Meeting Notice and Agenda
Community Advisory on Public Safety Commission

Thursday, July 6, 2023 at 3:00 pm – 4:30 pm
Hooker Conference Room (#245), Showers Building, 401 N. Morton Street
The public may also access the meeting at the following link:
https://bloomington.zoom.us/j/82618346916?pwd=MU9UUnVGR1dFcWo1bUxSNy9QUk5mZz09

I. ROLL CALL & INTRODUCTIONS (name & pronouns)

II. APPROVAL OF AGENDA

III. APPROVAL OF MEMORANDA/MINUTES
Regular Session Minutes – June 1, 2023

IV. REPORTS (if any)
  a. Co-Chairs
  b. Individual Members
  c. Committees
    i. APSO Special Committee's Research Report
    ii. Research Committee
  d. Staff

V. REPORTS FROM THE PUBLIC / PUBLIC COMMENT

\- *BRIEF RECESS* -

VI. NEW BUSINESS
  a. Commission Approval of APSO Special Committee's Research Report
  b. Annual Report to Council: 8/2/2023, includes APSO Report & START Report
  c. Council Review of Commission

VII. OTHER BUSINESS
  a. Anti-Trans State Legislation & Sanctuary City
  b. Fall Event Planning: Black Genealogy Event
  c. Budget: 2024 Requests & 2023 Proposed Expenditures
  d. Tabled Items: Deaf Club & Implicit Bias Training

VIII. TOPIC SUGGESTIONS FOR FUTURE AGENDAS
  a. Upcoming Work Session Topics
  b. Proposed Research Topics

IX. ADJOURNMENT

Posted: 5 July 2023

CAPS Commission Goals and Purpose:

Perform research and gather data on the perceptions and preferences about public safety from community members, with specific focus on perceptions and preference data gathered from minority community members, individuals who are disabled, and other often marginalized community members

Research evidence-based alternatives to traditional policing

Identify best practices in public safety globally and evaluate the efficacy of such practices for implementation in Bloomington.

Make recommendations to the Common Council, the Board of Public Safety, and/or the Mayor or the Mayor's designee on policies and programs that enhance public safety for all community members.

City of Bloomington

NOTICE

Thursday, 6 July 2023 at 3:00 – 4:30 p.m.

Community Advisory on Public Safety Commission

Regular Session

This meeting will be held in the Hooker Conference Room (Suite 245, City Hall, 401 N. Morton St) and may also be accessed electronically via Zoom (see information below).

Join Zoom Meeting
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+1 507 473 4847 US
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Find your local number: https://bloomington.zoom.us/u/kd2hhGhccH

As a quorum of this Commission or its committees may be present, this gathering constitutes a meeting under the Indiana Open Door Law (I.C. § 5-14-1.5). For that reason, this statement provides notice that this meeting will occur and is open for the public to attend, observe, and record what transpires.

MEMORANDUM

Community Advisory on Public Safety (CAPS) Commission
Monday, June 1, 2023, 3:00 p.m. – Hooker Conference Room (#245),
401 N. Morton Street, Bloomington, Indiana

The Regular Session meeting was called to order at 3:02 p.m.

Commission members present in person: Shelby Ford, Patty Moon, Carolyn Leinenbach, Matthew Needler (left at 4 p.m.), Jason Michalek

Commission members present remotely (Zoom): Tyler Shaffer, Nejla Routsong

Commission members absent: Kamala Brown-Sparks

City staff present: Ash Kulak

Public present: one member of the public (preferred to remain anonymous) attended in person, and three were present via Zoom

APPROVAL OF AGENDA:

- No amendments to agenda.

APPROVAL OF MINUTES:

- Cm. Needler moved and it was seconded to approve the minutes. The motion passed 7-0-0 by roll call vote.

REPORTS:

Co-Chairs:

- Cm. Ford reported on time commitments and personal reasons impacting service on Commission.
- Cm. Needler had no report.

Individuals:

- Cm. Leinenbach reported on some of the state legislation regarding gender and sexual minorities, requesting staff look into municipalities across the country that provide protections for transgender youth and healthcare workers.
- Cm. Shaffer requested the Commission look into the affordable housing report.
- Cm. Moon reported on how to facilitate work collaboration.

Committees:

- Cm. Routsong reported on compiling the report and recommendations for the Alternative Public Safety Outreach Special Committee and discussed the new timeline and schedule, requesting work sessions for full Commission feedback.

