Senate Finance Committee

February 9, 2023

SB 1: General Appropriations Bill
Article V - Public Safety and Criminal Justice.
RE: the Department of Public Safety
Presented by Brennan Griffin, Texas Appleseed

Introduction

Thank you to the Chair, Vice Chair, and committee for convening today and taking time to discuss Article V of the General Appropriations Bill. My name is Brennan Griffin of Texas Appleseed. Our organization is dedicated to changing unjust laws and supporting policies that are data-driven, safe, and efficient.

Today, we will be providing testimony on Article V of the state budget, more specifically the budget for the Department of Public Safety. We would like to discuss the need for and value of dedicated funds solely for the use of hiring mental health professionals for emergency response. Access to these funds should exist on a request for support basis, in which allocation to rural departments should be prioritized and incentivized. We are also asking that distribution of these funds be tied to continuous data collection, evaluation, and reporting.

Attached to this testimony you will find a more comprehensive brief on crisis response models and the need to rethink or add onto these approaches.

Background

Roughly one out of every five adults in America lives with a mental illness.[1] These conditions vary in severity, and they can manifest in several ways, including emotional and behavioral crises. Mental illness is not a static condition, and therefore symptoms can appear at any time or not at all. Law enforcement officers are increasingly responding to individuals with serious mental illnesses, including schizophrenia, bipolar disorder, psychosis, post-traumatic stress disorder, and depression.[2] **When responding to these crises, police utilize their training and the system they are familiar with - the criminal justice system.** As a result, individuals with mental health conditions are flooding into jails and prisons instead of treatment services.

Crisis response is ever-changing – from dealing with the changing needs of the public to the ubiquity of smart phones. Policing is also dynamic, with changing methods and training, but it is clear that police are not usually trained mental health professionals with years of specialized education, and nor should they be.

One in four of all fatal police encounters involves an adult with an untreated severe mental illness.[3] Law enforcement is often undertrained in community-based resources. We should eliminate the use of law enforcement as first responders to 911 calls involving individuals experiencing a behavioral health crisis, unless a serious crime is occurring, or specific harm is being threatened or carried out. **Crisis response services should be trauma-informed, community-centered, and supported by evidence-based practices for recovery.**

In places that have tried having mobile mental health response available through 911, the results are promising. In Eugene, OR, these mental health responders are taking up to 19% of all 911 calls that would have otherwise gone to the police department. In Denver, a pilot program reduced low level criminal activity by 34% in the downtown area where the program was available.

Current Models of Crisis Response

There are several models that are being implemented around improving response to these crises. Some 911 centers have begun directly employing nurses and mental health professionals who can provide telephone interventions and connect people in crisis to services without ever sending anyone in person. **There are also police-based mobile emergency response models, including:**

- Sole responder teams where police officers receive additional training to effectively manage behavioral health crises, and
- Co-responder teams where police officers are paired with mental health professionals for certain types of calls.[4]

Additionally, there are community-based responses. This model involves a wide variety of resources that focus on keeping an individual out of the criminal justice system and diverting them to services and programs that can support them instead. Some examples include peer navigator programs where peers will help individuals with behavioral health disorders who are at risk of criminality. Others use Mobile Crisis Teams composed of medics, crisis workers, and peers to respond to people in crisis and provide immediate de-escalation and referral to community-based mental health services. The most prominent example of this type of program is Crisis Assistance Helping Out on the Streets (CAHOOTS), which came out of Eugene, Oregon, but several Texas cities and counties are carrying out their own pilot programs, including Austin, Houston, and Harris County.

The Issue of Law Enforcement as the Primary First Responder in Calls of Crisis

Law enforcement has become the "first responder" in the place of many nonexistent systems of healthcare and human services.[5] It is unfair to render them responsible for providing services which often undercut their primary purpose of ensuring public safety. Furthermore, local law enforcement often lacks the resources and is stretched too thin to handle it all. Of the 18,000 state and local law enforcement agencies in the United States, nearly half have fewer than ten sworn officers.[6] For some of them to then specialize in other skills is impracticable, especially when other health and human service professionals already possess those skills. Even large police departments are experiencing high rates of vacancies, with fewer officers asked to do more.[7]

Calls to respond to behavioral health crises can take significant police resources for low-level issues that may not even rise to the level of a crime. Between transportation to mental health facilities and waiting for evaluation by a mental health professional, this can be a significant drain on police resources.[8] Additionally, by police serving as first responders to behavioral health calls, the likelihood of a police-citizen interaction resulting in the use of force goes up.[9] This finding may be unsurprising, given that law enforcement are primarily trained to handle hostile and dangerous behavior, and not mental or behavioral breakdowns. In addition, when police officers use force against an individual, it is shown to be disproportionately used against communities of color.[10] In other words, both police officers and community members of color lose in the current approach.

