LOS ANGELES COUNTY
HEALTH AGENCY

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"The mission of the Los Angeles County Health Agency is to improve health and wellness across Los Angeles County through effective, integrated, comprehensive, culturally appropriate services, programs, and policies that promote healthy people living in healthy communities."

March 21, 2019

To: Supervisor Janice Hahn, Chair
Supervisor Hilda Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Kathryn Barger

FROM: Fred Leaf
Interim Health Agency Director

SUBJECT: **REPORT TO THE BOARD OF SUPERVISORS FROM THE INTEGRATION ADVISORY BOARD**

Attached is the Integration Advisory Board's Final Report. I would like to thank each of the Commission members for their hard work in assessing Health Agency efforts to integrate services.

Please let me know if you have any questions or require any additional information.

FL:ct

c: County Counsel
Executive Officer, Board of Supervisors
Health Deputies
Department of Health Services
Department of Mental Health
Department of Public Health

Integration Advisory Board

313 N. Figueroa Street, Room 531
Los Angeles, CA 90012
213-288-8174

March 11, 2019

TO: Supervisor Janice Hahn, Chair
Supervisor Hilda Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Kathryn Barger

FROM: Al Ballesteros, Co-Chair
Bridget Gordon, Co- Chair

SUBJECT: **REPORT TO THE BOARD OF SUPERVISORS FROM THE INTERGRATION ADVISORY BOARD**

The Integration Advisory Board (IAB) was established August 11, 2015, as an advisory body reporting annually to the Los Angeles County Board of Supervisors (Board) on the impact (positive or negative) of the Los Angeles County Health Agency (Health Agency) on ongoing Departmental activities, operations and on achieving the County's health related priorities.

The IAB membership is honored by the opportunity to serve Los Angeles County during the past three years. We commend the Board for their insight and forethought in establishing our diverse group of stakeholders to assess the positive or negative effects of the Health Agency's integration of the Departments of Public Health (DPH), Mental Health (DMH) and Health Services (DHS). This ambitious endeavor provides opportunities in our County to restore health and well-being to communities that find themselves without a safety net and those who are especially hard hit by economic, social and medical challenges. The IAB believes, with thoughtful planning, healthcare integration can be done in ways that improve health outcomes for the most vulnerable residents while simultaneously elevating all communities to improve both individual and public health across the county.

In our final year the IAB focused on front line workers, those professionals who work directly with residents seeking county services.

We received candid feedback from professionals advocating for structural support and better outcomes for the people they serve. Much of the feedback was harrowing, the challenges were often "built-in" relating to systems, processes and entrenched ways of operating that focus on '*one thing only* - the immediate injury.' The challenge was in addressing unmet human need(s) and the life circumstances of the residents our front-line employees must be present to serve. We found many dedicated professionals giving their best effort to work within a deeply fractured, patchwork of systems and silos that are "stuck" in crisis mode. Because of this, we are missing opportunities to support actual healing in the people our health system is intended to serve.

Our health care system was built last century, it was not built to understand, anticipate or traverse the connections and partnerships required to guide residents back into well-being and health in 2019, particularly our most vulnerable and injured residents. The concepts of prevention, pathways to regaining health and restorative justice are still unfamiliar in our culture, our workforce and our communities. These concepts however, are the way forward – serving to mitigate the unyielding frustration and "toxic stress" that is so very unhealthy and often traumatizes both front-line healthcare providers and those who seek their services.

We believe that comprehensive health integration, fully immersed in prevention practices are critical to significantly improving health outcomes of residents. Further, healthcare integration that is based on understanding and addressing the root causes of poor health while utilizing thoughtful, coordinated processes to implement, measure and communicate change within the Health Agency and within Los Angeles County communities must move forward in alignment with a strong charter. The report that follows outlines many concrete recommendations to meet the goal of integration.

The following document is the report submitted respectfully to the Board on behalf of the IAB. If there is anything the IAB can do to further clarify any information put forth in this report, please do not hesitate to reach us by contacting the Los Angeles Health Agency at 213-288-8174 or via email at IAB@healthagency.lacounty.gov.

AB/BG:rj

Attachment

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

REPORT TO THE BOARD OF SUPERVISORS FROM THE INTERGRATION ADVISORY BOARD

MARCH 11, 2019

The Integration Advisory Board (IAB) was established in 2015 for two years by the Los Angeles County Board of Supervisors to assess the impact (positive or negative) of the newly created Health Agency in Los Angeles County. In December 2017, the Board of Supervisors extended the IAB for a third year. The Health Agency's original eight priorities were kept under consideration through the 2018 extension while we continued examining the opportunities for integration activities that more systematically address the broader context and the structure(s) that contribute to poor physical and/or mental health outcomes primarily in black, brown and poor communities.

The IAB is comprised of subject matter experts, people with lived experience, and members of various county health commissions, county residents and representatives from organized labor. To better understand what, who and how health integration is advancing, members of the IAB participated in regularly scheduled meetings and also attended public meetings throughout the County relating to healthcare, mental health, public health, homelessness and access to healthcare for residents in Los Angeles County. We received updates from the Health Agency Interim Director and had presentations from the Center for Health Equity to describe the Action Plan, Partnering for Change on collaborative efforts that identify and reduce family homelessness. California Surgeon General, Dr. Nadine Burke Harris's 2015 TEDMED Talk "How childhood trauma affects health across a lifetime" provided an understanding of the results of the Adverse Childhood Experiences Study (ACES), how to screen and how to mitigate harm.

The Health Agency mission is: "To improve the health and wellness of county residents through provision of integrated, comprehensive, culturally appropriate services, programs and policies that promote healthy people living in healthy communities". To achieve this mission, efforts to align the three county departments are underway. Alignment requires a shared understanding of the mission that is applied consistently throughout the organization(s). When one thinks about health integration, our minds gravitate to the following common definition:

The definition of 'Integrated Care' is *the care that results from a practice team of primary care and behavioral health clinicians working with patients and families using a systematic and cost-effective approach to provide patient-centered care for a defined population*. (https://www.integration.samhsa.gov/about-us/what-is-integrated-care)

At the same time, the IAB also recognizes that the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) do more than deliver care. Among their

many functions, these departments create programs, influence policies, allocate funding, operate and maintain facilities, conduct community engagement and outreach, and collect data. With this in mind, the IAB considered integration from a structural and systemic standpoint, recognizing that there are high value opportunities to integrate, streamline and coordinate activities that expand beyond the more narrow definition of integrated care into promoting healthy people who live and work in truly healthy communities.

During this period the IAB sought to focus on the experiences and perceptions of the front-line workers of the three departments in relation to the integration. This was accomplished with the assistance of the appointed IAB members representing organized labor unions taking the lead to seek out information from the workforce interfacing with communities served by the Health Agency.

The IAB sought to understand:

1. Is there a common understanding of integration among the workforce?
2. How are Health Agency clients/consumers benefiting (or not) from the ongoing integration activities between the three departments?
3. In general, what is the workforces' perception of the impact of the integration activities positive or negative from their perspectives as labor?
4. Is there ease in referring residents seamlessly between departments?
5. Aside from the specific high-level interdepartmental integration projects, can the workforce point to any specific integration activities which have impacted their work areas and clients positively or negatively; or proposed activities planned or currently under development?
6. What ideas does the workforce have to foster integration?
7. Other perspectives to share?

IAB members representing organized labor polled front line colleagues and the results are captured in this report. A common theme was that word of Health Agency integration had *largely* not reached the front-line workforce in the field**.** As a result of this, it is believed and assumed that the benefits expected from integration are not being maximized; that front-line workforce has not yet been provided with tools or shared resources; nor have partnerships and collaboration been established / facilitated at the front-line workforce level as a result of integration. The IAB's sense is that engagement of the front-line workforce is needed if integration is to occur. Integration of the departments was also expected to create cost-savings by streamlining operations and systems and potentially create a pathway for the three departments to find opportunities for investing resources upstream to remove pressure from acute care and downstream systems. The IAB acknowledges this is difficult when funding streams prevent the blending of resources to improve access, care and meet the needs of the consumer.

Recommendations:

1. **Define Integration across three departments**

   a) What are the common goals that all are working toward?
   b) Where is the overall statement of goals?
   c) What can all three departments come together around to move actual integration forward?

In contrast and as an example - The Center for Health Equity has a set of goals that people can work with; the Office of Diversion and Reentry also has a set of goals as does Housing for Health. They're looking at the same data and looking across the different systems. They are doing great work in those spaces but these are only carve outs. It seems to the IAB that the County's integration activities have only been centered on a few high-profile special projects. These initiatives are integrated but overall, there's not an integration conversation occurring. If you are not in any of the new initiatives then its lost, you still do your day-to-day work. If you are involved in any of the initiatives, you're very clear that an integration conversation is taking place. What hasn't been seen yet is what it means to function as an integrated agency. We wonder what full integration looks like within the structure of the Health Agency as opposed to limited examples of the aforementioned high-profile special projects.

Could the departments review how effective their conversations and efforts have been in these carved-out integration projects and then apply that to the broader context of the Health Agency, namely, place-based strategies, equity strategies where everybody is aligned in the same direction.

Specific Comments from Stakeholders:

- One coherent definition of integration is needed. What are the key domains of quality integration regardless of topical issues and how can we pay attention and keep our eyes on the smaller number of high impact levers. One of those is meaningful community engagement. How are the three departments thinking deeply about high quality community engagement; are they monitoring their efforts; what can they do together in terms of engaging and educating communities?

- Who does 'integration' best within or across the three departments, for instance integrating the whole health of children, or perhaps within the frame of integrating things that keep a whole person well, moving away from a 'disease model' into an optimal health model possibly using the social determinants of health. *As a suggestion, could those persons within the Health Agency currently working in an 'integrated' context come together under a single agency to work on a "population" rather than in silos or the disease based model?*

- Data collecting - how are the three departments reporting data together, how are the departments putting *data in* the three systems? Are they looking at "hotspots" to determine where to deploy prevention and population-health strategies to lessen the severity and frequency of illness or injury in places where it is disproportionately high?

- The promise of integration is really tantalizing. It's something that could be good and helpful to the residents of the County and the people that service them; I think it's necessary. We haven't been able to *learn of the early* results. I urge we *review the early* results to see how this is working for the people that are using the services and those offering it at the ground level.

- I think the promise is good and what we've heard here is very exciting. How it is executed is to be determined and that's where the County should focus its efforts going ahead. What matrix should we use? What reporting methods should we use? And, how do we measure success to see if the promise can be fulfilled? We take this to mean front line staff is interested in the leadership educating them on the benefits of integration as it relates to the outcomes measured.

2). Data Access/Integrated Data Access

Integrated data systems enable one to understand more fully where consumers are touching all the different systems. From this data we might possibly start to look at where we are failing and where we are doing well around individuals and communities. This is one of the strategies to improve an integrated model and the Health Agency needs to fully develop this capability. As an example, if the Health Agency were to examine data pinpointing where the majority of firearm related homicides occur and conduct an analysis of the costs to the Health Agency, they might develop a comprehensive strategy to identify where resources can best be spent to prevent gun-related injuries and death. In doing so they would identify roles for all three Departments to focus on prevention as well as intervention and long-term care issues.

<u>Recommendations:</u>

2a) Ensure the data systems are useful to the frontline staff and provide integrated information from all areas where the resident has touched the Health Agency.

2b) Provide the training and tools needed to understand how staff could use the data to improve the outcomes of those served by the Health Agency.

2c) Contribute DMH and DHS data to the community health profiles developed by the Department of Public Health to enable residents and organizations to examine their own data.

2d) Report data in ways that tell a full story and lead people to understand the necessary prevention, intervention and care strategies required along the continuum. So, for instance, rather than simply describing the number of individuals seeking mental health services, also describe issues like access to jobs, graduation/suspension rates, exposure to alcohol and drug outlets, etc.

Specific Comments from Stakeholders:

- Residents who use a County facility for care and then go to a different location for County services are better off now. Prior to ORCHID we had no clue what happened at the other facilities, which often times can impact a person's clinical decision for a patient's care. It's been very helpful at the medical level so it would be great if resident data would be integrated through mental health, housing and all those other *areas* as well. Because from a medical standpoint it helps to know all the factors that a person is dealing with when they come for care – maybe there is more that can be done to support that person. I can now see exactly what a clinician did, why they did it, what their thoughts were and what medication the patient is taking. It's all right there no matter what County facility they go to. It is very helpful to a medical care provider.

- *However*, no amount of data sharing matters if people are not thinking and working in integrated ways. Even at Kaiser, one doctor can pull records up (in an HER) and you know they'll have the whole record in front of them but if they don't really look at and know how to interpret it, it doesn't matter, they can still make medical errors and costly mistakes. It's valuable *to have integrated information available*. However, it is a big mistake to conflate departmental integration with an electronic health records or data integration. Data is only one aspect of integration.

- The administrative burden on people seeking services is unreasonable. When you think of the homeless, the very ill and those who can't care for themselves. I have people who bring stacks of papers from County departments, from Medi-Cal, Medi-Medi, and those who have Medicare and cannot afford the 20% co-pay or afford supplemental insurance. There are people who are denied care for several months because they were too sick to complete their annual reapplication for public health access although their health and income status was unchanged – I've known many who go bankrupt because of illness, it's a trap… people just get so much sicker in this system.

3). Enhance communication, internal and external

The IAB noted the importance of feedback and communication for front line workers to understand and learn about Health Agency Integration, what it means and how it impacts

their ability to get their jobs done. To date *it seems* only employees who work on the few projects that span across the three departments hear news about 'integration'. Very few understand the purpose and goal of the Health Agency or integration. Integration is not happening if front line workers are unaware of this effort beyond their specialized area of expertise.

Recommendations:

3a) The Health Agency with DHS, DMH and DPH begin communicating with employees at all levels by clearly defining health integration using a consolidated message so that every worker within the three departments and all organizations that provide services and support in concert with the Health Agency are clear about the purpose of integration and the intended outcome(s).

3b) Provide organizational charts for all Health Agency organizations to clarify direction, connection and increase transparency. Keep these charts up to date.

3c) Develop a communications campaign to clarify the vision of the core elements of integration. There are beacons of early work and related challenges of the integration process that have not been communicated. Transformation is difficult work while delivering healthcare, the communication is key.

