



Pay for Success and the Crisis Intervention Team Model

Insights from the PFS-CIT Learning Community

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November 2017

Policymakers and community stakeholders across the US are increasingly recognizing the crisis intervention team (CIT) model as a valuable approach for improving law enforcement's interactions with people with mental health issues. Though costs of initial training and partnerships are low, successfully integrating CIT into a jurisdiction's day-to-day activities requires investment from health systems and law enforcement that can be expensive. Pay for success (PFS) has strong potential for funding these critical CIT enhancements; however, both CIT and PFS require culture shifts and strong partnerships to be sustained.

This brief is intended to help stakeholders determine whether and how their jurisdiction might create or expand its CIT program, and to guide their assessment of how PFS might support those efforts.

To do this, this brief begins with primers on PFS and CIT. The next section describes overlap between starting a new CIT program and starting a PFS project. Then, the brief describes ways PFS could be used to support expansion of a jurisdiction's CIT program in a manner that suits the jurisdiction's specific needs. The final section provides a framework and considerations for determining whether PFS is the right approach for funding the jurisdiction's expansion of its CIT program.

The insights contained in this brief are based on CIT and PFS reference materials, as well as the experiences and expertise of a multidisciplinary stakeholder learning community convened over three months in summer 2017. The learning community members shared their perspectives, experiences, and understanding on specific issue areas through an in-person meeting and virtual workgroup meeting, email discussions, and several working group conference calls. These stakeholders were so invaluable in developing the content contained in this brief that they have been included as authors, rather than in the acknowledgments.

Primer on PFS: What Is Pay for Success?

Ordinarily, government-funded services are provided through activity- and output-focused programs or single agency contracts with an outside organization. Though this approach enables governments to offer services, it rarely assesses whether the sponsored activities achieve the intended results or outcomes. Moreover, payment is based on delivering predefined services or outputs (e.g., number of formerly incarcerated people receiving education and workforce development services) rather than outcomes (e.g., reduced rates of recidivism among people receiving that training).

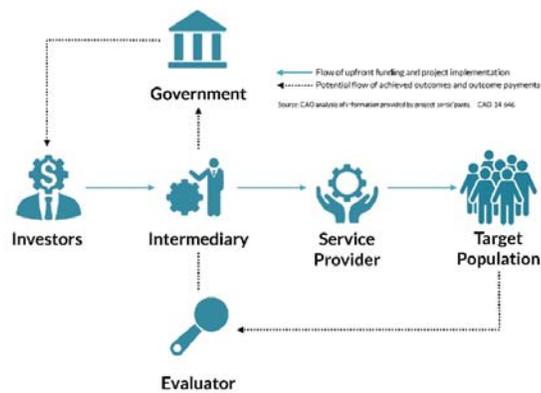
Pay for success, sometimes referred to as social impact bonds, is an innovative financing mechanism for evidence-based interventions that changes the ordinary government-funded services model. PFS shifts the focus to results, using data and evaluation to determine whether a program is successful and will be paid for by government. Thus, the risk of paying for programs that might not work is also shifted away from the government.

In a pay-for-success project, an **investor**, typically a private investor or philanthropic organization, commits up-front capital for a proven social intervention with the potential to achieve better outcomes. If the **service provider** delivering that intervention achieves predetermined outcomes for the **target population**, as assessed by an independent **evaluator**, the **government** repays the **investor** with interest. If that intervention does not successfully achieve the predetermined outcomes, the **government** does not pay for the services delivered. The finances of the project are often managed by an **intermediary**, an organization that specializes in structuring and managing PFS projects.¹

As described above, PFS projects involve active collaboration and management among stakeholders focused on achieving measurable social outcomes. This shift toward outcomes invites new stakeholders to the table (investors and intermediaries) and refocuses the roles of current players, such as service providers and the government, on the quality of services provided and their ability to be measured in real time by the evaluator.

FIGURE 1

Roles and Relationships in a PFS Deal



Typically, a PFS project involves several key roles:

- **Intermediary:** Organization that coordinates among partners to assess feasibility, structure the transaction, and manage payments
- **Investor:** Philanthropy or private firm that provides up-front capital
- **Government:** Agency or agencies that will pay if the program is successful (sometimes referred to as the “end payer”)
- **Service provider:** Organization that provides direct services to the target population
- **Evaluator:** Independent organization that determines if the program met its goals

In the PFS model, the process of delivering government-funded services is driven by whether the outcome is achieved, rather than whether a service provider or government program simply performed the activities it was funded to perform. As a result, the most crucial element of a PFS project is the social outcome the funded project is meant to achieve.

The critical social outcome for a PFS project is a specific desired change or result, around which every aspect revolves. Typically, this result is an improvement in outcomes related to an issue or condition affecting the target population. This result is what the government is trying to achieve with the funding resources they have allocated to the issue. The service provider is trying to produce this result, and the investors are betting that they will be able to achieve this result. Ultimately, the evaluator is measuring how successfully they achieved this result. The outcome is the lynchpin of the entire PFS project. For the project to work, all the relevant project components must appropriately fit together.

Structure of PFS

Not all projects are suitable for PFS financing. For instance, in programs without prior evaluations, the ability of the program to achieve the desired outcome may be too uncertain for investors to take the risk or evaluating whether the outcome was achieved could take too long. Several factors help to determine whether PFS is an appropriate funding mechanism, as summarized in table 1.

TABLE 1

When Is PFS Appropriate?

Appropriate for PFS	Not appropriate for PFS
<ul style="list-style-type: none"> Clearly defined problem 	<ul style="list-style-type: none"> Poorly defined or unmeasurable problem
<ul style="list-style-type: none"> Evidenced-based and/or promising interventions 	<ul style="list-style-type: none"> Untested programs or core services (e.g., ambulances, emergency shelters) provided regardless of outcomes
<ul style="list-style-type: none"> Strong and effective provider capacity 	<ul style="list-style-type: none"> Insufficient provider capacity
<ul style="list-style-type: none"> Committed support from relevant government agencies 	<ul style="list-style-type: none"> Weak government support
<ul style="list-style-type: none"> Strong data capacity 	<ul style="list-style-type: none"> Limited or poor-quality data capacity
<ul style="list-style-type: none"> Willingness and ability to participate in a rigorous evaluation 	<ul style="list-style-type: none"> Unwillingness or inability to participate in an evaluation

Note: This table presents only some of the highest-level criteria for a PFS deal to occur. Urban's Project Assessment Tool provides a much more in-depth and concrete scoring guide for jurisdictions seeking to assess the suitability of potential PFS deals (Milner et al. 2016).

PFS transactions are executed in four phases. During the initial **feasibility** phase, intermediaries coordinate with other stakeholders to assess whether a project is suitable for PFS based on program strength, local capacity, and other factors. If deemed feasible, projects proceed to **transaction structuring**, in which PFS partners develop the PFS contract and agree upon which outcomes will determine payment. Only after a contract is signed does the project launch and enter **implementation**, in which the service provider begins delivering program services and all stakeholders engage in active project management. Finally, though evaluation considerations are built in throughout the project, in the **evaluation** phase, evaluators determine if the program hit outcomes targets, and investors are repaid by government.

Examples of PFS in the United States

Between 2012 and 2017, 17 PFS projects were fully launched in the United States² and nearly 60 feasibility studies were funded by the Corporation for National and Community Service's Social Innovation Fund.³ Though Urban researchers could not identify any examples of PFS being applied to

CIT programs to date, many PFS projects have focused on outcomes similarly related to recidivism and behavioral health. More information about how PFS can be applied in a criminal justice context may be found in Urban’s forthcoming “Using Pay for Success to Address Criminal Justice Issues” brief.

To help illustrate how PFS works, the following tables describe two real PFS projects and key lessons learned for the field.

