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By First Class Mail and
By Electronic Mail

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Re: United States v. Police Dep't of Baltimore City, et al., No. 1:17-cv-00099-JKB

Dear Counsel:

We write following the publication last month of the Final Report from the Baltimore Public Behavioral Health Gap Analysis (Gap Analysis or Final Report).[1] The gap analysis is required by the Consent Decree in the above-captioned action, which resolved the United States' claims that the Baltimore Police Department (BPD) engaged in a pattern or practice of discriminatory or biased policing practices in violation of the U.S. Constitution and various civil rights laws, including the Americans with Disabilities Act (ADA).[2]

[1] Human Services Research Int'l, *Baltimore Public Behavioral Health System Gap Analysis: Final Report December 2019* (Dec. 2019) [hereinafter Gap Analysis or Final Report], *available at* https://www.baltimorepolice.org/baltimore-public-health-system-gap-analysis.

[2] Consent Decree, *United States of America v. Police Dep't of Baltimore City*, et al., No. 1:17-cv-00099-JKB ¶ 97 (D. Md. Jan. 12, 2017) [hereinafter Decree].

Baltimore organizations and advocates have written jointly before about the need for expanded behavioral health services, including crisis response services, in Baltimore.[3] Additionally, many of these same organizations have opposed the assignment of Baltimore Police Department (BPD) officers and units, such as the Homeless Outreach Team (HOT) and the Law Enforcement Assisted Diversion (LEAD) program, into public behavioral health roles.[4] And some of our organizations commented on earlier drafts of the Gap Analysis; this letter incorporates points made in those comments.[5]

The recommendations in the Final Report are basically sound and must be implemented to comply with the Decree's objectives as well as Baltimore city officials' ADA obligations. More work must be done, however, to analyze, understand, and address unlawful police interactions between persons with behavioral health disabilities or in crisis, including racial disparities.[6] Additionally, the parties must engage further with stakeholders in the process of implementing the Gap Analysis' suggested reforms.[7] Accordingly, this letter provides a list of recommendations that local organizations prioritized during a strategy meeting hosted by Disability Rights Maryland, Behavioral Health System Baltimore, and Open Society Institute-Baltimore in November 2019.[8]

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[3] *See* Disability Rights Maryland (DRM), *Sign-On Letter to Decriminalize Disability*, *available at* https://disabilityrightsmd.org/wp-content/uploads/2017/01/Sign-On-to-Decriminalize-Disability-PDF.pdf (last visited Jan. 6, 2020).

[4] Letter from Lauren Young, Disability Rights Maryland, to Crista Taylor, Behavioral Health Systems Baltimore (BHSB) & Encl. (June 8, 2018) (on file with authors).

[5] *See* Letter from Monique L. Dixon, NAACP Legal Defense Fund, to Kenneth Thompson, BPD Monitoring Team (Dec. 2, 2019) (on file with author) [hereinafter NAACP LDF Letter]; Letter from Jennifer Mathis, Bazelon Center for Mental Health Law to Kenneth Thompson, BPD Monitoring Team (Nov. 1, 2019) [hereinafter Bazelon/DRM Letter], *available at* http://www.bazelon.org/wp-content/uploads/2019/11/Bazelon-DRM-comments-on-Baltimore-behavioral-health-system-gap-analysis-11-01-19.pdf; Letter from David A. Prater, Disability Rights Maryland, to Members of Gaps Analysis Subcommittee (Sept. 29, 2019) (on file with authors).

[6] *See* NAACP LDF Letter, *supra* note 5, at 3 (citing Decree ¶ 97).

[7] *See* Final Report, *supra* note 1, at 99 (stating that "it is critical that service users and their families are fully involved in all aspects of the implementation phase," but that involvement must be "meaningful"). As the Bazelon Center and DRM noted in earlier comments, "support needs to be provided to promote the involvement of Baltimore residents, including people of color with disabilities, with lived experience in the criminal and behavioral health systems," including financial support and holding meetings "at accessible times in accessible places." Bazelon/DRM Letter, *supra* note 5, at 4 (citing October 2019 version of gaps analysis)

[8] *See* Disability Rights Maryland *et al*, *Decriminalizing Disability: The Case for Crisis Response in Baltimore City*, https://disabilityrightsmd.org/decriminalizing-disability-the-case-for-crisis-response-in-baltimore-city/ (last visited Jan. 1, 2020).