3d) Consider "rewarding" effective integration partnerships and efforts to encourage staff to align theirs across departments. Rewards could come in the form of "innovation grants", public acknowledgement for improvements in outcomes; or staff "flex" time for developing special integration efforts.

3e) Integrate trauma informed care, implicit bias education and trauma education across all three organizations, as well as, throughout the entire service delivery infrastructure and within communities. Be inclusive to move the needle on health for everyone.

Specific Comments from Stakeholders:

- There is that disconnect going on even within our department with the reorganization. That's the kindest thing to say-- that we are in this whole re-org thing that's taking a very long time to get down to the line staff. I don't know where the work of integration's going on and how we're supposed to get access; it sounds like it's indirect through somebody else.

- For example, if we are to fully address the current STI epidemic, make it a unified effort; all departments talk about it; internal and external with all stakeholders. Develop a unified campaign within LA County (public & private sectors) including the hospitals, clinics and partners, including public health and community based organizations to talk about drivers of these epidemics, get tested for a sustained period of time, provide accurate health education and

determine strategies for prevention. Everyone participates and no one group or demographic gets singled out.

- One example would be assuring we are not having three different meetings on the same topic by each of our departments, instead, for everyone's sake: meet about the same topic together.

- So you take a test, you learn you have HIV or another STI and you are sent to scary and inhospitable places for "care", punishment, and a prescription, ignoring the root causes. When will we communicate compassion, healthy connections and accurate information?

- We're missing the mark, why test when access to healthcare is unavailable in the hardest hit communities? So, if you are Black, or a woman, or transgender, or Native American you don't get "care", emotional support, mental health support, or comprehensive health care, you get 30 days of pills and you're sent on your way. The reality is, our silence and inaction in the face of sexually transmitted infection speaks volumes, while we may say we care; the proof is in our numbers.

- Mobilizing for systemic change in access is the best way to end the epidemics, producing better health outcomes, particularly for women living with and vulnerable to STIs and HIV. These epidemics continue because of poverty, the lack of access to health care services, preventive care that meet the needs of communities. Rates of new HIV incidence correlate strongly with access to health care, or lack thereof, and the reason is no mystery, those diagnosed with HIV, are more likely to live in poverty and to lack access to real comprehensive health insurance.

- Infections are further fueled by governmental policies which actively discriminate against the poor. Among many of the shortcomings: these and other failures, overcoming the scourge of HIV in African American communities will take more than just treatment. It will require vast changes in public attitude and the ways in which health care and other vital social services are distributed to communities most in need. https://www.verywellhealth.com/why-hiv-rates-are-high-in-african-american-communities-4151837

- The issue of the changes surrounding the integration is…people *are* getting lost in the organizational chart. There should be an organizational charting *system* that's changing based on the creativity that's taking place. We need to be sure there are lines of authority and structure when there are changes to inform the line staff. The line staff hears…the creativity and the changes that

are going on but they are not a part of it, yet *they may* still have responsibilities in terms of reporting. Make sure line staff understands the changes that affect them.

- I've had patients hospitalized with multiple life-threatening diagnoses, there *is no* mental health to help them cope with their worlds collapsing around them.

- Courtesy and kindness, the people who come through our doors sometimes have so many hard challenges - how can we bring health and healing if we're mean and dismissive?

4). Work to breakdown silos and the 'mindset mentality' which prevent partnering and collaboration.

The definition of silo from dictionary.com is "to isolate (one system, process, department, etc.) from others." In healthcare, silos segment payers, hospitals, and physicians. Silos are described as incapable of providing the type of integrated and coordinated care across a continuum that drives incremental value for patients and healthcare organizations.

The definition of *"mindset mentality"* from businessdictionary.com is "A mind-set present in some companies when certain departments or sectors do not wish to share information with others in the same company. This type of mentality will reduce the efficiency of the overall operation, reduce morale, and may contribute to the demise of a productive company culture."

It seems from reports that the three departments continue working in silos. Further, it has been reported that there are silos within each of the three departments that prevent internal collaboration in providing care and services to residents. Functions that are similar such as human resources, procurement and accounting are not integrated across the three departments.

<u>Recommendations:</u>

4a) The IAB recommends internal community building upstream and downstream of silos.

4b) The IAB recommends aggressively adopting the Trieste model of care that decentralized care and services into easily accessible locations for community members. The Trieste model treats the human being who is living with mental illness with support, respect and companionship in contrast to our current system that treat the illness only. See Appendix A. Trieste Model 'A Tale of Two Cities'

4c) Do community listening together (across the three departments) and work with residents to identify strategies designed to improve population health, prevent illness, injury and suffering and when needed, intervene and offer care.

4d) Partnership and simultaneous effort to support residents who are in need, assuring people are able to regain and maintain their health and stability. See Appendix E. Integrating Housing Safety Net.

Specific Comments from Stakeholders:

- Front line workforce is in crisis without tools, resources and support to address the crisis in homelessness, mental health crises, and epidemics rates of chronic illnesses such as diabetes, cirrhosis of the liver and sexually transmitted infections. All these things combined should constitute a state of emergency for residents of Los Angeles County and the workforce employed to address the crisis. Many of us are living these crises personally.

- Health care providers, social service providers are unable to meet dire needs of residents due to administrative barriers, rules which prevent the immediate (and complete) care and social support required to stabilize the sheer numbers of residents who find themselves in medical, mental or emotional disaster and who are simultaneously unstably housed or homeless.

- The current system as it stands blocks us from providing necessary care on a number of levels, it is outdated and creates trauma. The workforce is traumatized and overwhelmed, residents who need care are traumatized and overwhelmed.

5). Jails Health Services Integration needs further review

It was reported to the IAB that the jail's health services are worse off than before the three departments were brought under the health agency. The *representative reported* that the Sheriff's staff has taken a "hands off" approach to health services, given that it is now run by another department of the county (DHS). The issues included barriers in access to needed supplies, patient medical records, referrals and coordination of health care for those clients in the jails. See Appendix B. Narrative Summary Jails.

Recommendations:

5a) Prioritize a safety review for health workers inside jails to assure safety and well-being of the workforce and to meet the medical needs of residents who are jailed.

5b) Review the functionality of the electronic health record and departmental support to foster integration for the jailed population from throughout the Health Agency.

5c) Determine whether integration is really happening: assess whether adequate attention and resources are being placed to reducing violence and keeping people out of the criminal justice system in the first place.

5d) Adopt the American Public Health Association position on police/law enforcement violence. See Appendix C. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence Adopted on November 13, 2018 by *the American Public Health Association at their annual conference in San Diego, CA.* The policy statement explicitly names law enforcement violence as a public health issue. This statement is rooted in an understanding of how structural racism and institutional oppression shape population patterns of law enforcement violence and it is a statement firmly committed to a public health alternative, recommending upstream, community-based and community-led solutions.

Specific Comments from Stakeholders:

- The County Jails Health Services were also slated for integration since 2015. IAB members familiar with the health services work occurring in the jails expressed concerns that integration is not working in the jails for a number of reasons. In addition to the fact that human beings are not meant to live or work in cages, member's raised concerns that the workforce is exposed to dangerous working conditions without adequate medical supplies, without access to medical records, security or communications while working inside jail cells. If frontline medical workers have no access to medical resources to support patients who require medical care inside jail cells, then we surmise that patients (human beings) are receiving inadequate medical care inside the jails and that the safety of both patient and provider are in jeopardy.

- Electronic Health Records & the Jail System: The health information exchange system for Public Health and Health Services are both on ORCHID, this medical information for residents are accessible in County health facilities. Mental Health records are still separate and the Sheriff and Jails are on another electronic system, Cerner. It was reported to the IAB that for people in jails and who are requiring mental health and/or medical health attention, there is limited or no access for DHS workers to medical records inside the facility. This population is often most in need of informed care yet the system and structure does not allow for it – this set up is contrary in all ways to the goal of integrated health care and severely limits the medical personnel in the jails from doing their jobs.

6). Racial Equity as a key to Health Equity

In our last report we discussed the necessity to improve the overall health status of vulnerable populations. We now know that African Americans comprise only 9% of our population yet represent more than 40% of the homeless people living in our county with poorer health outcomes and less access to resources required to live and thrive. This is tied to less access to heathy, safe environments, education, housing and supportive resources with a greater exposure to risk factors and negative institutional/systemic interactions in the form of over policing, predatory business practices and mass incarceration.

We are including the Report by Ad Hoc Committee on Black People Experiencing Homelessness to assure the Health Agency utilizes the findings to better approach health integration activities. https://www.weingartfnd.org/files/LASHA-Report-12-14-18.pdf

Recommendations:

6a) Measuring the number of staff and community members of all racial and ethnic backgrounds participating in shared racial equity trainings.

6b) Addressing psychological trauma experienced across all demographics from cultural abuses, violence and living under the assault of hatred.

6c) Increase funding and improve coordination with the McKinney-Vento Homeless Assistance Act that funds school districts in support of school age children who are homeless.

6d) Adopt a definition to match McKinney-Vento's definition of homelessness - aligning the discrepancies in city and county definitions of homelessness to match the federal definitions as written in McKinney-Vento's Homeless Assistance Act. The McKinney-Vento Homeless Assistance Act's definition includes children from families who are doubling up in homes with relatives or other adults, as well as those living in shelters, motels, or cars.

Specific Comments from Stakeholders:

- Los Angeles County must lead in aligning the discrepancies in city and county definitions of homelessness to match the federal definitions as written in McKinney-Vento's Homeless Assistance Act. The definition includes children from families who are doubling up in homes with relatives or other adults, as well as those living in shelters, motels, or cars. School districts are mandated to support school age homeless children and residents must have access the robust services mandated by this underutilized legislation. https://sudikoff.gseis.ucla.edu/black-students-overrepresented-among-la-county-homeless/

7). Streamline funding opportunities

A common issue is the speed and accuracy with which funding reaches the people most in need. To illustrate the need for streamlining we are including the process flow chart from the Commission on HIV's 'Assessment on Administrative Mechanisms' to emphasis the complex processes required for funding to reach agencies and even longer time frame for funding to get into the population(s) it is intended to reach. The timeline to complete this process is between eighteen to twenty-four months. See Appendix D. Procurement Process.

We must note that the process for residents in need of county services is just as complicated. Learning about, applying for, re-applying, accessing and waiting months before finally receiving services. So the services that were originally funded for a specific population may never get to the people intended, dollars evaporate into the bureaucracy – administrative lag time and ER visits are expensive. The main question here is, how much of this process is necessary?

Recommendations:

7a) The IAB recommends a review of funding provided to the community from multiple departments through the lens of how integration is fostered by this funding.

7b) The IAB recommends a removal of barriers between funding sources at the local level.

7c) Identify and eliminate duplication of efforts within the Health Agency.

8). Limitations / Challenges / Concerns

The IAB had a complex charge and struggled with defining its purview in relation to the far-reaching task of Health integration. We struggled with getting the quorum needed for voting meetings. IAB members often questioned whether they had full visibility on the benefits and challenges of integration and often experienced receiving incomplete information from one program or department rather than a clear picture of "integration". The departure of the Health Agency Director and placement of an "interim" had an impact on integration efforts and appeared to slow some of its momentum from within the Health Agency itself.

The IAB submitted previous reports and weighed in on the continuation of an advisory body to the BOS as a formal Commission for 2019 and 2020. While we recommend keeping the current structure, we believe changes to the composition must be made to encourage relationships across silos. We support improving processes in selecting and vetting members for skill sets needed such as end users of Health Agency services and

those who can commit the time required to address the complex issues involved in access to care in these early stages of integration. One member strongly suggested aligning all County boards and commissions to support healthcare integration but quickly realized that the county boards and commissions operate in silos. This reinforced the understanding that integration is based on mutual support and connection (between organizations and people) beyond the silos. Building pathways and connection is the foundation for healthcare integration, research in human health shows that strong connections and healthy relationships improve health. The same member reminded us that consumers often attend board or commission meetings out of frustration and pain, believing they are reporting challenges to a body that can resolve issues, they show up out of a need to be heard by real people– usually bypassing the cold, impersonal and time-consuming grievance processes. We learned that consumers do not know that the grievance process exists. Furthermore, most don't know how to make their voices heard or that constituent engagement, the health deputies and the Board of Supervisors do indeed want to hear from residents. We wonder if an ombudsman can assist with resolving consumer issues with a human touch and guidance to a fair outcome. We understand there is a grievance process within departments, we ask if this is enough.

Recommendations

1. Residents who experience Health Agency services should be heavily involved in providing feedback on accessibility and their success / challenges in access to care.

2. Clearly state and communicate when residents can weigh in on public decisions that impact health, an example is wireless 5G service, we've heard a lot about cost and speed but nothing about the health consequences of this technology built into our neighborhoods – has this discussion occurred? https://www.jrseco.com/wp-content/uploads/2017-09-13-Scientist-Appeal-5G-Moratorium.pdf

3. Implement Health Neighborhoods, mental health access should be everywhere.

4. Ombudsman services to improve services and resolve conflicts and grievances.

Acknowledgments

We wish to thank Mr. Fred Leaf, Interim Director of the Health Agency and Health Agency staff, Avianna Uribe, Regina Jemmott and Cheri Thomas for their work on the next generation of Health Agency priorities, their assistance in providing updates to the IAB, setting up for presentations and supporting IAB activities. We also thank Commission Services and all IAB members who committed their time, experience, expertise and talent

to this effort. We appreciate those who shared insights, wisdom and your willingness to learn.

Finally, we want to thank the Board of Supervisors for their vision and commitment to healthcare integration for Los Angeles County residents, and for convening the IAB to pay attention to the work toward the critical goal of access to coordinated high quality healthcare. We look forward to any questions or additional support we may provide in support of integrated care in Los Angeles County.

This report is dedicated to the memory of nine-year-old Trinity Love Jones.