Staff:

- Council staff welcomed new members and explained the reversion dollars available to the Commission for the remainder of the year.

Public:

- One member of the public who preferred to remain anonymous had feedback on the Town Hall event, specifically encouraging the Commission to consider the perspective of crime victims with its work.

NEW BUSINESS:

Fall Event Planning: Cm. Ford proposed the Commission put on another larger event for the fall. Cm. Ford suggested getting public input, based on public comments made, including how the bigger issues are affecting individuals, the community discussion, and advocacy efforts. Cm. Ford also suggested CAPS Commission presence at Bloomington Pride.

Juneteenth Event: Cm. Routsong explained the change in the proposed event, due to time constraints and so as to not conflict with the City's preexisting Juneteenth events, from a Juneteenth Event to a Black Genealogy Event in September or October as a collaboration with the Monroe County History Center. Cm. Leinenbach proposed CAPS presence at the City's Juneteenth events. Cm. Moon volunteered to design flyers. Council staff agreed to print flyers.

OTHER BUSINESS:

Regular Schedule: Cm. Ford moved and it was seconded to change the meeting schedule Regular Meetings every month on the first Thursday at 3 p.m. The motion passed 7-0-0 by roll call vote.

START Program: Cm. Michalek summarized the START report on Bloomington Housing Affordability, identifying the main issues (lack of available units for low income households and increasing rent) and recommendations (large apartment complexes focused solely on affordability). Cm. Shaffer found compelling that the housing market is focused on development for students in luxury housing. Cm. Routsong proposed putting together a possible committee for this issue. Cm. Ford proposed sending the report as a recommendation to Council, either as a report to Council, as a CAPS resolution with recommendations to implement the report, or as a simple email attachment.

Budget: Cm. Ford proposed a google excel sheet for ideas on expenditure use for reversion funds allotted for the remainder of the 2023 year. Council staff explained process for 2024 budget, including written itemization. Cm. Ford suggested talking about future budgeting during working session.

TOPIC SUGGESTIONS FOR FUTURE AGENDAS:

Commissioner Ideas for Discussion: None

IU Cinema Creative Collaboration: Cm. Routsong proposed collaborating with the IU Cinema to show films on the topic of alternative public safety to engage with other people and organizations in the community on reframing how the community views safety, from a "command and control" to a "community resilience" effort. Cm. Leinenbach inquired about the cost. Cm. Routsong explained process for application and expected costs of two different programs, Creative Collaborations and Screen Share.

First Responders Research: Cm. Needler wants to begin research on first responders, either individually, as a separate committee, or within the Research Committee. Cm. Shaffer expressed interest in the topic. Cm. Routsong reported that the Alternative Public Safety Outreach (APSO) Special Committee conducted research and outreach on the issue of emergency dispatch and stated that there is room for continued work on this topic moving forward.

Updating Procedures & Bylaws: Cm. Ford proposed adding this to the work session list. No objections.

CAPS Annual Report to Council: Cm. Ford proposed adding this to the work session list. No objections.

Deaf Club: Cm. Ford proposed moving this to the next Regular Session when Cm. Brown-Sparks is able to attend. No objections.

Implicit Bias Training: Cm. Routsong believed this item was added by Cm. Brown-Sparks due to the Monroe County CHIPS Program offering implicit bias trainings. Cm. Ford proposed moving this to the next Regular Session when Cm. Brown-Sparks is able to attend. No objections.

Work Session Agenda: Cms. discussed prioritizing discussion of the following topics at the next work session: bylaws update, reviewing APSO report, budgeting and spending for this year, community event planning, annual report to Council.

Additional Public Comment: Jim Shelton, who was unable to comment during the official period, offered a public comment.

Additional Discussion: Cms. continued discussion about the initial public comment regarding victims and public safety responses.

Meeting adjourned.

Memorandum prepared by:
Ash Kulak, Staff

COMMUNITY ADVISORY ON PUBLIC SAFETY (CAPS) COMMISSION

City of Bloomington, Indiana

Alternative Public Safety Report: Safety for All, at the Expense of None

Photo of Bloomington’s B-Line pedestrian trail, courtesy of the Bloomington Visitors Center.

