-based partnerships and the substance of the Texas model. The legislation died in the Senate, leaving the

IC to officially expire in December 2013. HHSC Rider 87 of the state budget, however, contained some key provisions from HB 2038, including a requirement that CEDD advise various state systems on cultural competency training and partner with community to help deliver culturally competent services to children and families (SB 1, 2013). The rider also called for CEDD and the IC to develop and recommend to the HHSC executive commissioner policies for addressing disproportionality and disparities across several state systems, and to report back to the legislature on implementation of those policies (assuming the executive commissioner's approval).

Since the 2013 regular legislative session, at least five key things have occurred in the story of CEDD. First, leadership at CEDD changed hands, with Sheila Sturgis Craig taking over from James. Second, the IC officially dissolved in December 2013. Third, on January 6, 2015, HHSC and CEDD released to the Institute for Urban Policy Research & Analysis a report in response to Rider 87 (R. Patterson, personal communication, January 6, 2015). The Rider 87 report was 17 pages and contained no information regarding whether any of the state systems examined by the December 2012 report had made any progress in eliminating disproportionality or disparities; instead, the report highlighted that "only the Department of Family and Protective [*sic*] has a formal legislative mandate to address disproportionality and disparities within their agency." Fourth, CEDD has altered the Texas model, which was approved by the IC and reported to the legislature in 2012. While the Rider 87 report indicates that CEDD continues to refine the Texas model, which includes "[p]romoting anti-racist or race equity principles … ," CEDD's website explanation of the Texas model, as of the publication of this brief, includes no mention of anti-racist work. Furthermore, neither the Rider 87 report nor the website uses the term "institutional racism." Fifth, HHSC Rider 64 of the new state budget expected to be signed into law retreats from the legislative effort of the two previous regular sessions to carry out CEDD's mission across systems (HB 1, 2015). Instead, Rider 64 limits CEDD's advice on cultural competency training and development of and recommendation on policies to health and human services agencies, excluding key systems that 2013's Rider 87 included. Also, Rider 64 makes the first legislative mention of the "CEDD and the HHS Statewide Coalition on Addressing Disproportionality and Disparities." CEDD officials have said this coalition is intended to replace the IC. However, the names of the two groups tell the fundamental difference—the IC or *Interagency* Council was a cross-systems entity, while the "CEDD and the HHS Statewide Coalition" is limited to health and human services. As legislation on CEDD moves away from a cross-systems effort, the Center seems to be moving away from explicitly addressing "institutional racism."

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INSTITUTIONAL RACISM

Institutional racism has been defined as those established laws, customs, and practices that systematically reflect and produce racial inequities in American society (Jones, 1972; see also Knowles & Prewitt, 1970). While the practice of institutional racism has a long-standing history in the United States, the term was coined in 1967 by Kwame Ture and Charles Hamilton in the book Black Power: The Politics of Liberation (Ture & Hamilton, 1967). Institutional racism is different from individual racism, or the prejudice acts and attitudes of individuals against a member or members of an oppressed minority (Sears, Henry, & Kosterman, 2000). Institutional racism is "less overt, more subtle, less identifiable in terms of individuals committing the acts. But it is no less destructive to human life" (Ture & Hamilton, 1967).

It is important to understand that institutional racism does not necessarily result from intent. It can occur even when the institution or its agents—individuals—do not intend to make distinctions on the basis of race. Often, institutional racism occurs without any awareness that it is happening (Schafer, 2000). Cultural bias in standardized testing is an example of unintentional institutional racism. The results of such biases contribute to the "Black White test score gap" and have a wide-ranging effect on the educational opportunities of African American children. (Hilliard, 1979; Jencks & Philips, 1998).

Institutional racism looks beyond the maliciously motivated model of individual racism. In doing so, it stresses how past policies result in current inequalities and focuses on outcomes, as opposed to actions (Lopez, 2014). For example, the infant mortality rate for African American mothers is more than twice that of their White counterparts (Centers for Disease Control and Prevention, 2014). Maternal health, nutrition, and access to prenatal care contribute to pregnancy and childbirth outcomes (Centers for Disease Control and Prevention, 2014). African American women are more likely to live in a food desert and receive lower quality medical care than their White counterparts (Trehaft & Karpyn, 2010; IOM Unequal Treatment, 2002). Another example is the wealth gap. In 2013, the median wealth of Black households was $11,000, compared to $141,000 of White households (and $13,000 for Hispanic households) (Kochhar & Fry, 2014). Researchers have identified possible factors including, intergenerational inheritance, differing unemployment rates, differing rates of and policies on homeownership (including redlining, race covenants, and housing segregation), and college education (Desilver, 2013).

The policies and practices of institutions operate in a way that produces systemic and ongoing advantages and disadvantages based on race (Zatz & Mann, 1998). As a result, it creates and maintains racial and socioeconomic inequalities in communities across the United States (Fong, Dettlaff, James, & Rodriguez [Eds.], 2015, pp. 21-22). Institutional racism is reflective of the dominant group's cultural assumptions and leads to the systematic disadvantage of minorities (Anderson & Taylor, 2006; Knowles & Prewitt, 1970). As a result, minorities face overrepresentation in adverse outcomes (disproportionality) and unequal treatment or services as compared to the dominant group (disparity). Disproportionality and disparities exist across systems, in every societal sector that individuals have contact with, including health, education, criminal justice, and employment (Fong et. al. [Eds.], 2015).

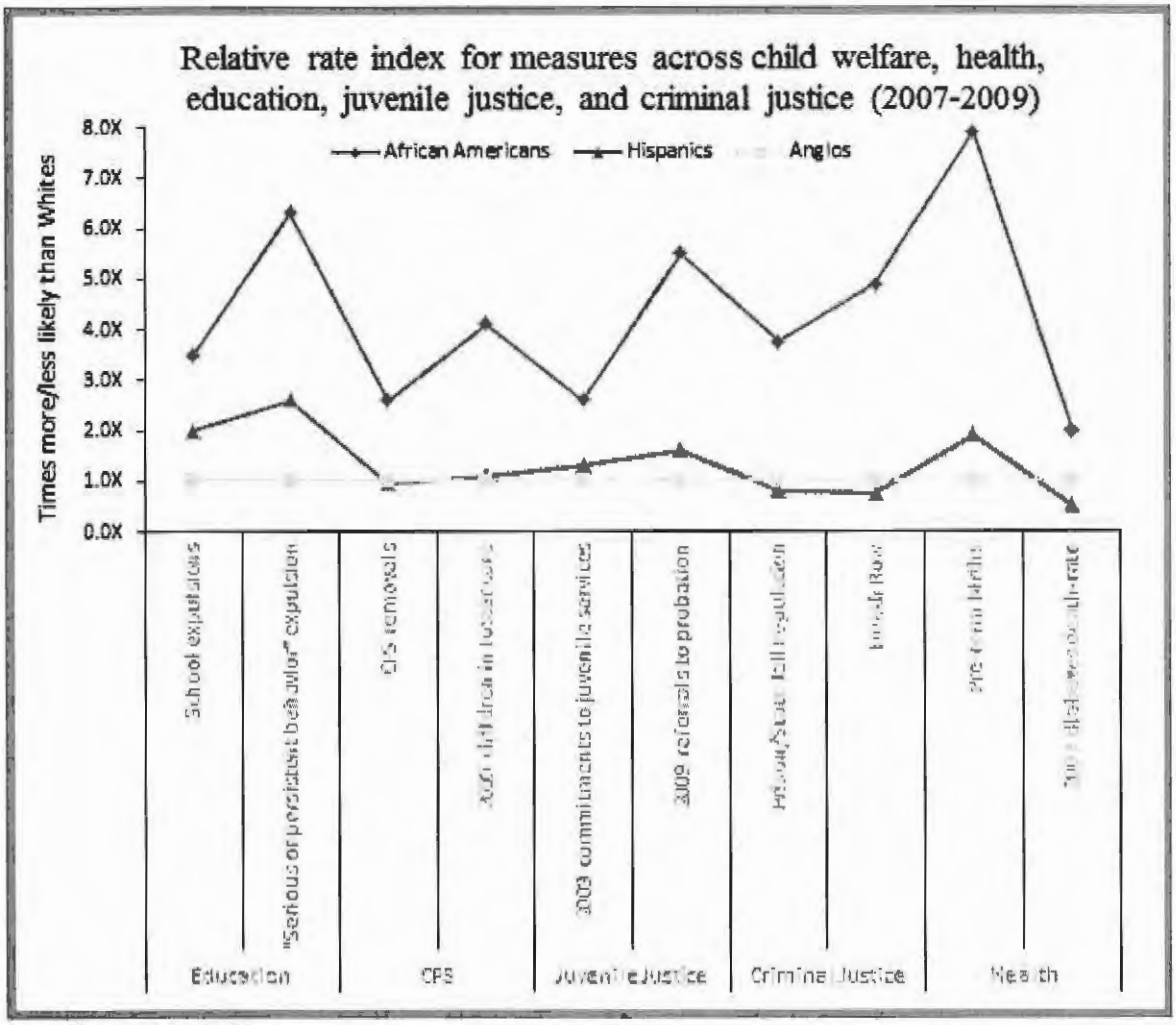
Key Terminology		
Term	**Definition**	**Most commonly used in:**
Disproportionality	The overrepresentation or underrepresentation of a particular race or cultural group in a program or system	Child welfare
Health Disparity	Preventable differences in the burden of disease or disability or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.	Health
Disproportionate minority contact (DMC)	The disproportionate number of minority youth that come into contact with the juvenile justice system	Juvenile justice
Achievement gap	The observed disparity on a number of educational measures between the performance of groups of students	Education
Equality	The concept that everyone should be treated in exactly the same way	Systems
Equity	The concept that everyone should be treated in a way that meets their specific needs so they have a fair opportunity to attain their potential	Systems

Source: Myers, S. L. (2010). Definitional Clarity. Presented at the Alliance for Racial Equity in Child Welfare Research Symposium on Racial Disparities in Child Welfare: What Does the Research Tell Us about Racial and Ethnic Disproportionality and Disparities in the Child Welfare System? Baltimore: MD. July 27-28, 2010.

Well-established empirical research has confirmed the pervasive existence of institutional racism, as well as the resulting disproportionality and disparities. African American and, to a lesser extent, Hispanic children are more likely to be taken out of the home and placed into foster care than Whites, even when families have the same characteristics and problems. (Department of Health and Human Service [DHHS], 1997; Fluke, Harden, Jenkins, & Ruehrdanz, 2010). For example, a child welfare study found that hospitalized Black and Hispanic children were five times more likely to be evaluated for child abuse and three times more likely to be reported than White children hospitalized for similar injuries (Lane, Rubin, Monteith, & Christian, 2002). Racial and ethnic minorities tend to receive lower quality health care and are less likely to receive needed care than Whites, even when controlling for access-related factors (IOM Unequal Treatment, 2002). Nationally, Black students are suspended and expelled three times more than White students and represent 31% of school-related arrests (Dept. of Education, 2013). Black men are given, on average, nearly 20% longer sentences than those served by White men for similar crimes (U.S. Sentencing Commission, 2013). The Texas populace is no exception to the widespread documented disproportionality and disparities.

Disproportionality and Disparities in Texas

Patterns of inequity are prevalent in the Texas health, child welfare, education, juvenile justice, and criminal justice systems. That is to say, disproportionality and disparities exist across systems. These systems are intertwined and often compound negative outcomes for people of color.



Source: (James & Love, 2013)

In 2007, the HIV infection rates for Texas adolescents were 0.8% for Whites, 1.4% for Hispanics, and 7.1% for African Americans. In 2009, the infant mortality rate of African Americans in Texas was twice that of Whites and Hispanics in the state. African American Texans, on average, live four years less than the state's average life expectancy (Lakey, 2013). African American and Hispanic Texans are five times more likely to die from diabetes. African Americans Texans are also more likely to die from heart disease, cancer, and stroke (James & Love, 2013).

African American children in Texas are twice as likely to be removed from their families and four times as likely to be placed in foster care when compared to their White and Hispanic counterparts

(James & Love, 2013). Hispanic children are twice as likely as their White counterparts to be expelled from school, while African American children are three times as likely as White children to be expelled (Governments Justice Center [CSGJC], 2011). Controlling for other variables, African American students have been found to be 31% more likely to receive discretionary disciplinary action when compared to otherwise identical White and Hispanic students (CSGJC, 2011). These systems are interconnected and have many points of overlap (Nicholson-Crotty, Birchmeier, & Valentine, 2009). Students suspended for a discretionary violation are nearly three times more likely to be in contact with the juvenile justice system (CSGJC, 2011). African American children are twice as likely to be committed to a juvenile detention center in Texas (James & Love, 2013). This pattern of disproportionate detention is carried throughout the larger criminal justice system in Texas. While African Americans make up only 12% of the Texas population, they account for roughly 36% of the prison population in Texas (Texas Department of Criminal Justice, 2012).

All of these statistics illustrate racial disproportionality and disparities that exist because of institutional racism in Texas. Arguably, the most clear and comprehensive research implicating institutional racism in this state came in 2011's "Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Student's Success and Juvenile Justice Involvement." The Council of State Governments Justice Center and the Public Policy Research Institute at Texas A&M University produced the study. Remarkably, the study followed all students in Texas public schools who began seventh grade in academic years 2000, 2001, or 2002 (CSGJC, 2011). Of the nearly one million students whose records were reviewed, 14% were African American, 40% were Hispanic, and 43% were non-Hispanic White.

Generally, the study found mandatory discipline for serious violations was relatively rare and nearly equal across racial groups during the secondary school years overall. However, when controlling for 83 factors—including sex, low-income status, special education status, at-risk status, attendance rate, limited English proficiency, immigrant or migrant status, campus teacher racial demographics, and a variety of academic performance factors—race was still a predictive factor for whether a student would be disciplined, especially for discretionary disciplinary actions. African Americans suffered the most from disproportionate discretionary disciplinary actions of school officials. In fact, in ninth grade, African American students were 23% *less likely* than White students to commit serious offenses that required *mandatory* discipline, yet school officials were 31% *more likely* to subject African American ninth-graders to *discretionary* discipline when compared with their White counterparts. The authors found this astounding disproportionality even after factoring in all other measurable student and campus attributes; race still dictated.

DISCUSSION

Nearly 22 years after Texas began formally striving for racial equity in its health and human services system, the Rider 87 and December 2012 IC reports make absolutely clear that there is still much work to do. Disproportionality and disparities in Texas, as throughout the country, are pervasive. They profoundly affect not just the children and families served by Texas's health or child welfare services and systems, but also the state's education, mental health, and juvenile justice systems. Black or African American children and families face particularly dire disproportionality and disparities, though many other Texas residents of color also suffer from disproportionate outcomes or disparate service or treatment.

Research shows that institutional racism—regardless of the intention of those working in the relevant institutions—has caused and continues to cause disproportionality and disparities in this country and this state. Understanding this fact requires that, amongst other things, one appreciates the differences between institutional and individual racism. A recent book on addressing disproportionality and disparities in human services quotes a White scholar in this regard: "I was taught to recognize racism only in individual acts of meanness by members of my group, never in individual systems conferring unsought racial dominance on my group from birth" (Fong et al. [Eds.], 2014, p. 251).

The main reason CEDD—and institutions like it—must train, present, and discuss institutional racism is not to place blame on any individuals within the relevant institutions; rather, it is because the opportunity to eliminate something within an institution is obviously greater when all stakeholders have a robust and common understanding of exactly what they seek to eliminate. That fact is why the Texas model formerly referred to "an understanding of the history of institutional racism." The former model was used for years, with some success during the CPS disproportionality remediation (Interagency Council for Addressing Disproportionality, Texas Health and Human Services Commission, Center for Elimination of Disproportionality and Disparities, 2012).

It is important to recognize that disproportionality and disparities likely can exist without institutional racism being the cause. Most researchers believe that the causes of disproportionality and disparities are complex and multiple. Thus, the best way to approach an effort to eliminate disproportionality and disparities is to appropriately address all causes to the fullest extent possible (Fong et al. [Eds.], 2014). This brief focuses on institutional racism because it is *one* widely misunderstood and profoundly pervasive factor that causes immense disproportionality and disparities.

CONCLUSION & RECOMMENDATIONS

Texas has been fighting to eliminate disproportionality and disparities affecting children and families for nearly a quarter-century, but they stubbornly persist across state systems. The state must make a concerted, robust, cross-systems effort to eliminate or, at least, minimize institutional racism, because research shows that it is a widespread cause of disproportionality and disparities. The Center for Elimination of Disproportionality and Disparities—an institution Texas should be applauded for creating—is the state institution best positioned to do that as part of its effort to rid this diverse state of inequity. Therefore, Texas should do three things to support and grow CEDD in the most efficient and effective way:

Recommendation #1: Transfer the Center for the Elimination of Disproportionality and Disparities from the Health and Human Services Commission to the Office of the Governor, while requiring relevant agencies within state systems—including health, mental health, juvenile justice, education, and child welfare—to regularly provide data to and otherwise cooperate with CEDD in identifying, tracking, and eliminating disproportionality and disparities.

Rationale: Instead of having each system address disproportionality and disparities issues in its own way, without a legislative mandate, CEDD can more comprehensively, efficiently, and consistently work with these interconnected systems to carry out its mission wherever it is necessary. This cross-systems approach was the reason SB 501 (2011) established the Interagency Council for Addressing

Disproportionality, in addition to codifying CEDD. It makes sense that an effort involving so many different state agencies comes from the Office of the Governor.

Recommendation #2: Pass legislation similar to HB 2038 (2013) reestablishing a statutory, cross-systems body similar to the IC and requiring each relevant agency to address disproportionality and disparities together with CEDD. The legislation should establish new duties for CEDD regarding a) officially adopting a Texas model to achieve equity and address disproportionality and disparities and all of their causes, b) implementing the Texas model in HHSC and other relevant state systems, and c) advising relevant state agencies regarding cultural competency training for staff and partnering with community to deliver culturally competent services.