A Tale of Two Cities: The Exploration of the Trieste Public Psychiatry Model in San Francisco

Article *in* Culture Medicine and Psychiatry · May 2015

DOI: 10.1007/s11013-015-9458-3 · Source: PubMed

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ORIGINAL PAPER

A Tale of Two Cities: The Exploration of the Trieste Public Psychiatry Model in San Francisco

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Abstract According to the World Health Organization (WHO), the "Trieste model" of public psychiatry is one of the most progressive in the world. It was in Trieste, Italy, in the 1970s that the radical psychiatrist, Franco Basaglia, implemented his vision of anti-institutional, democratic psychiatry. The Trieste model put the suffering person—not his or her disorders—at the center of the health care system. The model, revolutionary in its time, began with the "negation" and "destruction" of the traditional mental asylum ('manicomio'). A novel community mental health system replaced the mental institution. To achieve this, the Trieste model promoted the social inclusion and full citizenship of users of mental health services. Trieste has been a collaborating center of the WHO for four decades with a goal of disseminating its practices across the world. This paper illustrates a recent attempt to determine whether the Trieste model could be translated to the city of San Francisco, California. This process revealed a number of obstacles to such a translation. Our hope is that a review of Basaglia's ideas, along with a discussion of the obstacles to their implementation, will facilitate efforts to foster the social integration of persons with mental disorders across the world.

Keywords Anthropology · Mental Health · Basaglia · World Health Organization

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Introduction

"Up close, nobody is normal," 'Da vicino, nessuno e' normale,' reads a popular T-shirt created by the "users of mental health services" in a textile laboratory inside the former psychiatric asylum of Trieste. Nested on the Mediterranean coast, in between Venice and Slovenia, Trieste, an Italian seaport of 235,000 inhabitants, hosts a program of community mental health services called the "Trieste model," which has been recognized by the World Health Organization (WHO) as one of the most progressive in the world (World Health Organization 2001). Started as a pilot in 1974, Trieste is a Lead Collaborating Center of the WHO with a goal of disseminating its practices across the world. The "Trieste model" implements the ideas of Franco Basaglia (1924–1980), a radical Italian psychiatrist deeply committed to the vision that the person with mental illness, not his or her disorder or symptoms, be placed at the center of the mental health system (Scheper-Hughes and Lovell 1986). Basaglia's genius was in discovering that people with even the most severe mental illness could live a "normal" life accommodating their condition in the "community." An essential piece of this model is the creation of "life projects" by users of mental health services in concert with their care providers. These projects foster the engagement of persons with mental disorders in public life through proper housing, job placement, and opportunities to play sport and enjoy art or nature with other members of the community.

The Trieste model is extremely appealing for its original application of Basaglia's illumined vision. Foreign visitors are struck by the elegance of the environments used by users of mental health services, the enthusiasm of care providers, and the breadth of initiatives meant to integrate the persons with mental illness in their community. The visits of the authors to Trieste on different occasions sparked publications (Scheper-Hughes and Lovell 1987; Segal 1989), interactive conference and classroom exchanges in both countries, as well as a series of seminars in San Francisco Bay Area. The first 3-day-long seminar in 2005 centered on the visit of Dell'Acqua, a student of Basaglia and the director at the time of the Trieste Mental Health Department. The event generated so much interest that Dell'Acqua and Okin, the then chief of psychiatry of the San Francisco General Hospital, signed in 2006 an agreement of collaboration between the departments of Mental Health in Trieste and of Psychiatry at the San Francisco General Hospital, an institution affiliated with the University of California in San Francisco (UCSF). Over the ensuing 5 years, Mezzina, the new director of the Trieste Mental Health Department, closely collaborated with Okin and the other authors to determine what would be necessary to apply some of the principles, implement some of the programs, or "translate" the Italian model into the San Francisco system. The intention was to use this exploration to understand the obstacles and to conceptualize enabling mechanisms for the implementation of the Trieste model. In the end, it was concluded that the model could not be translated to San Francisco for a number of reasons discussed in this article. Our hope is that this experience can be useful to others as they consider initiatives to promote the genuine social

integration of users of mental health services in other parts of the world. The description of the mental health systems in the two cities will frame the discussion.

The Trieste Mental Health System

Starting in the 1960s, first in Gorizia and then in Trieste, Basaglia and his collaborators, mostly psychiatrists, and other care providers who endorsed his vision, challenged the prevailing medical, social, and legal justifications for the segregation of persons with mental illness. Basaglia, once an academic scholar who wrote dozens of dense essays on psychiatric phenomenology, technical scientific essays on neurology, and dabbled in experimental psychology (Basaglia and Basaglia Ongaro 1975, 1981, 2005), walked away from the ivory tower of academia, rooted in the asylum, and abandoned the medical scientific model of psychiatry to walk the streets of Trieste and to enter into the everyday lived world of the suffering.

Basaglia and his team refused to view even the most severe forms of mental illness as permanently incapacitating, as social deviance, or as a "dangerous" threat to "normal" people, as was common at the times. In radical contrast to these views, what came to be known as "The Trieste Model" promoted social inclusion and all forms of economic, political, and social opportunities for individuals with mental illness (Dell'Acqua and Cogliati Dezza 1985; Rosen, O'Halloran, Mezzina 2012). The successful phasing out of the mental hospital in Trieste led to the transfer of resources and services in the new community system of care (Rosen et al. 2012). This process culminated in the passage of Law 180 in Italy in 1978, the innovative legislation that led to the final closure of all asylums in Italy. Law 180, which mandated the creation and public funding of community-based therapeutic alternatives and affordable living arrangements, sought to restore the human, civil, and social rights of users of mental health services. The restoration of citizenship in its broadest sense—the right to live in and participate in the social life of the community, the right to housing, to form social cooperatives, to participate in unions, political parties, religious, and civil organizations, the right to be mentally different—was central to the process of deinstitutionalization in Trieste. The fulcrum of the restoration is the creation of a "life project" through the dialogue between service providers and the users of mental health services. Life projects are developed to infuse structure and to inspire meaning to the lives of those who seek mental health services. Through this project, therapist and user imagine the unfolding of relationships and resources over the course of the entire person's life. The focus on life projects raises the stakes as the psychiatrist and the entire care team shifts its attention from the symptoms and emphasis on bare survival to the long-term social integration of the individual. Providers enter a shared struggle with those suffering from severe mental health problems to fight the common existential experiences described as a void of daily life, as well as to restore or to build anew a network of social ties and support. The role of providers is to work side by side with the users who are seeking to change their subjective position of users from a state of passive dependence to one of active and engaged participation. In other words, the

life project enables the shift from managed exclusion to a true social inclusion, at least to the degree that users become individuals with the same rights and standing of other citizens. An essential ingredient to the success of the life project is the availability of resources such as affordable housing and health care services, as well as employment. The search for opportunities for recovery and social inclusion performed by the user in concert with the care team complements this approach.

Today, in Trieste, the Department of Mental Health that evolved from Basaglia's vision operates through 207 mental health workers, including 22 psychiatrists, 127 nurses, and 58 among psychologists, social workers, psychosocial rehabilitation specialists, and nursing aids. Providers operate in a small general hospital psychiatric unit, a rehabilitation and residential support service, and four community mental health centers. In 2012, they served more than 4000 users of these services. Most mental heath services in Trieste are provided through four community mental health centers, each covering a catchment area of 60,000 residents. Open 24 h every day, weekend and holidays included, each center has an average of six beds. On average, each of the four community centers provides inpatient and outpatient services for more than one thousand people per year. Persons in crisis or with acute psychiatric conditions sleep in their facilities rather than in the hospital (Mezzina 2014). As soon as their condition improves, they receive day care at home or in a community center. Started with the aim of reducing psychiatric hospital admissions and promoting rehabilitation and social integration, the community centers constitute the core of mental health services (Mezzina and Vidoni 1995). The community mental health centers epitomize the philosophy of the Basaglian deinstitutionalization through their design, locations, and services.

To elevate the status of the persons with mental illnesses in the community, aesthetic, comfortable well-lit, and tastefully furnished spaces were created. This has also the effect of nurturing a sense of self-worth and is meant to eliminate barriers between these spaces and the external world, as well as to eliminate the bleak look of many psychiatric institutions and even many community services. For instance, the "Barcola Mental Health Center" that Mezzina directed for decades is located in an elegant villa surrounded by a manicured garden facing the Adriatic Sea. Outside, its walls are painted in a bright yellow, and a rectangle of rosemary, lavender, and big pink daisies shields the front entrance veranda. Nearby trails leading to the beach or to a pinewoods park are often the backdrop of dialogs between providers and users. Inside, the first floor has a reception, an office, a pharmacy, and a large meeting room. The interior designer hired to create a social habitat employed colors, shapes, and a wooden floor to lighten the center. For instance, in the meeting room, a series of postcard-sized squared pictures of flowers are aligned on two white walls; wooden cream and azure chairs surround a white rectangular table. Sets against the wall are two wooden chairs with an extended seat so that they can accommodate three people. Sunlight enters in the community room where an interdisciplinary team meets every day to discuss the cases of persons followed by the center.

Community centers like Barcola are supported by the general hospital psychiatric unit that provides inpatient mental health services. Its six beds are mainly used as a filter for night emergencies, and it usually releases patients within 24 h, often referring them to their local community mental health center. Centers are also supported by staff of the rehabilitation and residential support service. Located in the former institution, the center manages 45 beds in group homes operated mostly by NGOs through personal budgets for the users. The aim of this service is to encourage users to move from living together toward independent or less supported housing schemes. Social workers, in coordination with providers in the rehabilitation and residential support service, help those in need of services in their search for a home. Once the home is found, sometimes the mental health providers organize a house-warming party with the help of neighbors to welcome the new residents to their community. Integration is also facilitated by various initiatives that encourage persons with mental illnesses to participate in community events such as soccer tournaments, literary and philosophical circles, music bands, and theatrical productions. Another important component of the Trieste model is the professional training in the form of on-the-job training, often with the participation and contribution of service users. The Trieste Mental Health Department pioneered these activities with the assistance of community members. The Department, which has control over the mental health system, led the development of initiatives aimed at integrating the psychiatric users into the social fabric and thus promoting their recovery.

The Trieste Mental Health Department also facilitated the creation of settings where users of psychiatric services manage small businesses following the social cooperative framework. Within this framework, workers participate in the decisions related to their business. In Italy, tax exemptions are provided for employees hired from disadvantaged members such as users of mental health services, as well as persons that were addicted to drugs, disabled, former prisoners, or youth at risk. In Trieste, the first cooperative was set up in 1973 by users supported by providers for cleaning the mental hospital where users resided. Despite an initial resistance from the administration, users of mental health services did join a cleaning cooperative and began working for the same hospital in which they were interned, under union rules and salaries. They were no longer inmates, but workers with salaries and rights. Today, the Tritone Hotel is a residence overlooking the sea entirely managed by a social cooperative mostly composed by users of services of the Trieste Mental Health Department. 'Il Posto delle Fragole' (Strawberry Fields Café) is a busy restaurant managed by users of mental health services. In Trieste, the cafés at the opera house, the public radio station, a historical bathhouse, all museums, public gardens, by contract with the social cooperatives employ at least one-third—generally more—of the mental health service users.

The allocation of funds by the Trieste Mental Health Department reflects the commitment to provide services in the community. In 2012, 20 % of the 18 million euros (approximately 25 million U.S. dollars) spent by the department were payments to service users, in the form of job grants and economic subsidies, as well as payments for group activities, trips, and personalized health care budgets, for an average of four million euros. On average, every year 180 people receive

professional training supported by work grants, with 13 % moving into non-subsidized jobs each year. Also, approximately 160 clients every year receive a personal health care budget to cover support services for their "life projects" including housing, work, and the building of relationships. Only 6 % of the overall budget in 2012 was spent on in-patient services and 6 % on pharmaceuticals. The remaining funds financed community-based services.

It is useful to place the reform of Trieste's mental health system into the context of what occurred in the rest of Italy. Basaglia was able to exploit the accomplishments in Trieste as a way of formulating and gaining approval for Law 180 in 1978. His success partially stemmed from the sudden receptivity of the political establishment that felt threatened by the "Radical party." The latter were preparing to promote a national referendum that would have abolished the current law based on asylums, but without creating a community mental health system to replace them. Through Law 180, Basaglia's intention was to create an extensive system of community mental health centers in the regions supported by a limited number of beds for crisis care in local general hospitals. Well aware that the Trieste model, such as other avant-garde experiences (Arezzo, Perugia) was attained as a result of a very committed team, a circumscribed and favorable political environment, and certain auspicious demographic factors, Basaglia sought through Law 180 to replace mental hospitals with a community-based system.

The process of reforming Trieste's mental health system and enacting Law 180 was relatively smooth in that city, but the process of disseminating the reform in the rest of Italy was hindered by a number of factors, including Basaglia's sudden death 2 years later. First, lacking a national budget to implement the law, each of the 21 Italian regions was often faced with the difficult challenge of executing the law without the money necessary to do so. Moreover, it was a full 15 years after the enactment of Law 180 that a national plan of mental health was developed to guide the implementation of the Law. This plan was authored by Basaglia's widow and former students. Second, care providers throughout many parts of Italy often felt uncomfortable in providing services outside the institution, which delayed both the implementation of the Law and the promulgation of supporting legislation in many regions.

The results of these obstacles can be seen in certain parts of Italy today. Some regions continue to have weak and unfocused community-based services and fail to provide adequate crisis care or long-term supportive services. Moreover, most community mental health centers are open only 8 h a day, 5 or 6 days a week, and rarely offer 24/7 service, or the kind of comprehensive, life-centered care available in Trieste. Trieste and the region of Friuli Venezia Giulia continue to provide the most progressive services in the country and follow users for their whole lives (Mezzina 2014).

Notwithstanding this evidence for an incomplete implementation of Basaglia's vision, the overall results of the Italian reform initiatives have been dramatic. By 1999 all mental hospitals were closed. Community mental health centers under the authority of regional Mental Health Departments were created in each region at a ratio of one center for a population of 80,000. Fifteen bed inpatient units in general hospitals (one bed every 10,000 residents) currently operate in most parts of the

country along with day centers and 19,000 sheltered community residential beds in small group homes, more than in any other country in Europe (Mezzina 2014). In the area of employment, there are over 4500 social cooperatives, each of which employs both disabled (30 %) and non-disabled people. These are supported by government tax incentives. Finally, the number of involuntary commitments throughout the mental health system has fallen dramatically and is the lowest in all Europe (Rosen et al. 2012). Notably, this has been accomplished without an increase in the suicide rate, without a significant increase in homelessness, and without trans-institutionalization to jails, prisons, or forensic hospital sector, all of which had been wrongly predicted by the Law's critics.