TABLE 2

Case Study 1: Santa Clara Project Welcome Home	
<p>Location: Santa Clara, CA</p> <p>Size of investment: \$6.9 million (maximum success payments possible: \$8 million)</p> <p>Partners:</p> <ul style="list-style-type: none"> ▪ Intermediary: None (Third Sector as transaction coordinator, government advisor) ▪ Service Provider: Abode Services ▪ Outcome Payer: Santa Clara County ▪ Investors: Reinvestment Fund, Corporation for Supportive Housing, Sobrato Family Foundation, the California Endowment, Health Trust, the James Irvine Foundation, Google.org, Laura and John Arnold Foundation (evaluation), Abode Services (service fees) ▪ Technology Partner: Palantir Technologies ▪ Evaluator: University of California San Francisco School of Medicine <p>Payment Outcome: Number of months in continuous stable housing</p> <p>Status: Implementation (ongoing)</p>	<p>This project provides permanent supportive housing to 150–200 individuals experiencing chronic homelessness defined as high-cost users of county services. A strong evidence base suggests that permanent supportive housing can increase housing tenure and reduce homelessness, emergency room visits, and hospitalizations.^a</p> <p>Project Welcome Home officially launched on July 1, 2015, with the goal of helping over 80 percent of participants achieve 12 months of continuous stable tenancy.^b Over the six-year service delivery period, the University of California San Francisco School of Medicine will evaluate payment outcomes using a randomized controlled trial and “intent to treat” analysis. The evaluation will also track other outcomes of interest (e.g., use of county services), but these will not determine payments. In December 2016, the county’s primary PFS legal advisor reported that the project was so far achieving its outcomes.^c</p> <p>Key Lessons: Project Welcome Home built data capacity and partnerships that enabled the county to enter a new PFS project providing assertive community treatment to adults with severe mental health conditions and frequent emergency room usage.^d</p>

Source: “Project Welcome Home,” PFS project fact sheet, Urban Institute, <http://pfs.urban.org/pfs-project-fact-sheets/content/project-welcome-home>.

^a Debra J. Rog, Tina Marshall, Richard H. Dougherty, Preethy George, Allen S. Daniels, Sushmita Shoma Ghose, and Miriam E. Delphin-Rittmon, “Permanent Supportive Housing: Assessing the Evidence,” *Psychiatric Services* 65, no. 3 (2014): 287–94.

^b Third Sector Capital Partners, “Project Welcome Home Fact Sheet,” 2015, http://www.thirdsectorcap.org/wp-content/uploads/2015/08/150811_SCC-CH-PFS_Fact-Sheet.pdf.

^c Greta Hansen, “Getting More Than You Pay For with Pay-For-Success,” *Stanford Social Innovation Review*, December 1, 2016, https://ssir.org/articles/entry/getting_more_than_you_pay_for_with_pay-for-success.

^d Hansen, “Getting More Than You Pay For”; “Santa Clara County Partners in Wellness,” Nonprofit Finance Fund, last updated May 31, 2017, <http://www.payforsuccess.org/project/santa-clara-county-partners-wellness>.

TABLE 3

Case Study 2: The NYC ABLÉ Project for Incarcerated Youth	
<p>Location: New York, NY</p> <p>Size of investment: \$9.6 million (maximum success payments possible: \$11.7 million)</p> <p>Partners:</p> <ul style="list-style-type: none"> ▪ Intermediary: MDRC ▪ Service Provider: Osborne Association, Friends of Island Academy ▪ Outcome Payer: NYC Department of Corrections ▪ Investors: Goldman Sachs Urban Investment Group, Bloomberg Philanthropies ▪ Evaluator: The Vera Institute of Justice <p>Payment Outcome: Recidivism, based on days avoided</p> <p>Status: Terminated, outcomes not achieved</p>	<p>In February 2013, the NYC Adolescent Behavioral Learning Experience (ABLE) project became the first PFS deal to launch in the United States. Using a cognitive behavioral therapy called moral reconnection therapy, ABLE sought to reduce recidivism among 16- to 18-year-old youth incarcerated in NYC’s Rikers Island jail. Earlier studies provided moderate evidence of the effectiveness of moral reconnection therapy in reducing recidivism,^a and stronger evidence for cognitive behavioral therapy generally.^b</p> <p>Using a quasi-experimental design, the Vera Institute evaluated whether participation in ABLE was associated with reduced recidivism in bed days, with success payments contingent upon a 10 percent reduction. However, the project was halted one year early for failing to meet this benchmark.^c</p> <p>Key Lessons: Suggested reasons for the ABLE project’s results include high turnover that made fidelity to program implementation more challenging;^d lack of prior evaluation of moral reconnection therapy with the target population and within a correctional setting; and the service provider’s lack of experience with this intervention.^e However, the project succeeded in applying the PFS model and promoting an outcomes-based culture.^f</p>

Source: “The NYC ABLÉ Project for Incarcerated Youth,” PFS project fact sheet, Urban Institute, <http://pfs.urban.org/pfs-project-fact-sheets/content/nyc-able-project-incarcerated-youth>.

^a Gregory L. Little, “Meta-Analysis of Moral Reconnection Therapy Recidivism Results from Probation and Parole Implementations,” *Cognitive-Behavioral Treatment Review* 14, no. 1/2 (2005): 14–16.

^b Mark W. Lipsey, Nana A. Landenberger, and Sandra J. Wilson, “Effects of Cognitive-Behavioral Programs for Criminal Offenders,” *Campbell Systematic Reviews* 6, no. 1 (2007): 27.

^c Vera Institute of Justice, *Impact Evaluation of the Adolescent Behavioral Learning Experience (ABLE) Program at Rikers Island: Summary of Findings* (New York: Vera Institute of Justice, 2015).

^d Megan Golden and Joe Waters, “What Does NYC Mean for the Pay for Success Field?” Institute for Child Success, July 8, 2015, <https://www.instituteforchildsuccess.org/what-does-nyc-mean-for-the-pay-for-success-field/>.

^e “The NYC ABLÉ Project for Incarcerated Youth,” Urban Institute.

^f Justin Milner, Erika C. Poethig, John Roman, and Kelly Walsh, “Putting Evidence First: Learning from the Rikers Island Social Impact Bond,” *Urban Wire*, Urban Institute, July 5, 2015, <https://www.urban.org/urban-wire/putting-evidence-first-learning-rikers-island-social-impact-bond>; James Anderson and Andrea Phillips, “What We Learned From the Nation’s First Social Impact Bond,” *The Huffington Post*, July 2, 2015/6, http://www.huffingtonpost.com/james-anderson/what-we-learned-from-the-_1_b_7710272.html.

Advantages of PFS over Traditional Funding Approaches

Lessons learned from PFS projects implemented to date suggest PFS has impacts that go beyond the project itself and may contribute to a larger shift in culture toward prioritizing evidence, outcomes, collaborative and active performance management, and the strategic deployment of resources.

Emphasizing performance based on outcomes, rather than activities, provides agencies and service providers with greater flexibility. Because their performance is no longer assessed based on adherence to predefined activities or outputs, they have more flexibility to take actions they deem necessary and appropriate to achieve the desired outcomes. At the same time, PFS establishes structures, such as integrated data systems, that can make services more data-driven and streamlined in the future. PFS can also address “wrong pockets” problems where government agencies may be unwilling to invest in projects whose benefits will be reaped all or partially by other agencies.

Finally, because the PFS model requires rigorous evaluation to determine whether the funded intervention has led to the desired outcome, PFS projects can also contribute to the larger evidence base on when and how interventions are successful.

BOX 1

Common Questions about Pay for Success

When you talk about government, what does that mean (city, county, state)?

Government payers vary by intervention and context. It is also important to distinguish between the level of the end payer and the scope of program implementation. For example, the end payer may be a state because that is where the project may produce cost savings, yet the actual project could be implemented at the county level within a few counties. State, county, and city governments have all served as end payers in PFS projects to date, but there have also been projects with federal payers (e.g., the Department of Labor).

