Adolescent Mental Health:
Systemic Factors Contributing to Cycles of Crisis in Michigan Youth

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Michelle Massey Barnes

Advocates for Mental Health of MI Youth
Co-Directions Laura Marshall | Rachel Cuschieri-Murray | Michelle Massey Barnes
https://mentalhealth4miyouth.com

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Advocates for Mental Health of MI Youth is a grassroots, parent-led group of over 500 parents that have come together from across the state of Michigan in the last 13 months. The group organized because parents are unable to access mental health treatment for children with the most intensive mental health and behavioral health needs. These families are frequently in crisis as they cycle in and out of Emergency Departments seeking mental health treatment they cannot access at inpatient or outpatient levels of care. These families are typically involved in multiple systems, and there is usually an overall lack of coordination of care between systems even though the systems themselves do not recognize this lived reality.

As the Co-Directors of this organization, we wanted to understand the wider contributing forces that shape the cycles of crisis parents experience as they struggle to find appropriate treatment for their children. We also wanted to understand the outcomes families face when therapeutic needs are not met.

With a blended understanding of both the factors that keep families stuck in cycles of crisis and the negative outcomes this causes, we went on to make recommendations for systemic changes based on lived experiences.

Presenting Problem:

Families across the State of Michigan are unable to access Home and Community Based mental health services designed to treat and stabilize emerging mental health conditions in children and adolescents. It is especially difficult when there are complex areas of needs such co-occuring mental health or neurodevelopmental needs and/or serious challenging behaviors. Instead of accessing medically necessary treatment, symptoms continue to exacerbate until the safety of the child or other family members can no longer be maintained.

At this point, families frequent emergency rooms seeking a higher level of care. Children are often denied admission to inpatient units, and families are told the child's needs are "behavioral." Families are routinely told inpatient units will not admit children with aggressive or other acute needs without 1:1 support, but the wait time for this level of staffing is months long. Families often wait days, weeks, and sometimes even months for inpatient beds while children are boarding in emergency departments without access to mental health treatment. Most frequently, after several days of unsuccessful inpatient bed searches, parents are told their children no longer

meet the criteria for inpatient admission, and children are discharged home from emergency departments without treatment and without adequate safety plans. Families are told to follow up with outpatient providers, but they are returned to the same outpatient system that could not provide adequate treatment before the emergency room visit.

As an organization, we wanted to understand:

1. Are there specific systemic factors contributing to this cycle of crisis?
2. What are the expected outcomes of these cycles of crisis?
3. From a parent driven perspective, what can be done to offset the difficulties of contributing factors and/or improve outcomes?

Methodology:

The Co-Founders of Advocates for Mental Health of MI Youth started a private Facebook group for Michigan parents and caregivers supporting children with Severe Emotional Disturbance or SED. These families self identify as families that frequently experience crisis because of the mental health or behavioral health needs of the child with SED. This group was started in February 2022. We created a website that also went live in February 2022, and in March of 2022, we started a public Facebook page to share stories collected in our private group. The public page allowed us to build awareness for the need for mental health by sharing true stories. We were able to protect the identity of individual parents by posting stories under the group's name without identifying the family that contributed the story.

The group did not advertise, but spread by word of mouth. New members typically join the group when invited by an existing member or when the link to the group is shared in a different Facebook group. Some members found the group through our website or our public facebook page. Each potential member must answer a set of membership questions, and each request is reviewed before the member is let into the group. We recognize that participation is limited to those that have internet access and the ability to spend time online networking with other parents.

The group is predominantly female. Although the group is also predominantly (though not exclusively) white mothers, many of the children being advocated for are children of color. Many of these children have previous involvement with the Child Welfare system through foster care and/or adoption. Some children were adopted internationally or from other states and they were not previously involved in the Michigan Child Welfare system.

As an online group, Advocates for Mental Health of MI Youth offers online support and advocacy, training guides, and advocacy calls with a professional advocacy organization

that supports our advocacy initiatives and outreach.

After trust was established with families, the Co-Directors started collecting stories of adverse experiences in the mental health system, and we began sharing these qualitative stories to our public Facebook page. We focused on teaching group members how to advocate for their individual families as well as how to advocate for system change. As our advocacy efforts grew, group members started filing more complaints and filing FOIA requests. We started speaking at board meetings, and for one particular board meeting in Jackson county, we had over 40 group members, allies, and community meetings attend the meeting via zoom. Scripts that concisely explained policy violations and gaps in the system were prewritten and assigned to a group member to read in advance of the meeting. (See Appendix C for example script)

It took a significant amount of time to organize this board meeting presentation. Multiple reminders were sent to all individuals that expressed interest in attending. Many families that wanted to attend could not attend that evening because they were in crisis. Some of the family members that did attend had to participate in the zoom meeting while sitting in their cars to avoid escalation of their children. As successful as this meeting was in bringing awareness to the issues our families face, to our surprise the Co-Founder of our group from Jackson County was repeatedly reported to Child Protective Service by Community Mental Health three weeks after the meeting. Because of the very real fear of retaliation, whenever possible, we now protect the identity of the families involved.

We also realize that our families are often in crisis, and our approach with parents has to be simple and concise, and to maximum participation, we need participation to require a relatively small time investment. In general, we now operate knowing that if we can't get a response on a mobile device in the amount of time it takes to brew a cup of coffee or wait in line for one, we are unlikely to get a response at all.

As we continued to collect qualitative stories, we started to see similarities in experiences, contributing factors, and outcomes. We went on to develop a simple questionnaire designed to collect quantitative data to help us determine if the similarities we were seeing would also be reflected in numbers across the group.

We drafted specific questions intended to quantify outcomes that were consistent in the stories being shared. We made the choices as simple as possible, and we added one comment box and the end of the survey to allow the person taking the survey to share any additional relevant information. We ran a small test, refined several questions, cleaned the data, and then shared the link in our Facebook group and tagged individual families that had already shared stories. The

link to the survey was also sent by direct message to families that were the most invested in the group. We collected 51 responses in 72 hours and put together the attached data set.

We also helped 20 families copy and paste information they had already shared in our private facebook group in posts and in comments into a cohesive story that could be shared with legislators, the Michigan Department of Health and Human Services, and other vested groups and organizations. Ten of these stories are included in this report.

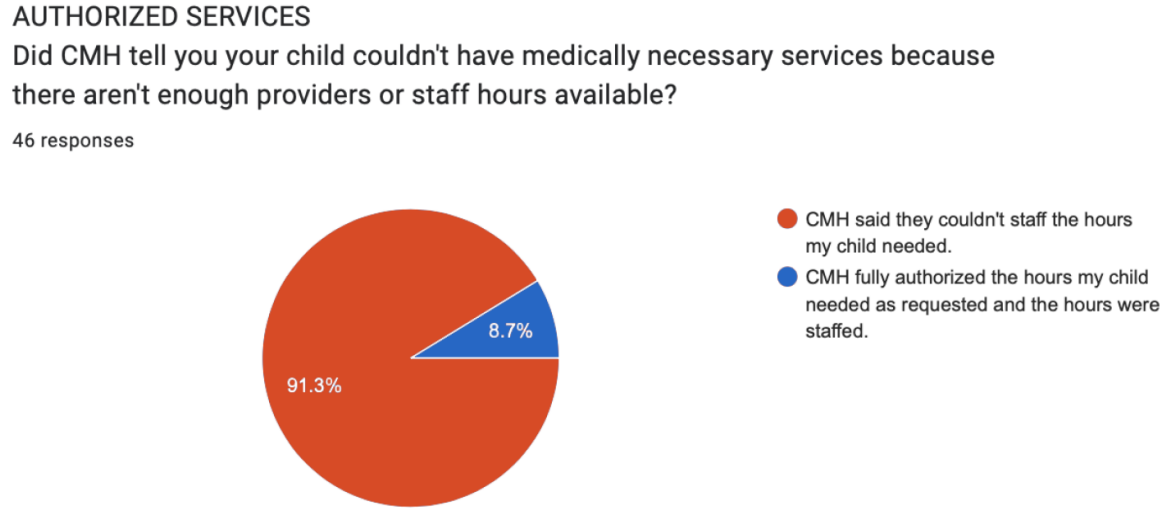
Contributing Factors:

Through our work connecting with families and collecting qualitative stories and quantitative data, we found that there are a number of factors that contribute to the cycle of crisis.

Lack of Specialized Mental Health Care

One of the most significant and pervasive problems identified in our qualitative research is that across the State of Michigan, children and adolescents with Severe Emotional Disturbance (SED) are underserved by the public mental health system. (Figure 1: Availability of Medically Necessary Services)

FIGURE 1: Availability of Medically Necessary Services



The current Community Mental Health system lacks innovative clinicians specializing in specific complex, challenging behaviors and diagnostic areas of needs. Children with the most intensive needs are paired with providers that do not have adequate experience providing mental health treatment to children with the complex needs that children with SED typically demonstrate. Often children with SED cannot access all of the medically necessary services they need even with an inappropriately trained provider.

The degree of inexperience identifying and treating complex areas of need is illustrated in this story from St. Clair County.

> ***Family Story 1:***
> *I spent almost 3 weeks in the Emergency Room with my 14 year old son trying to get him help. The nurse told me it could be months before they found him an inpatient placement. They wheeled a bed into his room so he would at least have somewhere to sleep. He also was in the hospital immediately before this. He was discharged to a Crisis Residential Program that called and said that I had to pick him up because he needed to go back to the Emergency Room only 10 hours after his arrival.*
>
> *Our local Community Mental Health (CMH) wouldn't open services until he was discharged from the hospital. The CMH Access Line told me the crisis would probably resolve while he was in the Emergency Room. He was hearing voices and hallucinating. He had already violently attacked me.*
>
> *After 2 weeks of sitting there with no mental health intervention or medication management, the CMH crisis team decided he no longer met criteria for inpatient care, and they discharged him home. We did not have a safety plan, and no one involved was willing to put it in writing that he would be safe. He didn't even have any mental health services to transition home to. When I pushed back and advocated for help, I was threatened and told Child Protective Services would be called if I refused to bring him home.*
>
> *We did manage to get CMH services opened. When his new home based therapist met with him, she informed me that she did not think he is schizophrenic. He explained that he only hears voices around certain topics and she thinks he is just really sensitive. She then asked me if I had ever heard of a psychic medium.*
>
> *Nine days after CMH sent him home from the emergency room, my son who has already been diagnosed with RAD, Major Depressive Disorder, Psychosis, CPTSD, and Anxiety,*

yet whose symptoms were still best described as supernatural, is back at the Emergency Room. He got angry and was saying he was hearing voices that were telling him to hurt himself and me. The police came because he didn't feel he could wait two hours for the CMH crisis unit to get there. He was taken to the hospital by ambulance.

The Public Mental Health System is not designed to provide a full spectrum of care. There are currently only two options for 24 hour care and supervision of psychiatric needs- inpatient psychiatric hospital units and the Hawthorn Center, the state's only psychiatric hospital that accepts children.

Inpatient psychiatric units often deny placement of children with the most intensive needs not because of lack of medical necessity, but because these children require 1:1 support to maintain safety, and this staffing is not available. Parents are told that their children are "behavioral" and do not meet the criteria for inpatient admission. Children are discharged home without access to intensive outpatient services or to adequately trained mental health providers even when doctors and care teams recommend 24 hour supervision and care to resolve symptoms.

The difficulty parents face accessing 24 hour care intended to stabilize complex psychiatric conditions and behavioral needs summarized in this story from Muskegon County.

Family Story 2:

My son is 13 years old. He has been receiving mental health services through Community Mental Health since he was 10. The services he received were in-home therapy, office-based, and trauma-informed therapy. He was discharged from community mental health, and we were able to find another counselor in the community. After his third hospitalization for mental health issues within a year we were discharged from services and referred back to community mental health.

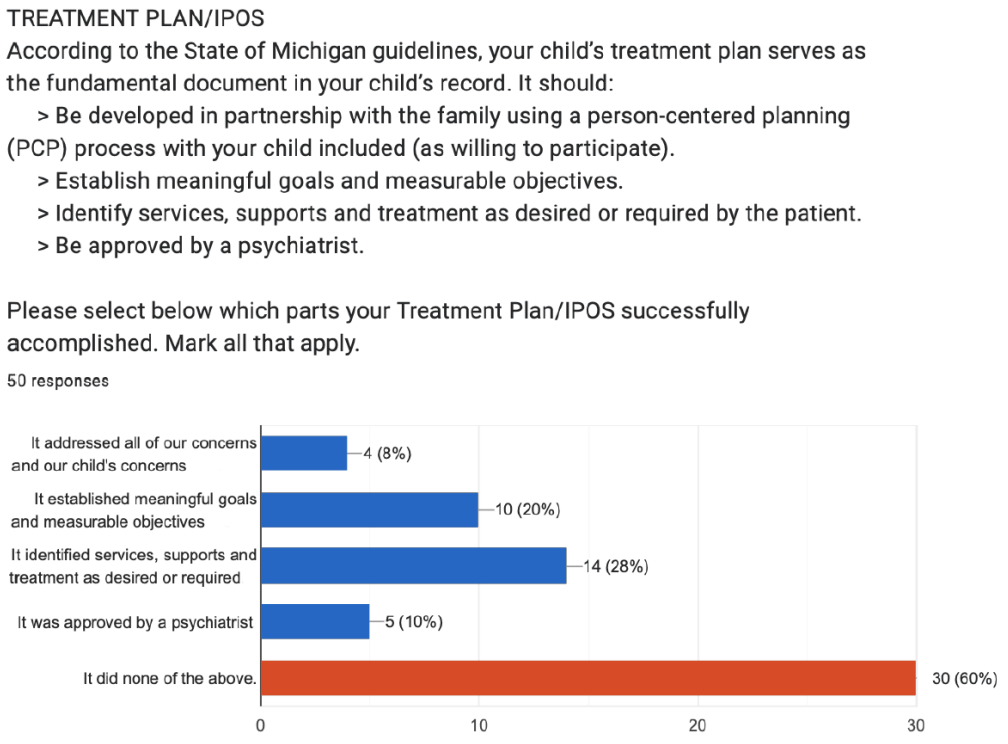
My son ran away, down the highway less than ten minutes after he was discharged from a psychiatric hospital three hours away. The hospital stated he was not a danger to himself or others yet he continues to appear to be in some state of delusion. It took five police officers to get him back into the car with me. When we got home he stated he wanted to start a religious militia and overthrow the American government, to take back the land which the whites took away from the Native Americans. He would then go to Mexico and recruit people to take back what Christopher Columbus took away from them and make white people pay.

> *There are currently no options for therapeutic placement and I am being left with the option of medical abandonment with CPS likely removing all four of my other adopted children from my home or CPS charging me with endangering my other children by bringing my son home.*
>
> *Now he has no services in place and we have to wait a week just to do an intake with community mental health, while in the meantime my son suffers from his mental illness, and the rest of my children are exposed to his unsafe behaviors and delusions. I can only access residential treatment through the adoption medical subsidy, but not until without "exhausting all avenues of community resources." How can I exhaust community resources that I cannot even access? This is an extreme gap in services based on income.*

Inadequate Plans of Service

Without a highly experienced clinician driving treatment, Person Centered Planning is ineffective because the needs of the family and child are not adequately identified and included in the planning process. Individual Plans of Service, or Treatment Plans, do not correctly or adequately identify clinical needs. Plans include under-serving, contraindicated, and/or conflicting interventions, and plans frequently do not meet the requirements in the guidelines set forth by the State of Michigan. (Figure 2: Treatment Plan Adequacy)

FIGURE 2: Treatment Plan Adequacy



When goals and objectives are not in alignment with clinical needs and when they are not measurable and data driven, it prevents medically necessary services from being put in place and treatment is insufficient.

This story from a different family in Muskegon County illustrates the difficulty families face trying to access treatment when needs are clearly articulated by the family, but the mental health providers do not have the experience needed to drive treatment.

Family Story 3:

My daughter is almost 17 years old. She should be receiving mental health services through Healthwest Community Mental Health, but our services are such a disaster no one is getting any help.

Right now, our daughter has an SED Waiver for Severe Emotional Disturbances. She is also autistic. She cannot perform all of her ADLs (daily living skills) without help, and she has violent meltdowns where she attacks me and destroys property.

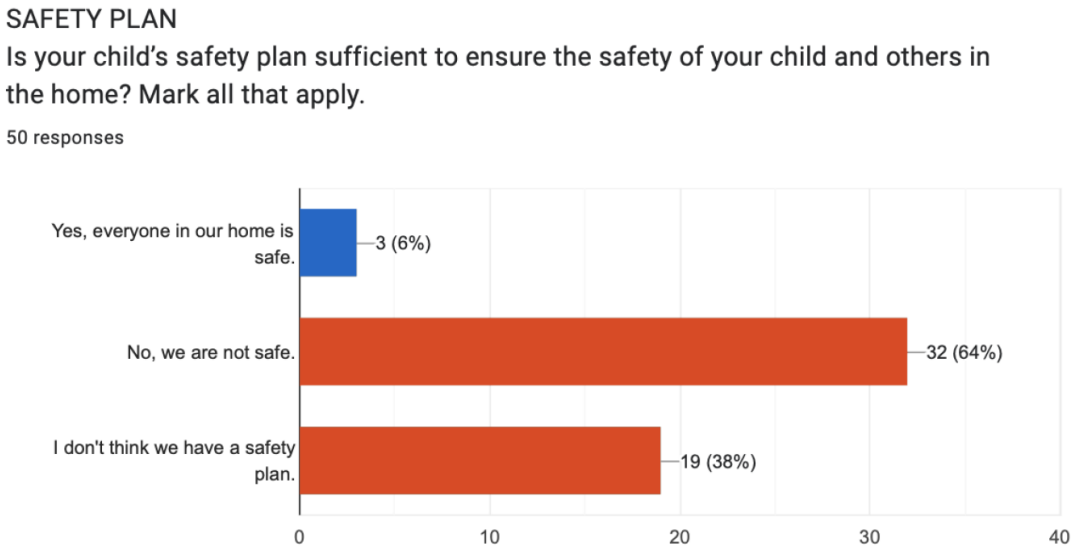
Instead of helping, Heathwest is not providing authorized services, Wraparound is canceling meetings, and they are preventing Person Centered Planning meetings so I can ask for the help she really needs. She is in and out of the Emergency Room because of the aggressive intensity of her meltdowns. It is very difficult to find her a bed because she needs 1:1 support, something that is largely unavailable in Michigan.

Last summer she was held at Helen Devos Hospital while they were looking for a bed. She was heavily sedated and incorrectly restrained to the bed. Her arms were bruised because the straps were not fastened correctly. I don't want to keep taking her to the ER because it is traumatic for all of us, but I also cannot have her attacking me at home.

Inadequate Safety Plans

Families largely self report that Safety Plans created by Community Mental Health Wraparound teams and/or Treatment teams do not ensure the safety of anyone in the home. This is especially true when needs are complex and safety risks are extreme. The plans do not correctly identify the needs or the triggers, and families largely do not feel that safety plans, if even provided, are helpful. (Figure 3: Safety Plan Adequacy)

FIGURE 3: Safety Plan Adequacy



The lack of safety in the home perpetuates the involvement of both the Juvenile Justice System and the Child Welfare systems as families are simply told to "call the police" if situations become unsafe when families truly need therapeutic level de-escalation training, detailed de-escalation plans, and 1:1 support implementing de-escalation tools and adjusting approach as situations develop. This is further compounded by the fact that there are no 24 hour care options for families with a child in need of stabilization. Parents are frequently left to manage intensive needs in the home without therapeutic support in place.

This crisis situation is illustrated in this story from a third family from Muskegon County.

> **Family Story 4:**
> *We approached Community Mental Health (CMH) in early January 2023 and applied for Wraparound and an SED Waiver for our daughter. The previous day, she had attacked my husband and me and left my husband with bloody bite marks and scratches. She has significant mental health needs that help explain why she has aggressive and violent behaviors.*

I told CMH we needed a medication evaluation immediately and the soonest they could get us in was March 6. I told CMH that I was sure that we would have to call the police before then in response to her aggressive behaviors. She had become increasingly aggressive and combative since November 2022.

We did not have a safety plan with proactive steps to ensure safety. The only reactive steps were give was to call the crisis line or to call the police. It was not helpful at all. Exactly one month later, Feb 8, she assaulted me. She punched me in the nose, pulled my hair, bit me and kicked me repeatedly in the ribs while we were both in the car. I had to call the police and she was taken by ambulance to the ER. She was there for 10 days waiting for inpatient placement, and no one would take her because her acuity was too high for some inpatient hospitals, meaning every inpatient hospital in Michigan refused to admit her and we had to take her home even though she was deregulating & escalating to dangerous levels.

Between her discharge from the ER on Feb 17 and March 5, we utilized the CMH crisis line 4 times. She attacked me again on March 8 by throwing a blender pitcher and a hard metal bowl at my head, and chasing me with a baseball bat and attempting to break our home's glass doors, while screaming that she was going to kill me and our other young children. I called the police and it was arranged that she would be admitted to Forest View Psychiatric Hospital in Grand Rapids. She is still there today. The hospital social worker is telling me that she needs residential placement, but no one is actively helping me find a place for her to go. Forest View is suggesting direct transfer to residential but this feels impossible if we can't even get any help finding her somewhere to go.

Child Protective Services is now involved because when my daughter attacked me, I had to try to get her to stop hurting me, and she told the hospital I was the one who attacked her. I did not try to hurt her. I just tried to get away so I could keep myself & our other 4 children safe.

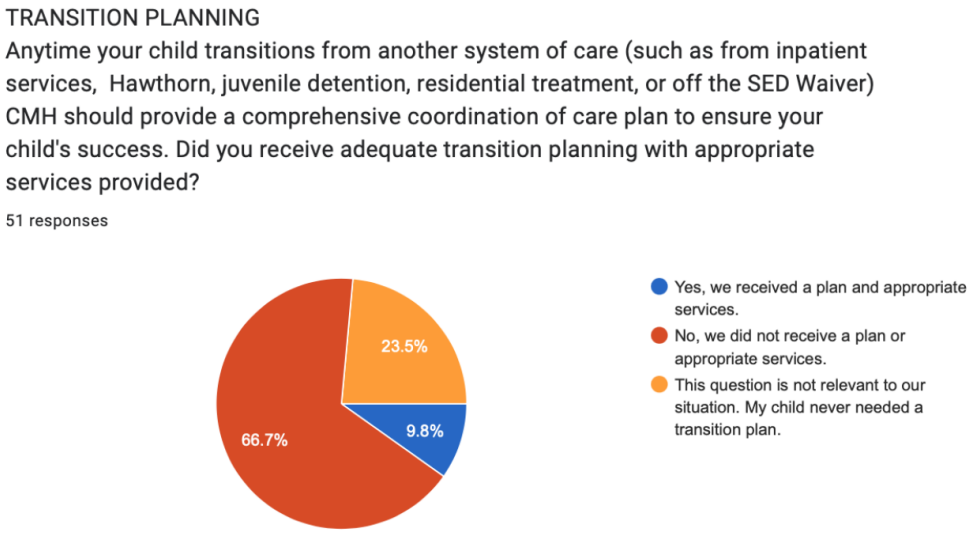
I cannot possibly bring her home from the hospital in her current homicidal state. CPS is saying they hope we do not get to that point, but no one has an answer that will keep all of us safe and make sure that our daughter gets the treatment that she needs.

We want her to get better. We don't want her to be the next child to enter the Juvenile Justice system because her mental health needs have gone untreated. We do not know how to get her help.

Inadequate Transition Planning

When a child transitions from another system of care (such as from inpatient services, the state psychiatric hospital, juvenile detention, residential treatment, or off the SED Waiver), CMH should provide a comprehensive coordination of care plan to ensure the child's success in the stepdown of services. Because of the same reasons that treatment plans and safety plans do not meet the needs, transition planning is also inadequate and does not meet the identified needs. (Figure 4: Transition Planning)

FIGURE 4: Transition Planning



When children are transitioning home from the hospital, safety plans are rarely updated even though there were precipitating crisis events that led to the hospitalization. This need for adequate Transition Planning is capture in this story from a Kent County Family when their daughter was transitioned home from the Hawthorn Center, a state psychiatric hospital:

Family Story 5:

Our daughter was at the Hawthorn Center for almost 11 months. She had to return to Hawthorne because she was not ready to be discharged when she was sent home. Community Mental Health did not have services set up and in place for the transition home. We did not have a safety plan. We tried to fight it. No one listened.

Our daughter attempted to hang herself from her ceiling fan 10 days after her discharge. When the sheriff and EMT's showed up, she was bragging about how this was her plan the whole time and how she outsmarted the doctors so she could get discharged before she was ready. She told the ER staff that as well.

The SED Waiver is designed to be a 1 year program with the option to apply for a second year as needed. In extreme situations, a third year can be requested and approved. Since children frequently transition off of the SED Waiver, transition planning into non-waiver services is an SED Waiver requirement. Because of lack of appropriate care during waiver services, situations frequently do not stabilize during the length of the SED Waiver. Transition planning off of the SED Waiver or into independent living arrangement as children reach young adulthood is frequently as unsuccessful as the waiver services.

The inability to successfully transition plan into young adulthood is captured by this story from a family in Jackson County.

Family Story 6:

Our daughter just turned 18 three weeks ago. She has been diagnosed with a psychotic disorder, a personality disorder, a developmental disability, as well as major depressive disorder. She has been on an SED Waiver since Spring of 2021. She turned 18 without a plan for stable housing, access to food, transportation, or mental health service suited to her condition. Now that she is 18, we cannot help coordinate any of her mental health care.Her thinking is distorted. She is self medicating with substances. She is refusing medication.

Instead of providing intensive mental health treatment, Community Mental Health fought with us and reduced services even as she repeatedly self identified that she was in crisis and required a 12 day psychiatric hospitalization this past January.

Our daughter is struggling immensely. She lost her job because she was not able to perform routine tasks that she is able to complete when her illness is managed. She is capable of daily living skills, but when she is symptomatic she stops showering, eating,

and taking medications as prescribed. She is unable to manage her own medical and mental health care. She isolates in her bedroom as her symptoms worsen.

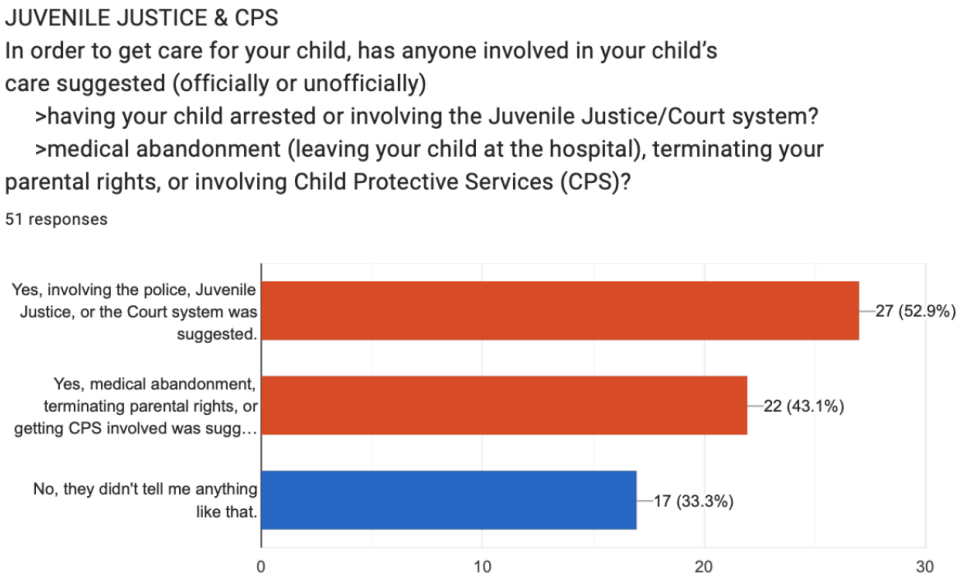
She is currently living in the equivalent of a homeless shelter for teenagers because she does not want to live at home. It is 3 doors down from the interfaith homeless shelter. She is being told that if she ever needs a hot meal, she can go next door to the homeless shelter and get one. We do not understand why the mental health system is putting such a vulnerable youth in this position except for the fact that they do not have anything else to offer.

She needs oversight and care of a program like Assertive Community Treatment to check in with her daily and ensure that she is safe and those around her as safe as well. Instead she has 1 weekly visit from a Wraparound Facilitator that does not understand her needs and 1 outpatient therapy session a week. She should not be left to languish with her mental health needs inadequately treated. She deserves a future worth living for.

Referral to the Juvenile Justice Systems and/or Child Protective Services

When the mental health system is unable to meet the needs of the child, families are frequently referred to the Juvenile Justice System and/or Child Protective Services as a way of maintaining safety in the home. (Figure 4: Juvenile Justice and Child Protective Services (CPS) Involvement)

FIGURE 4: Juvenile Justice and Child Protective Services (CPS) Involvement



In Michigan, Juvenile Justice and Child Protective Services have funding streams separate from Community Mental Health, and these funding streams can pay for 24 hour residential placements licensed as Child Caring Institutions. Families cannot access these placements without high levels of involvement from one of both of these systems because Community Mental Health focuses on Home and Community Based care at the exclusion of any form of specialized residential treatment. Frequently, families find that they are "passed back and forth" between multiple systems because no single system is able to address the needs. This is clearly illustrated in this story from a family living in Cass County.

Family Story 7:

My son is 14 years old and has been with CMH since he was four. When he turned 13, my family turned upside down. We have been with wrap around home based therapy and their clinical psychiatric doctor who has said our son has bipolar tendencies schizophrenic tendencies but can't be fully diagnosed till 18.

He has been in and out of the Emergency Room because of threats to kill himself and me. I spent 14 days with him in the ER because he threatened to shoot up the school. He said

he was going to shoot teachers and students and he wants to kill my family. He said he bought a gun with money he stole from the family and he hid it so no one would find it. The police found pictures of the gun on his phone. They are currently searching for it.

This level of crisis is not new. He has been on probation for over 6 months. He has had over 50 felonies, and tons of probation violations. Community Mental Health says it's mostly behavioral. The police say it's mental illness.

He had a court hearing and it was decided that he can be tried as an adult for terrorist acts for threatening to shoot the school and my family. He will face up to 30 years in prison if he is found competent to stand trial and found guilty. He would be off the streets and the community would be safe, but he would not get help for his mental illness.

He was in the ER 13 days. Hospitals would not take him because the risks were too high. It was finally decided that he no longer met inpatient criteria and he was sent home since there is not a detention center in our county. I am not watching him day and night hoping that he does get triggered. I pray it is cold and it snows over spring break, so he stays inside and does not run away and hurt someone. I cry every time I think about it.

When children need 24 hour care because of the severity of their mental health and/or behavioral health needs, and medically necessary treatment cannot be provided, the mental health system relies on Child Care Institution placements even though this requires involvement of another system that often has long term negative impacts (such as a criminal record) on the child or the family.

This "transfer" of care from the public mental health system to a different system to access funding and placement options is best illustrated in this story from a family in Kent County.

Family Story 8:

My son is 14 years old. He has been receiving mental health services through Community Mental Health since 2014 up until this past December of 2022.
We have had an in-home therapist, wraparound, music therapy, equine therapy, CLS and group respite. Despite these services, my son continued to get progressively more aggressive. We did not feel that any provider really understood his needs or how to work with a youth with Reactive Attachment Disorder (RAD).

My son's aggression became an extreme safety concern in our home during multiple days of the week, sometimes every day. We attempted to utilize the mobile crisis unit

multiple occasions, but never with any success. We were told to call another number or simply that there was no one available due to the time/day of the week.

This left us no option but to call the police. Many times. He was removed from our home by police, multiple times.

We could not get the level of mental or behavioral health we needed for my son from our CMH. The CMH management staff told me, while I was inside their building, that the court system had 'a bigger bucket of funding and a bigger bucket of options' and that I needed to pursue services and supports for my son through the Juvenile Justice system.

I needed to make my son a criminal. My son with a history of YEARS of mental and behavioral challenges was NOT going to get help through the CMH. Nothing more was offered by the CMH, and my son did truly fall solidly into the JJ system. At one point, as the courts looked for a place to send him, my 14 year old son sat in Juvenile Detention for 6 months straight. He now has a criminal record. He was placed by the courts in a residential facility in the state of Wyoming. We are unable to see our son to work on significant attachment issues that are typical when RAD is diagnosed.

Disruption of Family Resources

Families living in crisis are at a disadvantage when it comes to advocating for their children and for the systemic change that is needed. When a child is frequenting emergency rooms and in need of high levels of mental health care, caregivers often must take time away from work.

It is common for a parent to leave work for the day or even to have to leave the workforce to care for the untreated mental health needs. Care includes managing appointments, attempting to coordinate care, transportation to and from appointments, advocating for the help they are unable to access, and managing crisis. Families in crisis also experience an increase in expenses including co-payments on treatment, gasoline, food costs while boarding in hospitals, etc.

This story from a family living in Shiawassee County shows how family resources are over utilized when families are left to manage day to day crisis situations without the help they need.

Family Story 9:

I spent 3 days in the ER with my younger son. Several weeks ago we sat in a different ER for the same issue, Suicidal Ideation and Suicidial Intent. CMH NEVER followed up in any way other than to schedule him with his therapist.

While we were in the hospital the second time, he was given a placement in a new therapeutic group home setting for "high functioning and moderate functioning" kids on the Autism spectrum that also have mental health. The placement was described as a 14-30 day placement.

The hospital ER discharged him to me, and drove just under 100 miles to do the intake for this placement. Twenty minutes into intake they say this isn't the right program for him, and that it was apparent to me as well. He was a crisis with suicidal ideation and NOT in need of ABA in a group home setting. He was also considered a flight risk (and he admitted that he would run). This program did not have a way to keep him in the unlocked treatment house, and a suicidal child should not be running the streets of Grand Rapids. It is a liability for Everyone.

The placement told us to contact CMH to see what we should do. We called the crisis line and were told to either go back to the same ER in Owosso we were at for 3 days or take him home and if he could be kept safe, they would call me the next day. My son said "I'll be safe," so we were sent home even though he had just been denied a placement because he was in crisis and considered a flight risk.

He's staying with my dad today instead of going to school because he doesn't need more pressure at the moment. I'm praying I wasn't fired from my job as I had to leave work suddenly to take my child to the ER for 3 days. I'm still in my 6 month probation at work. Praying my son will be safe and I won't lose my job.

Sometimes families completely give up on the public mental health system and instead seek residential placements that must be privately funded. Parents go into significant debt and empty out IRA'S and 401k's to pay for treatment. They set up GoFundMe campaigns and borrow money from friends, family, and the community.

Even when families pay out of pocket for medically necessary out of state services, they find that transitioning their children back into the care of the Michigan public mental health system undermines the treatment that was provided at out of state facilities. Like other family stories have already expressed, it is difficult for these families to access the mental health supports that are needed to successfully reintegrate children back into the home and community.

This is illustrated by a story from a family living in Eaton County.

Family Story 10:

My son is 15 years old. He has been receiving mental health services through CEI Community Mental Health since November 2022. When we applied for services in August 2022, he was quickly approved for a waiver into Medicaid based on his Severe Emotional Disturbance. I was glad that they easily qualified him since he was supposed to be coming home from a residential treatment center (RTC) out- of-state. We needed CEI to help transition him home and support him in being safe at home.

Unfortunately, we were immediately put on wait-lists for all services except weekly therapy. We went further and further into debt, extending and self-funding his care at the RTC at a cost of $12,000/mo while we waited for CEI to have transition services available. Finally, we ran out of debt to leverage and we had to bring him home. CEI told us to "trust us", and they would have services ready upon his arrival.

The morning after my son returned home, we learned that he was still on the wait list. It took 2 weeks to get minimal services. My son was not adjusting well and in desperate need of more services. Even then, we were told at a team meeting 3 weeks after his return that it was time to start reducing his services.

Outcomes:

We found that in lieu of receiving medically necessary mental health treatment, families that are frequently in crisis self identify as experiencing 4 different primary negative outcomes. Often families experience more than one negative outcome or actively work to avoid other adverse situations.

The negative outcomes that were identified include:

1. Underserved children with mental illness enter the Juvenile Justice system as a way to access out of home placement. This is most likely to happen to children that emotionally deregulate and destroy property or or become aggressive toward others. Children are often charged with assault for physically attacking parents even if the parents do not seek to press charges. These children have mental health or developmental diagnoses that encompass these types of serious challenging behaviors. Frequently, instead of providing mobile crisis support, crisis lines tell parents to call the police which expedites entry into the Juvenile Justice system. Children are placed on probation or in juvenile detention centers at the expense of the families.

2. When safety cannot be maintained in the home, children also enter the Child Welfare System. Sometimes parents are told by providers in the mental health system that they can get out of home placement if they "medically abandon" the child by refusing to pick the child up from the hospital. This would trigger an investigation by Child Protective Services, and parents can be charged with abuse and neglect. When parental rights are terminated, children are placed in foster care homes or facilities, but this is at the expense of the unity of the family. It can also negatively impact parental rights of other children in the home. A foster care placement also does not guarantee mental health treatment because of the same contributing factors legal parents and guardians face.

   Parents of children that are chronically suicidal are often reported to Child Protective Services for failure to protect the child. When the child is physically aggressive, parents are often reported to Child Protective Services for failure to protect other children in the home.

3. Families pay out of pocket for costly out of state residential placements or therapeutic boarding schools. Families often take out second mortgages on their homes, max out credit cards, empty out retirement and college savings accounts and go into extreme debt to access the mental health treatment their children need.

4. Families continue struggling in a system that does not meet the needs of their family, and children remain underserved. Families lose access to employment opportunities while caring for children with SED. Children age out of or are discontinued from Waiver programs without adequate transition plans in place. Underserved children become underserved adults and remain at elevated risk for suicide, substance abuse, threatening the safety of the community, and/or incarceration, and they remain more vulnerable members of the community because of the ways their untreated mental illness/es impact their ability to navigate the adult world.

Recommendations:

In order to resolve these problems and address the mental health crisis families are facing, our parent advocacy group is making 4 overarching recommendations that each need to be thoughtfully developed with input from all stakeholders and carefully implemented into the existing mental health frameworks. Recommendations are as follows:

1. **Offer a full spectrum of specialized care for mental health and developmental needs.** Focus on early, proactive intervention as a means of preventing needs from escalating to crisis levels. When needs have escalated to crisis levels, provide access to 24 hour supervision and support as medically necessary in hospitals, specialized residential facilities, or through home and community services that are staffed at the appropriate level of need and offer access to equally intensive therapeutic treatment when safety can be maintain in this least restrictive environment.

2. **Explore and implement innovative models of treatment and ecosystems of care.** Working models should address individual areas of need or overlapping areas of need and consider best practices for working with complex diagnoses. This will require funding mental health research and development and attracting experts to Michigan. These experts would be available for consultation across the state to assist with development of appropriate treatment plans and safety plans so services provided are suited to condition.

3. **Create a statewide Mental Health Navigator program that pairs families in crisis with an advocate that helps them navigate from crisis to resolution**. Allow parent advocacy groups to play a leading role in the development of this program and in the selection of advocates or navigators to ensure fair and accurate representation. The Mental Health Navigator program would work directly with oversight and accountability at the State level to ensure that policy violations are reported and addressed. This program would ensure that individual CMHs and PIHPs are investigating complaints appropriately at the local and PIHP level. The oversight body would also play a key role in ensuring that systemic recommendations are successfully implemented to reduce gaps in the system that trigger increased levels of crisis.

4. **Revise the State's 1915(c) Waiver application**. Pay parents and primary care providers for providing direct support to children that meet medical necessity criteria for direct support when staffing is not provided due to inadequate provider availability. If one parent or primary caregiver is providing respite so another parent or primary caregiver can take a break, pay respite wages for these hours if respite staff are not provided because of network provider adequacy problems.

Conclusion:

In order to ensure families have access to effective and meaningful mental health treatment for their children, it is essential to include the voices of parents with lived experience navigating the mental health system. Not only are parents strong advocates for change, their personal stories help lawmakers, policymakers, and mental health providers understand the real life impact the mental health system has on the lives of the families it was designed to serve.

As the voices of these families have shown, the factors contributing to cycles of crisis are as complex as the adverse outcomes that families experience. Although there are commonalities across experiences, the root causes of these factors are further complicated by underlying social, economic, and political dynamics that we were not equipped to address as a parent group.

Our study relied on the voices of parents with internet access and devices that enabled them to contribute to online forums. Identification of racial and educational similarities as well as overall platform accessibility influenced the core groups of parents that contributed to both qualitative and quantitative studies. We are aware that as Co-Directors, our status as white, educated women helped bring similar voices to the table while also indirectly and unintentionally leaving other voices in the shadows. We would love the opportunity to bring more diverse voices into the conservation.

In order to create meaningful change, the stories that this report offers and the analysis and the recommendations provided must be incorporated into larger discussions. We must further consider how factors such as race, poverty, education, generational trauma, genetic predisposition to mental illness complexify the experiences of parents living in crisis. We need structures and policies that ensure that solutions are effective, sustainable, and in the best interest of the families receiving benefits. A wide variety of stakeholders and leaders must work together and commit to remain cooperatively invested in positive outcomes.

Embracing these voices of lived experience will require a level of courage and authenticity from the public mental health system that families are not accustomed to experiencing. The system must be willing to listen to families and hear their voices without blaming them for causing the mental health needs of their children. It must be willing to self reflect on policies and procedures. It must be willing to engage with families and self adjust instead of meeting families with defensiveness and dismissing the concerns the families bring to the table.

We know the stories of crisis and distress that families have shared are overwhelming, but the overwhelm felt by listening to these stories is nothing compared to the overwhelm and

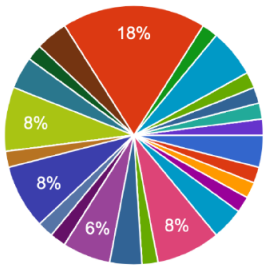
devastation parents feel living these experiences. It's time to work together across systems to ensure that performance measures and policy meets the needs of the beneficiaries.

We have more to learn. We have more to share. We look forward to changing the system together.

Appendix A: Community Mental Health Counties Represented in Survey

Select your CMH

50 responses



9 (18%) Oakland Community Mental Health
1 (2%) Pathways
3 (6%) St. Clair County Mental Health Authority
1 (2%) Saginaw County CMH Authority
1 (2%) Shiawassee County CMH Authority
1 (2%) Tuscola Behavioral Health Systems
1 (2%) Washtenaw Community Mental Health
2 (4%) Allegan County Community Mental Health Services
1 (2%) AuSable Valley Community Mental Health Services
1 (2%) Barry County CMH Authority
2 (4%) Cass County CMH Authority
4 (8%) CEI CMH Authority
1 (2%) CMH For Central Michigan
2 (4%) Detroit Wayne Mental Health Authority
3 (6%) Genesee Health Systems
1 (2%) Kalamazoo Community Mental Health
1 (2%) Lenawee County Mental Health Authority
4 (8%) Lifeways
4 (8%) Community Mental Health Services of Muskegon
1 (2%) Livingston County CMH Authority
2 (4%) Network 180
1 (2%) Northeast Michigan CMH Authority
2 (4%) Northern Lakes CMH Authority

Appendix B: Documentation Used for Policy Analysis

191 S(i) State Plan Home and Community-Based Services Administration and Operation
APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum
Michigan Medicaid Provider Manual
MDHHS/CMHSP Master Contract
Michigan Mental Health Code
Person-Centered Planning Practice Guideline
Treatment, Planning, Development, and Implementation
Appeal and Grievance Resolution Processes Technical Requirement

Appendix C: Board meeting Policy Script Example June 2022

As parents and concerned Medicaid beneficiaries, we are requesting that Lifeways address its authorization process. It is currently out of compliance with both State and Federal regulations.

Families are being told, in writing, that in order for authorization requests to be submitted for review, they must be attached to an assigned provider.

When there is not an available provider, the authorization request is never made. The services the team determines a child needs to be safe and successful in the home and in the community are never even requested. Treatment decisions are being made based on provider availability and not on medical necessity.

Since authorization requests are never made, we do not understand how Lifeways is determining how large their provider network needs to be even though maintaining an adequate provider network is a contractual requirement.

Since the authorization request is never made, families are also not issued adverse benefits notification. This is a violation of the family's right to due process because families are not being given our appeal rights.

There are so many services that are never provided because authorization is never even requested. We want to know if dollars that should have been spent on these medically necessary services are included in the money Lifeways considers its surplus.

U.S. Department of Justice
Office of Justice Programs
National Institute of Justice

Executive Office for Weed and Seed

What Can the Federal Government Do To Decrease Crime and Revitalize Communities?

January 5–7, 1998
Panel Papers

NIJ
Research Forum

A Message From the Assistant Attorney General

"What can the Federal Government do to decrease crime and revitalize communities?" This is a question policymakers, practitioners, and researchers have debated for more than 30 years. Over the past few years, the Justice Department's Office of Justice Programs (OJP) has brought together former administrators of OJP and its predecessor agencies and a broad range of other criminal justice experts to examine Federal criminal justice assistance over the past three decades and what lessons this experience holds as we move to shape criminal justice policy for the future.

In January 1998, OJP posed this question to a group of practitioners and researchers at a symposium sponsored by two OJP components—the Executive Office for Weed and Seed (EOWS) and the National Institute of Justice (NIJ). This session brought together those who are thinking and writing about crime from a practice or research perspective. It was a result of ongoing collaboration between NIJ, our research agency, and Weed and Seed, one of the Department's premiere community-based initiatives. It marked the first time these two OJP components have come together to focus on the issue of crime and its impact on communities, and I commend EOWS Director Stephen Rickman and NIJ Director Jeremy Travis for their vision and energy in designing this symposium.

I also want to thank the symposium participants for taking the time to ponder and discuss this critical question—and for their recommendations on how we should be setting priorities, what role the Federal Government should play, how OJP can best provide leadership and demonstrate new programs, what approaches are proving successful, what factors we need to learn more about, and what questions our research should be trying to answer.

It is so important for those of us at the Federal level to listen to those of you in the field—to see programs in action, to talk to people on the frontlines, and to get a better understanding of what's working, what's not, and what's needed. The Attorney General strongly believes that this kind of engagement is critical if we are going to keep our Federal programs responsive to the communities they serve, and I have yet to meet anyone "beyond the Beltway" who disagrees.

These are critical and complex issues we must continue to assess if criminal justice is to be prepared to meet the challenges of the future. I hope you will find that the products of our EOWS/NIJ symposium can help make a contribution to this ongoing debate.

Laurie Robinson
Assistant Attorney General

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NIJ

Jeremy Travis
NIJ Director

Stephen Rickman
EOWS Director

Opinions expressed are those of the authors and not necessarily those of the U.S. Department of Justice.

The National Institute of Justice is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime.

Introduction

We are pleased to present this volume of panel papers from the January 1998 Department of Justice symposium, "What Can the Federal Government Do To Decrease Crime and Revitalize Communities," which was jointly sponsored by the National Institute of Justice (NIJ) and the Executive Office for Weed and Seed (EOWS). While NIJ and EOWS often collaborate, this partnership was a unique opportunity for us to highlight important research, discuss problems facing the Nation's communities, and share some of the imaginative solutions to address them that are being implemented by cities and towns across the country. Conference participants discussed various ways to effectively address the needs of changing communities and initiated dialogues that we hope will continue.

We were delighted to host the speakers whose papers are included here. We were equally pleased with the active involvement of program participants who listened, questioned, and made observations about the speakers' presentations.

Teaming with EOWS to achieve the goal of reducing crime and revitalizing communities is a natural extension of NIJ's research, evaluation, and development mission and activities. It also reflects one of NIJ's strategic challenges that focuses on understanding the nexus between crime and its social context. The Weed and Seed strategy is essentially a coordination effort, making a wide range of public- and private-sector resources more accessible to communities. With the assistance of the U.S. Attorneys, the strategy brings together Federal, State, and local crimefighting agencies, social services providers, representatives of the public and private sectors, prosecutors, businessowners, and neighborhood residents—linking them in a shared goal of "weeding" out violent crime and gang activity while "seeding" the target area with social services and economic revitalization. The strategy combines law enforcement; community policing; prevention, intervention, and treatment; and neighborhood restoration. EOWS also provides a range of training and technical assistance activities to help communities plan, develop, and implement their programs. Combining EOWS' community focus with NIJ's research and development expertise made this symposium exceptionally productive.

This volume is intended to share the beneficial outcomes resulting from the symposium. It is our belief that discussions begun between participants at this conference will lead to action at the community level. It is our hope that these actions will provide new, creative, and effective approaches to address the issues of crime prevention and community revitalization that concern all of us.

Jeremy Travis
NIJ Director

Stephen Rickman
EOWS Director

Contents

Panel Four: What Do We Do Next? Research Questions and Implications for Evaluation Design

Panel One:
The Context

The Context

Bailus Walker, Jr.