The San Francisco Mental Health System

San Francisco is a relatively small, compact city with a population of 850,000 with stark disparities in the income of its residents. In the last 6 years, San Francisco surpassed New York as the U.S. city with the highest income gap between rich and poor residents, and the number of very poor and disadvantaged people is very large. This creates a situation in which the demand for human services is intense and competitive. In San Francisco, the intersection of a strong market economy and a retrenched welfare state led to two types of care for persons with mental disorders. According to the American Community survey, approximately 39,000 San Franciscans had a mental disorder in 2006. While affluent residents with mental disorders can afford private premium services that integrate them into their communities, the majority of those with meager resources cannot access these services and rely on the public mental health system. This system consists of a patchwork quilt of community-based services operated by many non-profit agencies. Because of the rash way in which deinstitutionalization was implemented in California and because of the relatively high migration of mentally ill people to the city, San Francisco is home to a very large number of people with severe mental illness. As in other parts of the U.S., the social safety net on which these people depend is thin, and their economic rights are very limited. In contrast to Italy, in San Francisco there is no right to housing, a very restricted right to health care, and a system of welfare payments that are so low as to keep people who depend on them in abject poverty. Compounding this is the fact that the family structure in the U.S. is much looser than that of Italy with much greater geographic dispersion of family members. Many people with mental and physical disorders, as a result, cannot rely on their families for support. This situation is further aggravated by the fact that housing prices in San Francisco are exorbitant and only a very limited stock of decent affordable housing exists (Erwert 2014). Even the middle class struggle to pay rent. San Francisco has one of the tightest housing markets in the country and no effective mental health service for people with severe mental illness has been successful without the provision of adequate housing. In addition, as in many poor and complex urban areas, the incidence of neglect is high, which creates a feeder system for certain kinds of mentally disabled adults. Finally, drugs are readily available and drug abuse is rampant, especially in the poorer areas of the city.

The San Francisco Department of Mental Health oversights the system of mental health care and provides the majority of its 212 million dollar funding. In proportion to the population, this budget is much greater than that of Italy; however, the populations served in the two cities are very different, as are the local political, economic, and social systems. The San Francisco mental health system comprises 21 acute involuntary inpatient beds and 42 locked sub-acute beds in the San Francisco General Hospital, 80 additional acute beds in non-profit hospitals, 250 sub-acute beds in several locked facilities outside the city, and an array of community mental health services, some operated by San Francisco Department of Public Health, others by nonprofits. The local community mental health services consist of outpatient clinics, case management services, crisis intervention programs, and over 3000 supported housing units for previously homeless people. In addition, one 24 hour supervised crisis intervention home provides emergency residential treatment to acutely ill patients who do not require hospitalization, and several group homes and cooperative apartments provide longer term residential treatment.

The UCSF-affiliated department of psychiatry at San Francisco General Hospital is a major provider of community mental health services. In addition to its inpatient services, the department operates the city's psychiatric emergency service, eight assertive community treatment programs, and other individual intensive case management services for thousands of patients at risk of psychiatric hospitalization, as well as for repeated users of inpatient treatment, high users of the criminal justice system, and high users of the medical emergency room (Okin et al. 2000). The department also operates a Trauma Recovery Center for victims of violence who are showing symptoms of emotional problems (Boccellari et al. 2007). Through their personal clinical relationships with clients, the case managers in each of these programs give their clients intensive, often daily support which they need to survive in the community. In addition, they help their clients get access to housing and public medical and welfare benefits.

Notwithstanding this array of services, the public mental health system has not been able to keep pace with the demand. Beginning in the 1970s, a large number of mentally ill people were discharged from state mental hospitals in California, all of which were closed or converted to forensic hospitals to house the severely mentally ill prison population. Because resources generally did not follow patients from the mental hospitals into the community, many formerly hospitalized patients ended up in San Francisco without services. Many others came to the city from other parts of the country, attracted by the mild weather and liberal politics of the city. The combination of a very large number of mentally ill people, the lack of affordable housing, the drug epidemic, the thinness of the social safety net, the dearth of affordable housing, and the relatively loose family structure has led to a virtual abandonment of many mentally ill people in the city. Despite the fact that many are cared for and supported by excellent state-of-the art case management programs, many others are treated by overwhelmed staff who can barely work to control their acute and chronic symptoms, much less help them develop life projects, attend to their social needs, or help integrate them into the life of the community. Because adequate health, welfare, and housing services are not provided through the public

human service system, the mental health system must pick up some of the slack through its own limited budget. Patients are consequently limited in what mental health services they can expect and often have to wait years for housing with on-site treatment and support. Others, cut off from their families, are forced to live alone in poor, dilapidated Single Room Occupancy Hotels with minimal supervision, where they barely survive in small, cramped rooms without a private kitchen and bathroom. They survive on Supplemental Security Income, a public subsidy that barely covers the cost of their rooms. Because of the paucity of vocational and social programs their lives are empty. They have little to do during the day except hang out in their rooms or on the street, often assuaging their symptoms and counteracting boredom through resorting to hard drugs. While a handful of people are occupied in supported work and other life projects, the overwhelming majority are not.

A cursory examination of streets and jails shows the abandonment of these people. There are 6000 homeless people in this relatively small city of which over 2000 are mentally ill, most having substance abuse disorders as well (Sullivan, Burnam, and Koege 2000). Many other mentally ill people are incarcerated in jails and prisons, facilities that have largely replaced mental hospitals as institutions fulfilling society's determination to segregate and hide from view these stigmatized people. An estimated 25 % or 13,000 San Franciscan jail inmates have a psychotic disorder based on DSM IV (James and Glaze 2006).

It needs to be emphasized that this situation exists in San Francisco despite the many successful, if inadequate, efforts at reform that have taken place in the U.S. over the past 50 years, most of which have prevented the situation from being worse than it is. These reforms, though often overlapping with those of Trieste, have a lineage that is independent of Basaglia and the Italian experiment, and have their own American wellsprings. In 1948, 30 years before Law 180 was passed in Italy, Fountain House, the first Clubhouse model of care, was opened in New York. This model, which centers on supportive vocational services, socialization, "member" empowerment, and inclusion in the life of the community now serves 100,000 people and has been replicated in many other countries. In 1963, under President Kennedy, the Community Mental Health Centers Act (Mechanic 1990) was enacted which represented the first time that the federal government substantially assumed some responsibility for people with mental illness, responsibility that had historically been held by the states. Since then, mental health services were included in the general health legislation of MediCaid[1] and MediCare[2] in 1966 (Mechanic 1990). Supplemental Security Income was broadened to encompass welfare payments to substantially and permanently disabled mentally ill people (Daly and Burkhauser 2003). In 1990, the Americans with Disability Act was passed in Congress, which prohibited discrimination on the basis of disability, and the Mental Health Parity Act was enacted which required health insurance companies to provide insurance for certain mental health conditions on a par with physical conditions. As it became apparent just how many mentally ill people needed

[1] Medicaid is the public health insurance system for indigent persons in the U.S.

[2] Medicare is the public health insurance system for adults 65 years of age and older in the U.S.

housing assistance, the federal government began to fund a variety of housing initiatives, which have now culminated in the provision of a Shelter-Plus-Care policy, enabling people to gain supported housing placements with opportunities for help in living more productive lives. In parallel with these federal executive and legislative reforms, the Supreme Court handed down a number of decisions restricting the use of involuntary medication and involuntary commitment and asserting a limited statutory right to community services under certain conditions. It must be said that these decisions, along with state legislation, though by and large positive, had the paradoxical effect in many cases of exchanging peoples' freedom from involuntary hospital care to involuntary incarceration and leaving many in need of protection of their health and safety on the streets to "die with their rights on."

Meanwhile, at the local level, experiments in the provision of services were occurring that had important effects on the ways that people with serious mental illness were being treated. Group homes (Okin 1983), Assertive Community Treatment Teams (Stein and Test 1980), Clubhouses (Sweet 1999), transitional employment services (Drake et al. 1996), integrated treatment such as the Village in Long Beach (Chandler et al. 1997), consumer-directed and -operated programs and other services of the consumer and survivor movements (Athena 2010; Tomes 2006), all had a major impact on the treatment landscape across America. An emphasis on person-centered care, rehabilitation and recovery, community integration, and experiments in the closure of state hospitals (Okin 1995) similar to Trieste's initiatives in many places supplanted the emphasis on mere symptom control. Underlying this emphasis was the conviction that mental illness could not exclusively be conceptualized in biological terms, but was highly influenced by the social circumstances in which they developed, ideas that were very prominent in Basaglia's writing as well. Anti-stigma community education efforts, which were a required service of the CMHC Act of 1963, have continued to be funded, though very modestly, at national, state and local level. These have their parallels in Basaglia's original initiatives in educating the city of Trieste about mentally ill people using patient-operated radio programs, articles in the press, and public events.

Structural Differences Between Trieste and San Francisco

Major historical and structural differences exist between Trieste and San Francisco that largely explain the difficulties the latter has had in implementing successful reform. Compared to San Francisco, Trieste is a middle class, homogeneous city with strong community support networks, very limited drug abuse, and no homelessness. There are, as a result, a relatively small number of people who need human services and an even smaller number who need mental health services. People with severe mental illness who are homelessness, as well as addicted to drugs, poor, and without family support practically do not exist in Trieste. Also, Trieste has a declining population and a surplus of affordable housing that enables its mental health services to accommodate their clients in affordable and dignified

apartments, and without a draw on its mental health budget. Housing is considered a right of citizenship supported by the government. Moreover, Trieste exists in a country with a strong family structure, a relative lack of geographic dispersion among family members, and a strong sense family responsibility. A crucial function of the Italian government is to protect the social and economic rights of its citizens. Italians have a right to health care, housing, support for families, and a concept of subsistence. Finally, the history of Trieste's mental health reforms, including the fundamental challenge to institutional values and the grass roots political support that the mentally ill garnered from other disadvantaged groups have all influenced the shape of the resulting community mental health system. The movement—at least in the 1970s—was supported in the political arena by a broad spectrum of allies among social movements for workers, women, and students whose social critiques overlapped with the critique of the mental asylum and a recognition of the mentally ill as the most disadvantaged and oppressed class in society (Scheper-Hughes and Lovell 1986). This strong alliance supported innovative services for mentally ill people, condemned their abandonment, and gave tremendous impetus to the social aspirations of the deinstitutionalization movement, including the full social integration of the mentally ill and the restoration of their citizenship and their buried human capacities. The widespread support among civil rights and labor rights groups in Trieste for the social integration of the mentally ill prevented the traditional medical establishment from toppling the movement as wildly romantic, impractical, and political sentiments that were widespread among traditional psychiatrists.

This context is extremely different from San Francisco, a city with wide economic disparities, a large class of people who are extremely poor and thus depend heavily on the government for services, a lack of affordable housing, substantial numbers of homeless people, an ongoing drug epidemic, and a lack of economic opportunities for very poor people, much less disabled poor people. In contrast to Trieste, San Francisco exists within a neoliberal nation that values freedom, individual autonomy, and civil rights over economic and social rights, including the right of mentally ill people to be a real part of society. There is limited mental health funding and much of what exists occurs through a medical reimbursement system that is severely capped and does not fund many of the interventions needed by mentally disabled people including jobs, and life projects. The biological model which underlies this fee-for-service reimbursement system requires that services be "medically necessary" as the condition of funding, rather than also "socially necessary."

Although deinstitutionalization first began 50 years ago, San Francisco, like many places in the U.S., has not been able to escape the way it was implemented (Segal and Jacobs 2013). Throughout most of the deinstitutionalization movement, people with mental illness had few political allies and were never adopted by either of the mainstream political parties or by advocacy groups that shared their marginalized status. In contrast to Trieste, the political forces interested in cost containment predominated over those invested in improving patients' lives. Most of the funds from the declining hospital system were reabsorbed by the state budget

rather than being used to finance a community system (Segal 1979). The community system was thus starved of resources at the outset.

Moreover, the political philosophy underlying the deinstitutionalization movement in the U.S. was not as radical as in Trieste. The American emphasis on liberty in the context of social and economic abandonment led to the dumping of patients from mental hospitals into the streets. Both a cause and an effect of the impoverishment of the community system, providers in San Francisco were forced to focus most of their attention on clients' bare survival rather than on the promotion of citizenship, inclusion, and life projects. Consistent with this, the historical lack of economic opportunities in San Francisco for very poor people, with no government support available to businesses that hired mentally ill people, insured that the latter would be deprived of resources, a reasonable social status and the self esteem that comes from working, and would remain dependent on a government welfare system that kept them in abject poverty. Since there was never any fundamental challenge to the hierarchical power relations including the role of clinicians as "experts" that suppressed patients in institutions, the "new" services that were developed in the community often perpetuated the authoritarian values that characterized and supported the "old" mental hospital. These values were frequently antagonistic to a more egalitarian relationship between providers and clients and made it more difficult to help the latter flourish in society. As San Francisco demonstrates, the reforms in the U.S. that have taken place over the years since deinstitutionalization has not gone far enough, have not been funded enough, and in many cases have only created islands of excellence, whose generalization has been hampered by funding limitations, by demographic problems, and by a thin social safety net.

In summary, the development of community services in the United States by and large took place in a sociopolitical and demographic context that was much less hospitable to reform than in Trieste. Moreover, in contrast to Trieste, the challenge to institutional values was less radical in the U.S., the anti-stigma efforts on which social inclusion depended were less extensive, and the health care system was saddled with a medically oriented form of reimbursement that did not pay for certain crucial services that mentally people needed to thrive in society. Further the process of deinstitutionalization was much less focused on what persons with mental disorders needed (certain kinds of community services), rather than on what they did not need (the institution), as the term deinstitutionalization so aptly conveys. Finally, in many places in the United States, the administrative authority for implementation of reform was fragmented between different levels of government, and among different agencies within each level. In Trieste, implementation occurred under the authority of a single administrative entity.

Different Approaches

The exploration of the translation of the Trieste model in San Francisco also stimulated a rich dialog among the authors of this paper as they grappled with the structural differences between the two cities. While all authors agreed that a wholesale translation of the Trieste model to San Francisco was unconceivable

given the above structural differences, questions emerged on the practical application of Basaglian ideals and on the efficacy of initiating ad hoc micro-initiatives. A report created by Mezzina (2007) after his one-week visit of the San Francisco's public mental health system started the discussions. It is important to share the report, as well as the questions it generates, as these ideas can inspire initiatives meant to increase the social integration of users of mental health services.