Who establishes the performance and/or outcome metrics for PFS?

Partners collaborate to define the metrics, but typically the government end payer(s) and agencies that own the data have particularly strong influence. Moreover, the following are key considerations: the data available, the quality of the data, and the outcomes of interest to the paying agency.

Who sets the interest rate in a PFS deal?

All players involved negotiate this as part of the contract development process. Some reports show that interest rates have typically been fairly low or less than market averages.^a One benefit of PFS deals is that they (and the interest rates) are less vulnerable to market forces than other investments because they are fully agreed upon in advance.

What role does the investor play in shaping how the program will be developed?

The investor’s role varies by project. For example, in a Cuyahoga County project, foundation investors were involved early on and had more input on developing the project.^b In other deals, investors have less or later involvement. Typically, governments play the larger role in defining the outcomes.

^a For example, the Improving Elementary School Student Performance in Utah had a 5 percent interest rate (Monitor Deloitte, *The Many Ways to Pay for Results: Funding Options for Innovation and Success* [New York: Deloitte, 2015]).

^b See Enterprise Community Partners and Third Sector Capital Partners, *Developing the Cuyahoga Partnering for Family Success Program: Partner Perspectives and Lessons Learned* (Boston: Third Sector Capital Partners, 2016).

Additional Resources

Several resources are available to learn more about pay for success:

- The Urban Institute's Pay for Success Initiative has developed a suite of resources at pfs.urban.org to support a wide range of stakeholders interested in PFS.
- The Brookings Institution has published a comprehensive report on social impact bonds worldwide (Emily Gustafsson-Wright, Sophie Gardiner, and Vidya Putcha, *The Potential and Limitations of Impact Bonds: Lessons from the First Five Years of Experience Worldwide* [Washington, DC: Brookings Institution Press, 2015]).
- The Nonprofit Finance Fund, a PFS funder and intermediary, has developed a website (www.payforsuccess.org) with resources on PFS. NFF's First Generation Report, which provides detailed information on the first 10 PFS projects, has been a key resource for the field (Dana Archer-Rosenthal, *Pay for Success: The First Generation* [New York: Nonprofit Finance Fund, 2016]).

Primer on CIT: What Is the Crisis Intervention Team Model?

Sworn to protect and serve, law enforcement officers are often first responders to challenging situations that do not necessarily involve criminal activity. Some of the more challenging interactions officers can face involve people in mental health, behavioral, or emotional crisis. Without the information or training to recognize the mental or emotional issues that may be at play, such interactions have demonstrated potential to escalate dangerously, resulting in use of force, officer injuries, or even fatalities (Fuller et al. 2015). In many cases, officers might repeatedly encounter the same person.

The Crisis Intervention Team (CIT) model was designed to break that cycle by training first responders how to diffuse volatile crisis situations and connect people with services. Originally developed in Memphis in the late 1980s, the CIT model partners law enforcement, behavioral health providers, hospitals, families, people with mental health conditions, and other key stakeholders to respond appropriately in situations involving apparent mental or emotional distress. Core components of a CIT program include training for key local stakeholders (including law enforcement and other first responders, hospitals, and treatment providers) and coordination with other health and crisis response systems.

CIT in Practice

Traditionally, law enforcement is alerted to a potential crisis situation through a call for service. The call goes to dispatch, which sends an officer to assess the scene and determine next steps. For most resource-constrained law enforcement agencies, the goal is then to uphold the law while resolving the

situation in the safest and *fastest* manner possible, enabling officers to quickly return to the street. Historically, the typical way to resolve such a situation would be a nonresponse, informal response, or arrest. If fully implemented and operating as intended, CIT provides alternative response options that minimize inappropriate arrests and increase connection to services.

The CIT model requires several core components for these alternative response options to be viable:

- **CIT coordinator(s) and coordinating body** to drive CIT efforts forward and ensure continued coordination between law enforcement and behavioral health professionals.
- **Training** for law enforcement, other first responders, and health services partners. For law enforcement, this includes the intensive 40-hour standard CIT curriculum, as well as potential enhancements such as basic mental health awareness training for all officers and/or ongoing training refreshers.
- **Coordination with health service providers, including drop-off locations** where officers can bring people to receive assistance when the situation requires. Optimally, this may be a crisis triage center that specializes in linking people to appropriate services. However, existing practice has often been to use emergency rooms. Other aspects of this coordination may include information sharing and referrals.
- **Partnership** with core stakeholders, including
 - » *Law enforcement*, including leadership, dispatch, CIT officers, and regular patrol officers
 - » *Other first responders*, such as the fire department or emergency medical services (EMS), who may also encounter crisis situations
 - » *Health services providers*, including behavioral health clinicians and case workers, to help coordinate response options and treat the person experiencing distress
 - » *Families of people with mental or behavioral disorders*, who may seek the help of CIT professionals and have an important perspective for shaping response options
 - » *People living with mental health conditions and/or directly exposed to CIT*, who may provide valuable insights about how CIT is experienced and may be involved in training in some cases

In addition to these core components, some jurisdictions have implemented further program **enhancements** such as information sharing tools or applications,⁴ hiring full-time clinicians into the law enforcement agency, conducting more preventive outreach with vulnerable individuals, and using secure communication apps or a “warm line” (as opposed to a hotline)⁵ to contact clinicians in the field. Learning-community participants also emphasized the importance of **culture change** in law enforcement to actively recognize and search for signs of behavioral health issues in calls for service and to value and use CIT and alternatives to arrest.

Evidence for CIT

In a 2008 literature review, Compton and colleagues found 12 empirical reports examining officer-level outcomes of CIT programs; in 2017, this number has doubled to roughly 24 pre-post and quasi-experimental studies. Of these, a majority have examined CIT's effects on officer attitudes and knowledge,⁶ and a smaller body of research has examined more direct impacts on behavior in the form of transportation to treatment,⁷ rates of arrest,⁸ use of force,⁹ longer-term engagement with treatment,¹⁰ and cost savings.¹¹ Generally, these studies have shown that CIT officers have greater knowledge of mental health conditions,¹² improved confidence in their ability to respond, improved confidence in the perceived effectiveness of CIT,¹³ reduced stigmatization of mental health conditions,¹⁴ and more positive attitudes toward treatment and health systems.¹⁵ These critical outputs show that CIT training has been received as intended. Findings on arrests and transportation to treatment are similarly positive, with multiple studies suggesting that CIT reduces rates of inappropriate or unnecessary arrest of people with mental health conditions¹⁶ and increases connection to treatment.¹⁷ Only one cost-benefit analysis has been conducted to date, finding evidence of modest cost savings from a reduction in the average length of stay after arrest.¹⁸

Though these results are promising, several methodological issues suggest the need to further strengthen this evidence base. Researchers have struggled with devising a feasible approach to more rigorously test CIT using the commonly recognized “gold standard” randomized controlled trial (Watson 2010), which presents significant ethical issues in this setting (i.e., randomly assigning how officers respond to a crisis situation). Few studies have used rigorous comparison methods to assess the effects of CIT training relative to a matched sample of non-CIT-trained officers. Furthermore, evaluations of CIT have focused almost exclusively on police officer training, with little empirical examination of the larger model or of the impact of other elements (e.g., reliable drop-off locations) on effectiveness. The question of program fidelity has also been largely absent from CIT research, despite findings that sustained adherence to the model faces several implementation challenges (Addy 2005; Compton et al. 2010; Dupont and Cochran 2000). According to learning-community participants, part of the challenge in assessing fidelity is the lack of clarity about what fidelity means and/or the lack of a concrete tool with which to assess it. Nevertheless, the current consensus is that CIT is a “promising practice,” which means it does not yet rise to the level of evidence-based but could reach this status with further, more rigorous research (Thompson and Borum 2006; Watson and Fulambarker 2012).