This brief discussion will review, in broad outline, selected health parameters of the context within which efforts to reduce crime and revitalize communities must be pursued.

My principal underlying thesis is that health conditions, the health status of populations, and the services available to address them are among the key determinants of community stability, economic viability, and the incidence of crime. Indeed, when the history of the 1990s is written, health status and access to health care for large segments of the population in the Nation's urban centers will appear repeatedly in many chronicles. Along with pictures of the homeless, the charts and tables of the rates of acute and chronic diseases and premature death among the poor and disadvantaged will illustrate many texts about crime, community instability, and family disruption. These data will also illustrate that the lack of access to comprehensive physical and mental health care, including health promotion and disease prevention, has a broad range of social and economic ramifications that lacerate the civic fabric and drive people from shared institutions—subways, buses, parks, schools, and neighborhoods.

Even to casual observers, a discussion of the prevention and control of crime and the revitalization of communities raises many issues that do not have a single or unambiguous solution because both crime and community development are affected by economic, health, social, behavioral, political, and scientific factors. Many of these factors are changing at an unprecedented pace, both in the United States and abroad. "Abroad" must be emphasized here because economic, health, and social systems have become increasingly interconnected and globalized.

As competition and trade have increased, people in virtually every country have benefited, and a remarkable degree of mutual interdependence has emerged. These changes have also brought risks that frequently cannot be adequately addressed within traditional national, State, or neighborhood borders and have created quality-of-life problems that have spread among nations at an accelerating pace. Indeed, the movement of more than 2 million people each day across national borders and the growth of international commerce are inevitably associated with the transfer of health risks, including such obvious examples as infectious diseases, contaminated foodstuffs, and terrorism, which have multiple dimensions and a broad spectrum of impacts—some subtle, some overt.

Transnational connections in health imply that health threats, including violence, can no longer be contained by national frontiers; most diseases do not require passports to travel. Due to the ease of rapid travel, emerging diseases in one country represent a threat to the health and economies of all countries. In the United States, local community leaders are now seeing clear evidence that the suburbs, which sprang up as an "escape" from the stress of urban decay, are themselves feeling the impact of "city ills." This was clearly delineated in a recent *Wall Street Journal* article headed, "More Suburbs Find City Ills Don't Respect City Limits."[1]

Demographics

At the same time, the demographic picture is changing. Demography is the study of the size, composition, and distribution of human populations. Although quantitative methods are employed, demography is also centrally concerned with the quality of human populations, such as their health status. It should be noted that demographic trends are already causing an increase in the demand for health services and altering the character of the demand.

The U.S. Bureau of the Census estimates that the United States population increased by 2.4 million people in 1997 to 268,921,733 as of January 1, 1998. The projection is based on the number of births (3.9 million), the number of deaths (2.3 million), and the number of people returning or

immigrating to the United States (867,600) during the previous year.[2] As the population grows, it will increasingly become more diverse along many socioeconomic dimensions. The increasing diversity will create challenges and opportunities for both the public and private sectors. In addition to population size, the age structure will be important in planning for community redevelopment and crime prevention.

Changes in the Age and Racial Makeup of the U.S. Population

Today, much attention is being focused on the "aging" of the U.S. population. Citizens 65 and older doubled in number between the 1950s and the 1980s. The fastest growing age group is between 55 and 65—now at 21.5 million but expected to increase to 30 million by 2000 as baby boomers approach retirement age.[3] This trend raises concerns about the economic and social aspects of care for the elderly and the ratio of elderly dependents to productive adults, whose caring responsibilities will shift increasingly from children to the elderly.

Another trend on the demographic landscape is the growth of the population share of nonwhite citizens. The minority population numbered nearly 70 million in 1996, about one in four Americans. By the middle of the 21st century, however, the size of the minority population should just about equal that of the non-Hispanic white population. In 1996, African-Americans made up the largest segment of the minority population—32 million people, about 12 percent of all Americans. Hispanics followed closely with 27 million (10 percent).[4]

Moreover, because of differential birth rates, a disproportionate fraction of the country's children, adolescents, and young adults will be nonwhite. Think of the economic and social implications of an aged population mostly white, combined with a youth population mostly minority.

New Health Stresses on Women in the Workplace

Another demographic trend is the large-scale movement of women from the home into the workplace, particularly into jobs that subject them to health risks of the kind previously prevalent among men. In addition to traditional industrial hazards and workplace pollution, both men and women now suffer the putative side effects of a range of new technologies. But our considerations must include the less overt but long-term impact of job stress on women's health along with the psychological and economic burden of single parenthood.

Women who work outside the home still do most of the housework as well. Added to the pressures of long hours of work inside and outside the home are the time conflicts that emerge when one is both a homemaker—and usually family caretaker—and a wage earner. Sick children, school holidays, and ill elderly relatives all contribute to stress and frustration in the context of inadequate health and social services and employers support for working women. Additional problems include inflexible work schedules, the trend among employers to "do more with fewer employees," and the lack of high-quality, accessible, and affordable child and elder care.

Each of these demographic trends has serious ramifications for social policy, economic planning, and health care reform. For example, the aging of Americans clearly implies a need for increased attention to a broad spectrum of geriatric health and social services. The age group between 55 and 65 is losing health benefits at a faster rate than any other group except children. Many in this age group cannot qualify for health insurance because of the preexisting health condition criterion imposed by a number of insurance plans. Another segment of this population no longer has health coverage because when they were in early retirement their former employers canceled their benefits to reduce costs. Unfortunately, women have a greater chance than men of being uninsured.

"Social Diseases" and the Growth of Economic Inequality

The growth in the nonwhite share of the population is distressingly bound up with the persistence of, and even increases in, certain familiar pathologies of disenfranchisement—substance abuse, teenage pregnancy, family disintegration—as well as more recent challenges to the health services system,

such as that of devising, supporting, and delivering culturally appropriate services to new immigrants (both legal and illegal) and refugees.

Within this matrix, there is another subset of problems that might be characterized as new "social diseases." By social disease, we mean a mixed bag of pathologies—some physical, some psychological, some both. They range from homelessness among veterans and others to child abuse (every 11 seconds a child is reported abused or neglected), with its long-term neuropsychological impacts from substance dependency to obesity. Some of these are pathologies of poverty due to changes in the distribution and location of jobs and in the level of education and training required to obtain employment.[5]

Let me hasten to insert here that there have always been homeless people in the United States. As economic circumstances have fluctuated, so have the size and composition of the homeless population. The homelessness problem has increasingly captured public attention. Take, for example, Washington, D.C. Evidence of the problem is not hard to find in the Nation's capital. Twenty-five families spent the Christmas holidays in an emergency shelter. Many others were housed elsewhere. The population at the shelter has been growing since it opened last November. Similar trends have been identified in other cities, according to a telephone survey of community leaders conducted in late 1997 by the Joint Center for Political and Economic Studies.

Of particular relevance to the present discussion is the fact that many homeless individuals, particularly single young men, have histories of encounters with the criminal justice system and a glaring lack of experience with the health care system. Most disheartening are the cases of adolescents and post-adolescents who grow out of foster care or child mental health and mental retardation facilities because they are no longer eligible for residentially based services for their age group, yet they have nowhere to live. They then resort to illegal means to get food and shelter.

Unfortunately, the otherwise robust economy of today has helped create the illusion that everyone is prospering, but that is not the case. Indeed, there is a rapidly widening gap between rich and poor. Although it is tempting to add the influence of the historic legacy of racial segregation and discrimination, that would only be assigning blame—which is not a productive exercise—and would blur the challenges and opportunities to recognize and address the underlying forces that have provoked economic stress for many Americans.

In this direction, William Julius Wilson, a long-time student of economic and social problems of urban America, writes:

> Many of today's problems in the inner-city neighborhoods—crime, family dissolution, welfare—are fundamentally a consequence of the disappearance of work. Work is not simply a way of making a living and supporting your family. It also constitutes a framework for daily behavior because it imposes discipline.[6]

The Troubling Issue of Mental Health

Then there is the deeply troubling issue of mental health, a problem so serious that it must be considered separately. It cuts across boundaries of race, class, and neighborhood. If it differs from group to group or community to community, it is in complexity, not in fundamentals. The relevance of mental health to our discussion today was underscored three decades ago in a 1967 paper of the American Bar Association (ABA). It is worth quoting at length:

> If one observes both persons who crowd our criminal courts and the population of our mental hospitals, one is struck not by differences between the two but by similarities. Our preoccupation with trying to separate the "mentally ill" from the "criminals" may have led us to overlook a more central reality; both mental illness and criminality are tributaries of some deeper mysterious channels. Certainly, there are differences between "criminals" and the "mentally ill," but it seems possible that the problems of

> mental illness and crime lend themselves to identical methods of handling.[7]

The ABA report goes on to state that there is a limited supply of mental health resources and inefficient use of those that exist.

This resource issue has been brought into much sharper focus by a recent study that shows that under the pressure of competition and managed care, two-thirds of the Nation's private hospitals that are equipped to take in mentally ill patients dump them on hard-pressed, financially weak public hospitals. The study also reports that hospitals discharge mental patients prematurely, either when their health insurance runs out or when the cost of their coverage exceeds the reimbursement rate that their insurance companies pay hospitals. Among adolescent psychiatric patients, it is more difficult for those without health insurance than those with insurance to obtain needed behavioral health services. How many of those who cannot get care become "students" in the juvenile justice system is not clear.

Added to this is the shortage of mental health care professionals. For example, in 1997, the Department of Health and Human Services—which recognizes areas with a paucity of mental health care services—designated 536 mental health care professional shortage areas in the United States. This trend could get worse if the organizational landscape of health care delivery continues to be rearranged (i.e., by mergers, consolidations, and alignments of health care organizations and institutions).[8]

Health Care to Meet the Nation's Changing Needs

The demographic trend pertaining to women raises basic questions about what health services are most critical for female heads-of-household and their children as well as about how, when, in what setting, and at what cost such services should be provided. Each of the other demographic trends previously cited expands or lends weight to a group with new or greater needs or with needs that have so far been inadequately addressed in the health and social services system. These needs have not been met for a number of reasons. One of the most prominent reasons is that many members of the group lack a regular source of health care with an emphasis on preventive health services. They lack these services because they do not have health insurance or other means to pay for care. In a recent study by the National Center for Health Statistics, it was found that African-American persons were four times more likely than whites to report "no insurance/can't afford" as their main reason for poor health.

I will close by underscoring the fact that near the top of any agenda for revitalizing communities and reducing crime must be a health care system that successfully addresses the issue of equity between the young and aged and among social and ethnic groups. The health care system must have the capacity, commitment, and community orientation to be an active part of efforts to address health care needs of adolescents, including behavioral disorders and related dysfunctions. It must also address past inattention to women's health issues that have created serious gaps in knowledge about the cause, treatment, and prevention of disease in women. Unfortunately, the health care system that exists today in the United States is not fully prepared to meet these and other challenges of the 21st century, as we are constantly reminded by the media, advocates for the poor and medically underserved, policymakers, and participants in forums and workshops.

As managed care has emerged as a principal system for health care and evidence indicates that the profit margins of health maintenance organizations are falling and services may be reduced, it is becoming increasingly clear that more health care reform is needed. These organizations are also confronted with angry consumers demanding better services and hospitals and physicians determined to resist further cutbacks in fees.[9]

Clearly, health care must be substantially reformed to meet the changing needs of all stakeholders in a system so essential to community revitalization and to a reduction in the incidence of crime and related social problems.

Notes

1. "More Suburbs Find City Ills Don't Respect City Limits," *Wall Street Journal*, January 2, 1998, B1.

2. U.S. Bureau of the Census, "U.S. Population Nears 269 Million as 1998 Begins," Press Release, Washington, DC: U.S. Department of Commerce, U.S. Bureau of the Census, December 24, 1997.

3. Day, J.C., "Population Projections of the United States: 1995–2050," *Current Population Survey*, Washington, DC: U.S. Bureau of the Census, 1995.

4. U.S. Bureau of the Census, March 1994 Supplement, *Current Population Survey*, Washington, DC: U.S. Bureau of the Census, 1995.

5. See The Commonwealth Fund, "Survey Finds Missed Opportunities to Improve Girls' Health," *The Commonwealth Fund Quarterly* 3 (3)(Fall 1997); Mushinski, M., "Teenagers' View of Violence and Social Tensions in U.S. Public Schools," *Statistical Bulletin*, Metropolitan Life Insurance Company (July–September 1996); Children's Defense Fund, "Key Facts About Children," CDF Report, Washington, DC: Children's Defense Fund, 1995; and Cropper, C.M., "10 Heroin Deaths in Texas Reflect Rising Use by Young," *New York Times*, November 18, 1997, 28.

6. Wilson, W.J., "Work," *New York Times Magazine*, August 18, 1996, 28.

7. Matthew, A.R., "Mental Health and the Criminal Law: Is Community Health an Answer?" *American Journal of Public Health* 57 (September 1997): 1571.

8. See U.S. Department of Health and Human Services, *Mental Health, United States*, Rockville, MD: U.S. Department of Health and Human Services, 1996; National Advisory Mental Health Council, *Health Care Reform for Americans With Severe Mental Illness: Report of the National Advisory Mental Health Council*, Rockville, MD: National Advisory Mental Health Council, 1993; and Kilborn, P.T., "Mentally Ill Called Victims of Cost-Cutting," *New York Times*, December 10, 1997, A20.

9. See General Accounting Office, *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort*, Washington, DC: General Accounting Office, May 1997; United Hospital Fund, *Primary Care Capacity and Medicaid Managed Care*, New York: United Hospital Fund, 1998; and Knickman, J.R., R.G. Hughes, H. Taylor, K. Binns, and M.P. Lyons, "Tracking Consumers' Reactions to the Changing Health Care System: Early Indicators," *Health Affairs* 15 (Summer 1996): 22–32.

Economic Shifts That Will Impact Crime Control and Community Revitalization

Cicero Wilson

As we approach the year 2000, the United States is nearing the end of a prolonged period of prison construction. The growth of violent crime and sentencing reforms in the 1980s and 1990s have led to record numbers of incarcerated adults and juveniles. Although crime rates declined in 1995 and 1996, it is not clear what the long-term crime and incarceration trends will be during the next 20 years. If crime rates do not continue to decline, local officials may divert government resources away from schools, community development, parks, and other public amenities for prison construction. Two important priorities for our Nation are to reduce the rate of crime and to minimize the impact of crime on children, families, and communities.

Despite improvements in the criminal justice system, such as community policing, drug courts, and increases in prison beds for violent offenders, the incidence of crime remains high in the United States. The focus of our attention in the criminal justice system is on improvements in how we deal with crime after it is committed. The criminal justice system must begin to monitor more carefully economic and community trends that influence the rate and depth of poverty. The efforts of policymakers and practitioners to achieve crime reduction goals in the next 20 years will require greater attention to the reduction of poverty. Rates of crime may be influenced more by rates of persistent poverty than by criminal justice interventions. Poverty, not race, sex, or age, still has the highest correlation with crime and violence.

Poverty helps create and maintain the behaviors and attitudes that contribute to crime, violence, and the onset of criminal careers by youths. Few criminal justice reforms and innovations directly address poverty or the systems charged with addressing poverty—housing, education, welfare, and employment and training. In the future, the criminal justice system must be more proactive in influencing antipoverty, community revitalization, family, and educational programs and policies. To have a stronger voice in the design of these programs and policies, economic trends need to be monitored and analyzed from a crime control and community revitalization perspective.

Three of the general trends that will influence the American economic landscape in the 21st century will have a special impact on crime rates and the success of efforts to revitalize distressed communities. These three trends are:

- Increases in populations with higher-than-average risk of participating in crime, including long-term unemployed adults and youths, unemployed ex-offenders, school dropouts, and children reared in fatherless homes.
- Increases in the number of high-poverty communities because of failing schools, unemployment, underemployment, and community abandonment strategies.
- The continued reliance on ineffective programs and policies to promote family self-sufficiency and revitalize distressed communities, including "deconcentration of poverty" approaches and the emphasis on income maintenance rather than on asset-building strategies.

Population Trends

Trend One: For Dropouts and Unskilled Workers, Finding Family Wage Jobs With Benefits Will Become More Difficult

It will be difficult for unskilled and uneducated labor to find family wage work in the 21st century. The globalization of the economy and technology are producing greater productivity, greater competition, larger profits, and fewer family wage jobs. Although foreign competition and lower overseas wages in some countries have cost the United States jobs, most of our job losses were because of competition from high-wage, high-technology countries such as Germany and Japan. Technology will have a greater impact than foreign competition on job loss and disruption of career paths. Technology will not only eliminate some jobs in industries such as banking and manufacturing, it will also change the educational skills needed for the new jobs.

Another major source of labor market problems is the corporate culture that promotes maximizing profits by downsizing, or converting full-time jobs with benefits into part-time jobs with no benefits. Jeremy Rifkin, in his book *The End of Work*,[1] predicts technology and corporate culture will determine unemployment levels in the 21st century. If unemployment grows to levels of 20–25 percent nationally as Rifkin and other authors predict, then the pressure on all of our social systems will be enormous. While such dire predictions are far from guaranteed, these trends must be carefully monitored by agencies and advocates concerned about reducing crime and revitalizing economically and socially distressed communities.

Trend Two: The Number of Youths Failing School Will Continue to Escalate Without Changes in School Policies, Tutorial Support Systems, and Parental Involvement

Youth crime prevention is often deemed synonymous with school failure prevention. Unfortunately, school failure is a growing trend in poor urban and rural areas. Two sources of school failure are extremely important to criminal justice and community development advocates: unaddressed learning difficulties and school suspension and expulsion policies.

Unaddressed learning difficulties. Students who fall behind two grades in school are more likely to drop out or become involved with drugs, alcohol, or the courts. Despite the emphasis on education standards, our schools are still struggling to help students master basic reading, math, and communications skills. Many students who are experiencing learning difficulties have nowhere to go for help. Working parents, especially single working parents, have limited time to check homework or tutor their children. Teachers are overburdened. Most churches do not offer latchkey or tutorial programs. The absence of adequate rural transportation is a major impediment to getting students to programs, if programs exist.

Without tutorial assistance for students in schools and juvenile institutions to supplement classroom instruction, many students will continue to fail and either drop out or graduate functionally illiterate. These youths lack the skills needed to succeed in the 21st-century working world and are at high risk of becoming involved in criminal activities to support themselves.

School expulsion and suspension policies. In response to student disruptive behavior, violence, weapons, and illegal substances, most schools have adopted zero-tolerance rules to quickly expel offending students. Schools penalize minor misbehavior with suspensions. However, unlike suspensions of two decades ago, some schools have added procedures to automatically fail students in courses in which they have five unexcused absences. A student who is suspended for 5 days fails all of his/her classes for the entire semester. Old policies would require students to attend afterschool detention and do more work and suspended students to make up all assigned work. Today, schools expel students without adequate provision for alternative schools. Schools also suspend students so frequently that they fail enough classes to fall more than 1 year behind their graduating classes. These students usually drop out of school. These policies remove the most troublesome students, but they also push

out students who could be helped. These policies are at odds with everything we know about school absence, dropouts, school failure, and delinquency. These school policies are filling communities with teenagers who are unsupervised most of the day. These out-of-school youths are at high risk for substance abuse, teen pregnancy, and criminal activity.

Whatever the sources of school failure, more than 1,100 youths drop out of school every day in the United States. Many students will graduate without the basic skills needed to succeed in the rapidly changing working world. Unabated, this school failure trend intensifies the problems of unemployment and poverty, which are primary contributors to crime rates.

Trend Three: The High Incarceration Rates of the 1990s Will Result in a Flood of Unemployed Releasees From Prisons and Jails in the Next Two Decades

The efforts of economic and community development programs, work force development projects, and welfare reformers erode when adult and juvenile parolees return to the community unemployed. They attempt to make money through street crime, drug sales, and extortion from women on welfare. The current lack of sufficient reintegration programs, high recidivism rates, and the number of persons to be released from jails and prisons during the next 25 years should alarm everyone. Furthermore, large numbers of these releasees are returning to the communities we are trying to revitalize.

The criminal activities of unrepentant parolees make the neighborhoods inhospitable to efforts to revitalize the family, community, and local economy. Crimes such as carjacking, school violence, and random shootings have fueled the move of many families and businesses to communities perceived as safe. Business tax incentives, business retention strategies, and community development efforts such as Empowerment Zones are severely diminished as development tools when businesses and residents perceive a community or city as crime ridden. Controlling community crime and violence is an important prerequisite to community revitalization.

Trend Four: There is an Increase in the Number of Fatherless Children, Who Are More Prone to Delinquency and Other Social Pathologies

As the incidence of father absence grows, community disintegration and crime, especially youth crime, will continue to grow. Between 1960 and 1990, the percentage of children living apart from their biological fathers increased from 17 to 36 percent. By the year 2000, half of the Nation's children may not have their fathers at home. While the heroic efforts of single women to raise their children alone are laudable, the economic and social requirements for raising healthy and productive children are hard to achieve by poor single parents alone. Reengaging fathers in the economic and social life of their children is an important but overlooked aspect of addressing poverty, community revitalization, and crime.

Many of our problems in crime control and community revitalization are strongly related to father absence. For example:

- Sixty-three percent of youth suicides are from fatherless homes.
- Ninety percent of all homeless and runaway youths are from fatherless homes.
- Eighty-five percent of children who exhibit behavioral disorders are from fatherless homes.
- Seventy-one percent of high school dropouts are from fatherless homes.
- Seventy percent of youths in State institutions are from fatherless homes.
- Seventy-five percent of adolescent patients in substance abuse centers are from fatherless homes.
- Eighty-five percent of rapists motivated by displaced anger are from fatherless homes.

Without fathers as social and economic role models, many boys try to establish their manhood through sexually predatory behavior, aggressiveness, or violence. These behaviors interfere with

schooling, the development of work experience, and self-discipline. Many poor children who live apart from their fathers are prone to becoming court involved. Once these children become court involved, their records of arrest and conviction often block access to employment and training opportunities. Criminal histories often lock these young persons into the underground or illegal economies.

Behaviors related to father absence that directly contribute to the growth of welfare and the difficulties in creating jobs in communities include:

- Sexually predatory behavior that results in out-of-wedlock births. (Most teen mothers are impregnated by older men, not teen boys.)
- Domestic violence that occurs as a result of arguments over enforcement of child support payments.
- Welfare pimping, which is the practice of men collecting part of the welfare check from girlfriends or the mothers of their out-of-wedlock children. Some pimps collect from five or six mothers on welfare per month.

Innovative father engagement programs have had an impact on child rearing, family economic stability, and gang involvement. Unless community revitalization and crime reduction programs begin to address the need for father engagement programs and services, the cycle of poverty and crime could continue virtually unabated.

Community Revitalization Trends

Trend Five: There is an Increase in the Number of High-Poverty Areas

Socially and economically distressed communities tend to promote behaviors and attitudes conducive to crime and dependency. High levels of crime also help to maintain and increase high-poverty communities. The 1990 census indicated that the number of high-poverty census tracts had increased since the 1980 census. The proportion of poor persons living in extreme poverty census tracts in the 100 largest U.S. cities tripled between 1970 and 1990, from 12.6 percent to 36.2 percent.[2]

Apparently, approaches to law enforcement and income maintenance in extremely poor communities had limited impact on poverty and crime during the last two decades. Although current welfare reform and broken windows approaches to law enforcement appear to have some impact, the underlying poverty and propensity for crime have been suppressed, not reduced. If recessionary economic conditions reappear with high levels of unemployment, the rates of poverty and crime could rise significantly. Federal programs and policies that have an impact on employment and education in poor communities are very important components of an effective crime reduction and community revitalization strategy.

Federal criminal justice and antipoverty policies need to consider more effective resource targeting to reduce the number of high-poverty communities. However, these policies and programs to combat the concentration of poverty should not rely on "deconcentration" or "dilution" approaches. These dilution approaches deconcentrate poverty by moving poor families into mixed-income communities. Generally, these programs do not help families improve their family income, gain economic literacy, or reduce or eliminate such problems as drug addiction before moving the family. Dilution programs should not be "problem export" programs. Simply moving to a better neighborhood will not automatically change destructive attitudes and behaviors.

Trend Six: Community Abandonment

Frustrated criminal justice, housing, and economic development officials often view communities with very high rates of crime, housing abandonment, substance abuse, and gangs as beyond help. Investing police and economic development resources in these communities is deemed a waste of limited resources. This approach is called a "community abandonment" strategy. The problems with this approach are numerous. First, these communities often spread their misery to neighboring communities. Second, crime and barriers to economic development extend far beyond the particular abandoned community. The presence of such a community adversely affects the reputation of entire segments of towns and cities. Third, these abandoned communities also serve as safe havens for criminals

who prey on other communities. Fourth, most of what we have learned about successful community revitalization has been learned from the efforts of local residents and their partners in distressed communities. The transformation of the Kenilworth Parkside Public Housing Development in Washington, D.C., is one of many successful transformations.

The frustration and failure associated with revitalization efforts in very distressed areas is the result of weak strategies that do not engage the support of local residents. These strategies also fail to focus on asset building and lack strong criminal justice responses to crime. An example of a good strategy is the Weed and Seed program. The Weed and Seed program has a major positive impact on economic development and revitalization when a coalition of community and law enforcement agencies work together to eliminate local crack houses. This strong law enforcement response, with media coverage of local residents cheering, boosts community development efforts. This program says to the public that something can be done about crime and that residents of poor neighborhoods want crime eliminated. Without such efforts, community abandonment is viewed as a logical response.

Trend Seven: Without Policies to Correct Asset Deficiencies, an Increasing Percentage of Families Will Not Achieve Self-Sufficiency and Efforts to Revitalize Poor Communities Will Continue to Have Limited Success

Until recently, our approaches to poverty and community development have been focused on deficits, problems, and income security programs. Programs that do not focus on teaching and asset building consistently fail to reduce poverty and revitalize distressed communities on a large scale. Asset building has been the primary vehicle for lifting individuals and families out of poverty. Assets such as savings, homeownership, property ownership, business ownership, and postsecondary education and training are the resources most Americans use to become self-sufficient and decrease the likelihood of poverty for themselves and their children.

Asset-building programs increase family income rather than supplement inadequate income and also create local jobs and local stakeholders in communities. Poor families that rise out of poverty through education and employment often leave poor communities because of crime, poor schools for their children, and lack of business ownership and homeownership opportunities. When these successful families leave, they take their disposable income, civic involvement, and examples of positive achievements with them, leaving the familiar concentration of poor families and problems behind.

Asset-building programs also create a positive economic future for youths. Many youths join gangs or engage in street crime because they feel they have no other economic options. Programs that provide youth enterprise skills or education trust funds influence their view of themselves and their risk-taking behavior. Crime prevention and treatment programs as well as community revitalization strategies need to include asset building to be effective. Poor and working poor families and individuals can effectively build assets when provided with specialized programs to help them. By increasing the availability of these programs and promoting asset building for the poor, families and communities can be strengthened. Policymakers and practitioners should explore the expanded use of the following programs and policies in reducing poverty and crime:

Economic literacy programs. Economic literacy programs provide basic budgeting and banking and savings skills for low- and moderate-income individuals and families.

Microenterprise and youth enterprise programs. Microenterprise and youth enterprise programs provide entrepreneurial training for low-income individuals. After assessing their talents and interests, each trainee is taught how to develop a real business plan by program staff. The program then makes small amounts of capital available to the trainees to launch their businesses.

Homeownership programs for low-income families. Homeownership programs provide counseling on the homeownership process and assistance with budgeting, savings, and the downpayment. These services create community stakeholders.

Individual Development Accounts. Individual Development Accounts (IDAs) are restricted savings accounts that can be used for buying a home, starting or expanding a business, or postsecondary education and training. Individuals or families are required to save for their dream, and their savings are matched by the private, nonprofit, and public sectors. For example, a family saves $20 a month, and those savings leverage $80 in matching contributions. IDAs are included in the new welfare law. The law also allows recipients of income maintenance benefits to have these accounts without affecting their eligibility to receive benefits. Legislation is pending in Congress to provide $100 million for IDA demonstrations.

Conclusions and Recommendations

Our real crime reduction and community revitalization challenges involve finding ways to reduce poverty, the number of high-poverty communities, family disintegration, and the number of young people entering criminal careers. Community development and crime reduction agencies must not sit by while employment, welfare, child support, and school agencies institute rules and guidelines that increase the difficulty of controlling crime and reversing community decline. For example:

- Local employment agencies have always put ex-offenders and youths at the bottom of priority lists for employment and training services. The willingness of noncustodial fathers to support their children is not considered when selecting participants for training programs. The importance of employment for noncustodial fathers, especially ex-offenders, will not become a priority without Federal guidance.

- New child support and paternity establishment rules have great potential to increase violence against women and children. State and local agencies need guidance in considering how to reduce these risks.

- Schools not only institute expulsion and suspension policies that push too many children out, they also are initially inept at addressing the emergence of gangs in schools. Information on best practices to prevent and control gangs and violence in schools is available at the Federal level, but few school administrators use it. Federal incentives to get schools to use this information are needed.

The U.S. Department of Justice has developed accessible databases on best practices in violence prevention, gang control, victim assistance procedures, and other important areas. In addition, the Department of Justice has funded demonstrations and evaluations of important innovations such as drug courts, community policing, Weed and Seed, and prison industries. These programs are having an important impact at the community level. Greater attention should be given to these databases and to innovations by other Federal, State, and local agencies.

Federal agencies with mandates to reduce crime and rebuild communities need to focus more attention on asset building, reshaping school suspension policies, and designing programs and policies to engage fathers as positive economic and social agents in families. Without these changes in our approaches, poverty, employment, school failure, and family trends will block efforts to reduce crime and revitalize communities.

Notes

1. Rifkin, Jeremy, *The End of Work: The Decline of the Global Labor Force and the Dawn of the Post-Market Era*, New York: Putnam Publishing Group, 1995.

2. Kasarda, John D., "Urban Industrial Transition and the Underclass," *Annals of the American Academy of Political and Social Science* 501 (1990): 26–47. Also see Wilson, William Julius, *When Work Disappears*, New York: Alfred A. Knopf, Inc., 1996.

The Context of Recent Changes in Crime Rates

Alfred Blumstein

The late 1980s saw a dramatic growth in U.S. homicide rates, particularly in homicides committed by young people. Between 1985 and 1992, the homicide arrest rate for youths and children age 18 and under more than doubled. This gave rise to considerable rhetoric about the "bloodbath" that was coming and the new generation of "superpredators" who had to be dealt with in harsh new ways. Fortunately, that growth peaked in the early 1990s and has declined appreciably since then. Aggregate homicide rates are now lower than they have been for more than 25 years, but the rate of homicides by young people is still well above the stable rates that prevailed from 1970 through 1985.

In this paper, I would like to address some of the contextual issues behind the growth in violence of the late 1980s, examine the decline since 1991, and explore some of the speculations about the factors that contributed to that decline. I will then follow with some suggestions for potential Federal roles in helping to decrease crime and revitalize communities.

Growth in Violence in the Late 1980s

In a recent paper,[1] I examined the time trends in three measures—youth homicides, handgun homicides by youths, and arrests of nonwhite juveniles for drug offenses. Each of these rose dramatically beginning in about 1985 and had more than doubled by 1992. Similar changes were not displayed in adult homicides, nongun homicides, and arrests of white juveniles for drug offenses.

My hypothesized link among these three trends is that crack arrived in the mid-1980s, initially in the larger cities, and spread from there to the smaller cities. Because crack required many more sellers to meet the increased demand (composed of many more buyers and with more transactions per buyer), there was major recruitment of young minorities to serve in that role. They were carrying valuable property—drugs or the proceeds from the sale of those drugs—and so they had to take steps to protect themselves from robbery. Because they were dealing in an illegal market, they could not call the police if someone tried to steal their valuables. Their self-protection involved carrying handguns. Because young men are tightly networked and highly imitative, their colleagues—even those not involved in selling drugs—armed themselves also, at least in part as a matter of self-protection against those who were armed. That led to an arms race in many inner-city neighborhoods.

It is widely recognized that violence has always been part of teenage males' dispute-resolution repertoire, but that has typically involved fights, the consequences of which were usually no more serious than a bloody nose. The lethality of the ubiquitous guns contributed in a major way to the doubling of the homicide rate by (and of) those 18 and under.

The emphasis on the presence of guns as a critical instrument in this process is reflected in the fact that gun suicide rates by young people, especially young African-Americans, escalated at the same time as homicide rates.[2] There were no comparable trends in nongun homicides or suicides.

At the same time, the homicide rate for older ages diminished. For those 30 and older, the reduction was about 20–25 percent. The growth in the prison population during that time (a doubling in the incarceration rate between 1985 and 1996) has undoubtedly contributed to that reduction, although no one has isolated that incapacitation effect from other factors (e.g., a general decline in intimate partner homicides) that may have contributed to the decline in the homicide rate by older offenders.

Shifts During the 1990s

The number of homicides by young people leveled off in the early 1990s and did not begin a significant decline until 1994. With the growth in the homicide rate among young people stopped, the continuing decline in the homicide rate by older offenders resulted in a peak national homicide rate in 1991 and a subsequent decline. That decline was dominated by the changes in the largest cities—New York in particular—which displayed very sharp declines, beginning in 1994.

One explanation that has been offered for the decline in crime rates is "demographic change." This probably harks back to the last time we saw a significant decline in crime rates, in the early 1980s, when demographic change—the aging of the baby-boom generation out of the high-crime ages of the late teens and early 20s—was indeed a major contributor to the crime rate decline.[3] Today, however, demographic change is working in the other direction—to increase crime rates. As can be seen in exhibit 1, which shows the number of people at each age in the United States in 1998, the smallest age cohort in the Nation under age 40 is now about 23. These are the people who were born in 1975 following the baby boom, which peaked in about 1960.

Thus, we are seeing a growing number of individuals entering the high-crime ages of the late teens and early 20s, and that will continue for at least the next 10 years. But we should also note that those changes are not dramatic, with the cohort sizes expected to grow by about 15 percent in 15 years, or roughly 1 percent per year. Even when one partitions this analysis by race (see exhibit 2, which shows the white and black male populations separately by age), we see that the young black male population (which is multiplied by a factor of seven to show the comparative growth, since the U.S. white population is about seven times the black population) follows a pattern very similar to the white male population, but with a somewhat faster rate of growth. Nevertheless, the growth rate of the black male population is only about 30 percent in 15 years, or about 2 percent per year.

Exhibit 1. Age Composition of U.S. Population, 1998

Source: U.S. Bureau of the Census

These demographic shifts represent but one factor contributing to changes in crime rates. If crime rates within each demographic group stay constant, then an increase in the size of the demographic groups with the highest rates contributes to an increase in the aggregate crime rate. But other factors are contributing to changes in demographic-specific crime rates well in excess of even 2 percent per year. During the late 1980s, for example, homicide rates by young people were growing by 10–20 percent per year. Declines in recent years, especially in the largest cities, have also been of that magnitude.

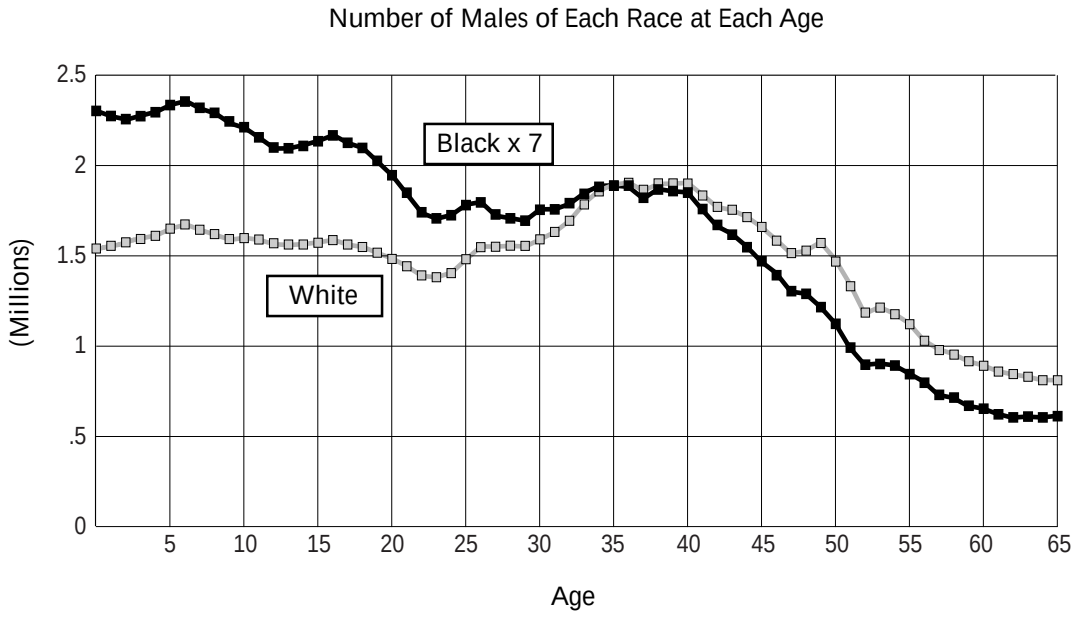
An important avenue to pursue is finding an explanation for the recent decline in homicides by young people. Possible explanations include:

- Changes in the nature of drug markets (crack markets in particular), induced by changes in the nature of the demand, that has led to less violence associated with those markets.
- Vigorous police and community efforts in at least some cities to get guns out of the hands of young people.
- Police and community efforts to resolve gang conflicts and encourage disarmament.
- Improvement in the economy that not only has provided jobs to young people but also has been a source of improved hope for succeeding in the legitimate economy.
- Increased incarceration of potentially violent offenders.
- Improvement in the largest cities that may be masking a situation that could be very different in many smaller cities.

These explanations certainly are not mutually exclusive, and different explanations could apply to different cities. We still need more effort to sort out these and possibly other contributors to the decline.

Even though the decline in the homicide rate by young people is encouraging news, it is important to note that the homicide rate by juveniles is still at least 60–80 percent above the rate that had prevailed for the 15 years from 1970 to 1985. Thus,

Exhibit 2. Age of U.S. Males by Race, 1997



Source: U.S. Bureau of the Census

we still have a long way to go in bringing that rate down.

Incarceration has been the Nation's dominant strategy against crime over the past 25 years. That has led to an incarceration rate (prisoners per capita) that is more than four times the rate that prevailed with remarkable stability for the previous 50 years. Incarceration with reasonable sentences is likely to have an important incapacitation effect on older offenders (ages 25 and older), whose lengthy criminal careers may reasonably predict future offending.

Such predictions are far more difficult with younger offenders, so it is important to address opportunities for investment in crime-prevention efforts targeting individuals in high-risk situations at an early age. Even though the payoff from such investments will take several years to be realized, it is likely to exceed the fiscal cost—let alone the social cost to the society and the economy—of widespread use of long-term incarceration of young people. But no one can make that assessment definitively because the evidence on the comparative payoffs is still poorly known and the payoffs will vary with different kinds of interventions with different target groups. A major national challenge lies in finding what approaches can be most effective with each of the different kinds of young offenders. We still do not have definitive solutions, but it is extremely important to invest in the research that will enable us to develop and identify them.

Windows on the Future

As we look to the future, there is little we can say with certainty. One strong predictor is the demographic composition of the Nation. It has already been indicated that demographic trends will contribute to making matters worse, but only at the rate of about 1–2 percent per year. The other matter of concern is the greater number of people who will be unemployed or without reliable sources of income if the economy turns down—a likely eventuality—but few people can say with any confidence just when that will occur. When that happens, we might see more people resorting to criminal activity to offset their displacement from the legitimate economy. One group in particular for whom that is an important issue is the people who will be displaced from welfare support when their time of eligibility expires. So far, we have seen an important reduction in the welfare rolls by those best able to move into the legitimate economy, while those without such opportunities have stayed on welfare. Within the next few years, more of that latter group will find themselves without welfare support, and—especially if there is concurrently a significant growth in unemployment—there is a serious risk that they will pursue illegitimate means for their sustenance.

Another important cloud on the horizon is the concern about the arrival of new drug epidemics in our major cities. We have seen an ebbing of serious drug abuse in recent years as young people have eschewed the crack cocaine that so often did serious damage to the lives of their parents and siblings. As that awareness fades in coming cohorts of young people, or if new drugs without the comparable stigma arrive, we might well see a reignition of some of the serious crime epidemics that characterized the late 1980s. The data to be collected in 75 cities by NIJ's Arrestee Drug Abuse Monitoring (ADAM) program, involving urinalysis of booked arrestees, should provide some early warning of the arrival of those problems.

The Federal Role

As one builds on this background to identify an appropriate Federal role for dealing with these problems, one is first faced with the complexity of the division of labor between the Federal Government and State and local governments. It is widely accepted that the primary operational responsibility for local crime control is inherently State and local. But there are important aspects of the crime problem for which the primary responsibility is Federal.

One relates to interdiction of criminal activity in which interstate transactions are particularly important. The most evident of these is the area in which there is already widespread Federal involvement—interstate trafficking in drugs. But it is also important to focus on another crime-related product, which is much more directly associated with violence and one in which the Federal role is still poorly developed. That relates to the illegal trafficking in firearms, particularly the semiautomatic handguns that have been implicated as a major factor in the rise of juvenile violence over the past

decade. Crime-gun tracing by the Bureau of Alcohol, Tobacco and Firearms (ATF) through its National Gun Tracing Center has seen some important growth over the past several years, but the capability and the effort applied are still far less than is needed to become effective in interdicting that illicit traffic. Better collaboration between local police and ATF could result in more effective interdiction of that traffic.

The other general role of the Federal Government relates to "public goods" that States or localities need but whose creation is expensive and is broadly beneficial, so the Federal Government appropriately becomes the agent to serve the combined interests of States and localities. These public goods include creation and maintenance of shared operational databases such as the National Crime Information Center (NCIC); fostering and evaluating a wide range of innovations and disseminating the results of evaluations of those innovations so that the successful ones can be replicated elsewhere; and organizing and sponsoring research and statistical projects and disseminating the information and new insights they generate. This last—the research and statistics function—is the critical one, and it is not likely to occur without major Federal involvement. These activities are the province of the U.S. Department of Justice's Office of Justice Programs—NIJ, the Bureau of Justice Statistics, the Bureau of Justice Assistance, the Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime.

Most people see these functions as merely a transfer of Federal money to alleviate local costs. The agencies' participation in providing the knowledge to enhance the overall effectiveness of the agencies of the criminal justice system is a far more critical Federal role because the functions could not be performed without that participation. In view of their importance, it is astonishing how little money the Federal Government invests in those functions.

Notes

1. Blumstein, Alfred, "Youth Violence, Guns, and the Illicit-Drug Industry," *Journal of Criminal Law and Criminology* 86 (1) (Fall 1995): 10–36.

2. See Blumstein, Alfred, and Daniel Cork, "Linking Gun Availability to Youth Gun Violence," *Law and Contemporary Problems* 59 (1) (Winter 1996): 5–24.

3. See Blumstein, Alfred, Jacqueline Cohen, and Harold Miller, "Demographically Disaggregated Projections of Prison Populations," *Journal of Criminal Justice* 8 (1) (January–February 1980): 1–25.

Community Watch

*Amitai Etzioni**

The way one thinks about and deals with crime depends on one's assumptions about human nature. If one assumes that people are good by nature, as many liberals do, then one blames conditions in society on ill conduct. Giving people jobs—well-paying jobs and not dead-end ones—is the most obvious treatment for anti-social behaviour. Education, rehabilitation, and psychotherapy are close seconds.

But if one shares the assumption of social conservatives (from the religious right to Michael Howard) that people have strong aggressive and sexual impulses, then one seeks ever stronger measures of law and order. In the US, Steve Forbes campaigned in favour of *one* strike and you're out. Yet there is a mountain of social-science evidence to support a third, communitarian position; infants are born without values (there are no altruistic genes) but, given the proper moral infrastructure, they can acquire values.

The building blocks of such an infrastructure are well known. Historically they have included families, schools, and communities (which encompass places of worship and voluntary associations). From this viewpoint, the sharp rise in crime in western societies is due to the weakening of all these moral elements. The family has clearly declined, and no new social agency has taken its place. Whatever one thinks about child-care centres, their focus is on custodial care, perhaps learning, but hardly on moral education. Schools in Britain still do a fair job of character-building, but as pluralism rises they are under increasing pressure to be value-neutral.

The sad fact is that even when families and schools are functioning to perfection as values-transmitters, as the moral agents of society they do not suffice. This takes us back to the pesky question of human nature. It is impossible to expunge all anti-social urges: we all occasionally experience aggressive feelings, inappropriate sexual desires and selfish inclinations. The best families and schools can do—and this is crucial for our understanding of crime and how to deal with it—is to develop a conscience that serves as a counterweight. Human nature is condemned to an eternal struggle between theses urges (which make us offend mores and often laws) and our conscience.

Most important, how law-abiding (and good) we are as adults is very much determined by the extent to which the conscience we acquired as children receives external reinforcement. This is particularly effective when it comes from those in whom we have an emotional investment: members of our communities. The stronger the communal bonds and the more they support pro-social behaviour, the more we are able to curb our urges, and the lower the level of crime. This is why we are all so surprised at crime in a small, tight-knit community, such as Dunblane.

The crimes I am talking about include not merely street violence, but also child and spousal abuse, white-collar crimes (embezzlement), corporate crime and political corruption.

Crime occurs in all social classes, not only in inner cities. While communities can curb even the most serious violent crimes, they are particularly effective in minimising most other crimes, releasing resources to fight the hard core.

Tony Blair's anti-crime programme, as drafted before his election, was successful in deflecting Tory accusations that Labour was soft on crime. Its focus on moving police from behind desks to the streets, "zero tolerance" for petty crimes, and fast-track punishment for persistent youth offenders, leaves plenty of room to make it more communitarian. The government programme could now take into

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account that crime is best prevented from the beginning rather than deterred by punishment after the fact. And that if one simply arrests most kinds of criminals (for instance, drug dealers), other people soon take their place. Both issues are best addressed when members of communities censure anti-social behaviour.

To mobilise communities to censure crime strongly, they must be treated as true partners with the police. Community policing does not quite cut it. While it is helpful to move more police on to the beat, it is also necessary to change the demographic composition of local police forces so they will not differ too much from the communities they are supposed to co-operate with. Community leaders must be involved in setting police priorities. Should the police concentrate on drug-dealers or on school safety? Should they focus on outsiders or entrap kerb-crawlers?

Some communities cannot be reached because they are hostile in general and to the police in particular. Yet in some instances, for example in Los Angeles, even gangs have been won over to help curb violence. Many disadvantaged communities already realise that they bear the brunt of crime. If they could be convinced that the police would deal fairly with them, they would be more likely to collaborate. Recently we learned that the curbing of quality-of-life offences—minor crimes such as playing cassette players loudly in public places, graffiti, and aggressive begging—is surprisingly effective in reducing more serious offences. Such drives re-establish community mores and mobilise the community to back crime-fighting.

Stigma is a useful device for addressing criminal behaviour; unfortunately it ruffles the feathers of liberals. They speak of returning to putting people in stocks. But while most everyone would agree that it would be a better world if one could prevent crime only by positive incentives, realistically, negative sanctions are unavoidable. Stigma is the least costly and the most—yes, the most—humane.

A young accountant is caught for the second time having embezzled money from a pension fund. Send him to jail, and he is most likely to graduate with even less respect for the law, be subject to punitive conditions, and carry the stigma of a criminal conviction, all at a high public cost. Make him carry a sign in his neighborhood (as a judge recently did in the US) and he will be deterred from repeating his offence—at minimal public cost.

Another way for communities to prevent crime is for them to wall themselves in—troubling, because communities sometimes employ these gates to keep out those of a different class or race. One notes that affluent communities and public institutions already have stringent entry controls. I cannot get into Parliament, the BBC, the High Court, and well-off people's residences, without identifying myself and explaining my business. Working-class neighbourhoods should be allowed the same protection, given that they are the likely victims of violent crime and that the state has not succeeded in keeping crime at bay. Gates and other methods of shielding target areas have proven surprisingly effective.

Gates have another constructive effect. They can help build community. When a neighbourhood in Dayton, Ohio, was flooded with drug-related crimes, gates—only to cars, not to pedestrians—blocked the traffic from the highway and divided the neighbourhood into six cul-de-sacs. Each of the six areas developed its own identity and social web. Children were heard to comment on the way to school that they must behave themselves because throwing stones or yelling aloud was not welcome in these parts. The undesirable effects of gated communities can be avoided by ensuring that neighbourhoods treat all who seek entry in the same manner. One still would prefer open communities, but gates seem necessary until crime, including terrorism, is better controlled.

Some pundits insist that the real issue is the exaggerated fear of crime, rather than crime itself. Fear is more pervasive in communities where crime rates are relatively lower. (A recent survey—which relies on self-reporting—found that in England more people reported themselves to have been a victim of crime last year than in the US, although crime rates in the US are several times higher.) This fear has barely declined even as crime has been reduced.