As a starting point, Mezzina suggested the consideration and review of the San Francisco General Hospital, as well as any services for the mentally ill. This review, he suggested, should include the inspection of the services provided, their vision, as well as of the relationships between staff and patients, the staff's attitudes, the psychiatrists' perspective and assumptions, and the overall social function of the "institution." This review should begin at the user's level. For example, with regard to the homeless, Mezzina suggested that the providers of services place themselves in the users' place and perspective. Care providers should reconstruct and analyze what normally happens when a San Franciscan presents with the first psychiatric problems, at what point in time either the service arrives, or the person arrives at the service. Once the person connects to the services, providers should study what happens within the service in terms of pathways of care, procedures, protocols, practices, as well as ways out of the circuit. To facilitate the empowerment of users of mental health services, all the care providers who serve these persons must feel empowered as well. Within this frame, the gap between psychiatrists and other professionals such as nurses and social workers should decrease. The continuity of care should be a priority of the entire mental health care team. As a result, the therapist and the mental health team should follow the users of services as they leave the hospital and move into the community. This implies a consistent transfer of resources, particularly staff, to services based in the community. On a related note, care providers should consider the person as a person and not simply as a patient, and thereby become responsible not only for the mental illness but the overall integration of the individual in his or her community. In this case, the attention expands from the illness to the person and their life as a whole. This essential paradigm shift initiated by Basaglia 40 years ago requires that mental health care providers become the 'missing link' that connects the person to essential social and community services, following up on them and making sure that the connection is maintained, and solving any issues that may arise in the process. This requires a new roadmap for mental health service workers who are contained within a paradigm that is overly bio-medical and clinical, focused on the diagnosis, the illness and behavioral problems, as if these encompassed the entire history and needs of the person with mental disorders.

The first question raised by this first set of recommendations is How is it possible to implement these changes within the constraints of a system that pays providers for specific bio-medical interventions rather than for recovery and social inclusion? In other words, how is it possible for providers to expand their role and the mission of their service when they are already overcommitted and their salaries tightly tied to specific actions that exclude their service seekers' lives in the broader context: housing, meaningful work, meaningful relationships, space for creativity, love, and recreation? In addition, how is it possible for providers to provide a continuity of

care given the scarcity of resources available for low-income users and given the elevated degree of co-morbidity of these individuals, who are also often drug-addicted, homeless, recently released from jail or from prisons where they have been subject to institutionalized human rights abuses and consequently often lacking or deprived of any informal support system?

What is the value of reviewing personnel roles when the time and the space needed for change is not supported by the limited requirements and salaries of the mental health service workers? First and foremost, the rules need to be changed and that is a huge and largely political undertaking. For example, a capitation model in which a set amount of money is provided for each enrolled person assigned to the care workers per period of time, rather than the existing fee-for-service model would give more leeway to providers to move beyond their traditional roles. However, changing the pay model would not solve the shortages in personnel, in community mental health services, rehabilitation, or safety net services. Moreover, in other areas of the U.S. where a capitation model has been used, it has often led to a neglect of persons with severe mental illness. This occurs because the model has incentivized providers to deliver the least amount of care they can get away with, as the lesser the services provided, the larger the profit margin.

The next set of questions challenges the value of initiating changes at the microlevel with the hope of breaking new ground at the macro-structural level. These structural questions are inspired by the work of Basaglia as he sought the endorsement of the political sphere to implement his vision on a long-term basis. The questions can be summarized as Is it really enough to beautify the environments provided for users of mental health services? For example, Mezzina's recommendation was to find resources to upgrade a single occupancy room facility (a so-called "hotel") occupied by users of mental health services and to have the upgrade done mostly by the new residents themselves. Questions arose about the amount of work required to renovate a hotel, the cost, and the extent of these upgrades. One, helping the future residents do the upgrade would take considerable time from care providers, unless these providers were willing to volunteer some hours each week to this end. Two, while temporary resources—grants from foundations or nonprofits for example—would likely fund and manage this original initiative, it is less clear though for how long these resources would be available on the long term. Creating and sustaining beautiful, dignified, and safe housing would have to be a long-term continuing revolution, to invoke the language of Franco Basaglia.

With the role of the state retreating, the overlapping initiatives of non-profits usually have a short reach because of the limited and temporary resources available to them. Even initiatives on a larger scale and funded by the state have limited long-term funding. For example, the Affordable Care Act signed by President Obama in 2010 allows states design "Health Homes" to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions. The underlining principle is that residents of these homes receive primary, acute, behavioral health, and long-term services and supports to treat the whole person. In line with the Basaglian vision, the state website states "CMS [Centers for Medicaid and Medicare Services] expects states health home providers to operate under a 'whole-person' philosophy" (Medicaid.Gov 2015). However, when we look at the source of

funding of this innovative initiative, we learn that federal funding will last for only the first 2 years of the project, and then the providers need to obtain resources in other unspecified ways. Overall, the obstacles to secure financial support for long periods of time challenges isolated initiatives such as the renovation of a hotel. A lesson from this experience is that unless government creates a stable source of funding, it is rather risky to develop long-term projects publicly endorsed in the first 2 years of their life.

A third set of recommendations revolved around the Basaglian therapeutic model of "life project." According to Mezzina, care providers should forge a "therapeutic alliance" with the users of mental health services and envision practical steps that will lead to the social integration of the user of mental health services. Questions that arise from these ideas are once again related to the feasibility of making this shift given the scattered and limited amount of resources available to low-income users and the fact that the weak to nonexistent safety net for poor people in general creates a vacuum which is under current conditions all but impossible to fill.

Finally, the last set of Mezzina's recommendations focused on the creation of events that would provide opportunities for synergies between users of mental health services and their community. With Basaglia, recruiting well-known artists such as Ornette Coleman and Nobel Prize awardee Dario Fo perform at events organized and hosted by the mental health department and attended, as well as organized by, those using mental health services helped dismantle the stigma associated to mental illness. Related initiatives involved acclaimed poets, philosophers, and theater directors collaborating in plays performed by users of mental health services at major local theatres. The media can also educate the public on the importance and challenges of integration. For example, acclaimed movies such as *The Best of Youth* showed the abusive conditions of a group of mentally ill who were forced to live in a basement and their liberation by the efforts of psychiatrists following the Basaglian model. Recently, an Italian television series dedicated to Basaglia appeared in prime time on the national television channel. Here is one instance where the strong and resilient arts and film and performance history and culture of California could be recruited to establish grants and events such as a summer film festival of the absurd, that might create a space to recognize the madness that is inside all of us. California is the birthplace of many famous music and film festivals, including the Dickens Fair, the Jewish film festival, and the Renaissance Faire in addition to radical projects like the Burning Man festival in Nevada. The Basaglia movement was enhanced enormously by music and film and by the radical Italian film collective, inspired by Basaglia, that produced award-winning films including *Madness My Love* and *Blue Planet*.

Conclusion

The demographic differences between Trieste and San Francisco, along with the structural problems of the latter, the drug epidemic, the thinness of the social safety net, along with other factors made it impossible for the authors to envision translating the Trieste model to San Francisco. Although San Francisco hosts many

excellent services with radical aims that have improved the lives of thousands, its experience demonstrates that the efforts at reform in the U.S. over the last 50 years, though significant could not alter enough the crucial structural obstacles to fundamentally transform the experience of people with mental disorders. They may have less symptoms, but most are still living in poverty, deprived of meaning and aspirations. A mental health model of care, no matter how progressive, cannot be fully implemented in the absence of a hospitable context in which to embed it. In fact, this is one of the reasons that the Basaglia's model has not been fully implemented in the rest of Italy beyond Trieste. Despite the robustness of the social safety net, and other elements conducive to reform, other factors crucial to its translation have not been fully present there.

Notwithstanding the profound differences between the two cities, the Trieste model has much to teach us and can serve as an important source of inspiration and validation of some of the American experiments whose lineage was different. It reminds us that any progressive mental health system must be based on a belief that mentally ill people are first and foremost human beings with social and economic rights, not just civil and political rights; that they have a right to flourish, not simply be free of overt forms of coercion; that their problems in many cases are not simply biological, but are aggravated by the society in which they live; and that providers are responsible for addressing the totality of their needs, not just their symptoms. The Trieste model is inspiring precisely because it demonstrates what people with mental illness are capable of when they are helped to lay claim to their economic, social, political, and civil rights, and are given access to mental health services that include a vision of mental health as part of life itself.

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Appendix B. Narrative Summary – Jails
Correctional Health Services

The Los Angeles County Sheriff's Department had control over the Medical Services Bureau for many decades. This Bureau included the medical professionals that worked throughout the jails and detention facilities countywide. Since they were employees of the Sheriff's Department, those professionals were well regarded and protected by the deputies while working inside correctional facilities.

When the Los Angeles County Health Agency was created to incorporate DMH, DPH, and DHS under one umbrella the Medical Services Bureau of the Sheriff's Department was moved into DHS as Correctional Health Services. Because of the integration, the staff of the Sheriff's Department and the Medical Professionals are separate and in effect work in silos.

This reduced the Sheriff Department's budget and also reduced protecting workers in the Medical Services Bureau. Apparently, correctional staff were directed away from protecting the DHS Professionals. At times, nurses are left alone with inmates of the opposite sex. There have been attempts by inmates to rape nurses, there has been physical altercations involving inmates and nursing staff, and other instances where deputies leave the nurses to fend for themselves. Several nurses have been mentally harmed by actions of inmates and the non-action of the deputies to protect them. Many nurses now have PTSD and are in mental health therapy.

There are other issues of two separate departments working together, as well.
One example was the grievance filed to get paper towels for the medical staff to dry their hands between seeing patients. Allegedly, the Sheriff's staff refused to supply them, because the towels were for DHS employees therefore not in their budget. Incidentally, dry hands spread fewer germs. A second example is that nurses who work at Men's Central Jail (MCJ) are excluded from using the LASD shuttle from Union Station to MCJ because they are under DHS. Therefore, the nurses must walk up Alameda to the jail, in many instances after dark, thus experiencing the abject poverty of homeless residents, discharged inmates, and whatever else may occur. The medical professionals that work in jails and detention facilities should be supported and safe rather than placed in a hostile and dangerous workplace environment.

The IAB reached a consensus on our recommendation that the Correctional Services Bureau should IMMEDIATELY be reviewed and encouraged to protect the lives of the County's medical professionals, create a somewhat safer work environment and facilitate medical care to persons housed in the county jails.

AMERICAN PUBLIC HEALTH ASSOCIATION
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Addressing Law Enforcement Violence as a Public Health Issue

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Abstract

Physical and psychological violence that is structurally mediated by the system of law enforcement results in deaths, injuries, trauma, and stress that disproportionately affect marginalized populations (e.g., people of color; immigrants; individuals experiencing houselessness; people with disabilities; the lesbian, gay, bisexual, transgender, and queer [LGBTQ] community; individuals with mental illness; people who use drugs; and sex workers). Among other factors, misuse of policies intended to protect law enforcement agencies has enabled limited accountability for these harms. Furthermore, certain regulations (e.g., anti-immigrant legislation, policies associated with the war on drugs, and criminalization of sex work and activities associated with houselessness) have promoted and intensified violence by law enforcement toward marginalized populations. While interventions for improving policing quality to reduce violence (e.g., community-oriented policing, training, body/dashboard-mounted cameras, and conducted electrical weapons) have been implemented, empirical evidence suggests notable limitations. Importantly, these approaches also lack an upstream, primary prevention public health frame. A public health strategy that centers community safety and prevents law enforcement violence should favor community-built and community-based solutions. APHA recommends the following actions by federal, state, tribal, and local authorities: (1) eliminate policies and practices that facilitate disproportionate violence against specific populations (including laws criminalizing these populations), (2) institute robust law enforcement accountability measures, (3) increase investment in promoting racial and economic equity to address social determinants of health, (4) implement community-based alternatives to addressing harms and preventing trauma, and (5) work with public health officials to comprehensively document law enforcement contact, violence, and injuries.

Relationship to Existing APHA Policy Statements

- APHA Policy Statement 7121: Substance Abuse as a Public Health Problem
- APHA Policy Statement 8817(PP): A Public Health Response to the War on Drugs: Reducing Alcohol, Tobacco and Other Drug Problems among the Nation's Youth
- APHA Policy Statement 9123: Social Practice of Mass Imprisonment
- APHA Policy Statement 9926: Support for Research on the Socioeconomic Causes of Violence
- APHA Policy Statement 9929: Diversion from Jail for Non-Violent Arrestees with Serious Mental Illness
- APHA Policy Statement 20128: Opposing the DHS-ICE Secure Communities Program
- APHA Policy Statement 200914: Building Public Health Infrastructure for Youth Violence Prevention
- APHA Policy Statement 201311: Public Health Support for People Reentering Communities from Prisons and Jails
- APHA Policy Statement 201312: Defining and Implementing a Public Health Response to Drug Use and Misuse

Problem Statement

Prevalence, impacts, and inequities: Law enforcement violence is a critical public health issue. Consistent with domains of violence defined by the World Health Organization (WHO), law enforcement violence has been conceptualized to include physical, psychological, and sexual violence as well as neglect (i.e., failure to aid).[1–3] While all forms of violence are important to consider and have been shown to correlate with poor mental health outcomes in at least one study,[1] this statement focuses on physical and psychological violence.