BOX 2

Common Myths about CIT

- **CIT is a police intervention.** Though officers are often the first responders, partnership and coordination with health services is integral to the CIT model and essential for success.
- **CIT is just training.** CIT requires sustained partnership across agencies and should be embedded in law enforcement and health operations to be successful. Training without drop-off locations or clinician support leaves officers without the tools to successfully resolve situations.
- **CIT is expensive.** Law enforcement agencies often think they can't afford CIT at all. However, the national curriculum is freely available for local adoption; thus, the main costs of *starting* a CIT program are time or in-kind contributions (e.g., printing materials) for training and coordination meetings. Higher costs come through enhancements such as crisis triage centers.
- **CIT is only for crisis situations.** CIT officers are trained to be mental health specialists in the department and are best equipped to respond to any calls involving a person showing symptoms of mental health conditions, even if they are not currently in crisis. Bringing in a CIT officer who knows how to handle the situation appropriately can also prevent a situation from escalating to a crisis.
- **“Crisis” always means mental illness.** Very often, mental health and substance use disorders are co-occurring. CIT trains officers to recognize a potential behavioral health crisis, but not to diagnose. Asking officers to distinguish *why* someone is in crisis—because of a mental health conditions, drugs or alcohol, or another cause—is impractical and may invite biased decision-making. The skills taught in CIT, including de-escalation, apply to a variety of crisis situations.
- **Arrest is always the wrong answer.** The ultimate goal of CIT is to ensure the safety of people in crisis, people around them, the responding officer, and the public. Though CIT generally promotes responses other than arrest, there may be some instances where arrest becomes necessary to ensure public safety.
- **Departments should always aim to train 20 percent of officers in CIT.** Based on recommendations from the original Memphis CIT developers (Dupont, Cochran, Pillsbury 2007; Watson and Fulambarker 2012), customary practice among law enforcement agencies is to seek to train 20 percent of patrol officers in CIT.^a However, there is little evidence to support this threshold for all agencies in all cases (Watson and Fulambarker 2012); instead, learning-community participants said that it is essential to ensure that all shifts and patrol districts have at least one CIT-trained officer available.
- **CIT training should be mandatory for law enforcement officers.** Though some departments have made CIT mandatory, learning-community participants emphasized that this approach can be detrimental. Mandating CIT can undercut officer buy-in and place officers who are neither interested nor appropriate to become CIT officers in the position of responding to sensitive crisis situations. Instead, learning-community members suggested emphasizing the value of CIT to officers as a tool to protect officer safety and liability and employing credible messengers (i.e., well-respected and experienced officers) to deliver this message.

Sources: Myths derived from learning-community discussions and supplemented with external resources where pertinent.

^aSee examples in [Spokane](#), [New York City](#), [Georgia](#) and [New Orleans](#)

Starting a New CIT Program: Parallels with PFS

Both CIT and PFS have their own explicit goals: CIT seeks to improve the way law enforcement responds in situations involving mental health, and PFS pays for programs based on the outcomes they achieve. A subtle but significant part of both models is that for their goals to be achieved, organizations must change their culture so that the norms and processes contribute to the overall goal.

For PFS, an integral part of the process is shifting a jurisdiction's culture to focus on delivering government services that improve the outcomes of the population being served. After all, achieving the predefined outcome is the linchpin of a PFS project. Similarly, CIT requires shifts in thinking (e.g., for officers to consistently think of mental health referral as an option, or for dispatchers to consistently think to call CIT officers) that will improve the *outcomes* of people with mental and behavioral health issues who interact with law enforcement. Though this type of culture change can often be a byproduct of meaningful reform, thinking of it as a discrete goal from the beginning can help to sustain efforts. However, culture change is also challenging and requires true buy-in from partners, rather than a desire to “check the box” or only minimally invest in solving a problem.

As an example, a common misperception about CIT is that a police department could create a program by simply mandating all officers take 40 hours of CIT training from a certified trainer. Learning-community participants described this as counterproductive in several ways. First, mandating CIT can create resentment toward the program that undermines culture change. Second, this forces officers who may be unwilling and not open to CIT to take the training, which would yield suboptimal results. Furthermore, the process of training itself is not sufficient to improve outcomes; CIT requires a partnership with health response systems. Where would officers take people who have been identified as having mental health needs and have been safely taken into custody? When implemented correctly, CIT is well integrated across law enforcement and health response systems with input and coordination from other key stakeholders, such as people with mental health conditions and their families.

Ultimately, *voluntary* training is a necessary but insufficient component of building a CIT program; however, a common and necessary first step for both CIT and PFS toward culture change is coordination across agencies and other stakeholder organizations.

Coordination across Agencies and Stakeholder Organizations

CIT requires active coordination across law enforcement, behavioral health agencies, and other community partners. Multiagency coordination is also a central component of a PFS deal. Learning-community participants agreed that the first step in launching a CIT program is to get key partners together to define the problem, reach consensus on what is needed, and start to build key partnerships. Specifically, there must be strong buy-in and involvement from leadership of agencies whose investment is most central to the model (i.e., law enforcement and behavioral health). To illustrate this point, participants offered several examples of how partnership helped drive CIT in jurisdictions they were familiar with:

- Baltimore, Maryland: Police leadership was critical in bringing other city stakeholders on board because they are respected and taken more seriously by other first responders such as Fire and EMS. Community input to the CIT partnership was added later but has been critical; in retrospect, participants said they would have added community input earlier.
- Chicago, Illinois: CIT was initially driven by a group called the Criminal Justice Task Force that was organized by the area mental health director. This committee had been laying the groundwork and advocating for training for years, but it wasn't until a critical incident (officer-involved shooting with a mental health component) that the mayor agreed and began moving CIT forward. Subsequent pressure from the Kennedy Forum and the Department of Justice investigation has helped continue to move things forward.
- Pima County, Arizona (*program redesign, not original launch*): The first step in revamping CIT was putting together a “coalition of the willing,” including high-level agency leaders willing to put their support behind growing the program. Though there were advocates outside of law enforcement pushing to move forward, progress was made only when the police department leadership bought into the concept.
- Summit County, Ohio: The county mental health authority learned about CIT during an annual conference. The Ohio Department of Mental Health approached the director of training for the Akron Police Department about visiting a model CIT jurisdiction to observe the program with a mental health clinician, followed by a walkthrough of the CIT training. The two returned from the visit believing in the program, and the training director got buy-in from the chief of police. The mental health authority served as the lead in organizing the training and program development, which over the subsequent years involved all law enforcement jurisdictions in the county.

STAKEHOLDERS

Law enforcement agencies. CIT is often misconstrued as solely a law enforcement initiative. This is misleading and fails to account for the role that health systems and other stakeholders must play, but law enforcement agencies are inarguably central to CIT. As the primary first responders to people in mental health crisis and the focus of CIT training, law enforcement agencies must be essential partners for CIT to be viable. Often, law enforcement leadership takes the lead in driving CIT forward; though this is not always necessary, clear demonstration of commitment from law enforcement leadership is essential for effecting culture change at all levels of the law enforcement agency.

Though departments often focus on training specialized CIT officers, employees across a variety of roles in the agency have the potential to contribute to or hinder the goals of CIT.

- **Agency leadership** plays a critical role in setting the vision for the agency, investing resources in CIT, and strengthening partnerships.
- **Dispatchers** are often the first to receive calls and thus should be able to recognize a potential CIT-related situation and determine which CIT-trained officers to send.

- **Patrol officers** may be the first to encounter a person in crisis and should have enough baseline knowledge to recognize the need to call a CIT officer.
- **Line-level supervisors** (i.e., lieutenants and sergeants) are particularly influential and should understand what CIT means for their role—for example, allowing officers to take time to resolve a situation when needed, rather than pressuring or criticizing them for taking time in a way that counteracts the message of CIT.
- **Nearby agencies** may also need to become collaborators for some jurisdictions to develop a successful CIT program. For example, county-level programs are unlikely to be very successful if constituent municipal agencies are not trained.