Many liberals draw from this the somewhat presumptuous conclusion that the members of such communities are irrational (the term "hysterical" is

sometimes used) and need reassurance, rather than more protection. But communities are sensible to worry about crime, even if after rising drastically (by more than five times between 1960 and 1990 in England and Wales) crime rates have now levelled off or been curtailed.

Crime has such devastating and lasting effects that limited changes in statistics do not much matter. Parents who yearn for a day when their children will be able to play outside unsupervised derive little comfort from a fall in crime of 11 percent. People won't walk at night in the "wrong" parts of a town simply because the murder rate is not as high as it used to be.

Among the more innovative ideas is an approach highlighted during the first Talk to Tony town meeting: restorative justice. It calls for offenders to meet their victims in the presence of other community members. The offenders are expected to apologise as well as perform community service that will help compensate the victim—for instance, restoring their vandalised property. The community determines the nature and scope of the compensatory service.

Untested so far is an idea from the Communitarian Network, which advocates sharing with communities savings that result from falling crime. The plan, "it takes a village to prevent a crime", offers communities a deal: it gives the community an estimate of the public cost caused by crimes committed on its turf. If the community agrees to fight crime, and if as a result crime falls in the following year, the community is awarded half the savings. These can be used for shared purposes, from building a playground to a swimming pool, but not for projects for the benefit of individuals. This further enhances the communal bonds, which in turn enables the community to combat crime.

These measures are not meant to supplant the conservatives' law-and-order measures or the liberals' job-creation. Communities are partners which can shoulder an important part of maintaining public safety, but they can hardly combat it single-handedly. One should note that for many crime-fighting purposes, police are over-skilled and expensive. It is best to draw as much as possible on alternative sources, and sentence first offenders to community work rather than jail.

When it comes to policing, a certainty of punishment is more effective than extensive punishment, and communities would be better off if the numbers of cops and courts were increased, rather than the number of jail cells. Jails should accommodate more people, for shorter sentences, to better effect. Providing the right jobs can significantly reduce crime; unfortunately such jobs are difficult for governments to produce, especially for the areas in which violent crime is most common. Yet law-and-order and socio-economic cures have long been the focus of the debate over the best ways to deal with crime. These have overshadowed the importance of community as a reinforcer of pro-social mores. Whatever portion of crime community-based methods can prevent, they eliminate it in ways that are low in cost and humane.

Panel Two:
The Roles of Federal, State, and Local Governments and Communities in Revitalizing Neighborhoods and in Addressing Local Public Safety Problems

Revitalizing Communities and Reducing Crime

Robert L. Woodson, Sr.

To reduce crime and revitalize communities, it is necessary to develop a strategy that can effectively intervene in the cycle of violence before it claims the next generation. A primary focus of our efforts, therefore, should be to reach and guide our Nation's youths who now, by the age of 18, confront more crucial moral decisions than their parents' generation faced in an entire lifetime.

A model of effective youth intervention does exist. There are hundreds of men and women throughout the country who have the proven capacity to provide the guidance and example that have the power to redirect at-risk youths to productive and positive activities. The importance and unique power of these dedicated community leaders can be appreciated best in light of the scope of the problems experienced by today's youths and the dismal track record of many conventional, professionally designed programs for at-risk youths.[1]

A Generation in Jeopardy

Throughout the Nation, crimes committed by juveniles, who often express a haunting sense of indifference, have created a public perception that a portion of the upcoming generation is already lost—beyond help. Reports and statistical analyses also reveal that the epidemic of spiritual malaise and violence is not an isolated "inner-city" problem and that it is affecting families of every income level. Throughout the Nation, youths from suburban neighborhoods and rural communities, like inner-city youths, are wasting, losing, and taking their lives. Five thousand children die each year as a result of assaults, illness, or suicide.[2] It is projected that 1 in 7 youths who are now between the ages of 10 and 18 will run away from home. Each year, 1.5 million young people are living on the streets.[3] Many of these children turn to the drug trade or prostitution as a source of money.

Trends in behavioral choices among adolescents indicate that the crisis will grow worse if effective intervention and support are not provided. In a recent survey of eighth graders, one-third of the respondents said they use illicit drugs and 15 percent said they had drunk more than five alcoholic beverages in a row in the preceding 2 weeks.[4] In 1996, the greatest increase in birth to adolescents was to girls younger than 15 years old. The firearms homicide rate among 10- through 14-year-olds more than doubled between 1985 and 1992, and suicide rates for these youths increased by 120 percent from 1980 to 1992.[5]

Clearly, our Nation's conventional responses to the problems of youth violence have not been effective in spite of the millions of dollars that have been invested in them. Researchers project that juvenile arrests for violent crime will more than double by 2010. A recent nationwide survey reported that gang membership in the United States has grown to more than 650,000 youths who are involved in 25,000 gangs. In response, a massive crackdown was launched by the FBI, which created 133 task forces that resulted in 92,000 arrests and 35,000 convictions nationwide throughout a 4-year period.[6] Yet in many cases, these arrests did no more than move a "bubble" of crime to a new location. In the words of one corrections officer in a State where half of a 38,000-person prison population has been identified as gang members, "The problem does not go away. When the community gets rid of its gang problem, that problem is then transferred to the correctional institution. In fact, it becomes more intensified."[7]

To date, most resources and efforts to rescue our Nation's children have been targeted to inner-city populations. Young people in low-income neighborhoods have felt the most severe impact of the moral free-fall that is afflicting the next generation because their communities lack the economic stability

that has provided a temporary buffer for middle- and upper-income youths. Yet, although millions of dollars have been invested in programs for inner-city at-risk youths, many of these projects have had little impact on the crisis.

Consider, for example, the case of a teenager in Washington, D.C., who murdered a taxi driver. The youth was sent to a psychiatric treatment center in a resort town in upstate New York where he received $100,000-a-year therapy. After several months of therapy, he simply walked away from the facility, returned to the District, and committed a second murder at a convenience store just blocks away from the first homicide. Psychiatrists who had treated the youth argued they had made progress because he reportedly expressed regret regarding the second murder.

Pitfalls of Conventional Approaches

The failures of a number of professional programs that have been launched for at-risk youths will show us that there is a need for a fundamental change in our approach to the problem, not that the situation is hopeless. There are at least four reasons why many conventional approaches have not been effective.

- Many conventional programs have been designed on the mistaken premise that the source of the problems faced by young people is external and that the root causes of the current youth crisis are economic and financial. It is assumed that if young people are simply offered employment and adequate educational opportunities, the crisis will eventually be resolved.

The spread of the youth problems across all income brackets provides evidence that the problem is not the result of economic and social disadvantage alone. Even when the economy of our Nation hit bottom in the Great Depression, families and communities remained strong, and young people did not suffer the alienation and anxiety they suffer today.

The problems affecting our Nation's youth are fundamentally spiritual and moral in nature. Community leaders who have addressed the crisis as a spiritual problem have been remarkably effective in changing the lives of the young people they serve. The most powerful agents of transformation are grassroots leaders whose outreach rests on principles of personal responsibility and reciprocity. Most of their efforts are faith-based and are guided by a steadfast conviction in the God-given potential of every human being. These neighborhood-based initiatives stand in sharp contrast to the conventional social service industry that, in essence, rewards deviance. The clients of conventional social services are identified only in terms of their deficiencies. If you are unwed and pregnant, there is a program for you. If you are addicted to drugs or alcohol, there is a program.

Effective community outreach, on the other hand, is aligned with the principles implied in the parable of the prodigal son. In order to be rewarded, young people are first expected to fundamentally change their attitude, values, and behavior. In the parable, a young man demands his share of his father's household, only to waste it away through a life of debauchery and immediate gratification. The father's heart may have been broken as he witnessed his son reaching his lowest point in life, lonely and impoverished. Yet, he could not embrace his son unless he first "came to himself" and underwent an internal transformation through repentance and resolve. Otherwise, the father's embrace could have been perceived as sanctioning his son's debauchery.

In the same way, grassroots leaders first lead the youths they work with to a point of conversion, where they personally accept responsibility for their wrongdoings and determine to change. Conventional programs for youths apply therapy and environmental modifications to produce a change in behavior, but the change is often temporary. When many "rehabilitated" youths reenter their old environments, they adapt to them and revert to their previous behavior. In contrast, faith-based neighborhood programs have the power to produce a lasting, substantial, internal transformation. This conversion then results in a long-lasting, consistent change in behavior. When "transformed" youths go back to their old environments, many are not only able to resist their influence but often bring about a major transformation in their communities.

- Academic degrees and professional credentials have been considered necessary prerequisites of "experts" who should be entrusted to solve societal problems.

In the arena of social policy, firsthand experience and personal commitment are not considered to be an essential part of a credible resume. Many authors who have reaped profits from books on the crisis of today's young people did not even talk with their subjects before pontificating on their problems. Professional sociologists, psychologists, and academicians who have negligible personal experience of, and have had no impact on the problems they talk about, have dominated lecture circuits and television shows. Meanwhile, the true experts—those who have proven track records of success in solving the problems—have been ignored.

In arenas including gang activity, unwed teen parenting, and substance abuse, many of the most effective agents of change are individuals who have personally experienced and overcome the problems they encourage others to overcome. Their daily lives provide a practical example of the values and standards they promote, and their unwavering, long-term commitment to the young people they serve has won the confidence, trust, and respect of youths, even those who had been considered incorrigible by the social service system. In spite of their effectiveness, in many cases regulations have prohibited such grassroots volunteers from providing services in their neighborhoods because they lack academic degrees or professional certification.

- "Rescuing" a young person from his or her environment may not be the solution.

The rescue mode of conventional programs ignores the value-generating, mediating structures that exist within the youths' own communities (families, neighborhood associations, etc.) and may, in fact, undermine and usurp them. It is assumed that the solution lies in the beneficence of those who are outside the community.

This is true even of the much-lauded mentor programs, which frequently bypass parents and neighbors. What message does a young person receive through programs that are built on the assumption that role models must be imported into their homes and communities? The lives of young people cannot be salvaged through outside intervention that ignores the necessity of supporting and strengthening their communities. The key to establishing consistent and sustainable support lies in using the indigenous, "natural antibodies" of a community, which have the power to ward off societal disease.

- Focusing on only one area of a complex of interrelated problems may not work.

In contrast, personal neighborhood-based outreach addresses the whole individual and the interrelated factors that affect a person's life. For example, one of the most effective substance abuse programs I have encountered, the San Antonio-based Victory Fellowship, does not focus exclusively on eradicating drug and alcohol addiction but also incorporates programs to reunite and strengthen families, meet the needs of the children of addicts, and provide educational and employment opportunities. Through Victory Fellowship's impressive Christian version of the Boy Scouts, the Royal Rangers, young men who have successfully overcome their addictions function as role models for boys age 5 and older, guiding them in projects of community service and civic responsibility.

Recently, a collaboration of grassroots initiatives in Washington called Hands Across DC has created a model comprehensive strategy. Five groups have joined forces to 'go deep' into troubled neighborhoods, supporting the survivors of homicide victims, equipping incarcerated men to fulfill their responsibilities to their families and communities, and providing productive activities and educational opportunities for young people.

Indigenous, grassroots, youth intervention programs throughout the Nation have shown us that solutions to this crisis exist. Neighborhood-based strategies have been remarkably effective in eliminating rather than simply displacing youth violence. Accounts of their efforts show us, however, that there is no shortcut to engendering the change in young people's vision and values. Such internal transformations are the harvest of long-term consistent effort, around-the-clock availability, and the personal example of adults who have committed themselves to a calling to salvage young lives.

Effective, Community-Based Youth Intervention

Two men, Leon Watkins in south central Los Angeles and Carl Hardrick in Hartford, Connecticut, live hundreds of miles apart but are linked by a common commitment to salvage the lives of young people from the lures of gangs and street violence. Both of these men have been active for more than 20 years and have worked tirelessly with minimal financial resources. Both have recognized that the most effective way to influence gang members is through existing youth leadership structures, working with the leaders to establish peace and to redirect activities of the group toward a positive end. This is not an easy or safe venture. In the volatile world of gang violence, street-savvy youths demand authenticity and proven commitment before they will enter a relationship of mutual trust. Through consistent investment, perseverance, and in spite of great personal risk, both men have been able to have a significant impact on the incidence of gang violence in their communities.

Leon Watkins: Los Angeles, California

In 1979, Leon Watkins launched his effort to stop the waste of young lives in senseless violence in south central Los Angeles. He created the San Pedro Business Association to develop alternative activities and employment opportunities for youths. In a door-to-door campaign to business owners in the community, Leon enlisted support for the jobs-creation project. In return for their participation, Leon worked to protect store owners who were often the targets of theft and extortion. He posted reward notices throughout the community, asking that any tips regarding crimes in the neighborhood be reported to what he dubbed the "Family Helpline." In time, this helpline would become an anchor of information exchange and crisis counseling for the community, but in the beginning, the hotline was simply one man, Leon, and a telephone booth.

Fearless, Watkins began his antiviolence efforts by seeking out the leader of one of the city's most notorious gangs, a youth whose street name was Quake. Leon recalls:

> I just put the word out on the streets that I was looking for Quake, and then one day as I was walking through an alley, a car pulled alongside and one guy stepped out and was flanked by four of his friends. He said he heard I was looking for him and asked what I wanted to talk about. I just answered, "about what you are doing with your life." We talked that day, and then many other times when I found him on the street. A relationship began to build, and he could see that what I was saying made sense. Gang life was a one-way street to prison or a coffin. He was ready to change, and he was willing to help me reach the kids that were under his control.

The majority of Quake's gang members did respond and followed his lead in participating in the first graffiti removal project in the neighborhood. There were some who didn't want to stop "gang banging," but most, like Quake, were ready to change. The graffiti was a constant reminder of the lives that had been claimed in turf wars. It was a powerful statement for the gang members to paint over the graffiti. Since the day of that historic cleanup project, Leon has continued to reach and change the lives of young people. In the following statement, he describes an attitude that is necessary to win the response of gang members:

> Before you come into a young person's life, telling him to change, you must understand the vital role that gang membership plays in his life. You have to recognize the value that the gang has in the eyes of these young people, and you have to give their reality its due respect. Many gang members would literally rather die than renounce this life, because it is the only place in their entire lives where they have found respect. It is the only culture that has embraced them. They have been rejected by the larger society. Here in their gangs, young people who have been abused in their own homes have found a place to go where they will not only be accepted but respected and where it is possible for them to receive a rank of accomplishment [different levels of leadership

and standing within the gang]. You cannot just walk in and tell them to drop what they have found. If you understand this, and respect it, you will have some foundation to begin to talk with these kids, and you can establish a level of communication where they can hear what you have to say.

Some people just come in and criticize the gangs and tell the kids how bad it is to be in a gang. What are they offering as an alternative? What are they telling those kids that they can do if they leave their gangs? The kids already know what society considers to be right or wrong. What we fail to understand is the far-reaching impact of despair. How can you measure the pain a person feels when he is hurt and shut out from society? When there is no trustable alternative, when they have seen other lifestyles filled with hypocrisy, all young people are susceptible to the call of the gang. Recruitment begins in elementary schools, and it knows no racial or economic boundaries. Even a young boy singing in a choir can be drawn to affiliate with this culture. All the kids know about it. It is always there, pulling them, and the first time they get into a serious crisis, they will enter that culture.

I try to get to the most practical level. I work with an individual until he can verbalize his own personal goal. I try to uncover what his own dream for his life is. I very seldom talk about negative things when I talk with them about what they are doing. I work on the premise that, deep inside, they have a vision for what they could be, and I work to pull out what they have inside and to make them aware of the intelligence and talent they possess. In most cases, I can sense that these young people are in pain, deep pain. That pain turns to anger, and it erupts in situations where they lash out and begin killing each other. And a cycle of violence begins. You have to cut through all of this and get down to the individual. You have to get him to the point where he can look at himself and the overall picture. He has to believe that he has a future and that he is worth something.

Carl Hardrick: Hartford, Connecticut

Like Leon Watkins, Carl Hardrick began his youth intervention efforts in the 1970s. Residents of the Belleview Square community of Hartford were being held in a virtual state of siege by warring gangs. The elderly locked themselves inside their homes and were afraid to come out. Only three residents dared to come out to a public meeting in the neighborhood about the rampant violence. Carl describes the strategy he adopted to reach the gangs. Similar to Leon Watkins' strategy, it involved working through the gang structure and its leader.

> One of the most notorious gangs in Hartford in 1975 was the "Magnificent Twenties." Its leader represented a huge population of nearly 1,100 youths who came from all over the city. Senior citizens and other residents of the Belleview Square community couldn't function. They locked themselves in the house when they came home, and they were afraid to come out. We had a meeting in Belleview Square and only about two or three people showed up. They told me that they were very concerned about the gang and the violence that was going down in the community.
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> At that point, I went out to seek the leadership of the gang. The name that kept coming up was Steven Holter. Steven was a young man who was labeled as 'learning disabled,' yet he controlled 1,100 young men and was pretty much responsible for their actions. I began to work with Steve and talk about what he was doing.
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> There was another gang at that time that wasn't as strong as Steve's but was pretty big, with a membership of about 500. The two gangs were having feuds and going at each other. What I attempted to do with Steve was to talk about the things that he was doing that were negative and to begin to work with him to turn around to do positive things. As I worked with the leadership, Steve, in turn, worked with the youths who were directly under him. The strategy I developed to work with the gangs and my discovery of the things that work started back then.

At that time, we were invited to attend a gang workshop at the Urban League to talk about our successes and to see what other people were doing. That is where I first met Bob Woodson, who was coordinating that first gang workshop. Sister Falaka Fattah was there from the House of Umoja, a gang intervention effort that reached thousands of youths in Philadelphia. We also met "Fat Rob," a former gang member who had played an important role in addressing the problem of gang violence in Philadelphia, and we began to exchange information. We were able to dialogue with people who were working with young people throughout the Nation, and at that time Philadelphia had the biggest gang problem. As the youths interacted, they began to talk about what could be done to stop the violence.

After that time, we established a good relationship with the people in Philadelphia, and Fat Rob would come to Hartford whenever there was difficulty. Fat Rob was committed to making peace. He was responsible for bringing all those brothers to the table.

So that was the beginning of my work. We took a negative situation, in a very explosive environment, and we turned it into a positive. Steven and his followers went from gang banging to hosting dances in the community, providing escorts for senior citizens, and sponsoring a youth day and a community day. They served in every aspect where there was a way for them to fit in. We found out that when you give kids positive things to do, you get positive results. It's difficult to dismantle a gang. But you can change the attitude and behavior of a gang, and once you do that, they will change themselves.

As the years went on, these kids grew up. Some of them went to school. Some went to college. Some of them remained out there and went to jail. But the majority of them got jobs and married and are doing fine today.

In that process, we learned that Steve Holter and Fat Rob had much in common and that they were natural leaders. But we couldn't give them the tools or the expertise that they needed to diffuse a lot of what they saw was happening on the streets. In a sense, they predicted what would be happening now. Back in the '70s and '80s they said, "If you think that we are tough, watch what our little brothers will be like. They will be much harder, much crueler, and much deadlier."

When we sought the reason that young people were involved in gangs, we learned that the gangs filled a gap that was left in the absence of solid family and community structures. The gang fulfilled the role of an extended family. The need for this kind of relationship was natural, though the gangs themselves turned to negative activities.

The gang became an essential part of the lives of many young people and we could not just step in and tell them to leave those relationships behind. Instead, our task was to work through the leadership structures and network of influence to lead the youths to positive behavior. Our first challenge was to convince them to bring their differences to the table—where they could talk them out—rather than the streets where they fought them out.

There are times when I am criticized for meeting with gang members by people who would rather address the problem through officials and community representatives. But I know of a meeting called by those officials that was organized with 3-months notice yet had only 8 participants. Compare that with 1,300 who came to a meeting with 1-day notice. Compare the responses to those two meetings and you will see who is controlling that community.

To turn the situation around, you had to deal with the leadership. In some cases, kids were being forced into gang activity. When Steve Holter and I visited schools

and talked about making the right decisions, kids would come up and ask, "What do you do when someone comes up to you and puts a gun to the side of your head and asks, 'Who are you down with?' You would say 'I'm going with you.'" You have to show the kids that what they are doing is damaging to the community. You have to be there for them and sacrifice for them until they believe in you. And once you approach them, you have to be in there for the long haul and offer solutions.

In Hartford, we were able to convince a number of gang leaders, who had street names such as "Bird" and "Bookman," that there is another way. They were ready to change. They didn't want to continue down a pathway to destruction. Yet, there was no one to tell them how they could make that change. When they did, the turnaround was remarkable. They went from being enforcers to being peacemakers. They knew that it was better to solve their problems at the table than on the streets. I believe that there were more people who wanted peace than war, but no one was talking to these young people. When you get them to the table and clear up the confusion and find out what the real issues are, you will get a sense that they all want the same things. Then you can work together to address those issues.

First, you have to establish yourself and show your sincerity and commitment over time if the young people are to respond. There is no shortcut to that. It takes time and investment. It doesn't happen overnight, but once there is visible progress, the whole community will begin to change. Once the young people declare, "This is what we want to do," you can hold them to that. In a sense, they will force themselves into doing the right thing.

Often, when grassroots leaders approach government agencies, they are questioned—not about their outcomes and strategies but about their credentials. When a city launches a program to do gang mediation, the people who are successful with the kids on the streets seldom apply for the job. If these programs are to be effective, they should value effective experience as much as certificates and diplomas, and they should enlist the people who can reach the youths who are making decisions.

The value of an intervention strategy is determined by its fruits, its results. One of the first gang leaders I worked with, Steve Holter, is now the owner of a bonded construction company and has currently been contracted for a $4-million project. From a position of success, he is now able to reach back and hire former gang members and at-risk youths. He understands where they are coming from. He sets down the rules, and then he trusts them and assigns them the work. He knows that someone once took the time and made the investment to give him a break. I just wish that I had more Steves, and that he had more work.

It is important, once the young people are willing to turn themselves around, that you have opportunities for them and that you can keep them busy. In Hartford, the Upper Albany Neighborhood Collaborative launched a project for youth enterprises. Young people had entrepreneurial skills and innovative ideas, but they were selling the wrong products. This project came as a result of an assessment we conducted on the neighborhood's needs and capacities. It was one example of how, with proper support, young people can turn their negatives into positives.

The kids responded immediately. They wrote business plans and even talked of franchising some services. Former gang members came up with detailed plans for small enterprises such as Jeanie's laundromat, Bird's bakery, and Bookman's barbershop. But now that [entrepreneurial] project is on hold. The most pressing need was for capital investment. Conventional lending institutions did not want to take the risk involved in new businesses such as these. Even if the project has come to a halt, the kids are still looking forward to these enterprises: they still have their dreams.

The strategies that were successful in Hartford can work in other cities as well. I wish we could take a corps of these young people and "go deep" into other cities, staying there for a year and setting the foundation for things to turn around. Kids from other cities will respond to what the former gang members from Hartford have to say because they can relate to them, and they recognize leadership. The ones who have come through successfully have "been there." They did it. They know the situation that other kids are in, and they also know the consequences of not falling in line.

A transformation could spread in the same way that destructive behavior spread. When the Crips and Bloods spread out from Los Angeles, they were organized around violent gang enforcement. The same network and organization can apply in a positive direction.

It's important to reach the kids before they go to prison or get involved in the kinds of activities that will take them to prison. Once you have identified the youths who are ready to change and you start working with them, they will respond. They really don't want to live a life on the line. There is a "ripple" effect from the kids who turn their lives around. Once Steve Holter made that change, he was able to reach thousands of other young people I couldn't reach. As each young person is helped, they will pass on the baton. That is why you can anticipate expanding results. There is power when someone says, "That is where I was. I used to do that, but I'm not doing it anymore, and let me tell you why."

Acknowledging Grassroots Victories

In spite of the remarkable success of neighborhood-based initiatives for at-risk youths, grassroots outreach has received little public recognition. Typically, even the most effective programs have received one of the following responses: they are ignored, they are dismissed as chance occurrences of charismatic leadership, or they are awarded token accolades rather than substantial support. It is said that, when compared to the scale of the problem, their successes are limited.

Rather than dismissing the success of these grassroots efforts, we should be investing all of our energy and resources to learn how we can expand, multiply, and "export" their effective strategies. We should treat their victories as we would treat a medical breakthrough. If, for example, in laboratory experiments, just three out of hundreds of mice that were exposed to the AIDS virus were discovered to be immune from the disease, all resources would be invested in an effort to understand what factors contributed to their survival. Their case would inspire hope and would be on the front pages of newspapers throughout the world.

The success of grassroots leaders such as Leon Watkins and Carl Hardrick has precedents in community-based outreach that has been going on for more than two decades. One of these precedents is the effective youth intervention strategy that was employed in the city of Philadelphia during the summer of 1973. At that time, the city was paralyzed with fear as small gangs of marauding black youths arbitrarily targeted citizens on the streets and in shopping malls. In what police termed as "wolf pack" attacks, the victims were knocked to the ground and stripped of rings, watches, gold chains, wallets, and purses.

A virtual reign of terror spread as reports of the attacks were published and other youths joined in the melee. Because these robberies were not connected to organized gangs and occurred sporadically, police and law enforcement officials found it impossible to predict or contain the rash of attacks. Neither increased police patrols nor emergency funding to traditional social service institutions had any impact on the problem. As the city was held hostage in this crime wave, movie theaters closed early, stores and shopping centers shut down, and many civic events were canceled. Public officials were at a point of hopelessness when two grassroots leaders stepped forward with a unique strategy. Within 1 day of the implementation of their plan, the attacks ceased and never again resumed.

Valuable guidelines for addressing the current epidemic of youth crime and gang violence can be gained by studying who it was who solved Philadelphia's crisis and the resources they enlisted in their solution. The agents of this successful strategy, David and Falaka Fattah, were well-known veteran community activists who had discovered that one of their own six sons was an active gang member. At that time, Philadelphia was known as the youth gang capital of the Nation. Newspapers published statistics of victims of gang violence weekly next to the death tolls of the Vietnam war.

In responding to their son's gang activity, the Fattahs reached out to embrace his circle of friends rather than trying to isolate him from them, inviting 13 of the youths to come to live with them in their small row house in West Philadelphia. This informal arrangement blossomed into a gang rescue program called the House of Umoja.

Word of the safe haven soon spread on the streets, and the number of young gang members seeking asylum steadily increased. Within a few years, the influence of the Fattahs' outreach spread throughout the entire city, and they were able to coordinate a citywide peace pact that dramatically reduced the annual number of gang-related homicides. The Fattahs brought this established reputation and foundation of trust and respect with them when they came to the table to address the crisis of the wolf-pack attacks. Their first step was to call in the "experts" with invaluable street experience, former gang members—the "Old Heads" or "OGs"—they had worked with. This group suggested a collaborative effort with their counterparts who were incarcerated at the local prison, the "House of Correction."

When the Fattahs sent out a call for help in stopping the violence, more than 130 inmates signed up to join a crime-prevention task force. The prisoners identified young people who were influential on their "corners" in their neighborhoods who were invited to a conference at the prison the following Saturday. The response was overwhelming. On the day of the conference, buses ferried more than 300 youths to the prison. After hearing presentations from the inmates on personal responsibility and moral obligation, the group broke up into smaller workshops and discussion groups focused on ending the violence. The following day peace prevailed.

Although the Fattahs and their group received official recognition from the mayor, the acknowledgment of their unique ability to reach the city's young people was more ceremonial than substantive. When funds were later allocated for crime prevention or youth services, they were designated for conventional social service programs and for increased police patrols. The Fattahs were applauded but then ignored.

Our national strategy, likewise, has failed to provide substantial support for alternative grassroots responses to youth crime and gang activity, in spite of its undeniable effectiveness. While plaques may be bestowed on numerous successful neighborhood-based antigang efforts, there has been no effort to develop structures that can harness the capacities of grassroots initiatives to sustain and expand their impact. Instead, as in the case of the Fattahs, massive funding has been channeled to conventional social programs, therapeutic treatment, police interdiction, and incarceration.

We cannot afford to continue to ignore our most powerful agents of healing and transformation. The Nation's attention should be focused on the impact that these models of excellence have had on the youths in their communities. All our energies and resources should be invested in understanding how successes that have been achieved in low-income neighborhoods could be adapted and applied throughout society. Until now, we have been unwilling to study the strategies of grassroots leaders who have claimed a beachhead in the battle against youth crime and gang activity. Men and women who have reached and changed the lives of hundreds of young people have accomplished dramatic results, against the greatest odds, with meager resources. If we were to invest in them just a small portion of what we have squandered on ineffective, top-down programs, we could salvage the future of the next generation.

Exporting and Adapting a Successful Youth Intervention Model

Recently, a remarkably effective grassroots youth intervention effort in one of Washington, D.C.'s, most crime-ridden areas has alerted policymakers

and law enforcement officials to the power of neighborhood healing agents.

The Benning Terrace public housing development appeared a hopeless case to David Gilmore, the official in charge of Washington, D.C.'s, public housing, when he conducted his first tour of the properties that were entrusted to his management. His driver refused to turn into Benning Terrace and opted to merely slow down as they passed the site, which was notorious for its violence: 59 homicides had been reported in a 5-month period. Gilmore recounts, "I saw the devastated conditions that have been a day-to-day reality for families for many, many months, perhaps even years. The area was filthy, ill-maintained, and ill-equipped. It was silent and deserted, with one exception. The stoop of one unit was guarded by a group of fierce-looking young men. With their caps pulled down, huddled in big Starter jackets, even in the sweltering summer heat, their message was clear: 'We dare you to approach us.'" At that time, Gilmore believed that he had only one option for dealing with this property. He would tear the buildings down and disperse their residents to other locations.

In spite of the hopelessness of the scenario in the summer of 1997, those buildings were not razed, and, though they remain, today the site bears little resemblance to the scene Gilmore encountered scarcely more than a year ago. The graffiti that once defaced those buildings is gone. Well-planned flower beds and lawns have replaced litter-strewn lots. Neighbors chat on their front stoops and little children are everywhere—playing on a once-desolate football field, riding bicycles, and practicing basketball shots. The members of youth factions whose turf wars had once virtually held the residents hostage still reside in the development, but they, too, are scarcely recognizable. In Gilmore's words, "Today, there is not only life and laughter in the community, but there is light and hope beginning to shine in the eyes of those young men. Their dreams and aspirations had always been there, but now they have been awakened. They have been given the opportunity to step back from the conflict and to see who they really are. Recently, two of those once-calloused young men risked their lives and suffered injuries to pull babies from a burning unit in their development. They possess more heart than you can imagine, and they have a desire to live."

The agents of this transformation are members of a grassroots organization, the Alliance of Concerned Men, which evolved from a common commitment that five men made to help the next generation of young men deal with the lures of gangs, drugs, and crime that had once nearly claimed their own lives. The Alliance first became affiliated with the National Center for Neighborhood Enterprise (NCNE) as members of a project entitled Hands Across DC. The eight participants in this project are Washington-based grassroots initiatives ranging from safehouses and youth intervention programs to support groups for families of homicide victims. Hands Across DC provided two types of linkage. Internally, participants shared ideas, strategies, and encouragement with one another. Externally, connections were made with private institutions and individuals who could provide resources for their efforts.

The Alliance was aware that NCNE's nationwide network of community-based programs included a number of counterparts that had implemented effective strategies to quell gang warfare. When youth violence at Benning Terrace climaxed with the abduction and murder of a 12-year-old boy, the members of the Alliance made a commitment to go into that community and devote themselves to stopping the violence. They requested NCNE's assistance in coordinating communication with other youth intervention programs as a first step in developing their strategy.

NCNE arranged for a conference call between members of the Alliance and two other grassroots youth intervention "experts"—Carl Hardrick, who has worked with youths in Hartford, Connecticut, for more than 20 years, and Omar Jahwar, a 23-year-old in Dallas, Texas, who established an antiviolence youth development program that has instilled a sense of vision and value in hundreds of young people, both within correctional institutions and in the community.

The advice given by these grassroots leaders coincided with the experience and natural instincts of the Alliance: to reach the youths and win their trust, they should identify and work through the established leaders of each of the youth factions. The men went into the neighborhood and went to the homes of residents who were familiar with them and their work. The residents told the Alliance

which youths were influential, and they arranged for them to meet and talk with these leaders. After a period of consistent outreach by the Alliance, the youths admitted that they wanted the killing to stop but didn't know how to begin: unilateral disarmament seemed the equivalent of suicide.

The Alliance convinced representatives from each faction to meet to discuss the possibility of a peace pact. The offices of NCNE were neutral territory where the talks could be held. A series of closed-door meetings were held in which the youths worked out terms of a truce. The Alliance performed the role of facilitator as the young men described their vision for what the neighborhood could be and listed the resources that they thought would be needed to bring revitalization to their community: Among these were a recreation center and the means for themselves and their families to travel beyond the neighborhood boundaries.

On January 29, 1997, a peace pact was forged, and NCNE went into swift action to alert the press, hoping that media coverage of this victory would elicit private-sector support for the renewal of the community. The story of Benning Terrace appeared in news media from the New York Times, Washington Post, and Washington Times to ABC News. While the story engendered inspiration and hope, it evoked little concrete support—with the exception of the response of public housing official David Gilmore, who was moved to offer crucial opportunities for job training and employment to the young men who were at a vulnerable point in their transformation. The youths eagerly embraced jobs such as landscaping, graffiti removal, and repair work for $6.50 an hour, dispelling the notion that they would never give up a lucrative life of crime or drug trade for low-paying but steady jobs.

One of the greatest skeptics of the truce, a gang leader named Derrick who had been dubbed by police as one of the seven most dangerous individuals in the District, became one of its most faithful converts. He would rise early to inspect and water the flower beds his crew had planted before reporting for work. Another young man who was inspired by the potential of a job training opportunity exhibited remarkable determination to complete his course. When his car broke down, he rode a bicycle to his classes. When even the bike broke down, he picked it up and literally carried it to the job training site.

Through the committed efforts of the Alliance, the lives of 35 young men and their families have been changed forever. A newspaper column recently recounted how one newly employed young man literally broke into tears as he signed health insurance papers for his little daughters, realizing that, for the first time, he could provide them with security and reliable support.

The courageous intervention of the Alliance of Concerned Men, supported by the National Center for Neighborhood Enterprise, has yielded the following results:

- Thirty-five young men have rejected a lifestyle that destroyed their neighborhood and have become productive, contributing members of their community.
- A cycle of despair and violence has been stopped and reversed as young fathers take responsibility for their children and older youths function as positive role models for youngsters in the neighborhood.
- A community once considered off-limits for business ventures or services is now "open for business."
- To date, the housing authority projects cost savings of nearly $2 million from this intervention, at a site that was previously slated for demolition due to crime that was deemed uncontrollable. This immediate assistance from the housing authority provided a "missing link" that previous grassroots youth crime interventions have lacked due to bureaucratic indifference to such efforts in many cities.
- A model of youth intervention has been established that can be exported and adapted in other cities and regions throughout the Nation. The truce between rival youth factions that was brokered by the Alliance with NCNE support has become a catalyst for initiation of other youth peacemaking efforts by the Alliance in 10 crime-ridden Washington, D.C., public housing sites to date.

Policy Recommendations

The grassroots intervention at Benning Terrace has received consistent support from Eric Holder, who offered his offices as a former U.S. Attorney and as the current Deputy Attorney General to support law enforcement partnerships with the youth initiative. A new effort with the Washington, D.C., Metropolitan Police Department—Operation Fresh Start—could serve as a model for bringing formerly delinquent youths through a process of legal validation as a reward for renouncing destructive behaviors. Through this program, youths receive counsel and guidance to deal with past offenses and outstanding child support payments.

On May 8, 1997, House Judiciary Committee Chairman Henry Hyde and Ranking Minority Member John Conyers convened a full committee hearing to examine the policy implications of this grassroots youth intervention success. In addition to the Alliance of Concerned Men, Carl Hardrick of the Hartford Youth Peace Initiative, Leon Watkins of the Los Angeles Family Helpline, and their counterparts from other cities were invited to testify. The Judiciary Committee leadership has committed itself to a partnership with NCNE to fully examine the national policy implications of this grassroots youth crime intervention.

With the support of the U.S. Department of Housing and Urban Development (HUD), NCNE has commenced planning for the Hartford Youth Peace Initiative and hired a third-party evaluator to document program results. A "best practices" manual and tool kit will be developed for use in other high-crime housing sites around the country.

Among the policy recommendations NCNE is making are the following:

- A seven-city National Demonstration of Grassroots Youth Crime Intervention Success should be established, with the goal of creating "Violence Free Zones" similar to the Benning Terrace intervention in Washington, D.C. NCNE is already planning the intervention in four of the cities (Hartford, Dallas, Los Angeles, and the District of Columbia). With appropriate investment, NCNE is prepared to establish a 3-year, multisite demonstration through a public-private partnership in support of local grassroots anti-crime initiatives that could be fully documented in terms of cost savings as well as its impact in reducing the death rate among at-risk youths.
- The District of Columbia Housing Authority's affirmative support for the grassroots youth crime intervention success at Benning Terrace should be examined by policymakers as a model for public housing agencies nationwide. NCNE is in the process of capturing this process through a best practices manual supported by HUD.
- Operation Fresh Start should be supported by the U.S. Department of Justice for replication in other communities, as a vehicle to "mainstream" youths who are making the constructive transition from violent to productive citizens and "ambassadors of peace" to other communities.
- The Office of Juvenile Justice and Delinquency Prevention's antidrug technical assistance voucher program operated by NCNE can serve as a model of support to build capacity for grassroots youth crime initiatives. The procedures and lessons learned from this national initiative could be incorporated as an eligible activity within State juvenile justice block grants.
- The prohibition of effective faith-based drug treatment programs for juvenile delinquents should be removed through reform of archaic and counterproductive licensing and credentialing requirements. In addition, "Charitable Choice" provisions, which bar discrimination against faith-based drug treatment programs, should be expanded to include all forms of Federal anti-drug assistance.

The biggest hurdle that remains to be overcome is a prejudice against information and experience offered by the untutored, the uncredentialed, the unanointed. For the sake of this Nation, we must overcome the elitism that is at the core of this bias. We must have the wisdom to listen and learn from the men and women who, with quiet tenacity, have established track records of success and effectiveness in addressing our Nation's most critical problems. We must have the humility to recognize them as our guides and to provide the support they will need to continue and expand their efforts.

Notes

1. National Network of Runaways and Youth Services, telephone conversation, March 1995.

2. Carnegie Council on Adolescent Development.

3. National Network of Runaways and Youth Services, telephone conversation, March 1995.

4. Studies prepared for "Great Transitions: Preparing Adolescents for a New Century," The Carnegie Corporation of New York, 1995.

5. Ibid.

6. Greene, Marcia Slacum, "Outside Allegiances Exert Lethal Force, Even Behind Bars," *Washington Post*, September 9, 1996, A01.

7. Ibid.

Cooling the Hot Spots of Homicide: A Plan for Action

Lawrence W. Sherman

The most useful role the Federal Government can play in decreasing crime is to develop and support effective methods for reducing gun violence in national hot spots of homicide. While other goals are important, this one is by far the most important. It is also the most challenging. It requires that we put recent good news into context, that we understand the geographic concentrations of gun violence, that we rethink the current patterns of Federal spending, and that we focus on learning about what works in the small number of neighborhoods that suffer most of the gun violence.

Good News in Context

The good news is that homicide rates are dropping. The decreases are substantial. They are long term. And they are concentrated in the inner-city poverty areas where homicide increased in epidemic proportions in the late 1960s and late 1980s. New York City experienced a drop from 2,262 homicides in 1992 to 767 in 1997, a two-thirds decrease. The number of homicides in Los Angeles in 1997 dropped more than 40 percent from 1993, when they hovered around 1,000. In 1997, Washington, D.C., had the lowest homicide count in a decade at slightly over 300, down from almost 400 the year before (Roane, 1998; Suro, 1997).

The bad news is that homicide rates in urban areas of concentrated poverty remain far higher than they are in the rest of the United States. Our national homicide rate therefore remains far higher than it is in any other economically advanced nation. Although the rates of white-on-white homicide in the rural United States remain much higher than national homicide rates in many other comparable nations (Zimring and Hawkins, 1997: 80), the extraordinarily high concentrations of homicide in certain inner-city areas drive the national homicide rate to a degree that few Americans appreciate.

The Rocky Mountains and the Prairie

The geographic distribution of homicide can be compared to the geographic distribution of elevation in the United States. Consider an elevation map of the country. Most of us recognize the familiar bulge of the Eastern mountains in the Appalachian chain and the high peaks of the Rocky Mountains in the West. Few are surprised that the highest mountain in the United States is Mount McKinley in Alaska at 20,320 feet and that Death Valley in California is the lowest point at 282 feet below sea level.

What many people find surprising is that the *average* elevation of the United States is 2,500 feet, even though most Americans live far below that average. (For comparison, the average elevation of Washington, D.C., is 150 feet above sea level.) Forty-two States have average elevations lower than the national average, and only Denver and a few other cities have large populations at or above the average elevation. It is safe to assume that 90 percent or more of all Americans live below the average elevation (Wright, 1992: 47).

It is equally safe to assume that 90 percent or more of all Americans live within census tracts or small geographical neighborhoods where the homicide rate is well below the national average. Even in cities like Chicago, the homicide rate in middle-class neighborhoods such as Hyde Park is comparable to that of Sweden and is 80 percent lower than the national average. Yet 100 yards to the south of Hyde Park lies Woodlawn, where the homicide rate in 1996 was 12 times the national average (Crime Prevention Effectiveness Program, ongoing research).

The cumulative effect of neighborhoods like Woodlawn on the overall homicide rate is similar to the effect of the Rocky Mountains on the mean

elevation of the United States. Almost half (44 percent) of all homicides in 1996 occurred in only 47 of approximately 14,000 police jurisdictions in the United States (Federal Bureau of Investigation, 1997). The concentration within those cities is almost as great. A recent University of Maryland survey of homicides by census tract in large cities found that less than 1 percent of the U.S. population produced more than 10 percent of the homicides (Crime Prevention Effectiveness Program, ongoing research).

Most Americans live at a very low risk of homicide, by both national and world standards. If we want to reduce homicide in America, we would be ill advised to spread our resources equally across the entire Nation. If we want to lower our average elevation, we would be ill advised to bulldoze the prairie simply because more land mass is there. Knocking down the mountain peaks would lower the average elevation far more effectively.

The case for focusing on homicide is very strong. As Zimring and Hawkins (1997) have shown, the rates of most types of crime in the United States are as low or lower than they are in other advanced economies. Even the rate of *all* violent crimes is lower in the United States than it is in Australia, Canada, and New Zealand (Crime Prevention Effectiveness Program, ongoing research). What gives the United States its reputation as a high-crime country are its homicides and robberies, which comprise only a small fraction of all violent crimes. The United States has a very high rate among the advanced economies for these crimes and these alone, although even these rates are lower than in many developing nations.

Serious injuries from gun violence remain unmeasured in the national crime data, but such injuries are believed to closely track homicide rates. These injuries occur at several times the rate of homicides and cause far more pain and suffering through disability and lifetime impact on quality of life. Economic costs of these injuries make gun violence among the most expensive of all crimes (Crime Prevention Effectiveness Program, ongoing research). Crime prevention programs could easily pay for themselves in reduced health and social welfare expenditures of tax dollars if effective programs focused on the peaks, or hot spots, of gun violence. But that is far from how Federal dollars are focused at present.

The Spending Mismatch

Almost $4 billion per year in Federal crime prevention assistance is given out primarily on the basis of population rather than homicide rates. Put bluntly, the money goes where the votes are, not where the crime is. If we divide the number of dollars of Federal aid based on population by the number of homicides, we see that four of the lowest homicide States get almost $1 million in Federal aid per homicide, while a city with an above-average homicide rate like Mobile, Alabama, gets only $200,000 per homicide, and the highest homicide rate neighborhood in Chicago gets only $6,000 per homicide (Crime Prevention Effectiveness Program, ongoing research).

This distribution does *not* reflect the concentration of homicide in America. In 1996, there were almost as many homicides in Mobile, Alabama (51), as there were in New Hampshire (20), Vermont (11), South Dakota (9), and North Dakota (14) combined. Yet with only 207,000 residents in Mobile and 3.1 million in these 4 States, a population-based formula allocates 15 times as much Federal funding per homicide to the low-crime areas. Compared to West Garfield Park in Chicago, these 4 States receive approximately 150 times as much Federal aid per homicide (Crime Prevention Effectiveness Program, ongoing research).

Even within States and cities, there is no formula requirement to put Federal money where the homicides are. Even the one Federal program (Local Law Enforcement Block Grants) that takes crime explicitly into account in allocating funding makes no attempt to direct funds to the highest crime neighborhoods (Crime Prevention Effectiveness Program, ongoing research). It is entirely legal, although arguably a missed opportunity, to spend Federal funds outside of the areas that need them the most—again because those areas in need may lack sufficient political clout.

Learning What Works

Even if Federal funds were spent in the areas of greatest need, there is no guarantee that "throwing money" at the homicide rates will reduce them. "Throwing knowledge" at the problems, however, could do more good. The role for which the Federal

Government is uniquely suited is as the producer of such knowledge, through the proven methods of trial and error, research, and development.

Nowhere is the distinction between money and know-how more apparent than in the Woodlawn area of Chicago. At a rate of 91 homicides per 100,000 residents (or 21 homicides among its estimated 23,000 people), Woodlawn is not the highest homicide peak in the Chicago mountain range; that distinction went to West Garfield Park in 1996, at 217 homicides per 100,000 residents, almost 30 times the national average rate (Crime Prevention Effectiveness Program, ongoing research). But the Woodlawn rate is important for what it says about our capacity to use community organizations and government intervention to decrease crime and revitalize communities. If there is any neighborhood in America that has attempted or received more efforts of that kind in the past three decades, I would be surprised.

Despite the resources and the community control that have been created in Woodlawn, the homicide rate remains far too high. So what is to be done? My distinguished former colleague George Kelling has recently suggested that communities need to do many things, but they do not need social science evaluations to guide them in choosing effective policies (*COSSA Washington Update*, 1997). Offered by the leader of one of the most important social science evaluations in history, the Kansas City Preventive Patrol Experiment (Kelling et al., 1974), Kelling's opinion on this question is very important, although I disagree with it.

The reasons we have failed to see a good return on Federal investment in many hot spots of homicide are complex and manifold. One reason is that we have failed to approach the process systematically, in a way that allows us to learn from our mistakes. It is often said that a nation capable of putting people on the moon ought to be able to solve its homicide problem. Yet it is rarely said that we have failed to use careful methods of controlled testing in our attempts to deal with homicide. Had we used the same sloppy methods on the space program, we would still be trying to get a rocket off the ground.

Crime prevention programs need evaluations as their primary purpose, not as an afterthought. Until we know what works, our primary task is to answer that question and not just throw in everything but the kitchen sink. Once we know what works and what doesn't work, we can do more of the former and less of the latter. But if we disregard the need for evaluation, we will be fooling around with the problem from here to eternity.

This point is most important when defining the Federal role. It is arguable as to whether the Federal Government should redistribute income to support effective homicide prevention programs in high-homicide areas. After all, that can also be done by States and cities. But what the States and cities *cannot* do is launch national tests of effective methods. Such field tests are absolutely vital, yet they have never been done.

As a matter of science, it is essential to study what scientists call the "unit of analysis." To attack the homicide problem in the United States and learn what works, we must focus on the relevant unit of analysis: the hot-spot neighborhoods where most homicides are concentrated. Most federally funded evaluations of programs in such neighborhoods have examined them one at a time. As a matter of scientific method, that is a woefully inadequate approach and may be a major waste of money. Unless we start to use larger samples of homicide hot spots, including multicity experiments, we will remain uncertain about what works to reduce gun violence.

A Plan for Action

The following steps are not easy to accomplish, but they do offer the best prospect for the long-term capacity of this Nation to control its number one crime problem: the high rate of homicides. If we fail to take these steps, we will watch homicide rates rise and fall without any knowledge of what causes them to change. If we do take these steps, we can start to build on what the National Institute of Justice and other federally funded research has already shown about the patterns and control of

crime (Sherman et al., 1997). To summarize, the steps include:

1. **Putting the money where the homicides are.** Census tracts or other small geographical areas with homicide rates five or more times higher than the national average should receive at least half of all Federal crime prevention funding.

2. **Making evaluation the primary purpose of Federal aid.** This means that Federal programs should be designed around strong evaluations, rather than weak evaluations tacked onto programs after they are already set in motion.

3. **Using large samples of homicide hot spots, including multicity evaluation programs.** Only this approach will make it possible to rule out the many rival explanations for changes in homicide rates and provide reasonable certainty about what works.