July 6, 2023

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Summary

The **face of US public safety is shifting rapidly** in response to the **changing needs of local communities** who face **rising rates of crime, violence and other safety threats** caused by persistent or growing rates of **housing insecurity and homelessness, drug use and mental illness**. In this report, the Community Advisory on Public Safety (CAPS) Commission describes the **evidence-based** and **community-led policy design process** that it followed, and the resulting recommendations on how the City of Bloomington can create **a community-based crisis response and public safety program** that will **improve safety for all** residents.

The main recommendation is to create **a Department of Community Safety and Resilience (DCSR)** that has the organizational structure, institutional goals, staffing, long-term funding and community-wide support to **coordinate a strategic response to emerging threats** facing the community, and to **reduce crime, costs and injustice** in a community-led, evidence-based way. This recommendation is contingent upon **a feasibility study** that should first be conducted by a qualified firm. A secondary recommendation is to track and **incorporate key indicators of community safety and resilience** into City organizational assessment procedures. These recommendations are based on the Commission's findings that the **key problem areas driving the systemic growth** of these safety threats are: **1) barriers to access** of important safety resources, **2) conflicting institutional goals and interests** in existing safety-related departments, and **3) a functional gap** around coordinating a strategic response to emerging safety threats.

This Report and the recommendations in it were created for the **Mayor**, the **Common Council**, and the **community**. The research conducted by the Commission includes case analysis of **best practices** across the US, scholarly work in **policing** and **institutional governance**, local and national **reports**, and **analysis of dispatch** calls. Targeted outreach was performed with **safety-marginalized people** and **advocacy organizations**, **key operational stakeholders** from both **city and county governments**, including **police and fire** departments, local **service providers** of **drug treatment** and **housing** services, national and local **scholarly experts**, **business** and **housing market** leaders, **university** representatives, **Mayoral candidates** and any **members of the public** who wished to

participate. Outreach also included a **Public Safety Town Hall** event at the Monroe County Public Library held in-person and online on April 11, 2023. The Commission was assisted in this work by **local volunteers** from the **Community Justice and Mediation Center (CJAM)**, **IU Student Agile Response Team** (START), the **Net Impact club** of the Kelley School of Business of Indiana University, and **Help Ourselves** mutual aid organization.

Background

Three years ago, **thousands of Bloomington residents attended the Black Lives Matter march held on June 5, 2020** on the downtown square, protesting against nation-wide perceptions of excessive policing practices in the wake of the murder of George Floyd by Minneapolis police officers.[1] The chants of the protestors in our city echoed nationwide protests held across the US **calling for a systemic overhaul of public safety services,** a call **led by Black and Brown communities** who have suffered disproportionate harm from the existing policing, justice and carceral systems.

Just one month prior, **on May 6, 2020, the Common Council established the Community Advisory on Public Safety Commission** by passing Ordinance 20-20.[2] The CAPS Commission was established to:

> promote **"a concept of public safety with broad meaning across community demographics"** with an emphasis on protecting civil and human rights, especially with a focus on protecting the rights, health and safety needs of marginalized people and **"giving voice"** to those who are often unheard.

The ordinance directs the Commission to gather data and perform local outreach, research evidence-based alternatives to policing programs, identify best practices across the US and

[1] "Thousands Rally In Bloomington For Black Lives Matter Movement," ADAM PINSKER, June 5, 2020 <https://indianapublicmedia.org/news/thousands-rally-in-support-of-black-lives-matter-movement.php>
[2] Ordinance 20-20, City of Bloomington, <https://bloomington.in.gov/onboard/legislationFiles/download?legislationFile_id=5564>

worldwide and make recommendations to the City. This report is the result of three years of the Commission's work on this topic.

Mission, Founding Principles & Objective

The Alternative Public Safety Outreach Special Committee's **mission to reduce crime, costs and injustice** was decided by consensus in the Alternative Policing & Crisis Response Committee of the CAPS Commission in 2021. This mission is based on what members perceived to be the main problems that the community attributes to the local public safety system in general, and to local law enforcement agencies in particular. When the independent research stage was complete, our Alternative Public Safety Outreach Special Committee, a standing committee of the CAPS Commission, was formed in 2023 to continue work on this project.

The **objective** of this work is:

To empower the community to resolve these problems in a way that aligns with the principles of: **human dignity, racial equity, decriminalization of poverty, harm reduction** and **restorative justice.**

Goals

The three (3) goals of this report are to:

1. Recommend a community-led alternative public safety program that will **reduce crime, costs** and **injustice.**
2. **Empower the community to have maximum control** of program design, implementation and oversight.
3. **Ensure sustainability of program** through wide community endorsement, recommendations for civic and institutional partnerships and metrics for success.