Behavioral health agencies. Even if officers receive excellent training and an agency is fully on board with CIT, the model risks failure without necessary health services and support. Optimally, this includes a dedicated drop-off location such as a crisis triage center, where police can drop off an individual in crisis to receive immediate assistance and linkage to further care. Crisis triage centers are interdisciplinary crisis response centers staffed by nurses, behavioral health clinicians, and social service providers. In the context of CIT, the goal of these centers is often speed—a location where officers can quickly drop someone off after diffusing a situation and then return to the street. Ideally, staff at the crisis triage center then help to connect a person with longer-term services that can help address any underlying problems and prevent future problematic encounters.

However, challenges can emerge when health services are insufficient or not easily accessible. In jurisdictions where crisis centers do not exist, law enforcement agencies may rely on emergency departments as drop-off locations, which presents significant problems for hospitals attempting to quickly triage and treat high volumes of life-threatening health issues. Having strong partnerships with stakeholders in local health systems can help manage expectations and mitigate challenges even when resources are not available for more dedicated drop-off options.

CATALYSTS FOR COORDINATION

Achieving coordination across agencies can be difficult, but several factors can catalyze or renew support for CIT across agencies. This includes critical incidents such as publicized use of force, as well as more diffuse motivators. For example, learning-community participants highlighted that the current climate surrounding police-community relations, enhanced by media attention,¹⁹ has increased the appeal of CIT for many departments. Others recalled departments taking interest in implementing CIT after nearby agencies had done so. However, these types of catalysts are external to any deliberate government actions to crystalize multiagency support. For both PFS and CIT, developing and sustaining multiagency support for efforts that will change the jurisdiction’s culture is the role of a coordinator or policy champion.

CRYSTALLIZING COORDINATION: ROLE OF A COORDINATOR AND CHAMPION

As CIT programs develop, partnerships benefit from formalizing into a **collaborative oversight body** that continues to meet, monitor, and drive implementation and identify any implementation issues.

Having a CIT “champion” and/or CIT coordinator (who may or may not be the same person) is central to maintaining the commitment and consistent communication of this group. This role is comparable to that of the intermediary in PFS—a central figure or body whose role is to drive efforts forward.

Learning-community members suggested that where possible, programs should have dual CIT coordinators from both law enforcement and behavioral health agencies. These coordinators would have a better understanding of how CIT works in their respective contexts and can communicate this in ways that others in their field understand. Additionally, having a champion outside the law enforcement agency (in addition to one inside) can help insulate efforts from turnover in police leadership.

INFORMATION EXCHANGE AND DATA INTEGRATION

Coordinating effectively across multiple agencies and stakeholder organizations requires sharing information. However, information sharing can also help to institutionalize cross-agency perspectives by placing agency-specific information within the larger context of the jurisdiction’s entire processes and interactions on a given activity, issue, or person. For CIT, this can be an important way to refer people to the most appropriate services, call on family members for assistance, or share information among officers so that they are aware a person is living with a mental health condition. Data sharing is required at every stage of PFS, from the initial process of identifying a program’s target population and outcomes to the ongoing evaluation and performance monitoring that determine success payments.

Data sharing can take a variety of forms, from individual communication between people at an agency, to fully integrated platforms that retrieve and combine datasets from various sources. Though privacy and legal concerns can make the latter difficult, finding ways to reliably and regularly exchange information in some form is essential.

These aspects of developing coordination create a critical and often informal foundation for a CIT program. Training often represents the first formal step toward establishing these programs.

Training

Though coordination is a prerequisite for launching both CIT programs and PFS projects, CIT programs also typically require specialized stakeholder training. CIT training is often the first concrete component of the model to be implemented, and one of the most standardized pieces of the curriculum. Though some law enforcement agencies may pay direct costs for external trainers to provide CIT, more often the true costs of CIT training are the time and personnel required to modify the curriculum to local context and bring officers off the street for training while ensuring continued coverage across patrol districts. Departments may need to provide overtime pay for officers to either attend training or work additional hours to cover others attending training. Learning-community participants noted that though this arrangement and reliance on volunteer work is challenging, this way of providing training can be more sustainable than applying for grants.

CIT training varies most when it comes to how departments train their employees. Some jurisdictions opt to train the department, but others aim to sustain the principles of CIT by incorporating

it into academy training. Learning-community participants expressed caution about both implementation strategies. First, making CIT voluntary and conveying its value to officers helps to ensure that those who are willing and open to CIT self-select into the program, and those who are not ready or do not want to change do not become bad CIT officers and “poison the well.” Similarly, learning-community participants agreed that providing the full 40-hour CIT training in the academy is ineffective at best and risky at worst. New officers lack the experience in which to ground CIT or fully understand its implications. They are seeking to rapidly learn a variety of skills and may be more immediately preoccupied with their own survival than more experienced officers. That said, basic awareness training on mental health conditions and the circumstances that justify calling a CIT officer can lay a foundation for continued changes in practice and culture.

Developing an Outcome-Oriented Perspective

A foundation of cross-agency coordination and collaboration is necessary to begin either PFS or CIT. This perspective and capacity is a prerequisite for PFS to work, and jurisdictions have reported that just preparing to support a PFS project was beneficial—whether or not the intervention was eventually financed by PFS—because it provided outcome-oriented perspective and cross-agency coordination. After training, the effects are similar for jurisdictions starting CIT.

CIT is far from a “plug and play” intervention. One jurisdiction could not simply copy a fully developed CIT program from another jurisdiction. Developing a CIT program is an iterative process that involves cultivating partnerships, providing training, setting up structures for ongoing coordination and information sharing, putting in place key infrastructure such as crisis triage centers, and more. Each of these steps takes time, and time itself is an important resource that allows necessary culture change to occur. CIT is also very specific to the characteristics of each jurisdiction, which can affect how and why a program develops. Some agencies may need to train more or different partners; others may need better data integration systems, more proactive follow-up services, a tool for police and clinicians to communicate, or other supports. Though there are unique considerations for each CIT component, this layered nature provides multiple points at which PFS financing could help to build or enhance a CIT program in a jurisdiction-specific manner.

Enhancing an Existing CIT Program with a PFS Project: Facilitating Jurisdiction-Specific Progress

CIT programs do not get up and running overnight. The process of developing a CIT program (and related culture change) is different for every jurisdiction. However, once the seeds of change are present for cross-agency collaboration and outcome-oriented thinking, PFS can provide a financing option for taking the next step. to improve a CIT program’s ability to provide responsive, coordinated, and comprehensive engagement with people expressing their mental health needs in a crisis.

One of the most consistent themes discussed by the learning community was that CIT is a **multilayered intervention** that is built up over time. Though training and partnership are consistent core components, there can be greater variation in how jurisdictions coordinate with health agencies and further enhance programs. Learning-community members also noted that allowing sufficient time to build CIT into local operations is essential for cultivating the **culture change** and partnerships necessary for CIT to be successful.

Whether they stem from grant funding or another source, efforts to implement CIT are very closely tied to the conditions and needs within the jurisdiction. A CIT program is developed slowly and incrementally to allow the culture to change along with the jurisdiction's new capacities that support CIT. PFS should be considered a potential solution to fund those specific increments, whatever the jurisdiction determines them to be.

This section provides some examples of common incremental CIT program enhancements described by members of the learning community. This is certainly not a comprehensive list, nor are all these incremental components appropriate for every jurisdiction. Rather, these examples are meant to solidify the concept of how PFS could be used to support a jurisdiction's efforts to incrementally expand and enhance its CIT program.