The specific content of the programs that merit testing is properly a matter for partnerships and negotiations between local communities and the Federal Government. Many programs have already been found effective against some crimes, including early-infancy home visits and one kind of mentoring (Crime Prevention Effectiveness Program, ongoing research). But few programs have been tested using decreased gun violence as the primary measure of program success. The Boston and Kansas City gun program evaluations have produced the most encouraging case study results to date, but they urgently need large-scale testing (Crime Prevention Effectiveness Program, ongoing research). Unless these programs are tested in a systematic fashion, we will continue to see the homicide rates of inner-city poverty areas rise above the national average like the Rockies rise above the prairie.

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Communities and Crime: Reflections on Strategies for Crime Control

Jack R. Greene

Communities and Crime: An Overview

The relationship between crime and disorder in community settings is complicated by many factors, including land use (e.g., residential, commercial, industrial), population and residential density, housing stock age and infrastructure, the local economy, and local social ethos. These factors conspire in many ways to either stabilize or destabilize communities. The lack of community stability has for many years been associated with crime and delinquency.

In recent years, communities have increasingly become the targets for criminal justice interventions, particularly those of the police. National programs aimed at "weeding and seeding" as well as youth firearms prevention have included "the community" in the conception and resolution of neighborhood crime and disorder. In addition, community- and problem-oriented policing have sought, among many things, to recontextualize the police—putting them in closer proximity to residential communities and local social and economic institutions, building more effective alliances between the police and the public (both residential and business), and solving persistent and complex community crime and disorder problems (see Kelling and Coles, 1997; Hope, 1995). Cumulatively these efforts, it is hoped, will help stabilize communities, thereby making them less crime prone and more resistant to criminal invasion.

Destabilized communities are said to produce an environment of criminality, and result in an acceleration in the exodus of local businesses and homeowners. Moreover, destabilized communities such as residential neighborhoods are seen as places governed by fear and criminal victimization, furthering the spiral of decline, particularly in urban areas (Skogan, 1990).

While crime and disorder have always been seen to have a community attachment, historically much of the work of the police and the criminal justice system has focused on individuals and cases, not necessarily on social aggregates of people in defined places. Moreover, while communities have long been a focus of criminological inquiry, much of the explanation of crime dynamics within community contexts has not been "actionable" by criminal justice agencies. That is to say, while criminology has identified several important indicators of the likelihood and persistence of crime in communities, criminal justice interventions are the least likely to address those indicators in any direct or systematic way. For example, neighborhood studies beginning with Shaw and McKay (1959) and continuing to the present suggest that concentrated poverty, ethnic heterogeneity, and community or residential instability lead to social disorganization within communities. Social disorganization, in turn, has a linkage to delinquency, crime, and disorder, generally through the inability of the community to adequately define and supervise public community behaviors (see Taylor et al., 1984; Sampson and Groves, 1989).

Refinements in the social disorganization thesis have caused many to investigate the linkage between crime and disorder and the following factors: poverty, inequality, community mobility, the ethnic and racial composition of communities, family structure, and the density and types of housing within communities (see Sampson, 1995, for an extensive review of this literature). While some agreement exists that these factors dramatically shape and account for community crime patterns as well as the differences in crime rates across communities, the justice system continues to have little opportunity to directly affect these community crime factors. Several other government agencies, however, particularly those associated with education, housing, job training, family support, and health care, do impact on the factors

that shape both the level of community crime and disorder and, perhaps more importantly, the ability of the community to fend off criminal behaviors. Linking the capacities of various government and local agencies in the strengthening of local communities should become a central theme in community crime prevention efforts.

Community social disorganization essentially refers to the inability of any particular community to effectively maintain social control or to establish shared values (Sampson and Groves, 1989; Bursik, 1988; Bursik and Grasmick, 1993). Social disorganization theory assumes that communities, when functioning as social aggregates with shared values and regularized patterns of interaction, exercise considerable social control through networks of local, informal relationships. These local networks and affiliations provide clout for the community to sanction inappropriate behavior, while at the same time socializing those within the community to accepted community norms. Although communities have historically been defined in terms of their geography, many define them in terms of their ability to build and sustain networks.

The social disorganization perspective also argues that neighborhood decay not only reduces the horizontal bonds between neighbors within communities but also reduces the vertical linkages between communities and larger political, social, and economic institutions. These linkages are essential if communities are to defend themselves; that is, muster the political, economic, and social resources to stem criminal activity.

The Use of "Community" as an Organizing Framework

To some extent the criminal justice system has been in a quandary over the importance of communities in the control of crime. This quandary stems in part from oftentimes conflicting research findings about the effect of justice system interventions on crime and disorder, as well as from the shifting focus of crime prevention efforts—from offenders to victims to communities.

Historically, the justice system has linked crime with individuals—either those who commit crime or those who are the victims of crime. Many police tactics have sought to address types of offenders or victims. So too have prosecutorial and court interventions sought to isolate repeat offenders from the community. But until recently, the community has had a passive role in crime prevention and order maintenance work. Although we often do not see it directly as such, effective crime prevention is about building and sustaining relationships in community settings. The presence or absence of relationships within neighborhoods and communities has been suggested as greatly affecting disorder and crime. Strengthening the community's involvement in and capacity to sustain local crime prevention efforts should become a central goal of any community crime prevention initiative.

As previously indicated, much of the study of crime has concentrated on offenders and victims; that is, the people who are either involved in or affected by crime (Clarke, 1980). In recent years, there has been a shift in focus from people to places in the explanation and prevention of crime—at least certain types of crime. This shift is built on a recognition that crime is not equally distributed within cities and that criminals make decisions about where their crimes will take place.

The idea of "social structure" is fundamental to the study of people in places. Social structure essentially refers to the regularized pattern of social interaction occurring among people in any given place and the values and/or beliefs that people attach to these interactions. Social structure accounts for both the interactional nature of human relations and the social psychology of these interactions—or their meaning to the people engaged in such interactions.

The idea of "place" has a significant role in understanding human behavior. People are inextricably linked to places. They have identities with their homes and families, their neighborhoods, and their communities. In a word, they have an environment within which they take cues and direct their behavior. At the same time, people direct their behavior toward the environment, ultimately reshaping it through continual person-environment-person interaction. How we use space, how we identify spatial issues, and how we build primary and secondary social networks, in part on the basis of place, are important to understanding the design of criminal

justice and other community support interventions. Such understanding helps to identify who belongs, who has ownership of the neighborhood, and who is likely to support police and other social controls.

Focusing the Federal Role in Community Crime Prevention

The Federal Government plays a potentially significant role in shaping State and local crime prevention policies, first and foremost by setting the tone of the discussion about community crime prevention and then by setting evaluation standards and a funding agenda for State and local programs to participate in such efforts. These three activities—*shaping a clearer agenda, setting standards for program assessment, and providing funding*—are consistent with the historic role the Federal Government has played in addressing domestic issues, although this role has been significantly diminished by the agency-centered approach to policymaking and funding that has long dominated the Federal process.

Shaping the agenda in community crime prevention is a critical role for the Federal Government, as it sets the general tone of the process by identifying goals, objectives, and outcomes as well as a range of potential interventions. At times the tone set by the Federal Government in the crime prevention discussion has been less clear in the messages sent. This circumstance is created largely by differences in the ideological approach adopted by many in the justice debate, coupled with a Federal agency focus that has been client and not problem oriented. While it will likely be more difficult to address conflicts in the ideological premises undergirding the justice debate, the agency focus issue is much more actionable.

Historically, there has been a significant tension in the way the justice debate has occurred. Two major positions appear to have been drawn from this discussion. First, there are those who see the debate centered around issues of the root causes of crime, such as the macrolevel social structure, distribution of wealth, employment opportunities, and decay in the American family and social values. The second position suggests that we should first control the streets before we worry about the root causes of crime (Wilson, 1995). In some respects, the former argument is about long-term change (or its potential), while the latter approach is more pragmatic and focused on current problems. In recent years, the more pragmatic of these approaches has captured public attention. While many of these approaches have included some attachment to larger social, economic, and structural forces shaping crime in local communities, by and large these programs have been enforcement and not prevention focused.

In the current climate, the Federal Government can play a significant role in furthering crime prevention in communities by placing crime prevention within a wider arena and more directly linking government agencies that impact on community quality-of-life issues. Those at the Federal level can also broaden the approach to enforcement and prosecution to include a greater focus on prevention.

Such an approach will require that we focus not on offenders, victims, and crimes exclusively but also on children, families, and communities, providing interventions that strengthen individual and collective capacity to resist criminal behavior. One step along this path would be creating a policy forum within the Federal agency system that better links justice, housing, education, and health and human services capacities within the Federal Government to address issues of strengthening families and communities.

While Federal agencies currently have overlapping responsibility for community crime prevention either through improved education, housing, child care, or social welfare policies (as well as through the actions of the criminal justice system), much of the crime debate is agency or topic centered, relying far too much on the justice system as the source of intervention. That is to say, policies developed in education, public housing, urban development, or health and human services, to name a few, have a great potential to have an impact on community safety, although they are not necessarily designed or articulated with such goals in mind. For example, Federal agency policies affecting the availability of day care, preschools, and health care for children and their families are important influences on a family's ability to participate in community life because they build local support networks and help to develop a community ethic governing prosocial behavior. Similarly, policies shaping the

concentration of poverty in neighborhoods and the rebuilding of urban communities also significantly affect the ability of those neighborhoods to provide social control and link with others in local areas to stem criminal behavior. Educational policies that seek to create safer schools are significant in linking this process to safe neighborhoods, communities, and families. Despite these linkages, at present the forum for such a discussion and policy coordination is at best fragmentary. Since crime is a problem that destabilizes families, communities, and larger cities, creating a forum for the coordination of Federal programs and objectives seems an important shift from client- to problem-specific community-based programming.

Until such a policy forum is created, specific Federal agencies can craft policies for multiple purposes. For example, policies that promote neighborhood stabilization through housing and public assistance and efforts aimed at deconcentrating poverty and dependence strengthen neighborhoods and ultimately impact on criminal behavior. For this reason, policies supporting communities, families, and children need to integrate crime prevention as one of their intended outcomes rather than as a latent effect. Integration of crime prevention into a wide range of Federal programs affecting community quality of life will require that some agreed-upon goals be established so that agencies can design policies to achieve those goals while at the same time monitoring their attainment.

Designing an assessment framework and providing funding opportunities follow the creation of an expanded definition of Federal agency involvement in crime prevention. Currently, there is a wide array of funding possibilities for the myriad of problems that confront communities. Each has differing objectives and outcomes, and in some cases they actually compete for the same clients—defined as individuals, families, and communities. Outcomes sought for these programs should include concern for how they strengthen local communities and build social capital (Coleman, 1990). In this regard, with discrete programs in education, health and human services, housing and urban development, and the like, assessing community and family cohesion and stability and then measuring change in those conditions resulting from these programs are necessary steps in building better links among these agencies. All too often, local client-specific agencies are unaware of programs offered by Federal agencies that may have an impact on their needs or even of those other local programs designed to work in the same community. At present, there is a patchwork of Federal, State, and local efforts—often in the same community and with little cross specification, evaluation, and communication.

Finally, Federal agencies addressing community crime issues need to be more directly linked with those of State and local governments, particularly as projects unfold in local communities. Over the past several years, oversight boards or management processes emphasizing Federal, State, and local involvement in *program design, implementation, and monitoring* have become more evident. Their coordination is often quite complicated. Nevertheless, requiring such interactions as part of program delivery, monitoring, and reporting can go a long way toward reducing some of the operational barriers that occur between Federal, State, and local agencies addressing aspects of community crime prevention.

Enhancing the State Role in Coordinating Community Crime Prevention

State governments also play a potentially significant role in community crime prevention, primarily in the ways State resources are brought to bear on local crime problems: through the coordination of State services with local government services and through the integration of differing levels of jurisdiction, often complicating the integration of justice services. For example, typically, police and prosecutorial services are provided locally (in municipalities and, to some extent, counties), probation and juvenile services are provided by the county together with local jails, and correctional services are generally supervised by State governments. The judiciary typically spans all levels of government, further complicating the administration of justice in communities.

A primary role for State governments, then, might be to focus on integrating services in areas targeted for crime intervention while at the same time linking State and county correctional and probation policies and enforcement practices with local police and community-based intervention efforts. Moreover,

State governments must hold State agencies accountable for their impact on localities, not just on aggregated statistics for the State. At the same time, State governments should actively encourage and support local initiatives for rebuilding communities and supporting families and children.

Broadening the Role of Local Governments to Rebuild Community Order and Safety

Local governments are charged with creating a safe and secure environment within which community residents and local businesses work, reside, and recreate. Such a responsibility requires that local governments refocus the efforts of their police to identify and address community hot spots of crime.

A better understanding of the spatial and territorial nature of crime has led to better police interventions. Over the past several years, important criminological literature has emerged that postulates that the routine activities in any location and the rational choices made by reasoning criminals greatly affect the level of crime in that place. According to the routine activities and rational choice perspectives, crime and victimization occur through a natural process in which individuals' work and leisure patterns create crime opportunities that are acted upon by discerning criminals. That is to say, the pattern and type of human activity (e.g., houses abandoned while people are at work, women walking alone, drunks, strangers) produce potential victims or targets (unlocked cars, convenience stores, automated teller machines), which reasoning criminals observe, assess, and make decisions about. These decisions are influenced by the routine activity as well as the physical environment in which the activity takes place (Clarke, 1980; Clarke, 1995; Clarke and Felson, 1993; Felson, 1986; 1987).

Using these perspectives, the natural pattern of usage of an area can be studied and choices made as to when places are under less surveillance and control and therefore are more susceptible to criminal attack. These patterns and offender decisionmaking have been well documented for burglary, drug offending, retail theft, and auto theft, among several crime types. If criminals can make such assessments and act on them, so too can the police, communities, and others attempting to increase local safety. Increasing guardianship for communities is consistent with situational crime prevention theories and practices. These and other studies about community crime prevention activities stress the importance of understanding locations and adjusting police and other responses to address problems that may be concentrated in those locations.

Hot spot analysis suggests that 3 percent of the places in Minneapolis accounted for 50 percent of the calls for police service, that no police cars were dispatched to 40 percent of Minneapolis addresses or intersections, and that the remaining intersections and addresses each logged about one call for service per year (Sherman et al., 1989). In Jersey City, a recent project to police drug hot spots reported that 56 hot spots accounted for only 4.4 percent of the street sections and intersections but 86 percent of narcotics sales and arrests and 84 percent of emergency calls before the project was started (Weisburd and Green, 1995).

In addition to identifying and addressing local crime hot spots, local governments need to focus the efforts of all city agencies on solving community problems and integrating local services. This will require building local crime prevention coalitions that can address local problems.

Under the general rubric of "community crime prevention" (Hope, 1995), a wide range of programs aimed at strengthening social and institutional relationships within communities have emerged, often directed by the police. Essentially, community crime prevention efforts have focused on rebuilding communities, particularly urban communities, that have been greatly affected by changing social, economic, and political conditions. They have included programs aimed at organizing communities, improving citizen-police interactions, protecting the vulnerable, and changing the physical environment. They have included storefront police stations, Weed and Seed programs, police athletic leagues, and other youth intervention programs such as D.A.R.E.® and G.R.E.A.T., as well as community mobilizations for drug marches and neighborhood cleanups. More often than not, research assessing these programs has concluded that they have failed to produce their intended results (Rosenbaum, 1986), often because they were poorly implemented

or did not involve significant agencies within cities that might have improved their impact.

Such findings about the effects of community crime prevention programs have shifted attention from the broad realm of communities to smaller areas evidencing high crime, particularly among youths (see Hope, 1995, for a discussion). By focusing on more discrete areas—those with high crime rates among youths—program specialists and researchers hope to simultaneously address high crime offenders while supporting the victims and other community residents within these areas. Such coordinated, place-bound strategies are continuing to emerge as part of community crime prevention efforts. Recent work completed in Boston showed a dramatic decrease in firearms usage among crime-prone youths, primarily due to coordinated local interventions as well as refinements in the definition of youths and handgun problems in that city (Kennedy et al., 1996).

Finally, local governments need to continue to focus on infrastructure development in three important areas—physical, social, and political. There is a significant amount of literature in criminology that suggests that the level of physical and social incivility in any particular community is related to increased fear of crime (Wilson and Kelling, 1982; Skogan, 1990; Kelling and Coles, 1997). This line of reasoning suggests that communities can affect crime and disorder by reclaiming public spaces, reducing the signs of crime (graffiti, trash, drug paraphernalia), tightening up on the licensure of bars and liquor stores that habitually sell to minors or operate illegally, picketing or marching against drug or prostitution locations, cleaning and sealing abandoned housing, and tagging and towing abandoned autos, among a wide array of community-based and often community-initiated activities. Strengthening and supporting local initiatives of neighborhoods to reclaim their communities should be part of any local government crime prevention agenda. Increasing the capacity of the community for local surveillance and prompt response to anti-social behaviors must also be part of this agenda.

Addressing the physical and social incivilities evidenced in any community is perhaps an easier task than building community political support or empowering local community organizations to provide leadership for their community. Often, communities most in need of intervention are least capable of defining and supervising community standards. Nonetheless, as Etzioni (1993) suggests, "communities themselves need some major fixing if they are to provide the social foundation for a life that is more cognizant of the values we all share." This is perhaps a major political dilemma requiring that we redefine individual, community, and governmental rights, responsibilities, and actions. It will require that we reshape authority and accountability in communities while at the same time reshaping how core governmental services are provided. Some of this work is currently under way. Police, public health, and education systems have all built stronger community alliances over the past several years. This reinvention of government and reengineering of services suggests that empowerment is a complicated process. Nonetheless, rebuilding local community leadership is an important element of any community crime prevention effort.

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Panel Three:
Promising Programs and Approaches

Crime Prevention as Crime Deterrence

David Kennedy

I have been directing something called the Boston Gun Project for the last 3 years under NIJ support, and the able stewardship of NIJ's Lois Mock. This is a project, a type of open-ended problem-solving project, directed at serious youth violence in Boston. Many of you may have heard this project described as a juvenile violence project. It wasn't. It was aimed initially not at legal juveniles but at violence among young people. We started at the age of 21 and moved that up, for reasons I will explain, to about age 24 during the project. A lot of you will recognize this as sort of the typical crack-and-gun curve of the last 15 years. Crack showed up in Boston in a major way in 1988. The city had its homicide peak in 1990. Homicide rates in Boston do not mirror rates in Chicago or Los Angeles, but our homicide rate jumped by nearly 50 percent in 1990, totaling 150. The rate fluctuated for a year or two, and from 1992 to the present, remained stable at this historically elevated level. In the middle of 1996 and into 1997, rates changed and the death toll in this 24-and-under age group dropped by two- thirds from the figures between 1988 and 1995. These are not controlled experiments that I am going to be talking about; there is room for interpretation. But I think most people looking at this curve would say that something happened in 1996, which is what I am going to talk to you about.

Elements of the Gun Project were also put in place in Minneapolis. So these are June through November homicide series for all age groups. Minneapolis is one of a group of worrisome smaller cities that seems to be experiencing a new round of crack and gang problems. The homicide rate doubled between 1994 and 1995 and continued to go up. This intervention I am going to be talking about began in early June 1997, and it appears that something has happened there across all age groups.

The Boston Gun Project

There are two elements that comprise what we in Boston called the Ceasefire Initiative. One—this was the inspiration for the Boston Gun Project and why it is called the Boston Gun Project—is that this is a gun problem, and there seemed to be an opportunity to do something directly about the illegal acquisition of firearms. It was not gun control, traditionally construed, but attention to what seemed like a missed opportunity, focusing on the fact that where young people and adult felons are concerned, gun acquisitions are already illegal. However those guns are acquired, it is a crime, and to the extent that new guns and used or stolen guns are being sold within these circles and on the street, that is a criminal enterprise. If you went to most local police departments and asked them about their burglary strategy, their car theft strategy, or their prostitution strategy, they would have one. Some strategies might be good, some might be bad, but departments would have one. But if you asked them about guns, the response generally would be, "Huh?" One of the goals in the Gun Project is to try to change that.

This is a profile of a gun trafficker. Boston has been tracing all of the firearms recovered by the police for the last 5 or 6 years. Generally, we trace guns only in support of particular investigations. We find the smoking gun next to the body and no perpetrator, and we trace the gun to try to find out who might have been the shooter. Finding the same situation with somebody standing there, we don't trace the gun. Boston started tracing all of its guns, not to solve particular crimes but to try to figure out how this illicit market in firearms might be working and whether there was something that could be done about it. And, it turns out, there was. So these are real guns, real gun stores, and real people. When you look at these traces, you find patterns.

A number of guns used in crimes came from one gun store in Georgia. They were all bought by a handful of first purchasers. This is information that the Bureau of Alcohol, Tobacco and Firearms (ATF) can give you when they trace guns. Anybody familiar with the street scene could see that these guns were the kinds of guns that are popular among gang members. And when we matched the possessor information—that is, from whom the guns were taken—with the Boston Police Department information, it turned out that the majority of these individuals were known Boston gang members. Something was wrong here. When this was investigated by ATF, what was wrong turned out to be that these purchasers were selling guns to two individuals who did not show up anywhere, because they did not have their names on any of the paperwork. These two individuals were taking guns up to Boston and selling them in the neighborhoods. Both of these guys are now in Federal prison. It turns out that this unapproachable gun market is actually not that unapproachable after all. These relatively new guns turn out to be more popular among gang members and youth offenders than among older people.

We still have many used and stolen guns floating around out there, and you are not going to find the providers of those through traces. But the good news is, at some level, the people who know where those guns are coming from get arrested all the time because they are chronic, active, street offenders. The way you get the older and stolen guns is by talking with these offenders, the same way we have always "flipped" narcotic offenders around narcotics. Police are now interviewing these guys about where their guns are coming from. They can lead you to these providers of both the new guns and the old and stolen guns. Subsequent police work can put these guys out of business. So there is, in fact, a meaningful opportunity for doing something about guns out there.

Here is the second thing that quite unexpectedly came out of this problem-solving process. The Gun Project worked by convening a large group of front-line practitioners. We had police; probation; parole; local and Federal prosecutors; youth corrections; school police; and street workers, who in Boston do direct outreach to gang members and at-risk youths. Later in the process, a number of other groups got involved. What all of them said at the outset was that this was a gang problem, that these are chronic offenders hurting one another: "We know who they are. When they get killed we know both the victim and the shooter." For various reasons, my Harvard team was not enamored by this analysis. But we pursued it, and it turned out to be largely correct. And again, there are reams of research out of both Boston and Minneapolis on this. There were 155 victims, 21 and under, between 1990 and 1995. Again, this is not Chicago or Los Angeles, but it is bad enough.

When we ran criminal histories on each of these victims, we found that 55 percent had an arrest record in Massachusetts, about 20 percent had been in either an adult or juvenile lockup facility before they were killed, more than 40 percent were on some sort of probation at some time before they were killed, and 15 percent were on active probation supervision at the time they were killed. In addition, 25 percent of offenders committed murder while on probation. The offense counts were remarkable. Each of these groups, both offenders and victims, had an average of 10 or less offenses. About half of them had more than 10 offenses. And they were being arrested for all sorts of crimes. This is a classic concentration of offending. Criminologically, the only new thing about this was that it applied to this new population of young offenders. We always knew this about adults. Guided by our practitioner partners, we examined the gang problem in Boston. In Boston, these are small, fluid street groups. But they know who they are in the community, and the authorities know who they are. We found 61 gangs, with about 1,300 members, total. In the summer of 1995 when we did this analysis, the Intervale Posse, which is a group in Roxbury, had an active dispute with the Big Head Boys, and a historical but at the moment quiescent dispute with the Castlegate and Fuller Street gangs. What our practitioners said, and our own subsequent research showed, was that this was what was generating most of the killing among young people in Boston. This was not primarily about drug business. It was mostly about respect and personal issues, very Hatfield and McCoy. It was vendetta-like, extended over time, sometimes extending to younger siblings and friends. There were 1,300 kids in total in these groups. That is less than 1 percent of their age group in the city, less than 3 percent in

gang-troubled neighborhoods. There were 61 crews, and they were responsible, conservatively, for 60–70 percent of the youth homicide. This was a very focused problem. Once again, this is classic criminal justice stuff. Matters turned out to be essentially the same in Minneapolis where we did similar analyses. So now we come to what changed in both of these cities, in Boston in the summer of 1996 and in Minneapolis in June of 1997. We told them to stop. That is what happened.

When we think about crime control, we tend to think about prevention and criminal justice as separate enterprises, almost by definition. I think that is wrong. Prevention, in criminal justice, is deterrence. It is the use of authority in the exercise of changing behavior. We would prefer not to use authority, but there are always individuals and groups that need authority. We have almost given up on the idea of actually creating deterrence in criminal justice. The Ceasefire strategy as it emerged was an attempt to try to create meaningful deterrence among chronic offenders. It is an unusual strategy that makes different use of some routine tools. The first unusual piece is to sit down with your target population—in our case, these gangs—and explain to them how the world is going to work. In mid-1996, there were formal meetings between this working group of authorities and Boston gang members. The authorities explained that they knew who the gang members were and what they were doing. While the city would continue to pay close attention to all their offenses, the authorities stressed that there was now going to be a new regime where violence was concerned, and violence-related offenses, such as carrying guns and firing shots, would subsequently draw a unique response. The authorities told the gangs that they were informing them of their intentions because nobody wanted to do any unnecessary enforcement. No one wanted to sweep the streets of these youths. But when these rules were broken, the interagency group would sit down, examine the groups in question, and figure out ways to reach out and touch them.

A handout was given to Bowdoin Street gang members, a group called the Vamp Hill Kings, as part of the first structured Ceasefire crackdown. It simply states, "We said it and we meant it." Here is what happened to the Kings, a gang that was killing each other from the inside out: There were three intragang homicides within the Kings within a very short time in early 1996. The flier said that the authorities that usually work separately now were working together and any information that one group had would be shared with the others. They indicated that these cooperative efforts were the reason that none of the Kings had been able to work the corners (to sell drugs) and that the authorities had deliberately made the gang broke because of their violent behavior. They explained that this was why there had been such a heavy police presence in the gang's area doing what police know how to do: serving warrants, making street drug arrests, enforcing disorder laws, and talking to parents and neighbors. This was why those on probation or parole had been subject to stricter supervision. This was why a gang member who pulled a gun on a police officer in the course of the operation had been given over to a Federal prosecutor rather than the county prosecutor and why the local prosecutor had been giving priority to gang-related cases and opening old cases in which these gang members might have been involved. The message was that these efforts were being undertaken because of the violence, that this was the way police and other authorities would do business henceforth.

After the May meeting, most of the summer of 1996 was quiet. For a time, most of the Ceasefire interventions consisted of authorities reaching out to gangs that looked to be turning violent and explaining, "We are the guys who brought you Bowdoin Street. If this goes any further, then you are next." This is what we started to think of as "retail deterrence." Usually in criminal justice we would send these terribly broad messages. These were narrowly focused messages, and gangs listened. One group that did not attend was the Intervale Posse in Roxbury, and in late August 1996, the core of this gang was arrested by the Drug Enforcement Administration (DEA) on Federal drug charges. Once again the authorities went out on the streets and said, "You are reading in the [Boston] Globe that this was a drug investigation, but it was a means to an end. They were warned and they didn't listen. We did this because they were being violent; now we are sitting back waiting. Who wants to be next?"

That was the last operation of anything on this scale as part of Ceasefire. The streets got quieter and quieter.

These are not controlled experiments. It is going to be impossible to parse out exactly what went into the interventions in Boston and Minneapolis. But it looks like something important is happening.

Crime Control Implications

I would like to talk about the crime control implications of this approach. We are concerned about crimes committed by chronic offenders: drug activity, domestic violence, youth and adult homicide. It is well known that these serious crimes are embedded in patterns of chronic misbehavior. One can focus on any selected dimension of that chronic misbehavior and influence it by imposing costs across the other dimensions. Retail deterrence is, in theory, a strategic communication component, which makes it clear to the people you are dealing with that there are going to be consequences—we call them "pulling levers" consequences, because you "pull levers" to create rapid costs, for example, by serving warrants—around homicide, street drug markets, or other illegal activities.

We had a large interagency group that was a powerful tool. We brokered social services. We introduced kids to the Ten Point Coalition, a wonderful group of activists and black clergy in Boston. The larger message was: "We want the violence to stop. We will give you any help you need, but we are all standing here together saying it stops today." That was shoulder-to-shoulder communication. If you make it very clear—and we usually do not—to these chronic offending populations what is going to draw a special kind of response and then have the organization and surveillance to follow up on it, you can deliver a type of sanction with a swiftness and predictability that appears to create compliance. Having done something similar to gun control to curb violence, you can move on to a second target. In Minneapolis, the conversation is about a similar type of approach to control street drug activity, which is that city's other big community problem. It is easy to imagine how you might do this. Go to a bunch of crack houses and say, "We are not going to tolerate this anymore. We have five DEA investigations ready to roll. We will deploy them to crack houses associated with violence or generating a high level of community disorder." Over a period of 5 or 6 months, one could control those problems associated with crack dealing, even if one perhaps would not be able to shut down drug dealing citywide.

I think this is a promising approach. We will see whether it can be applied to other types of crime problems.

Revitalizing Communities: Public Health Strategies for Violence Prevention

Deborah Prothrow-Stith

As a public health professional, medical doctor, former Commissioner of Health of the Commonwealth of Massachusetts, and activist in the field of adolescent violence, I am constantly aware of the heavy toll violence takes on our Nation's spirit, health, and economy. Violent injury, disability, and death consumes enormous health care resources and diminishes the quality of life of individuals, families, and communities.

The United States has a problem with violence that is unlike any other country in the world. Our homicide rate for young men is eight times that of the developed country with the next highest rate, and 100 times that of the developed country with the lowest rate.[1] The Federal Bureau of Investigation estimates that 1.8 million people in the United States are victims of violence each year. Partner and child abuse plague many of our homes. Schools, the place where young people spend a significant amount of time, are increasingly unable to provide secure settings where learning can take place. Meanwhile, our media glorify violence. We are tired of reading about it in the newspaper. Too many people have suffered the tragic and senseless loss of a family member or friend to violence.

If violence were inevitable—just a part of the human condition—then one would expect the homicide rate to be relatively similar from country to country. When I learned that our homicide rate was so much higher than that of other countries, I was horrified and daunted. Later, I realized that these statistics also revealed an important truth: Violence is preventable. We do not need to have this problem.

Our public policy teaches us to view violence mainly as a criminal justice issue. People believe that building more prisons, lengthening prison sentences, trying children in adult courts, and preventing early parole are solutions. The criminal justice system intervenes only after someone has committed an act of violence. We need solutions that prevent violence from happening in the first place.

Public Health Strategies

In 1985, then Surgeon General C. Everett Koop held a landmark conference to address violence in the United States as a public health problem. The conference ignited professional interest and sparked an array of activities throughout the last decade that continues to grow and expand. Public health professionals not only began using quantitative methods to better understand violence and its risk factors, they also started developing a variety of prevention strategies. They have convened conferences; produced reports; designed, implemented, and evaluated programs; and contributed to a growing public awareness of violence prevention.

Public health approaches to violence prevention are analogous to the prevention methods used to reduce lung cancer: primary prevention for the general population, secondary prevention for those at higher risk, and tertiary prevention or treatment for those with the disease. Though not perfect, the analogy illustrates the three levels of prevention and demonstrates the need for comprehensive efforts at all levels of risk.

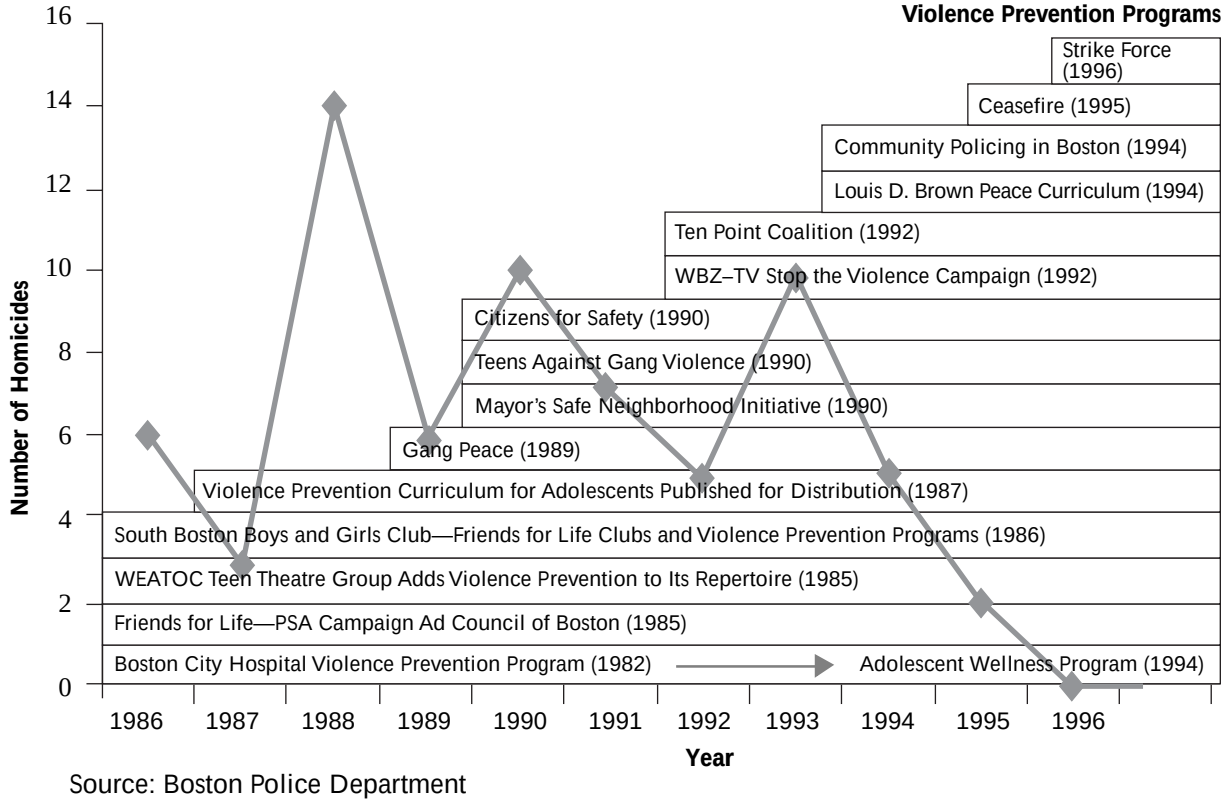
Primary lung cancer prevention programs create negative and offensive images of smoking using health education and mass media campaigns. Primary violence prevention uses mass media messages, classroom education, peer leadership and mediation, and community-based training programs to change social norms and attitudes. The goals are to redefine the "hero"; create alternative, problem-solving strategies; and reward and celebrate nonviolent problem solving.

Secondary prevention strategies are designed to help people at greater risk—those who smoke—using behavior modification programs, counseling, or group therapy. Children at risk for violence require secondary prevention, including mentoring/nurturing programs, individual and group counseling, "in school" suspension, and first-offender programs for court-involved youths. Children who witness violence or are victims of violence, two of the most defining risk factors, need specialized attention from professionals.

With lung cancer, tertiary prevention is treatment—surgery or chemotherapy. With violence, it is medical treatment and the criminal justice response—arrest, prosecution, defense, incarceration, and rehabilitation. A campaign to reduce lung cancer that focused only on improving treatment would not be successful; more surgery will not reduce lung cancer rates. A successful campaign would have to help those who smoke to stop and prevent people from beginning to smoke by making it unpopular. The same is true with violence prevention; more severe punishment will not prevent violence.

The magnitude and characteristics of violence-related problems cry out for new and creative approaches. The most effective programs must be comprehensive, family- and community-oriented,

Exhibit 1. The Number of Children Under 17 Murdered With Guns, 1986–1996, and Violence Prevention Program Examples by Start Date in Boston



Source: Boston Police Department

and collaborative in nature. Some schools, communities, social service agencies, and politicians around the country have incorporated this formula for success and developed strategies to help children and their families prevent or cope with violence. These programs offer the opportunity to learn from their successes and failures.

The Boston Violence Prevention Movement: Promising Programs

In many ways, Boston is the birthplace of the use of public health prevention strategies to address youth violence. One of the major contributions of public health professionals is their focus on prevention, not intervention. In 1978, a precursor of the Violence Prevention Curriculum for Adolescents[2] was taught in all 10th grade health classes at the Boston Technical High School. In 1982, the Boston Program for High Risk Youth was started at Boston City Hospital, 1 of 20 across the Nation funded by the Robert Wood Johnson Foundation specifically to address adolescent health issues. Based on the curriculum, the Boston program focused on adolescent violence as a public health problem at the outset. In 1986, the Boston Program for High Risk Youth became the Boston Violence Prevention Program and focused solely on applying public health techniques to violence prevention.[3] Over the years, a diverse and comprehensive set of strategies were employed. The basic strategy of the Boston Violence Prevention Program is to train youth-serving professionals from many disciplines in the key ingredients needed to prevent youth violence and to provide technical assistance as they develop strategies to use in their respective agencies and work. The trainings focus on:

- A "can do" or "can prevent" attitude that emphasizes the instigation and escalation phases of fights rather than aggressive responses to fights.
- The application of the same strategies used for smoking, drunk driving, or teen pregnancy reduction to violence prevention. This analogy is helpful because many of those trained are already working with teens on one of the three issues.
- A holistic approach to violence prevention that not only acknowledges the need for a transformation of cultural attitudes and social norms but also draws upon, is predicated upon, and encourages individuals to take responsibility for their actions and the things they do to promote fighting and violence.

The trainings use the Violence Prevention Curriculum for Adolescents, and the participants are encouraged to adapt the classroom activities and discussions to their specific programs (afterschool, peer leadership, theater groups, etc.). Spinoff activities, programs, and trainings are directly encouraged and technical assistance is provided. A trainee's clearly stated responsibility is to return to his/her agency and design and implement violence prevention strategies that could be integrated into his/her agency program. The program was incorporated into the city's Adolescent Wellness Program in 1994.

After its use at the Boston Technical High School, *The Violence Prevention Curriculum for Adolescents* was developed in a Boston public high school, officially published in 1987 by the Education Development Center, and has sold more than 20,000 copies. It continues to be used in several Boston schools and other youth-serving programs. Two separate and recently published evaluations associate the use of the curriculum with declines in student suspension rates in two Boston public high schools as well as with behavior changes among students in Augusta, Georgia.[4,5]

It is fair to estimate that over the years the Boston Violence Prevention Program trained several thousand professionals from Boston's schools, youth programs, human service agencies, police and criminal justice organizations, religious institutions, business groups, recreation programs, and health centers and hospitals, as well as public housing residents and teenagers. Boston is now the site of numerous violence prevention and peace promotion programs, many of which emerged as direct spinoffs from the Boston Violence Prevention Program. Exhibit 1 illustrates the year of startup and the cumulative accomplishments of several of these programs. Some examples of these spinoffs are described below.

- In 1990, Boston City Hospital began a project of visiting and providing special violence prevention counseling to adolescents admitted to the hospital for gunshot and stab wounds. The program eventually grew to involve patients' friends and family. A safety plan is developed for each patient and followup includes more than attention to the physical wound.
- Citizens for Safety was founded in 1990. It has held several gun buyback programs in conjunction with the police and sponsored several neighborhood-based public policy initiatives. Its most recent campaign, "Hands Without Guns," is headed by Michael MacDonald, a survivor of violence. This campaign is a middle-school-based initiative that promotes nonviolent options for students, coordinates and promotes youth activities, and develops mass media messages highlighting youth accomplishments.
- In 1990, Ulrich Johnson started a volunteer, anti-gang-violence teen peer leadership program called Teens Against Gang Violence that has consistently provided workshops for parents, schools, and community groups.
- Joseph and Clementina Chery started the Louis D. Brown Peace Curriculum after their son was killed in 1993. It is now used throughout the Boston public schools.
- Ann Bishop, director of the school-based clinic at Brighton High School, has been teaching violence prevention to Boston teenagers for 12 years and runs a special initiative for students who have experienced or witnessed violence. Her students developed and produced a rap song on violence prevention.
- Peter Stringham, a physician at East Boston Health Center, has been teaching his patients violence prevention strategies for several years. He has been providing parents with guidance on discipline practices and their arguing patterns as early as the first well-baby visit. He also educates other physicians on how to do the same.
- In 1992, Boston City Hospital initiated a special program for children who witness violence, and the Harvard Community Health Plan Foundation has sponsored parent information brochures on television watching and disciplinary techniques in addition to their "Think—Violence is for Those Who Don't" campaign. WBZ–TV's (Boston's CBS affiliate) Stop the Violence Campaign is 4 years old and represents a concerted media blitz with measurable impact on public policy and funding for domestic violence initiatives.

Numerous other programs have been established over the past decade, including Gang Peace, the Living After Murder Program of the Roxbury Comprehensive Health Center, the peer leadership programs at local health centers, and the teen peer theater and education group We Educate!—A Touch of Class (W.E.A.T.O.C.). The list also includes several new initiatives such as the national "Squash It" campaign, which focuses on using the media to make it acceptable to walk away from fights. Other national initiatives that have complemented efforts in Boston include the Children's Defense Fund's Safe Start Initiative; efforts by the Center to Prevent Handgun Violence, the American Medical Association, and the American Academy of Pediatrics; and several publicly funded programs from the Centers for Disease Control and Prevention, the National Institute of Justice, and the U.S. Department of Education.

Other programs such as those addressing economic development and homeownership in Boston's poor neighborhoods must also be considered. As a result of consistent activism and advocacy, in Massachusetts home mortgage lending to all minority borrowers increased to 33 percent between 1993 and 1995, outpacing the national average. And within Boston, multifamily mortgage originations increased nearly 40 percent during those years.[6]

Conclusion

The Boston violence prevention movement has involved a determined, coordinated, multidimensional, and lasting campaign across agencies, disciplines, and institutions. There are many promising programs that are having an impact in the Boston community and are being celebrated nationally. Such programs require ongoing support and commitment.

The contributions made by public health professionals toward efforts to prevent violence have been tremendous. The continued application of public health strategies to the understanding and prevention of violence assures success. The public health campaign to reduce smoking took 30 years after the first Surgeon General's report to reduce smoking. Violence reduction can be expected to take at least as long and will require as many, if not more, diverse strategies.

Notes

1. Centers for Disease Control and Prevention, "Rates of Homicide, Suicide, and Firearms-Related Death Among Children—26 Industrialized Countries," *Morbidity and Mortality Weekly Report* 46 (5) (February 7, 1997).

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3. Prothrow-Stith, D., H. Spivak, and A.J. Hausman, "The Violence Prevention Project: A Public Health Approach," *Science, Technology and Human Values* 12 (1987): 67–69.

4. Hausman, A., G. Pierce, and L. Briggs, "Evaluation of Comprehensive Violence Prevention Education: Effects on Student Behavior," *Journal of Adolescent Health* 19 (1996): 104–110.

5. DuRant, R., F. Treiber, A. Getts, K. McCloud, C.W. Linder, and E.R. Woods, "A Comparison of Two Violence Prevention Curricula for Middle School Adolescents," *Journal of Adolescent Health* 19 (1996): 111–117.

6. Speech given by Eugene Ludwig, Comptroller of the Currency, to Massachusetts Housing Investment Corporation members, January 17, 1997.

Lawyers Meet Community. Neighbors Go to School. Tough Meets Love: Promising Approaches to Neighborhood Safety, Community Revitalization, and Crime Control

Roger L. Conner

The purpose of this session is to identify promising programs and approaches that can enhance the Federal Government's efforts to decrease crime and revitalize communities.

For the past 8 years, I have served as Executive Director of the Center for the Community Interest (CCI) in Washington, D.C. CCI does research, public education, and advocacy for civic associations and neighborhood groups on crime and quality-of-life issues. One of our primary objectives is to keep the innovative grassroots activists and local government officials out of trouble with the courts. We also maintain a clearinghouse on legal challenges to strategies that improve the quality of life in urban neighborhoods and business districts, and we go to court whenever balanced, effective strategies come under legal attack.

As you might expect, local leaders on crime and quality-of-life issues are in touch with us a great deal. I could fill the entire conference agenda with a list of the promising programs that have come across my desk in the past couple of years, because there is an enormous effort under way in neighborhoods and communities across this country.
I would like to highlight four clusters of promising approaches that should draw more attention and support at the Federal level.

A New Role for Lawyers

Almost 2 years ago, Jeremy Travis gave a talk in New York entitled "Lessons for the Criminal Justice System From 20 Years of Policing Reform." In that talk, he offered a prediction (or, perhaps, what he hoped would be a self-fulfilling prophecy): That other elements of the criminal justice system will start looking over the fence at the progress being made by their policing brethren and import the lessons into their own territory. He postulated "three essential lessons from the development of community policing that can be applied to the rest of the criminal justice system":

- View the community as a full partner.
- Focus on solving the problems that matter to the community.
- Pay attention to little things.[1]

As a lawyer, I feared that my colleagues would be the last to look to the blue-collar workers of the justice system for guidance. The inner momentum of the law is enormous, as is its resistance to change. However, I am glad to report that a growing number of attorneys working in and in association with the criminal justice system are developing a new approach to their work that draws on the lessons of community policing. There are enough of them, and their work is so distinctive, we can now say that a new kind of practice, a new legal specialty, is emerging. Jeremy Travis has suggested a name for the specialty: Community Safety Law. I hope that community safety law (CSL) will eventually take its place alongside environmental law, securities law, and communications law as a recognized specialty.

Briefly, CSL practitioners are attorneys who take a direct, working interest in the public safety problems of particular places. Right now, they're a diverse and scattered body—some employed as "community prosecutors," some as city attorneys or solicitors, some engaged in delivery of legal services to the poor through nonprofit organizations, some working for nonprofit "public interest law firms," and some in private practice. At this time they have few opportunities to network, share information, recognize one another's achievements, or gain a clear sense of themselves as a distinct group. But insofar as there is a community justice movement—one that is gradually opening up the criminal justice system to popular collaboration and reorienting it in the direction of practical problem solving—these are the men and women who are defining what it means to be a lawyer in this new paradigm.

The common public perception of the lawyer's role in the criminal justice system is straightforward: to process cases efficiently and uniformly and maximize convictions (or defend against prosecution). CSL lawyers do not fit comfortably into this mold. They take a *direct, active* role in the provision of public safety in the communities where they work, and not primarily by processing criminal cases. Some have nothing whatever to do with case processing; others are not even prosecutors. A few illustrations will serve to suggest how far from the conventional CSL model practitioners are straying:

- The Community Law Center, a nonprofit community legal services agency in Baltimore, has become so deeply involved in drug nuisance abatement; vacant housing receivership actions; direct enforcement of housing, building, health, and zoning codes; and other "purely civil" efforts to fight crime and disorder on behalf of the neighborhood groups it serves that it now operates its own anonymous tipline for crime reporting.

- A "Neighborhood District Attorney" in Portland, Oregon, brokered a "partnership agreement" between local police and operators of motels suspected of conniving at prostitution and drug dealing on their premises, granting the operators special services (extra patrols, prompt trespass enforcement) in exchange for their taking measures to safeguard against criminal use of their rooms (screening guests, accepting only certain types of identification, requiring visitor registration, granting police access to registration records).

- A former homicide trial lawyer in the U.S. Attorney's Office for the District of Columbia, now stationed in a police district as part of a community prosecution pilot project, quickly discovered that: (1) local residents wanted something done about nuisance properties in the area, especially abandoned buildings being used by local drug dealers and users, and (2) local agencies were not inclined to help. So she made a video. That is, she went out with a police officer, a housing inspector, and a camera to put together a video tour of the area's 30 worst abandoned properties. The footage she came up with was dramatic and eye-opening—at one point, on camera, a quantity of heroin was actually discovered in a chimney—and resulted in public and media pressure that eventually prodded the responsible agencies to act.

Abstracting from these and many other examples of CSL work undertaken to date, it is possible to isolate six basic features that both distinguish CSL from traditional criminal practice and serve to define it as a distinct legal specialty.

1. **The unit of work is different.** In the traditional model, the basic unit of work is the criminal case, which is "delivered" to the prosecutor by way of a police investigation/arrest and thereafter "handled" in various ways until eventually "disposed of." The individual case may or may not be related to a broader public safety problem in the community from which it arose, and the handling of the case may or may not have some impact on the broader problem. But either way, the attorneys (both prosecutor and defense) literally take things "one case at a time."

   Portland's Neighborhood District Attorneys rarely even handle cases. However, most community prosecutors have conventional case-processing responsibilities and work at seeing past individual cases. Ronnie Earle, long-time head of the Travis County District Attorney's Office in Austin, Texas, "look[s] at crime as an

opportunity to intervene, to solve the problem that led to the crime in the first place."