According to The Counted (a United Kingdom–based Web site that operated from 2015 to 2016 and was the most timely, comprehensive source of U.S. data at the time),[4–6] at least 1,091 individuals were killed by law enforcement officers in the United States in 2016.[7] These deaths amounted to 54,754 years of life lost.[8] Based on data from the Centers for Disease Control and Prevention (CDC), there were 76,440 nonfatal injuries due to legal intervention in 2016.[9] At least 28 serious injuries were inflicted on students between 2010 and 2015 by school-based law enforcement officers.[10] The CDC estimates that the overall cost of fatal and nonfatal injuries

by law enforcement reported in 2010, including medical costs and work lost, was $1.8 billion.[11] Legal scholars describe a clear connection between increased exposure to stops and an elevated risk of death or physical harm by law enforcement officers.[12]

Inappropriate stops by law enforcement are one form of psychological violence with serious implications for public health.[1,2] Even in the absence of physical violence, several studies have shown that stops perceived as unfair, discriminatory, or intrusive are associated with adverse mental health outcomes, including symptoms of anxiety, depression, and posttraumatic stress disorder.[1,13,14] In addition, one study revealed that neighborhood-level frisks and use of force were linked to elevated levels of psychological distress among men living in these neighborhoods.[15] In two large surveys, Black individuals were more likely than White individuals to report stress as a result of encounters with police[13,14]—a concern given evidence of an association between stress due to perceived racial discrimination and risk factors for chronic disease and early mortality.[16] A nationally representative study showed an association between deaths among Black individuals due to legal intervention and subsequent poor mental health among Black adults living in the same state.[17]

The impacts of physical violence likewise extend beyond injuries and death, affecting individuals' and communities' ability to achieve positive health outcomes in the short and long term and compounding extant health inequities. For example, one study revealed that residents of neighborhoods with high rates of law enforcement use of force were at increased risk for diabetes and obesity.[18] Among youths, exposure to violence from school-based law enforcement officers has been linked to "denial of educational and social growth"[19]—both key determinants of health [20]—and ethnographic research indicates that current policing practices alter key developmental processes among Black male adolescents.[21] In summary, aggressive policing is "a threat to physical and mental health" that may be exacerbated among marginalized populations.[13]

Marginalized populations are inequitably affected by law enforcement action and violence. People of color accounted for more than 50% of years of life lost due to legal intervention in 2016 but account for just under 40% of the U.S. population.[8] Native Americans have been killed by law enforcement at a higher per capita rate than any other group in the United States (3.5 times higher than White Americans), with these mortality data likely to be an undercount.[7,22] In 2016, Black and Native American individuals were more than two and three times (respectively) as likely to be killed by law enforcement as White individuals.[7] Stratification by gender and age showed that male Blacks and Native Americans 15 to 34 years of age were nine and six times (respectively) more likely to be killed than other Americans in their age group.[7] Similarly, Black women are disproportionately represented among women killed by police.[23] Black and Latino individuals are more likely to be stopped and arrested and to experience nonfatal violence by law enforcement.[1,24–27] Of the 4,400 individuals shot by officers from the 50 largest police departments from 2010 to 2016, 55% were Black, more than double the proportion of the Black population in these departments' jurisdictions.[28] In 2012, Black and Native American individuals were admitted to emergency departments for injuries due to legal intervention at proportions three and six times (respectively) their representation in the general population,[29] and in a nationally representative sample of emergency departments during 2001 to 2014, Black individuals 15 to 34 years old were treated for legal intervention injuries at almost five times the rate of their White counterparts [30]. Students most at risk for violence by school-based law enforcement officers include children with disabilities, students of color, and poor students.[31]

Other marginalized populations also experience inequitable exposure to law enforcement violence. Among recorded U.S. deaths attributed to law enforcement in 2015, an estimated 27% involved individuals with mental illness.[32] Other groups highly affected by law enforcement violence include people who identify as transgender, lesbian, gay, and/or bisexual[1,33]; individuals experiencing houselessness[34]; low-income individuals[1,35]; sex workers[36,37]; and people who use drugs.[2] Women also experience sexual violence by police officers, particularly women of color. In a 2003 study in New York City, 38% of Black women, 39% of Latina women, and 13% of Asian or Pacific Islander women reported being sexually harassed by police officers.[38] Immigrant communities are subject to policing from local, state, and federal immigration authorities such as the Department of Homeland Security's Bureau of Immigration and Customs Enforcement. Immigration raids result in "immigration enforcement stress" and fear of interacting with government agents and informal social networks.[26] Policies that increase law enforcement contact or fear of contact create barriers to health care and other health-supportive services (e.g., Medicaid, harm reduction programs, and domestic violence services) for undocumented individuals and their U.S. citizen family members.[39–43] The disproportionate impact of policing on these communities has been documented since at least the 1960s.[44]<

Insufficient monitoring and surveillance of law enforcement violence: The data presented above likely underestimate the magnitude of law enforcement violence given that comprehensive information on deaths, mental and physical injuries, and frequency of encounters is limited (e.g., there are no systematic public health data on sexual assaults committed by police).[45] While the Federal Bureau of Investigation's Uniform Crime Reporting System and the CDC's National Violent Death Report System (NVDRS) generate some data on injuries and fatalities by law enforcement, they neglect indicators vital to understanding the magnitude and scope of the issue, such as type of injury, deaths on federal property (e.g., federal prisons, tribal lands, military bases), and types of law

enforcement officers involved.[46–48] Most concerning, reporting occurs on a voluntary basis. As a result, even the NVDRS—the most reliable of the official reporting systems[48]—notably underestimates deaths by law enforcement.[6] The U.S. National Vital Statistics System failed to capture 55% of such deaths in 2015 due to misclassification.[4] The magnitude of disparities in violence committed by school-based law enforcement officers is likely underestimated as well, given communication challenges and unreliable mechanisms for reporting abuse . [31] Given this situation, public health practitioners and researchers must rely on nongovernmental, Web-based social media data sources such as The Counted, which captured 93% of deaths by law enforcement in 2015.[4,5] Yet, it is feasible to gather reliable, real-time data on law enforcement-related deaths via existing public health reporting mechanisms.[6]

Policing as a mechanism of social control that exacerbates social inequity: The ecosocial theory of disease distribution holds that to meaningfully analyze and interpret the population distribution of a health exposure, a grounding in the historical context from which the exposure emerged is necessary.[49] Namely, U.S. policing was historically deployed for the social control of communities deemed socially marginal (i.e., in the 19th century, it evolved from ruling-class efforts to control the immigrant working class in the North and slave patrols in the South).[50]

Policies and practices continue to implement and sustain this historical intent. For example, the war on drugs assigned drug use intervention to law enforcement in lieu of formulating a public health approach. Scholars suggest that the associated “tough on crime” rhetoric was a racially coded appeal to White populations across class lines aimed at legitimating targeted policing in communities of color.[51,52] By encouraging drug arrests with cash incentives, loosening restrictions on searches, and creating a culture that encouraged law enforcement to repeatedly stop and search people of color without reasonable cause, the federal government disproportionately subjected marginalized communities to increased contact with the law enforcement system.[51] Data-driven policing is another example of a structural and targeted policing practice that links crime to place and race and facilitates increased contact with law enforcement among marginalized communities.[53,54]<

Policies and practices that facilitate a system of discriminatory policing are particularly problematic given the weakening of the Posse Comitatus Act, the enactment of the National Defense Authorization Act, and the 1033 program, which distribute surplus military equipment to local and state law enforcement agencies.[24,55,56] Delivery of military equipment to law enforcement agencies precipitates military-style training, allows military weapons to become the tools of law enforcement, and increases the use of special weapons and tactics (SWAT), resulting in increasing rates of use of force and extrajudicial murders by law enforcement—disproportionately among marginalized communities.[24,57] The observed militarization and extensive purview of domestic law enforcement are facilitated by mounting investments of federal funds in police departments and financial enticements.[51]

Research on predictors of police force size has indicated that the system of law enforcement upholds existing racial and class hierarchies by targeting socially marginalized groups, often low-income communities of color. Key predictors maintaining an association with police force size after control for crime rates include the size and growth of populations of color, racial economic inequality, and poverty.[58,59] Such findings suggest that these populations are perceived as a threat to the social order and that policing is used as a mechanism of control.[58,60] Upholding social hierarchies perpetuates and exacerbates adverse health outcomes among those who are already disproportionately affected by inequities in key social determinants of health, or those underlying factors that “affect a wide range of health, functioning, and quality-of-life outcomes and risks” and are widely understood in the field of public health to be the primary contributors to persistent health inequities.[61] These factors include access to education and economic opportunities, perceptions of public safety and exposure to violence, quality of housing and transportation, social norms and attitudes (e.g., discrimination, racism, and distrust of government), and availability of community-based resources.[20,61]

Ineffective response to social problems: The concentration of policing in socially marginalized communities—and the associated public health threats—stems from a framework that crime originates from inherently “bad” individuals and communities, or a “thin blue line” ideology.[44,50,60,62] Yet, the social determinants of health framework indicates that efforts to promote physical, mental, economic, and social well-being are more effective if premised on an assessment of the social conditions underlying the behaviors that are typically addressed through the criminal justice system. With this framework, the range of interpersonal harms and behaviors deemed “criminal” can be understood from a social determinants of health perspective as emerging from social inequities. Theft, as just one example, can be understood as a behavior to meet material survival needs in the context of poverty due to long-standing, systematic economic disinvestment from low-income communities of color, and intra-community violence has been shown to be linked to the chronic stress of poverty.[61]

Criminalization of houselessness, sex work, and drug abuse exemplifies how law enforcement is deployed to rectify social inequities.[34] However, laws that criminalize houselessness (e.g., local and state laws prohibiting loitering and sleeping in public spaces) are costly to enforce, perpetuate houselessness, and violate basic human rights, among other harms to public health.[63,64] According to the National Law Center on Homelessness and Poverty, criminalizing behaviors associated with houselessness violates the United Nations Convention Against Torture,

and it recommends that federal agencies take active steps toward decriminalization while funding constructive alternatives.[65] Police officers have also indicated that criminalization of houselessness is an ineffective response to the root cause and that responsibility for addressing houselessness should reside outside of law enforcement's purview.[66] Criminalization of sex work likewise results in high rates of law enforcement violence toward sex workers and those assumed to be sex workers, such as transgender women of color.[33] Similarly, punitive strategies of addressing drug abuse show little evidence of reducing substance abuse and have proven harmful to working-class communities of color.[67]

Although the need to invest in addressing the social determinants of health is clear, government spending on social services such as housing assistance and education has decreased since the 1980s. The Center for Budget and Policy Priorities documents a median budget reduction of 26% among 11 of the 13 largest health, housing, and social service block-grant programs between their inception in the 1980s and 2016 and a $13 billion reduction in these funding streams between 2000 and 2016.[68] Yet, spending on policing increased 445% between 1982 and 2007, including a 729% increase in federal funding[34] The Center for Population Democracy found that, in nine of the 10 cities it examined, more than one quarter of general funds were committed to local police departments. For instance, in Oakland, California, 41% of the general fund went to the police department, which had a 19% budget increase between 2013 and 2017 while total city expenditures increased by just under 8%.[3]

Barriers to accountability and reform: Between 2005 and 2011, only 47 police officers across the United States were charged by prosecutors with a crime for their involvement in civilian deaths, with 11 of these 47 individuals convicted.[69] Multiple barriers impede accountability and obstruct meaningful reform. Cultural barriers such as efforts to "protect one's own" can manifest in a "code of silence," or a norm of not reporting other officers' misconduct and protecting them during investigations.[26,70,71]

Laws and policies such as state-based police bills of rights (generally referred to as law enforcement officers' bills of rights, or LEOBORs) and police union contracts provide law enforcement officers accused of excessive use of force or murder with protections from investigation and disciplinary action, known as "super due process."[72,73] including suppression of law enforcement data related to deaths.[74] LEOBORs are found in 14 states and first emerged in the 1970s, when law enforcement officers pursued unionizing efforts in reaction to grassroots mobilizations demanding democratic accountability and transparency over police (e.g., civilian review boards) given experiences of officer misconduct, corruption, and brutality.[75,76] LEOBOR provisions can generally be broken into two categories: those that should be eliminated due to their ability to hinder efforts to hold law enforcement officers accountable (e.g., investigative delays)[76,77] and some protections that should be extended to everyone, including civilians suspected of a crime (e.g., limits on the duration of interrogations).[78] Rights and protections present in some LEOBORs that protect law enforcement officers from merited accountability include the following: unreasonable limitations on reporting time that disqualify civilian complaints, restriction of interrogation of officers to other sworn officers, preventing civilian investigators from interviewing or investigating officers, and restrictions of public access to disciplinary records.[76] In addition, investigative delays, coupled with notifications of who will interrogate an officer and unrestricted access to all of the evidence brought against an officer, allow officers to prepare the most exculpatory and/or least inculpatory narrative.[75–77]

Structural racism embedded within "legal, social, and political systems…enable[s] police officers to disproportionately stop people of color, often without cause…with greater use of force [and] without any repercussions."[79] Protective laws and policies, obstruction from oversight, and cultural norms inhibit accountability, confound reform, and lead to harm, especially among marginalized communities.

Evidence-Based Strategies to Address the Problem

Improving surveillance and reporting of law enforcement violence: Improvements to existing public health monitoring systems, such as expanding the NVDRS to include all states and moving to more timely processing and release of data at the local level—not just the state level—could prove highly effective.[6,48,80] To leverage the success of The Counted in capturing and classifying deaths by law enforcement, state and local public health agencies could collect additional data beyond what are typically reported by using validated, existing social media sources. In addition to these data already being publicly available, they capture real-time reports that include data on age, gender, race/ethnicity, and census tracts of residence and death, and they serve to correct misclassification in vital statistics.[4,5] With regard to reporting, transparency can help identify appropriate policy and programmatic interventions; evidence indicates the success of transparency measures such as making health inequities visible by presenting data stratified in relation to categories of race/ethnicity, nativity, gender identity, sexual identity, and socioeconomic position; including housing tenure (as a proxy for houselessness); and including type of law enforcement official, mechanism of death (e.g., firearm, Taser, chokehold), and locale of death (e.g., on the street, in the decedent's home, at a school, at a border crossing).[3,6,81] Furthermore, a mechanism for state and local public health agencies to share data with various entities can encourage appropriate prevention and intervention measures, such as sharing with state attorney generals for further investigation.[82]

Decriminalization of activities shaped by the experience of marginalization: As criminal justice scholars have argued, mass criminalization is a key mechanism through which communities of color experience heightened rates of law enforcement violence.[12] Others have concluded that disparities in contact with law enforcement may be a

root cause of differential exposure to physical violence by law enforcement and that "reducing inequality in police stops can simultaneously reduce inequalities in exposure to violence."[1] Therefore, a critical step in reducing structurally mediated physiological and psychological violence by law enforcement is to repeal laws that promote or justify increased scrutiny of specific populations. Such laws include those relating to drug use or possession, sex work, houselessness, and immigration. By removing justification for law enforcement intervention, this will reduce encounters between law enforcement officers and individuals whose activities are presently criminalized. Crimes should not simply be downgraded to lower-level offenses; for example, research shows that marijuana-related arrest rates remained stable or increased when possession was reclassified as a lesser offense but was still considered against the law.[83] By contrast, in Massachusetts courts ruled to limit police enforcement of marijuana possession, and arrests fell by 86%.[83] Not only can drug decriminalization reduce arrests and incarceration, it also has the public health benefit of increasing uptake of drug treatment, with cost savings due to redirecting resources from criminal justice to the health system.[84] Regarding sex work, one meta-synthesis of qualitative studies concluded that New Zealand's full decriminalization of sex work was associated with reductions in law enforcement contact and improvements in HIV prevention among sex workers.[85] These findings may be generalizable to the U.S. context and serve as a model for structural intervention. Decriminalization is consistent with the WHO recommendations for structural interventions that address social determinants of health for marginalized groups.[61]

Under certain legislation, criminalization extends to protesting and mass mobilizations, which are vital means by which marginalized communities voice concerns. In 2017, several states passed anti-protest legislation; among them were North Dakota and South Dakota, where, in 2016, protestors against the Dakota Access Pipeline at the Standing Rock Indian Reservation—including many Native Americans—were met with violent force by local law enforcement and the North Dakota National Guard, leading the United Nations to declare human rights violations.[86,87] Advocating against such laws is critical to protect free speech and human rights and to reduce unnecessary contact with law enforcement.