The gaps in Baltimore's behavioral health system that have been filled by Baltimore Police Department (BPD) officers and units have resulted in the criminalization of disability, disproportionately affecting people of color with disabilities, and resulting in disproportionate incarceration and segregation of people of color with disabilities in jails, state psychiatric hospitals, and emergency departments.[9]

Meaningful stakeholder involvement in the implementation process is critical and has already begun, including at the "Decriminalizing Disability" symposium at Coppin State University on November 21 and 22, 2019. The Symposium featured a review of a community survey on the priority of the recommendations in the first public drafts of the Gaps Analysis. This was followed by a facilitated discussion about priorities with participants representing a cross-section of stakeholders in Baltimore's behavioral health system, including residents, providers, advocates, and representatives of the parties, including the U.S. Department of Justice and the BPD.

Symposium participants prioritized six of the gap analysis recommendations for implementation.[10] We agree with this prioritization. In order of priority, they are:

1. Increase Housing Availability: The Final Report concludes that housing availability, specifically tenant-based housing vouchers and subsidies for individuals in need of housing, must be increased.[11] The Final Report recognizes that permanent supported housing (PSH) under a "Housing First" model is an evidence-based practice that has been shown to produce positive outcomes for people with disabilities.[12] PSH should be implemented in Baltimore to help ensure that "individuals with the greatest needs are able to access housing."[13] Development of PSH is needed to help reduce a "root cause"

[9] *See, e.g.*, NAACP LDF Letter, *supra* note 5, at 3 (citing gap analysis findings that 78.4% of individuals in crisis were African American, even though Black or African American residents comprise only 62.8% of general population); Bazelon/DRM Letter at 2-3 & n.4 (citing gap analysis findings that Black or African American people comprise 62.8% of Baltimore's population but 77.2% of recipients of public behavioral health services, and study from Baltimore and New York City indicating that police violence exposures were commonly reported among adult residents, communities of color were disproportionately affected, and exposures were associated with greater odds of psychological distress and concurrent suicidal ideation, suicide attempts, and psychotic experiences). As the Final Report notes, over 85% of Baltimore City residents in Maryland's state psychiatric hospitals are African-American, and the overwhelming majority of people in these hospitals are forensically involved. Final Report at 46-47.

[10] *See* Stollenwerks LLC Consultants, *Decriminalizing Disability Symposium High Level Summary* 3-4(Nov. 2019), https://m.box.com/shared_item/https%3A%2F%2Fapp.box.com%2Fs%2Fm59so3zi9mpdib8lj0n9slci087c5rff/view/574705121967.

[11] Final Report, *supra* note 1, at 110-11.

[12] *Id.* at 111-12.

[13] *Id.* at 111.

of behavioral health crises that result in inappropriate police calls. Symposium participants added that housing development efforts must ensure flexibility to address individuals' needs and preferences.

2. Expand Crisis Response Capacity: Both the Final Report and Symposium participants endorsed the expansión of the behavioral health crisis response system in Baltimore.[14] To function as a meaningful alternative to BPD response to crisis calls, crisis services including mobile crisis teams, crisis stabilization houses or apartments, comprehensive crisis response centers, and peer-operated "living rooms" must be available 24 hours a day, seven days a week, 365 days a year. Crisis response providers must serve adults, youth, and children.

3. Enhance Funding for Peer Supports: Both the Gap Analysis and Symposium participants recognized the value of including peer support specialists in the behavioral health workforce.[15] Both affirmed supporting peer services by supporting their financial sustainability and ensuring that peers can earn a living wage. The Final Report recommends developing peer organization revenues through public and private investments and by ensuring that peer services are Medicaid reimburseable.[16] As the Bazelon Center and Disability Rights Maryland stated in prior comments, increasing the availability of peer supports in Baltimore's behavioral health system, including on assertive community treatment (ACT) teams and mobile crisis teams, should help improve cultural competence and reduce bias in the delivery of these services.[17]

4. Reform 911: Symposium participants prioritized reforming Baltimore's 911 system to help divert people with behavioral health disabilities or in crisis from criminal system involvement. The Final Report identifies a number of ways in which Baltimore's 911 system must be reformed, including training 911 dispatchers to route behavioral health calls to the behavioral health system's crisis response system, as that system becomes more robust, and the need to educate providers and the general public about short-term and long-term alternatives to calling 911.[18] This would include public education on 211, 311, and crisis hotlines, and enhancing the capacity of ACT teams to respond "24/7" to clients with emergent needs.

5. Develop a Behavioral Health "Air Traffic Control": Symposium participants also prioritized the development of an "air traffic control" model for Baltimore's behavioral

[14] *Id.* at 90-97.

[15] *Id.* at 106-08.

[16] *Id.* at 106-07.

[17] Bazelon/DRM Letter at 11-12.