2. **The source of the work is different.** It follows from the distinction described above, between cases and problems as units of work, that traditional and CSL attorneys get their work in different ways. For traditional case-processing prosecutors or defense attorneys, "intake" is fairly simple. They need not be entirely passive in accepting casework—they may lead or influence investigations, confer closely with police before arrests are made or warrants issued, screen out some cases altogether and assign varying priorities to others—but their casework will arrive regularly whatever they do. Most lawyers serving the poor in legal services or nonprofit organizations also have their priorities driven by the walk-in cases, and collective action tends to be for the purpose of addressing a collection of individual rights against landlords, businesses, or governmental agencies.

   A CSL practitioner, on the other hand, must *go out and look* for problems. Several of the practitioners I have met spend a significant amount of their worktime doing what can only be described as *mixing:* attending neighborhood association meetings, participating in marches, dropping in on community-based social service providers, even lending a hand to church groups that need help with flier distribution and other routine tasks. One practitioner laughingly calls it "unskilled labor"—and yet cultivating and maintaining these contacts with the community could not be more essential to her work. Without them, she would have no way of knowing what work there was to do.

3. **The connection with the "client" is different.** Traditional case processors naturally focus on what matters to their work—the individual defendants, witnesses, and victims whose actions alone have significance as part of the drama of the criminal case; the "law-abiding community" is at most a vague backdrop, a rhetorical device for summations, an abstraction well to the rear.

   In contrast, the CSL practitioner has something more like a lawyer-client *relationship* with the community: direct, intimate, face-to-face. The difference, particularly for prosecutors, may have something to do with physical location: respondents in community-prosecutor positions repeatedly (and apparently unconsciously) use physical-spatial terminology in contrasting their jobs "out here" with those of conventional prosecutors "downtown." CSL prosecutors are not merely physically removed from the center—and incidentally isolated from the conventional prosecutorial subculture, with its peculiar preoccupations, status rivalries, and assumptions about the world. Their responsibilities now cover a much smaller part of the whole.

   Even the part of a CSL practitioner's work that concerns individual case handling is affected by this more intimate lawyer-client relationship. Because of their many contacts with local people—at block meetings, ward meetings, patrol service area meetings, church meetings, even informal "walk-along" meetings with volunteers in citizen patrols—they are much more knowledgeable about the human context in which crimes occur than a traditional prosecutor could be. A case screener with a CSL orientation will tend to "know the problems," Stephanie Miller says, and "who the players are." She is much more likely to "call around" to dig up background before making a screening decision, and much less likely to "work in the dark." So, for example, trespass, unlawful entry, and other "insignificant" offenses will get her attention in certain cases, where they would not have before, because she understands their importance to real, flesh-and-blood people.

   For some CSL attorneys, the community—at least in the form of a community group and its elected leaders—is literally the client. When the firm of Davis, Polk, and Wardwell in New York intervened for a local public housing tenants' group in a court case challenging a new speedy drug-eviction policy, they did it for the same straightforward reason that most lawyers do most legal work: because that's what their clients wanted them to do.

   The same was true of attorneys with the Community Organizations Legal Assistance Project (COLAP) in Indianapolis, who, on behalf of neighborhood associations, community

development corporations, and other representative groups, hammered out a comprehensive memorandum of understanding with various city and county agencies outlining a step-by-step plan for eradicating drug markets in seven city neighborhoods.

Anne Blumenberg, Executive Director of the Community Law Center (CLC) in Baltimore, estimates that about 15 percent of the work CLC staff attorneys do for the community organizations that make up their clientele concerns straight corporate, tax, and transactional matters, but, since these organizations are based in "some of the worst crime and drug areas in the city," the remaining 85 percent of the work they need done is pure CSL.

4. **The priorities are different.** Traditional case processors, typically remote from neighborhood-level concerns and accustomed to dealing with each criminal case in isolation from its neighborhood context, naturally tend to prioritize cases according to their abstract "seriousness," with major felonies at the top and many common, street-level offenses beneath notice. One CSL practitioner calls this the "reactive, episodic" approach to strategic and resource-allocation decisions in which individual crimes are considered "without examining the landscape of the criminal cases or the impact of cases tried on the community." She is now studying her office with an eye toward moving Federal prosecutors away from this traditional, "case-by-case" view to get them to take into account the connections among cases and between cases and problems. But she admits it will be a "daunting task." For the traditional prosecutor, the equation is automatic: a community's "serious" problems are by definition its "serious" crimes and vice versa; to find out what these are, you simply "run the stats."

   CSL lawyers experience a total shift in their thinking. From assuming that only "big felonies" matter and that a neighborhood with, for example, a lot of armed robberies could not possibly be concerned about vandalism or panhandling, they typically discover that it is the misdemeanors and noncriminal infractions that cause the most concern. These are the very matters that are allocated few resources in the criminal justice system. The "offenders" are not the kind of people you can "put away," even hypothetically. And yet, at a neighborhood meeting, they are all residents want to talk about.

5. **The tools are different.** A traditional prosecutor has, in essence, two tools to work with: criminal prosecution and the *threat* of criminal prosecution. The traditional legal services lawyer functions as an adversary of landlords, housing agencies, cities, and even the police to protect the individual rights of low-income people by defending them in litigation. This is so even where the individual who obtains legal assistance is actually part of the problem for the surrounding neighborhood. CSL attorneys have many additional, unconventional tools to choose from, including the following:

   - *Community consultation and mobilization.* CSL practitioners invariably address localized public safety problems by enlisting the creativity, support, and energy of local residents themselves. All of the CSL practitioners I have met and talked with report that frequent consultation with residents is central to their jobs—for purposes of both problem definition and problem solving. So, for example, Neighborhood District Attorney Wayne Pearson learned early on from residents of Portland's Lloyd District that many of their low-level disorder problems—public intoxication, littering, vandalism, petty theft, etc.—emanated from a growing population of transients illegally camping in a nearby gulch. The solution: Once it was cleaned, cleared, and posted with "no camping" signs, voluntary resident-patrols monitored the gulch for signs of new encampments.

     The Community Law Center in Baltimore has been intimately involved with community groups in developing training for community mobilization against drug markets and writing legislation that simplifies civil actions against landowners. Legal Services in Kansas City, Missouri, has written new laws to clear titles to abandoned properties to speed them into the hands of community development corporations.

   - *Focused education.* A large part of CSL work involves formal and informal teaching. One

community prosecutor conducts special presentations to educate prosecutors working in the local municipal courts, public housing managers, and special deputies handling security in large housing complexes on how to make trespass laws stick. Baltimore's Community Law Center has produced a book on how to use civil remedies to deal with problem properties. The law firm of Cadwalader, Wickersham & Taft wrote a 350-page book on civil remedies and how they could be improved in New York State.

- *Interagency collaboration.* Ronnie Earle, Travis County, Texas, District Attorney and outspoken proponent of what he calls "community justice," reports that his office is engaged in 25 different collaborations, task forces, and working groups with local nonprosecutorial agencies, ranging from those in which the office takes a leading role to those in which staff members sit on boards. The "convening power" of the DA's office—basically, the power to cut across traditional bureaucratic barriers to focus the whole community's energies on a public safety problem—is perhaps best exemplified by Travis County's "Neighborhood Conference Committees," in which local school, police, juvenile court, and health and human services officials as well as private citizens came together under the sponsorship of the DA's office to form an elaborate alternative sanctions system for juvenile first offenders.

- *Partnerships with police.* Attorneys under Robert Messner, who heads the Civil Enforcement Unit of the Legal Bureau of the New York City Police Department, work with police to target stolen-auto "chop shops," unlicensed social clubs, prostitution and drug-dealing fronts, and other illegal businesses, using civil nuisance abatement and forfeiture procedures rather than traditional criminal prosecutions to shut them down. According to Messner, because of the sophisticated organization of these businesses as well as the intricacy of the law in this area—the body of laws and regulations pertaining to auto-dismantling chop shops is "more complex than the tax code"—police continuously need to consult with lawyers to have any impact.

- *Civil and administrative remedies.* The Community Law Center in Baltimore has no power to prosecute criminals, and yet it has made itself into a formidable force against "crime and grime" in the neighborhoods in which it operates—primarily through an aggressive program of "private" code enforcement and nuisance abatement litigation. As legal counsel for community organizations with broad, welfare-promoting purposes, the Center files hundreds of actions each year to enjoin drug trafficking in neighborhood properties, force landlords to take security measures against criminals, and compel property owners to rehabilitate buildings or turn them over to nonprofit receivers for renovation and resale. In fact, the Center has gone so far in this direction that it now sees itself at the forefront of a movement toward what is called "the coproduction model" for the delivery of government services—in which private citizens and their voluntary organizations "coproduce" as well as "consume" traditional government services.

  The Los Angeles County Prosecutors Office, in cooperation with the local law firm of Latham & Watkins, was the first to file civil suits to have specific gangs declared a "public nuisance." The resulting injunctions have dramatically altered the quality of life in Southern California neighborhoods that had been terrorized by gangs for many years. Other California jurisdictions have implemented the same approach, which was recently approved by the California Supreme Court.

- *CSL innovations.* There is "no form book" for CSL attorneys. As one neighborhood DA put it: "The community wants a solution. You're a lawyer. Go find it." There is a sense of freedom from traditional assumptions and arbitrary limits in the work that all CSL lawyers have in common.

6. **The definition of success is different.** A traditional case processor's definition of success is more or less dictated by the nature of the work: Success is winning cases. There is, of course, at least a theoretical relationship between winning cases and larger goals of public safety and justice

for the individual. It is not just a matter of winning for the sake of winning, but the fact remains that a conventional lawyer in the justice system has only one way of furthering those larger goals and cannot afford to concentrate on anything else.

A CSL attorney—anchored to a particular place, answerable to its residents, focused directly on its safety—must have a definition of success that is at once more concrete and more complicated than this. Most actual public safety problems never "go away" in the way that even the most drawn-out criminal cases eventually do: Success is a matter of maintaining a critical balance, first holding and then gaining ground, gradually increasing residents' confidence, but never actually winning the day. In a broad sense, CSL successes are always related to actual problem-solving improvements in public safety—to better coordination, more community commitment and vigilance, and less fear. But the ideal CSL attorney would be a kind of all-purpose fixer, like a beat cop who understands that the most important part of the job is staying on the job.

Many district attorneys, prosecuting attorneys, and U.S. Attorneys have always seen themselves as policymakers and problem solvers in addition to prosecutors of individual cases. Indeed, it was U.S. Attorney Michael Baylson of the Eastern District of Pennsylvania who invented the model that became the Weed and Seed program. If you think about the parallel to community policing, the chief and his or her top staff focused on problem solving even during the heyday of 911-driven policing. Community policing pushed discretion and a problem-solving orientation much deeper into the ranks. Similarly, the innovation we are seeing among lawyers is pushing the collaborative, problem-solving orientation deeper into the ranks.

Preparing the Community for Community Justice

There is much talk around the U.S. Department of Justice these days about community justice. The discussion represents recognition, at the Federal level, of a range of experiments introduced by innovative, pragmatic leaders at the State and local levels. "While the concept of community justice is still developing," Assistant Attorney General Laurie Robinson wrote in a February 1997 invitation letter to the community justice conference, "two key principles stand out . . . making the community a full partner with agencies of the justice system to promote public safety and addressing the needs of the community and the victim through a problem-solving approach."

The trouble is, it's hard to tango with someone who doesn't know how to dance. When I was in college, there weren't any courses on organizing your community to get rid of drugs or crime. My high school civics course didn't cover how to keep block clubs going from one year to the next or the difference between community policing and 911-driven random patrol. Like me, most citizens have no training, experience, or knowledge of how to be more than passive cheerleaders for police and prosecutors.

In a handful of jurisdictions, organizations have emerged to recruit, organize, and train citizens and serve as the local "institutional memory" on how to make the justice system work for the community. The structure of such organizations is quite diverse. For example:

New York. The Citizens Committee for New York City (CCNYC) provides training, technical assistance, small grants, and self-help literature for more than 11,000 block clubs in New York City. It also operates formal training programs for neighborhood safety advocates, block club leaders, and youths. Although it deliberately avoids taking advocacy positions, CCNYC is the institutional memory for many past public safety volunteer efforts and a place for new activists to come and learn what works.

Chicago. Chicago has a number of organizations with public safety as their mission and full-time organizers and trainers on staff. The most prominent, the Chicago Alliance for Neighborhood Safety (CANS), at one time had a contract with the city to organize and train citizens in every precinct in the city on how to be "coproducers of safety." The evaluation reports on their work are in: CANS organized and trained citizens to understand problem solving and work effectively with police as partners. The Northwest Austin Council is another Chicago group that has had full-time organizers on

staff for over a decade, and the difference between their neighborhood and others similarly situated is remarkable. Chicago now has a number of organizers on staff, but whether they can match the independent citizens' groups in effectiveness has yet to be determined.

Baltimore. In Baltimore, the Community Planning and Housing Association (CPHA) has been an advocate for low-income neighborhoods for many years. It believes neighborhood safety is necessary for neighborhood development and stability. More important, they have created a "train the trainers" curriculum by which the original handful of inspirational leaders have passed on their knowledge to new staff and new neighborhood activists. I understand that the evaluation report from Baltimore's Comprehensive Communities Program is giving significant credit for the progress in the target neighborhoods to the trainers and organizers of CPHA.

Fort Worth. The Citizens' Crime Commission of Tarrant County has created a "Community Leadership Development" (CLD) program. CLD volunteers receive a year of leadership training seminars similar to those offered to corporate or government middle managers. In exchange, they pledge to participate as members of their police precinct's Citizens Advisory Committee, to team with city officials to address problems in their own neighborhoods, and to recruit their own replacements after 1 year. Along with this effort, the police department has recruited and trained 145 block and neighborhood groups (with 2,800 members) to patrol streets for code violations. The most visible crime problems (open-air drug markets and prostitution) were driven out by their organized presence.

Pennsylvania. The Pennsylvania Crime Commission is providing a year or more of intensive leadership training to citizens from specific neighborhoods (called State "Weed and Seed" sites). The idea is to strengthen the capacity of the communities by training leaders. Interestingly, the Pennsylvania program selects a mixture of people who reside in the target area and who work there, because both residents and institutions need to get involved in meaningful solutions.

Everyone seems to agree that having the community as a partner in safety and justice issues is a good idea. It is remarkable to me that formal, organized training and technical assistance are recognized as a necessity for the justice professionals but as a luxury or an afterthought for the citizens who are being asked to be partners in implementing the new paradigm of community justice.

Consider the success of community policing in Portland, Oregon. Much has been made of the police chief's leadership, and I do not discount it. However, Portland's 94 identifiable neighborhoods are supported by the full-time staff of the Office of Neighborhood Associations, and I suspect they have played a bigger role than we can see.

Granted, we need to know a lot more about the creation and nurturing of such groups. Can the city government or the police provide the training and organizers? Will the money be wasted if it goes to nonprofits? Is the "support group" model (CCNYC) better than the advocacy model (CANS)?

However, I make this assertion on the basis of my own experience: Citizens will never be effective partners with the criminal justice system without institutionalized recruitment, training, and education. President Clinton once observed that 10,000 effective community organizations could do more than 100,000 police officers. If he is right, it is a pity that there are untold resources for training police for community policing but none for training citizens.

Addressing Disorder in Urban Centers and Commercial Districts

Another cluster of promising programs that has emerged recently has to do with restoring security and civility in the central business districts and older commercial strips of our Nation's cities.

If a trip to the downtown area or the neighborhood stores requires citizens to run a gauntlet of unpleasant encounters, people with options are going to leave. At CCI, we have received hundreds of requests for assistance over the past 2 years for

help dealing with aggressive panhandlers, homeless people who have set up encampments in public parks, frightening and dangerous persons apparently afflicted with mental illness, and "Deadheads" sprawled across sidewalks near university districts.

The problems to be overcome are both political and legal. No one wants to be, or to be seen as, hostile to destitute and homeless people who cannot care for themselves, and the courts are not willing to give police broad discretion to force people to "move on." The compromise that seems to be emerging in the interplay between courts and communities is that ordinances that target specific antisocial *conduct* rather than broad categories of *people* will be accepted. Cities are saying that a tolerance for diversity is not inconsistent with reasonable standards of conduct that apply to everyone, and the courts, with some notable exceptions, are agreeing.

Some of the newly adopted ordinances include:

Panhandling controls. Total bans on panhandling have been rejected. When New York City attempted to enforce an old law that banned loitering and panhandling, the Second Circuit Court of Appeals rejected the ordinance as an infringement on the First Amendment. The same result occurred in Massachusetts. In contrast, the same courts have consistently held that "reasonable time, place, and manner" regulation of panhandling is permissible. For example, bans on "aggressive" panhandling have been adopted in several cities and approved by Federal courts in Seattle, Atlanta, Santa Monica, and Dallas. But one Federal District Court in Los Angeles has recently ruled to the contrary, and an appeal is expected.

Restrictions on locations where panhandling presents special problems have also been approved, ranging from subways, airports, State fairgrounds, and post offices. To the extent that future judges follow their peers, panhandling bans in locations that are inherently provocative (near automatic teller machines) or crowded (beachfront boardwalks) appear to be on firm constitutional footing. Again, however, a Southern California District Court judge recently went against this trend and threw out a ban on panhandling at the Los Angeles International Airport.

Some innovative area bans include:

- Las Vegas put a huge, expensive glass canopy over the main central business district thoroughfare on which a light show is displayed hourly each night, then banned panhandling within "The Freemont Street Experience."
- A new Santa Monica law says panhandlers may not be intoxicated and must not approach closer than 3 feet from their targets.
- The City Council of Berkeley banned all panhandling at night as inherently threatening.

Urban camping, public sleeping, and sidewalk obstruction. Ordinances that restrict public sleeping in specific places, such as the immediate surroundings of public buildings and monuments or heavily used urban parks, and that prohibit camping (the colonization of public spaces) thus far have been approved in every instance. The use of trespass laws to break up concentrations of people who set up encampments on public land has also been approved. However, where cities have attempted to defend depression-era laws banning public sleeping in all public places in a city, the record is mixed. Some courts agree with the theory that sleep is essential to life and thus have ruled that it violates due process if, in fact, there are persons with no place to sleep on private or public property in an entire community.

Seattle and other jurisdictions have also banned people from sitting or lying on sidewalks in business districts during business hours. These efforts have been upheld by the Ninth Circuit Court of Appeals and the State courts as well. Many other laws can be used as a part of quality-of-life enforcement efforts, including ordinances on excessive noise, dumping the contents of public trash cans, automobile cruising, and the like. While constitutional arguments have been made against all of these, courts have been uniformly hostile.

The most persistent quality-of-life problems will not yield to enforcement efforts alone, for they are rooted in untreated addiction, mental illness, or a combination of both.

One of the worst social experiments this country ever imposed on its weakest citizens was the

deinstitutionalization of people affected by such neurological disorders as schizophrenia and bipolar disorder. In 1955, there were more than 559,000 patients in State psychiatric hospitals in this country. The population of the United States has almost doubled since then, and the number of people with severe mental illness has increased accordingly. There are fewer than 90,000 persons in State mental hospitals, and even taking into account the psychiatric wards of general hospitals and aftercare facilities, there are approximately 750,000 people living in the community who would likely have been inpatients in State psychiatric hospitals in an earlier day. What looks like a quality-of-life problem to be addressed by law enforcement is actually an untreated medical problem.

Although it may not appear to be related to quality of life on the surface, laws that require insurance companies to provide "parity" for mental illness—so that the need for medication for schizophrenia is treated the same as the need for medication for HIV or Parkinson's—will have a direct effect on quality of life by preventing some, perhaps many, from falling into the clutches of the "street shrinks" (i.e., drug dealers). The Mental Health Parity Act of 1996, which took effect January 1, 1998, will require large companies to make annual and lifetime benefits for mental illnesses equal to those offered for other physical disorders. Several States have adopted or are considering similar laws.

As much as we would wish it, however, more services alone will not do the job. Mental illness often blinds the individual to the nature of his or her own condition. Ed Ehrenright, the son of the founder of the California Alliance for the Mentally Ill, recently stabbed his beloved brother, Mark, to death. The same disorder that made Ed believe he must kill his brother also convinced him that he was not ill and did not need to take his medication.

States are slowly beginning to address the problems of persons like Ehrenright who "lack insight" into their condition and become "treatment resistant" or "noncompliant." North Carolina has been a leader in the use of outpatient commitment, which combines release into the community with a meaningful threat of institutionalization should the person fail to follow through on needed medication. California has used "conservatorships" and "guardianships" so that a loved one or friend can step in after the patient loses contact with reality but before he or she lands on the streets. Other States are using conditional releases from mental hospitals, although this affects only a small minority who are admitted to a mental institution in the first place. In a handful of jurisdictions, most notably Massachusetts, local judges are using quality-of-life infractions as an opportunity to plead with, cajole, threaten, and pressure mentally ill persons to return to their treatment and medication regimens; this experience suggests that we need the mental illness equivalent of drug courts. Finally, New York is in the midst of a 3-year experiment with "mental health warrants," which give judges greater leeway to return patients to State and city institutions.

All of these experiments are edging toward greater community capacity to protect persons with neurobiological disorders in the same manner that it would protect minor children or persons with Alzheimer's. This discussion may seem far removed from the topic of this conference, but it is intimately connected. In the end, you will not be able to provide quality of life in urban centers without getting mentally ill persons, particularly those who have severe mental illness, off the streets. Unless we find a legal way to address the needs of persons whose mental illness prevents them from accepting needed help, quality-of-life enforcement will fill the jails with broken people; indeed, it already has. The sheriff of Los Angeles County says he is running the largest mental institution in the world. We should not, as a matter of morality, allow this to continue, or else the courts will eventually step in.

Tough Meets Love

Consensus is hard to come by on crime in America. However, there is broad agreement across the political spectrum that there is a small and "distinct group of [juvenile] offenders who tend to start early and continue late in their offending" who constitute a disproportionate share of the "violent and serious personal property offenders" among juveniles. A recent Office of Juvenile Justice and Delinquency Prevention (OJJDP) study report calls this group "serious and violent juvenile (SVJ) offenders." The Reagan and Bush administrations reached the same

conclusion but used a different term: "SHOs" ("serious habitual offenders").

The recent OJJDP report drives home the point that many—perhaps most—of the serious criminals in the United States make themselves known to neighbors, teachers, principals, juvenile probation officers, police, judges, and jailers early in their "careers" with "behavior problems, including aggression, dishonesty, property offenses, and conflict with authority figures." When I walk with people at the neighborhood level, they say it is these same young people who provoke the most fear and anger with their swagger, their guns, and their drug-based money.

We cannot talk about revitalizing communities without dealing with this group of young people. They drive law-abiding residents into their homes, draw other youths into the streets, and create an insurmountable barrier to the private investment that our distressed neighborhoods need desperately.

What are we to do? I think the experience of Patrick Hadley of Ocala, Florida, is instructive. Hadley, a recovering addict and ex-convict who had put his own life back together, was living in West Ocala, a neighborhood suffused with crack-driven violence, when a drive-by shooting in front of his home impelled him to act. After watching the evening news, this anguished father stood on the steps of city hall with a simple sign: "I care about West Ocala." Soon he was joined by other men, and they formed the "Mad Dads" of Ocala.

The Mad Dads marched the streets of West Ocala, driving out the drug dealers with civil rights-style chants ("Drug dealer, drug dealer, you can't hide, we charge you with genocide"). At some point, Hadley did the unthinkable. He offered a hug and a chance to one of the young people who served as a "tout" (one who introduces buyers to sellers) for dealers. Others followed. The Mad Dads now operate a mentoring program for hundreds of young men and women, a diversion program for the juvenile courts, and a scholarship program that places their mentoring graduates in junior college.

I use the phrase "tough meets love" to describe the Mad Dads because the antidrug marches are continuing. Hadley still works with police to identify people who are beyond the reach of the love and support he offers. The Mad Dads in Ocala, Chloe Cooney's Corporation to Develop Communities of Tampa, and the Alliance of Concerned Men at Benning Terrace in Washington, D.C., are only a few examples of hundreds you can find across the country. The Corporation to Develop Communities of Tampa has organized civil rights-style marches against drug dealers, replete with chants of "Drug dealer, drug dealer, you can't hide; we charge you with genocide." The group also offers mentoring, training, and job referrals to win young people away from the dealers. Benning Terrace was one of the most violent places in Washington, D.C., until a handful of "OGs" (old guys)—former prisoners and drug addicts—went into the streets and embraced warring gangs, bringing them to the table for a peace summit. A truce was arranged; the city housing authority offered gang members jobs rehabilitating the development. The alliance members mentored and counseled the young people daily. As a result, the entire neighborhood is safer. In 1997, there were 45 murders in Benning Terrace. There have been none since the peace accord was struck.

The promising approaches to dealing with this problem group appear to have at least three things in common:

1. The leaders of the programs exude love and support for young people who everyone else has given up on. The love is real because it is rooted in a deep religious faith.

2. The leaders are confident that the targets of their work are making wrong choices, that they need to "change the way they do business." There are no relativists in this group, and no one is intimidated by taunts or criticism of paternalism.

3. Neighborhood safety is as important to them as saving individual lives. While they believe in every young person they take in, there is a tough side to their love for those who spurn the outreached hand, who try to drag the fellows back to the streets. "I offer these young men unconditional love," Hadley says, "but if you are going to keep poisoning my children, you ain't my brother."

There is a fourth feature that most of these programs lack: A means to keep going once scarce

Federal demonstrations dollars move on to the political leaders' new hot spot. I applaud the Office of Weed and Seed's decision to include training for local program managers on fund raising so they can dig in for the long haul. Almost every community in this country has a Lung Association (the old TB Society), a Red Cross chapter, Boy Scouts, and more, none of which are receiving Federal grants to keep their programs alive. I believe there is a key Federal role, one that has not been recognized, in leading foundations, local governments, and philanthropists to recognize tough love organizations as a necessary component of a city's health. There are a number of organizations, such as the Council on Foundations and the Philanthropic Round Table, that provide guidance to philanthropists and foundations. I urge those of you in the Federal Government to make them a target of your educational outreach, to prepare the way for the Patrick Hadley's of the world to make their pitch for funds.

It is also important for our groups to find self-renewing funding sources. For example, as local legislators look for alternatives to incarceration, our neighborhood safety groups should be developing proposals for court-funded diversion programs that would be much more cost effective than jail. Even more important, however, is the private marketplace. There are many streams of money flowing through our communities that could be captured to finance community-based organizations.

For example, a new shopping center was recently developed in Anacostia, bringing a new Safeway store, among others, to the poorest part of Washington, D.C. We can all point to individual examples of success in low-income neighborhoods. But the Anacostia Economic Development Corporation (AEDC) has gone one step further. It operated as an *investor/developer* for this project rather than as an observer or even catalyst. As a result, AEDC has the contract to manage the Good Hope Market Shopping Center, a responsibility that will bring money to their organization in perpetuity. It also leveraged government grants into an equity position in the development. Linda Goldstein, a lawyer with Goodwin, Proctor & Hoar in Washington, D.C., was the architect of AEDC's new role, and she observes that Safeway, Inc., and other similar businesses will not take the initiative to make community groups economic partners, but they are not opposed to the idea if the community group is represented by lawyers with the skill to assemble the deals.

Some organizations that provide treatment and training for addicts are marketing their clients as a work force to finance their drug and alcohol treatment. Robin Roberts Harven of Austin has made "work therapy" a central component of her drug treatment program. She argues that the addicts are getting the benefits of the program and should pay for it with their labor, and the program has been able to generate enough money from contract work to get off the treadmill of government funding.

Not every community has a Robin Roberts Harven, a Chloe Cooney, or a Patrick Hadley. Is government powerless in such places to focus on young people who seem destined for lives of crime? Several communities are creating ersatz substitute parents in the form of intensive supervision delivered by government employees. The Community Intensive Supervision Project (CISP) in Pittsburgh involves small sites that allow 20–40 offenders to attend a program based in their own neighborhoods. Young people are picked up at school and transported directly to the CISP sites, where they spend the evening working on catching up to their peers in school, physical fitness, Narcotics Anonymous sessions, and job readiness. Community service is a required part of the program. Young offenders go home at night with electronic ankle bracelets. Early evaluations look promising, and CISP is significantly less expensive than jail.

There is a mighty struggle going on in low-income communities between the teachers, ministers, and parents and the drug dealers, or what social scientist Elijah Anderson terms the "decent" versus "street" culture. It is extremely hard for government and nongovernment leaders outside the afflicted neighborhoods to know how to strengthen the forces of community rather than try to impose an authoritarian solution. Some of the questions yet to be addressed include:

- How do foundations and local government distinguish between a Patrick Hadley and a ripoff artist?
- Can Hadley train other leaders in other communities?

- Once some of the volunteers are given staff positions, will the other volunteers stop working and leave it to the paid staff? Or if there are no staff positions for full-time volunteers, will the volunteers burn out and eventually quit or move on?
- Can government programs that supply paid mentor/counselors, backed by sanctions, substitute for the families these young people need?

The Weed and Seed program in particular has created a wealth of experimentation on these questions, and I hope that some of the evaluations to come will provide answers.

A somewhat different approach to intervening in the lives of the most crime-prone offenders is intensive drug testing for persons on probation, parole, or otherwise under the control of the criminal justice system (i.e., after arrest and before trial). I mention this only briefly, since it is one of those rare programs blessed by both academic evaluation research and politicians (President Clinton made it the topic of a radio address and pushed legislation through Congress). What is striking to me is how little headway this common sense idea has made, despite its pedigree. Do local officials believe the research? Have we failed to get the information out to them? Have treatment professionals convinced them that drug testing without an expansion of inpatient treatment is cruel (although the research indicates that many offenders can get off drugs on their own with sufficient incentives)? Is money really so tight at the local level that successful programs cannot be replicated without Federal grants? Is the problem that intensive drug testing is neither punitive enough to generate support from the right nor gentle enough to generate enthusiasm from the left? Or did the idea succeed too quickly? (As of this writing, there is no citizens' coalition for drug testing; there are, however, several for extending prison sentences and building more jails.)

In any event, I suggest drug testing as an idea that should command much more forceful leadership from Federal officials whose job it is to speed the adoption of innovative ideas across the country. And I suggest it as a good case study for those of you of a more academic bent to identify the impediments to the spread of innovative ideas within the justice system.

A final example of focusing on individuals that I want to mention in passing is the quiet revolution going on with probation and parole. I hope everyone here is familiar with "Managing Adult Sex Offenders in the Community: A Containment Approach." As reported in that NIJ study report, something very important is happening in Maricopa County, better known as Phoenix, Arizona. They have achieved a recidivism rate among sexual offenders of less than 2 percent. The Maricopa County Probation Department now considers the prevention of crime as its *first priority,* and it has proven that investments in probation can produce tangible benefits for the community.

Maricopa County has two innovations that merit your attention. The first is the way the conditions of probation, which have been tailored for this specific group of offenders, are enforced: Offenders must submit to weekly Alcoholics Anonymous-type group therapy sessions, monthly lie detector tests, and frequent interaction with specially trained probation officers with small caseloads. The second is that the duration of community supervision has been disconnected from the duration of the maximum sentence. That is, in Arizona, sexual offenders often receive lifetime probation; there are 500 persons on *lifetime* probation in Phoenix alone.

I could say more about the reinvigoration of probation and parole, but since I share this session with one of the Nation's leading experts on that subject, David Kennedy, I will leave further discussion of this important topic to him.

One way of thinking about crime prevention is to focus on the offenders who have committed most of the crimes—the approach of the programs I have just discussed. Maryland and Pennsylvania are taking another approach entirely; they are focusing on the places where most of the crimes take place.

Under the leadership of Lt. Gov. Kathleen Kennedy Townsend and Michael Sarbanes, Executive Director of the Governor's Office of Crime Control and Prevention, Maryland has applied crime-mapping techniques to every county in the State. What they found was that every city and town, even quite small ones, had specific locations that accounted for much of their local reported crime. From this insight and Sarbanes' experience at the Community Law Center in Baltimore has come the "Maryland

Hot Spots Communities Program," which encourages local officials to use community mobilization and collaborative problem solving to address the environment in each of these locations.

Although Pennsylvania is a much bigger State, it is taking a similar approach. David Castro, who formerly ran the Drug Nuisance Task Force for Philadelphia District Attorney Lynn Abraham, is now Director of the State Weed and Seed program, operated out of the Pennsylvania Crime Commission. Castro's staff tries to identify "hot spots"; create collaborative teams of State, Federal, and local officials; generate highly concentrated enforcement activities; and promote leadership development.

Conclusion

It seems to me that the promising approaches I have outlined above have some features in common. They involve a renewed focus on specific people and specific places in order to solve specific problems that are of concern to the community. Most of them involve the community outside the justice system in a newly robust partnership with the traditional agencies responsible for crime and punishment. In other words, there are signs that Jeremy Travis' prediction, which I cited at the beginning of this talk—that the ideas at the heart of community policing might spill over into other parts of the justice system and the community itself—might be more than wishful thinking after all. I certainly hope so.

Notes

1. Travis, Jeremy, "Lessons for the Criminal Justice System From 20 Years of Policing Reform," keynote address, "New Beginnings"—the First Annual Conference of the New York Campaign for Effective Crime Policy, March 10, 1996.

2. I would like to give special credit to Catherine Coles and Barbara Boland for their groundbreaking work on community prosecution, which first introduced the lawyer-innovators among prosecutors to the rest of us.

3. Foote, Joseph, *Expert Panel Issues Report on Serious and Violent Juvenile Offenders,* Fact Sheet, Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, October 1997, FS–9768.

4. In a recent interview in the *Chicago Sun-Times,* researcher Robert J. Sampson summarized a decade of research on crime and delinquency this way:

> [T]he little things matter . . . we ask about things like kids skipping school, spray painting graffiti, showing disrespect to an adult . . . these are simple, everyday activities of children, not serious crimes . . . what we find is that the collective willingness of adults to intervene and show responsibility for children with regard to these activities varies considerably across neighborhoods. Where it is high, crime seems to be low.

Groups such as the Mad Dads are, perhaps, a way to return this kind of consistent adult feedback to youths who have a foot on the slippery slope.

5. Anderson, Elijah, "The Code of the Streets," *Hope* (March/April 1996): 26–43.

6. English, K., S. Pullen, and L. Jones, "Managing Sex Offenders in the Community: A Containment Approach," Research in Brief, Washington, DC: U.S. Department of Justice, National Institute of Justice, January 1997, NCJ 163387.

7. See Kennedy, David M., "Pulling Levers: Chronic Offenders, High-Crime Settings, and a Theory of Prevention," *Valparaiso University Law Review* 31 (2) (Spring 1997): 449–484.

Panel Four: What Do We Do Next? Research Questions and Implications for Evaluation Design

Dynamic Strategic Assessment and Feedback: An Integrated Approach to Promoting Community Revitalization

Terence Dunworth

About 70 years ago, John Dewey wrote a book called *The Public and Its Problems*.[1] Dewey was one of the foremost educational and social thinkers of this century, and the observations he made in his writings are perceptive and provocative. I first read this book about 25 years ago, and its timeless themes have stayed with me over the years. This book has been constantly on my mind during the 2 years that I have been involved in the national evaluation of Weed and Seed, because it directly focuses on the kinds of things that we have been considering in the evaluation—that is, issues that we have been discussing at this conference.

One of the main arguments in *The Public and Its Problems* is that the sense of community that existed at an earlier time eroded as the Western industrialized world developed. Dewey wrote that this erosion in the sense of community that people once felt has led to many of the problems that the public now faces. These problems are, of course: crime; social disorder; a loss of the sense of community and well-being; a decline in the sense of interdependence among people; and the idea that the future and the present are intermingled and that when things go well for a neighborhood they go well for you, and when they go badly for a neighborhood they go badly for you. The erosion of these concepts led to a sense of isolation for many people.

For me, Dewey's book illustrates something that I have come to believe since I have been involved in Weed and Seed. There is hardly anything, certainly no idea that I have had, that hasn't been said or written previously. Many of the ideas that we think are fundamental now in the discussions that we are having about Weed and Seed are in this book. In addition, I see them reiterated when you look at the relevant literature. When James Gibson gave his talk at the beginning of this conference, he summarized the actual responses and the interventions that have been made, particularly at the Federal level, focusing on this idea that communities are declining and that many are in a state of distress. He made the point that what he has seen in the 30 years that he has been involved in this field is a reinvention, a redeclaration, a rediscovery—he used many words beginning with "re." I am using the same "re" with respect to the ideas that we have. We are repeatedly expressing ideas that others developed previously.

If we buy into this notion that most of the ideas and most of the interventions have been tried before, and yet we still have distressed communities, we have to ask ourselves what we are doing. We have a national Weed and Seed effort trying to address these problems. How are we going to go about doing it? If we acknowledge that most of the interventions that we can think of have been tried before, then what is it that we can do that we think is different and that will accomplish things in the future that we haven't been able to accomplish in the past?

It is easy to become disheartened by this thought. But I am not, because I believe there are ways we can do things differently. Change is possible not so much in the area of the specific interventions but in the way we go about things. This is what I want to talk about today. Before I go on, I want to stress that my comments should not be construed as a criticism of the work that has been done, the ideas that have been expressed, or the interventions that have been undertaken in the past—some of which have been successful, some of which have not.

I want to suggest that we need to reorient the way we think about community revitalization and how we go about trying to achieve it.

There are two primary areas where I think it is possible to accomplish something. One of them is the structure and the organization of the effort that we want to make; the other area is how we assess whether or not that effort is having the effect we want it to have. The latter, of course, is what we have always referred to as research and evaluation. Over time, I have become somewhat disenchanted with these two terms because they imply an orientation toward finding out what works and what does not work that, in my opinion, has become outmoded and lost its utility. I will elaborate on that idea as I go along.

Structure and Organization

With respect to structure and organization, there are a few basic premises that must be emphasized. I don't mean that these premises have never been discussed before. I expect that most of you have thought about them yourselves. But I would suggest that we—and I include the Federal agencies as well as the research community—have not implemented these ideas effectively.

The first premise is that community revitalization must be approached strategically at the governmental level. A government program that focuses on a relatively narrow definition of the problem—with the definition of that problem being made at the Federal level—will not be effective. A community revitalization effort has to be strategic and has to embrace all of the issues that influence community revitalization. This means that at the Federal level, interagency cooperation and collaboration must occur in an overt and direct way. Communities will not be helped if the Department of Justice does its own thing, the Department of Education does its own thing, the Department of Labor does its own thing, and so on. Traditionally, however, our political system leads to that kind of orientation. It establishes turf boundaries between these different agencies, and these boundaries are difficult to break down. This is one of the reasons why our current ideas about intervention have probably been defined and attempted in some setting other than the one we are presently considering. What we have not done is develop the interventions in a strategic fashion, especially at governmental levels. I think that needs to change if we are going to make much progress.

The second premise with respect to structure and organization is that as we define community revitalization and think about the things we want to do, we must do so from the community up, not from the government down. The definition of the problem has to be at the community level, not at the Federal level. There has been a tendency in the past where the Federal agency involved essentially says:

> Uh huh, there is a problem out there. Here is the definition of that problem, and this is the solution we want to apply to it. We will do a couple of things to get local communities to embrace our solution. One is that we will throw money at them to get them to accept our approach. The other is that if they do not do it our way, then we will take the money back.

There has been an imposition from the Federal level to the community level not only with respect to the definition of the problem but also with respect to the approach to dealing with it. I think that has to change. I don't mean to imply that there are zero instances in which this already takes place. I know there are some. But there are not enough, and they are not systematic. The Federal Government and the Federal agencies involved need to embrace this notion overtly, start from the bottom up, bring community agencies and organizations into the planning process at the outset, and concentrate on strategic designs for community revitalization efforts.

This leads to another consideration: Community revitalization and the strategic design that should be undertaken with respect to it need to be multifaceted. This underlines the point I have been trying to make—that interagency coordination is a prerequisite because you cannot have a multifaceted approach unless you have different agencies participating collaboratively. This has to take place at *both* the Federal and local levels.

Another problem experienced in urban areas is that local politics with respect to these kinds of turf issues and interagency conflict can be destructive. The best intentions can be thwarted by the local political considerations that come into play. We have to find some way to deal with these issues and develop an integrated approach on the local level as well as the Federal level.

There is an implication behind these ideas that we often do not address well or think about much: If these considerations are true, then what is needed is diversity of approach. By that I mean that the approach to be undertaken in "jurisdiction A" may not be suited to the approach needed by "jurisdiction B." This confounds in some ways a fundamental principle of the Federal approach to these kinds of problems. For instance, those of you who have been around for some time will be familiar with phrases such as "programs of proven effectiveness" and "technology transfer." The idea embodied in these terms is that if you go out to a particular community, try a particular approach, and it works, then you have developed something that can be essentially lifted, taken somewhere else, and put down with the expectation that it will work in the same way. The actual practice of doing this has not produced much in the way of positive results. It would be a terrific concept if it worked, but it doesn't seem to work in practice very often. One of the reasons it does not is that the situation in the new place where this program is put down is, in fact, quite different than the one from which the program came, but the key ways in which this is so are not well understood. The point is that something entirely different has to be developed for this second jurisdiction. Locally focused strategic planning offers the hope of accomplishing this.

These ideas have enormous implications for every aspect of community revitalization and the funding stream. It suggests that having the same level of funding for "jurisdiction A" and "jurisdiction B" may not make sense because the problem and the context are different and so may require a different level of funding. It also implies that the mix of programs in this multifaceted approach may need to be quite different. Even if "jurisdiction B" has a problem that seems similar to the problem experienced in "jurisdiction A," an approach that works in the latter does not necessarily fit the former. It is the reason an intervention that seems to have positive results in one jurisdiction has disappointing consequences when transferred. I think this is because we have not properly understood the variation between local jurisdictions, and we have not defined local needs properly. This stems from the lack of orientation that I was talking about earlier.

Research and Evaluation

There are also research and evaluation imperatives that flow from these ideas that are quite different from the traditional approach that researchers and evaluators like myself have tended to take in the past. Loosely speaking, we are trained to follow the medical research model as closely as we can. We would like to randomize selection of participants in programs. We would like to have experimental and control groups. We would like to track things over a period of time and have a lot of information that we can compare from one place to another and from one time to another. In the end, with that orientation, the medical model promises a better chance of defining the actual impact and the outcome of a particular strategy and a particular intervention. I have lost confidence in the idea that this will work in the community revitalization world. I have not lost confidence in the idea that it can work in other kinds of contexts or that it can work with respect to a particular, relatively narrow intervention within a community. But I am arguing that the medical model of inquiry will not help us decide whether or not a particular community revitalization effort based on a particular strategy design for that jurisdiction is doing what we want it to do. Something different is needed. I will try to state some general parameters defining what that orientation ought to be.

First, one of the premises of the traditional approach that I was describing is that the evaluation and research component is of the stand-back type. We stand back here and look at you implementing an intervention, and we make our notes and observations, and at the end of your intervention we will say it did or did not work. We will do a process kind of orientation as well and say, "Well, the reason it didn't work is that they didn't do this or they didn't do that, or they didn't cover their bases," and

so on. I do not think that is good enough. What is going to be needed is for the research and evaluation component to participate intimately with the programmatic component from the beginning. I do not think there is any point in expecting research and evaluation to produce useful information about a community revitalization program unless participation of the research and evaluation people starts at the beginning. If you admit this, the nature of what comes next has changed because you are no longer the detached, objective observer. You get drawn into being a participant with the programmatic effort. This is the price, and it is a high price, that has to be paid for the orientation I am promoting. That price is that you lose objectivity and your independence, because you get drawn in and have a vested interest in the outcome. For example, as you are going along with this process, you become involved in midcourse corrections. You can say in conjunction with the program people—let's say after 10 percent of the time has gone by and 10 percent of the program has been implemented—that it looks like you are going in the wrong direction and maybe a change is needed.

If we are shooting an astronaut to the Moon and I am evaluating that program for its effectiveness, and I see when she is halfway there that she is going to hit Mars, not the Moon, what am I going to do? Can I stand back and say, "Boy, am I going to have a story to write when this is over," when that astronaut is on Mars but she ought to be on the Moon? Of course I am not going to do that. I am going to say that a midcourse correction must be made because we want this ship to go to the Moon, not to Mars. We need to do the same thing in respect to community revitalization. Once I start doing that, I am no longer a traditional evaluator. I've lost my independence and my objectivity. To me that no longer matters. I know it matters to many researchers and evaluators, and I understand that point of view. But to me it no longer matters because I want what I do to have an effect and to help the program. I view the role that we can play as researchers and evaluators to be one in which we will make a contribution to programmatic success in the present and not one that will only turn in a scorecard and maybe provide a guide to future programmatic design.

Many things will be affected by this change in orientation. The notions of technology transfer and programs of proven effectiveness are two of them. I do not look to them as being the primary outcomes of what we can do in the research and evaluation world. I also think that my orientation will produce outcome evaluations that are probabilistic rather than definitive. It will be "iffy." It will be extremely difficult to be definite about what the outcomes actually are and what one's own objectivity is with respect to them. Further, the timeframe for most interventions is probably unrealistic. To some extent, this is a Federal funding issue, a political issue, and it is of extreme importance. The timeframe that most Federal programs have in mind is 1 or 2 years at the most, occasionally a bit longer. Weed and Seed has had a 3- to 4-year timeframe. At the end of that time, an evaluation will be written, saying whether the program succeeded or failed. I am not sure that is even long enough to expect a community to start to turn around. How about a decade? How about 15 years? The problem with that, of course, is that your political capital may not last that long. This is a very difficult issue to deal with.

This suggests that not every distressed community is a candidate for community revitalization. There are some preconditions needed to determine whether a community can be turned around. These should be considered in the problem definition stage when the strategic orientation toward revitalization is being set up in a locally specific context. We should expect to find that certain communities that clearly are distressed to the point of needing intervention are nevertheless not likely to respond to the kind of interventions that can be mounted by programs such as Weed and Seed.

For example, the central tenet of Weed and Seed is that a community can be strengthened by reducing criminal activity and increasing social programs. This approach is likely to make a community more resistant to the resurgence of crime. Implicit in this view is the idea that long-term residence in the community is likely for a significant number of its inhabitants. It is through these residents that a community will revitalize itself. If, on the other hand, a troubled community is characterized by high turnover, with residents' objectives being to leave as

quickly as possible, then it is difficult to have confidence that the Weed and Seed approach can have much long-term effect.

I'll conclude by restating three main points. First, how things are organized at the Federal level is critical. The effort must extend beyond agencies, and it must be strategic. Second, the approach that we want to undertake must be communitywide. It must be a saturation model, multifaceted and community driven. We cannot impose anything from the Federal level. It has got to come from the bottom up. And third, we have got to have what we are calling a dynamic strategic assessment and feedback approach to research and evaluation where researchers like us participate from the very beginning and continue until the very end. We must be more than detached observers: We must be directly involved.

Note

1. Dewey, John, *The Public and Its Problems*, New York: H. Holt, 1927.

Community Crime Analysis

John P. O'Connell

Analyzing Crime in Our Communities

Community Crime Analysis

Analysis of community issues in relation to crime tends to examine the criminal and crime events as separate factors. Most headlines and political responses are reactions to changes in crime. If crime is up, we wring our hands and we speculate about associations between crime and unemployment, funding shortages for criminal justice system operations, illicit drugs, and the decay of social order. If crime is down, we congratulate ourselves and speculate about associations between crime and employment, programs for the criminal justice system, and the decline of the importance of illicit drugs.

A significant reason that criminal justice analysis is so focused on this type of "univariate" analysis is that opportunities for resources for new criminal justice data are scarce. We are excited if we can find a database that is complete, accurate, and timely. Even when we find a "good database," it is limited to a local or State criminal justice system that records data for only one part of the criminal justice system—such as reported crime, arrests, or correctional populations. We can count crime or criminals in prison, and we can even apply sophisticated models to this one dimensional view of crime, but we are not necessarily conversant with the nature of crime.

As important as U.S. Department of Justice intensive studies are, their impact is largely theoretical; they seldom have a direct impact on State or local policies, budgets, or programs. These reports are usually not timely and are of secondary interest to politicians and practitioners because they do not pertain to their particular community. Improvements in criminal justice analysis need to take place at the State and local levels of government, where crime and crime policy meet in the United States.

New Tools for Mapping Crime

Probably the best example of progress in crime analysis is the trend in police departments to move from crime pin maps to computerized geocoding of crime. Merging jurisdiction maps with crime and arrest data is transforming crime analysis from crime counts to assessments of types of crime in time and space. This "simple" expansion of our knowledge of crime is revolutionizing our concept of crime. New York City, Chicago, San Diego, Montgomery County, Maryland, and others using off-the-shelf mapping software know more about crime in their communities than they have ever known before. This hands-on knowledge is fundamentally changing police operations. Crime statistics are no longer limited to end-of-year summaries.

With the new computer software, precinct- and street-level reporting are changing how police deal with crime. District commanders are required to use changing profiles of crime in their progress reports and strategic plans. Precinct captains and shift commanders are required to review and comment on the previous day's crime maps. For the first time, officers in each new shift, as they hit the streets, know what happened during the previous shift.