Rationale: The December 2012 legislative report produced by CEDD and the IC indicated that significant disproportionality and disparities exist in every examined state system (Interagency Council for Addressing Disproportionality, Texas Health and Human Services Commission, Center for Elimination of Disproportionality and Disparities, 2012). The CEDD and IC report produced in response to HHSC Rider 87 of SB 1 (2013) gave no indication whatsoever as to whether any improvement had been made in any of the state systems examined by the December 2012 report (R. Patterson, personal communication, January 6, 2015). In fact, the report required by Rider 87 points out that "only the Department of Family and Protective [*sic*] has a formal legislative mandate to address disproportionality and disparities within their agency." Presumably, the "mandate" the report refers to is Section 265.004 or Section 264.2041, Texas Family Code. Recommendation #2, together with Recommendation #1, would ensure that all relevant agencies address disproportionality and disparities with the guidance of CEDD.

Recommendation #3: Pass legislation to require CEDD and the Legislative Budget Board to collaboratively produce an economic analysis on the cost of disproportionality and disparities to the State of Texas.

Rationale: The issue of disproportionality and disparities is a moral issue concerning equity for the future and foundation of the state—children and families; however, it is also an economic issue. For example, research indicates that dropping out of the education system is linked to a greater likelihood of involvement in the juvenile justice system, and, in turn, is linked to greater likelihood of involvement in the criminal justice system, which, of course, costs Texas taxpayers dramatically (Texas Appleseed, 2007). Similarly, the impact of health disparities comes at a substantial cost to the State of Texas. The years of potential life lost, time or days away from work, and additional costs to the health care system all contribute to an excess cost or loss of economic value for Texans. A number of states have developed a method of measurement for health disparities using one or more of these metrics (HCUP, 2011). In Texas, these costs will likely increase given the state's growing population of color. It would be hugely beneficial to understand just how economically impactful disproportionality and disparities are to Texas.

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The Institute for Urban Policy Research & Analysis
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To become the major policy research organization that identifies, proposes, and measures solutions to social justice problems that disproportionately affect populations of color and their communities.

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July 23, 2015

Maryland General Assembly Public Safety and Policing Workgroup - Town Hall Meeting: Law Enforcement issues across the State
Senator Catherine E. Pugh, Senate Co-chair
Delegate Curt S. Anderson, House Co-chair
Members of the Workgroup

The National Alliance on Mental Illness (NAMI) Maryland is a grassroots organization that represents families and individuals living with mental illness. We are dedicated to providing education, support and advocacy for persons with mental illnesses, their families and the wider community. Further, NAMI's members include countless families and friends of persons living with serious mental illness that have been incarcerated or otherwise involved with the criminal justice system.

NAMI Maryland and its local affiliates have worked for years to improve mental health services in the community, to increase diversion from the criminal justice system to the mental health system, where appropriate, and to improve the criminal justice system's response to mental illness. We work regularly with agencies at a local, state and national level to improve training and procedures for law enforcement's response to individuals with mental illnesses. We are honored to partner with mental health provider agencies, law enforcement, corrections, courts and other leaders who want to improve society's response to mental illness, increase chances that people with mental illness can ***live productively in the community***, and ***reduce costs to systems*** such as criminal justice.

When someone experiences a psychiatric crisis or acts out as a result of symptoms of their illness, often law enforcement are the first-line responders and too often the result is in injury to the officer or the individual. These interactions result in an arrest – not because the individual committed a violent crime, but because officers have few alternatives to resolve the situation. In fact, the vast majority of people with mental illnesses are no more likely to be violent than anyone else and only 3%-5% of violent acts can be attributed to individuals living with a serious mental illness. The reality is that people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population.1 However, there is the potential for violence when people are left untreated. The result, for many, is years of cycling through prisons and jails, shelters, and emergency rooms, which is costly for communities, a burden on law enforcement and corrections, and tragic for individuals with mental illnesses. Most people leave the system worse off and with fewer options for getting needed treatment and services.

While there are numerous "intercepts" within the criminal justice system that could prevent individuals from progressing further into the system, such as courts and reentry from jails and prisons, these remarks are directed at one intercept point: law enforcements response to individuals with mental illnesses (see the Sequential Intercept Model Attachment).[2] The adverse outcomes between law enforcement and individuals

[1] This document cites statistics provided by www.mentalhealth.gov.

[2] (The Sequential Intercept Model, developed by Mark R. Munetz, MD, and Patricia A. Griffin, PhD, offers a framework to help communities understand the big picture of interactions between the criminal justice and mental health systems and identify where to intercept individuals with mental illness as they move through the criminal justice system).

with mental illnesses can be managed and resolved in a humane and effective manner depending on the service system design, as well as preparation and training.

Maryland has taken steps over the last decade to address law enforcements response to people experiencing a behavioral health crisis through Crisis Intervention Team (CIT) programs. CIT programs should not be mistaken for mobile crisis response teams, which are teams made up of behavioral health professionals. There are some mobile crisis response teams that do not have a law enforcement component. NAMI Maryland has been involved in numerous efforts to expand CIT programs across the state, as well as enhance the programs that have been established. Our members that have lived experience, either as an individual with a mental illness or a family member of an individual with a mental illness, participate in CIT trainings across the state to deliver their personal experience with law enforcement and their response to mental illness. NAMI Maryland has also been actively involved in developing training curriculum for law enforcement, dispatch and corrections. Our National organization, NAMI, has a CIT Center dedicated to expanding CIT programs nationwide and is a noted expert in this area.

Many people who have come into contact with a CIT trained officer have a history of cycling through emergency rooms, homeless shelters and jails. This cycle of crisis is very expensive. CIT programs are intended to address the cycle of crisis and improve the outcome of police interactions with individuals with mental illness. The successes of CIT programs are well documented and have several significant and valuable outcomes associated, such as:

- reduction of the use of lethal force when law enforcement, corrections, and parole and probation respond to a mental health crisis;
- reduction of hospital emergency department visits and costs;
- reduction of unnecessary arrests and costly incarceration;
- increased linkages to effective mental health services in the community, and in correctional settings;
- decreased exposure to legal liability; and
- reduction of stigmatizing attitudes within communities.

There are several essential elements that enhance the success of the program (**for more information on the essential elements see the *Improving Reponses to People with Mental Illnesses: The Essential Elements of a Specialized Law Enforcement-Based Program* attachment**). One component of a best-practice designed CIT program includes 40-hours of training for law enforcement on how to better respond to people experiencing a mental health crisis. These trainings include educational information about mental illness, de-escalation skills, how to decrease use of force and information on how to link mental health consumers to behavioral health services. Ideally, 20% or more of a police force would have CIT trained officers that are not only able to respond to crisis calls from dispatch, but will use these skills in a variety of situations that arise in their day-to-day patrol work. Unfortunately, in Maryland, the training provided to law enforcement personnel in local jurisdictions, as well as the critical response protocols and crucial partnerships with local behavioral health care providers, are uneven at best and totally absent in many areas of the state.

It is important to keep in mind that *CIT is not just a training program.* While one outcome of creating a CIT program is training for law enforcement, training is not the only goal. If implemented properly, CIT programs serve as a springboard for broader collaboration and partnerships between local law enforcement agencies and behavioral health providers, as well as ensuring community participation to map out the problems and solutions. The International Chiefs of Police (IACP), the Bureau of Justice Assistance (BJA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) released a publication that outlines the scope of the problem, identifies factors that have contributed to current challenges and describes innovative policies, programs and practices that have emerged in recent years to provide a foundation from which to begin these conversations and programs (**for more information see the *Building Safer Communities: Improving Police Response to Persons with Mental Illness* document**).

We wanted to point out that law enforcement's response to mental illness is a national issue and it is finally receiving the attention it deserves. There are several nationwide initiatives happening that are geared to assist states address these issues. One such initiative is ***SteppingUp***, a national initiative to divert people with mental illness from jails and into treatment. The campaign brings together a powerful coalition of national organizations, including NAMI, the Council of State Governments, the National Association of Counties, the American Psychiatric Foundation and numerous law enforcement associations, mental health organizations, and substance abuse organizations. The initiative will challenge counties and local communities to work together to find solutions that work for the local community. The campaign will also support local leaders by providing examples of effective reforms and connecting them with other communities that are successfully reducing the number of people with mental illness in jails.

Finally, we would be remiss if NAMI Maryland did not acknowledge that solutions to divert individuals with mental illnesses from the criminal justice system should not rest solely on law enforcement, courts, corrections or parole and probation. The need for mental health care services in Maryland continues to grow, state resources have diminished and the criminal justice system has become the "default" system responsible for individuals with mental illnesses and their families. This is unacceptable.

While all jurisdictions in Maryland have some type of mobile crisis response system, they are all missing vital elements of a full continuum of crisis services that can help prevent unnecessary involvement with the criminal justice system or unnecessary hospitalization. But, even with a full continuum of crisis services the only way to ensure these individuals do not cycle in and out of crisis, is to ensure there are corresponding support services in the community. Ideally, Maryland's behavioral health system would be comprehensive, focused on wellness and recovery, and centered around people living with mental illnesses and their families. It would be inclusive, reaching underserved areas and neglected communities, and fully integrated into the broader health care system. This however, cannot be done without sufficient funding. If all systems that an individual with a mental illness may interface with continue to work in silos, mental health providers will continue to be unprepared to meet the growing needs of Marylanders who need access too timely and effective mental health care services. There must be greater, long-term and sustainable investments in behavioral health services and supports.

NAMI Maryland believes that the strength of CIT is in the local and state partnerships between the criminal justice system, behavioral health system and communities. And like CIT programs, we believe that the spirit of the Public Safety and Policing Workgroup is the same, to ensure safer communities and strengthen communication between the public and law enforcement. We are confident that Maryland will build effective strategies for diverting people needing treatment from jail, reducing officer injuries and saving taxpayer money. By supporting CIT, Marylanders can build safer and more compassionate communities. We thank you for your tireless efforts to address these difficult and complex issues.

Sincerely,

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Jessica L. Honke, MSW
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NAMI Maryland

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S Department of Health and Human Services

BJA
Bureau of Justice Assistance
U.S. Department of Justice

Building Safer Communities: Improving Police Response to Persons with Mental Illness

Recommendations from the IACP National Policy Summit

June 2010

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Executive Summary

Every day across the country law enforcement officers respond to disturbances or crises involving a child, youth or adult with mental illness. The people experiencing a mental health crisis and their families rely on first responders, particularly law enforcement officers, to respond in an effective manner, treating the person with mental illness with compassion and respect. Law enforcement officers who face these complex situations would like to be as fully prepared as possible so that they can respond in ways that ensure the safety of the responding officers, the person in mental health crisis, and that person's family. Unfortunately, due to the current lack of consistent policy, procedure, training and education among law enforcement agencies, too many of these calls end badly for all involved. Most response calls involving persons with mental illness are not the result of criminal behavior, but of emotional crisis. While law enforcement officers have the duty to arrest anyone who is breaking the law, it is critical for the officer responding to a mental health call to have the information needed to adequately assess the situation and the support required so that a determination of appropriate action can be made in the best interests of the subject, the officer, and the public.

To address this critical law enforcement issue, the International Association of Chiefs of Police (IACP) Past President Ronald Ruecker urged that recommendations be developed that would reduce the risk of law enforcement officer and citizen injury or trauma during police response to incidents involving persons with mental illness. In an effort to make this possible, the IACP, in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), held a roundtable discussion on the subject in September 2007, with attendees including law enforcement officers and executives, family and youth representatives, and partners from the National Federation of Families for Children's Mental Health (National Federation). The primary purpose of the roundtable was to gain the insights of children and youth with mental illness and their families regarding their perspectives on law enforcement response to crisis calls for service.

Based largely on Ruecker's Presidential Initiative and the concerns raised during the roundtable, the IACP selected "Police Response to Persons with Mental Illness" as the focus for its May 2009 National Policy Summit. The Bureau of Justice Assistance (BJA), SAMHSA, the JEHT Foundation, the National Federation, and the National Coalition of Mental Health Consumer/Survivor Organizations (NCMHCSO) partnered with the IACP to design and sponsor the summit. The scope of the summit was expanded beyond the initially proposed focus on law enforcement response to people in emotional crisis to include other ways in which law enforcement leaders and their sworn and civilian staff can contribute to enhancing communities' responsiveness to persons with mental illness or who are experiencing emotional crisis.

The IACP summit gathered over 100 leaders from across the country to share their knowledge and views on these complex issues. Participants included law enforcement executives and officers, consumers/survivors of mental health services, community and family members, mental health practitioners, representatives of courts and corrections agencies, and researchers. All participants came as equals to the discussion and collaborated to create an action agenda of collaborative solutions to the challenges confronting families, communities, law enforcement and the justice system, and the systems of care responsible for supporting those with mental illness.

This report outlines the scope of the problem, identifies factors that have contributed to current challenges and describes innovative policies, programs and practices that have emerged in recent years to provide a foundation of this blueprint for change. These promising approaches offer safer, more compassionate and often cost-effective ways for police and their community partners to respond to adults and juveniles with mental illness. Ultimately, the effectiveness of these new approaches depends on the strength of the collaborative working relationships on which they are founded and on the willingness of states and localities to invest in providing a continuum of education and training for first responders and effective services and supports for persons with mental illness and their families.

Recommendations developed by summit participants suggest ways that:

- Law enforcement leaders can establish policies, protocols, and strategies to improve their agencies' responses to persons with mental illness.
- Law enforcement officers can best prepare to de-escalate crisis situations to which they are called, to avoid injury and trauma.
- Consumers of mental health services, their families, and advocates, should be engaged in planning, delivering, and monitoring the impacts of crisis intervention training for officers and other crisis responders.
- Essential partners can be engaged to work with state, local and tribal law enforcement agencies to decriminalize (i.e., utilize non-justice system options whenever possible) responses to persons with mental illness, and the strategies these local collaboratives can employ.
- Approaches proven to be effective alternatives to arrest for persons with mental illness apprehended for minor offenses can be implemented.
- School resource officers can be involved in supporting children and youth with mental, emotional, or behavioral issues.
- The unique characteristics of children and youth with mental, emotional, or behavioral issues should be taken into account in developing effective prevention and crisis intervention approaches that will minimize trauma and stigma for these children and their families.
- Law enforcement leaders and officers can support effective reentry strategies and programs for jail and prison inmates with mental illness who are returning to their communities.
- Legislative, funding, and technical assistance initiatives at the federal, state local and tribal levels should be developed to support law enforcement agencies and their partners in enhancing responses to persons with mental illness.
- The IACP can work with its national and local partners to advance the training, policy development, and action research initiatives necessary to enhance police response to people in emotional crisis and persons with mental illness.

The final section of this report highlights recommendations that law enforcement leaders and their line staff can translate into actions that will improve their agencies' response to persons with mental illness. A central goal of these recommendations is to increase the safety of persons with mental illness, their family members, and the officers who respond to crisis calls.

This report is intended to serve as a catalyst, opening dialogue, increasing mutual understanding and strengthening collaboration among all those with a stake in the success of this endeavor – law enforcement, community residents, mental health service consumers and their families, advocacy groups and the mental health and justice systems.

Summit Background and Goals

Every day across the country there are many calls for law enforcement to respond to disturbances involving a child, youth or adult with mental illness. Law enforcement officers would of course like to be prepared to safely respond to these crisis calls in ways that result in a safer, calmer community, family, tribe, or campus. People who are experiencing a mental health crisis and their family members rely on first responders, including law enforcement officers, to respond calmly, compassionately and respectfully to all involved. Successful resolution of emotional crises also requires increased community investment in a continuum of prevention and care options that will enable law enforcement to facilitate positive outcomes in these high-risk situations.

While serving as President of the IACP, (2007-2008) and Director of Public Safety for the City of Sherwood, Oregon, Ronald Ruecker (currently an Assistant Director of the Federal Bureau of Investigation) urged the IACP to design a process to develop recommendations for enhancing police response to persons with mental illness. His Presidential Initiative centered on the goal of reducing law enforcement officer and citizen injury or trauma during police response to incidents involving persons with mental illness. He also emphasized the importance of joining the voices of law enforcement with those of mental health professionals, family members, children and youth advocates, and consumers of mental health services to devise strategies that will improve outcomes for all.

In 2007 the IACP, in collaboration with SAMHSA, held an initial roundtable discussion hosted by the U.S. Capitol Police in Washington, DC. The roundtable participants included law enforcement officers and executives, family and youth representatives, and partners from the National Federation. The primary purpose of the roundtable was to gain the insights of children and youth with mental illness and their families regarding law enforcement response to crisis calls for service. The results of that roundtable, and of a subsequent panel at the National Federation's annual conference, were clear: family members and advocates all concurred that, while they sometimes must call the police to intervene when a family crisis situation results in violence, their experiences with police intervention have often been frustrating and unsatisfying.

Based largely on Past President Ruecker's Presidential Initiative and the concerns raised during the roundtable, the IACP selected "Building Safer Communities: Improving Police Response to Persons with Mental Illness" as the focus for its May 2009 National Policy Summit, the most recent in a series of annual summits that have identified and addressed vital community and law enforcement issues since 1993. The BJA, SAMHSA, JEHT Foundation, National Federation, and the NCMHCSO partnered with the IACP to design and sponsor the summit.

The Advisory Group designing the summit recognized that law enforcement policies and priorities have an impact well beyond the individuals with mental illness to whom they respond as a result of crisis calls for service. In particular:

- Law enforcement interventions can have very different impacts on children and youth with mental, emotional, or behavioral issues in comparison to those experienced by adults with mental illness.
- Law enforcement officers responding to crisis calls for service often interact with family members of the person in crisis who have their own perspectives, resources, and needs.
- Law enforcement executives can influence and provide input to a broad range of public policy and resource allocation decisions relevant to community mental health systems and services.
- In addition to responding to individuals in emotional crisis, law enforcement officers may encounter persons with mental illness who are under justice system supervision or those who are reentering community life after a period of incarceration or residential mental health treatment.

Based on these observations, the scope of the summit was expanded beyond the initial IACP Presidential Initiative's focus on law enforcement response to people in emotional crisis to include other ways in which law enforcement leaders and their sworn and civilian staff can contribute to enhancing communities' responsiveness to persons with mental illness.

The IACP invited over 100 leaders from across the country to share their knowledge and views on these complex issues. Participants included law enforcement executives and officers, consumers/survivors of mental health services, community and family members, mental health practitioners, representatives of courts and corrections agencies, and researchers. All came as equals to the discussion and collaborated to create an action agenda of collaborative solutions to the challenges confronting families, communities, law enforcement and the justice system, and the systems of care responsible for supporting those with mental illness.