[18] Final Report, *supra* note 1, at 42, 64, 77.

health crisis response system. The Final Report states that an "air traffic control" system uses "real-time" data dashboards to

> help the crisis staff assess and engage individuals at risk who have contacted or been referred to the crisis system, tracking them throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage. . . . [this allows] crisis staff, contracted providers, and others to know and access real-time resources such as hospital and diversion beds, care management intake slots, psychotherapy and prescriber appointments, peer services, psychotherapy, and other services.[19]

We believe this level of sophistication is needed in Baltimore's system so that it can be a meaningful alternative to BPD involvement with individuals with behavioral health disabilities or who are in crisis, including as an alternative to specialized BPD units such as HOT and LEAD, which should be phased out as capacity in the behavioral health system is expanded.

6. Implement Crisis Intervention Team (CIT) Training for All BPD Officers: Finally, both the Final Report and Symposium participants prioritized providing CIT training to all BPD officers.[20] Such training must be intensive and ongoing. It should include components educating officers on reducing stigma and bias against people with behavioral health disabilities, including people of color with such disabilities. Training must also include an understanding of how law enforcement involvement with individuals in crisis can escalate risk and cause additional danger and trauma for individuals with disabilities, others on the scene, and responding officers themselves and include strategies to de-escalate police interactions with persons with behavioral health disabilities.

These core recommendations, as identified by Baltimore stakeholders, track recent reforms around the country designed to avoid the unnecessary institutionalization and incarceration of, and injury to, people with disabilities. In a 2011 ADA settlement agreement the state of Delaware agreed to establish an extensive crisis response system and significantly expand and enhance other community behavioral health services.[21] The state created new PSH under a Housing First model and increased the availability of supported employment and peer supports. Over a five-year period, Delaware implemented a 24/7 crisis hotline and created crisis response teams staffed with clinical professionals to provide support and de-escalation services in the community or to connect individuals to local resources. Community-based short-term acute care in stabilization centers was also made available.

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[19] *Id.* at 96.

[20] *Id.* at 96-97.

[21] Settlement Agreement, *United States v. Delaware*, No. 11-cv-591 (D. Del. Jul. 6, 2011), *available at* https://www.justice.gov/sites/default/files/crt/legacy/2011/07/06/DE_settlement_7-6-11.pdf.

Similarly, pursuant to a 2010 settlement agreement the state of Georgia established mobile crisis response teams, stabilization units, and short-term crisis apartments; significantly increased its community mental health services, including ACT teams, supported employment, and peer services; and created subsidized permanent supported housing vouchers for thousands of individuals with behavioral health disabilities.[22]

The recommendations identified by Baltimore residents and stakeholders must be timely implemented in order to comply with the Consent Decree's objectives to prevent unreasonable use of force, promote connection of people with disabilities, including people of color with disabilities, to the behavioral health system, and decrease inappropriate criminal system involvement, by diverting people with disabilities from unnecessary police interactions. We understand that the Collaborative Planning and Implementation Committee (CPIC) will continue to prioritize and oversee implementation of the Gap Analysis recommendations.[23] The CPIC is an appropriate existing structure to facilitate this effort going forward – but, as implementation of the recommendations is required for Decree compliance, the parties, including the City of Baltimore and the BPD, are ultimately responsible for implementation.[24]

We urge the parties to develop a plan for implementing all recommendations in the Final Report and prioritizing those listed above. Also, as stated above, we urge the parties and the CPIC to continue to gather and analyze data, including information about the race or ethnicity of persons with disabilities who interact with police, needed to refine initiatives to implement the recommendations. Finally, we strongly recommend that you to continue to make every effort to engage Baltimore residents with lived experience in decision making regarding the systems that will serve them. To the extent such efforts are already underway, they must continue. Otherwise, they must begin now.

[22] Settlement Agreement, *United States v. Georgia*, No. 1:10-CV-249-CAP (N.D. Ga. Oct. 19, 2011), *available at* https://www.ada.gov/olmstead/documents/georgia_settle.pdf.

[23] *See* Final Report, *supra* note 1, at 112 (outlining "next steps").

[24] As some of us have cautioned, however, "[s]tate officials who can support whatever policy changes or additional appropriations may be needed must be at the table going forward; otherwise, we fear the gap analysis' many helpful recommendations will not be implemented." Bazelon/DRM Letter at 9.

Thank you for all your work to ensure compliance with the Consent Decree. Please do not hesitate to contact David Prater of Disability Rights Maryland at 410-727-6352 x2500, Lewis Bossing of the Bazelon Center at 202-467-5730 x1307 or Monique L. Dixon of the NAACP Legal Defense Fund at 202-682-1300, with any questions or concerns.

Sincerely yours,

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cc: Kenneth Thompson, BPD Monitoring Team