Reallocation of funds from policing to the social determinants of health: As described above, policing reproduces inequitable social and economic conditions that precipitate intervention by law enforcement. This places both law enforcement officers and marginalized community members at risk of injury, death, and adverse health outcomes. By contrast, a public health approach targets the structural inequities that manifest in criminalized behaviors by addressing the social determinants of health[88,89] This type of approach includes increasing access to housing, expanding educational and employment opportunities, increasing access to mental health and substance use treatment, and restoring a sense of safety by addressing interpersonal and institutional factors contributing to perceptions of safety and experiences of discrimination.[61] The social determinants of health approach is associated with reduced community trauma and interpersonal harm and improved community health and safety,[88] and it is the basis of the CDC's recommendations for data-driven, community-level, prevention-focused interventions.[90] This approach is a key element of the Movement for Black Lives platform, a policy agenda that calls for "reallocation of funds at the federal, state, and local level from policing and incarceration…to long-term safety strategies such as education, local restorative justice services, and employment programs."[91]

Evidence demonstrates the benefits of shifting from criminalization to a framework grounded in social determinants and primary prevention. For example, there is a well-established link between improving educational attainment and positive employment and socioeconomic outcomes and subsequent positive short- and long-term health outcomes.[92] More evidence is found in houselessness services. The U.S. Interagency Council on Homelessness recommends providing permanent housing as a proven approach to improve health among those experiencing houselessness, as such efforts have been associated with higher housing retention rates, reductions in use of crisis services and institutions, and improvements in health and social outcomes[93] and have been cost effective.[94,95] Similarly, because exposure to violence is a critical determinant of health and can lead to further violence by trauma survivors and later contact with law enforcement,[96] "trauma-informed" approaches to care and policy are recommended across sectors.[97] Reinvestment in community resources can also occur in tertiary prevention by using a health model for crisis response. For example, health workers in Oakland are training community members to respond to mental health crises and suspected overdoses in ways that minimize law enforcement involvement.[87]<

The above evidence, combined with decreasing crime rates,[34] suggests that funds disproportionately allocated to policing could be more effectively invested in social services to improve health, particularly in communities where historically rooted endemic disinvestment has negatively contributed to health disparities.

Strategies to ensure community safety without reliance on armed law enforcement: Although greater social and economic equity is likely to lead to higher quality of life for marginalized communities, interpersonal harm will still exist, and strategies to ensure community safety will still be necessary. Alternative approaches can improve public safety without the harms associated with the system of policing. For instance, community-based violence intervention programs that detect and interrupt potentially violent conflicts, identify and address high-risk situations, and mobilize the community to change norms have significantly reduced homicides and nonfatal

shootings in urban neighborhoods with the highest numbers of incidents.[98] These programs have had success employing violence interrupters and culturally appropriate unarmed street outreach workers; these interrupters have been able to defuse potentially harmful or violent situations with no, or minimal, intervention by police.[98]

Similarly, restorative justice is a nonpunitive approach to resolving interpersonal harm through dialogue among perpetrators, victims, and others affected without reliance on law enforcement. Its implementation in school settings has been associated with reduced suspensions, expulsions, and referrals to law enforcement.[99] Future programs might increase efficacy by ensuring that the populations most affected by law enforcement violence lead program design and implementation, which is a widely acknowledged best practice.[100]

Opposing Arguments and Evidence

Arguments against reducing law enforcement presence and ensuring accountability as mechanisms to address law enforcement violence assert that these strategies will increase crime, decrease public safety, and harm public health. Others propose to address law enforcement violence through tactics such as community-oriented policing, use of body-mounted cameras and Tasers, and increases in officer training. This section presents these arguments along with research that suggests the former strategies are aligned with a public health approach and have a negligible impact on increasing crime or decreasing public safety, while the latter tactics do not address the structural predictors of law enforcement violence or its health implications..

Decriminalization harms the public's health: Proposals to decriminalize drug possession and sex work are often met with concern that doing so will negatively affect the public's health. For example, opponents suggest that decriminalization of drugs leads to an increase in drug use and higher rates of traffic accidents. Initial research on decriminalization has yielded mixed findings.[101,102] and studies show that the legitimate concern about negative health effects of drug use is better addressed with health service approaches. Data from Portugal, which decriminalized all drug use in 2001, as compared with Spain and Italy—which maintained criminal penalties for drug use—showed increased uptake of drug treatment, reductions in opiate-related deaths and infectious diseases, and increases in the quantity of drugs seized by the authorities due to shifting law enforcement resources from minor possession crimes to a focus on traffickers.[103] Many organizations support drug decriminalization to improve human rights and public health, such as the Office of the United Nations High Commissioner for Humans Rights,[104] the Joint United Nations Programme on HIV/AIDS,[105] and the UN Office on Drugs and Crime.[106] Existing APHA policy supports a public health strategy on drug use marked by recommendations for an end to criminalization of personal drug possession and use (APHA Policy Statements 7121, 8817, and 201312) and prioritization of treatment and harm reduction strategies such as ensuring access to sterile syringes.[107] WHO recommends that countries work toward decriminalization of drug use and sex work as a means of reducing known barriers to health services and treatment.[107]<

Regarding sex work, there are concerns that decriminalizing sex work could facilitate human trafficking, exploitation, and other forms of violence. Sex workers and advocates note that sex work is not synonymous with "sex trafficking" and distinguish among various forms of sex work (sex work, survival sex work, and forced sexual labor) as it relates to the nuances of sex workers' experiences (including interactions with police).[108] As noted above, an environment of fully decriminalized sex work can improve health outcomes and reduce interactions with police.[107] Decriminalization and/or full legalization of all forms of sex work have been overwhelmingly recommended by sex worker study participants and by human rights organizations, including Amnesty International and WHO, citing these approaches as means to remove harms caused by disproportionate psychological and physical law enforcement violence and to eliminate punitive laws that inhibit sex workers' abilities to report human trafficking, forced sexual labor, and other forms of violence and exploitation.[36,108,109]

Increased law enforcement funding protects the public's health: Because of the current structure of civil society, institutions of law enforcement are perceived as necessary to protect the public from harm and violence either through direct intervention or as a crime deterrent vis-à-vis increasing perceived risk of arrest. The argument follows that reducing law enforcement budgets will adversely affect communities. However, an incremental increase in the quantity of law enforcement officers has not been linked to decreased violent or property crime. In fact, a meta-analysis of studies published between 1973 and 2013 showed that there was no statistically significant association between police force size and combined violent and property crime rates and that violent crime remained stable when law enforcement abruptly withdrew from neighborhoods.[110] A nationally representative survey of urban areas revealed that police force size did not act as a crime deterrent for violent or property crimes vis-à-vis increasing perception of arrest risk.[111] In school settings, there is no evidence that school crime or mass shootings have been reduced by increasing campus presence of law officers (known as school resource officers).[112] Ultimately, research suggests that law enforcement presence has not been shown to consistently reduce crime, especially violent crime, and its adverse impacts on people's lives. Nonetheless, spending on municipal policing has increased substantially over the last few decades.[34] Proponents of increases in law enforcement funding argue that decreasing crime trends are a result of this increased investment. However, the Congressional Budget Office and researchers note that multiple drivers can explain this reduction, including demographic and economic changes and social investments.[3,113]

Interventions should implement novel policing strategies (e.g., community-oriented policing, body cameras, Tasers, training) rather than reducing law enforcement presence: Some have argued that specific policing strategies such as community-oriented policing (COPS) will reduce law enforcement violence. COPS was designed to increase policing effectiveness by building relationships between law enforcement and communities to address the crisis of legitimacy police departments experienced after the urban rebellions of the 1960s.[114] Seventy percent of police departments across the United States report COPS activities.[115] COPS strategies have changed over time and are inconsistent across departments but may include assigning specific patrol officers to a single neighborhood, encouraging partnerships with community organizations and other city agencies, and emphasizing problem solving in conjunction with the community,[34] arguably "significantly broaden[ing] the reach of the police, perhaps giving them even more discretion."[114]

Numerous investigations of COPS — including a 2014 meta-analysis — show little impact on crime prevention or community members' feelings of safety; however, COPS appears to be associated with increases in citizen satisfaction and perceived police legitimacy and decreases in perceived disorder.[34,116] Historically, government agencies have recommended COPS strategies as a means of improving relationships between community members and law enforcement officers, especially after high-profile deaths by law enforcement, rather than as a mechanism for reducing law enforcement violence.[44,62]. For example, the Chicago Alternative Policing Strategy (CAPS) at the Chicago Police Department, which was lauded as effective and helped pave the way for the national COPS program, has been under continued scrutiny as a result of police brutality and killings.[26] If the goal of public health is to reduce violence due to underlying structural and social determinants of health, strategies should aim to reduce the violence of the system of law enforcement rather than be designed primarily to improve relationships between law enforcement officers and members of marginalized communities.[82]

Few studies of COPS critically assess the nature of partnerships that police develop with communities and who is included in—or excluded from—the "community." An important exception is a grassroots research project conducted by a community group that visited meetings of CAPS in neighborhoods across the city, focusing on neighborhoods affected by gentrification.[116] The group reported that police officers encouraged the mostly White, property-owning residents who attended CAPS meetings to surveil their neighbors, report minor infractions such as loitering and public drinking, and report anyone who seemed "out of place," turning to law enforcement interventions more frequently and quickly, which results in increasing "surveillance of a community's most vulnerable residents or visitors."[116] This pattern of increased surveillance has been observed in other cities and has been posited by legal scholars as one pathway that promotes law enforcement violence against African Americans, raising important questions about perpetuation of social and racial discrimination through COPS.[52] Finally, community policing coexists in many departments alongside more aggressive policing styles, including increased surveillance and racial profiling, which may be employed to address issues identified in community contexts even as departments publicly emphasize community-oriented activities.[117]

Another tactic argued to address law enforcement violence is technological tools, such as conducted electrical weapons (known as CEWs or Tasers). While CEWs may be less lethal than handguns, they were associated with more than 500 deaths from 2001 to 2014, 90% of which occurred when the victim was unarmed.[118] Risk of adverse effects from Taser shocks is higher among people who suffer from preexisting cardiac conditions or other medical conditions, such as those who are prone to epilepsy or who are experiencing drug intoxication.[118] Adverse consequences of CEW shocks are also higher after a struggle.[118] Amnesty International and the UN Committee on Torture recommend restricting use of CEWs to situations in which police would otherwise use lethal force.[118,119]

Increased funding for body-mounted cameras is often put forth as a measure to reduce law enforcement violence because of the presumed increase in transparency and accountability offered by these devices. An oft-cited example of body cameras' success is in Rialto, California, where reports of use of force by law enforcement dropped by 50% in the first year of body camera implementation and citizen complaints dropped by 88%.[120] However, more representative studies have shown harmful associations of use of force with body camera use or no associations at all. A national study of more than 2,000 departments revealed a statistically significant association between wearable body cameras and a 3.6% increase in fatal police shootings of civilians and no significant association with use of dash cameras.[121] The largest and most rigorous randomized controlled trial on the use of body cameras, conducted by the District of Columbia's Metropolitan Police Department, showed that wearing body cameras had no statistically significant effect on use of force, civilian complaints, officer discretion, whether a case was prosecuted, or disposition.[122]

Issues related to policy, protocol, and intentional sabotage raise additional questions about the efficacy of body- and dashboard-mounted cameras in decreasing law enforcement violence or increasing accountability for perpetrated violence. One third of police departments using body cameras do so without written policies, which may give officers discretion over their use and lead to selective recording.[123] Most existing policies on body cameras do not guarantee that law enforcement agencies must make footage publicly accessible, and many other policies are inconsistent or unclear.[123] Recordings may also be deleted by police; in Chicago, 80% of dash-

camera video footage was missing sound due to error and "intentional destruction."[124] Even when key events are recorded, these videos do not necessarily increase accountability because of the cultural, institutional, and structural barriers described above.

Another oft-touted reform is mandatory training to reduce implicit bias of law enforcement officers against communities of color. This training is predicated on the understanding that officers' decisions to use (or restrain from) force are influenced by unconscious biases, such as associations between Black individuals and criminality.[125] However, little is known about the effects of these biases on behavior, and no experimental studies have measured the impact of implicit bias reduction interventions among law enforcement officers.[126]

Other methods of proposed training to improve community experiences with law enforcement include crisis intervention team (CIT) training, generalized deescalation training, and mental health training, which can involve interagency collaborations. For example, CIT-trained officers are taught to recognize people suffering from mental illness and crises, deescalate the situation, and link individuals with mental health care rather than having them face arrest. A systematic review of interagency collaboration models for contact with police among mentally ill people revealed that evidence regarding the efficacy of such training and collaboration models is limited, that there have been no robust evaluations, and that existing efforts rarely examine the impact of community experience with police or police use of force, focusing instead on organizational outcomes such as arrest rates, which occur after initial contact with police.[127] In the example of CIT, existing studies are based on data collected from surveys of officers in classroom settings and not actual outcomes with citizens.[128] Public health scholars and organizations including the International Association of Chiefs of Police and the National Research Council acknowledge that only very limited evaluation of law enforcement training has occurred, and extant evaluations have focused on officers' attitudes rather than on-the-job performance.[129–131]

Officers generally receive limited deescalation training,[132] and national efforts to increase deescalation training have been met with resistance from police chiefs and the national Fraternal Order of Police.[133] Leaders from these groups have expressed fear that hesitation to use force may put officers' lives at risk. In this context, it remains to be seen whether deescalation training will lead to less law enforcement violence, and more rigorous evaluation will be necessary to warrant any scalable implementation.