Process

The Alternative Policing and Crisis Response Committee was created by the CAPS Commission in 2021. That Committee agreed to use a **community-centered and data-driven approach** that is adapted from the design-centered entrepreneurship[3] method of business innovation and problem-solving to the civic sector, optimizing for social goals rather than business goals. This approach also utilizes **root cause analysis**[4] (RCA) and **systems thinking**[5] to resolve complex social problems and improve organizations. This process was designed to **synthesize local needs and priorities with national best practices and scientific evidence.**

Design-Centered Entrepreneurship Process

The eight steps in the design-centered entrepreneurship process are:

1. **Problem-Finding**
2. **Fact-Finding**
3. **Problem Definition**
4. **Idea-Finding**
5. **Evaluate and Select**
6. Plan
7. Acceptance
8. Action

This report documents the CAPS Commission's efforts to facilitate this process of **community innovation** and **problem-solving** up to and including Step 5 - Evaluate and Select. We hope that once this Report and its Recommendations has been delivered to the Common Council, Mayor's Office and all other key City stakeholders in public safety, that

[3] Basadur, Min, and Michael G. Goldsby. Design-Centered Entrepreneurship. Routledge EBooks, 2016. https://doi.org/10.4324/9781315686912.
[4] Wikipedia contributors, "Root cause analysis," Wikipedia, The Free Encyclopedia, https://en.wikipedia.org/w/index.php?title=Root_cause_analysis&oldid=1158416790 (accessed June 12, 2023).
[5] Wikipedia contributors, "Systems theory," Wikipedia, The Free Encyclopedia, https://en.wikipedia.org/w/index.php?title=Systems_theory&oldid=1155576948 (accessed June 12, 2023).

they will decide to join in completing the last three steps together with the CAPS Commission to **improve safety outcomes, enable more equitable justice outcomes and reduce overall costs.**

Root Cause Analysis (RCA)

RCA was developed in the fields of science and engineering as an effective way to optimize system performance, and it has also been applied in industrial and social settings. The benefit of using RCA is that it allows the Committee to view public safety in the community as a **whole system**, recognizing the **driving forces** behind the community's threats to public safety, the specific **causal mechanisms** that enable those driving forces to operate in the community, and the **symptoms** which manifest in our local community as threats to public safety.

Project Stages

Project Stage	Research (Steps 1-2)	Outreach (Steps 2-3)	Recommendations (Steps 4-5)
Goal 1	Review relevant scholarly work, local subject matter experts, relevant quantitative data, reports, and 4-5 existing US models that exemplify best practices	Identify local safety needs and major challenges	Recommend program combining best practices w/ local needs
Goal 2	Identify local institutions, individuals and any other key stakeholders in public safety in the community	Perform targeted stakeholder outreach, including a facilitated town hall event to guide program design	Recommend organizational structure, implementation practices and oversight procedures to maximize community control

Goal 3	Research key sustainability factors including budgeting, partnerships, staffing, key performance indicators	Consult with city departments, local service providers and other key stakeholders to maximize sustainability	Recommend policy or programming improvements, including partnerships, staffing and KPI's to measure success

Initial Problem Question

Following the design-centered entrepreneurship process Step 1: Problem-Finding, the Committee formulated an initial problem question that it seeks to answer. This question guided the research and outreach completed in Step 2: Fact-Finding. The Committee created the initial problem question **based on testimony from local advocates for safety-marginalized groups** that was heard by the Alternative Policing and Crisis Response Committee in 2021:

How might we design, fund and maintain an alternative public safety program that protects the civil and human rights of all members of our community while giving voice to the most marginalized members who are often unheard?

Research

The first part of the fact-finding stage, or Step 3 Problem Definition, involved **identifying recent scholarly work, case studies, reports, best practices** and **relevant quantitative data** that illustrates the initial problem question to be solved in a **multidimensional, evidenced-based way**.

Scholarly Work and Local Experts

During the last three years since May 2020, the Special Committee has met with community leaders in the areas of racial equity (**Black Lives Matter-Bloomington**), harm reduction (**Indiana Recovery Alliance**), homelessness (**Heading Home of Monroe County United Way**) and conflict resolution (**Community Justice and Mediation**), consulted directly with scholars of policing (**Alex Vitale at Brooklyn College - City University of New York)** social work (**Donyel Byrd at Indiana University**), and expert practitioners of conflict resolution and restorative justice (**Liz Grenat and others at Community Justice and Mediation Center).** The Special Committee has also performed in-depth research with operators and designers of some of the most successful alternative public safety programs in the US.