As exciting as the computer-aided crime maps are, they are only the first step toward breaking out of the "counting" syndrome. Adding the two "real time" variables of time and location to crime analysis demonstrates that crime is not an isolated event. Police departments moving to real-time computerized crime analysis also are moving toward more proactive policing and depending less on reactive methods.

Analyzing Crime as a Non-Isolated Event, or Four Ways to Better Understand Crime in Our Communities

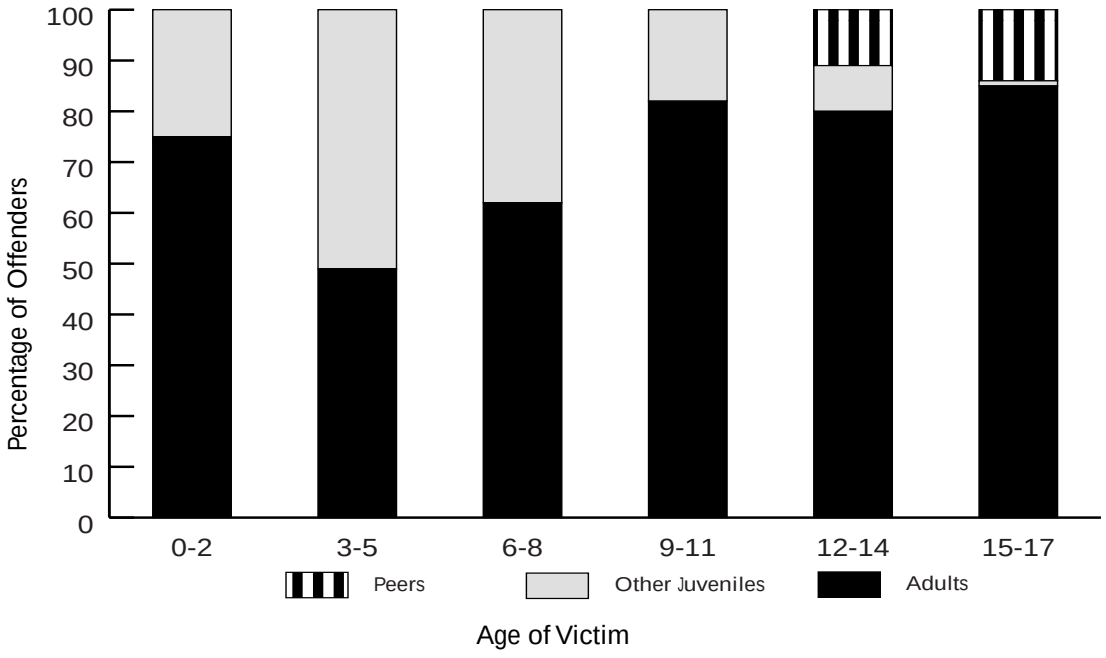
Crime is Not an Isolated Event: Crime Has Victims

Our understanding of crime and how to deal with it in our communities will improve as we conceptualize crime not only as something limited to criminals but also as a troublesome and tragic event for crime victims and communities. Expanding crime analysis to include victim-offender relationships is important for understanding crime in our communities. Two useful examples of victim-offender relationships are shown below.

Juvenile Crime Victims and Their Perpetrators: Felony Sexual Assault (see exhibit 1) shows the relationship between the ages of juvenile victims of felony sexual assault and the ages of the perpetrators. This analysis provides important information for both police investigators and social workers. Although there are proportionally fewer infant victims of felony sexual assault (compared with other age groups), the perpetrators in these cases are usually middle-aged males. Juveniles (under 18) raping juveniles becomes a significant problem when the victim is between 3 and 5 years old. Peer rape (i.e., juveniles raping juveniles of the same age) is not a major phenomena but is most likely to happen when both the victim and perpetrator are between 15 and 17 years old.

Criminal History Patterns for Victims and Perpetrators of Wilmington Shooting Incidents (see exhibit 2) shows a different aspect of victim-offender relationship studies. Shootings in Wilmington, Delaware, have increased significantly over the past 2 years, causing not only fear in the at-risk communities but also in the surrounding neighborhoods. An indepth study of the sudden change in firearm violence showed not only that shootings were associated with open-air drug markets but that the victims where almost as likely to be involved in prior drug sales, felony crime, and firearm activity as the perpetrators. While not diminishing the importance of the increase in shooting, the victim-offender

Exhibit 1. Juvenile Crime Victims and Their Perpetrators: Felony Sexual Assault



Source: Delaware Statistical Analysis Center, January 1998

relationship study helped pinpoint the fact that the increase was not random but was tied to a significant degree to the illicit drug trade.

Crime is Not an Isolated Event: Offenders Who Go to Prison Return to the Community and Often Recidivate

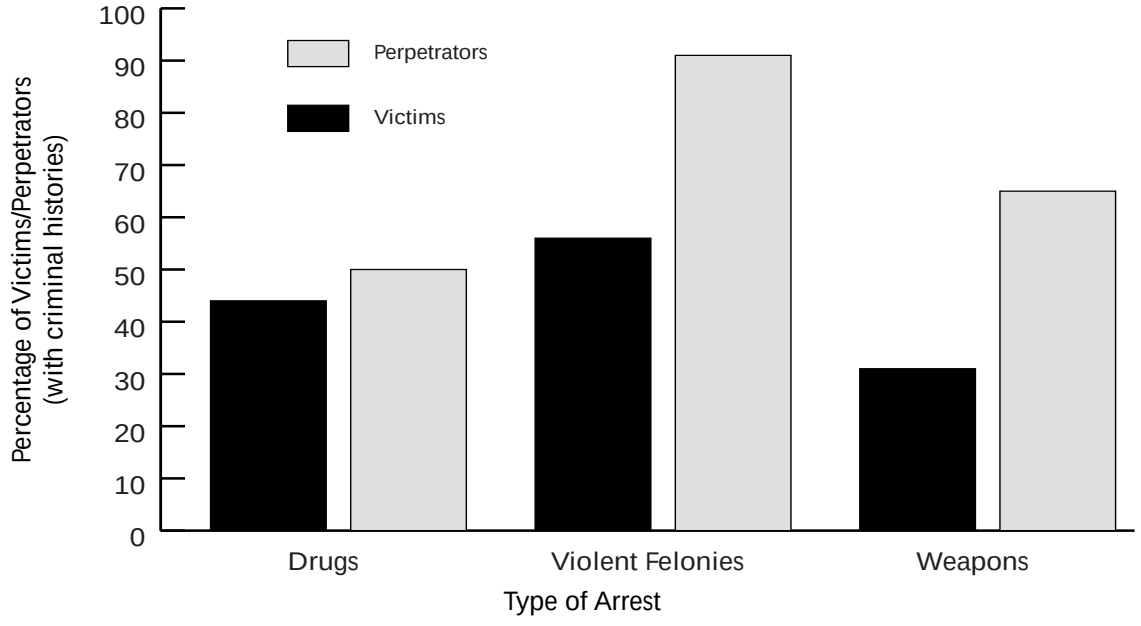
One of the solutions to crime has been to target those perceived to be the most dangerous and remove them from the streets for longer periods of time. Mandatory sentences and truth-in-sentencing laws, which require offenders to serve a minimum of 85 percent of their sentences, are two examples of this policy. These incarceration policies provide increased "specific deterrence" in that selected offenders are kept out of a community for a greater period of time. However, even these offenders eventually return to the community. A community may have "bought time" by keeping some of the worst offenders locked up longer, but when they return, the issues of rehabilitation and recidivism become the community reality. Can these offenders be successfully integrated into their communities? Currently, we know that 60 percent or more will be back in prison again within 5 years—after committing other serious crimes in the community.

New Castle County, Delaware: Locations of Department of Correction Inmates Released in Fourth Quarter, 1996, and *Wilmington: Locations of Department of Correction Inmates Released in Fourth Quarter, 1996* (see exhibits 3 and 4), show the relationship between the geographic dispersion of offenders returning to their communities and the location of important community rehabilitative services that can be key to their becoming constructive members of the community.

In the southern part of New Castle County, there are significant clusters of former Department of Correction inmates with few drug rehabilitation or social services located nearby. This represents reduced opportunities for rehabilitation.

In Wilmington, there appears to be a better association between the location of social services facilities and former inmates. The irony is, however, that the services may not be well used by former inmates despite the fact that they are located closer to them. In part, this may reflect how difficult it is to place offenders in services well matched to their needs.

Exhibit 2. Criminal History Patterns for Victims and Perpetrators of Wilmington Shooting Incidents



Source: Delaware Statistical Analysis Center, January 1998

Exhibit 3. New Castle County, Delaware:
Locations of Department of Correction Inmates Released in Fourth Quarter, 1996

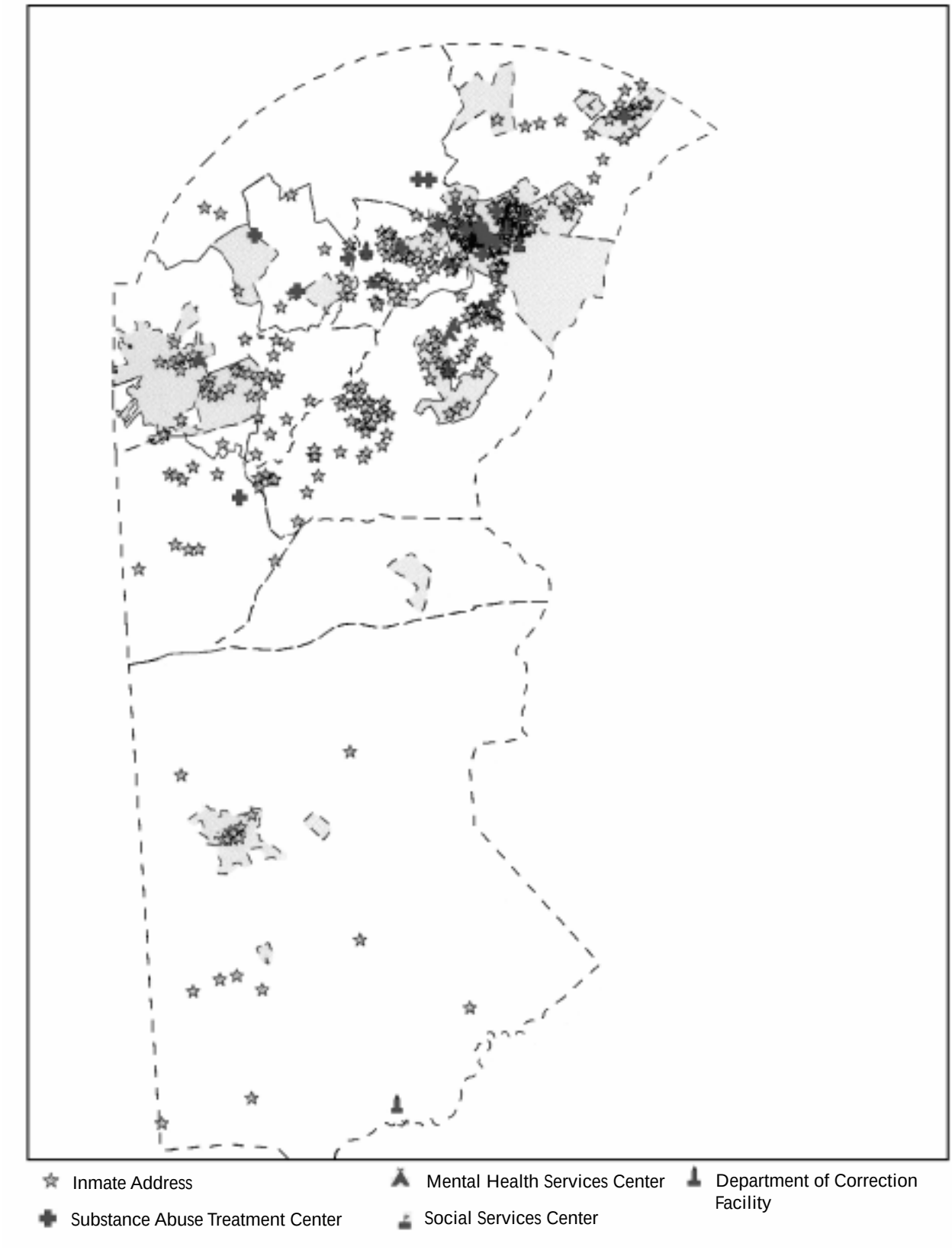
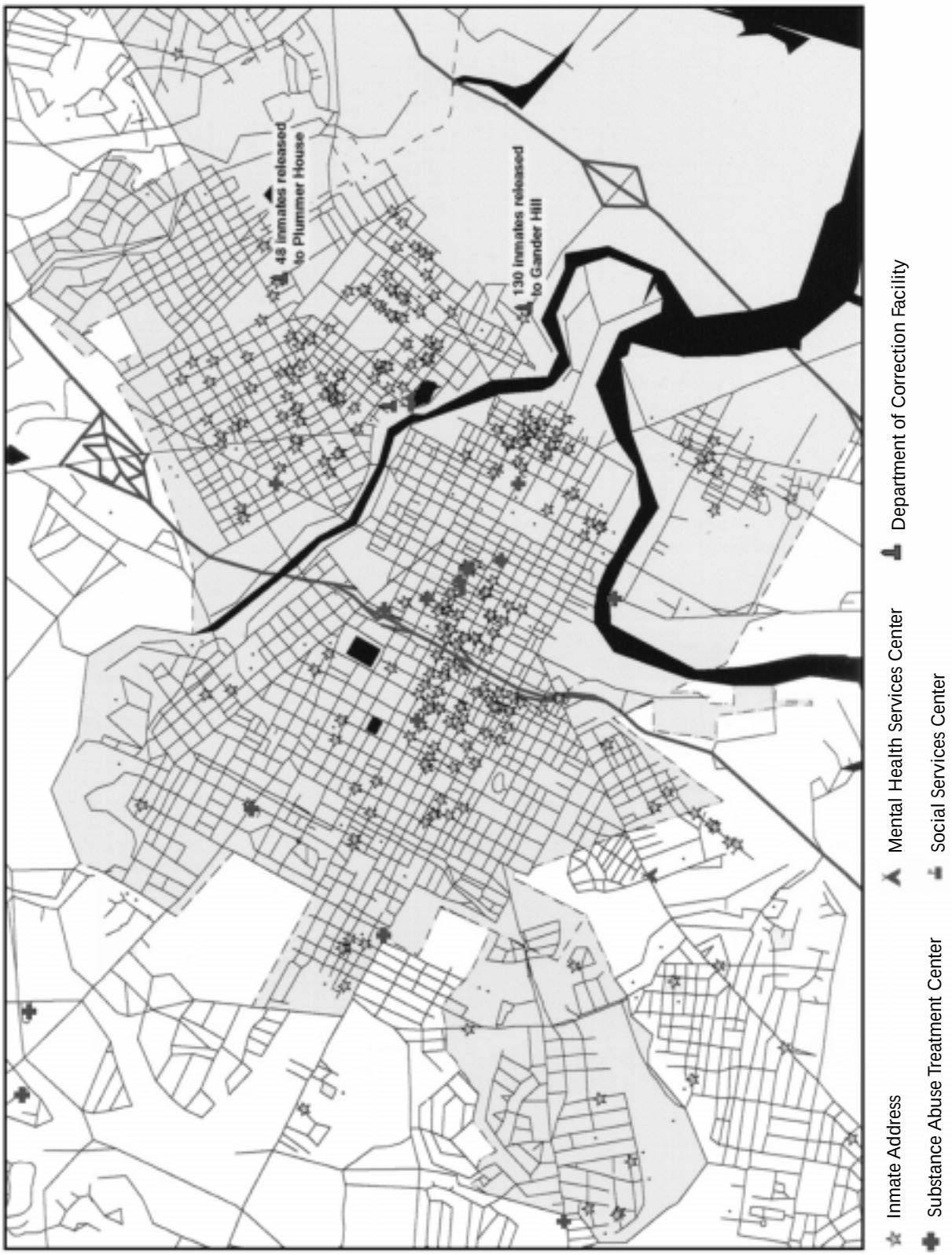


Exhibit 4. Wilmington:
Locations of Department of Correction Inmates Released in Fourth Quarter, 1996



Crime is Not an Isolated Event: Residents of High-Crime Communities Do Not Always Victimize Themselves

Delaware has been fortunate in that the U.S. Department of Justice (DOJ) Weed and Seed program has provided it with long-term program evaluation funds. In part, these funds have allowed Delaware and the city of Wilmington to build a crime database focusing on a "community at risk." From this database, new analyses are emerging that demonstrate different dimensions of crime in our communities.

An important finding from Delaware's Weed and Seed database is that at-risk communities are not having difficulty just because of internal problems. A significant portion of crime in Weed and Seed neighborhoods is committed by perpetrators who live outside the areas.

Journey to Crime: Weed and Seed Area Drug Arrests (see exhibit 5) shows that 45 percent of the persons arrested in Delaware's Weed and Seed neighborhoods for illicit drug sales and possession reside outside of the neighborhoods. Twenty percent of the arrestees live elsewhere in Wilmington, 16 percent live in suburban New Castle County or other counties in Delaware, and 6.5 percent are from other States (2.4 percent do not have a known address).

Taking into account the amount of crime committed by outsiders in at-risk neighborhoods creates a new policy issue. How would quality of life in a neighborhood improve if people from outside the area were somehow dissuaded from coming into these neighborhoods?

Crime is Not an Isolated Event: The Association Between Crime and Other Social Problems Needs Greater Exploration

Wilmington Shooting Incidents and Poverty-Level, Female-Headed Households With Children Under 18 (see exhibit 6) shows the association between shooting incidents and households headed by poor women in at-risk neighborhoods. The association between crime and such social indicators takes on stark reality when we see that many of our most vulnerable families live close to where shootings occur. Although there is an association between social indicators and crime, the meaning of this relationship is not well understood.

It is not uncommon to believe that low income, unemployment, lack of education, and families headed by single parents somehow result in crime. Arrest and sentencing patterns would indicate that this is true to some degree. However, will reducing the prevalence of such social indicators alone be a cure for crime? The fact that crime is more prevalent in our at-risk communities raises the possibility of a feedback or "interaction" effect; that is, the level of crime in at-risk neighborhoods is just as likely to be related to the mere presence of criminals, because they provide social interaction and examples that can influence those not involved in criminal behavior.

Two Federal programs may provide an opportunity to analyze community crime in a way that goes beyond merely counting, reporting, and emotionally reacting to crime. The first, the Weed and Seed strategy, addresses some of the issues raised in this paper. First you control crime, then you build programs that strengthen the community and enable it to resist crime—an approach that does more than just arrest and incarcerate criminals.

The second program, which is smaller in scale than the Weed and Seed program, is DOJ's Safe Streets initiative. This program also takes a comprehensive social approach to crime in at-risk neighborhoods. Not only is this initiative concerned with crime and social programs, it includes education, employment, child abuse, and child development as variables to be addressed and studied in an interactive manner.

Hindrances to Improving Crime Analysis In Our Communities

Bringing the Analysis to the Local Level

For crime analysis to be effective in communities, a significant change needs to take place. Today, except for a few efforts around the country, most

Exhibit 5. Journey to Crime: Weed and Seed Area Drug Arrests

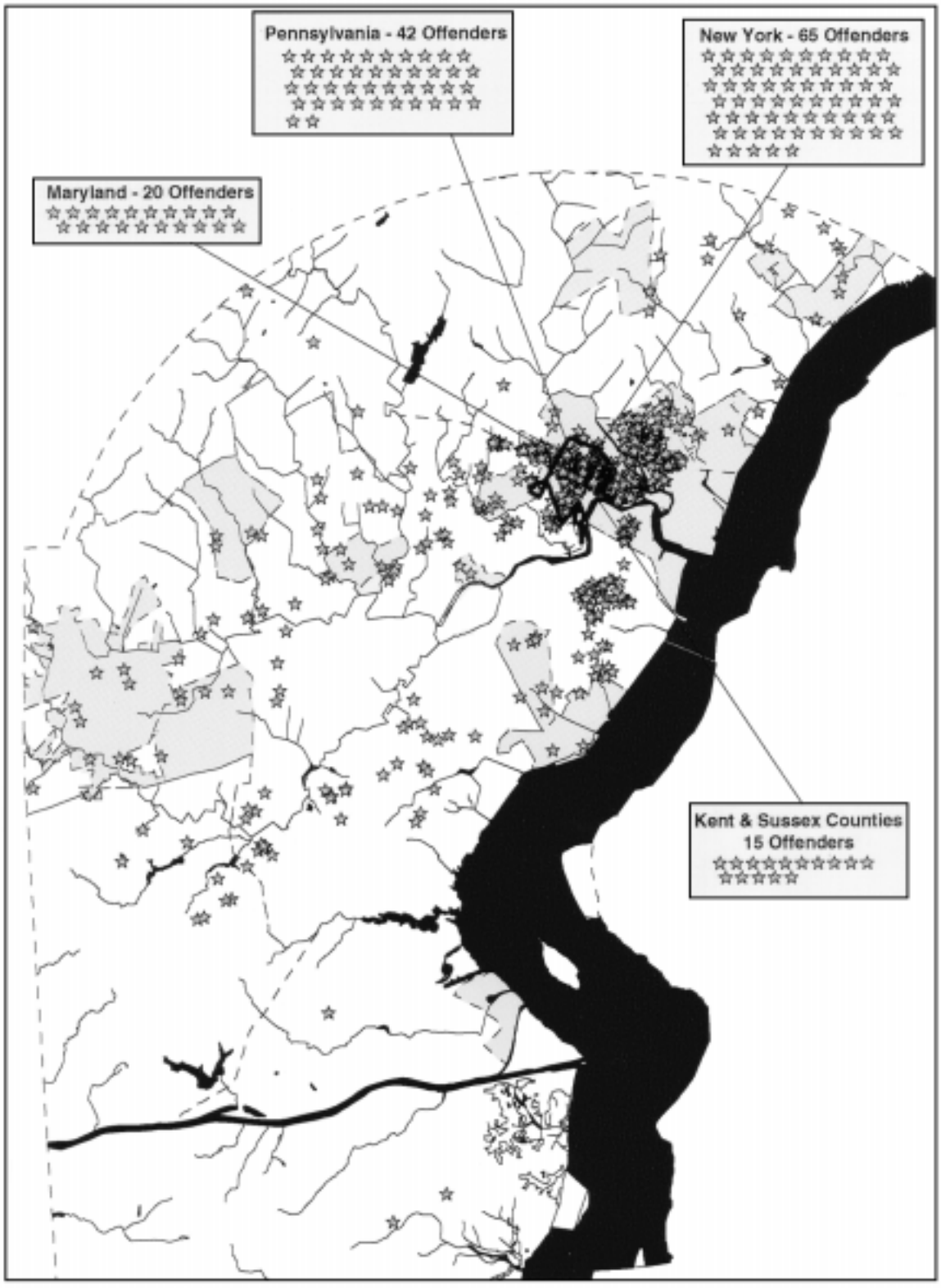


Exhibit 6. Wilmington Shooting Incidents and Poverty-Level, Female-Headed Households With Children Under 18

community crime analysis is limited to counting crimes and reporting change. This level of knowledge does not allow us to understand the cycle of crime and the best ways to break it. Policymakers' thinking is limited to believing that if crime is going up, you put more police resources on the job; if crime is going down, you declare success because the upward trend has changed.

Local analysis that goes beyond crime counting is recognized and embraced wherever it happens. Each step in expanding our knowledge of community crime sources and patterns will change our policy and programmatic points of view on better ways to address crime. The most striking example of this is computer-aided mapping of crime in communities. This single advancement of knowledge about crime in a community is causing a paradigm shift in how police recognize, deal with, and plan for crime. New methods of policing will no doubt change the way police and citizens interact.

In Wilmington, the methods described in this paper have affected policy regarding crime in communities. Community policing has a chance of being institutionalized because a decade of community crime analysis has shown neighborhoods with active community policing not only routinely reduce crime, but the citizens report a better sense of ownership and quality of life. Less crime in a neighborhood also seems to be a precursor of economic development.

Getting States and local communities to do this level of crime analysis requires a change in how criminal justice analysis and planning are viewed at the State and local levels. First, a research unit needs to have the authority to work with single or multiple jurisdictions across the State. The products of this State and local research unit need to be described to tactical and strategic decisionmakers. New knowledge is one of the ingredients of innovation. Without verifiable knowledge about the nature of crime, we will find ourselves falling back on the convenient emotional responses of fear, denial, and congratulations.

Lack of money and leadership to encourage the development of State and local community crime and policy analysis are the greatest limitations to better understanding crime in our communities.

Joining Criminal Justice Databases With Social Services Databases

DOJ's Safe Streets initiative is one of the first criminal justice initiatives that explicitly seeks to examine crime in our communities from more than just a criminal justice point of view. In this initiative, DOJ is expanding community crime analysis to include employment status, child abuse, and educational success as crucial variables to better understand crime in our communities.

Expanding criminal justice analysis beyond criminal justice statistics will help community criminal justice analysts move in the same direction as other Federal agencies that are studying harmful indicators in our communities. For instance, the Centers for Disease Control and Prevention has expanded public health research into the areas of victims of shootings and domestic violence, although traditionally these were solely in the criminal justice bailiwick. An advantage of cross-fertilization of criminal justice and noncriminal justice research methods is that the study of harm in our communities would be expanded. We would be able not only to understand crime from the criminal justice point of view but also to expand our perceptions to include the relationship of crime to family development, education, addiction, and economics.

Combining the traditional criminal justice study topics with the points of view of other disciplines, while potentially fruitful, will mean at least two technical changes. First, as we find the need to integrate criminal justice and social services databases, we will need to work through confidentiality requirements. Second, optimal analysis would allow us to commingle an individual's data from various disciplines. This will be problematic because all data systems have difficulty in positively identifying and tracking individuals. The problems of individual identification will increase significantly as we try to join databases.

What Do We Do Next? Research Questions and Implications for Evaluation Design

Jan Roehl

Overview

Because the roots of crime, fear, and disorder in communities are complex and intertwined, current and future programs to address these problems tend to encompass a variety of prevention and intervention strategies under the auspices of many actors and agencies. This paper advocates an emphasis on rigorous *process* evaluations of these "kitchen sink" programs, aimed at describing what has happened, where it has happened, what the immediate results are, and how others might best package these multifaceted approaches to effect positive community change.

Community Crime Prevention and Revitalization Efforts of the Future

Today, programs to decrease crime and revitalize communities tend to involve comprehensive and coordinated efforts to control crime and drugs and improve the quality of life. They combine the "best" prevention and intervention approaches of the past two decades with the recognition that the causes and solutions of crime and community problems are interconnected and are best addressed on multiple fronts with extensive involvement from many community institutions. Examples of these "kitchen sink" programs—which at times seem to include every strategy known—are the U.S. Department of Justice's Weed and Seed and Comprehensive Communities programs, the Center for Substance Abuse Prevention's Community Partnership Program, the Robert Wood Johnson Foundation's Fighting Back program, and many comprehensive efforts launched locally (see, for example, Clarke, 1992; Davis and Lurigio, 1996; Green, 1996; National Crime Prevention Council, 1992; Roehl et al., 1995a; Weingart et al., 1993).

The main characteristics of these programs are partnerships among the community, police, city agencies, the private sector, and others; problem solving to address specific problems and problem places; an emphasis on prevention; and efforts to increase community capacity building and citizen empowerment for problem solving. The specific strategies applied are many and varied, ranging from primary prevention efforts targeted to young children to intense drug enforcement efforts by the police. Some of these programs, notably Weed and Seed, also encompass macrostrategies such as economic development and community health care. The "leader"—the sponsor, catalyst, grant recipient, etc.—varies from city to city and may be the police department, a community organization, a nonprofit group, or a city agency.

These "kitchen sink" programs may include other strategies popular today, such as place-based research (Eck and Weisburd, 1995), community policing efforts (Rosenbaum and Lurigio, 1994; Goldstein, 1993), and school- and family-based prevention programs (Sherman et al., 1997). Many problem-solving and civil remedy strategies focus on specific locations—in Weisburd's (1997) view, crime reduction might be more effective if it focused on the criminal history of a place rather than an individual.

Recent reports suggest that these types of partnership-based, multifaceted programs will continue to flourish. A recent monograph on innovative State and local programs to revitalize communities, for example, presents case studies of 24 current programs (Bureau of Justice Assistance, 1997). Of the 24 programs, about half are com-

munitywide partnerships with multiple strategies underway; one-third are prevention/intervention programs for youths (alternative schools, role modeling, etc.); two programs are civil abatement oriented; and three programs offer, respectively, an offender work program, a domestic violence program, and antigang efforts through a task force. The common themes of these programs are partnerships, multiple intervention strategies at the neighborhood level, prevention, problem solving through nuisance abatement, interventions with delinquents and offenders, and targeted law enforcement.

In Sherman et al.'s (1997) report on "What Works, What Doesn't, and What's Promising" in crime prevention, the authors conclude that seven institutions—communities, families, schools, labor markets, places, police, and criminal justice—are interdependent in affecting crime at the local level. They promote the study of programs that invest simultaneously in these multiple institutions, such as the Weed and Seed program. While Sherman et al. advocate more rigorous study of innovative programs with adequate scientific controls for the careful study of program effectiveness, they also suggest that more support is needed to "learn **why** some innovations work, exactly **what** was done, and **how** they can be successfully adapted in other cities" (p. xii).

The key variable in designing evaluations for "kitchen sink" programs is that the *unit of analysis is the community* or neighborhood. For any form of evaluation research, we need to usefully define community; such a definition would go beyond outlining its physical characteristics and boundaries to encompass the cultural, social, and political factors that define community. The community as the unit of analysis has far-reaching implications for evaluation design.

Research Questions

The global research question for programs that aim to decrease crime and revitalize communities is whether they result in a safer, better community. Measuring "safer" and "better," of course, is the challenging task. I suggest that the key questions should be whether the communitywide programs make a positive difference, at the neighborhood level and over time, in:

- The quality of community life, measured by residents' and businessowners' satisfaction with their neighborhood, fear of crime, level of problems (e.g., drugs, incivilities, trash), and physical character (e.g., vacant buildings).
- Crime and delinquency.
- The social character of the neighborhood (e.g., informal social control, empowerment of residents, and the organizational capacity of community organizations).
- Economic vitality (e.g., unemployment, Aid to Families With Dependent Children levels, need for subsidized housing, property values).
- The stability of the neighborhood.
- Citizen satisfaction with the police, based on principles of procedural justice (e.g., fairness, trust, respect).

One of the problems faced by evaluators is the lack of data easily available at the neighborhood level. Existing indicators of change—for example, truancy or unemployment figures—are rarely available for defined areas such as neighborhoods. Even with the growing adoption of sophisticated mapping capabilities, data on reported crime, calls for service, etc., remain costly and difficult to get at the neighborhood level.

Implications for Evaluation Design

In a recent solicitation for evaluations of programs funded under the 1994 Federal crime bill released by the California State Office of Criminal Justice Planning (OCJP), the proposal requirements include the following: "Proposals must demonstrate a balance between rigorous research and evaluation methodology and usefulness to customers, stakeholders, and policymakers" (OCJP Request for Proposals, December 5, 1997, p. 5).

This requirement implies that one cannot have it both ways and extends the commonly held belief that "rigorous" pertains only to *impact* evaluations, not to process evaluations. I contend that one *can* have it both ways, with rigorous process evaluations producing a wealth of infor-

mation useful to customers, stakeholders, and policymakers. A rigorous process evaluation will describe in detail, using multiple qualitative and quantitative measures, program implementation, daily operations, management, strategies and services, actors and agencies involved, and immediate outcomes.

To answer the multiple research questions sketched out above is to ask the single, classic evaluation question: What works where? My focus is first on *what* and second on *where*, partly because others will argue strongly for a focus on *works* and propose an emphasis on impact evaluations with experimental designs. But mostly my focus on what and where stems from strong beliefs that process evaluations are most needed to meet the goals of *usefulness* and that the most rigorous impact evaluations we can hope to implement with available funds will always leave open questions of attribution, displacement, and measurement bias.

Recent crime reduction efforts serve as illustrations of the need for process evaluation. In New York City, dramatic decreases in reported crime have been attributed by former Commissioner William Bratton to police actions. These police actions, primarily reported in the media, apparently included "results-oriented management" and a focus on petty crime and youth offenders. For the most part, however, we don't know exactly what was done there, and many are skeptical of reported crime outcomes and/or that police action caused them. Until recent journalistic accounts by Bratton (1998) and Kelling and Coles (1996), no written documentation on the strategies or their outcomes was available. Without a process evaluation, details on what took place—positive and negative—are scarce. Jurisdictions desiring to emulate the New York City model must contract with Bratton's new consulting firm to get this assistance.

Community policing has been in full flower for nearly a decade. There has been much debate about what it entails, whether it is effective, how the community and others are involved, and how it is best managed and operationalized. While there is general acceptance that two dominant characteristics of community policing are partnerships and problem solving (Bureau of Justice Assistance, 1994; Roberg, 1994), we are still arguing about what it is and what it is not. Only a handful of studies address what community police officers "do" while they are doing community policing (e.g., Wycoff and Oettmeier, 1994; Capowich and Roehl, 1994; Mastrofski et al., 1998).

A final, positive example of the need for process evaluation is the Weed and Seed program. The Weed and Seed program was launched in 1992 with funding to 19 cities to implement the multifaceted programs focused on weeding (intensive arrest and prosecution), community policing, and seeding (prevention, intervention, and treatment and neighborhood revitalization). Today, as many as 120 cities have been funded or officially recognized as Weed and Seed sites. Yet the national impact evaluation is just reaching completion today, as scheduled, nearly 6 years after the start of the program. The belief in the value of the Weed and Seed approach may be partially attributed to the findings of the national process evaluation, which produced both an interim report (Institute for Social Analysis, 1993) and summary, cross-site, and case study final reports (Roehl et al., 1995b, 1996).

What We Do Next: Rigorous Process Evaluation

Process evaluation (also known as implementation evaluation and program monitoring) has always been considered an integral part of comprehensive program evaluation. It is clear that such studies "are essential to understanding and interpreting impact findings. Knowing what took place is required in order to explain or hypothesize why a program did or did not work" (Rossi and Freeman, 1993). In short, it is useless to know whether something works or not if you do not know what that something is. Process evaluations also serve to strengthen impact results concerning theory versus program failure: If no or negative impact was observed, was it due to a wrongheaded program theory or to weak implementation?

Process evaluation can also serve independently as program assessment, providing information regarding its form, scope, and value to practitioners *and* to policymakers considering adoption and/or expansion of the program. A broad view of process evaluation is needed in which comprehensive process evalua-

tions include rigorous, unbiased measurement and the assessment of immediate and short-term outcomes. Process evaluations need to include baseline measures, prepare for future impact assessments, and fully understand the program or policy being implemented. The line between process and impact evaluation *should* be blurred. Comprehensive evaluations should include multiple measurements over time—before, during, and after the major program interventions are in place—to tap community perceptions and neighborhood changes. In essence, comprehensive process evaluations should be pre/during/post studies with rigorous, multiple assessments in one site, with no control or comparison group. They should begin when the program is merely a gleam in an agency's eye.

It would be foolhardy to suggest that rigorous impact evaluations are not needed, but given "kitchen sink" programs with the community as the unit of analysis, impact results will always be disputed. No matter how rigorous the design—with matched comparison neighborhoods, surveys in all experimental and comparison neighborhoods with randomly selected respondents, crime mapping, etc.—there will always be questions of attribution. Even if random assignment of programs to communities could be achieved (a tall order), matches between communities will never be perfect, and impact methods provide few ways to determine which facets of these multifaceted interventions can be linked to specific outcomes.

With crime mapping, researchers are beginning to hone in on displacement, even in place-based research. Yet I argue that displacement is more a mark of success than failure, and spending precious research dollars on its measurement may be unwarranted in some situations. In the simplest example, in recent years many problem-solving efforts within urban communities have focused on eliminating crack houses. Process evaluation will indicate how the crack house problem was tackled, whether the crack house remains active or not, and whether the community partnership and capacity-building efforts are enough to keep the problem at bay. If the crack house is gone, the problem-solving activities can move on to the next crack house or neighborhood.

Process evaluations, however, do need to be more useful and rigorous than many currently are. Rigorous process evaluation methods should include:

1. New, improved, and cost-effective methods to tap community perceptions. Community surveys, whether by phone or in person, are increasingly difficult to implement, particularly in high-crime, distrustful communities. Yet the community's perceptions are critical, and the following should be considered:

   a. The use of computerized telephone systems for quick, frequent surveying. Oakland, California, for example, has installed a new system to automatically send messages to households; other cities have similar systems for the relaying of neighborhood watch messages. Oakland's system can be used for computerized surveying, with residents responding to multiple choice items with touchtone phones.

   b. The use of small group methods, such as key informant surveys, community leader interviews, and focus and discussion groups. Additional research is needed on the relative cost, value, and results of such techniques compared with traditional community survey methods.

2. Unobtrusive measures. Most of our traditional measures—surveys, focus groups, calls for service, reported crime, etc.—are subject to errors of measurement, reactivity, and bias. We need to develop and test innovative measures for assessing changes in crime, drug problems, and neighborhoods.

   One form of unobtrusive measures currently in use in community-based and place-based research (Mazerolle et al., in press; Taylor, 1997) is the objective observation and measurement of social and physical changes in the neighborhood, including the licit or illicit use of public places, graffiti, trash, and level of paraphernalia. These measures are worthy of further use and study. Additional unobtrusive measures to consider include hair analysis through anonymous collection by barber shops and beauty salons to assess community drug use over time and the use of traditional attitude measurement devices such as the lost letter technique.

3. The routine collection of process data in a standard manner in cross-site process evaluations. Within a strong case study design with multiple measures over time, numerous methods of data collection should be used, including stakeholder interviews, collection of program documents, interviews with residents and businessowners, observation of program events, collection of routine process data (level of services, numbers of target groups reached, etc.), and collection of routine impact data on immediate outcomes (see below).

4. Immediate and short-term outcome assessments. These outcomes—for example, the closing of a crack house—may be considered process or impact measures, but I argue firmly that they belong in rigorous process evaluations. They serve to assess program coverage and the potential for longer term impact. In the Weed and Seed program, for example, the process evaluation reported the number of arrests in the program's first year and the status of their prosecution—necessary immediate outcomes before the successful impact of weeding can reasonably be expected—and the funding, types, and levels of seeding activities—necessary to know before the impact of seeding can be judged.

5. Timely reporting of process results. Swift reporting of process information, preferably on an interim basis accompanied by review and comment by program staff and policymakers, is needed.

The Federal Role

Federal agencies, particularly those within the Office of Justice Programs, have been very supportive of evaluation research in the past decade. As any researcher is likely to do, I advocate increased funding for evaluation, particularly increased support for process evaluations. The tendency over the past decade has been toward rigorous impact-oriented experimental designs—applying the designs of the laboratory to field research—which, as I have argued in this paper, are not easily applied to community research, nor do they guard against ongoing questions about "kitchen sink" programs and their effects.

In addition to funds, the Federal Government has much to offer in developing evaluation methods and measures and providing technical assistance to communities in evaluation research. For national, multisite programs such as Weed and Seed and Comprehensive Communities, I suggest that a national evaluation model be implemented. Under this model, coordinated Federal support would be provided to national and local evaluators. The local evaluations would be given substantial onsite research support for data collection, and they would be conducted under the guidance of a national evaluator and advisory board. The national evaluator would develop common instruments and procedures; validate local data collection; provide assistance in evaluation methods and local customization; and complete cross-site data collection, analysis, and reporting. Such a national evaluation model leads to routine, standard data collection and improved cross-site comparisons for both process and impact evaluations as well as enabling local sites to get the information they need.

Finally, useful evaluation research must be produced and disseminated in a timely manner. Process results can guide local programs in fine-tuning and redirecting their efforts and provide information to policymakers concerning expansion, replication, and support. The Federal Government can assist this process by supporting rapid dissemination through electronic and print media.

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Appendix A

Author Biographies

Alfred Blumstein, Ph.D., is J. Erik Jonsson University Professor of Urban Systems and Operations Research with the H. John Heinz III School of Public Policy and Management at Carnegie Mellon University in Pittsburgh, Pennsylvania.

Roger L. Conner is Executive Director of the Center for the Community Interest, which has offices in Washington, D.C., and New York, New York.

Terence Dunworth, Ph.D., is Managing Vice President of Abt Associates Inc. in Cambridge, Massachusetts.

Amitai Etzioni is the first University Professor of The George Washington University and is the editor of *The Responsive Community: Rights and Responsibilities*, a communitarian quarterly.

Jack R. Greene is Director of the Center for Public Policy at Temple University in Philadelphia, Pennsylvania.

David Kennedy is Professor at the John F. Kennedy School of Government at Harvard University in Cambridge, Massachusetts.

John P. O'Connell is the Director of the Delaware Statistical Analysis Center in Dover.

Deborah Prothrow-Stith, M.D., is Associate Dean of Faculty Development and Professor of Public Health Practice, Harvard School of Public Health, Harvard University, in Boston, Massachusetts.

Jan Roehl, Ph.D., is President of the Justice Research Center in Pacific Grove, California.

Lawrence W. Sherman, Ph.D., is Professor and Chair of the Department of Criminology and Criminal Justice at the University of Maryland in College Park.

Bailus Walker, Jr., Ph.D., M.Ph., FACE, is Director of the Health Policy Program with the Joint Center for Political and Economic Studies and is Professor of Environmental and Occupational Medicine at Howard University Medical Center, both in Washington, D.C.

Cicero Wilson is a former Senior Research Associate with the Institute for Families in Society at the University of South Carolina in Columbia. He now resides in Atlanta, Georgia.

Robert L. Woodson, Sr., is President of the National Center for Neighborhood Enterprise in Washington, D.C.

U.S. Department of Justice
Office of Justice Programs
810 Seventh Street N.W.
Washington, DC 20531

Office of Justice Programs
World Wide Web Site
http://www.ojp.usdoj.gov

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SUPPORT AND PARENTING TIME ENFORCEMENT ACT (EXCERPT)
Act 295 of 1982

552.642 Makeup parenting time policy; establishment; approval; provisions of policy; notice; response; procedures.

Sec. 42. (1) Each circuit shall establish a makeup parenting time policy under which a parent who has been wrongfully denied parenting time is able to make up the parenting time at a later date. The policy does not apply until it is approved by the chief circuit judge. A makeup parenting time policy established under this section shall provide all of the following:

(a) That makeup parenting time shall be at least the same type and duration of parenting time as the parenting time that was denied, including, but not limited to, weekend parenting time for weekend parenting time, holiday parenting time for holiday parenting time, weekday parenting time for weekday parenting time, and summer parenting time for summer parenting time.

(b) That makeup parenting time shall be taken within 1 year after the wrongfully denied parenting time was to have occurred.

(c) That the wrongfully denied parent shall choose the time of the makeup parenting time.

(d) That the wrongfully denied parent shall notify both the office of the friend of the court and the other parent in writing not less than 1 week before making use of makeup weekend or weekday parenting time or not less than 28 days before making use of makeup holiday or summer parenting time.

(2) If wrongfully denied parenting time is alleged and the friend of the court determines that action should be taken, the office of the friend of the court shall send each party a notice containing the following statement in boldfaced type of not less than 12 points:

"FAILURE TO RESPOND IN WRITING TO THE OFFICE OF THE FRIEND OF THE COURT WITHIN 21 DAYS AFTER THIS NOTICE WAS SENT SHALL BE CONSIDERED AS AN AGREEMENT THAT PARENTING TIME WAS WRONGFULLY DENIED AND THAT THE MAKEUP PARENTING TIME POLICY ESTABLISHED BY THE COURT WILL BE APPLIED.".

(3) If a party to the parenting time order does not respond in writing to the office of the friend of the court, within 21 days after the office sends the notice required under subsection (2), to contest the application of the makeup parenting time policy, the office of the friend of the court shall notify each party that the makeup parenting time policy applies. If a party makes a timely response to contest the application of the makeup parenting time policy, the office of the friend of the court shall utilize a procedure authorized under section 41 other than the application of the makeup parenting time policy.

History: 1982, Act 295, Eff. July 1, 1983;—Am. 1985, Act 210, Eff. Mar. 1, 1986;—Am. 1996, Act 25, Eff. June 1, 1996;—Am. 2002, Act 568, Eff. Dec. 1, 2002.

Shelterhouse
SERVE • HEAL • EMPOWER

March 31, 2023

Michigan House of Representatives
Sub-committee on MDHHS Budget

RE: Written Testimony for Domestic Violence and Sexual Assault General Funding

My Name is Denise Berry and I am a retired Army veteran, military sexual assault survivor, and executive director of Shelterhouse of Midland and Gladwin Counties.

Shelterhouse is a comprehensive domestic violence and sexual assault shelter and services center. Our mission to serve, heal, and empower. In the most basic terms, our mission is to save lives of victims of domestic and sexual violence, a problem that is far too pervasive in Michigan.

We know that nationally, approximately 1 in 3 women and 1 in 4 men have experienced some form of domestic violence and about half of all women and 1 in 3 men have experienced sexual violence. Each year we answer approximately 5,000 crisis calls and serve 1,000 people come through the doors of Shelterhouse. What is significant about those numbers is that these are just the people who reach out. We know that domestic violence and sexual assault are both severely underreported. It is estimated that 50% of domestic violence and 63% of sexual assaults go unreported.

In these last three years, Shelterhouse maintained our services uninterrupted during the COVID-19 pandemic, but the cost has been tremendous – both financially and on a human level. One crisis after another in so many different sectors of our communities increased the calls for help and made serving victims (or who we call survivors) more difficult.

I submit this testimony to ask this committee and the state of Michigan to invest in saving lives – saving victims of domestic and sexual violence across the lifespan who in many cases become homeless, lose their children, lose their jobs, experience food insecurity, lose their sense of safety, and in many cases ultimately lose their lives to the violence.

In 2020, the United Nations Office on Drugs and Crime Report noted that a woman or girl is killed every 11 minutes by an intimate partner or family member. In the United States, in 2020, more than 3 women were killed by their husbands/boyfriends every day (Emory University).

Our agencies across the state are serving as many people as we can with the resources we have – but they are just not enough. Shelterhouse is one of the well-funded programs, and we have deep gratitude for the extremely generous community support we receive. Of our $3.5m budget, approximately 62% comes from state and federal funds, the rest is private support; however, it is still not enough.

Shelterhouse (Council on Domestic Violence and Sexual Assault)
2500 Waldo Ave. | Midland, MI 48642
Crisis Help Line: 877-216-6383 | Business: 989-835-6771 | Fax; 989-835-7449 info@shelterhousemidland.org |
www.shelterhousemidland.org | @shelterhousemidland

Michigan's SERVICE TO SURVIVORS OF VIOLENCE ACROSS THE LIFESPAN

The recent history of repeated funding reductions for service providers has created an existential threat for Fiscal Year '24.

To mitigate the impact, MCEDSV combined its advocacy efforts with the Child Advocacy Centers and Tribal service providers to request a first-of-its-kind appropriation for Michigan survivor services.

The total request is for $30 million in funds for direct services, capital improvements, administration, technical assistance, civil legal services, and nonprofit management.

A Breakdown of the Numbers:

For direct services, capital improvements, and administration

- $12 million to DV & SA programs
- $12 million to Child Advocacy Centers

For civil legal services for survivors:

- $3 million to legal aid providers

For support, administration, training, and technical assistance:

- $1 million to MCEDSV
- $1 million to Uniting Three Fires Against Violence
- $1 million to Child Advocacy Centers of Michigan

Predictable, stable funding is the problem; not a “one-time cut.”

VOCA Administration and Budgeting:

- Division of Victim Services (DVS) is administrator of VOCA funds in Michigan
- The VOCA cut is a result of a diminished federal fund due to non-prosecution of crimes and collection of fines
- The state had added additional requirements over federal requirements, which has added to the administrative and reporting burden without an increase in funds to cover those requirements (unfunded mandate)
- The VOCA DV/SA split was not federally mandated, it was an MDHHS decision; having one pool of funds would be more beneficial to survivors

Current Budget Recommendations from the Government:

- $4.5M for the crime victim's fund, 80% of which goes to the prosecutor’s office (this is not VOCA and also funds SANE programs and direct payments to victims)
- $<4M as a "VOCA Cushion", which does not fill the gap for programs

Comparisons:

- Ohio just announced $20M in general funds for DV services annually
- Collectively, five other Great Lakes states budget over $80m in GF dollars for DV and SA

Additional funding issues:

- Trials and sentencing are backlogged due to COVID and fines are down; also fines for people in poverty with minor infractions related to their situation provide an additional burden to marginalized communities; having less money in assessed fines keeps the VOCA-funded balance down
- By statute, tribal and culturally-specific programs are not given access to VOCA-comprehensive dollars, which is inequitable and hurts survivors; this needs to change

Contact with Capitol Services:

Stephanie Glidden | sglidden@capitolservices.org | 517.372.0860

Prepared by the Michigan Coalition to End Domestic and Sexual Violence (MCEDSV)

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Last year we had to refer out or turn away over 650 people seeking services; whether it was because our shelter was full or we didn't have the staff capacity to serve them. Our turnover rate was over 50% last year because we are unable to pay our personnel competitive wages and the workload seems to increase each day, which has led to burnout and people leaving the field of work altogether. We struggle mightily to meet service demand at times.