While not addressing the root causes of law enforcement violence discussed above, CIT and other deescalation training could function as harm reduction for law enforcement violence. In keeping with this statement's other recommendations, if additional training of law enforcement officers is used as a harm reduction strategy, then one must consider the investment of funds and other resources required to do so as restitution, ideally using reallocations from existing law enforcement budgets and savings from eliminating enforcement of laws that do not promote public safety. Furthermore, as previously stated, such programs would require rigorous evaluation to maintain funding.

To sum up the opposing argument regarding implementation of novel policing strategies, efforts to improve the behavior law enforcement officers are at best unsupported and at worst perpetuate harm. The notion that escalating law enforcement presence is the antidote to inequality is inherent in these opposing arguments. Even if some strategies demonstrate benefit, they fall short of addressing the fundamental causes of the issues law enforcement agencies are deployed to address. Moreover, they obscure the fact that law enforcement presence in marginalized communities has historically served to maintain state control over said communities. While President Obama's Task Force Report on 21st Century Policing recommended training, COPS, and body and dash cameras,[62], it did not incorporate upstream, public health strategies to address root causes of law enforcement violence. Although it acknowledged unrealistic roles delegated to police officers and that policies related to drug use and sentencing affect policing, it deemed these policies "beyond the scope of a review of police practices."[62] This acknowledgment lends support for an upstream, public health approach to mitigating law enforcement violence, focusing on community-based alternatives, and reducing contact with law enforcement. Such upstream approaches will prove even more critical in the context of federal administrations that promote aggressive policing policies and practices.

LEOBORs protect law enforcement officers from unfair administrators and false accusations: As described above, LEOBORs were intended as law enforcement protections from aggressive, coercive administrators and false accusations. However, as noted by Jonathan Smith, former chief of special litigation in the Civil Rights Division of the U.S. Department of Justice, LEOBORs and collective bargaining agreements create "barriers to actual accountability that don't serve the public good," given that law enforcement officers can accumulate multiple complaints and remain employed (and even see upward career mobility).[78] Provisions in LEOBORs that rightfully protect officers from coercive interrogations when they are suspects of crime—such as conducting interrogations at reasonable times and guarantees that they can attend to their biological needs—would better serve public health if extended to all suspects.[78]

Conclusion: While public safety is essential for public health, as a society we have delegated this important function almost exclusively to law enforcement. Evidence of continued law enforcement violence shows that U.S. policing has failed to equitably deliver safety, placing an inequitable burden of mental and physical harm on socially

and economically marginalized populations.[134] Indeed, as argued by Geller et al., "any benefits achieved by aggressive proactive policing tactics may be offset by serious costs to individual and community health."[13] Community-centered strategies for addressing harm and violence can increase public safety without the violence associated with policing. Investment in these strategies, as well as comprehensively documenting and intervening in cases of law enforcement violence, is a promising way forward.

Action Steps

Therefore, APHA:

1. Urges federal agencies, localities, and states to add death or injury by legal intervention to their list of reportable conditions, including the CDC adding legal interventions to its list of nationally notifiable conditions. APHA further urges the CDC to expand the NVDRS to include all states and move to more timely processing and release of data at the local level. APHA urges the CDC and the National Center for Health Statistics to create surveillance protocols informed by research on causes of misclassification and underreporting of deaths due to legal intervention and to provide technical assistance to states to rectify problems.

2. Urges that Congress fund the National Institute of Justice and the CDC to conduct research on the health consequences, both individual and community-wide, of law enforcement violence, particularly exploring the disproportionate burden of morbidity and mortality among people of color, people with disabilities or mental illness, people who are experiencing houselessness, poor people, LGBTQ populations, and immigrant populations. Funds should also support research to determine how to generate valid estimates of injuries due to police violence.

3. Urges that Congress also fund the National Institutes of Health to study the effectiveness of interventions that may decrease reliance on law enforcement, including decriminalization, increased investment in social determinants of health, and community-based alternatives that promote public safety, such as violence intervention and restorative justice.

4. Urges federal, state, tribal, and municipal governments to fund programs that meet human needs, promote healthy and strong communities, and reduce structural inequities (economic, racial, and social) — such as employment initiatives, educational opportunities, and affordable housing—including by using resources currently devoted to law enforcement.

5. Urges federal, state, tribal, and municipal governments to advance equity and justice by decriminalizing activities shaped by the experience of marginalization and eliminating officer enforcement of regulations designed to control marginalized people, including but not limited to substance use and possession, sex work, loitering, sleeping in public, and minor traffic violations (e.g., expired registrations, jaywalking, broken taillights) as well as targeting undocumented immigrants. Also, APHA urges these governments to ensure that decriminalized offenses are removed from the purview of law enforcement. An existing precedent is the Massachusetts Decriminalization of Misdemeanors Law.

6. Urges federal, state, tribal, and municipal governments and law enforcement agencies to engage in a review of law enforcement agencies' formal and informal policies and practices in order to eliminate those that lead to disproportionate violence against specific populations, contracting with nongovernmental organizations to do so to encourage objectivity. Examples of such policies and practices may include racial and identity profiling, stop and frisk, gang injunctions, and enforcement of laws that criminalize houselessness.

7. Urges federal, state, tribal, and municipal governments to allocate funding from law enforcement agencies to community-based programs that address violence and harm without criminalizing communities, including mental health intervention and violence prevention and intervention and restorative justice programs, particularly in the communities currently most affected by law enforcement violence. In the development and scaling of newer modalities for addressing and preventing harm, careful consideration should be given to constructing protections for privacy, dignity, and legal rights.

8. Urges federal, state, tribal, and municipal governments and law enforcement agencies to reverse the militarization of law enforcement, including by eliminating acquisition and use of military equipment and reducing the number of SWAT teams and the frequency of their deployment.

9. Urges state legislative bodies to eliminate legislative provisions that shield law enforcement officers from investigation and accountability and urges municipal governments (both executive and legislative branches) to negotiate police union contracts that eliminate barriers to identifying, investigating, and addressing possible misconduct on the part of law enforcement officers.

10. Urges law enforcement agencies and oversight bodies to provide full public disclosure of all investigations of law enforcement officer brutality and excessive use of force as well as access to recordings of any incidents in question, which should be deemed public property. These materials could be made public through an online database.

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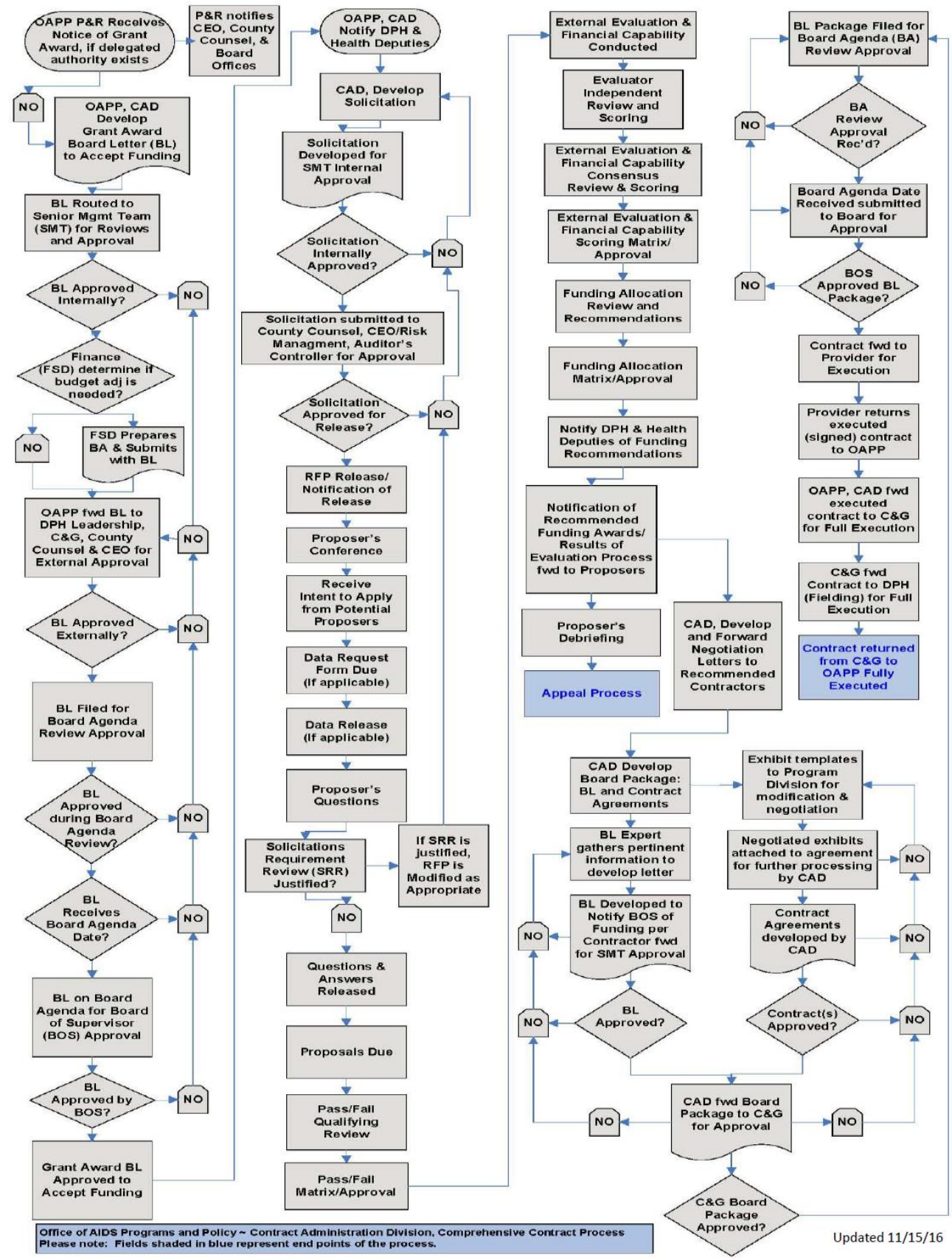
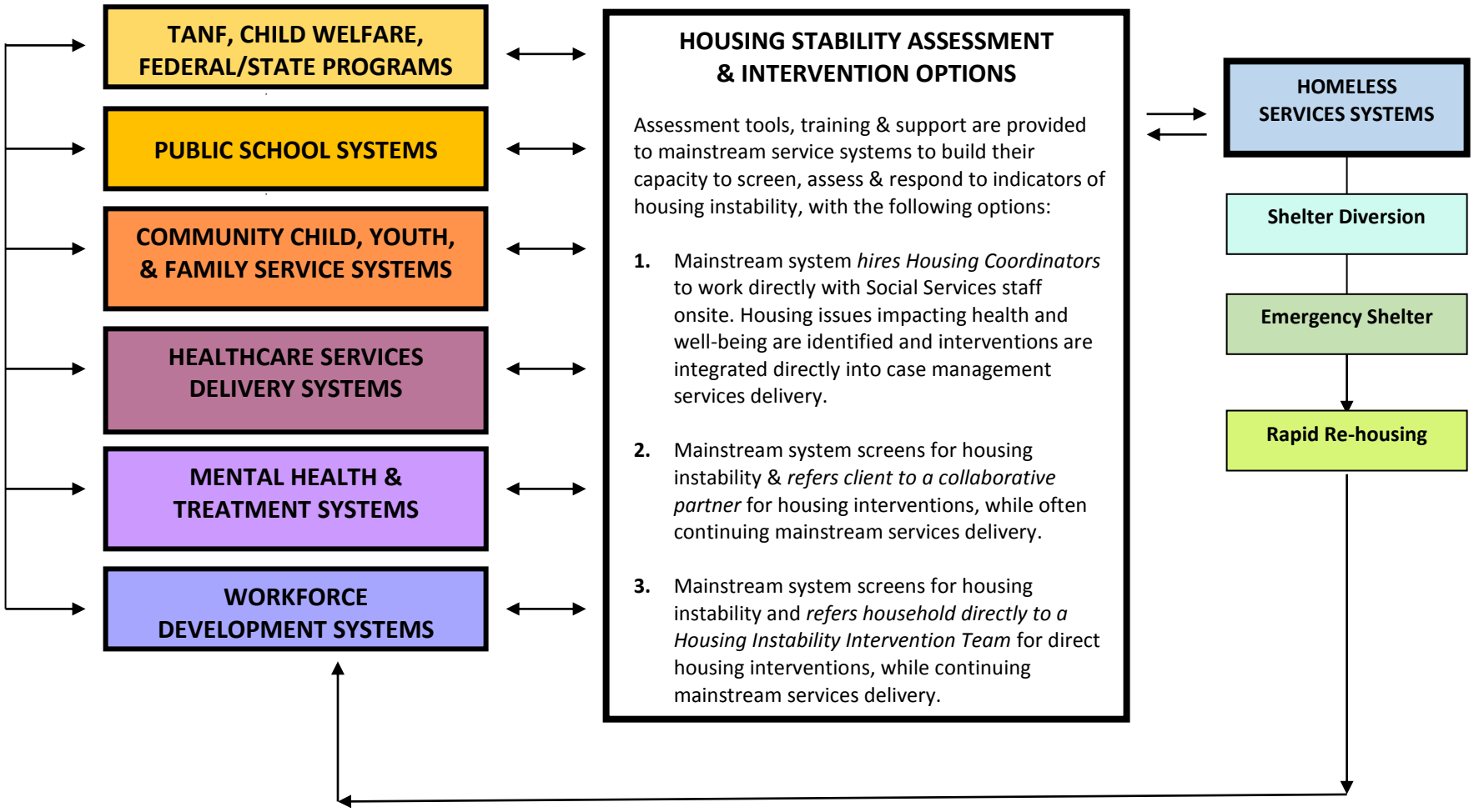
Appendix D. Procurement Process

Diagram of steps in procurement process as generated by Chief of Planning at DHSP *(note: references to OAPP are now DHSP)*



A SAMPLE FLOW CHART

Housing Stability Screening & Intervention Strategies



THE PREMISE: (1) Mainstream and community-based services systems screen for housing instability.
(2) Timely and appropriate interventions promote improved child and family health and well-being.
(3) Cross-sector, integrated and collaborative strategies provide a vital "housing safety net."