It is important to note that some of the foundational components of CIT often come at little or no budget cost. For example, trainings are often provided through volunteer trainers and in-kind contributions that cover backfill time for officers attending CIT training and minimize costs for agencies. At the same time, greater coordination across agencies can help realize savings for one agency based on costless changes in another agency. For example, limited evidence suggests that CIT may lead to cost savings in the form of deferred hospitalizations, reduced inpatient referrals from jail, and reduced jail bed usage (El-Mallach, Kiran, and El-Mallach 2014).

In determining how PFS might make sense, it is important to first ask what the direct costs are—what would “pay for success” actually pay for? Though specific CIT components vary, learning-community participants identified three core “big ticket” costs associated with a well-functioning CIT program:

- **Formal CIT Coordinator(s):** Having a funded coordinator whose primary responsibility is to ensure that CIT efforts move forward can be critical to success. However, funding a full position requires a substantial investment that may be challenging to provide, especially for smaller jurisdictions or those with particularly limited resources.
- **Crisis Triage Center:** Crisis triage centers are integral to CIT but represent a substantial investment because they should operate 24 hours and require coverage from clinical staff. In many cases, police that do not have access to a crisis triage center rely instead on emergency departments, which further strains already stretched hospital capacity.
- **Enhancements:** Learning-community members described a number of ways that CIT could be further enhanced, including improved data integration infrastructure, greater involvement and/or direct hiring of clinicians, and more proactive outreach to people who frequently

encounter CIT officers. Though not included in the core CIT model, these enhancements represent investments that may help to increase success.

The payers of these costs vary. Learning-community participants cited CIT programs that received funding from city police departments, mental health agencies, county governments, and foundations. Each of these costs represents an opportunity where PFS could help to finance an enhancement to CIT, though some may be more appropriate than others. Crisis triage centers may have operating costs that are more definable but much harder for jurisdictions to pay up front. Program leaders must assess whether alternative funding can be obtained and whether the costs are clearly definable. Training, for example, may not be an appropriate avenue for PFS financing because many opportunity costs of training are unpredictable (e.g., how much overtime a department must pay to ensure patrol coverage). Further, departments have found other ways to fund training, whether through agency budgets or grant funding, though this may not be the case in all jurisdictions.

A jurisdiction could many steps take to enhance its existing CIT program. The following examples model how a jurisdiction might expand its program through a PFS project.

HYPOTHETICAL PFS-CIT PROJECT: CRISIS TRIAGE CENTER

Problem: One of the largest and most important investments in enhancing a CIT program is building a crisis triage center, where officers can transport a person who is in crisis or needs treatment and then quickly return to duty. However, crisis triage centers are often an underdeveloped component of CIT because of their up-front costs. Instead, CIT officers often bring people to local hospitals or emergency departments, which can strain these resources particularly in jurisdictions already lacking robust health care infrastructure.

Current Funding Sources: Learning-community participants said that crisis triage centers are often difficult to fund, though they cited examples of jurisdictions that did so. Illinois has been operating a state-funded crisis triage center and recently opened a new county-funded center. In Portland, a crisis triage center was funded through a collaboration of different health care and hospital systems and with philanthropic contributions. In some parts of Ohio, crisis triage centers are funded by local mental health providers. These examples suggest that there is momentum for governments to invest in crisis triage centers, even if the up-front costs are a deterrent in many places.

Program Strength: Bringing people in crisis to hospital emergency rooms is costly to hospitals (Alakeson, Pande, and Ludwig 2010) and can worsen symptoms and heighten distress for the person in crisis (Clarke et al 2000; Clarke, Dusome, and Hughes 2007). Early research has found that by providing a safer, more homelike environment and access to clinical staff (Action Alliance 2016), crisis triage or stabilization centers are effective at avoiding unnecessary hospitalizations (Action Alliance 2016; SAMHSA 2014) and may help to reduce hospital costs (Bengelsdorf 1993). Little research at this time examines how crisis triage centers may impact law enforcement operations.

Provider Capacity: Locally specific.

Public System Partners and Political Will: Learning-community members agreed that having a well-connected group of stakeholders is the first step to building a crisis triage center, and the array of funders above indicates that many agencies may take interest.

First Step to Build: Having a strong, well-connected partnership of stakeholders who can identify and agree on the gaps and the solutions to fix them; then, determining who pays.

Outcomes/Problems Likely to Motivate Investment: Demonstrating cost savings from reduced jail and hospital stays.

HYPOTHETICAL PFS-CIT PROJECT: HIGH USERS OUTREACH AND DATA

Problem: Many jurisdictions have noted that a small number of people with high behavioral health and other needs often have repeated interactions with hospitals, law enforcement, and public service systems (Chambers et al. 2013). The basic CIT model is often reactive, but proactively identifying and reaching out to so-called high users (people who have high rates of contact with criminal justice, health, and/or other public services systems) has the potential to help prevent crises and reduce costs. In Chicago, a partnership of stakeholders decided that outreach groups that include a CIT officer and clinicians will help to ensure safety, based on either the individual's history or because of the neighborhood. (Though some private providers have provided outreach to this group in the past, their capacity is too low; also, providers tend to avoid the most vulnerable areas because of safety concerns.) However, systematically identifying high users has proven challenging, and such a strategy will require resources, flexible support from the city, and a strengthened partnership between law enforcement, EMS, and other stakeholders.

Program Strength: Growing evidence supports targeting services at people with the highest needs to reduce costs and minimize inefficient or inappropriate service use (Culhane, Metraux, and Hadley 2002; Simon et al. 2001). Potential enhancements could include installing data infrastructure or other tools to identify high users and building outreach teams. This could also bring value to other city projects.

Provider Capacity: In Chicago, learning-community participants perceived that outreach teams will be most effective if the police department can hire clinicians. This is predicated on having the funding and infrastructure in place to support their work.

Public System Partners and Political Landscape: An interagency group has been meeting and has demonstrated interest in moving forward; however, one challenge is determining who pays for this type of intervention because it would require resources from different systems.

Project Alignment: Multiple agencies, including law enforcement and hospitals, are likely to benefit, making this a promising potential opportunity for PFS. In Chicago, one potential payer may be the state of Illinois, which funds mental health services. However, though some PFS projects have successfully entered contracts with state payers, both Chicago and Illinois currently have significant financial troubles (e.g., Illinois had no state budget for two years).^a

Project Evaluability: Chicago has data from the Criminal Justice and Mental Health Coordinating Team, which has led CIT efforts, and data from a class-action lawsuit about putting people in nursing homes. The University of Chicago has also begun efforts to obtain and integrate data to identify high users. However, data sharing and privacy concerns are presenting early challenges and likely to complicate evaluation efforts.

A randomized controlled trial is also likely to generate significant pushback from partners who want to serve everyone who asks for services or has a need. Emphasizing that the need is so high that providers *can't* serve everyone, and using a list of people with the highest needs or highest use as a naturalistic waiting list may help to alleviate some of these concerns. However, collecting control group data will likely remain a challenge.

^a Jessica D'Onofrio, Sarah Schulte, and Craig Wall, "Illinois Misses Budget Deadline, House will Reconvene Saturday," ABC 7, July 1, 2017, <http://abc7chicago.com/politics/no-budget-deal-friday-house-will-reconvene-saturday/2167095/>.

Assessing CIT Program Elements through the PFS Framework: Determining Whether PFS Is Appropriate

As the previous sections have explained, the path of developing organizational culture and responses is different for every jurisdiction. After cross-agency coordination and trainings, the next steps for incrementally growing a jurisdiction’s CIT program will vary across jurisdictions because of their unique characteristics, conditions, and needs. As jurisdictions consider their next incremental step to improve their CIT program, they should also consider whether that step could be financed through PFS. This section provides a framework for considering whether a given incremental improvement in a jurisdiction’s CIT program is suitable for financing through PFS. (More information on this framework is available in Urban’s PFS Project Assessment Tool; see Milner et al. 2016.)

TABLE 4

PFS and CIT: Who Are the Main Players?