The summit began with a keynote address that identified shared issues and promising trends, followed by a plenary panel with members who presented the perspectives of youth, consumers/survivors, family members of persons with mental illness, advocacy organizations, courts, corrections, and law enforcement. Summit participants then gathered in working groups that focused on critical issues facing law enforcement and its community partners. Areas of concern addressed by the groups were:

- Legislation and Policy
- Crisis Intervention/First Responders
- Youth
- Cross-Systems Collaboration
- Reentry into the Community

This final summit report includes recommendations for change that were developed by these working groups. The IACP offers it as a guide for the continuing work of U.S. law enforcement agencies and their community partners to improve police response to persons with mental illness at the federal, state, local, and tribal levels. The recommendations presented here are intended to aid law enforcement agencies in optimizing their crisis response training, reducing liability concerns, improving cost-effectiveness of Crisis Intervention Teams (CIT) and other crisis response programs, and enhancing officer and citizen safety in crisis situations involving persons with mental illness.

Issues and Opportunities

In order to develop a strategy for enhancing law enforcement responses to people with mental illness, it is essential first to understand the issues currently facing law enforcement and its community partners. Outlining the scope of the problem, identifying factors that have contributed to current challenges and recognizing promising policies and practices that have emerged in recent years provides the foundation of this blueprint for change.

People With Mental Illness Involved in the Justice System

Justice systems across the country, with law enforcement agencies on the front lines, have increasingly been required to respond to and intervene on behalf of people who are in emotional crisis. Many but not all of these individuals have been diagnosed with a mental illness. A 2008 BJA report on law enforcement responses to people with mental illness indicates that behaviors resulting from mental illness are a factor in 3 to 7 percent of all law enforcement calls for service. Calls for service involving people with mental illness as suspected offenders, victims or witnesses are often disproportionately time-consuming.[1] BJA reported that a very small proportion of crisis calls involving persons with mental illness tragically result in the injury or death of officers, persons with mental illness, or innocent bystanders.[2]

Persons with mental illness have been stigmatized by a false association between violence and mental illness that has been promoted by the news and entertainment media. In fact, most persons with mental illness never behave violently, and the vast majority of those people who do behave violently are not mentally ill. Research shows that people with mental illness are much more likely to be victims than perpetrators of violent crime.[3]

A number of studies also document that persons with mental illness are more likely than those without mental illness to come into contact with police as suspected offenders, most often for relatively minor offenses,[4] and to be re-arrested more frequently.[5] Some studies indicate that persons with mental illness suspected of committing offenses are more likely to be arrested, particularly if they live in communities with a limited range of community-based intervention options for individuals experiencing a mental health crisis.[6]

According to a 2006 Bureau of Justice Statistics (BJS) analysis, 24% of state prisoners report a recent history of mental illness, as do 21% of jail inmates and 14% of federal prisoners. Nearly three-quarters of these inmates also have a co-occurring substance abuse disorder.[7] About 15% of state prisoners and 24% of jail inmates interviewed for the BJS study reported current symptoms that met Diagnostic and Statistical Manual (DSM) IV criteria for a psychotic disorder, compared to just 3% of the general population.[8] Across all types of adult correctional facilities, the BJS study shows that a higher proportion of female than of male inmates are assessed as having mental health problems. These statistics should

[1] Matt Schwarzfeld, Melissa Reuland and Martha Plotkin. (2008) "Improving Responses to People with Mental Illness: The Essential Elements of a Specialized Law Enforcement-Based Program." Council of State Governments and Police Executive Research Forum, New York.

[2] "Suicide by cop" is a controversial phrase that is sometimes used inappropriately to explain incidents when deadly force was unnecessarily employed by officers responding to persons in emotional crisis. See for example: Centre for Suicide Prevention. (1999) "Suicide by Cop." Canadian Mental Health Association http://www.suicideinfo.ca/csp/assets/alert34.pdf ; and, H. Huston, et. al. (1998) "Suicide by Cop." *Annals of Emergency Medicine* 32: 665-69.

[3] Substance Abuse and Mental Health Services Administration (SAMHSA), Understanding Mental Illness: Factsheet, http://www.samhsa.gov/MentalHealth/understanding_MentalIllness_Factsheet.aspx Last updated 9/24/08.

[4] Melissa Reuland, Matthew Schwarzfeld and Laura Draper. (2009) "Law Enforcement Responses to People with Mental Illness: A Guide to Research-Informed Policy and Practice." Council of State Governments Justice Center, New York.

[5] Ann Crocker, Kathleen Harford and Lisa Haslop. (2009) "Gender Differences in Police Encounters Among Persons With and Without Serious Mental Illness." *Psychiatric Services* 60: 86-93.

[6] Amy Watson, Patrick Corrigan and Victor Ottati. (2004) "Police Responses to Person With Mental Illness: Does the Label Matter?" *The Journal of the American Academy of Psychiatry and the Law* 32:378-85; Hank Steadman, M.W. Deane. R. Borum and J. Morrissey. (2001) "Comparing outcomes of major models of police response to mental health emergencies." *Psychiatric Services* 51:645-49.

[7] Doris James and Lauren Glaze. (2006) "Mental health problems of prison and jail inmates." US Department of Justice, Bureau of Justice Statistics Special Report.

[8] Ibid.

not be interpreted as evidence that persons with mental illness are inherently likely to be lawbreakers, but rather as indicators that too many of these individuals who are unable to find supportive services behave in ways that bring them to the attention of law enforcement and the courts.

A more recent (2009) study by the Council of State Governments and Policy Research Associates shows that jail inmate populations still have a disproportionate number of persons with mental illness. Of particular interest is the finding that the percentage of female jail inmates with serious mental illness (31%) is double that of male inmates (14.5%).[9] Research on female offenders documents that women who enter the criminal justice system are more likely than male offenders to have been victims of sexual and physical abuse, and a large proportion suffer from co-occurring mental health and substance abuse disorders.[10] Despite the relatively high prevalence of mental illness among jail and prison inmates, the 2006 BJS study documented that only about one-third of state prison inmates with mental illness and one-sixth of local jail inmates with mental illness receive any type of mental health treatment while they are incarcerated. The American Psychiatric Association asserts that "being thrown into the hostile world of the prisoner is almost certain to make any existing psychiatric condition worse" and "failure to treat [can cause some inmates with mental illness to] become resistant to treatment." [11]

Compounding the problem, most inmates lose access to Medicare, Medicaid and Social Security benefits during their jail or prison term, and when they are released many do not receive timely assistance in re-applying for these entitlements. Without supportive resources, persons with mental illness released from jail or prison are at high risk of continuing to be untreated, remaining or becoming homeless, re-offending, and making extensive use of costly emergency medical services.[12]

Children and youth who are seriously emotionally disturbed and come in contact with juvenile justice system fare no better than their adult counterparts. A 2006 Office of Juvenile Justice and Delinquency Prevention report indicates that in Cook County Illinois 60 percent of male and 70 percent of female juvenile detainees meet diagnostic criteria for one or more psychiatric disorders, but receive little or no mental health treatment during their detention.[13] Even more surprising, a 2004 report to Congress by the Special Investigations Division of the House of Representatives documented that in 280 detention facilities from around the country (those able to supply data), during the first six months of 2003, nearly 15,000 children and youth with mental illness were held without charges while waiting for access to scarce community mental health services, representing 8% of the total number of juveniles held by these facilities.[14] It is likely that most of these children and youth come from poor or underinsured families unable to afford private mental health treatment or other supportive services.[15]

Causes of the Overrepresentation of People with Mental Illness in the Justice System

Many trends have converged to result in jails, prisons and juvenile detention centers housing a larger number of persons with mental illness than do publicly funded mental health treatment facilities. The Community Mental Health Centers Act (CMHCA), passed more than forty years ago, initiated the process of deinstitutionalization of the United States mental health system. Between 1955 and 2005, the national ratio of available public hospital (state and county) beds per 100,000 population decreased by 95 percent (from 340 to 17 per 100,000).[16] In contrast, the number of inmates in the nation's jails

[9] Council of State Governments Press Release 6/01/09. http://consensusproject.org/press_releases/new-study-documents-high-prevalence-of-serious-mental-illnesses-among-nations-jail-populations

[10] Barbara Bloom, Barbara Owen and Stephanie Covington. (2003) Gender Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders. National Institute of Corrections.

[11] The American Psychiatric Association (APA). (2004) "Mental Illness and the Criminal Justice system: Redirecting Resources Toward Treatment, Not Containment." Resource Document. Arlington VA.

[12] National Alliance on Mental Illness (NAMI). " CIT Toolkit: Criminalization Facts." Arlington, VA.

[13] Linda A. Teplin, Karen M. Abram, Gary M. McClelland, Amy A. Mericle, Mina K. Dulcan, and Jason J. Washburn. (2006) "Psychiatric Disorders of Youth in Detention." Office of Juvenile Justice and Delinquency Prevention Bulletin

[14] United States House of Representatives Committee on Government Reform, Special Investigations Division. (2004) "Incarceration of Youth Who Are Awaiting Community Mental Health Treatment in the United States."

[15] Op. cit., APA (2004).

[16] EF Torrey, Kurt Entsminger, Jeffrey Geller, et. al. "The shortage of public hospital beds for mentally ill persons: a report of the

and prisons tripled between 1985 and 2005, while the incarceration rate rose from 313 to 737 per 100,000.[17]

The infusion of public resources into community mental health options that was supposed to accompany deinstitutionalization has never materialized. People with mental illness who are unable to obtain effective treatment through the limited and often uncoordinated resources that are available are likely to behave in ways that bring them into contact with law enforcement. In far too many communities the local jail is the primary or only location available for police to bring those who are behaving erratically due to mental illness.

Hospital emergency rooms, another referral option used by law enforcement officers for persons with mental illness who are in crisis, are often ill-equipped to appropriately respond to these individuals. Because of the lack of crisis mental health services and outpatient and residential treatment options in communities across the country, the American College of Emergency Physicians (ACEP) documents in its 2008 survey that the number of persons with mental illness who must await appropriate placement while being "boarded" in hospital emergency rooms is significant and growing. This contributes to overloading emergency departments and negatively affects access to emergency services for all patients.[18]

Simultaneous with deinstitutionalization, court litigation was initiated on behalf of persons with mental illness that revealed inhumane and unsafe conditions in publicly funded mental hospitals and provided for the first time increased due-process safeguards that protect persons with mental illness from being subjected to such conditions. At the same time, debate has raged about the efficacy of involuntary commitment to psychiatric facilities, which has become more rare and subject to stricter court oversight.

The growing scarcity of community-based mental health services and resources has likely led some law enforcement officers to arrest persons with a mental illness who they would otherwise not have arrested in the hope that these individuals will receive services not available through other avenues. This tendency has also been cited as an unintended consequence of implementing court-based diversion programs (e.g., mental health courts) without also ensuring that community mental health and pre-booking diversion options are adequate and accessible.[19]

Another trend that has increased the likelihood that persons with mental illness will be arrested is law enforcement's increased emphasis on responding assertively to "quality-of-life" crimes. These include petty theft, aggressive panhandling, public urination, littering, and trespassing; offenses that often characterize the behavior of homeless people with untreated mental health disorders. Unless enhanced enforcement is accompanied by creative community sanctioning options and increased access to treatment and support services, persons with mental illness committing these "nuisance" offenses will likely become trapped in a repetitive cycle of arrest, short jail stays, and return to the streets *without treatment* to commit more minor illegal acts that result in their re-arrest.

Treatment Advocacy Center." Consulted June 15, 2009.
http://www.treatmentadvocacycenter.org/storage/tac/documents/the_shortage_of_publichospital_beds.pdf

[17] Bureau of Justice Statistics Key Facts at a Glance: correctional populations. Consulted June 15, 2009. *http://www.ojp.usdoj.gov/bjs/glance/tables/corr2tab.htm*

[18] ACEP Psychiatric And Substance Abuse Survey 2008, *http://www.acep.org/uploadedFiles/ACEP/Advocacy/federal_issues/PsychiatricBoardingSummary.pdf*

[19] Robert Bernstein and Tammy Seltzer. (2003) "The Role of Mental Health Courts in System Reform." http://www.bazelon.org/issues/criminalization/publications/mentalhealthcourts Consulted July 21, 2009.

Promising Directions

It has become apparent that over the past several decades the United States has replaced one dysfunctional system for addressing the needs of persons with mental illness--state hospitals that were often merely warehouses for persons with mental illness--with another--local jails and state prisons that are unsuited and unable to provide adequate mental health treatment. Clearly it is time to redirect societal resources from containment to treatment of people with mental illness whose behaviors are seen as annoying, troubling or threatening.

In a number of jurisdictions, law enforcement agencies have partnered with justice system, mental health and community partners to develop more compassionate and cost-effective approaches that emphasize providing community-based treatment instead of arrest and incarceration for adults and juveniles with mental illness. Several of these promising options are briefly described below. Their effectiveness depends to a large extent on the strength of the collaborative working relationships on which they are founded.

Crisis Intervention Teams (CIT):

CIT is a pre-booking jail diversion program intended to "improve the outcomes of police interactions with people with mental illnesses"[20] by de-escalating crisis situations, decreasing the use of force by officers and increasing mental health consumers' access to community treatment options. Key to this initiative, according to the National Alliance on Mental Illness (NAMI), is ongoing collaboration between law enforcement, mental health professionals, consumers, their families and advocates.

In jurisdictions that have implemented CIT, its central feature is a 40-hour training program for law enforcement officers that includes information on how to recognize the behavioral characteristics of persons with mental illness; local mental health system characteristics; and methods of de-escalating crisis situations. In most communities, some of the training is planned and delivered by mental health consumers and family members. In some jurisdictions, only select law enforcement officers who volunteer for CIT or who carry an electronic control weapon receive the training, but in an increasing number of jurisdictions, all officers, both new recruits and veterans, are required to complete the full 40 hours of CIT training. For instance, the Southwest Louisiana CIT includes five parishes of law enforcement agencies that partner with advocacy groups, family members, and medical professionals to form their emergency response. The Calcasieu Parish Sheriff's Office and the Lake Charles Police Department coordinate a 40 hour first responder certification class, a school resource officer 40 hour certification class, and two eight hour certification classes for public safety dispatchers each year. Since its inception, Southwest Louisiana CIT has certified nearly four hundred peace officers, medical professionals, and area teachers and educators.

[20] NAMI CIT Toolkit: CIT Facts. *www.nami.org*

Law Enforcement and Mental Health Co-Responder Teams:

Initially developed in Los Angeles, this approach pairs trained police officers with mental health professionals in teams that provide specialized responses to incidents involving persons with mental illness.[21] These teams can be called in to assist when responding officers or SWAT teams are unable to de-escalate a situation involving a person known or presumed to have a mental illness. Some communities have mobile crisis teams comprised of mental health professionals who are available to respond to 911 calls at the request of responding officers. Because they take some time to mobilize, these specialized teams are not intended as alternatives to CIT but rather as supplemental resources that can assist law enforcement with resolving calls for service that are particularly challenging or threatening to suspects with mental illness, officers or bystanders.

Assertive Community Treatment (ACT) Approaches:

ACT is a model that has proven over the past three decades to be more effective than traditional office-based mental health treatment for those who are most severely disabled/affected by their mental illnesses. Key features of the ACT approach are a team approach to working with consumers in their own environment, focus on crisis prevention, and commitment to time-unlimited service and support of clients.[22] For individuals resistant to medication and treatment who come into frequent contact with law enforcement both as victims and offenders, ACT provides an option that can reduce their incidence of homelessness, emergency hospitalization and incarceration. Forensic Assertive Community Treatment (FACT) programs have been implemented by some communities as a way to break the cycle of chronic re-arrest experienced by persons with serious mental illness who have not been well-served by traditional treatment methods. These programs depend on the collaboration of mental health professionals, law enforcement, and local jails to maximize their effectiveness.

Mental Health Consumer-Driven Services:

Many consumers of mental health treatment, their families and advocates have united to urge that all services be focused on recovery rather than simply on symptom management or maintenance.[23] There are hundreds of non-profit, mental health consumer-run organizations in the U.S. and internationally with track records providing evidence that many individuals labeled with mental illnesses can and do recover.[24]

Consumer-driven approaches consistent with principles of hope, self-determination, choice, and dignity differ from traditional treatment approaches by empowering consumers/survivors to offer support to one another. Consumer-driven peer support is based on the principle that people who have experienced mental health recovery can provide effective support to others in ways that will enhance and support their own recovery. This approach encourages the development of reciprocal relationships between givers and receivers of support that enable both parties to feel valued and empowered, thus facilitating their well-being and increasing their opportunities for meaningful community integration. Peer support can reduce the risk of institutionalization and incarceration through offering a wider array of options for persons with mental illness to work with strong emotions in comfortable, non-judgmental environments. Helping individuals develop new stress management skills and options reduces the risk of them experiencing emotional crises that may require law enforcement intervention.

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[21] Op. cit. Schwarzfeld, Reuland and Plotkin. (2008).

[22] Assertive Community Treatment Association. http://www.actassociation.org/actModel Consulted July 31, 2009.

[23] Daniel Fisher and Judi Chamberlain. (2004) "Consumer-Directed Transformation to a Recovery-Based Mental Health System." National Empowerment Center, Inc.

[24] Some examples of successful consumer-drive programs are Stepping Stone Peer Support and Crisis Respite Center in Claremont NH, *www.steppingstonenextstep.org*; Main Street Housing, Inc. in Baltimore MD, *www.onourownmd.org* ; and Collaborative Support Programs of Freehold NJ, *www.cspnj.org*

Grass-roots, peer-run programs led by and for people in recovery from mental illness clearly are an important part of the continuum of services that should be offered to persons with mental illness who come into contact with law enforcement. These programs can encourage community integration in ways that are beyond the capacity of professional mental health practitioners.