The Special Committee's consultations with Alex Vitale, Professor of Sociology at Brooklyn College, CUNY and Coordinator of the Policing and Social Justice Project, emphasized the importance of **ensuring community control** over the design and oversight of any alternative public safety program, as well as **detailing the scientific evidence for the programs that limit the harm** posed to communities by systemic public safety problems. Critically, the Special Committee discovered that **increased spending or staffing to policing programs**, **including reforms** such as adding social workers and/or other unarmed response officers to be embedded within police departments **have not historically produced lower levels of either crime or injustice** in communities who have tracked the outcomes of such reforms.

Working with Donyel Byrd at the School of Social Work at Indiana University gave us a direct connection to the lived experiences of marginalized community members of Bloomington who expressed to us how **their safety is compromised by existing policing and public safety programs,** including **those who experience criminalization** on the basis of their race, gender, sexual orientation, drug use, housing status, previous incarceration or socioeconomic status. While performing community outreach under the expert advice of Liz Grenat, Executive Director of the Community Justice and Mediation Center, the Special Committee learned about effective practices of **community facilitation and problem-solving, restorative justice** and **non-coercive methods of conflict resolution**.

Through local research with subject matter experts, the Special Committee learned that the main perceived threats to public safety in the community are: **increasing rates of violent crime, homelessness, mental illness** and **drug use**. We learned that all of these problems **harm Black residents and other racial minorities disproportionately** in our community, but they also **especially harm unhoused people, people with mental illness, drug users** and **those who have experienced incarceration.** Furthermore, we learned that the increasing visibility of these problems near downtown Bloomington also **poses threats to the economic prosperity of the City**, inspiring a broad set of community stakeholders to engage with the Committee on this project.

Quantitative Data

To better assess how our community compares to the rest of Indiana in public health and safety areas, we first consulted the **County Health Rankings**[6] that are compiled by the University of Wisconsin using US county health department data. These rankings include important indicators of threats to public safety, such as **severe housing problems** and **income inequality**, in which both categories **Monroe County takes the top position out of 92 counties** in Indiana.

To understand how local law enforcement officers currently respond to crisis situations in our community, we utilized the **Calls for Service dataset** of the **City of Bloomington's Open Data Dashboard**. The Special Committee's initial analysis of the BPD Calls for Service in the last 12 months according to the protocols recommended by the Community Responder Model Report of the Center for American Progress,[7] which is represented in the figure below, indicates that **up to 54% of all service calls to which BPD officers are currently being dispatched might be served by community responders.**

Figure 1. Analysis of recent 12-months of Bloomington Police Department Service Calls

[6] "County Health Rankings Model." n.d. County Health Rankings. https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model.
[7] The Community Responder Model." 2020. Center for American Progress. https://www.americanprogress.org/article/community-responder-model/.

Nature of call	Number of calls	CR/Police
Welfare check	17,321	CR*
Extra patrol	13,252	P
Follow up	10,295	P
Sus Act Person	9,825	P
Service	8,804	CR
Trespass	7,701	CR*
Noise	7.264	CR
Alarm	7,143	P
Disturbance	6,729	CR*
Accident	6,537	CR
Theft	6,211	P
TOTAL	101,082 (100%)	CR = 54,356 (54%)

P = Police are likely the most cost and outcome-effective responders for this kind of service call, according to the protocols recommended in the Community Responder Model report

CR = Community Responders may be cost and outcome-effective in these kinds of service calls according to the protocols recommended in the Community Responder Model report

CR* = Community Responders are recommended in these kinds of calls according to the Community Responder Model report on best practices across the US in community policing, however there may be statutory or other reasons why police must respond to these calls, according to feedback received from Bloomington Police Department

Reports

Next our Committee studied the conclusions reached in the most relevant local and national reports created on this topic, including the **2017 Safety, Civility and Justice Report**[8] created by the City of Bloomington's Safety Civility and Justice Task Force, which concluded that "**a key missing piece for Bloomington and Monroe County" is "The community does not have adequate collaborative infrastructure**," to enable the "rich array of organizations from the public, private, and nonprofit sector who can help address" the shared threats to safety, civility and justice. The report also notes that "there is **no shared information portal** and **no structured and comprehensive collaborative network fitted to the problems**. This requires **an assessment of what organizations exist and who can contribute what to the shared concern about safety, civility, and justice**."