Not only are wages a problem, but we all know the cost of everything keeps increasing while private giving is going down as the economy shows signs of recession, markets continue to fluctuate, and now banks are failing.

The current grant funding models are also so restrictive it's like fitting a square peg in a round hole. Our administrative burdens and expenses increase, yet our funding does not. Our need for capital improvements increases as shelters and other facilities age and fall apart, yet funding is not available. Our requirement to serve certain types of crime victimizations with certain types of funding and the allowable expenses never fully matches the people and their needs who walk through the door, so we are left to find other means. Many agencies and their staff have been barely hanging on for a long time and now we are at a crossroads.

In 2021, we were made aware of impending cuts to Victims of Crime Act funding. We were given an approximate of 35% at the time, so we immediately started planning what that would mean for our agency. Shelterhouse receives a little over $1m in VOCA funding among our three programs each year. A 35% cut would reduce us to the point where I could have to eliminate all seven of my licensed mental health counselor positions (because that is not a required service of the contract), reduce the rental and utility assistance to transitional supportive housing clients in half, and reduce the allocation or bring to part-time status 14 additional staff, given that we were unable to increase private support to make up the gap. That impacts approximately 46% of my staff.

A cut of this magnitude, really any cut, would destabilize my agency and would close other programs around the state. Survivors will be harmed without a clear commitment for their safety going forward.

Ultimately, while an impending cut for FY24 would be devastating across the state, a failure to commit to a long-term, stable funding plan will cost lives. Collectively, 5 other Great Lakes states invest approximately $80m in general fund dollars for DV and SA. Ohio just set aside $20m for DV alone.

I've heard there is a perception that DV/SA agencies are flush with COVID-based funds, this simply isn't the case. While there has been some relief with these one-time infusions, again the restrictions of how the money could be used and its limited time frame provided us with temporary stop gap abilities to deal with the exact situation we were facing at the time and doesn't address the ongoing needs. I believe it was last year when DV shelters were shut out of dollars for capital improvement projects that were allocated to homeless shelters around the state.

The $3.4m in the Governor's proposed budget that is supposed to make up the VOCA shortfall is not enough to stabilize programs. We are already behind and some programs are one emergency away from closing their doors – not because of mismanagement or lack of planning – but because

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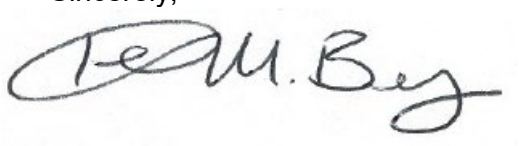
there has never been a predictable, stable investment in the lives of domestic violence and sexual assault survivors across the lifespan and the agencies who serve them.

We acknowledge the work of the Division of Victim Services to administer our agencies' grants and look forward to collaboratively working together well into the future.

On behalf of my sister agencies serving victims of crime, I hope you consider the general funds proposal put forth by the three coalitions.

Sincerely,



Denise M. Berry
Executive Director

Shelterhouse (Council on Domestic Violence and Sexual Assault)
2500 Waldo Ave. | Midland, MI 48642
Crisis Help Line: 877-216-6383 | Business: 989-835-6771 | Fax; 989-835-7449 info@shelterhousemidland.org |
www.shelterhousemidland.org | @shelterhousemidland

JAMA Pediatrics | Original Investigation

Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample

Associations Across Adverse Childhood Experiences Levels

Christina Bethell, PhD, MBA, MPH; Jennifer Jones, MSW; Narangerel Gombojav, MD, PhD; Jeff Linkenbach, EdD; Robert Sege, MD, PhD

IMPORTANCE Associations between adverse childhood experiences (ACEs) and risks for adult depression, poor mental health, and insufficient social and emotional support have been documented. Less is known about how positive childhood experiences (PCEs) co-occur with and may modulate the effect of ACEs on adult mental and relational health.

OBJECTIVE To evaluate associations between adult-reported PCEs and (1) adult depression and/or poor mental health (D/PMH) and (2) adult-reported social and emotional support (ARSES) across ACEs exposure levels.

DESIGN, SETTING, AND PARTICIPANTS Data were from the cross-sectional 2015 Wisconsin Behavioral Risk Factor Survey, a random digit-dial telephone survey of noninstitutionalized Wisconsin adults 18 years and older (n = 6188). Data were weighted to be representative of the entire population of Wisconsin adults in 2015. Data were analyzed between September 2016 and January 2019.

MAIN OUTCOMES AND MEASURES The definition of D/PMH includes adults with a depression diagnosis (ever) and/or 14 or more poor mental health days in the past month. The definition of PCEs includes 7 positive interpersonal experiences with family, friends, and in school/the community. Standard Behavioral Risk Factor Survey ACEs and ARSES variables were used.

RESULTS In the 2015 Wisconsin Behavioral Risk Factor Survey sample of adults (50.7% women; 84.9% white), the adjusted odds of D/PMH were 72% lower (OR, 0.28; 95% CI, 0.21-0.39) for adults reporting 6 to 7 vs 0 to 2 PCEs (12.6% vs 48.2%). Odds were 50% lower (OR, 0.50; 95% CI, 0.36-0.69) for those reporting 3 to 5 vs 0 to 2 PCEs (25.1% vs 48.2%). Associations were similar in magnitude for adults reporting 1, 2 to 3, or 4 to 8 ACEs. The adjusted odds that adults reported "always" on the ARSES variable were 3.53 times (95% CI, 2.60-4.80) greater for adults with 6 to 7 vs 0 to 2 PCEs. Associations for 3 to 5 PCEs were not significant. The PCE associations with D/PMH remained stable across each ACEs exposure level when controlling for ARSES.

CONCLUSIONS AND RELEVANCE Positive childhood experiences show dose-response associations with D/PMH and ARSES after accounting for exposure to ACEs. The proactive promotion of PCEs for children may reduce risk for adult D/PMH and promote adult relational health. Joint assessment of PCEs and ACEs may better target needs and interventions and enable a focus on building strengths to promote well-being. Findings support prioritizing possibilities to foster safe, stable nurturing relationships for children that consider the health outcomes of positive experiences.

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Supplemental content

Author Affiliations: Johns Hopkins Bloomberg School of Public Health and Child and Adolescent Health Measurement Initiative, Baltimore, Maryland (Bethell, Gombojav); Alliance for Strong Families and Communities, Milwaukee, Wisconsin (Jones); The Montana Institute, Bozeman, Montana (Linkenbach); Institute for Clinical Research and Health Policy Studies, Tufts Medical Center, Boston, Massachusetts (Sege).

Corresponding Author: Christina Bethell, PhD, MBA, MPH, Bloomberg School of Public Health, Johns Hopkins University, 615 N Wolfe St, Room E4152, Baltimore, MD 21205 (cbethell@jhu.edu).

EMS is on life support

After decades of underfunding, Michigan EMS providers received nearly $13 million in additional funding for EMS reimbursement in the Fiscal Year 2021 budget. Before this investment, the Medicaid reimbursement rate hadn't been increased in more than 20 years. For reference, Medicaid only pays 35% of what commercial insurance pays for ambulance services.

This increase made a significant difference for EMS providers, but it fell short of the intended result, due to ambiguity in the boiler plate language, resulting in payments below the intended allocation. The legislative intent was for Medicaid allowable reimbursement rates for EMS treatment to be equal to that of Medicare's allowable rates. For the funding increase to be allocated as legislatively intended, all Advanced Life Support and Basic Life Support "lines" need to be increased to achieve parity with each Medicare rate. Only allocating the increase to the Medicare Base rate does not properly increase reimbursement for the level of work being done in EMS.

To fix this error and make sure the funding is properly allocated, the boilerplate needs to be changed. Our updated boilerplate must read:
"Sec. 1788. From the funds appropriated in part 1, the department shall provide Medicaid reimbursement rates, including Medicaid reimbursements from the ambulance provider quality assurance assessment, for ground ambulance services at not less than 100% of the Medicare ALLOWABLE rates for Locality 01 for those services in effect on the date the services are provided to eligible Medicaid recipients."

Without proper reimbursement, ambulance service is not sustainable.

Contact: Angela Madden, Executive Director
angela@miambulance.org or 517-281-4695

MAAS
MICHIGAN ASSOCIATION OF AMBULANCE SERVICES

Research demonstrates that both positive and adverse experiences shape brain development and health across the life span.[1-5] Understanding human development requires a model that incorporates both risks (factors that decrease the likelihood of successful development) and opportunities (factors that increase the likelihood of successful development). On the positive side, successful child development depends on secure attachment during the first years of life.[6,7] As the child grows, exposure to spoken language[8] and having the presence of safe, stable, nurturing relationships and environments are important factors for optimal development.[9,10] On the other hand, children with adverse childhood experiences (ACEs) are at risk for observable changes in brain anatomy,[11] gene expression,[12,13] and delays in social, emotional, physical, and cognitive development lasting into adulthood.[3-5,14-17]

According to standardized measures, an estimated 61.5% of adults[18] and 48% of children[19] in the United States have been exposed to ACEs, with more than one-third of these having multiple exposures.[18,19] The wide-ranging negative associations between exposure to multiple ACEs and diminished adult and child health are well documented.[14,19-22] Most notable is the especially strong evidence linking ACEs with adult mental health problems including depression.[22-28] A robust literature also exists regarding the effect of ACEs on adult relational health (often assessed by whether adults report that they get the social and emotional support they need) and how diminished adult social and emotional support contributes to poorer adult physical and mental health.[29-56]

Beyond the extensive and growing body of research dealing with lifelong correlates of adversity, many prior studies identify resiliency factors and adaptive skills and interventions associated with improved child development and child and adult health outcomes.[2,3,16,17,25-55] For example, the Search Institute developed a list of "40 Developmental Assets" and demonstrated associations between the number of assets and both positive and negative outcomes.[52] A national population-based study[53] on child flourishing and resilience shows strong associations with levels of family resilience and parent-child connection for children with exposures to greater ACEs, poverty, and chronic conditions. Similar studies, such as those assessing the US Centers for Disease Control and Prevention (CDC)'s "safe, stable, and nurturing relationships" model, show similar findings.[55]

Despite these advances, standardized measures and the prevalence of positive childhood experiences (PCEs) at the population level for adults or children are still unknown. Yet prior studies, using data from small or nonrepresentative samples, have explored interactions between PCEs and ACEs.[25,41,56] For example, 1 study,[41] conducted by Kaiser Permanente and CDC investigators, analyzed a cohort of 4648 women. They found that adult reports of specific positive family experiences in childhood (including closeness, support, loyalty, protection, love, importance, and responsiveness to health needs) were associated with lower rates of adolescent pregnancy across all ACEs exposure levels.[41] The protective effects of reported interpersonal PCEs against mental health problems in adulthood have also been found among pregnant women[25] and young adults[56] exposed to ACEs. Despite these findings, few subsequent studies on ACEs have simultaneously evaluated PCEs.

Collectively, prior studies on child development point to the importance of research focusing on PCEs, especially those associated with parent-child attachment, positive parenting (eg, parental warmth, responsiveness, and support), family health, and positive relationships with friends, in school, and in the community. Knowledge of whether retrospectively reported PCEs co-occur with ACEs and how PCEs interact with ACEs to effect adult mental and relational health is needed to inform the nation's growing focus on addressing early life and social determinants of healthy development and lifelong health.

This study used data from the 2015 Wisconsin Behavioral Risk Factor Survey (WI BRFS), a representative, population-based survey,[57] to assess the prevalence of PCEs in an adult sample and evaluate hypothesized associations with adult mental and relational health across 4 ACEs exposure levels. This study builds on a 2017 *Health Outcomes of Positive Experiences* report[58] featuring bivariate findings from the 2015 WI BRFS associating individual PCEs with negative adult health outcomes. Here, we construct a PCEs cumulative score measure and use multivariable regression methods to assess the magnitude and significance of associations between this PCEs score and (1) adult depression and/or poor mental health (D/PMH) and (2) adults' reported social and emotional support (ARSES). Separate assessment of associations was conducted for each of 4 ACEs exposure levels.

Key Points

Question Are positive childhood experiences (PCEs) associated with adult depression and/or poor mental health (D/PMH) and adult-reported social and emotional support (ARSES) independent from adverse childhood experiences (ACEs)?

Findings In this cross-sectional study, adults reporting higher PCEs had lower odds of D/PMH and greater ARSES after accounting for ACEs. The associations of PCEs with D/PMH also remained stable when controlling for ARSES.

Meaning Positive childhood experiences demonstrate a dose-response association with adult D/PMH and ARSES after adjustment for ACEs; assessing and proactively promoting PCEs may reduce adult mental and relational health problems, even in the concurrent presence of ACEs.

Methods

Population and Data

Data were from the cross-sectional 2015 WI BRFS, a representative, telephone survey of noninstitutionalized Wisconsin adults 18 years and older who speak English or Spanish (n = 6188).[57] The WI BRFS response rate was 45.0% (weighted American Association of Public Opinion Research median, 47.2%). The cooperation rate was 64.9% (weighted

American Association of Public Opinion Research median, 68.0%). The 2015 WI BRFS core and state-added items data sets were linked. Institutional review board (IRB) approval was not required because data are based on a survey conducted by a public agency and do not include personal health information. Respondent oral consent methods and construction of race/ethnicity variables used standard CDC BRFS approved methods.

There were 18.1% to 21.1% missing cases for state-added ARSES, ACEs, and PCEs items. "Don't know/refused" responses to these questions were 0.2% to 0.9%. A 10% missing value rate for the WI BRFS state-added items is expected and is attributed to the administration of the core WI BRFS survey by another state to Wisconsin residents who have out-of-state cellular phones. In these cases, the WI BRFS state-added items were not available to be administered.[59] The remainder of missing cases were nearly all owing to respondent dropoffs prior to administering the ARSES, ACEs, and PCEs questions after administration of the core WI BRFS. Differences in D/PMH prevalence rates between respondents and missing cases were not notable. See eTable 1 in the Supplement for additional details.

Key Measures

Positive Childhood Experiences Score

The PCEs score included 7 items asking respondents to report how often or how much as a child they: (1) felt able to talk to their family about feelings; (2) felt their family stood by them during difficult times; (3) enjoyed participating in community traditions; (4) felt a sense of belonging in high school (not including those who did not attend school or were home schooled); (5) felt supported by friends; (6) had at least 2 nonparent adults who took genuine interest in them; and (7) felt safe and protected by an adult in their home. The PCEs score items were adapted from 4 subscales included in the Child and Youth Resilience Measure-28 [60]: (1) 4 items from the Psychological, Caregiving subscale (see PCEs items 1, 2, 7, and 6 listed previously); (2) 1 from the Education subscale (PCEs item 4); (3) 1 from the Culture subscale (PCEs item 3), and (4) 1 from the Peer Support subscale (PCEs item 5). Items were designed in the Child and Youth Resilience Measure-28 for cultural sensitivity, and their validity was supported by associations with improved resilience.[61] Psychometric analyses confirmed use of a PCEs cumulative score. See eTable 2 in the Supplement for details.

Adverse Childhood Experiences

We used data from the standardized ACEs survey items defined by the CDC.[62,63] The ACEs measure included 11 ACEs items assessing recollections of childhood experiences of physical or emotional abuse or neglect, sexual abuse, and household dysfunctions such as substance abuse, parental incarceration, and divorce. As recommended by the CDC, items were coded using cumulative score groupings of 0, 1, 2 to 3, or 4 to 8 ACEs. Subjective reports of experiences in childhood are the intended construct for assessment of both PCEs and ACEs and not whether what is reported would be validated using objective assessments.[64]

Adult-Reported Social and Emotional Support

Adult-reported social and emotional support is assessed using a standardized single item, "How often do you get the social and emotional support you need?" Response choices were "always," "usually," "sometimes," "rarely," or "never." Based on previous research and analysis of this ARSES variable, this study separately evaluated "always" and "usually" responses and created a combined "sometimes/rarely/never" response category.[45,47,48]

Depression/Poor Mental Health

The D/PMH category was constructed using (1) the single item on depression asking whether a physician or other health professional "ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"; and (2) a score of 14 or higher on the single item validated as an indicator of current poor mental health[59,60,65,66] that asked, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Adults reporting either or both of these outcomes were included in the D/PMH variable.

Other Covariates

Demographic covariates included age (18-34 years, 35-54 years, 55-64 years, and 65 years or older), race/ethnicity (nonwhite or white/non-Hispanic), and annual income (less than $25 000, $25 000-$49 999, $50 000-$74 999, and $75 000 or more). Sample size and statistical power analysis findings required combining race/ethnicity subgroups into 2 categories for purposes of statistical analysis.

Analytic Methods

Prevalence rates for all variables were computed, and bivariate associations between individual PCE items and PCEs cumulative score groups and all other variables were evaluated using χ^2 tests. Iterative and recursive analyses confirmed independent variable construction and focused on confirmation of assumptions on the linearity and comparability of associations with study outcomes when ordinal (count) or cumulative score groupings of PCEs and ACEs were used. Cumulative score groups of 0 to 2, 3 to 5, and 6 to 7 PCEs and 0, 1, 2 to 3, and 4 to 8 ACEs were also selected to ensure adequate statistical power to detect meaningful associations. Such score groups also simplify reporting of results by narrowing the number of comparative groups requiring reporting. Interaction variables crossing PCEs by ACEs and PCEs by ARSES were also analyzed for each study outcome and supported decisions to assess PCEs, ACEs, and ARSES as independent (vs interacting) variables in regression models.

As noted, multivariable logistic regression analyses evaluated 2 association pathways between PCEs items and cumulative score groups and 2 outcome variables: (1) meeting criteria for D/PMH and (2) reports of "always" on ARSES. Regression models were adjusted for age, sex, race/ethnicity, income, and ACEs. Separate models were evaluated for each ACEs exposure level (0, 1, 2-3, and 4-8) to examine stability of associations across ACEs exposure levels. We further as-

Table 1. Study Population Characteristics and Prevalence of PCEs by D/PMH, ACEs, ARSES, and Demographic Characteristics

Population Characteristics (n = Unweighted Sample Size)	Statewide Population Prevalence Estimates		Prevalence of PCEs (n = 4926)[a]						P Value (Test of Independence)
			0-2 PCEs		3-5 PCEs		6-7 PCEs		
	Unweighted No.	Weighted %	Unweighted No.	Weighted %	Unweighted No.	Weighted %	Unweighted No.	Weighted %	
All respondents	6188	100	635	13.2	1606	34.5	2685	52.3	NA
D/PMH (n = 6187)									
Yes	1289	21.2	294	29.4	402	40.1	347	30.5	<.001
No	4898	78.8	341	8.7	1204	33.0	2338	58.3	
ACEs exposure levels (n = 4974)[a,b]									
0 ACEs	2275	43.3	106	4.9	567	27.3	1568	67.8	<.001
1 ACE	1142	23.0	100	8.3	406	38.6	625	53.1	
2-3 ACEs	967	19.9	174	18.5	400	42.1	390	39.5	
4-8 ACEs	590	13.7	255	39.4	232	39.4	100	21.2	
ARSES (n = 5021)[a]									
Always	2707	55.1	195	7.9	687	27.3	1743	64.8	<.001
Usually	1337	25.8	171	12.9	507	41.9	635	45.2	
Sometimes, rarely, or never	977	19.1	263	28.7	393	44.7	284	26.6	
Age (n = 6127), y									
18-34	977	28.8	98	13.0	267	37.9	350	49.2	.03
35-54	1737	33.0	201	15.6	407	31.9	748	52.5	
55-64	1426	17.6	169	12.6	389	36.0	613	51.4	
65 or older	1987	20.5	163	10.4	532	33.1	954	56.5	
Sex (n = 6188)									
Male	2720	49.3	248	11.9	763	36.3	1133	51.7	.09
Female	3468	50.7	387	14.3	843	32.8	1552	52.9	
Race/ethnicity (n = 6129)									
Nonwhite	757	15.1	107	17.0	208	44.7	233	38.3	<.001
White, non-Hispanic	5372	84.9	521	12.6	1385	33.1	2433	54.3	
Income level (n = 5461),[c] $									
<24 999	1331	22.5	219	22.0	387	38.3	437	39.6	<.001
25 000-49 999	1511	27.8	168	14.9	431	36.9	631	48.3	
50 000-74 999	1010	18.9	83	9.7	288	39.1	465	51.3	
75 000 or more	1609	30.7	105	8.2	334	25.9	888	66.0	

Abbreviations: ACEs, adverse childhood experiences; ARSES, adult-reported social and emotional support; D/PMH, depression and/or poor mental health; NA, not applicable; PCEs, positive childhood experiences; WI BRFS, Wisconsin Behavioral Risk Factor Survey.

[a] A 10% missing value rate is expected and attributed to core WI BRFS survey administration to out-of-state cellular phone holders who never received the WI BRFS state added items.[59] The remainder were nearly all owing to respondent dropoffs prior to administering the ARSES, ACEs, and PCEs questions, which were administered after the end of the core WI BRFS. No notable differences in prevalence of D/PMH were found between respondents and cases missing ARSES, ACEs, or PCEs data. See eTable 1 in the Supplement.

[b] The ACEs cumulative scores were created placing adults into categories of 0, 1, 2 to 3, or 4 to 8 ACEs based on their responses to the 11 ACEs items. Three sexual abuse items were combined into a single item, and alcohol and substance abuse items were presented as a single ACEs item.

[c] Income missing values rate was 11.7%.

sessed the stability of associations between D/PMH and PCEs when ARSES were or were not controlled for in regression models. This was done to further understand more nuanced association pathways between PCEs and ARSES and their individual or interacting association with D/MPH. Additional sensitivity analyses of PCEs associations when ACEs were or were not included in models were also conducted. The survey data were weighted to be representative of the Wisconsin population. We used SPSS Complex Samples, version 24 (IBM Corporation) for data analysis.[67] A *P* value of .05 or less was used to determine statistical significance.

Results

Population Characteristics and Prevalence of Study Outcomes by PCEs

Demographic characteristics for the 2015 WI BRFS mirrored the state population: 50.7% women and 84.9% white. About half (52.3%) reported 6 to 7 PCEs, more than half (56.7%) reported ACEs, 21.2% met D/PMH criteria, and more than half (55.1%) reported "always" to getting the social and emotional support they needed (ARSES). Nonwhite, younger, and lower-

Table 2. Prevalence and Adjusted Odds Ratios of Adult D/PMH and Reports of "Always" on the ARSES Item by PCEs and Other Regression Model Variables

Population Characteristics (Raw Sample Size)	Prevalence of D/PMH			Adjusted Odds Ratio (95% CI) for Meeting D/PMH Criteria	Prevalence of "Always" on ARSES Item			Adjusted Odds Ratio (95% CI) for Reports of "Always" on ARSES Item[a]
	Unweighted No.	Weighted %	*P* Value		Unweighted No.	Weighted %	*P* Value	
All Respondents	**1289**	**21.2**	**NA**	**NA**	**2707**	**55.1**	**NA**	**NA**
Positive childhood experiences (PCEs) (n = 4926)[a,b,c]								
0-2 PCEs reported	294	48.2	<.001	1 [Reference]	195	33.0	<.001	1 [Reference]
3-5 PCEs reported	402	25.1		0.50 (0.36-0.69)	687	43.6		1.31 (0.97-1.78)
6-7 PCEs reported	347	12.6		0.28 (0.21-0.39)	1743	67.9		3.53 (2.60-4.80)
Adverse childhood experiences (ACEs) (n = 4974)[a]								
No ACEs reported	252	11.9	<.001	1 [Reference]	1394	62.4	<.001	1.22 (0.88-1.69)
1 ACE reported	215	20.2		1.62 (1.18-2.21)	596	53.9		0.93 (0.67-1.30)
2-3 ACEs reported	294	29.2		2.40 (1.77-3.24)	439	47.6		0.90 (0.64-1.27)
4-8 ACEs reported	285	42.4		3.10 (2.20-4.37)	226	44.2		1 [Reference]
Age (n = 6127), y								
18-34	215	21.0	.01	1.09 (0.78-1.53)	408	56.8	.44	1.09 (0.84-1.42)
35-54	406	22.6		1.51 (1.10-2.06)	766	54.9		0.97 (0.76-1.23)
55-64	331	24.2		1.64 (1.20-2.24)	600	52.1		0.88 (0.69-1.13)
65 or older	332	16.9		1 [Reference]	911	55.8		1 [Reference]
Sex (n = 6188)								
Male	444	16.9	<.001	0.59 (0.47-0.74)	1189	55.3	.80	0.97 (0.81-1.17)
Female	845	25.5		1 [Reference]	1518	54.8		1 [Reference]
Race/ethnicity (n = 6129)								
Nonwhite	203	23.8	<.25	0.98 (0.67-1.42)	294	53.5	.64	1.19 (0.84-1.70)
White, non-Hispanic	1078	20.9		1 [Reference]	2391	55.2		1 [Reference]
Income level (n = 5461),[d] $								
<24 999	454	33.3	<.001	2.91 (2.11-4.02)	465	47.8	<.001	0.67 (0.51-0.88)
25 000-49 999	340	22.6		1.76 (1.29-2.41)	667	53.4		0.81 (0.64-1.03)
50 000-74 999	172	18.4		1.43 (1.02-2.01)	458	54.3		0.81 (0.62-1.05)
75 000 or more	205	13.1		1 [Reference]	857	62.3		1 [Reference]

Abbreviations: ACEs, adverse childhood experiences; ARSES, adult-reported social and emotional support; D/PMH, depression and/or poor mental health; NA, not applicable; PCEs, positive childhood experiences; WI BRFS, Wisconsin Behavioral Risk Factor Survey.

[a] A 10% missing value rate is expected and attributed to core WI BRFS 5 survey administration to out-of-state cellular phone holders who never received the WI BRFS state added items.[59] The remainder were nearly all owing to respondent dropoffs prior to administering the ARSES, ACEs, and PCEs questions, which were administered after the end of the core WI BRFS. No notable differences in prevalence of D/PMH were found between respondents and cases missing ARSES, ACEs, or PCEs data. See eTable 1 in the Supplement.

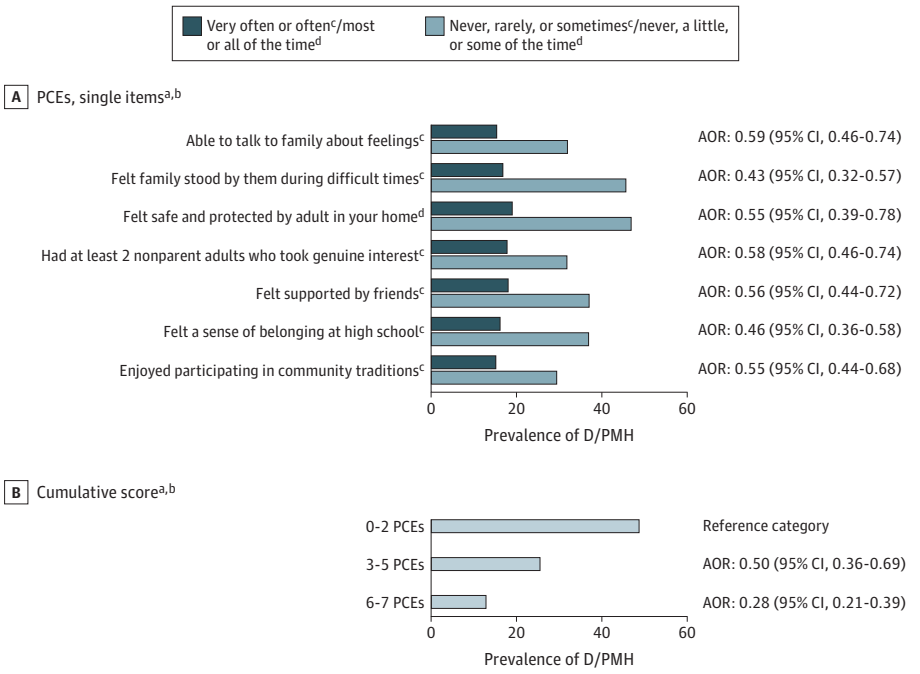
[b] Without adjustment for ACEs, PCEs associations with D/PMH were 0.19 (95% CI, 0.14-0.25) and 0.40 (95% CI, 0.30-0.54) for adults reporting 6 to 7 and 3 to 5 PCEs vs 0 to 2 PCEs, respectively.

[c] Without adjustment for ACEs, PCEs associations with "always" on the ARSES variable were 3.83 (95% CI, 2.89-5.06) and 1.35 (95% CI, 1.01-1.81) for adults reporting 6 to 7 and 3 to 5 PCEs vs 0 to 2 PCEs, respectively.

[d] Income missing values rate is 11.7%. Income was not imputed for the WI BRFS by the Wisconsin Department of Health Services so federal poverty level could not be calculated.

income adults reported fewer levels of PCEs (**Table 1**). Compared with those reporting 6 to 7 PCEs, adults reporting 0 to 2 PCEs had nearly 4 times higher prevalence of D/PMH (48.2% vs 12.6%) and were half as likely to report "always" to getting the social and emotional support they needed (33.0% vs 67.9%) (**Table 2**). Similar variations in prevalence were observed when each of the 7 PCEs items were separately evaluated for each study outcome (**Figures 1** and **2** and eTable 5 in the Supplement). As hypothesized and shown in these Figures, stronger associations emerged for cumulative PCEs scores.

Figure 1. Prevalence of Depression and/or Poor Mental Health Among Adults by Positive Childhood Experiences (PCEs) Single Items and Cumulative Scores



See eTable 5 in the Supplement for percentages of depression and/or poor mental health and adult-reported social and emotional support across PCEs items and scores.

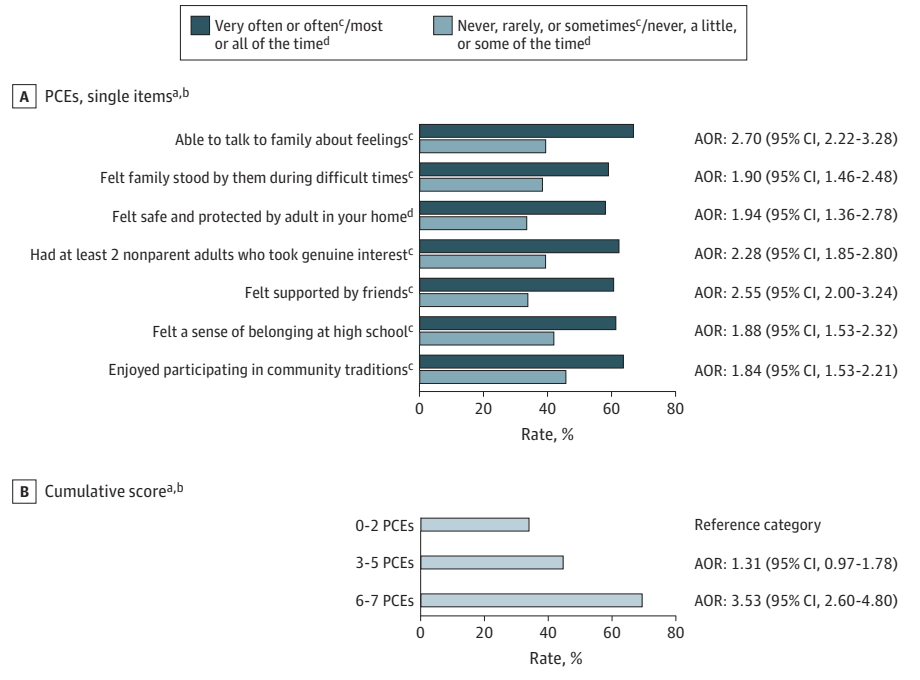
[a] Source: authors' analysis of the 2015 Wisconsin Behavioral Risk Factor Survey.

[b] Adjusted odds ratios (AORs) shown are adjusted for age, sex, race/ethnicity, income, and adverse childhood experiences.

[c] Never, rarely, or sometimes is the reference category.

[d] Never, a little, or some of the time is the reference category.

Figure 2. Prevalence of Adult Reporting Always Receiving Needed Social Emotional Support by Positive Childhood Experiences (PCEs) Single Items and Cumulative Scores



See eTable 5 in the Supplement for percentages of depression and/or poor mental health and adult-reported social and emotional support across PCEs items and scores.

[a] Source: authors' analysis of the 2015 Wisconsin Behavioral Risk Factor Survey.

[b] Adjusted odds ratios (AORs) shown are adjusted for age, sex, race/ethnicity, income, and adverse childhood experiences.

[c] Never, rarely, or sometimes is the reference category.

[d] Never, a little, or some of the time is the reference category.

The lowest adult D/PMH prevalences were observed for respondents reporting both 6 to 7 PCEs and either no ACEs (10.5%) or "always" on the ARSES variable (8.5%). Highest D/PMH prevalences were for those reporting 0 to 2 PCEs and either 4 to 8 ACEs (59.7%) or "sometimes/ rarely/never" on the ARSES variable (61.7%). Yet, even among those reporting always getting needed social and emotional support, a subset reported 0 to 2 PCEs, and this group had 4 times greater prevalence of D/PMH compared with those reporting 6 to 7 PCEs (33.8% vs 8.5%). Likewise, 21.2% of those with 4 to 8 ACEs and

Table 3. Prevalence of D/PMH and Reports of "Always" on the ARSES Item by PCEs Scores for Each of 4 Adverse Childhood Experiences ACEs Exposure Levels (0, 1, 2-3, or 4-8)

Categories by ACEs and PCEs	Meets D/PMH Criteria[a]			Reports of "Always" to Getting Needed Social and Emotional Support (ARSES)		
	Unweighted No.	Weighted %	Adjusted Odds Ratio[b] (95% CI)	Unweighted No.	Weighted %	Adjusted Odds Ratio[b] (95% CI)
No ACEs reported						
0-2 PCEs	17	12.1	1 [Reference]	35	34.6	1 [Reference]
3-5 PCEs	86	15.8	1.15 (0.51-2.62)	266	47.3	1.58 (0.84-2.95)
6-7 PCEs	148	10.5	0.88 (0.42-1.87)	1072	70.5	4.18 (2.31-7.55)
1 ACE reported						
0-2 PCEs	35	45.7	1 [Reference]	38	30.9	1 [Reference]
3-5 PCEs	85	24.2	0.38 (0.17-0.83)	161	39.5	1.33 (0.68-2.62)
6-7 PCEs	94	13.4	0.21 (0.10-0.46)	390	67.6	4.93 (2.54-9.58)
2-3 ACEs reported						
0-2 PCEs	87	53.3	1 [Reference]	47	30.3	1 [Reference]
3-5 PCEs	131	31.4	0.47 (0.26-0.84)	167	43.9	1.65 (0.90-3.02)
6-7 PCEs	76	16.0	0.18 (0.10-0.34)	223	59.2	2.80 (1.53-5.13)
4-8 ACEs reported						
0-2 PCEs	155	59.7	1 [Reference]	75	35.1	1 [Reference]
3-5 PCEs	100	36.9	0.49 (0.28-0.84)	93	41.7	1.19 (0.69-2.03)
6-7 PCEs	29	20.7	0.23 (0.11-0.46)	56	65.6	3.37 (1.66-6.84)

Abbreviations: ACEs, adverse childhood experiences; ARSES, adult-reported social and emotional support; D/PMH, depression and/or poor mental health; PCEs, positive childhood experiences.

[a] Prevalence of D/PMH varied across levels of ACEs within each PCEs cumulative score category (0-2, 3-5, and 6-7) at $P < .01$.

[b] Adjusted odds ratios adjusted for age, sex, race/ethnicity, and income.

26.6% of those reporting "sometime/rarely/never" to the ARSES item nonetheless also reported 6 to 7 PCEs. (Table 1, **Table 3**, and eTable 3 in the Supplement).

Association Pathway 1: PCEs and D/PMH

After controlling for ACEs, the adjusted odds of D/PMH were 72% lower (odds ratio [OR], 0.28; 95% CI, 0.21-0.39) for adults with the highest vs lowest PCEs scores (12.6% vs 48.2%). Odds were 50% lower (OR, 0.50; 95% CI, 0.36-0.69) for those reporting intermediate PCEs scores of 3 to 5 (25.1% vs 48.2%) (Table 2). Associations were similar in magnitude for adults reporting 1, 2 to 3, or 4 to 8 ACEs (Table 3).

Association Pathway 2: PCEs and ARSES

The adjusted odds of "always" reports on the ARSES item were 3.53 times (95% CI, 2.60-4.80) greater for adults with the highest vs lowest PCEs scores. Adjusted odds of reports of "always" on the ARSES variable were not significant for adults with intermediate PCEs of 3 to 5 (adjusted OR, 1.31; 95% CI, 0.97-1.78) (Table 2). Findings were similar across all ACEs exposure level subgroups (Table 3). Because PCEs and ARSES were strongly associated as hypothesized, we further examined whether each variable demonstrated an independent association with D/PMH and whether associations of PCEs with D/PMH remained stable when ARSES was included in regression models. Results showed that PCEs associations with D/PMH remained significant and changed only modestly when ARSES was included. Associations between ARSES and D/PMH also remained stable when PCEs were or were not included. See eTable 4 in the Supplement for details.

Discussion

This study examined the prevalence of adult reports of both PCEs and ACEs in a statewide sample and found that PCEs both co-occur with and operate independently from ACEs in their associations with the adult health outcomes evaluated here. Findings also confirm the hypotheses that PCEs may exert their association with D/PMH through their association with ARSES. However, PCEs maintained an association with D/PMH independent from ARSES. Findings are both consistent with prior research showing that relational experiences in childhood are associated with adult social and relational skills and health[3,15,56,68] and also point to enduring effects of PCEs on D/PMH separate from their influence on adult ARSES.

While PCEs associations with D/PMH were substantial and similar for adults reporting ACEs, associations were not statistically significant for those reporting no ACEs. Insignificant findings may be owing to low sample sizes for respondents with no ACEs and fewer PCEs. Results still raise questions for further exploration. We hypothesize that PCEs may have a greater influence in promoting positive health, such as getting needed social and emotional support or flourishing as an adult. In turn, these positive health attributes may reduce the burden of illness even if the illness is not eliminated. This is consistent with prior research demonstrating a dual continuum of health whereby flourishing is found to be present for many adults despite concurrent mental health conditions.[69]

Limitations

First, this study is cross-sectional and cannot confirm causal effects. Second, the 2015 Wisconsin adult population is less diverse than the United States as a whole. Third, PCEs focused on the domain of positive emotional experiences in interpersonal relationships. Other types of positive experiences, (eg, safe and supportive environments, nature or spiritual experiences, participation in activities, or accomplishment) require further study, highlighting the need to develop and test additional measures of PCEs. Fourth, we were not able to directly examine bias in reporting of PCEs among adults with depression, although studies show an absence of such biases for reports of ACEs.[64,70] Finally, the WI BRFS did not assess overall well-being or flourishing.[69] As such, we were not able to assess whether PCEs affect positive adult health outcomes as hypothesized. Sample size limitations may have resulted in false-negative findings in some cases.

Conclusions

Overall, study results demonstrate that PCEs show a dose-response association with adult mental and relational health, analogous to the cumulative effects of multiple ACEs. Findings suggest that PCEs may have lifelong consequences for mental and relational health despite co-occurring adversities such as ACEs. In this way, they support application of the World Health Organization's definition of health emphasizing that health is more than the absence of disease or adversity.[71] The World Health Organization's positive construct of health is aligned with the proactive promotion of positive experiences in childhood because they are foundational to optimal childhood development and adult flourishing. Including PCEs as well as positive health outcomes measures in routinely collected public health surveillance systems, such as the National Survey of Children's Health and state Behavioral Risk Factor Surveillance Surveys, may advance knowledge and allow the nation to track progress in promoting flourishing despite adversity or illness among children and adults in the United States.

Even as society continues to address remediable causes of childhood adversities such as ACEs, attention should be given to the creation of those positive experiences that both reflect and generate resilience within children, families, and communities. Success will depend on full engagement of families and communities and changes in the health care, education, and social services systems serving children and families. A joint inventory of ACEs and PCEs, such as the positive experiences assessed here, may improve efforts to assess needs, target interventions, and engage individuals in addressing the adversities they face by leveraging existing assets and strengths.[72] Initiatives to conduct broad ACEs screening, such as those ensuing in California's Medicaid program, may benefit from integrated assessments including PCEs.[73]

Recommendations and practice guidelines included in the *National Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*[74] and the CDC's *Essentials for Childhood* initiative[9] encourage policies and initiatives to help child-serving professionals and programs to adopt effective approaches to promote the type of PCEs evaluated in this study. The *Health Outcomes of Positive Experiences* framework[48] and the Prioritizing Possibilities national agenda for promoting child health and addressing ACEs[75] each seek to advance existing and emerging evidence-based approaches[44,45,47,48,50,54,76,77] that promote a positive construct of health in clinical, public health, and human services settings. This study adds to the growing evidence that childhood experiences have profound and lifelong effects. Results hold promise for national, state, and community efforts to achieve positive child and adult health and well-being by promoting the largely untapped potential to promote positive experiences and flourishing despite adversity.[53,78]

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Chair Morse, Vice Chairs Martus and Green, and members of the Appropriations Subcommittee on Health and Human Services, thank you for allowing me to provide testimony on the removal of the five-year waiting period for Medicaid and the Children's Health Insurance Program (CHIP) for lawfully residing children and pregnant women. My name is Sara Ismail, and I am a Public Policy Associate for the Arab Community Center for Economic and Social Services (ACCESS).

For more than 50 years, ACCESS, the nation's largest Arab American community nonprofit organization, has built communities and institutions that span multiple sectors with a focus on community empowerment. From human service programs serving recent immigrants, to a national program promoting Arab American philanthropy, ACCESS transitions people from being service recipients to fully engaged citizens able to advance justice and equity. As a premier human service provider with 10 sites throughout southeast Michigan offering 120 programs, we serve thousands of diverse individuals and families every day through our integrated and comprehensive program model of service delivery for low-income and immigrant communities in the areas of health, education, economic empowerment, workforce development, civic engagement, and arts and culture. These programs serve the diverse populations of southeast Michigan and have been the foundation of our community empowerment, moving individuals, families, and communities from poverty to economic stability.

In her FY24 executive budget recommendation, Governor Whitmer included $32,125,200 toward enhancing Michigan's maternal and child health services by increasing health care coverage and expanding Michigan's evidence-based services to new and expecting mothers.

ACCESS strongly supports this recommendation. As a community-based organization, ACCESS sees first-hand what residents in southeast Michigan are experiencing. The organization serves diverse clientele, particularly Middle Eastern and North African populations with an influx of those fleeing war from Syria, Iraq, and Yemen. ACCESS serves residents who would be impacted by this daily, and the following is a story from one of our clients.

> "I have been living in the U.S for almost four years, and I have a very hard time getting covered by insurance. We are a family of six and are low-income, and my husband cannot work much due to his critical illness. Due to our immigration status and not yet completing the five-year time frame to receive the benefits, we had a tough time with medical bills, and we have not paid any off. When we first moved to the states, we stayed in New York for a year and received all types of benefits from the department of health and human services, but when we planned on moving to Michigan everything changed and the benefits, we had in New York were not available. My husband has a critical condition where it limits his ability to work, and he not eligible to enroll in insurance from his work because he is a part time employee. We were told about free clinics that offer free care to uninsured people and that is our go to place when we feel ill. We try to limit ourselves with visiting the ER or urgent care due to the bills that we cannot afford, unless we encounter an emergency and need to be seen as soon as possible we have no other choice but to seek medical care from the ER."

Individuals from Middle Eastern and North African countries face many barriers, including access to high quality and culturally competent health care services, linguistically appropriate health care services, and representation in federally conducted or supported health data.

Currently, there are 3,000 to 4,000 children and thousands of adults who are otherwise eligible for these programs in Michigan but who have not met the five-year waiting period. Federal law requires those who are lawfully residing—including lawful permanent residents known as "green card" holders—to wait five years before accessing Medicaid or CHIP and a variety of other public programs. Michigan is one of only 15 states that has not taken up the federal Immigrant Children's Health Improvement Act (ICHIA) option for both children and pregnant women.

The governor's proposed FY24 budget includes an expansion of the Healthy Moms, Healthy Babies initiative. This expansion would eliminate the five-year waiting period for children and pregnant women, as is allowed under ICHIA, so that lawfully residing immigrant children and pregnant people can access Medicaid and CHIP sooner if they are eligible. With this change, pregnant and postpartum individuals served by the more limited Maternity Outpatient Medical Services (MOMS) program would instead be provided comprehensive coverage during their pregnancy and through 12 months postpartum. Michigan's approved April 2022 extension of Medicaid postpartum coverage from 60 days to a full year would be available to all eligible lawfully residing immigrants.

It has been found that 58.2 percent of MENA residents have private health insurance, compared to 65.8 percent of the general population. About 28.8 percent of MENA residents utilize public health insurance. For the general population, that number is 31.1 percent. Moreover, 25 percent of the MENA community has no health insurance, compared to 14.2 percent of the general public. It is important to highlight this issue to understand and address the unique health needs of racial and ethnic minority groups. While these dynamics impact all individuals, they are exacerbated by additional barriers to access quality health coverage due to eligibility, health literacy, or discrimination at the point-of-service.

ACCESS supports the Governor's expansion of the Healthy Moms, Healthy Babies Initiative to achieve the goal of more robust coverage for these groups. Providing additional health care resources will allow lawfully present immigrants to utilize preventative care and, additionally, address health equity issues faced by racial and ethnic minority groups within Michigan. I urge you to support this language within the FY24 budget.

Thank you for holding this important hearing, and I can be reached for any questions you might have.

Sara A. Ismail
Public Policy Associate
sismail@accesscommunity.org
2651 Saulino Ct., Dearborn, MI 48120
Ph: 313-203-1669 Ext. 1479

Advocates for Mental Health of MI Youth
advocates@mentalhealth4miyouth.com
https://mentalhealth4miyouth.com

April 3, 2023

The Honorable Christine Morse, Chair, MDHHS Appropriations Subcommittee and Members of the Subcommittee,

The attached story packet includes stories from families that are in crisis right now. We have already shared this story packet with the individual State Representatives of each family. We are sending it to you as members of the Appropriations Subcommittee you know know what families in Michigan are truly going through when they try to access mental health help for their children.

These stories are collected from counties around the state. We feel this illustrates that there are systemic issues that exist and need to be resolved. We know there are many other parents with similar stories, but they didn't have the time to write a letter. They are too busy managing daily crisis in their homes. Our children deserve better.

Advocates for Mental Health of MI Youth is a grassroots, parent-led group of almost 500 families that have come together from across the state of Michigan in the last 13 months. We're organizing because we are unable to access mental health treatment for children with the most intensive mental health and behavioral health needs, despite the fact that every CMH in this state claims to be providing that treatment. We are joining together because we do not think our leaders understand the far reaching systemic failures our children are facing as we struggle to find appropriate help.

We would welcome a meeting with you to discuss this further. You may also learn more through our Facebook page at www.facebook.com/mentalhealth4miyouth.com and website, www.mentalhealth4miyouth.com. You can see our news coverage put out by CBS here: https://www.cbsnews.com/detroit/news/mothers-find-support-on-social-media

Thank you so much for taking the time to listen to our stories today.

Sincerely,
Laura Marshall
Michelle Massey Barnes
Rachel Cuschieri-Murray
Co-Directors of Advocates for Mental Health of MI Youth

Co-Director Rachel Cuschieri-Murray: Eaton County

My name is Rachel Cuschieri-Murray. I live in Eaton County and my son has a waiver into Medicaid for Severe Emotional Disturbance.

The hardest decision I've ever made in my life was to send my child out of state so that he could get the mental health treatment that he needed. That lead to the second hardest decision… to go a $1/4 Million into debt to pay for it. My family has had a front row seat to all of the ways Michigan's siloed system abandons children with severe and complex mental health needs. I'm going to map that out for you so you can see it from a family's perspective and I'll share with you what it will take to get this right in the future.

A child like mine makes contact with the state of Michigan through Schools, CMH, Child Welfare, and Juvenile Justice. With so many access points, it should be easy to get help. But in reality the opposite is true and the stakes are high. Families like mine are at high risk to lose our children to the courts or foster care when things go wrong. And for kids with the highest level of needs, things go wrong a lot. That is why our foster care system and juvenile detention centers are busting at the seams.

You may not have known this was happening if you are only talking to the department heads. But in the last year, I've connected to over 500 families who live in crisis everyday and the stories are strikingly similar. Everyone is fighting to keep their kids and families safe while trying to avoid abandoning their children to foster care or jail. I invite you all to follow our group's Facebook page at @mentalhealth4MIyouth so you can read the stories for yourself.