Jail and Prison Reentry Programs:

Concern about how best to support people reentering society after a period of incarceration has grown substantially in recent years. Several federal initiatives have funded program planning and evaluation to determine the most effective approaches. The National GAINS Center, with funding from the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, has developed the Assess, Plan, Identify, and Coordinate (APIC) model that can "guide transition planning for people with co-occurring mental illness and substance use disorders, improve the chances of successful reentry, and reduce relapse and recidivism."[25] Another initiative, the "Outside the Walls" project of the Urban Institute, documents the successes of a wide variety of community-based reentry programs in decreasing the recidivism of people returning from prison.[26] The success of all of these reentry initiatives depends in large part on the collaboration of local, state, federal, and tribal law enforcement with the many other agencies that must commit to ensuring that returning inmates, particularly those with mental health issues, receive appropriate support and treatment that will enable them to avoid re-offending or relapsing. For a valuable IACP resource guide on reentry strategies that have shown to improve success rates at the local level, see: http://www.theiacp.org/Portals/0/pdfs/Publications/CISOMResourceGuide.pdf

Federally Funded Initiatives:

In 2004 Congress enacted the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) which created the Justice and Mental Health Collaboration Program (JMHCP) to help states, local jurisdictions, and tribes design, implement, and enhance collaborative efforts between adult and juvenile justice and mental health systems. In 2008 Congress reauthorized the MIOTCRA at $50 million per year until the year 2013. This reauthorization expands training for law enforcement and supports development of law enforcement receiving centers to assess individuals in custody for mental health and substance abuse treatment needs.

Federal agencies, particularly SAMHSA and BJA, continue to provide grants that support development of innovative approaches to enhancing police response to persons with mental illness (see subsequent recommendations on Legislative, Funding and Technical Assistance for more details on these and other federally sponsored initiatives). The Summit process coordinated by the IACP and summarized in this report was sponsored in part by SAMHSA and BJA.

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[25] Fred Osher, Henry J. Steadman, and Heather Barr. (2002) "A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-Occurring Disorders: The APIC Model." The National GAINS Center, Delmar NY.

[26] Amy L. Solomon, et. al. "Outside the Walls: A National Snapshot of Community-Based Prisoner Reentry Programs." *http://www.urban.org/UploadedPDF/410911_OTWResourceGuide.pdf and www.reentrymediaoutreach.org*

Summit Recommendations

Summit participants developed multifaceted recommendations for improving police response to persons with mental illness. A central goal of Summit recommendations summarized in this document is to keep people with mental illness from entering the justice system. This requires that mental health systems at the state, local, and tribal level have the resources and capabilities to provide services to all those in need. The first set of recommendations focuses on strategies to improve the quality and accessibility of community mental health services and outlines the ways that law enforcement can support these efforts.

All five working groups emphasized the fundamental importance of engaging a broad range of key stakeholders in community-wide collaborations. Since mechanisms for structuring and sustaining community-wide collaborations provide the foundation for accomplishing many other goals, recommendations to enhance local collaborations and their impacts are outlined next.

Communities vary dramatically in resources available to support local collaboratives. Recognizing that smaller and tribal communities have distinct challenges, summit participants recommended considering regional partnerships to assist smaller communities with implementing recommended training and crisis intervention strategies.

The "sequential intercept model" proposed by Munetz and Griffin provides a helpful framework for planning systems change, conceptualizing justice system decision points as a series of "filters" which can serve to divert persons with mental illness from further involvement with the justice system. Consistent with fundamental Summit goals, this model is based on the assumption that "the presence of mental illness should not result in unnecessary arrest or incarceration" simply because of lack of access to appropriate treatment, housing or other supportive services. Ideally, best clinical practices should enable most persons with mental illness to avoid any involvement with the justice system.[27]

Recommendations for justice system policy and program change in the following pages are organized according to decision points ("points of interception"), from crisis response through post-arrest diversion and reentry. Some of the proposed change strategies discussed below will best be led by law enforcement, and all others will benefit from police support.

Legislative and funding initiatives necessary to promote and enable recommended changes are described after the decision point recommendations. The report concludes with an action agenda for law enforcement leadership that summarizes recommended change strategies to be led or supported by law enforcement agencies at the state, local and tribal levels.

Improving Quality and Accessibility of Community Mental Health Services Recommendations

Ideally, the only persons with mental illness who should come into contact with law enforcement are those who are suspected of committing crimes or who are a danger to themselves or others. If mental health services and other social support systems, especially affordable housing, were functioning optimally, a much smaller proportion of persons with mental illness would likely engage in criminal, threatening or suicidal behavior. Therefore, preventing people with mental illness from coming into contact with law enforcement depends on having a mental health system that is accessible, culturally competent and effective for persons with mental health disorders, and on having triage systems in place to refer persons with mental illness to treatment and other supportive services before they behave in ways that require law enforcement intervention.

Ensuring that community mental health services have sufficient capacity has become an even more challenging task in the wake of the current recession. A recent survey by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) reports that 32 states (of 42

[27] Mark R. Munetz and Patricia A. Griffin. "Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness." *Psychiatric Services* 57:4, April 2006. www.ps.psychiatryonline.org

responding) plan to cut funding for community mental health by an average of 14% (total for FY 2009 and 2010). In 28 of these states, Medicaid funding for mental health care is also being reduced.[28] Unless these trends are reversed and mental health care is adequately funded, a larger proportion of people with mental illness will be unable to access treatment and therefore more likely to show up in emergency rooms, to require hospitalization, and to come into contact with the justice system. The situation is critical in many states, as noted in a report on community mental health funding for the Ohio mental health system that asserts "the ability of the mental health provider network to survive cuts of this magnitude is doubtful. Provider rates have not changed since 1997. As funding for non-Medicaid services dries up and as Medicaid rates fail to keep up with inflation, more and more providers of mental health services will leave the marketplace, decreasing system capacity and consumer access."[29]

Decriminalizing mental illness is both compassionate and cost-effective. In order to accomplish this goal, law enforcement leaders must work with their community partners in local, collaborative policy development groups to ensure that community mental health services are adequately funded. Maintaining persons with mental illness in their communities costs taxpayers much less than repeatedly recycling them through the justice system.

1. **Law enforcement executives should work with other community leaders to ensure that community mental health service systems are adequate and accessible to people in need.**

   As the American Psychiatric Association states, "when best practices are deployed, people with mental illness are maintained within the health and human resources systems, treatment is provided, the cycle of recidivism never has a chance to begin, and public safety is better served."[30] As competition for increasingly scarce public funds intensifies, it will become even more important for law enforcement leadership at national, state, local, and tribal levels to advocate for full funding of mental health care.

2. **In order to keep persons with mental illness from unnecessary involvement with the justice system, mental health treatment and supportive services should be organized around programs and strategies that have been proven effective for this population.**

   An effective community-based continuum of care should include outreach services like assertive case management, use of the most effective psychiatric medications, family psychoeducation programs, consumer-run programs focusing on recovery, and integrated substance abuse and mental health treatment for those with both substance abuse issues and mental illness (the dually diagnosed), who are at greater risk of being arrested and jailed.

   In addition, the availability of safe and affordable housing and social support services is essential for many persons with major mental illnesses. There must also be adequate capacity in specialized community mental health residential facilities that provide crisis intervention, stabilization and longer-term care as needed. Finally, communities should provide mental health crisis intervention services such as crisis hotlines and mobile crisis teams that can operate without law enforcement intervention except in circumstances where individual or public safety is at issue. In rural areas, some of these services, particularly residential options, may best be provided on a regional basis, with primary health care practitioners providing their patients screening and referral to mental health services as well as ongoing case management.

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[28] National Association of State Mental Health Program Directors Research Institute, Inc. (NRI). (2008) "SMHA Budget Shortfalls: FY 2009, 2010 & 2011." *http://www.nri-inc.org/reports_pubs/2009/BudgetShortfalls.pdf*

[29] John Honeck. (2009) "Proposed Funding Levels Push Community Mental Health System to Brink of Collapse." The Center for Community Solutions.

[30] APA. (2004) Op. cit.

3. **Local multidisciplinary advisory groups (see Community-Wide Collaboration Recommendations) should develop policies and protocols for emergency dispatchers that encourage referring calls for service involving persons with mental illness who are not suspected of criminal conduct or dangerous to self or others to mobile crisis teams rather than to law enforcement.**

   An increasing number of communities across the country have implemented mobile crisis teams comprised of mental health professionals operating under the auspices of public and private non-profit agencies. These teams can be called by those who are concerned about a person with mental illness, including family members, neighbors, friends, landlords, clergy or law enforcement officers. In order to minimize trauma that can occur when law enforcement officers are first responders to a mental health crisis situation, it is desirable for mobile crisis teams to be first responders to psychiatric emergencies that do not present a safety risk, as assessed by 911 dispatch services. In communities with 311 non-emergency call service (as of September 2008, about 18% of the US population had access to the 311 number[31]), this may serve as another means of diverting persons with mental health issues from law enforcement to treatment and other supportive services.

   Research indicates that mobile crisis teams are cost-effectively reducing the use of emergency medical services and arrest, and are perceived positively by consumers and law enforcement.[32] To ensure that the unique needs of youth with mental illness in crisis are addressed, communities should provide mobile crisis teams that specialize in child and adolescent crisis intervention. Optimally, mobile crisis teams should be available 24/7 so that law enforcement does not become the default responder simply because other crisis response resources are not available. In rural areas, cities or counties can form consortiums to support mobile crisis teams able to serve large geographic areas.

4. **School personnel, including administrators, teachers, counselors and school resource officers (SROs), should be trained and supported in identifying children and youth at risk of an emotional or mental health crisis and referring them and their families to appropriate mental health treatment and other services before they are actually in crisis.**

The earlier that someone with mental illness is properly assessed, and if necessary, receives appropriate treatment and support, including particularly peer support services, the more likely it is that a potential crisis can be avoided.

Community-Wide Collaboration Recommendations

Summit participants agreed that it is vital to expand and strengthen community partnerships to help ensure that people experiencing mental health crises are diverted to non-justice system options as often as possible. There was also consensus that collaborative working relationships must be tailored to local circumstances and priorities. Specific recommendations for strengthening collaboration across agencies and within local communities follow.

1. **Law enforcement agencies should take the lead in establishing local multidisciplinary advisory groups to focus on decriminalizing responses to persons with mental illness.**

   These multidisciplinary groups should engage a broad range of stakeholders, including representatives of the local justice system (the judiciary, prosecution, defense bar, community corrections and jail), mental health agencies, health care and supportive housing providers, adult and youth mental health consumers/survivors and their families, and advocacy organizations

[31] Dispatch Magazine Online. *http://www.911dispatch.com/info/311_page.html*

[32] Roger L. Scott. (2000) "Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction." Psychiatric Services. 51: 9.

such as the National Coalition of Mental Health Consumer/Survivor Organizations (NCMHCSO). Others who may be invited to participate in selected planning and policy-making efforts include local school districts, child welfare agencies, affordable housing providers, and state corrections agencies. This stakeholder team should develop shared goals and objectives and establish a common language that will facilitate open communication and information-sharing. The group should also clarify the roles that each agency represented on the team will play in strategies designed to resolve crisis situations with non-justice system responses/interventions.

2. **As part of developing shared goals, the local advisory group should establish performance measures that will be used to monitor progress in improving outcomes of responses to persons with mental illness.**

   By connecting its goals and strategies to expected outcomes and defining benchmarks or indicators of progress, advisory group members can establish a system of performance measurement that will enable continued fine-tuning of the partners' approaches and protocols. As part of this work, agencies should develop mechanisms for routinely collecting, analyzing and sharing information relevant to the agreed-upon performance measures. These measures could include the proportion of crisis situations involving persons with mental illness that result in arrest and booking into jail, and the cost per case for those resolved via non-justice system responses or interventions. Carefully documenting progress toward goals will not only inform the group and its community, but will also provide practice-based evidence upon which program providers can rely in their funding requests.

3. **A central goal of local advisory groups should be collaborative development of guidelines that will inform all law enforcement encounters with persons with mental illness who are in crisis.**

   Through sharing experience and perspectives with their community partners, law enforcement agencies will be able to develop best practice policies and decision tools that lead to better outcomes for their encounters with people with mental illness. Key partners in this work are health and mental health first responders, mental health consumers and their families, and mental health agencies that provide residential and outpatient treatment options.

4. **To ensure that appropriate resources are available to law enforcement officers and others responding to persons with mental illness, local advisory groups should maintain an up-to-date inventory of available resources and develop plans for addressing identified gaps in the continuum of options.**

   First responders need to have information about options available to them when they are called to intervene in situations involving persons with mental illness. By sharing information on available resources, including eligibility criteria and capacities, advisory team members can help ensure that first responders are knowledgeable about the continuum of justice and non-justice system alternatives they can utilize to de-escalate and resolve crisis situations. Based on the results of a systematic inventory, group members can also work together to plan, advocate for and implement services that are missing from or not adequately represented in the community's continuum of mental health care.

5. **Local advisory group members should collaborate to develop educational materials and strategies to inform consumers, families and community members about mental health issues and to engage them in efforts to ensure that there is a full range of services and supports available to people with mental illness.**

   Consumers, their families, and other community members should be informed about all options available to them in mental health crisis situations, so that law enforcement will be called only when

necessary and appropriate. Community-wide education can also help to reduce stigmatization and fear of persons with mental illness and increase their acceptance in mainstream culture. Informed citizens, mental health consumers and family members are among the most effective advocates for resources and for changes in laws and policies necessary to provide cost-effective services to persons with mental illness.

Community education efforts should utilize multiple methods and venues, including but not limited to public service announcements (PSAs), presentations to civic and faith-based groups, school-based programs, and community-based print and electronic media. Many law enforcement agencies have experience with community education that will be useful to the advisory group in designing and implementing local mental health public information initiatives.

6. **Local advisory groups should review training protocols for law enforcement and other agencies that serve persons with mental illness in crisis and make recommendations to improve training curricula and methods as needed.**

   A multidisciplinary group is well-positioned to recommend topics that should comprise a comprehensive training curriculum for law enforcement and other first responders. The group can also suggest techniques and approaches that will maximize positive impacts for all participants. Participating agencies can provide qualified trainers to work with consumer representatives to provide ongoing training opportunities. (See Justice System Decision Point Recommendations, Law Enforcement Crisis Intervention Strategies, Recommendation 4 for more detailed proposals regarding content and approaches.)

7. **Law enforcement executives and other agency leaders should support and encourage their middle management and line staff in developing mutually respectful working relationships with their peers in partner agencies.**

   In a crisis situation, the quality of relationships between those who are making decisions can affect the outcomes of those decisions for all involved. Cross-training has been shown to be an effective strategy for building trust and mutual understanding among professionals from different agencies. (See Justice System Decision Point Recommendations, Law Enforcement Crisis Intervention Strategies, Recommendation 6.)

8. **Protocols enabling agencies to share essential information about persons with mental illness who are in crisis should be established and maintained by the multidisciplinary advisory group.**

   Maintaining confidentiality of consumers' mental health records is an important priority for treatment agencies, and most state statutes require patients' written consent for clinicians to share information with others.[33] Local mental health advisory groups should develop internal protocols to obtain such consent as appropriate, and establish Memoranda of Understanding (MOUs) that define the types of information that can be shared, and when, how and with whom the information will be shared. Family members may also be able to provide information in the event of a crisis involving their loved one. One local advocacy group suggests preparing a crisis file of materials that can easily be shared with treatment or law enforcement professionals who respond to a call for service.[34] The central goal of information-sharing is to ensure that law enforcement officers and/or their crisis intervention partners have knowledge that can help them to avoid injury or death and achieve a positive resolution when responding to a crisis call for service.

[33] Council of State Governments Justice Center. (2002) *The Criminal Justice / Mental Health Consensus Project Report.* http://consensusproject.org/jc_publication

[34] See, for example, NAMI of Metropolitan Baltimore's publication *Beyond Punishment: Helping Individuals with Mental Illness in Maryland's Criminal Justice System. (2008)* http://www.nami.org/Content/Microsites82/NAMI_Metropolitan_Baltimore/Home78/Mental_Health_Crisis_and_Criminal_Justice_Resources1/BeyondPunishment-Version1.2LoResforwebsiteposting(2).pdf

Justice System Decision Point Recommendations

In the "sequential intercept" framework, the overarching goal is to filter out as many people with mental illness as early as possible in the sequence of intercepts (justice system decision points). In communities with limited mental health resources and little or no collaboration between justice and mental health systems, the "filters will be porous," but as collaboration and services are enhanced, filters "will become more finely meshed, and fewer individuals will move past each intercept point."[35] Recommendations developed by Summit participants are presented by key justice system decision points.

Law Enforcement Crisis Intervention Strategies

When law enforcement officers are called to intervene in a situation involving a person with mental illness who is in crisis, the outcome of their response depends upon many variables, including the officers' training and experience, the quality of information received from dispatchers prior to entering the scene, the ability to take the time needed to make assessments, their knowledge and understanding of the community to which they are responding, their access to mental health professionals' support as needed during the call, and the availability of non-justice system referral options. Many law enforcement agencies have been working with their community partners for a number of years to improve their agencies' responses to persons with mental illness. Because law enforcement officers have discretion to choose how to intervene in a crisis situation, it is essential that they be fully informed about available options and trained to select the one most likely to be effective in safely resolving each situation.

The following recommendations were developed by Summit working groups to guide law enforcement agencies interested in further enhancing the quality and results of their mental health crisis intervention responses. These strategies are founded on the community-wide collaboration approaches outlined earlier, and assume that most law enforcement agencies will choose to adopt and sustain some form of the Crisis Intervention Team (CIT) approach briefly described earlier in this report.

1. **Law enforcement leaders should work with their personnel to establish the goals of their encounters with persons with mental illness and to put in place mechanisms for recognizing officers and other staff with exemplary skills and documented results in achieving the stated goals.**

   Summit participants recommend that officers make the safety of all who are involved in or could be affected by the crisis situation their first priority. To de-escalate situations requires that officers communicate respectfully with persons with mental illness, practice active listening, and avoid stereotyping.

   Law enforcement agencies also should strive to increase the number of persons with mental illness that officers are able to divert to non-justice system options in lieu of arrest. Another overarching objective should be to minimize the trauma that can occur when people with mental illness encounter law enforcement officers.

   These and other goals can be translated into performance measures that law enforcement agencies can use to monitor their progress and fine-tune their approaches when responding to persons with mental illness.