Our Special Committee also reviewed the **2023 State of Public Safety**[9] created by the Bloomington Police Department, which includes the observation that **their successful pilot program of police-embedded community responders** has already enabled their department to have "**more capacity to address emergent concerns in a timely fashion**," and that their top three 2023 goals include, "**Address violent crimes by working** in concert with **not only the entire criminal justice system but with the community as a whole**."

Finally, the **2022 Future of Policing Task Force Report**[10] created by the City of Bloomington's Future of Policing Task Force included the following recommendations that are relevant to this Report:

[8] "Safety, Civility and Justice Task Force Report 2016." City of Bloomington, Indiana. https://bloomington.in.gov/sites/default/files/2017-07/SCJ_Final_Report.docx.
[9] "State of Public Safety Report 2023." City of Bloomington, Indiana, https://bloomington.in.gov/sites/default/files/2023-02/State%20of%20Public%20Safety%20Report%202023.pdf.
[10] "Future of Policing Task Force Initial Report 052022.docx." City of Bloomington, Indiana, 1 April 2022, https://bloomington.in.gov/sites/default/files/2022-05/Future%20of%20Policing%20Task%20Force%20Initial%20Report%20052022.docx.pdf.

- "Further **explore community policing** – Realizing that some of the stated benefits of Community Policing include closer alliances between the police and the community; reducing community fear of crime; improving community-police relations and the facilitation of **a more effective response to community problems**. Community policing is not without its challenges. The task force will explore multiple community policing models and initiatives to see how they might be adapted or utilized in Bloomington. One of the benefits of community policing is the adaptability to the culture of a given community. It is not one size fits all, however, **it will be beneficial to know what has worked or not worked in other communities similar in size, scope and culture to Bloomington,** Indiana," and to
- "Explore possibilities to **have agencies outside of the police department with the ability to respond to mental and physical health emergencies**. Research other community programs of this type to determine what might be applicable to Bloomington/Monroe County. "

Our Special Committee also consulted the **21st Century Fire and Emergency Services Report**[11] that was created in 2020 with feedback from 1,200 fire, emergency services and local government management professionals in the US by the International City/County Management Association (ICMA) and the Center for Public Safety Excellence, which recommends the following Initiatives:

- A1. Celebrate the heritage of the fire and emergency services while **recognizing that [public safety] services** provided **have evolved and will continue to experience significant changes** over the next 30 years.
- B1. **Enhance alignment between community, elected officials,** [public safety] **management**, labor/volunteer representatives, and overall [public safety] workforce.
- B2. Promote an organizational environment that is **adaptable, open to change, innovative, and focused on continuous improvement.**
- C1. Utilize **quality data for evidence-based decision making** to assess and produce the best outcomes.

[11] "White Paper: 21st Century Fire and Emergency Services." 2020. ICMA. https://icma.org/documents/white-paper-21st-century-fire-and-emergency-services.

- C2. Implement **advanced data analytics** to make **informed decision**s.
- E1. Acknowledge the need to **work with a wide range of partners to serve the community** and **develop local strategies to create new approaches to providing services more effectively**.
- E3. Continue to **expand community emergency response** capabilities.

This Report was also informed by the **volunteer research and reporting** efforts of several teams of **Indiana University students**, including a report by **Net Impact** business and IT students who concluded that **current police staffing shortages are an opportunity for the City to consider alternative policing programs**, a report by START program students who concluded **the City should take more direct action in providing access to very low-income housing**, and IU School of Social Work students who provided our committee with direct information on **perceptions of public safety by residents who utilize local service providers of access to basic safety resources**.

National Best Practices

Northampton, MA

The Northampton Policing Review Commission was created by the City Council of Northampton, Massachusetts to address calls for racial equity and better oversight of police by the community. In 2021, the Commission released a report titled “Reimagining Safety”[12] which calls for the creation of a **Department of Community Care,** improved options for **crisis response**, a **housing first approach to homelessness**, and resources for **harm reduction for drug users**. In-depth study of this report and a personal interview with one of the Commission Chairs revealed several valuable lessons, including:

1. **A shift in viewing public safety** from the punishment of crime to the protection of public health through the decriminalization of poverty and using readily available data to assess outcomes.