It's true that the dismantling of the mental health system in the 90's and the constant defunding of all these departments have contributed to this situation. We are starting to see funding increased for individuals with low and moderate mental health needs, and I fully support and encourage that. Prevention is always the least expensive option.

But we still have a whole population of children and adults with severe and complex mental health needs that are languishing. It's not enough to wait weeks or months to see if a crisis will resolve itself and then barely stabilize a child before sending them home with no support. That's what's happening now and it is putting lives at risk. Instead, Michigan needs to properly fund mental health programs that are meaningful.

- We MUST attract specialized talent to this state and provide intensive and ongoing trainings to build the expert knowledge base within our state.
- We must open cutting edge treatment facilities that are more than just numbers of "beds" but provide critical specialized therapeutic care that is holistic and suited to condition.

- And we must fund that treatment to be completed so that it can prevent and reduce reoccurrence.

Our departments of education and justice need funding for mental health, too.

- We need proper funding for training and programs to provide true FAPE in schools (Free and Appropriate Public Education).

- We need proper funding to Juvenile Justice so that children who are pushed into the justice system get proper treatment suited to their condition while they are incarcerated… that's not happening now.

- We need all families… foster, adoptive, kinship and bio families to receive help from the child welfare system when they are referred to juvenile justice or CPS because these are signs that CMH has failed to provide the services and supports needed to keep the child and family safe.

- We also need to fund cooperation and coordination between all departments so that services can be seamless, with proper transition plans when children move between departments. Technology like Opeeka could help with that.

- Lastly, something that doesn't cost anything, we need strong insurance parity laws so that insurance companies can't weasel out of paying for treatment that is medically necessary and covered under the plan as happened to my family with Anthem BCBS.

It's been decades since the dismantling started and it has been ongoing. Michigan has some of the worst statistics in the nation regarding mental health care, but you all can change that. You can make us a leader in the nation. Please hear the voices of families who know this whole system better than any expert within the system could. We are here to help you.

When I made the decision to send my child out of state for his mental health treatment, people accused me of wanting him away from me. Nobody would say the same if I had sent him for cutting edge cancer treatment. He is back home now and he is so much better. He is improving every day. But my family shouldn't have gone through all that. And families who cannot access debt shouldn't have to send their kids to jail or a foster home instead of treatment. Those children deserve to be well, too. Let's build a system we can all be proud of.

Co-Director Laura Marshall: Kent County

My name is Laura Marshall. Thank you for allowing me this opportunity to share my family's experience navigating mental health supports. I am going to tell you about my middle son, currently 14 years old. We started seeking help through our CMH when he was a 3rd grader, at the age of 8.

Our son has a number of significant mental health diagnosis including Attention deficit hyperactivity disorder; Oppositional Defiance Disorder; Reactive Attachment Disorder; Pediatric Bi-Polar.

Our home environment was unsafe:
While at home, our days consisted of defiance toward nearly every suggestion, reminder, or request to him - even as simple as washing hands with soap, brushing teeth (resulting in gingivitis) or ensuring he had clean clothing to wear.

We dealt with daily anger and aggression, often destructive and assaultive behaviors. We had to remove everything from his bedroom; still he found ways to make weapons out of closet shelving or splinters of wood from broken structures. His bedroom walls and door are damaged and destroyed. We lived in a constant state of vigilance, trying to maintain safety at home. We attempted to utilize CMH during aggressive episodes. In vain we called the Crisis Mobile line. We called his therapist or on-call services numerous times. We handled countless situations on our own. Often the only effective help was calling 911 and asking for police assistance to keep everyone safe.

Eventually, a Network 180 management staff person looked me in the eye and told me to pursue services through the Juvenile Justice system. A criminal system.

My employment was at risk, until I had to completely leave the workforce to handle the constant behaviors and situations in my home.

My health became at risk. Due to the relentless behaviors and level of stress in our home, I have multiple health concerns, including a TIA (mini-stroke) at the age of 46.

My son qualified for an 'SED' Waiver [Serious Emotional Disturbance] for the last number of years. The SED Waiver program is intended to provide services at a level sufficient to keep a child in their home and community.

"Promised" of supports provided by the SED Waiver:

- Respite - (11 days/mo)the one time we used respite needed to picked up early due to aggressive behavior. [That facility has since been closed.]
- Crisis respite - (3 days/mo). CMH staff didn't feel he was aggressive enough to utilize this service.
  *Our respite reality: 3 hours once a week (during the school year) which involved two hours of transportation time for us.
- In home therapy - Therapies attempted include CBT CogBehavioralTherapy, DBT Dialectical Behavioral Therapy, Trauma Focused-CBT, EMDR -Eye movement Desensitization and Reprocessing -- unfortunately nothing helped.
- Wraparound – a mandatory service under the SED Waiver. Wraparound is intended to support the family, is strengths-based as it considers each individual in the family, and helps with communication and coordination of care.
- CLS (Community Living Supports) – helps with daily activities of living.
- Additional SED Therapy options - Art, Music, Sports. After a year of music therapy, we discontinued it as there were no gains. CMH authorized one block of 8 sessions for Equine therapy. My son made significant connections but we were told it was not covered under the SED waiver so additional sessions were denied.

Crisis Help:

- First attempt to get help outside of home (8 years old)
- Medical Hospital - we did not know where else to go.
- Doctor on staff with hospital did not agree with the private psychiatrist's diagnosis of 'Pediatric Bi-Polar' so took him off meds and sent home unstable. When questioned this decision based on concern for the SAFETY of my other two children, I was threatened with CPS and child abandonment charges.
  I was also informed that if a sibling was injured, CPS would be called due to not protecting my other boys. They moved to grandparents for a MONTH while we worked to stabilize.

Mental Health Facility experience:

- After 3 continuous days of raging, culminating in violent/graphic descriptions of his plan to kill his youngest brother, attempt suicide, and kill my husband and me was called for outside help (Sheriff).
- He was admitted to Pine Rest and stayed 12 days. Pine Rest is a facility intended for stabilization and medication management. Once a youth is stabilized, they will be returned to the home. Less than 3 hours after getting home he was raging. The following day we requested another emergency med review through CMH. We were told we needed to wait a week as no appointments were emergently available.

Conclusion:
Raising a child with severe mental and behavioral challenges is beyond difficult in itself. Having little support, ineffective or no services, and learning to navigate systems while in the middle of crisis adds exponentially to the burden. Legally our children and families are entitled to care and support based on medical necessity. Unfortunately we have been denied, given misinformation about services and even lied to at nearly every effort to gain those supports.

Under the SED Waiver our goal is supposed to be to keep our son in our home community. When appropriate services are withheld or unavailable, we found it impossible to maintain a basic level of safety in our home.

My son is now in the juvenile justice system. My son is NOT a criminal; he is a youth with severe mental and behavioral health challenges. The current system left me no option but to pursue police involvement, which results in my son having a criminal record.

Make no mistake – Juvenile Detention offers no mental health services. He sat for 6 months in the juvenile detention facility with no programs to support him. The court decided to send him to a program in Cheyenne, Wyoming. There is therapy, counseling, group therapy, horses, classes and support staff available to him 24/7.

Michigan needs to rebuild the mental health support system. Funding must be provided for oversight and accountability to ensure that CMH's are providing supports and services in fidelity to the models they profess to follow. Michigan need to provide facilities (with appropriately trained staff) that offer both short and long term residential placements. We need facilities that can provide more than just stabilization. We do NOT look to institutionalize our youth, sending them away and locking the door. We want effective treatments so that our children can return home and have
the hope of a meaningful future.

Co-Director Michelle Massey Barnes: Jackson County

My name is Michelle Massey Barnes. I live in Jackson County. I am the mother of a young adult with something that the State of Michigan calls Severe Emotional Disturbance or SED. There is a special Medicaid waiver for children with SED. This waiver, the SED Waiver, states that these children need intensive services and support so they do not have to be hospitalized or institutionalized. Many of the families you will hear from today have children on this waiver.

I am explaining this because as a group, we are not coming to you with children with mild or even moderate mental health needs. We are coming to you as parents of children with the most intensive needs in the State of Michigan. We know what it means to live in crisis. We are accustomed to being told there is no help and advocating for help anyway.

One of the many things that we have in common is that the services that we are receiving from Community Mental Health are not helping our children or our families. In fact, the services are often making our situations worse and causing more distress to the entire family.

I knew I needed help navigating the public mental health system. I needed allies, support, and even “back up.” We were advocating everyday for help and instead of getting more help, services were getting cut, the mobile crisis unit was refusing to respond to our calls, and we were singled out and told that our child had to have an assessment completed by a nurses when no other child was required to have this assessment completed by a nurse per our CMH’s own policy.

The behaviors we experienced from CMH staff were unacceptable, retaliatory, and oftentimes, completely disgusting. It was impossible to navigate this system alone, especially when I often felt like the system was actively working against my child and my family. If you would like specific examples, please reach out to me. We can have coffee (or coffee over zoom), and I will tell you about the 3.5 month CPS investigation that we endured because CMH continued to make false allegations against us as parents. At the end of the investigation nothing substantiated and the CPS investigator told us the best advice she had for us was to leave our CMH because they were more interested in fighting with me, the “hands on mom”, than helping my child.

In the process of living through these incredible situations, I found my way to Marianne Huff of MHAM, and I found my way to Laura, Rachel, and to many other friends including those here in the room and on zoom.

Our grassroots parents group, Advocate for Mental Health of MI Youth, hit the ground running. We spoke at the appropriations committee meeting last year very shortly after meeting one another. Many of us are before you again this year, and I think you will hear us say that in the last year nothing has changed…

Except for our advocacy. We have come together as mental health advocates, we have shared our lived experiences, and we have demanded better for our children. In the last 2 weeks alone, we have helped over 24 parents tell their stories to 20 different state representatives. Thank you to those of you that have already helped.

We have 509 parents in our facebook group and the truth is that we cannot keep up with the stories, with the crisis, and the desperate pleas for help. Although Representatives have heard from 24 of us, we need you to understand that you are not hearing from families that do not have discretionary income for internet access or mobile devices, you are not hearing from families struggling to make ends meet and working instead of searching Facebook for private groups that help you learn how to advocate. You are not hearing from families who speak English as a second language, and you are not hearing from families living in fear of the very real retaliation that could follow if they speak up and speak out.

We are coming to you today because we need a mental health navigator program that helps all families and puts the experiences of the families front and center. We need to pair families in crisis with 1:1 support, and we need the navigator to help families advocate in meetings and walk side by side with the family until the crisis has resolved. We need navigators that understand how the mental health system is actually working instead of navigators that assume the system is working the way it should be working. There's a huge difference.

We need this program to ensure that our complaints are being investigated and corrected. Most of all, we need parent voices included in the role of oversight and accountability because the truth is, unless the distress of families decreases, the problems have not been adequately resolved.

We believe a mental health navigator program can fill both of these roles, and Michigan can move forward ensuring that the needs of families are heard and responded to and that the mental health system works in a way that builds families up instead of tearing families apart.

Ottawa County:

Our daughter was at the Hawthorn Center for almost 11 months. She had to return to Hawthorne because she was not ready to be discharged when she was sent home. We tried to fight it. No one listened.

Our daughter attempted to hang herself from her ceiling fan 10 days after her discharge. When the sheriff and EMT's showed up, she was bragging about how this was her plan the whole time and how she outsmarted the doctors so she could get discharged before she was ready. She told the ER staff that as well.

My daughter's psychiatrist called me today because I had questions about why they haven't done either the med wash I asked about last month nor added the med they wanted to. They've made zero med changes.

The Dr told me Aliyah is telling them everyday that if she comes home she will immediately kill herself, yet they want to start discharge planning!!!!

I asked what our plan forward is if she continues to state she intends to die and she said discharge isn't her specialty that's therapy but from her experience with families like our we have 3 options:

1. She comes home
2. Make her a temporary ward of the state and she goes to residential care or foster care (with a goal of eventual reunification with the family)
3. Permanently terminate parental rights and she becomes a ward of the state

I asked how those can be the only options - our kid comes home with no plan to keep her safe or we give up rights?

If we don't get help, we will likely lose our daughter either to suicide or to the Child Welfare System.

Muskegon County:

My son is 13 years old. He has been receiving mental health services through Community Mental Health since he was 10. The services he received were in-home therapy, office-based, and trauma-informed therapy. He was discharged from community mental health and we were able to find another counselor in the community. After his third hospitalization for mental health issues within a year we were discharged from services and referred back to community mental health to "exhaust all services" in order to meet the requirements to even apply for residential treatment through Medicaid.

Right now, we have an open CPS case, with serious allegations against me regarding sexual abuse, neglect, and that I held a gun to my son's head. Although these allegations were unfounded they continue and my other four adopted children all of whom have serious mental health diagnoses are being re-traumatized by this process. My son ran away, down the highway less than ten minutes after he was discharged from a psychiatric hospital three hours away. The hospital stated he was not a danger to himself or others yet he continues to appear to be in some state of delusion. It took five police officers to get him back into the car with me. When we got home he stated he wanted to start a religious militia and overthrow the American government, to take back the land which the whites took away from the Native Americans. He would then go to Mexico and recruit people to take back what Christopher Columbus took away from them and make white people pay. Does this sound like someone who is mentally stable? There are currently no options for therapeutic placement and I am being left with the option of medical abandonment with CPS likely removing all four of my other adopted children from my home or CPS charging me with endangering my other children by bringing my son home.

Now he has no services in place and we have to wait a week just to do an intake with community mental health, while in the meantime my son suffers from his mental illness, and the rest of my children are exposed to his unsafe behaviors and delusions.
I cannot access residential services without exhausting all avenues of community resources, yet if I have private insurance I could get him into a residential treatment facility out of state within days! This is an extreme gap in services based on income.

My son needs 24-hour care in a residential placement immediately. I need respite options for all of my children who suffer from mental health needs. My son needs services in place prior to returning home from a psychiatric hospital, not just an appointment for an intake. While we are waiting for placement in a residential treatment facility my son needs 24-hour care in our home to ensure his safety and the safety of the others in my home and community.

If we don’t get this help, my son will end up in jail, or dead. His mental health is not stable and I have concerns that he will commit murder or a mass school shooting as he talks about both quite often, and draws detailed pictures. The community is not safe and my family is not safe. The lack of mental health treatment will cause a substantial impact not only on our family but also on our community.

Cass County:

My son is 14 years old and has been with CMH since he was four. When he turned 13, my family turned upside down. We have been with wrap around home based therapy and their clinical psychiatric doctor who has said our son has bipolar tendencies schizophrenic tendencies but can't be fully diagnosed till 18.

He has been in and out of the Emergency Room because of threats to kill himself and me. I'm in the ER with him again right now because he threatened to shoot up the school. He said he was going to shoot teachers and students and he wants to kill my family. He said he bought a gun with money he stole from the family and he hid it so no one would find it. The police are currently searching for it.

This level of crisis is not new. He has been on probation for over 6 months. He has had over 50 felonies, and tons of probation violations. Community Mental Health says it's mostly behavioral. The police say it’s mental illness.

He had a court hearing and it was decided that he can be tried as an adult for terrorist acts for threatening to shoot the school and my family. He will face up to 30 years in prison if he is found competent to stand trial and found guilty. He would be off the streets and the community would be safe, but he would not get help for his mental illness.

If the courts find him incompetent to stand trial, he will not have a criminal record and he will likely be sent home. I will continue to live in fear that he will kill himself or someone else. He will still not get the mental health help he needs because Michigan offers no long term hospitalizations or residential placements that will keep others safe while he gets help.

I'm truly in the middle and afraid for my family and for the teachers and students at his school. I'm scared to have him home, but being in adult jail isn't an answer. He is only 14 years old. He deserves mental health treatment and he deserves a chance for a better future.

Can you please help me get him into the Hawthorn Center or another therapeutic long term placement so he can get the mental health treatment that he needs? If you can’t help, I am being told the only other option I have is to give up my parental rights so the Foster Care system can find a long term placement for him.

Berrien County:

My 15 year old daughter has homicidal ideations and “cannot control” her alter Tori that wants to kill people. She is currently at Forest View in Grand Rapids on the inpatient unit and they are stating residential placement is needed.

She is diagnosed with unspecified mood disorder and unspecified psychosis. We love her so much, but we are scared because she reminds us of Ted Bundy. She has swindled others for years hiding her disassociation and Psychotic, Sociopathic, and Schizophrenic behavior. She’s made false CPS allegations which makes everything worse, and she is very delusional.

CMH didn’t involve us in safety plans, goals, therapy or anything. Each visit it was as if parents didn’t exist. Medications were not increased or changed despite visions and voices remaining. My husband had to go back into the psychiatrist and demand her medication be increased to therapeutic level as it was supposed to be done after an inpatient crisis visit. They never investigated who her alter wants to kill and if anyone was in danger.

She has Private Insurance, and she has Medicaid as secondary. Private Insurance is helping us look for a residential placement. We called CMH to find out who our case worker is to help with residential placement and medicaid. We were told they don’t know who we would talk to about that. CMH is basically a comedy of errors.

Will you please step in and help us make sure that our daughter gets a residential placement and the help that she needs? If she is discharged home without placement, our lives and her life will be in danger. She needs intensive mental health treatment, and we are trying to manage intensive psychiatric needs while CMH appears to be working directly against us.

Ingham County:

I am the adoptive mom of two beautiful children and the legal guardian of my oldest child. All my children came to me via foster care when my husband and I were stationed in California. We are both military veterans. I got out in 2020, and he did this month.

I was born and raised in Michigan, and I moved with my children to Michigan before the school year started last year to have family support. Carlos, my husband, joined us at the start of the year after his contract ended and he began terminal leave.

I explain the background because 3 of my children have permanency with us, and we fought hard for their special needs sibling to be placed with us and be allowed to move to MI as well so the children were reunited. These children had been separated for years from their sister, H, as they all entered foster care in 2018 and had not been able to live with H because of her significant needs.

H was doing great, and she was stable with us and the children were overall happy. Then H hit puberty. At 9 she started her women cycle and her hormones went crazy as happens with most children. However, it's worse for children who are on medication that keeps them stable. Often medications need to be changed as their body changes. H started becoming unstable. We had 2 police visits (one to school and one to home) in December. The violence was significant enough that 4 teachers ended up in urgent care in December after she assaulted them. We advocated to CMH for more support. We got more therapy and eventually respite. H stabilized a bit and then things got worse.

We have had 3 police visits, 3 hospital stays and 5-6 crisis screenings in March. H has attacked my husband and I leaving bruises and injuries, she was done thousands of dollars in property damage, and had made violent threats at school saying she wanted harm and kill other students. She's destroyed her classroom several times as well. H has stated she hears voices telling her to hurt herself and others. She bangs her head trying to get the voices out while being screened by CMH.

It has been recommended that her medication be changed. We asked for inpatient to do it because she was already unstable and medication changes often make things a lot worse before better. The psychiatrist who did one of our screening agreed and told us it would get worse when we changed medications until the right combination was found.

The doctor then back tracked and said she'd likely be fine so we should just try it. We asked how to keep H, ourselves and our other children safe with a medication change if things did get worse. I noted that I've had minor concussions from her throwing and hitting me while raging and my husband was covered in bruises and bite marks. She was regularly stating she wanted me dead so she could have all her father's attention. Still, CMH did not deem her in need of inpatient care even though they did not have any ideas regarding how to help us safely change her medications.

CMH couldn’t get us into the med clinic to even facilitate a med change, and referred us to a provider that went on to say she needed a therapeutic placement. CMH still denied H needed such a setting. We couldn’t get a solid plan to safely change medication or even recommended changes.

We continued to ask for inpatient. We contacted advocates and our state representative. H’s California social workers have asked for inpatient for her. H’s CMH team has reached out to their supervisors to try and get her a bed. No one would help.

Now a 9 year old girl, who is dangerous because she is so big for her age at 5’5” and 140 lbs, is likely going to be permanently separated from her siblings because no one in Michigan was willing to provide her with appropriate level of care.

We have been in the sparrow hospital for a week today. She was finally approved for inpatient but this was after the plan to move her to California was finalized. At the hospital, her current medications are not given on time or correctly so she’s likely going to be more violent at/after discharge then she was before.

I’m asking that this doesn’t continue happening. Our youth in crisis need to be provided for, especially our most vulnerable children who are on state insurance.

I have explained H’s behaviors brought on by mental illness, but the real H is a sweet funny girl. She likes playing with her play kitchen and family. She is mentally closer to 5 then 9, and she has a unique imagination. She is active and loves anything outdoors. She was thriving here. She increased almost a whole grade level in part of a year. She went from a Kindergarten reading level to knowing half her second grade site words! She LOVES animals. She loves her siblings and family. But that is often overshadowed by her mental health struggles and instead of helping her, she is left in a broken system that continues to beat her down.

St. Clair County:

Less than 2 weeks ago I spent almost 3 weeks in the Emergency Room with my 14 year old son trying to get him help. The nurse told me it could be months before they found him an inpatient placement. They wheeled a bed into his room so he would at least have somewhere to sleep.

You have to understand, he was in the hospital immediately before this. We were back at the emergency room because the Crisis Residential Program he had just been discharged to called and said that I had to pick him up because he needed to go back to the Emergency Room only 10 hours after he arrived there.

Our local Community Mental Health (CMH) won't open services until he was discharged from the hospital. They were not helping at all. The CMH Access Line told me the crisis would probably resolve while he was in the Emergency Room. He was hearing voices and hallucinating. He had already violently attacked me. This isn't something that resolves while you are camped out in the Emergency Room.

After 2 weeks of sitting there with no mental health intervention or medication management, the CMH crisis team decided he no longer met criteria for inpatient care, and they discharged him home. We did not have a safety plan, and no one involved was willing to put it in writing that he would be safe. He didn't even have any mental health services to transition home to. When I pushed back and advocated for help, I was threatened and told Child Protective Services would be called if I refused to bring him home.

We did manage to get CMH services opened. When his new home based therapist met with him, she informed me that she did not think he is schizophrenic. He explained that he only hears voices around certain topics and she thinks he is just really sensitive. She then asked me if I had ever heard of a psychic medium.

Today, 9 days after CMH sent him home from the emergency room, my son who has already been diagnosed with RAD, Major Depressive Disorder, Psychosis, CPTSD, and Anxiety, whose symptoms were still best described as supernatural, is back at the Emergency Room.

He got angry and was saying he was hearing voices that were telling him to hurt himself and me. The police came because he didn't feel he could wait two hours for the CMH crisis to get there. He was taken to the hospital by ambulance.

Can you please step in and help us find placement in an inpatient facility or at the Hawthorn Center? He needs to stay somewhere until his medication is stabilized and he is able to remain safe in our home. We love our son, and we just want him to get the help that he needs!

Montmorency County:

My child is 17-years-old, has Down syndrome and autism, as well as complex medical conditions and severe behaviors. In 2017 he was approved for the Children's Waiver, and we believed we would finally get the help we needed to keep him safe in our home. In the six years since we have received minimal support from our Community Mental Health (NeMCMH).

Last year we finally found an inpatient psychiatric hospital that could care for his complex needs (University of Michigan). After five months on a waiting list, he received treatment for a month, was discharged, and returned home, still unstable. Long term residential treatment was recommended based on the complexity and severity of his Needs.

Since then we have facilitated another referral to that unit and have been advised that the wait list is now over six months. Our child is currently unstable and unsafe in our home and in his school. Yet there are only 3 inpatient beds in the state of Michigan for children like him, and a backlog of children needing those beds.

Additionally, the CMH leadership team declined to refer our child to a residential program citing his lack of failed hospitalizations, without recognizing that access to beds and failure of staff to facilitate inpatient care are barriers to the failed hospitalizations required to meet their standards.

We are currently seeking out of state options for our child; our only option for the help he needs. In the meantime, our Community Mental Health system lacks the programs needed to keep our child safe in our home. He hurts himself, other family members and destroys property, and all we can do is sit with him through the struggle. The agony we endure as his parents, powerless to give him the help he needs because it is unavailable is exceeded only by the agony he endures from the lack of treatment and support options. No family should live this way.

Our child is too complex for the vast majority of inpatient psychiatric beds in the state, even with 24 hour nursing and trained technicians, but we are left with a paucity of resources to keep him safe in our home.

I bring this to your attention to ask that you as a body address both the paucity of community resources and the paucity of inpatient beds for children, especially children with other health conditions and intellectual developmental disabilities as well as access to robust programs promote behavioral well- being in addition to medication, such as a

residential facility.

Our goal is always to have our child safe in our home, and despite our efforts, we have made no progress in the six years he has had access to Community Mental Health services. I welcome any assistance to us in our plight. Can you please help us find a safe path forward for our son?

Shiawassee County:

My younger son is suffering. He is also experiencing depression. This is happening because his severely mentally ill older brother is not receiving mental health treatment. We are all continually traumatized in our home. His older brother does not get the care he needs. I have exhausted all resources per CMH, CPS, and the court system.

We live in Shiawassee county and the former Sheriff, Mr. Begole, is also our state representative. He may recognize my boy's last name Kabteni (cab-tea-knee) as the police, sheriff, and state police have all responded to calls for my oldest son's mental health crisis a multitude of times since we became residents of the county. At this time, when we call 911 for help to keep us safe, Central dispatch notifies both the local police and two state troopers to respond due to the severity of my oldest son's mental health issues and his resulting actions.

My oldest son has been in the care of CMH (Shiawassee Health and Wellness as well as Genesee Health System) and Private Psychiatrists and therapists since the age of 3. That's almost 12 years. He has multiple diagnosis, Autism, DMDD (a mood disorder), Major Depressive Disorder, Anxiety, Suicidal Ideation, psychosis at times and he was most recently given a diagnosis of Conduct Disorder, a severe mental health condition that all people with anti-social personality disorder have as children.

We colloquially know anti-social personality disorder as "sociopathy." To give you an idea of what that means, my son has been in intensive home care for Cognitive Behavioral Therapy most of his life, he has done ABA the "gold standard" therapy for autism, twice with no results, and we are about to start a third time. He has had a "Wrap team" and is in special education for "Emotional Impairment". He has been on dozens of medications for his mental health disorders, big anti-psychotics, and continues to be on them now, Abilify, Risperdol, Haldol, Zyprexa, Triliptal, Depacote, to name a few.

While we have continuously sought intensive therapy and the right medications for years, he is still uncontrollable. I have begged for residential care because he is dangerous. I have been continually denied. We are refused the intensive residential placement his Psychiatrist has requested since June of 2020.

In that time, he has amassed multiple felony assault charges. The police have responded for hitting a teacher in the head with a rock causing great bodily harm, for assaulting people with deadly weapons, for attacking police officers, attempting to get officers guns (twice), physically assaulting me (I have three herniated discs in my neck from one assault) assaulting his step dad, assaulting his biological dad, assaulting his

grandfather, assaulting his brother, assaulting other children in the community and assaulting other teachers. I have pictures of the results of these assaults, punches, kicks, digs, bites, and strangulation marks if anyone would like to see them.

In that tim,e CMH points it's fingers at the Justice system and the Justice system finds him incompetent to face his charges and points the finger back at CMH. No one will help him, so the entire community continues to suffer.

My oldest son is released back to me immediately after arrest and refusal of placement and I am told to do my best, keep him safe. When the Justice system did his competency evaluation for his first felony assault, they found in one year he had been to ER 19 times for placement (many of those times escorted by the police) and NO ONE was willing to accept him, even in crisis, for short term inpatient because of his violence and that required physical restraint and chemical restraint at the hospital.

He has since been to the ER with police escort dozens of more times. We are BEGGING for help before my son, who has exhausted all resources according to medical professionals and the Justice system, costs someone their life.

Each time he is arrested, we go to the hospital just to be released back into public because no one will help us. Per Judge Gadola in Genesee county court January of this year, 2023, "Mother, I would just continue to encourage you to pursue services. Ms. Bade's input (juvenile delinquency case worker in Genesee county) is that you have done everything you can, probably above and beyond to try and help your son. Please keep doing that."

Since that court date in January he has assaulted me, my husband, a Durand police officer (bad enough to injure him) and caused destruction of police property in one incident as well as attempted to take control of a vehicle to kill me and my younger son which took 5 officers to catch him and get him under control.

So here I am, with other parents, struggling, publicly addressing this issue to the people with the most power in this state. Please help us since CMH will not.

Please help us keep my son from harming himself, harming someone else again, or worse yet our police department being scrutinized in the court of public opinion for doing what they very may well may have to do someday to keep the community safe since the mental health services we pay for both publicly and privately are obstinately choosing not to do their job.

Please choose today to save not only my son’s life but our community and our officers. There is only one way this will end without placement for my oldest son. Thank you for taking the time to listen.

Muskegon County:

We approached Community Mental Health (CMH) in early January 2023 and applied for Wraparound and an SED Waiver for our daughter. The previous day, she had attacked my husband and me and left my husband with bloody bite marks and scratches. She has significant mental health needs that help explain why she has aggressive and violent behaviors.

I told CMH we needed a medication evaluation immediately and the soonest they could get us in was March 6. I told CMH that I was sure that we would have to call the police before then in response to her aggressive behaviors. She had become increasingly aggressive and combative since November 2022.

We did not have a safety plan with proactive steps to ensure safety. The only reactive steps were give was to call the crisis line or to call the police. It was not helpful at all. Exactly one month later, Feb 8, she assaulted me. She punched me in the nose, pulled my hair, bit me and kicked me repeatedly in the ribs while we were both in the car. I had to call the police and she was taken by ambulance to the ER. She was there for 10 days waiting for inpatient, and no one would take her because her acuity was too high for some inpatient hospitals, meaning every inpatient hospital in Michigan refused to admit her and we had to take her home even though she was deregulating & escalating to dangerous levels.

Between her discharge from the ER on Feb 17 and March 5, we utilized the CMH crisis line 4 times. She attacked me again on March 8 by throwing a blender pitcher and a hard metal bowl at my head, and chasing me with a baseball bat and attempting to break our home's glass doors, while screaming that she was going to kill me and our other young children. I called the police and it was arranged that she would be admitted to Forest View Psychiatric Hospital in Grand Rapids. She is still there today. The hospital social worker is telling me that she needs residential placement, but no one is actively helping me find a place for her to go. Forest View is suggesting direct transfer to residential but this feels impossible if we can't even get any help finding her somewhere to go.

Child Protective Services is now involved because when my daughter attacked me, I had to try to get her to stop hurting me, and she told the hospital I was the one who attacked her. I did not try to hurt her. I just tried to get away so I could keep myself & our other 4 children safe.

I cannot possibly bring her home from the hospital in her current homicidal state. CPS is

saying they hope we do not get to that point, but no one has an answer that will keep all of us safe and make sure that our daughter gets the treatment that she needs.
We want her to get better. We don't want her to be the next child to enter the Juvenile Justice system because her mental health needs have gone untreated. Will you please help us make sure she gets the residential placement she needs? I cannot risk the safety of my family by bringing her home.

Otsego County:

My 13 year old daughter has been in and out of short term hospitals or placements three times since October 2022. She has been diagnosed with ADHD, DMDD, PTSD, Anxiety, and Depression. She also has developmental delays. All of this is causing her to become suicidal and homicidal.

The last time she was in the hospital earlier this year, even CPS said she wasn't ready to be discharged, but Havenwick discharged her anyway. I was afraid to bring her home, but I had no choice. I left the hospital with her and CPS helped me drive her home. We were only 5 miles down the road when she started saying that she wanted me dead and wanted to kill me. She got so physically aggressive that the CPS worker had to stop her from choking me.

Police were called and she was taken back to the hospital via the police to be rescreened for mental health needs. She hit, shoved, and pinched me everyday in the Emergency Room while we were waiting for an inpatient bed. She cussed me out telling me again how she wanted to kill me. This went on for two weeks.

I was advised by Community Mental Health and CPS not to be at the hospital with her. I left and have been told for my safety to not return until we get her placed into a facility. CPS has been involved because she keeps making false accusations against us that can not be substantiated through CPS investigations. She has now been in the ER for two months waiting for a bed at Hawthorn. We were told over a month ago she would get the next female bed.

She is giving up hope that they will place her. We talk on the phone. Sometimes the calls are good, other times not so much. But it's hard to keep telling her it will happen when it is taking so long. That ER room is like jail in itself.

Can you please help me make sure that she gets an immediate placement at Hawthorn? We love our daughter and we only want her to get the treatment that she needs so she can return home. Her mental health needs to be addressed and I fear that we are losing time and her condition will only worsen the longer she waits.

Ingham County:

I need help right now. My daughter is 15 years old, her father and I adopted through foster care when she was 8. We are divorced, and he lives in Grand Rapids. I got physical custody of her in October due to escalating behaviors in her father's home. She ran away 7 times while with him, mostly staying with her biological mother during these times, who is now deceased. She also physically assaulted him, resulting in charges being filed with Kent County. We were awaiting a date for a hearing for probation, but due to the last runaway situation, and her complete disregard for authority, she moved in with me to ensure the safety of the other child in her father's home. Since being in Ingham County, Kent County said they transferred the case to Ingham, but there has been no follow up as to the status of the case.

My daughter is currently in the Pediatric Emergency Room at Sparrow Hospital in Lansing. On Tuesaday, March 14th, I utilized Clinton-Eaton-Ingham Community Mental Health Mobile Youth Crisis services due to escalated behaviors in my home, and due to statements made in the home regarding suicidal and homicidal ideation. My daughter stated that "if I had a gun or a knife, I would kill you and dad". She was extremely aggressive both physically and verbally, and unable to utilize identified coping/de-escalation strategies. Mobile crisis did come to the home at which point, my daughter de-escalated and went to bed. A safety plan was emailed to me the following day, which meant there wasn't even a time when the CMH staff reviewed it with her.

On Wednesday, March 22nd, just over one week later, while out with her Family Support Worker, she disclosed that she had a knife on her. The Family Support Worker took her to the public library and told her that weapons were not allowed in public spaces, and my daughter left the knife in the cupholder of the worker's vehicle. The worker called me at this point, and I came to pick her up. Due to the threats of causing harm if she had access to a weapon, I took her to CEI-CMH again due to safety concerns, and her continued suicidal and homicidal statements. At that time, the therapist did not speak with me regarding the reason for bringing her in, spoke only to my daughter, and we were sent home. I did file paperwork to receive a second opinion at that time.
The next day, Thursday, March 23rd, my daughter had a half day at school. She receives door-to-door bussing through her IEP, but had convinced her bus driver that her grandma was picking her up from the basketball courts near our home. She did not return home on the 23rd and I filed a missing persons report with Meridian Township Police Department around 11 am, after talking with the driver who confirmed that he did not drop her off at the home. I also posted to social media a photo of her with a description, encouraging the community to call the department if she were seen, and also to reach out to me via messenger. I received several leads from the community,

and around 8:30 that evening, she was brought home by police. I requested that the bring her to Sparrow for a PRT. The officer scoffed at this request, not fully understanding the depth of concern around my daughter's mental health state.

Once at Sparrow, we went through security and my daughter gave me her cell phone that I pay for, in addition to two other cell phones that were not working. It was later determined that she two phones came from peers at school. Once in the pediatric ER, my daughter required 3 security team members, and several nurses to get her to change into the hospital's uniform. She eventually complied, and it was discovered that she had a vape, and an additional cell phone on her at that time. We sat in a hallway until 1 am when we were sent from Sparrow to CEI-CMH to stay in their "crisis unit" to see if she met criteria for inpatient hospitalization. She was transported by ambulance, and the hospital nurse was attempting to give my daughter, a minor, her belongings from when she changed into the hospital uniform, even though I insisted that they needed to come with me out of concern of what else was potentially on her when she came in. Once at CMH, it was determined that she did meet the criteria for inpatient hospitalization, and we stayed in one of the crisis services rooms together until around 10 am Friday (3/24) morning. At that time, we were told we were moving to the Families Forward building. While there, the therapists separated us into two rooms due to my daughters aggressive behavior and escalation in behaviors just by me sitting in the same room. In the evening, we were moved back to the crisis services building. She went through security, and although she "beeped" they allowed her to continue to a room. At this time, one of the workers said it was fine for my daughter to be alone in one room, and lay under two chairs that were pushed together with a blanket over them. This was extremely unsettling to me given she had attempted suicide by hanging herself with a blanket under her bed. I was under the impression that CMH staff was assisting in supervision and ensuring psychological safety while there. When I questioned the staff, they said that I could tell her to go take it down, but that it wasn't their responsibility to do anything because I was the guardian. I was required to administer her medication during this time, be present at the facility, all while she could not be seen on camera, could have easily just ran out of the building, and otherwise was not truly being monitored at a level of care needed for someone who was deemed needing inpatient hospitalization. We were there until Sunday evening when she became very aggressive, punching furniture and throwing furniture. At that time, she was taken back to Sparrow via ambulance.

On Monday 3/27, CMH came to do a reassessment to see if she still qualified for inpatient hospitalization. They said she did not meet criteria any longer, and that I would have to take her home. The only thing that had changed since then was time passing. The hospital staff said that there was no way they were letting her leave

because she is a danger to herself and others. I requested a second opinion again from CMH. On Tuesday, Sparrow had their psychiatrist meet with myself, her father, and her, and did not feel that it would be safe for her to return home right now. Throughout the day on Tuesday, myself, along with one of the safety sitters at the hospital, was suspicious that she had something she shouldn't have. He stated that he could see a reflection in her glasses that was not the TV. Late afternoon, the Sparrow psychiatrist asked me to go home and call a few phone numbers that were found on her when she came into the ER on Thursday. I made contact with the numbers that were written on papers, and additionally found a few different logins written down for various social media sites. I attempted to get into the one cell phone that was found in the bags from the hospital using information written on the papers. I was able to figure out the passcode, and it was found that she was actively communicating with people in several apps on that phone. I immediately called Sparrow and let them know that our suspensions of her having another phone were correct, and they proceeded to search. She was reluctant to allow them to search, and did get physical with the security staff, biting, and hitting them. They recovered the phone, and I came to pick her up. She did receive a minimal dose of Ativan to help calm her.

Once I was home, I started going through that phone as well, only to discover that she was sending extremely sexually explicit videos and photos to random strangers, all of which were taken in either the CMH "tent" that was allowed to be created, or here at the hospital. Several of the videos/photos that were taken were in the bathroom of the hospital, and she was completely unclothed, masturbating on the floor. It is unknown where these phones came from, and the phones were turned into the Meridian Township Police Department to determine where they came from, and additionally, see if any other action needs to be taken due to the content on the phones.

Today is Friday March 31st, it has been over a week that I have been advocating for my child to get the help that she needs. During the second opinion appointment with the CMH psychiatrist yesterday, she said that if she returns home to my home, or her dad's in Grand Rapids, that she would absolutely kill herself. It is very evident that she is physically, emotionally, and sexually out of control. CMH is here as I write this to do a reassessment. Unfortunately even if authorized for inpatient again, it is highly doubtful that any hospital would admit her due to her high level of supervision needed. When calling hospitals about open beds on Friday, Saturday, and Sunday - she was denied placement at places that had open beds due to the extreme behaviors - and that was before more information was discovered about the sexual concerns. CMH wanted to discharge her and send her home Monday, and while I do feel that Sparrow is in support of the idea that she needs a higher level of care, sitting here in the ER is not treating

any of her mental health concerns. She has required ambulatory transport for all transitions due to the high level of safety concerns.

I am reaching out because I need someone to step in immediately and figure out how to handle this situation in a way that is safe for my daughter, myself, her dad's family, and in alignment with policy. Professionally, I am a public school educator and fiercely advocate for my students and families. Right now I am fiercely advocating for my daughter. She needs help and is not getting it from the current systems that are set up to provide assistance. She is an absolute imminent risk to herself, her caretakers, and the greater community.

Macomb County:

My 9 year old son needs 24 hour care in a residential placement due to his inability to cope with his anger, violent physical aggression towards me or any other authority figure that places a reasonable demand on him or even help him to make the right decisions. He is diagnosed with Mental Illness, Emotional Impairment, ODD, DMDD, ASD, and anxiety from multiple medical professionals and also academically through multiple school districts. He has had psychiatric care for the past 5 years and has been on over 25 different medications, none of which have worked.

He's been to MANY MANY multiple medical professionals, none of which are helpful or got us any further to a solution for his behavior. He currently goes to an intermediate school and can hardly make it through a school day without having to be tranquilized due to physical and verbal abuse he places on staff members; teachers, aides, bus drivers, etc. He has had autism case management from Easter Seals and Wraparound Case Management through CMH neither of which have provided any real viable services to help. My son has been referred to many different providers through both agencies who we cannot receive treatment from due to their lack of staff and extensive waitlists, some for up to 4 years long. Perhaps the most frustrating part is that the facilities and professionals have no reasonable timeline as to when we can expect care. Meanwhile, my son is suffering. Time is passing and we are getting nowhere.

When my child is in crisis, we have been recommended to take him to the ER for help and further "documentation" that will get him into a short-term treatment center, that will ultimately regulate and release him within 7-10 days. While in the ER, we have waited up to 10 hours only to be told that there is no placement for him in any facility in our state and then discharged. I absolutely refuse to put my child through this process anymore for a completely ineffective outcome.

We have also been told we can contact law enforcement which will then place him in the Juvenile Justice System. This option is quite possibly the worst place for a child with mental illness who doesn't understand why he's there in the first place. He would be in the company of juveniles with criminal records who absolutely shouldn't be interacting with children who have mental illness and low emotional understanding as to what's going on around them.

If I can't get him the help he needs I will have to endure many more years of physical abuse and mental regression. He will eventually graduate to hurting himself and he is and will always be a threat to society. He is too violent and unpredictable to be in the community currently and is only getting worse. He needs serious observation and

treatment in order to even have the chance for a decent quality of life. I am at the mercy of our broken system, within the state of Michigan, getting no help or real answers on what we are supposed to do.

It is imperative to create residential facilities to save our *young* children from a life of disparity, poverty, and constant mental crisis. There are extremely beneficial facilities out of state who accept children as young as 5 years old, but they are up to $1000/day and do not accept Michigan Medicaid. Some aren't even covered by private insurance. They have long-term placement and end up with real results that are life changing for families.

We. Need. Help.

I am looking forward to a response and direction to take moving forward.
We are at a loss.

MENTAL HEALTH CODE (EXCERPT)
Act 258 of 1974

330.1712 Individualized written plan of services.

Sec. 712. (1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.

(2) If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.

(3) An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996;—Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997.

michigan dental ASSOCIATION
YOUR CONNECTION TO ORAL HEALTH

March 31, 2023

Michigan House of Representatives
Appropriations Subcommittee on Health and Human Services
Room 352, State Capitol Building
Lansing, MI

Re: Michigan Dental Association Public Comments on FY 2023-2024 Executive Budget Proposal

The Michigan Dental Association offers these comments in support of the FY 2023-24 Executive Budget Recommendations that propose investments to expand access to care for the adult Medicaid population, ensure the continued success of the Healthy Kids Dental Program, and support the overall oral health of our state. The MDA's reasons for support, and recommended improvements to the Executive Budget proposal, are below.

Adult Dental Medicaid

Last year, the Legislature made a historic investment to redesign adult dental Medicaid benefits by significantly improving fees for the first time in 30 years, reduce administrative burdens for providers who treat Medicaid patients, and enroll the majority of fee-for-service patients in a health plan. The changes were announced in early 2023, with an effective date of April 1, 2023, for improved administration, increased fees, and expanded covered services. The initial feedback from MDA members has been overwhelmingly positive, with many requesting information about the steps they should take to be able to treat adult dental Medicaid patients when the changes go into effect. The Michigan Dental Association has been working closely with MDHHS as they prepare for increased provider enrollment after April 1st and educate patients about their new benefits. Continued funding for adult dental Medicaid will continue to improve access to care and the oral health of Michigan's Medicaid population.

The Michigan Dental Association supports the proposed investment for dental redesign and dental services included in Sec. 8-120: Health Services of the Executive Budget.

Medicaid Anesthesia Rate Increase

Many vulnerable Medicaid patients, such as young children, the elderly, disabled individuals, and individuals with serious health conditions, are unable to receive routine or complex dental care unless they are under general anesthesia at an ambulatory surgical center (ASC) or outpatient hospital (OPH) setting. Last year's State Budget made a substantial investment to increase the Medicaid facility fee for dental procedures from $200 per procedure to $1,495 per procedure in an ASC and $2,300 for OPHs. With this increase, vulnerable Medicaid dental patients are no longer priced out of the facilities that they need to receive routine dental care.

The Medicaid reimbursement for anesthesiologists is the other significant barrier to these patients receiving dental care. Currently, anesthesiologists are reimbursed at approximately $200 per Medicaid dental procedure, which is well below the costs of providing the service. The FY 2023-24 Executive Budget Recommendation includes a $2,900,000 gross investment ($700,000 GF/GP; $2,199,900 Federal) to increase the Medicaid Anesthesia rate 5%, bringing the reimbursement to 49% of the Medicare fee. While an increase is needed, the Executive Budget Recommendation does not account for anesthesiologists being reimbursed at a lower rate than other providers. For example, the Executive

Budget Proposal recommends funding to increase Medicaid Professional Services, which includes physician, podiatry, chiropractic, and vision and hearing services, by 5%. However, this would place Medicaid Professional Services at 63% of the Medicare rate.

The Michigan Dental Association supports increasing the Medicaid anesthesia rate. However, the Michigan Dental Association recommends that the Medicaid anesthesia rate be increased by 19% so that anesthesiologists are paid at 63% of the Medicare rate, which creates equity between them and other providers. This would require an $11 million gross appropriation ($2.66 million GF/GP; $8.34 million Federal).

Healthy Kids Dental

Since the initial Healthy Kids Dental pilot was launched in 2000, the program has expanded across the entire state and became the national model for children's dental Medicaid programs. At the core of the Michigan Healthy Kids Dental program's success is the funding that it has received, which allows providers to treat children in a financially sustainable manner.

The Michigan Dental Association supports the proposed investment in dental services included in Sec. 8-120: Health Services of the Executive Budget Recommendation.

Michigan Donated Dental Services Program

The Michigan Donated Dental Services Program connects elderly, permanently disabled, or medically fragile patients who require significant dental care with MDA Members that donate the necessary lifechanging care. The patients treated through the Donated Dental Services Program are individuals who are not able to afford or access care through any other program. Over the last 25 years, MDA members have donated nearly $26 million in care to patients with cancer, requiring organ transplants, undergoing dialysis treatment, and many other serious health problems. Often times, these patients are unable to receive important medical care unless their oral health issues are addressed. The MDA has operated this program with a $150,000 grant from MDHHS, which is used to employ 2 fulltime caseworkers that recruit volunteers, process applications, and coordinate care. This grant has not been increased in at least 10 years.

The Michigan Dental Association requests an increase in the grant, found in Sec. 8-1315: Family Health Services of the Executive Budget Recommendation, to $200,000. This $50,000 increase will be used for outreach to eligible patients who may be unaware of the program and to recruit new dentists into the program, both of which were negatively impacted by the pandemic.

Thank you for considering our input. We hope that you will support these investments to improve the oral and overall health of our state. If you have any questions, please contact Bill Sullivan, Vice President of Advocacy and Professional Relations at bsullivan@michigandental.org or (517) 346-9405.

Meet Al

The support of Direct Care Workers is critical to his independence.

Al wants nothing more than to live in his little house in Marquette, MI. He loves to hike on the many trails in his beloved UP, grab takeout to eat y the beach and go to the gym. His easygoing lifestyle changed drastically in 2020.

Perhaps in part due to the pandemic shutdowns, Al, a man who is non-verbal living with autism, began to struggle behaviorally.

His staffing provider was already having difficulty filling his 24/7 staffing needs. After a particularly difficult incident, his provider finally gave notice. They simply did not have the capacity to support Al any longer.

At that time Al was taken to the emergency room so that doctors could determine if his behaviors were related to a medical cause. With Al's provider out of the picture, he was unable to leave the ER until either a residential placement or replacement staff could be found.

Each day his case manager checked with group homes and hospitals all over Michigan. Each day she was told that there were no beds. In the meantime, his mother found a small team of staff that she was able to hire to support Al in his home. He finally came home.

Unfortunately, settling back into his life was not easy. Al was struggling with extreme anxiety. The staff team was very small and there were not enough people to cover all of the hours in the day. Al experienced another incident that brought him to the ER. This time he was admitted into the mental health unit.

The doctors made some medication adjustments and Al could have gone home, but in the time he was in the hospital, he lost some of his staff. That meant that he did not have enough staff to come home.

Again, his mother and support system began searching for more staff. It took over 100 days before Al could go home. Even now that he is back home, one staff injury or resignation will put him back in jeopardy. His mom lives in constant worry that someone from the team will leave and Al will again be left without support. Al and his mother need our help to solve this staffing shortage.

MICHIGAN NEEDS TO SUPPORT DIRECT CARE WORKERS WHO ARE THE LIFELINE FOR SO MANY PEOPLE LIKE AL.