2. **Law enforcement leaders should consider developing mental health crisis response resources within their agencies to assist CIT officers in responding to persons with mental illness.**

   A number of law enforcement agencies around the country have not only implemented CIT but also have augmented that approach with mental health professionals hired as staff members to provide on-site and telephone consultations to officers in the field. In a few communities, mental

[35] Munetz and Griffin. (2006). Op. cit.

health agencies have located some of their staff members in law enforcement facilities to provide these services. This approach can provide more immediate access to mental health consultation than can mobile crisis teams comprised of mental health staff that may not be available 24/7 and usually cannot respond to a call for service in less than 15 minutes.

3. **Law enforcement agencies should develop detailed policies directing officers to avoid use of restraint techniques or other control mechanisms unless they determine that these are the only means to ensure the safety of those involved in a mental health crisis situation.**

   Officers should be committed to using every possible means to verbally de-escalate crisis situations and calm persons with mental illness who are agitated before resorting to use of handcuffs or other physical restraints. Electronic control weapons should be even further along the continuum of methods used to control agitated individuals, and firearms are, of course, to be used only in life-threatening situations.

4. **Law enforcement agencies should carefully review their training curricula to ensure that they collectively cover all topics necessary to prepare officers to respond to and communicate effectively with persons with serious mental illness who are in crisis.**

   Essential topics to be covered by comprehensive CIT training include behaviors associated with current Diagnostic and Statistical Manual (DSM) IV categories of serious mental illness and developmental disabilities (e.g., autism spectrum disorders); issues unique to youth with mental illness; co-occurring disorders; psychotropic medications and their effects; de-escalation techniques; communicating effectively with consumers and family members; preventing unnecessary use of force; resources available in the local community for persons with mental illness; policies, procedures and decision-making tools for responding to mental health crisis situations; cultural sensitivity guidelines; and liability issues and concerns.

5. **Law enforcement executives should determine, with input from their community partners, whether all officers will be required to participate in comprehensive CIT training or whether it will be a voluntary program with some agreed-upon level of basic crisis intervention training required for all other officers.**

   Local law enforcement agencies should determine whether all line officers will be required to take comprehensive CIT training based on community needs and priorities and on the availability of crisis response capacity in the local mental health system. At a minimum, it is recommended that enough officers to cover all shifts and geographic service areas receive such training, and that sworn supervisory personnel also participate in this training. Optimally, all police personnel should receive basic training and periodic updates on mental health issues as part of academy, agency orientation, in-service and ongoing roll call trainings. Smaller, rural and tribal law enforcement agencies may find it advantageous to collaborate with nearby jurisdictions to obtain training for their personnel.

6. **Cross-training opportunities for mental health professionals and other stakeholders should be incorporated into law enforcement agencies' CIT training curricula.**

   Inviting mental health professionals and other crisis response partners (e.g., emergency service dispatchers, social workers, residential housing counselors, mental health and supportive housing case managers, nurses, emergency medical technicians, school resource officers, victim advocates, and advocates for persons with mental illness and their families) to participate in CIT training will nurture cross-system understanding, help develop a common language, and facilitate access to non-justice system options for persons with mental illness referred by law enforcement. It is also essential that people with the lived experience of mental health recovery who understand principles of self-determination and de-escalation be involved in designing and

delivering CIT training. Law enforcement agencies may choose to invite CIT training participants to join in ride-alongs to enhance their appreciation for the demands of police work and build personal rapport among crisis responders.

7. **Law enforcement leaders should ensure that emergency service dispatchers receive specialized training to familiarize them with local guidelines regarding the appropriate crisis resource to which each type of call for service involving a mental health crisis should be referred.**

   Dispatchers are quite often the first representatives of the justice system that the public contact when emergency assistance is required. They are vital gatekeepers who can help ensure that persons with mental illness in crisis are referred to sources of stabilization and care that will be optimal for their unique needs and circumstances. Initial training and ongoing consultation with mental health professionals is essential to help dispatchers discharge this vital responsibility. Law enforcement agencies should provide both dispatchers and officers with up-to-date listings of crisis resources to which persons in crisis can be referred.

8. **Law enforcement agencies should involve consumers of mental health services, their family members and advocates in planning, delivering and monitoring the impact of CIT and related training for officers and other crisis responders.**

   Those who have experienced mental illness and its impacts on individuals and families, and particularly those with the lived experience of mental health recovery, are in the best position to provide crisis responders with insight on communicating with people in crisis and de-escalating tense situations. They can also suggest consumer-driven resources that should be added to the list of potential referral options, and help to counter any stereotypes of mental illness with examples of successful recovery. Peer support specialists can also assist in providing training and consultation to CIT officers.

9. **The local advisory group should determine the capacity and accessibility of mental health resources available to law enforcement as alternatives to arrest for persons with mental illness and develop plans for building on system strengths and remedying any identified deficiencies.**

   Mental health resources that should be available for law enforcement as alternatives for persons with mental illness include mobile crisis teams (discussed previously), emergency psychiatric evaluation facilities, mental health crisis stabilization centers and respite care facilities (including peer-run respite centers). A number of communities have designated specific mental health facilities as 24/7 "drop-off" sites that guarantee there will be space for people with mental illness transported there by law enforcement. For individuals under the influence of alcohol or non-prescribed drugs, detoxification facilities may also be an appropriate placement. The collaborative relationships nurtured by the local advisory group should help agencies make the most of their collective resources and advocate for more options necessary to improve outcomes of responses to persons with mental illness who are in crisis.

10. **Law enforcement agencies should convene periodic after action reviews for all responders to calls for service involving persons with mental illness to identify successful approaches and learn from any missteps or oversights that might have occurred.**

    It is important to assess and fine-tune performance on a regular basis. Qualitative or experiential information is as important as quantitative data in analyzing outcomes and learning from mistakes and successes. Debriefings may also include family members of consumers and other community members who were present during the crisis, as well as persons with mental illness who are in recovery.

Post-Arrest Diversion Recommendations

After law enforcement officers opt to arrest persons with mental illness and charge them with criminal offenses, the role of law enforcement shifts to providing support and back-up to other justice agencies and their treatment partners. This section and the next suggest ways that law enforcement leaders and line staff can help to keep persons with mental illness from entering or returning to jails, prisons or juvenile detention/corrections facilities.

Post-arrest diversion options that prosecutors and the courts use to keep people with mental illness from progressing further into the justice system include deferred prosecution, deferred sentencing and mental health courts (which use a variety of diversion strategies). All of these diversion strategies use the leverage of the justice system to encourage persons with mental illness to voluntarily enter community-based treatment in lieu of sentencing to jail, prison or a juvenile facility. Research suggests that diversion reduces the amount of time persons with mental illness spend in confinement facilities without increasing risk to public safety. In the short run, diversion programs generally decrease justice system costs and increase mental health treatment expenditures for diverted individuals, who probably would not have received treatment had they not been placed in a diversion program. In the long run, however, overall public agency costs do not increase if diversion is successful in breaking the cycle of recidivism that characterizes many participants' criminal histories.

Law enforcement officers are a natural part of the community supervision team for individuals with mental illness diverted to community-based supervision and treatment programs. Guided by agreed-upon protocols, law enforcement officers can play an important role in helping to ensure that sanctions for violations of diversion conditions are immediate and predictable, thus increasing the likelihood that sanctions will be effective in influencing behavior. Recommendations outlining ways that law enforcement agencies can enhance the success of post-arrest diversion follow.

1. **Law enforcement leaders should support the development of a range of post-arrest diversion options that can help to break the cycle of recidivism in which too many persons with mental illness become enmeshed.**

   Through the local advisory group, law enforcement representatives should participate in the planning and ongoing monitoring of diversion options for persons with mental illness. As part of this process, law enforcement executives should work with their justice system and mental health agency partners to advocate for treatment and supportive resources necessary to effectively implement post-arrest diversion programs. Unless there are sufficient resources to serve all individuals with mental illness in a community, development of diversion options can have the unintended consequence of making it more difficult for non-participants to access treatment. This may occur either because scarce slots are filled by diversion program clients and/or because programs actively prefer to have clients who are more likely to be compliant because they are under justice system supervision.

2. **Law enforcement agencies should work with the prosecution, judiciary, and probation to clarify law enforcement's role regarding diverted individuals.**

The goal of diversion programs is to maintain persons with mental illness in the community and in treatment unless the person is dangerous to self or others or is suspected of committing a serious offense. Most programs allow for some degree of relapse tolerance and use of community-based sanctions rather than arrest and jailing for most instances of non-compliance. Law enforcement officers should be informed about program expectations so that they can help diversion programs and their clients achieve shared goals. With input from justice system partners, law enforcement agencies should establish protocols for officers to use in reporting non-compliant behaviors (e.g., intoxication) to diversion program officials. There also must be clear guidelines for officers about whether and how to respond to various levels of non-compliance, including a descriptive listing of individuals and program resources to which officers may refer diversion clients indicating which referral option is preferred for which types of non-compliance.

Reentry from Jail, Prison, or Juvenile Justice Facilities Recommendations

Reentry programs are designed to prepare inmates about to be released from jails, prisons or juvenile facilities for community life, and to support them in living law-abiding lives after release. Critical Time Intervention (CTI) is one reentry approach (in addition to the GAINS Center's APIC model discussed earlier) designed to assist persons with mental illness returning to their communities after incarceration or confinement in a secure treatment facility. CTI supports "vulnerable individuals through difficult transitions while also assuring that most basic human needs of shelter, companionship, sustenance, and a sense of purpose in life are also addressed."[36] CTI involves conducting pre-release needs assessments of inmates and engaging them with appropriate community mental health treatment providers, mental health peer-run programs, and other resources such as housing, employment and leisure activities. Another initiative, SSI/SSDI Outreach, Access and Recovery (SOAR) operates in 34 states to help homeless individuals and people returning to communities from jails, prisons and mental health facilities obtain federal SSI benefits to which they are entitled. The most recent outcome study documents that the SOAR approach expedites the application process and increases the approval rate significantly.[37]

For persons with mental illness, research suggests that effective reentry programs can reduce risk of homelessness, victimization, substance abuse and recidivism. Recommended ways that law enforcement agencies can support reentry efforts are summarized below.

1. **Law enforcement leaders should partner with their peers in corrections and detention facilities, community-based treatment and justice system agencies and community service providers to plan and implement reentry programs for all inmates returning to their communities.**

   In the absence of structured reentry programs, a high percentage of released inmates will be arrested for new offenses. A BJS study published in 2002 found that within three years of release 67.5% of state prisoners had been re-arrested and 51.8% were back in prison, half of them for technical violations of release conditions.[38] It is in law enforcement's best interests to support the development of effective reentry programs for all inmates, particularly those at highest risk of committing new offenses, i.e., those with mental illness or co-occurring disorders. The most effective reentry programs for these groups are person-centered, recovery-oriented, trauma-informed[39], risk-responsive and culturally competent.

2. **Reentry approaches for persons with mental illness should take into account their unique needs in order to maximize their likelihood of successful reintegration into community life.**

   Inmates with mental illness should be identified soon after they are incarcerated, if not before, so that appropriate treatment can be provided to them during their confinement. To ensure that persons with mental illness have access to Medicare, Medicaid and Social Security benefits immediately upon their release, the process of re-applying should begin while they are still incarcerated. Promising reentry strategies, such as CTI, and APIC should be implemented consistent with local needs and priorities.

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[36] Jeffrey Draine and Beth Angell. (2008) "Critical Time Intervention for Prison and Jail Reentry." Rutgers Center for Behavioral Health Services & Criminal Justice Research.

[37] For more information, see *http://www.prainc.com/soar*

[38] BJS Recidivism Study Overview. (2002) *http://www.cor.state.pa.us/stats/lib/stats/BJS%20Recidivism%20Study.pdf*

[39] See *http://mentalhealth.samhsa.gov/nctic/trauma.asp* for a wealth of information on trauma-informed care and trauma-specific interventions for persons with mental illness and substance abuse disorders.

3. **Law enforcement agencies should be involved in all stages of the reentry process, including prerelease assessment and service planning as well as ongoing monitoring of the releasees' progress toward full reintegration.**

   As part of the community team working with inmates while they are preparing for their reentry, law enforcement officers can offer their insights into community life and learn about the goals that reentry professionals have for returning inmates. Once releasees with mental illness are back in their communities, officers can help them to succeed by sharing with them information about community resources, protecting them from victimization and

   providing treatment professionals, peer support people and family members with early warning of observed problems so that crises can be prevented. When persons with mental illness involved in reentry programs experience crises, law enforcement officers can prevent these persons from re-entering the justice system by exercising discretion to divert them to non-justice options if at all possible. For additional resources on this topic, go to: http://www.theiacp.org/Portals/0/pdfs/Publications/CISOMResourceGuide.pdf

4. **Law enforcement leaders should encourage their communities to invest in providing the supportive resources necessary to ensure that persons with mental illness are reintegrated into the community in a manner that respects their dignity and assists them to become and remain stable, law-abiding and contributing citizens.**

   Just as at the federal level the Departments of Justice, Education, Health and Human Services, Housing and Urban Development and Labor work to coordinate their efforts to reintegrate released inmates, so too should local agencies collaborate to provide reentering persons with mental illness with housing, education and vocational assistance, health care, and substance abuse and mental health treatment. Working together, this coordinated effort

   can significantly reduce the risk of relapse and recidivism. Law enforcement agencies can be very effective advocates for strengthening collaboration and for allocating the resources necessary to implement effective reentry strategies.

Legislative, Funding, and Technical Assistance Support

Legislative and funding support is essential to the success of local efforts to build safer communities by enhancing police response to persons with mental illness. As discussed earlier in this report, communities must have adequate resources for treatment, housing and other supportive services so that law enforcement officers can help prevent criminalization of mental illness by diverting eligible individuals to these non-justice alternatives. Law enforcement and other justice system agencies also must have sufficient resources to expand and sustain their collaborative efforts to improve their crisis responses and decision-making about persons with mental illness.

Laws and policies that regulate access to Medicaid, Medicare and Social Security should be carefully crafted to ensure that persons with mental illness can readily access benefits to which they are entitled both before and after incarceration. Regulations that protect consumers' privacy and dignity of choice should also permit necessary and appropriate information-sharing across agencies when it can positively affect intervention outcomes. These and other policy issues should be addressed by Congress and state legislatures with assistance from national organizations with expertise in relevant areas.

There are many agencies and organizations currently engaged in national policy-making efforts in areas relevant to decriminalizing mental illness. Some are also funding pilot projects that test new ways of supporting the recovery of persons with mental illness. These include:

- **SAMHSA's GAINS Center:** Has a variety of research and practice initiatives focusing on persons with mental illness and co-occurring disorders
- **BJA, OJP:** The Second Chance Act authorized the Department of Justice to provide federal funding for reentry initiatives at the state and local levels
- **The Council of State Governments:** The Criminal Justice / Mental Health Consensus Project and the Reentry Policy Council
- **NCMHCSO:** Advocacy for consumer-driven, holistic treatment approaches, a variety of public information and training initiatives including certification in Emotional CPR designed to assist people through emotional crises
- **NAMI:** A variety of public information, advocacy and training initiatives around programs such as CIT, ATC and consumer-led support groups
- **National Federation of Families for Children's Mental Health:** Advocacy for family-driven care, youth-centered treatment approaches, and consumer involvement in planning, implementing and evaluating mental health treatment for children and youth
- **Office of Juvenile Justice and Delinquency Prevention:** Various initiatives and publications related to identifying youth with disabilities and mental health issues as early as possible and preventing their involvement with the juvenile justice system, as well as facilitating reentry of youth from detention and corrections facilities
- **National Association of Counties and BJA:** Transition Planning for Jail Inmates with Co-Occurring Substance Abuse and Mental Illness Disorders
- **National Institute of Corrections and Urban Institute:** Transition from Jail to Community and Transition from Prison to Community Technical Assistance Projects

While it is very encouraging that so many organizations are committed to this work, much more remains to be done.

The IACP and its national partners can best support the work of state, local and tribal law enforcement agencies and their many community partners through:

- Formulating, promoting and supporting model legislation, policies and training curricula
- Advocating for federal funding for pilot projects and evaluation research
- Offering technical assistance in planning, implementing and evaluating programs that can both enhance police response to persons with mental illness and improve communities' capacity to support them in avoiding criminal justice system involvement.

Recommendations for Legislative, Funding, and Technical Assistance Support

Summit participants developed several recommendations regarding the legislative, funding and technical assistance support necessary to accomplish the policy and program goals discussed earlier in this report.

1. **A coalition of national law enforcement, justice system, mental health system and advocacy organizations should develop and promote behavioral health legislation that can be integrated with the federal health care reforms currently being developed by Congress.**

   It is essential that national health care reform include provisions for behavioral health care that support the decriminalization of mental illness by providing access to appropriate community-based crisis intervention (including 24/7 crisis centers) and treatment for all persons with mental illness and those with co-occurring disorders.

2. **In partnership with BJA, SAMHSA and HUD, the IACP should identify funding streams and delineate best practices that can eliminate barriers to successful reentry for persons with mental illness and co-occurring disorders.**

   Barriers that can impede reintegration include limited availability of affordable housing and transportation as well as lack of access to public benefits, health and mental health care, substance abuse treatment, educational opportunities and vocational assistance.

3. **Congress and executive branch agencies responsible for administering Medicaid, Medicare and Social Security benefits should modify laws, policies and procedures as needed to ensure that these benefits can be easily restored to individuals reentering communities from jails, prisons or juvenile detention/corrections facilities.**

   Persons with mental illness and co-occurring disorders are particularly vulnerable to relapse and recidivism upon release from incarceration if they are unable to obtain benefits to which they are entitled. Current application and re-application processes can be dauntingly complex for individuals who are already overwhelmed with the demands of transition from confinement to community life.

4. **The IACP should collaborate with BJA to encourage changes in HUD and other public housing regulations to permit ex-offenders with mental illness to reside in public housing.**

   To ensure that reentering inmates with serious mental illness do not become homeless and thus at greater risk of relapse and recidivism, it is essential to reconsider regulations that prevent them, as ex-offenders, from being housed in publicly-funded projects. It is also important to adjust definitions of "chronic homelessness" to include those who were homeless prior to incarceration, so that individuals do not lose eligibility for certain funding streams simply because of their temporary confinement in jail, prison or a juvenile facility.