[12] Northampton Policing Review Commission, City of Northampton, Massachusetts <https://www.northamptonma.gov/DocumentCenter/View/16810/Reimagining-Safety---Northampton-Policing-Review-Commission-Report>

2. Prioritizing the **staffing of alternative public safety programs with people who have the lived experience of marginalization** and/or criminalization to ensure a focus on equity and harm reduction.
3. Maintaining the **independence** of such a program outside of the oversight of the police, and directly **planning for funding sources** and **community oversight mechanisms**.

Denver, CO

The Denver STAR Corresponder was created as a community response program made possible through **collaboration between the Caring for Denver Foundation, Denver Police Department, Mental Health Center of Denver (MHCD), Denver Health Paramedic Division, Denver 911, and community supports and resources** through funds generated through a 2018 ballot initiative that allocated funds for specific public safety services and training related to mental health and substance misuse services. In this collaboration, the program provided a third path of addressing community safety issues in addition to the criminal justice system or the health/hospital system–though the funding avenue situated the program within the Denver Police department.[13]

In 2021, funding and management shifted to the City and County of Denver in partnership with the Mental Health Center of Denver, gradually moving to a **fully functional alternate responder model**. We arrived at several valuable lessons through in-depth study of this report, the new contractual agreement, and personal interviews with the new director of the advisory board, a program specialist, and a member of the correspondents, including:

1. Oversight from the director of Denver Department of Public Health and Environment allows **active adjustments to community concerns**
2. The internal operations of the team addresses quality control issues through a mediated **restorative justice process**
3. The above items offer a **real-time, standardized way of resolving community compliments and complaints**

[13] STAR Program Evaluation, City of Denver, Colorado <https://wp-denverite.s3.amazonaws.com/wp-content/uploads/sites/4/2021/02/STAR_Pilot_6_Month_Evaluation_FINAL-REPORT.pdf>

4. A **34% drop in reported crimes over six months** by utilizing alternative services to handle nonviolent calls, thus resolving community problems without unnecessary criminalization of people experiencing crises. [14]

Eugene, OR

Eugene, Oregon has spent decades developing a community-led response to public safety. Their program is noted as one of the oldest models for police alternatives. It got its roots from the "Bummer squad", a 1960's team of volunteers who responded to unmet needs in the community with crisis intervention strategies. These grassroots efforts developed into two main programs, both vital to its success. The White Bird Clinic, and later in the 1980's, CAHOOTS (Crisis Assistance Helping Out On The Streets), a renowned program of responding to crises by community and mental health professionals. Their response model **diverts 17% of the Eugene Police Department's total call volume while saving the city an estimated $8.5 million in public safety spending per year**.[15]

The White Bird Clinic has an all-in-one resource center for those experiencing houselessness with the Front Room providing clothes, drinking water, mail services and bathroom access. Workers of the Navigation Empowerment Services team act as a resource for the community for everything from document assistance, deposit assistance and treatment referrals. The center also offers **24/7 crisis intervention services such as counseling, special transport, information/referrals and rapid rehousing** for youth experiencing unstable housing. White Bird Clinic has created a partnership with a mental health clinic. Furthermore, they have expanded their services to include offering **dental, medical, substance use treatment, and a school based walk in clinic**.[16] Efforts to approach public safety through this holistic lens can prevent crimes and better the city's social health and security, all while saving money in the long run.

[14] https://news.stanford.edu/press/view/43952

[15] https://www.themunicipal.com/2021/04/cahoots-serves-as-crisis-intervention-resource-in-its-communities/

[16] https://whitebirdclinic.org/services/

CAHOOTS is located in both Eugene and Springfield, Oregon, and is dispatched through the emergency communication system. A medic and crisis worker respond to urgent needs such as psychological concerns, referrals, advocacy and treatment transportation requests. Their employees do not act on lifestyle choices but rather provide assistance for clients through client-centered, harm reduction, and trauma-informed frameworks. While funding for CAHOOTS is incorporated in the police contract, the staff are not law enforcement and do not work directly with the city. Their funds are controlled by the city council. In 2019-2020, the program operated on $2.4 Million for both cities. Funding sources included a city investment of $800,000, $630,000 county investment, federal sources, and fundraising efforts. This funding allows for four crisis response vans to run throughout the day. A 50% increase in budget would be needed to fully serve both communities. Valuable feedback is collected to improve the current model by the stewardship council and Ad Hoc to Cahoots.