Key CIT partners and their PFS roles

PFS role	Potential CIT partners
Intermediary: coordinates among partners to assess feasibility, structure the transaction, and manage payments	Locally specific. Should be a neutral third party able to coordinate across groups, ideally with experience in each stage of the PFS process (feasibility, structuring, and implementation). For CIT, the intermediary could be a local chapter of the National Alliance on Mental Illness, for example. PFS projects may also bring in a “financial intermediary” whose specific expertise lies in navigating the PFS contracting process.
Investor: provides up-front capital for a project and gets paid back with interest if it succeeds	<ul style="list-style-type: none"> ▪ Foundations ▪ Insurance companies that cover jurisdictions in use-of-force settlement cases
End Payer: pays for the program if it is successful	Potential end payers may include: <ul style="list-style-type: none"> ▪ Mental/behavioral health agencies ▪ Jails/correctional agencies (e.g., if jail usage is measured and reduced) ▪ Hospitals (may be interested in reducing emergency department visits and/or frequent follow-up visits)
Service Providers: delivers the actual intervention	<ul style="list-style-type: none"> ▪ Police and sheriff’s departments ▪ Crisis triage centers ▪ Hospitals ▪ Other mental/behavioral health service providers
Evaluator: determines if a program achieved successful outcomes	Variable; should have experience conducting rigorous program evaluations

Public System Partners and Political Landscape: *How strong is political and bureaucratic support from the public partner (government) for the proposed project and financing structure?*

Strong partnerships and the committed support of agencies—including law enforcement and behavioral health—are prerequisites for CIT and enable information sharing that is critical to program success. PFS requires partners to be actively engaged, invested in program implementation, and willing to share data to measure performance. Though actual commitment from agencies varies by jurisdiction, the centrality of partnership to each model is promising.

CHALLENGES

Collaboration failures. Collaboration can be challenging to maintain, and learning-community participants identified several specific concerns for CIT. In jurisdictions without designated drop-off locations, it can be challenging to secure the buy-in of local hospitals, which may have concerns about security or accommodating CIT users. Like any collaborative venture, CIT may also face waning support from individual partners or vulnerability from changes in leadership.

Local government resources. Though PFS provides up-front investment in projects to offset the risks of potential failure, governments still must pay for programs if they are successful. If a jurisdiction does not have the resources to do so, then a PFS deal will not be viable.

Problem Definition: *How clearly defined and understood is the problem?*

CIT tends to be presented as a solution to two primary problems. First, in the short term, CIT seeks to ensure the safety of people with mental/behavioral health conditions, the people around them, and officers. In the longer term, CIT seeks to reduce unnecessary contact with the criminal justice system for people with behavioral health issues. Both problems can be measured using data such as police call dispositions and jail admissions.

Identifying the problem begs the question of what a successful solution to that problem looks like. The solution should not be broad or general, such as “improve responsiveness to the target population.” Instead, it should be a specific objective of the incremental next step a jurisdiction is considering to advance their CIT program. This requires special attention to properly defining a measurable and appropriate form of success.

DEFINING A MEASURABLE AND APPROPRIATE FORM OF SUCCESS

One of the most important and challenging aspects of a PFS deal is determining which outcomes will decide whether a project was successful (and whether the investor gets repaid). Often, PFS projects will measure payment outcomes (which determine payment) and nonpayment outcomes (which may be of interest as performance metrics but do not determine payment).

For CIT, outcomes may depend on what specific goal jurisdictions are most interested in achieving. For example, a jurisdiction primarily interested in diverting people with behavioral health issues from

the criminal justice system and/or emergency departments may think about outcomes in a different way than a jurisdiction primarily interested in officer safety and liability. CIT may also have secondary goals, such as changing agency culture or law enforcement awareness of mental health. Drawing on earlier evaluations and practical experience, the learning-community members proposed outputs (measures that show a CIT program is doing what it should be to reach its goals) and outcomes (measures that show CIT is achieving its goals). These are presented in figure 2.

FIGURE 2
Measuring CIT

Examples of measurable outputs and outcomes related to CIT

CIT Components	Outputs	Outcomes
<ul style="list-style-type: none"> ▪ Training ▪ Partnership ▪ Coordination with health service providers 	<ul style="list-style-type: none"> ▪ Training appropriate number of CIT officers ▪ Successfully identifying calls as CIT-related (911/dispatch) ▪ Percentage of calls with an identified mental/behavioral health where CIT officer responded ▪ Officer awareness of CIT ▪ Crisis triage center use ▪ Service referrals and/or connections to case management 	<ul style="list-style-type: none"> ▪ Reduced percentage of calls with a mental health component that result in arrest ▪ Reduced use of force ▪ Reduced officer injuries ▪ Reduced inappropriate emergency department usage ▪ Improved quality of interactions between law enforcement and people with mental health problems ▪ Increased linkage to appropriate mental health services ▪ Decline in mental health crisis calls ▪ Cost savings (e.g., from connecting high users to more sustainable treatment services or reducing use of force, use of sick leave, loss of capacity because of injury or suspension, and lawsuits) ▪ Culture change ▪ Improved police-community trust

Learning community participants also described several challenges with measuring the success of CIT. There is little information on the prevalence of police encounters with people with mental health conditions, partly because it can be challenging to determine whether calls have a mental health component. Emergency operators and dispatchers responding to 911 calls may not have the information or training to ask and affirm that a situation may involve a person with a mental health condition, and officers may have trouble assessing this on the street. These challenges extend to reporting; for example, officers may be inconsistent in noting whether an interaction involved a mental health component, compared with simply listing it under another crime or incident code (e.g., labeling a

behavioral health–related situation as an assault). Police data systems may not have an easy way to identify such incidents in aggregate.

The learning community also identified some measures to avoid. For example, officer time spent on a call is a problematic performance measure in the context of CIT. Ideally, a CIT operation would allow officers to quickly address a situation and move on to their next call. However, part of a CIT officer’s training is to know when to take time to resolve a situation; using time as a performance metric may exacerbate these competing priorities. Learning-community members also emphasized that metrics related to insurance coverage (e.g., treating people with insurance coverage) were inappropriate because first responders are required to respond regardless of insurance status.

Another problem is that success for one agency may raise challenges for another. For example, if law enforcement successfully diverts someone away from the criminal justice system, this may transfer a greater burden to behavioral health treatment providers. CIT may also cause some outcomes to increase initially, then decline: one participant said that when they first launched CIT, there was a spike in mental health calls for service as people became aware of the program’s existence. It was only after this initial reaction stabilized that it became possible to rely on this metric.

Program Strength: *How strong is the proposed solution to address the problem?*

Though existing research is insufficient to place CIT in the realm of “evidence-based practice,” (Watson and Fulambarker 2012) it is generally considered a promising or “best practice” in law enforcement (Thompson and Borum 2006; Watson and Fulambarker 2012), with examples of success in several jurisdictions (see Compton et al. 2008). The evaluation component of a PFS deal has the potential to strengthen this body of research.

Given the variation across jurisdictions, many different program components or increments could be required to enhance a jurisdiction’s ability to provide responsive and coordinated services to people with mental health needs. Some of the reasonable next steps for a jurisdiction will be supported by an evidence base, but others will not, providing limited insight on the selected program component’s effectiveness.

Project Evaluability: *Does the proposed project have a clear, rigorous, and feasible evaluation plan?*

CIT has been evaluated, though few studies have met the level of rigor necessary for a PFS evaluation. Drawing on the literature and practical experience, learning-community members identified potential outcomes and data sources that could be used to measure the success of CIT (see figure 2). Where there is no evidence base for a specific program component but all the PFS stakeholders agree the program component is reasonable, PFS can actually be used to help *create* the evidence base because evaluation is part of the PFS process.