5. **The IACP should join with SAMHSA and HUD to encourage expansion of Housing First options for persons with mental illness who are diverted from or returning after incarceration in justice system facilities.**

   The Housing First approach has proven to be successful in "promoting housing stability and other positive outcomes" for persons with serious mental illness and co-occurring substance

disorders. Housing First elements that lead to these positive outcomes include the lack of prerequisites (sobriety or treatment participation), availability of supportive services that use client-driven approaches, and the capacity to access a variety of funding streams to sustain supportive interventions. [40]

6. **The IACP, with input from relevant stakeholders, should update its model policy on police response to children, youth and adults with mental illness to reflect the current consensus on best practices.**

   NAMI, NFFCMH and NCMHCSO should collaborate with the IACP and other partners to review the IACP's current policy and suggest revisions that will make it more useful to law enforcement and partner agencies working to enhance responses to people with mental illness.

7. **The IACP and its partners, including consumers, family members and advocates, should develop recommendations to Congress and regulatory authorities, possibly including revisions of HIPAA rules, which will facilitate sharing information about persons with mental illness in crisis situations.**

   The importance of preserving client confidentiality must be weighed against crisis responders' need for background information about persons with mental illness who are in need of assistance. Clarifying the types of information that can be shared with crisis responders under what circumstances is an important and necessary refinement of confidentiality and information-sharing protocols.

8. **The IACP should work with CALEA to establish a model curriculum that law enforcement agencies can use in implementing, expanding or maintaining CIT programs.**

   There are many good examples of CIT curricula that have been developed and used by law enforcement agencies across the country. It is time to build on the experience of these agencies to create a model curriculum that can be adapted and used by a wide variety of agencies at the state, local and tribal levels. The curriculum should also tap other sources, such as the NCMHCSO's Emotional CPR (eCPR) curriculum, to enrich the model. This curriculum should be both comprehensive and flexible so that it can support a range of training opportunities from 40-hour academy training engagements to in-service updates and roll call briefings.

9. **The IACP should collaborate with BJA and SAMHSA to develop public information strategies that will counteract negative stereotypes of persons with mental illness and highlight the importance of decriminalizing mental illness.**

   Improving the outcomes of law enforcement responses to persons with mental illness depends in large part upon the extent to which communities are willing and able to support the requisite policies and programs. People who understand the challenges faced by those who are mentally ill and appreciate the contributions that they can make to community life are more likely to support mental health treatment and other essential community services with their taxes and their advocacy.

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[40] Carol L. Pearson, Gretchen Locke, Ann Elizabeth Montgomery and Larry Buron. (2007) **The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness: Final Report.** Department of Housing and Urban Development. *http://www.huduser.org/Publications/pdf/hsgfirst.pdf*

Law Enforcement Action Agenda

This section highlights recommendations that law enforcement leaders, supervisors and line staff can translate into actions that will enhance their agencies' response to persons with mental illness. Rationales and suggested approaches are described in greater detail in the body of this report.

1. **Law enforcement executives should work with other community leaders to ensure that community mental health service systems are adequate and accessible to people in need.**

2. **Law enforcement agencies should take the lead in establishing local multidisciplinary advisory groups to focus on decriminalizing responses to persons with mental illness.**

3. **Local multidisciplinary advisory groups should develop policies and protocols for emergency dispatchers that encourage referring calls for service involving persons with mental illness who are not suspected of criminal conduct or dangerous to self or others to mobile crisis teams rather than to law enforcement.**

4. **A central goal of local advisory groups should be collaborative development of guidelines that will inform all law enforcement encounters with persons with mental illness who are in crisis.**

5. **To ensure that appropriate resources are available to law enforcement officers and others responding to persons with mental illness, local advisory groups should maintain an up-to-date inventory of available resources and develop plans for addressing identified gaps in the continuum of options.**

6. **Local advisory groups should review training protocols for law enforcement and other agencies that serve persons with mental illness in crisis and make recommendations to improve training curricula and methods as needed.**

7. **Law enforcement executives should support and encourage their middle management and line staff in developing mutually respectful working relationships with their peers in partner agencies.**

8. **Protocols enabling agencies to share essential information about persons with mental illness who are in crisis should be established and maintained by the multidisciplinary advisory group.**

9. **Law enforcement leaders should work with their personnel to establish the goals of their encounters with persons with mental illness and to put in place mechanisms for recognizing officers and other staff with exemplary skills and documented results in achieving the stated goals.**

10. **Law enforcement leaders should consider developing mental health crisis response resources within their agencies to assist CIT officers in responding to persons with mental illness.**

11. **Law enforcement agencies should develop detailed policies directing officers to avoid use of restraint techniques or deadly force unless they determine that these are the only means to ensure the safety of those involved in a mental health crisis situation.**

12. **Law enforcement agencies should carefully review their training curricula to ensure that they collectively cover all topics necessary to prepare officers to respond to and communicate effectively with persons with serious mental illness who are in crisis.**

13. Law enforcement executives should determine, with input from their community partners, whether all officers will be required to participate in comprehensive CIT training or whether it will be a voluntary program with some agreed-upon level of basic crisis intervention training required for all other officers.

14. Cross-training opportunities for mental health professionals, family members of consumers and other stakeholders should be incorporated into law enforcement agencies' CIT training curricula.

15. Law enforcement leaders should ensure that emergency service dispatchers serving their agencies receive specialized training to familiarize them with local guidelines regarding the appropriate crisis resource to which each type of call for service involving a mental health crisis should be referred.

16. Law enforcement agencies should involve consumers of mental health services, including youth and their family members and advocates in planning, delivering and monitoring the impact of CIT and related training for officers and other crisis responders.

17. The local advisory group should determine the capacity and accessibility of mental health resources available to law enforcement as alternatives to arrest for persons with mental illness and develop plans for building on system strengths and remedying any identified deficiencies.

18. Law enforcement agencies should convene periodic debriefings for all responders to calls for service involving persons with mental illness to identify successful approaches and learn from any missteps or oversights that might have occurred.

19. Law enforcement leaders should support the development of a range of post-arrest diversion options that can help to break the cycle of recidivism in which too many persons with serious mental illness become enmeshed.

20. Law enforcement agencies should work with the prosecution, judiciary, and probation to clarify law enforcement's role regarding diverted individuals.

21. Law enforcement leaders should partner with their peers in corrections and detention facilities, community-based treatment and justice system agencies and community service providers to plan and implement reentry programs for all inmates returning to their communities.

22. Law enforcement agencies should be involved in all stages of the reentry process, including prerelease assessment and service planning as well as ongoing monitoring of releasees' progress toward full reintegration.

23. Law enforcement leaders should encourage their communities to invest in providing the supportive resources necessary to ensure that persons with mental illness can become and remain stable, law-abiding and contributing citizens.

Glossary of Terms

The IACP has compiled this list of terms and acronyms from law enforcement, consumer, and youth perspectives. This glossary is not intended to be comprehensive or exhaustive, but rather to foster a shared language that can be used by all who are concerned with improving police responses to persons with mental illness.

72 Hour Evaluation – If it is determined that an individual is a danger to themselves or others a law enforcement officer can transport the person to an appropriate facility to be held up to 72 hours for an evaluation by mental health professionals.

BJA – The Bureau of Justice Assistance of the U.S. Department of Justice.

Board and Care Facility – Independently operated temporary housing available to people with mental illness and/or those recovering from substance abuse.

CIT/CRT – Crisis Intervention Teams (also known as Crisis Response Teams) are based on community partnerships between a police department, local mental health providers, mental health consumers, and family members. CIT/CRT officers receive specialized training in how to calmly and safely approach mental health crisis events.

Consumer or Mental Health Consumer – A person who has used or is currently using mental health services. It generally means that the person has had a significant period when they were unable to fulfill their major life role (e.g., worker, student, and/or parent) and experienced severe emotional distress.

Crisis Plan – Plans for providing assistance and support during a crisis.

DSM – The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, describes the symptoms, causes and prognoses of known mental disorders.

Dual Diagnosis – When an individual is diagnosed with a mental illness as well as addiction to alcohol and/or street or prescription drugs.

EPU – An Emergency Psychiatric Unit is the most likely location that law enforcement can take an individual in mental health crisis for a 72 hour evaluation.

Evidence-Based Treatment – Treatment for mental illness deemed effective through clinical research methods. Exact criteria for what is considered "evidence-based" varies across states and agencies.

NFFCMH – National Federation of Families for Children's Mental Health.

Family Member – A person who is raising or has raised a child with a mental, emotional, or behavioral disorder.

IACP – The International Association of Chiefs of Police

IEP – Individualized Education Plans are governed by federal legislation. They are individual plans tailored to the needs and unique challenges of students with disabilities.

NAMI – National Alliance on Mental Illness

Peer-Run Respite – A peer-run alternative to hospitalization based on the principles of recovery and self-determination. On average respite services cost 25% less than psychiatric hospitalization.

Peer Support – Individuals helping one another to achieve their own goals. Peer supporters, whether volunteer or paid, assist and encourage people to define what they want in life and help them learn to advocate for themselves. Peer supporters also function as role models, demonstrating that it is possible for people with mental illness to live fuller and more satisfying lives.

Person First Language – A person should not be solely defined or labeled either by their abilities or disabilities. Person first language is the respectful way to address people with disabilities, mental illness, or who are involved in a crisis situation. For example, "people with mental illness" is more appropriate than the generalized label "the mentally ill".

SAMHSA – The Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services.

Self Medication – Using alcohol and/or narcotics (prescription or non-prescription) in an attempt to mitigate the symptoms of mental illness or feelings of emotional crisis.

Serious Emotional Disorder (SED) – Mental illness or mental, emotional, and behavioral disorders. Similar terms are used for mental health issues as they relate to children and youth (e.g. "seriously emotionally disturbed"). While SED is a term that is controversial among consumers and family members, it is the term used in the Federal Registry and many federal funding opportunities.

Severe Emotional Distress – A temporary emotional state or distress that no reasonable person is expected to endure and typically caused by a traumatic event that a person is either experiencing in the present moment or re-experiencing internally.

Wraparound – A team approach by mental health professionals and family members that is focused on identifying and enhancing the natural, informal support systems of children, youth and adults with mental illness to help them avoid or address crises and remain in their home communities.

Youth/Juvenile – In mental health systems, youth are most commonly defined as persons under 14 years of age, though this differs somewhat among advocacy organizations and public agencies. Each state determines sentencing rules for juveniles and it varies. In the majority of states, the juvenile court can retain jurisdiction over individuals who are convicted and sentenced as juveniles until age 20, and even up to age 24 in some states. In other states, juveniles at age 15 can be sentenced in adult court, depending on offense.

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Building Safer Communities:
Police Response to Persons with Mental Illness
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May 7-8, 2009

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The International Association of Chiefs of Police

The International Association of Chiefs of Police is the world's oldest and largest nonprofit membership organization of police executives, with over 20,000 members in over 100 different countries. IACP's leadership consists of the operating chief executives of international, federal, state and local agencies of all sizes.

Founded in 1893, the association's goals are to advance the science and art of police services; to develop and disseminate improved administrative, technical and operational practices and promote their use in police work; to foster police cooperation and the exchange of information and experience among police administrators throughout the world; to bring about recruitment and training in the police profession of qualified persons; and to encourage adherence of all police officers to high professional standards of performance and conduct.

Since 1893, the International Association of Chiefs of Police has been serving the needs of the law enforcement community. Throughout the past 114 years, we have been launching historically acclaimed programs, conducting ground-breaking research and providing exemplary programs and services to our membership across the globe.

Professionally recognized programs such as the FBI Identification Division and the Uniform Crime Records system can trace their origins back to the IACP. In fact, the IACP has been instrumental in forwarding breakthrough technologies and philosophies from the early years of our establishment to the present. From spearheading national use of fingerprint identification to partnering in a consortium on community policing to gathering top experts in criminal justice, the government and education for summits on violence, homicide, and youth violence, IACP has realized our responsibility to positively effect the goals of law enforcement.

Even with such an esteemed history, we are continually initiating programs to address the needs of today's law enforcement professionals. Our members have let us know that they consider IACP to be a progressive organization, successfully advancing the law enforcement profession.

If you would like additional information about the IACP, please contact IACP Headquarters at 1-800-THE-IACP (1-800-843-4227) or visit our website at www.theiacp.org

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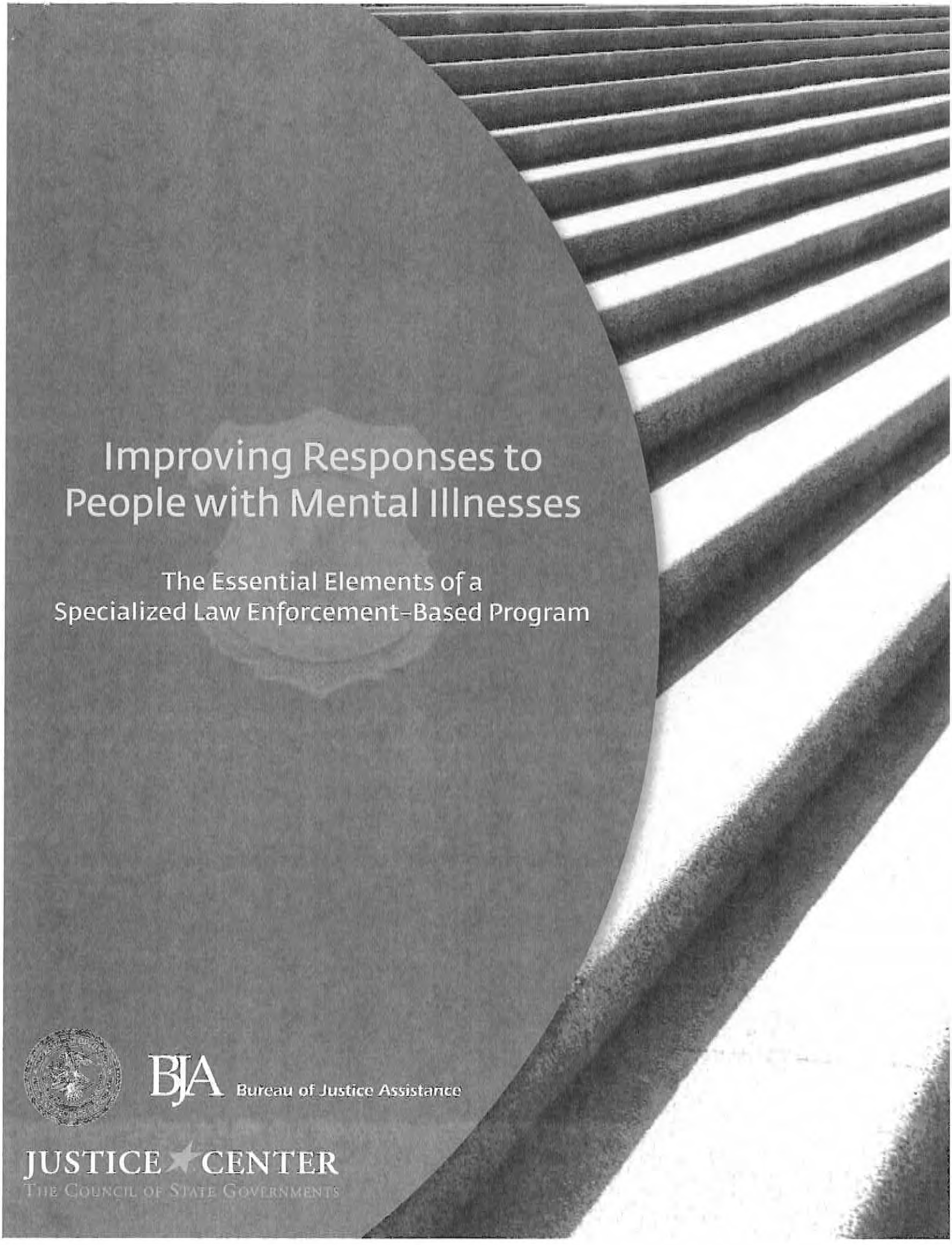

Improving Responses to People with Mental Illnesses

The Essential Elements of a Specialized Law Enforcement–Based Program

BJA Bureau of Justice Assistance

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

Improving Responses to People with Mental Illnesses

The Essential Elements of a Specialized Law Enforcement–Based Program

A report prepared by the
Council of State Governments Justice Center
in partnership with the Police Executive Research Forum

for the

Bureau of Justice Assistance
Office of Justice Programs
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JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

POLICE EXECUTIVE RESEARCH FORUM

BJA Bureau of Justice Assistance

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This report follows and builds on the format and scope of *The Essential Elements of a Mental Health Court*, published in 2008 with the support of BJA (available at www.consensusproject.org/mhcp/essential.elements.pdf). A similar document describing the elements of programs that bring together the corrections and mental health systems is in production at this writing and will be made available at www.consensusproject.org.

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Contents

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Thanks are also due to members of a project advisory group, listed alphabetically below.[1] A subset of the group (indicated by an asterisk) met in October 2005 and February 2006 to review earlier drafts of this document, and the entire advisory group convened in September 2006 to provide their insights on a more recent version of the document.

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Introduction

Law enforcement officers throughout the country regularly respond to calls for service that involve people with mental illnesses—often without needed supports, resources, or specialized training.[2] These encounters can have significant consequences for the officers, people with mental illnesses and their loved ones, the community, and the criminal justice system.[3] Although these encounters may constitute a relatively small number of an agency's total calls for service, they are among the most complex and time-consuming calls officers must address.[4] At these scenes, front-line officers must stabilize a potentially volatile situation, determine whether the person poses a danger to him- or herself or others, and effect an appropriate disposition that may require a wide range of community supports.