The Need for Reform

Alternative response programs such as those mentioned above constitute strong first steps in decreasing exposure to the police for people in crisis and freeing up police time for other public safety work. But there is still much room for improvement and further evaluation of policies and practices that are becoming the standard. Implementing these programs involves close coordination with multiple entities, from 911 call centers to police departments to mental health providers.

That said, the potential gains are enormous. **For someone suffering from depression, psychosis, schizophrenia, or a behavioral crisis, the presence of armed police often only serves to exacerbate their fear and paranoia.** Police are trained to be authoritative and commanding, characteristics that are necessary when dealing with a hostile individual not experiencing a mental health crisis; however, they are antithetical when dealing with those in crisis. Someone in crisis requires patience, assurance, and a non-threatening demeanor. Meanwhile, police departments around the country are having difficulty filling funded positions with qualified applicants, and scarce police resources are being used in situations where other professionals would be more effective.

It is vital for the protection and well-being of individuals with behavioral health disorders that we move away from reliance on the police. **It is unfair to ask law enforcement to respond to non-criminal activity for which they have little or no training and expect them to do it well. Instead, we must implement practices with mental health**

professionals who are trained and experienced in helping these individuals. Additionally, programs should use peer specialists with lived experience to help individuals beyond their crisis and prioritize connecting people to ongoing mental health care. There has been an increase in mental health conversations in the wake of mass shootings, increased exposure to police brutality, and the de-stigmatization of mental health disorders. However, fundamental changes remain an urgent and widespread need.

Recommendations

How we respond to calls of crises in this state, needs to change. As discussed, there has been too heavy a reliance on armed law enforcement for these types of calls, which results not just in wasted time and resources, but in detrimental outcomes for the people experiencing these crises. To alleviate the burden placed on law enforcement during these calls, and to provide safe and effective assistance to Texans who are experiencing behavioral and mental health crises, **the Legislature should dedicate funds solely to the hiring and incorporation of mental and behavioral health professionals into Texas police departments and/or 911 call centers.**

Access to this fund should exist on a **request for support basis**, in which departments should be required to illustrate, via data and records, an expressed need for financial support to bring on mental or behavioral health professionals. Allocation to rural departments should be prioritized and incentivized. Additionally, the distribution of these **funds should be tied to data collection, evaluation, and reporting**, as modeled by the city of Denver's STAR program goals and evaluation criterion.[11] Which include but is not limited to:

- Incidents (or Calls for Service) by Problem Type
- Program Eligible Calls (despite availability)
- Demographics of the Callers
    - Race/Ethnicity
    - Gender Identity
    - DOB & Age at Time of Encounter
    - Mental Health Diagnoses
- Specifics of the Call:
    - Clinical Encounters v. Non-Clinical Encounters
    - Referral Details
    - 90-day Follow Up of Services Rendered Post Encounter
    - Geographic Location Associated with the Call
    - Time Spent Responding to Call
        - En route to call from time received
        - On scene until resolution/referral

Alternatively, the State Legislature could consider mandating that a specific percentage of police budgets be dedicated to meeting the goal of establishing and fully supporting mental health and behavioral response models that *do not* rely on armed law enforcement. These funds should be dedicated *solely* to supporting community-based models that alleviate police officers from responding or even co-responding to these calls.

Conclusion

The current policy movement regarding mental health is extremely encouraging. Even a decade ago, we were still fighting stigmas regarding mental and behavioral health issues that today are met with sympathy, compassion, and treatment. **Diversion programs recognize the need to keep people out of jail and instead offer treatment, housing, food, and other resources.** However, progress for the sake of progress is not enough**.** Crisis response is an ever-evolving practice and therefore we must meet this challenge with meaningful assessments and adjustments.

The modern trend of co-responder models is a step in the right direction, but people in crisis are still suffering from contact with the police. **Reducing police interaction with individuals in crisis represents the most immediate and practical strategy for diminishing the many costs of exposure to the criminal justice system.** With the recommendations provided in this testimony, legislators can lessen the heavy burden placed on their law enforcement agencies and better utilize trained mental health professionals and behavioral specialists.

Thank you for your time and consideration. If you have any further questions, comments, or concerns, please do not hesitate to contact me.

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References & Endnotes

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