Provider Capacity: *Is the service provider capable of effectively delivering the program?*

PFS requires ample provider capacity and data capacity, which vary greatly across jurisdictions. Current trends lay a promising foundation for PFS data capacity: a growing number of jurisdictions are seeking to link health and criminal justice systems, often to reduce costs and provide more targeted outreach and support to high users. Such efforts not only increase data linkage across agencies, but also help to cultivate a culture of information sharing.

SPECIFIC CONSIDERATIONS AND CHALLENGES RELATED TO PROVIDER CAPACITY

Weak health infrastructure. One of the most common challenges identified by the learning community was the weakness of local health infrastructure. If officers have nowhere to take individuals after addressing a crisis, they may feel compelled to arrest people they do not feel are safe to leave on the street because they don't see an alternative. Participants noted that many officers view jail as the only way to get someone into treatment because of the lack of community-based options.

Limited law enforcement capacity. Prioritizing CIT takes a great deal of commitment from law enforcement agencies, which can be challenging to balance with their high volume of work and limited budgets. Ensuring that leadership is willing to prioritize CIT in this way is essential to success but also a vulnerability of CIT partnerships.

Culture change. Shifting culture in any way, shape, or form is often challenging. Though officers are accustomed to calling for specific types of backup (e.g., a CIT officer), learning to look for signs of mental/behavioral health issues, as opposed to criminal activity, requires a shift in thinking that can be difficult and contradictory to prior training.

Project Alignment: *How well do all the key components of the proposed project fit together in a specific jurisdiction?*

The resources and capacity of each jurisdiction will differ, so it's difficult to predict how PFS-CIT project components would fit together. For example, local health care providers may be initially reluctant to work with police or to accept people after a crisis situation. In another jurisdiction, a stakeholder agency may be unwilling to provide data or depart from their standard procedures and protocols, even if it is necessary for the PFS project to succeed. It is critical that all the stakeholders understand and agree on the key components of the PFS project, and that they fit together in a manner that will allow the project to function properly.

SPECIFIC CONSIDERATIONS AND CHALLENGES RELATED TO PROJECT ALIGNMENT

Data sharing. Exchanging information between law enforcement and health agencies can be greatly beneficial to CIT, but also raises challenges related to patient privacy. The ability to work out a solution to these issues reflects how well stakeholder agencies are aligned with common objectives for the CIT program they are attempting to support through PFS.

Large versus small jurisdictions. Learning-community participants noted that though CIT is discussed most often in large urban contexts, it may require special considerations for small and/or rural departments. Small departments may have some advantages because dispatchers are more likely to know the CIT-trained officers to call. However, small departments often have limited budgets with less flexibility. In some cases, it may be appropriate for small jurisdictions to be part of a larger regional CIT effort (e.g., multicounty programs), which requires considering the priorities of all the relevant stakeholder agencies within that regional unit.

Summary Insights and Considerations for Policymakers

The pay for success model is focused on financing government programs, and the Crisis Intervention Team model is focused on responses to mental health issues in the community. Though these two models deal with different aspects of public administration, they both emphasize achieving certain outcomes, rather than simply performing certain actions or producing certain outputs. This shared emphasis represents these models' departure from common approaches to public administration.

Similarities between the PFS and CIT models create a natural opportunity for PFS to support the development and growth of CIT. The elements necessary to start a new CIT program (cross-agency coordination on improving responses to mental health in the community, followed by training) have a lot in common with the elements necessary to start a new PFS project (cross-agency collaboration on defining and attempting to solve a specific social problem). Though PFS may not be the most appropriate means of *starting* a new CIT program, the emphasis and infrastructure involved in starting a CIT program does appear to lay the foundation for PFS to support *expanding* an existing CIT program.

The expert stakeholders who contributed to this brief explained that a CIT program can be different for every jurisdiction based on its specific needs, circumstances, and culture. Though every CIT program begins with cross-agency coordination and stakeholder training, there does not appear to be a standard next step or specific program element for enhancing the program. Each jurisdiction needs to consider its own circumstances, determine the specific outcomes to be improved, and decide on the best approach for achieving those outcomes. These considerations are a natural fit for many elements of the PFS model. Whether the jurisdiction's plans fit within the rest of the PFS model will determine whether PFS is a suitable means of financing the jurisdiction's expansion of its CIT program.

Providing guidance on developing and growing CIT programs through PFS projects is the primary objective of this brief, but a second objective is to highlight how both models necessitate an important shift in a jurisdiction's public administration priorities. Rather than following specific actions or producing specific outputs, an important emphasis on achieving specific outcomes is shared by Pay for Success and the Crisis Intervention Team model.

Notes

- ¹ This synopsis draws heavily from Milner (2016).
- ² Includes projects categorized as “in progress” or “finished” as of August 2017 on [payforsuccess.org](http://www.payforsuccess.org), operated by the Nonprofit Finance Fund. See “Projects,” Nonprofit Finance Fund, accessed September 22, 2017, <http://www.payforsuccess.org/projects/?sort=recent>.
- ³ Cecilia Muñoz and Shaun Donovan, “Administration Nearly Doubles Number of ‘Pay for Success’ Feasibility Studies,” *White House Blog*, April 19, 2016, <https://obamawhitehouse.archives.gov/blog/2016/04/19/administration-nearly-doubles-number-pay-success-feasibility-studies>.
- ⁴ Such as the Ridealong app, which provides first responders with key background information about people with mental health conditions to help officers more effectively de-escalate situations.
- ⁵ A warm line serves as a resource for people struggling with mental health issues. Unlike hotlines, warm lines hope to help people before they reach a point of crisis.
- ⁶ See Bahora and colleagues (2008); Borum and colleagues (1998), Broussard and colleagues (2011); Canada, Angell, and Watson (2012); Compton and colleagues (2006, 2009, 2014a, 2015); Demir and colleagues (2009); Ellis (2014); Hanafi and colleagues (2008); Ritter and colleagues (2006, 2010); Wells and Schafer (2006).
- ⁷ See Compton and colleagues (2014b); Steadman and colleagues (2000); Teller and colleagues (2006); Watson and colleagues (2010).
- ⁸ See Franz and Borum (2011); Morabito and colleagues (2012); Skeem and Bibeau (2008); Steadman and colleagues (2000).
- ⁹ See Morabito and colleagues (2012) and Skeem and Bibeau (2008).
- ¹⁰ See Broner and colleagues (2004).
- ¹¹ See El-Mallakh, Kiran, and El-Mallakh (2014).
- ¹² See Canada, Angell, and Watson (2012); Compton and colleagues (2006, 2014a); and Ellis (2014).
- ¹³ See Borum and colleagues (1998); Compton and colleagues (2014a); Hanafi and colleagues (2008); Wells and Schafer (2006).
- ¹⁴ See Bahora and colleagues (2008); Broussard and colleagues (2011); and Ritter and colleagues (2006, 2010).
- ¹⁵ See Borum and colleagues (1998).
- ¹⁶ See Franz and Borum (2011); Morabito and colleagues (2012); Skeem and Bibeau (2008); and Steadman and colleagues (2000).
- ¹⁷ See Compton and colleagues (2014b); Steadman and colleagues (2000); Teller and colleagues (2006); and Watson and colleagues (2010).
- ¹⁸ See El-Mallakh, Kiran, and El-Mallakh (2014).
- ¹⁹ Examples include the *Washington Post*’s finding that a quarter of officer-involved shootings in the first half of 2015 killed someone in mental or emotional crisis. See Wesley Lowery, Kimberly Kindy, Keith L. Alexander, Julie Tate, Jennifer Jenkins, Steven Rich, “Distraught People, Deadly Results,” *Washington Post*, June 30, 2015, http://www.washingtonpost.com/sf/investigative/2015/06/30/distraught-people-deadly-results/?utm_term=.4052cadf7730.

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Acknowledgments

This project was supported by Grant No. 2012-DJ-BX-K001 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the authors and do not necessarily represent the official position or policies of the US Department of Justice.

We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at www.urban.org/support.



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