In the interests of safety and justice, officers typically take approximately 30 percent of people with mental illnesses they encounter into custody—for transport to either an emergency room, a mental health facility, or jail.[5] Officers resolve the remaining incidents informally, often only able to provide a short-term solution to a person's long-term needs. As a consequence, many law enforcement personnel respond to the same group of people with mental illnesses and the same locations repeatedly, straining limited resources and fostering a collective sense of frustration at the inability to prevent future encounters.[6]

In response, jurisdictions across the country are exploring strategies to improve the outcomes of these encounters and to provide a compassionate response that prioritizes treatment over incarceration when appropriate. These efforts took root in the late 1980s, when the crisis intervention team (CIT) and law enforcement–mental health co-response models, described in more detail below, first emerged. Since that time, hundreds of communities have implemented these programs; some have replicated the models, and others have adapted features to meet their jurisdiction's unique needs. Although this number represents only a small fraction of all U.S. communities, there are many indications that the level of interest in criminal justice–mental health collaborative initiatives is surging.[7]

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2. For the purposes of this document, "officer" refers to any law enforcement personnel with direct contact with the community; this includes sheriffs' deputies, state troopers, and other individuals with arrest powers.
3. The nation's prisons and jails hold unprecedented numbers of people with mental illnesses—many of whom came into contact with law enforcement as a result of behaviors related to their illness. For example, in 1999 the Los Angeles County Jail and New York's Rikers Island jail each held more people with mental illnesses than any psychiatric inpatient facility in the United States. The most recent data from the Bureau of Justice Statistics, U.S. Department of Justice, reveals that more than half of all prison and jail inmates reported that they had any one of a number of mental health symptoms. E. Fuller Torrey, "Reinventing Mental Health Care," *City Journal* 9 (1999):4; Doris J. James and Laura E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, U.S. Department of Justice, Bureau of Justice Statistics, NCJ-213600 (Washington, D.C.: Bureau of Justice Statistics, 2006).
4. Recent data indicate that behaviors that appear to be the result of a mental illness are a factor in approximately 3–7 percent of all law enforcement calls for service. See Martha W. Deane, Henry J. Steadman, Randy Borum, Bonita M. Veysey, and Joseph P. Morrissey, "Emerging Partnerships between Mental Health and Law Enforcement," *Psychiatric Services* 50 (1) (1999): 99–101; Lodestar, *Los Angeles Police Department Consent Decree Mental Illness Project Final Report* (Los Angeles: Lodestar, 2002); Jennifer L.S. Teller, Mark R. Munetz, Karen M. Gil, and Christian Ritter, "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls," *Psychiatric Services* 57 (2006): 232–37; William Terrill and Stephen Mastrofski, "Situational and Officer-Based Determinants of Police Coercion," *Justice Quarterly* 19 (2002): 215–48.
5. Linda Teplin, "Managing Disorder: Police Handling of the Mentally Ill," In *Mental Health and the Criminal Justice System*, ed. Linda Teplin. (Beverly Hills, CA: Sage Publications, 1984); Thomas M. Green, "Police as Frontline Mental Health Workers: The Decision to Arrest or Refer to Mental Health Agencies," *International Journal of Law and Psychiatry* 20 (1997): 469–86; Jennifer L.S. Teller, Mark R. Munetz, Karen M. Gil, and Christian Ritter, "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls," *Psychiatric Services* 57 (2006): 232–37.
6. Thomas M. Green, "Police as Frontline Mental Health Workers: The Decision to Arrest or Refer to Mental Health Agencies," *International Journal of Law and Psychiatry* 20 (1997): 469–86; Gary Cordner, "People with Mental Illness," *Problem-Oriented Guides for Police Problem-Specific Guides Series*, 40, U.S. Department of Justice (Washington, D.C.: Office of Community Oriented Policing Services, 2006).
7. Federal interest in criminal justice–mental health initiatives is perhaps best illustrated by the broad bipartisan support for the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA) and its subsequent appropriations. MIOTCRA facilitates collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems in diverting individuals to treatment when appropriate. Among its allowable uses, MIOTCRA funds can support law enforcement training. For more information on MIOTCRA, see www.consensusproject.org/resources/government-affairs/fed-leg-MIOTCRA.

Specialized Law Enforcement–Based Response Programs

This document focuses on specialized law enforcement–based response programs that meet three criteria: (1) they enhance traditional law enforcement roles to provide a new set of response options for frontline personnel that are tailored to the needs of people with mental illnesses; (2) when appropriate, they establish a link for these individuals to services in the community; and (3) they are based in law enforcement agencies with strong collaborative ties to mental health partners, other criminal justice agencies, and community members.[8]

Specialized law enforcement–based response programs include both the CIT and law enforcement–mental health co-responder models.

- The CIT model originated in the Memphis (Tenn.) Police Department and is therefore often called the Memphis Model. It was developed in response to a tragic incident in which a law enforcement officer used lethal force against a person with a mental illness. This model is designed to de-escalate tensions at the scene and to reduce the need for use of force during these types of encounters. To improve the likelihood of a safe and effective outcome, the CIT model includes training and deployment of self-selected officers to provide a first-response to the majority of incidents involving people with mental illnesses.
- The co-responder model was developed in Los Angeles County and implemented soon after in San Diego (Calif.). Leaders in those jurisdictions were concerned that they were unable to link people with mental illnesses to appropriate services or provide other effective and efficient responses. They identified limitations on officers' time and lack of awareness about both community mental health resources and the characteristics of individuals who need access to those services as major obstacles. They then developed an approach that pairs specially trained officers with mental health professionals to provide a joint secondary response to the scene.

About the Elements

As the growing number of interested communities grapple with implementing specialized law enforcement–based programs at the local level, there is a commensurate demand for more information on the key elements of promising programs. Several communities have tried to identify critical program elements, particularly for CIT initiatives, to promote consistency and quality.[9] Until this BJA-supported effort, however, there had been limited debate or agreement at the national level about which elements were essential to successfully implement any specialized law enforcement–based response program—regardless of the specific model.

This report articulates 10 essential elements for *any* specialized law enforcement–based response program. The elements are derived from recommendations made by a broad range of practitioners and other related experts to ensure they are practical and valuable (see the "Document Development" section, p. ix). They provide practitioners and policymakers with a common framework for program design and implementation that will promote positive outcomes while being sensitive to every jurisdiction's distinct needs and resources. Each element contains a short

8. Many communities also have developed teams of community mental health professionals, such as mobile crisis or assertive community treatment teams, to assist officers at the scene. While these models are undoubtedly a valuable resource for many communities and departments, they are not law enforcement–based and thus are not within the scope of this document. For further discussion of how law enforcement have collaborated with mental health mobile crisis teams, see www.uc.edu/criminaljustice/ProjectReports/MCT_Report.pdf. For more on how mental health agencies have tailored assertive community treatment teams to work with a justice-involved population, see www.gainscenter.samhsa.gov/text/ebp/Papers/ExtendingACTPaper.asp.

9. Most notably, promoters of the CIT model have recently formed a national group, the CIT National Organization (www.cit.memphis.edu/cno.html), to provide leadership and guidance to jurisdictions implementing CIT programs. Several members of the CIT National Organization also serve on the advisory board that has guided the development of this publication, to ensure complementary products. The National CIT Organization's guide describes critical elements of the CIT model using three categories: operational, ongoing, and sustaining elements. A draft of the guide is available at www.cit.memphis.edu/~cjus/dw.php?id=cjuscitdw01. In contrast, this document provides a framework for developing or enhancing elements of a specialized law enforcement–based response of *any* type.

statement (in italics) describing criteria that specialized law enforcement–based response programs should meet to be effective, followed by several paragraphs explaining the element's importance and how its principles can be achieved.

The document reflects two key assumptions: First, each element depends on meaningful collaboration among professionals in the criminal justice and mental health systems. Although achieving the requisite level of collaboration is often difficult—particularly when faced with long-standing system barriers—successful partnerships are needed to carry out any of the elements. Second, law enforcement represents only the first of several criminal justice agencies with which people with mental illnesses may come in contact. Addressing problems raised by the large numbers of people with mental illnesses in the criminal justice system requires a comprehensive community- and systemwide strategy in which the law enforcement–based program plays only one part. The impact of a specialized law enforcement–based response program on jails, courts, the community-based mental health system, and the larger community must therefore be considered when planning and implementing the program.

The elements are meant to help guide individuals in communities that are interested in developing a law enforcement–based program or improving the organization and functions of an existing program. This document can be used as a practical planning tool for a specialized response at each stage of the process (e.g., designing the program, developing or enhancing policies and procedures, monitoring practices, and conducting evaluations). This report is meant to be a "living, breathing document" and thus will be updated or supplemented as specialized law enforcment–based programs mature, and to address new research studies that can provide a stronger base of knowledge about how these programs can best operate, their impact on the community and various affected systems, and the relative importance of the elements that form them.[10]

Document Development and Related Materials

The essential elements are based on information from a variety of sources, including interviews with law enforcement executives and officers, mental health professionals, advocates, and mental health consumers who have been engaged in these programs for many years, as well as a review of the scholarly literature. A panel of national experts guided early drafts of this document. It was then posted on a Web-based discussion forum through which hundreds of stakeholders reviewed it and provided feedback.[11] An advisory group of leading executives, practitioners, researchers, and other experts subsequently reviewed and discussed the comments and suggested revisions.

The Bureau of Justice Assistance (BJA), U.S. Department of Justice, is developing a series of resources for law enforcement practitioners and their community partners as part of BJA's Law Enforcement/Mental Health Partnership Program. This report serves as the centerpiece of this series. The *Improving Responses to People with Mental Illnesses* series includes a collection of resources that will complement the essential elements: a practical handbook on implementing effective training strategies; a monograph on tailoring law enforcement responses to the unique needs of the jurisdiction, which will include specific examples from the field; and Web-based information on statewide efforts to coordinate these law enforcement responses. Also available is an online database, the Criminal Justice/Mental Health Information Network, which includes profiles of local law enforcement responses to people with mental illnesses. This project is coordinated by the Council of State Governments Justice Center in partnership with the Police Executive Research Forum.

10. Updates to this document will be available at www.consensusproject.org/issue-areas/law-enforcement.
11. Throughout this document, the term "stakeholders" is used to describe the diverse group of individuals affected by law enforcement encounters with people with mental illnesses, such as criminal justice and mental health professionals; myriad other service providers, including substance abuse counselors and housing professionals; people with mental illnesses (sometimes referred to as "consumers") and their loved ones; crime victims; and other community representatives.

Ten Essential Elements

1 Collaborative Planning and Implementation

Organizations and individuals representing a wide range of disciplines and perspectives and with a strong interest in improving law enforcement encounters with people with mental illnesses work together in one or more groups to determine the response program's characteristics and guide implementation efforts.

Specialized responses to people with mental illnesses are an outgrowth of community policing and as such should reflect a partnership between a law enforcement agency and other stakeholder groups and individuals. Partners for the lead law enforcement agency should include mental health service providers, people with mental illnesses and their family members and loved ones, and mental health advocates. Based on the nature of the problem, additional partners could include other area law enforcement professionals; health and substance abuse treatment providers; housing officials and other service providers; hospital and emergency room administrators; crime victims; other criminal justice personnel such as prosecutors and jail administrators; elected officials; state, local, and private funders; and community representatives. Any stakeholder may initiate the planning for the specialized response, but to take root, the lead law enforcement agency must fully embrace the effort.

At the outset of the planning process, leaders from each of the stakeholder agencies who have operational decision-making authority and community representatives should come together as a multidisciplinary *planning committee*. This executive-level committee should examine the nature of the problem and help determine the program's objectives and design (see Element 2, Program Design), taking into consideration how the committee will relate to other criminal justice–mental health boards that may be in place or are in the process of being established. The planning committee also should provide a forum for developing grant applications and working with local and state officials. Although focused primarily on planning decisions, members should remain engaged during the implementation phase to provide ongoing leadership and support problem solving and design modifications throughout the life of the program.

Agency leaders on the planning committee also should designate appropriate staff to make up a *program coordination group* responsible for overseeing day-to-day activities. (In some jurisdictions, the two bodies may be the same—particularly those with small agencies, in rural areas, or with limited resources.) This coordination group should oversee officer training, measure the program's progress toward achieving stated goals, and resolve ongoing challenges to program effectiveness. The group also should serve to keep agency leaders and other policymakers informed of program costs, developments, and progress. Both groups' members should reflect the community's demographic composition.

To overcome challenges inherent in multidisciplinary collaboration, including staff turnover and changes in leadership, partnership and program policies should be institutionalized to the extent possible. Interagency memoranda of understanding (MOUs) can be developed to address key issues such as how each organization will commit resources and what information can be shared through identified mechanisms.

Program Design

The planning committee designs a specialized law enforcement–based program to address the root causes of the problems that are impeding improved responses to people with mental illnesses and makes the most of available resources.

As a critical first step in the design process, the planning committee should develop a detailed understanding of the problems in its jurisdiction and identify all contributing factors. In this analysis, it is important to understand the driving force(s) behind current efforts to improve the law enforcement response. In some jurisdictions, law enforcement executives may become aware of the problem because of a tragic incident. In others, executives may realize there are operational challenges presented by particularly complex field encounters, such as the inordinate amount of time officers spend waiting for medical clearance in emergency rooms or the frequency with which officers repeatedly come in contact with the same individuals without an effective resolution.

The committee must examine the reasons why these incidents occur and other aspects of the problem that may not have been raised by the single high-profile incident. It should look at law enforcement data on calls for service, beat boundaries, feedback from officers, community survey data, and other sources of information. To enhance their understanding of root causes and available resources, committee members also should examine factors such as the community's inpatient and outpatient treatment options, crisis response services, ancillary services such as housing and substance abuse treatment, population, and geography. They also may want to talk to people in other jurisdictions who have grappled with limited community resources to see what alternatives are available to increase the reach of existing services.

The analysis of the problems and assessment of available and potential resources to address them should drive the short- and long-term goals of the program. For example, if the analysis reveals that a significant barrier to improving the law enforcement response is that officers lack the training to safely de-escalate situations involving people with mental illnesses, one program goal would be to correct this deficiency. If officers cannot efficiently link people to mental health treatments, another goal may be to revise and streamline processes for connecting to these services.

Once the program's purpose is defined, the committee must address personnel assignments and related considerations. The planning committee must decide whether some or all officers should be trained to stabilize and de-escalate situations involving people with mental illnesses in immediate response to the call for service. Should all officers receive some baseline training and others receive more extensive training? Should a subset of officers be trained to respond with a mental health professional? When considering the answers to questions like these, the committee should explore the practical implications of different staffing options and present them to the chief law enforcement executive or his or her designee on the committee. The committee also must help interpret the criteria for emergency mental health evaluation and decide how officers will access that service. These decisions will help the committee determine which additional skills and information the identified group of responders should receive in training.

If committee members, including representatives from policing, conclude that a subset of officers will respond to incidents involving people with mental illnesses, they should help the law enforcement executive determine how many officers are needed to cover all shifts and geographic districts. The committee also should develop personnel selection criteria and a process for identifying officers best suited for the challenges of this new role. In particular, planners should consider officers' ability to reorient from the more traditional method of gaining control by using an authoritative approach during a field contact to a nonadversarial, crisis-intervention style. To the extent possible, the selection process should be voluntary, yet selective.

Specialized Training

All law enforcement personnel who respond to incidents in which an individual's mental illness appears to be a factor receive training to prepare for these encounters; those in specialized assignments receive more comprehensive training. Dispatchers, call takers, and other individuals in a support role receive training tailored to their needs.

Training must be provided to improve officers' responses to people with mental illnesses. Agencies may differ in the amount of training they offer: some will provide comprehensive training to all officers, some will provide this training only to a subset, and some will provide basic training to everyone in combination with more comprehensive training to a subset. At a minimum, a group of officers sufficient to cover all time shifts and geographic districts should receive extensive skills and knowledge training that builds on the more cursory information routinely given on this topic at recruit and in-service trainings.[12] The chief law enforcement executive should ensure that training is also provided to supervisory and support personnel, such as midlevel managers, field training officers, call takers, and dispatchers, who advance the specialized program's operations.

Planning and implementing a training initiative that supports the specialized program should be a collaborative effort between the law enforcement agency and stakeholders represented on the program coordination group. The coordination group should help guide training decisions, which include selecting content and techniques, ensuring the instruction is culturally competent, identifying and preparing trainers, and evaluating effectiveness. The group's multidisciplinary/multisystem composition helps make certain that the training initiative reflects an appropriate range of perspectives; members can identify mental health practitioners, consumers, and family members to provide some of the training instruction. Likewise, the group helps ensure quality by establishing a process for consistently reviewing and evaluating training and then modifying the curriculum based on the findings. The group can be particularly helpful in identifying resources to defray law enforcement agency costs.

Specialized training should, at a minimum, provide officers with an improved understanding of the following: mental illnesses and their impact on individuals, families, and communities; signs and symptoms of mental illnesses; stabilization and de-escalation techniques; disposition options; community resources; and legal issues. Trainers should provide sufficient opportunities for hands-on experiential learning, such as role play and group problem-solving exercises.

Training should address issues specific to the community in which it is being given. Mental health personnel and other stakeholders should be invited to participate in the specialized training to help improve cross-system understanding of agencies' roles and responsibilities, as well as to convey any requirements for accessing community-based services. Planners should brief any trainers outside law enforcement about effective techniques, language, and sensitivities to the law enforcement culture that will improve their connection with this audience. When possible, additional cross-training should be provided to improve the mental health professionals' understanding of law enforcement issues, such as ride-alongs and other opportunities to see policies translated into action.

12. For more information on various types of training opportunities for law enforcement personnel, see Council of State Governments, *Criminal Justice/Mental Health Consensus Project Report* (New York, N.Y.: Council of State Governments, 2002), www.consensusproject.org.

Call-Taker and Dispatcher Protocols

Call takers and dispatchers identify critical information to direct calls to the appropriate responders, inform the law enforcement response, and record this information for analysis and as a reference for future calls for service.

When 911 or other call takers receive a request for service they suspect involves a person with a mental illness, they should gather descriptive information on the person's behavior; determine whether the individual appears to pose a danger to him- or herself or others; ascertain whether the person possesses or has access to weapons; and ask the caller about the person's history of mental health or substance abuse treatment, violence, or victimization. All call takers should receive training on how to collect the most useful information quickly. To supplement this training, members of the coordinating group with mental health backgrounds should develop a concise list of questions for call takers to have on hand when answering service requests that seem to involve someone with a mental illness.

Call takers and dispatchers must have an understanding of the purpose of the specialized program and how it works—particularly what types of calls for service should be directed to particular officers or teams. Dispatchers must be provided with up-to-date information on staffing patterns during all shifts and over all geographic areas that identify law enforcement or mental health responders designated to respond to calls that appear to involve a person with a mental illness.

The coordinating group should also provide these personnel with specific guidance on how to record information in the dispatch database about calls in which mental illness may be a factor. The information should be used for assessing procedures, informing future responses, and evaluating program outcomes (see Element 10 for more on how evaluations promote sustainability). Locations of repeat calls for service involving individuals with mental illnesses can be coded to help ensure that specially trained officers will be dispatched to respond to those locations in the future. Coding can help agencies ultimately reduce call and transport time, as well as potential injuries to all involved, by dispatching experienced officers. To protect community members' privacy, the notes made on these locations must never identify specific individuals and must be reviewed periodically to ensure accuracy (see Element 7 for more on confidentiality concerns). Responding officers should also validate and update this information when they clear a call to that location. All communications personnel and responding officers should be instructed to avoid using slang and pejorative language when describing individuals thought to have a mental illness.

Stabilization, Observation, and Disposition

Specialized law enforcement responders de-escalate and observe the nature of incidents in which mental illness may be a factor using tactics focused on safety. Drawing on their understanding and knowledge of relevant laws and available resources, officers then determine the appropriate disposition.

Specialized law enforcement–based response programs are designed to resolve officers' encounters with people with mental illnesses safely and, when appropriate, link these individuals to mental health supports and services that reduce the chances for future interactions with the criminal justice system. The success of these programs is contingent on officers' using tactics that safely de-escalate situations involving someone who is behaving erratically or is in crisis. The high prevalence of trauma histories in this population requires the use of trauma-informed responses. In addition to de-escalating the incident, responding officers should assess whether a crime has been committed and observe the person's behavior within the given circumstances to determine if mental illness may be a factor. Officers should draw upon expertise acquired in specialized training and from their experiences to identify signs and symptoms of mental illness. Officers must ascertain whether the person appears to present a danger to him- or herself or others. To assist in this determination, officers may gather information from knowledgeable individuals at the scene, including mental health co-responders.

Officers must make disposition decisions based on their observations, information they gather at the scene, and their knowledge of community services and legal mandates. To assist officers in their decision making, the planning committee should develop clear guidelines that are consistent with the program's goals and governing authorities. For example, such programs might promote alternatives to incarceration for eligible individuals. If a person has come to the attention of law enforcement because of behaviors that appear to result from a mental illness and no serious crime has been committed, guidelines and protocols consistent with existing law should enable officers to divert the individual to mental health supports and services. When a serious crime has been committed, the person should be arrested.

To make these decisions, officers must be familiar with available community resources—particularly any 24-hour center that can receive individuals in mental health crises. Officers also must understand their state's criteria for involuntary emergency evaluation to make appropriate decisions regarding whether to detain and transport the person to a facility where he or she can undergo an emergency mental health evaluation. Officers must take into consideration both the individual's treatment needs and civil liberties and should pursue voluntary compliance with treatment whenever possible.

In the rare case when an incident involves barricaded individuals or de-escalation fails, responding officers will require additional support. Some agencies may equip officers who most frequently encounter people with mental illnesses with less-lethal weapons, so as to minimize injuries that could occur if there is a threat to safety and some use of force becomes necessary. Agencies should provide officers with additional training on the safe and appropriate deployment of these weapons and should establish protocols to guide officers in their decisions to use them. The planning committee also should develop protocols to make certain there is effective coordination during such incidents among specialized law enforcement responders, SWAT teams, and mental health professionals. Although agencies often are under pressure to resolve these situations quickly, it may be best, when there is no imminent threat of danger, to allow time for mental health personnel with expertise in crisis negotiation and law enforcement operations to communicate with the individual.

Transportation and Custodial Transfer

Law enforcement responders transport and transfer custody of the person with a mental illness in a safe and sensitive manner that supports the individual's efficient access to mental health services and the officers' timely return to duty.

Law enforcement is authorized to provide transportation for people who are under arrest or who they believe meet the criteria for emergency evaluation (whether the evaluation is voluntary or involuntary). These individuals are in law enforcement custody, and rules and regulations regarding restraints in custodial situations apply.[13] Given the frequent history of traumatic experiences among people with mental illnesses, custodial restraints may create acute stress, which in turn may escalate their degree of agitation. Law enforcement executives, with input from other program planners, should review policies regarding restraints in custodial situations and balance considerations of officer and citizen safety with the impact of these controls on people with mental illnesses.

The planning committee should identify facilities that are capable of assuming custodial responsibility, are available at all times, and have personnel qualified to conduct a mental health evaluation.[14] Speedy custodial transfer is critical to the overall success of law enforcement responses. To enable officers to return quickly to their duties, staff in the receiving facility should efficiently and accurately obtain relevant law enforcement information. Protocols should ensure that medical clearance is achieved in a timely manner and that people brought by law enforcement are never turned away. If law enforcement responders determine that the person with a mental illness should be arrested and officers take the person to jail or lockup, then qualified staff should be available to screen the arrestee at intake for mental health status, medication needs, and suicide risk.

In noncustodial situations in which the person does not meet the criteria for emergency evaluation and is not under arrest—but officers determine he or she would benefit from services and support—officers should try to connect the individual with a friend or family member, peer support group, or treatment crisis center. Similarly, officers should seek to engage the services of the individual's current mental health provider or a mobile crisis team. In some jurisdictions, law enforcement may also collaborate with mental health professionals to help transport individuals to evaluation or treatment facilities.

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13. Law enforcement agencies generally define custody using a case law standard that can be described as whether or not a "reasonable person" would feel free to leave.
14. H. Steadman and colleagues have used the term "specialized crisis response site" (SCRS) to refer to such a facility. SCRSs are defined as "sites where officers can drop off individuals in psychiatric crisis and return to their regular patrol duties. These [prebooking diversion] programs identify detainees with mental disorders and work with diversion staff, community-based providers, and the courts to produce a mental health disposition in lieu of jail." They also can link individuals to substance abuse and other treatment. See H. Steadman, K. Stainbrook, P. Griffin, J. Draine, R. Dupont, and C. Horey, "A Specialized Crisis Response Site as a Core Element of Police-Based Diversion Programs," *Psychiatric Services* 52 (2001): 219–222.

Information Exchange and Confidentiality

Law enforcement and mental health personnel have a well-designed procedure governing the release and exchange of information to facilitate necessary and appropriate communication while protecting the confidentiality of community members.

Law enforcement and mental health professionals should exchange information about people with mental illnesses who frequently come in contact with the justice system for many reasons: foremost among them, information sharing is essential to achieve desired outcomes by helping responders be more sensitive to individual needs, reduce injury, and enhance their ability to determine next steps. To facilitate an appropriate disposition decision, law enforcement officers should collaborate with mental health professionals to better understand the individual's mental health needs. Similarly, mental health providers working at receiving facilities can conduct a more effective mental health evaluation if law enforcement officers share their observations regarding the person's behavior at the scene. In addition to improving the outcomes of specific incidents, sharing information across systems will help program planners as they develop the program and its outcome measures.

The program's planning committee should carefully consider the type of information needed and existing barriers to its exchange and then develop procedures (and in some cases MOUs) to ensure that essential information is shared in an appropriate manner. These protocols should be reviewed during cross-training sessions, which will provide law enforcement and mental health professionals an opportunity to develop relationships with their counterparts and learn why they need certain information. Agency leaders also can explore the possibility of linking information systems to share certain information either on an ongoing or a one-time basis.[15]

Information should be shared in a way that protects individuals' confidentiality rights as mental health consumers and constitutional rights as potential defendants. The planning committee should determine which personnel have the authority to request and provide information about an individual's mental health and criminal history. In general, mental health records should be maintained by mental health professionals. Information exchanges should be limited strictly to what is needed to inform an appropriate incident response or disposition, and officers should focus on documenting observable behaviors only. All communications must, of course, comply with state and federal laws requiring the confidentiality of mental health records, such as the Health Insurance Portability and Accountability Act.[16] Cross-training should ensure that program staff understand relevant state and federal regulations about issues such as how medical information is released, secured, and retained.

Individuals with mental illnesses who have been in contact with a mental health agency should be offered an opportunity to provide consent in advance for mental health providers to share specified information with law enforcement authorities if an incident occurs (sometimes called an advance directive).[17] Individuals should be asked if an advance directive exists, and if so what the instructions are and who should be contacted to verify this information.

Officers can play an important role in exchanging information with family members and crime victims by providing explanations about criminal proceedings or diversion programs. They may inform the person with a mental illness and his or her family members about mental health treatment linkages and how to access other services or support groups, such as those related to substance use disorders. Law enforcement officers also can assist victims of crimes committed by people with mental illnesses by providing information about protective orders, victim support groups, and other services.

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15. The Bureau of Justice Assistance has supported groundbreaking advances that facilitate the electronic exchange of information between agencies. To learn more about efforts involving the development of national policies, practices, and technology capabilities that support effective and efficient information sharing, see www.it.ojp.gov.
16. For more information, see John Petrila, "Dispelling the Myths about Information Sharing between the Mental Health and Criminal Justice Systems," National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness (February 2007).
17. For more information on psychiatric advance directives, see the National Resource Center on Psychiatric Advance Directives (NRC-PAD), at www.nrc-pad.org. NRC-PAD provides an overview, forms to complete psychiatric advance directives, links to state statutes, educational Web casts and discussion forums, and other resources.

Treatment, Supports, and Services

Specialized law enforcement–based response programs connect individuals with mental illnesses to comprehensive and effective community-based treatment, supports, and services.

Law enforcement officers often are called to respond to incidents that are the manifestation of an untreated or inadequately treated mental illness. Specialized law enforcement–based responses provide an opportunity to link these individuals to community mental health supports and services that promote long-term wellness and reduce the chance of future negative encounters with officers.

When law enforcement responders bring individuals who are not under arrest to licensed mental health professionals at a receiving facility, staff there should be qualified to conduct a mental health evaluation; assess the contributions of mental illness, substance abuse, and other medical conditions to current behavior; and manage crisis situations. With their knowledge of available community-based treatment resources, mental health professionals can then link the individual to needed supports and services.

Individuals with mental illnesses often require an array of services and supports, which can include medications, counseling, substance abuse treatment, income supports and government entitlements, housing, crisis services, peer supports, case management, and inpatient treatment. Planners of the specialized response program should anticipate the treatment needs of the individuals with whom law enforcement will come in contact and work with service providers in the community to better ensure these needs can be met and coordinated.

Because many individuals with mental illnesses who come into contact with law enforcement have co-occurring substance use disorders, follow-up services will be most effective when delivered by providers with the capacity to integrate treatment approaches. Accordingly, the planning committee should consider how the program can help connect individuals with co-occurring disorders to integrated treatment and should advocate for greater access to this and other evidence-based practices.[18] Planners should pay special attention to the service needs of racial and ethnic minorities and women by making culturally competent and gender-sensitive services available to the extent possible.

18. For our purposes here, evidence-based practices (EBPs) refer to mental health service interventions for which consistent scientific evidence demonstrates their ability to improve consumer outcomes. R. E. Drake, H. H. Goldman, H. S. Leff, A. F. Lehman, L. Dixon, K. T. Mueser, and W. C. Torrey, "Implementing Evidence-Based Practices in Routine Mental Health Service Settings," *Psychiatric Services* 52 (2001): 179–182. Other EBPs include assertive community treatment, psychotropic medications, supported employment, family psychoeducation, and illness self-management. For more information on the application of EBPs in forensic settings, see materials produced by the National GAINS Center at www.gainscenter.samhsa.gov/html/.

9 Organizational Support

The law enforcement agency's policies, practices, and culture support the specialized response program and the personnel who further its goals.

Law enforcement leaders who recognize the value of a specialized response program to reduce repeat calls for service and produce better outcomes for people with mental illnesses must create an organizational structure to support it. Leadership cannot be limited to endorsing the program and authorizing staff training. Establishing that the response program is a high priority for the agency is essential and is best demonstrated through visible and practical changes in how the agency partners with the community and realigns internal processes.

Specifically, leaders should embrace new partners and foster a supportive culture through frequent messages about the value of this type of "real" policing work. Communications with officers at every level of the agency should stress the benefits of the response program. Officers should be encouraged to volunteer for the program's assignments when possible, rather than receive mandatory reassignment. Enlisting the support of supervisors and field training officers is critical to transforming how the program will be viewed by others in the agency. A program "champion" in a position of authority within the agency and with a demonstrated commitment to the specialized program should be identified to serve as the agency's representative on the coordination group and the program's representative within the agency.

Leaders should modify officers' performance evaluations to take into account the initiative's unique objectives. As a program designed to improve the safety of all those involved in an incident and to reduce the number of people inappropriately taken into custody, success should not be measured by the number of arrests. As with other successful law enforcement problem-solving efforts, personnel performance should be evaluated and rewarded based on officers' success collaborating with and making referrals to community partners, addressing the underlying causes of calls for service, and taking measures that reduce the need for force.[19] The law enforcement agency and planning committee should acknowledge these professionals' hard work through commendation ceremonies and other forms of recognition.

Agency leaders may need to adjust officers' schedules, obtain grants, or devote funds to specialized program training, create new positions dedicated to coordinating program activities and recruiting and screening responding officers, and revise deployment strategies to maximize the availability of trained law enforcement responders across shifts and geographic areas. Agencies may find it beneficial to develop a standard operating procedure to enumerate specific processes and roles and responsibilities within the program. In some jurisdictions, these issues will require close cooperation with labor unions.

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19. For more information on innovative personnel performance measures for community policing initiatives, see Mary Ann Wycoff and Timothy N. Oettmeier, *Evaluating Patrol Officer Performance under Community Policing: The Houston Experience*, U.S. Department of Justice (Washington, D.C.: National Institute of Justice, 1993).

10 Program Evaluation and Sustainability

Data are collected and analyzed to help demonstrate the impact of and inform modifications to the program. Support for the program is continuously cultivated in the community and the law enforcement agency.

The planning committee should take steps early in the design process to ensure the program's long-term sustainability. Accordingly, the committee should identify performance measures based on program goals; these measures should consider quantitative data on key aspects of program operation, as well as qualitative data on officers' and community members' perceptions of the program. It may be helpful to aggregate baseline data before program implementation for later comparisons with new program information. To the extent possible, existing law enforcement and mental health agency data collection mechanisms should be adapted to accommodate the program's specific needs; planners may consider engaging a university partner to guide these data collection efforts. The planning committee should work with law enforcement and mental health agencies to ensure that the data are collected accurately and appropriately.

The data law enforcement personnel collect should focus on questions most critical to the program's success in achieving its goals, including the number of injuries and deaths to officers and civilians; officer response times; the number of incidents to which specially trained officers responded; the number of repeat calls for service; officers' disposition decisions, such as linking a person with services; and time required and method used for custodial transfer. Data should be used to refine program operations as needed, as well as review individual case outcomes and determine if follow-up by a mental health professional is warranted.

Program leaders should gauge the attitudes of community leaders, the media, key public officials, and other policymakers toward the program. It may be helpful to engage elected officials early in the process and keep them involved—from the initial kickoff through refunding and long-term implementation—to promote sustainability and desired legislation. The committee also should survey officers—both specialized responders and others—so that law enforcement leaders can better assess the program's usefulness to the entire department and address any concerns. Based on this information, the planning committee should determine the most effective way to promote the program's positive impact on the community, individuals, and agencies and respond to program shortcomings or high-profile tragic events.

While in-kind contributions from partners can go a long way toward offsetting certain program costs, planners should identify and cultivate long-term funding sources to cover costs that would otherwise fall to the law enforcement agency to absorb. Requests for funding should be based on clearly articulated program goals and, to the extent possible, should incorporate data demonstrating program outcomes.

Departments also should focus on sustaining internal support for the program, such as offering refresher training to help officers refine their skills and expand their knowledge base. To promote longer-term commitments from specialized officers, departments also should provide incentives and other organizational support for serving in the program.

Conclusion

Many law enforcement agencies around the nation struggle to respond effectively to people with mental illnesses. Officers encounter these individuals when citizens call them to "do something" about the man exhibiting unusual behavior in front of their business, the woman sleeping on a park bench, or someone who is clearly in need of mental health services—whether or not a crime has been committed. Law enforcement professionals in many jurisdictions have lacked community-based support, guidance, and a clear framework for crafting a program to improve their response to people with mental illnesses.

But innovative solutions are at hand. Increasingly, law enforcement agencies of all sizes are implementing creative approaches despite scarce resources. The range of approaches in communities across the country reflects the realization that strategies must be tailored to each jurisdiction's unique needs. These agencies are engaged in problem solving with a range of partners from diverse disciplines and have access to a growing pool of programs and knowledge about promising practices. This publication outlines the essential elements of successful specialized law enforcement–based efforts that reflect this expanded knowledge base and experience to better guide practitioners initiating or enhancing their own programs.

The tone of the elements may suggest that these changes are easy to make. They are not. There are many challenges to these efforts, including politics, turf battles, competition for limited funding, lack of legal foundations for officers' actions, and scarce law enforcement and community mental health resources. Leaders in jurisdictions that have implemented a specialized response acknowledge that it takes commitment to overcome these obstacles, but agree that the costs—in dollars and human lives—are too high to sanction continuing with only more traditional law enforcement responses to people with mental illnesses. Their efforts have resulted in increased public safety and improved public health.

The Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, provides leadership training, technical assistance, and information to local criminal justice agencies to make America's communities safer. Read more at www.ojp.usdoj.gov/BJA/.

The Council of State Governments (CSG) Justice Center is a national nonprofit organization serving policymakers at the local, state, and federal levels from all branches of government. The CSG Justice Center provides practical, nonpartisan advice and consensus-driven strategies, informed by available evidence, to increase public safety and strengthen communities. Read more at www.justicecenter.csg.org.

The CSG Justice Center also coordinates the Criminal Justice/Mental Health Consensus Project. This project is an unprecedented national effort to improve responses to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system. Read more at www.consensusproject.org.

The Police Executive Research Forum (PERF) is a national membership organization of progressive police executives from the largest city, county, and state law enforcement agencies. PERF is dedicated to improving policing and advancing professionalism through research and involvement in public policy debate. Read more at www.policeforum.org.

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