Our three main takeaways from the Eugene, Oregon alternative public safety program are:

1. The use of a **medic/social work/peer response[17] model allows for ethical harm reduction strategies** to be used in places where armed law enforcement responses may escalate a crisis situation. The **separation of emergency response from police response allows police to focus on ongoing crimes and violent encounters** and **gives citizens a security net** to call for assistance in nonviolent crises.
2. Due to some client concerns about using the 911 dispatch system, **a separate call dispatch system should be created to remove the risk of an armed response for community members who are hesitant to use the 911 system**. This also has the goal of reversing the priority of response so that the alternative responders will be the first to any crisis call where a police presence is not required.

[17] "Value of Peers Infographics: Peer Support." 2017. SAMHSA. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf.

3. Any program developed must have three core elements, which are also confirmed in the 2020 SAMHSA National Guidelines for Behaviorial Health Toolkit [18]:
    a. Someone to Talk To (Crisis Call Services),
    b. Someone to Respond (Mobile Crisis Services) and
    c. A Place to Go (Crisis Receiving and Stabilization Services).

Ithaca, NY

In February 2022, the City of Ithaca was presented with recommendations for a new umbrella organization for public safety called the **Department of Community Safety**, which would **oversee the existing police department** and a **new Division of Community Solutions, made up of unarmed civilian responders**. The report[19] was created by a working group made up of both advocates for marginalized communities and law enforcement representatives, and it included detailed stipulations for which types of emergency calls should be responded to by police versus civilian responders, or by both.

Additionally, the civilian responders are tasked with performing regular community patrols to increase community engagement and to make referrals to local social service agencies. Besides creating the civilian emergency response division, the report also suggests several changes to training, equipment and technology. In December 2022, several parts of the plan were approved and put into the planning stages for 2023 implementation.[20]

The main takeaways from the Ithaca report are as follows:

- **Clear delineations between what kinds of emergency calls should be diverted to police, fire, EMS or to civilian responders** should be made in coordination between all of these agencies and in consultation with best practices by other alternative policing programs included here.

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[18] "National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit." 2020. SAMHSA. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.
[19] Implementing the City of Ithaca's New Public Safety Agency, <https://www.cityofithaca.org/DocumentCenter/View/13725/WG_IthacaReport_Final>
[20] City of Ithaca, New York, Reimagining Public Safety, News, Dominick Recckio, "2022 and 2023 Reimagining Public Safety Work Plans Approved" <https://us.qmarkets.cloud/live/tompkins/subdomain/news-1396/end/node/3604?qmzn=XpYRsn>

- **A mechanism for reporting low-level calls online by smartphone or computer** allows community members to have less contact with police and emergency dispatch.
- A **data analyst of community safety** will work to review existing data sets for actionable insights, establish new metrics of gauging success and create a live dashboard for public safety.

Oakland, CA

In July 2020, Oakland's 2030 Equitable Climate Action Plan (ECAP) was adopted by City Council alongside a Racial Equity Impact Assessment + Implementation Guide (REIA).[21] The REIA provides a comprehensive set of recommendations and best practices which include **Neighborhood Resilience Hubs** for a more localized and equitable distribution of community resources, as well as a Climate Action Network which **builds local civic capacity for more inclusive engagement for improving two-way accountability between community residents and city officials**.

Additionally, Oakland has successfully implemented **participatory budgeting** practices that allows local district residents to vote to decide how city funds should be used to develop resources for residents in low-income neighborhoods.[22] Participatory budgeting is an important tool for **increasing levels of democratic participation and building social trust**.

Durham, NC

The Special Committee was not able to meet with anyone from this program before completing this Report, however according to their website, the City of Durham, North Carolina, home to Duke University, operates a **Department of Community Safety** that

[21] City of Oakland, Californica, 2030 Equitable Climate Action Plan, Racial Equity Impact Assessment + Implementation Guide <https://cao-94612.s3.amazonaws.com/documents/FINAL_Complete_EF-Racial-Equity-Impact-Assessment_7.3.2020_v2.pdf>
[22] Participatory Budgeting Oakland <https://pboakland.org/page/about>

"works to **enhance public safety through community-centered approaches to prevention and intervention as alternatives to policing** and the criminal legal system. In its second year, the department has three primary functions:

1. **Piloting new response models for 911 calls for service**,
2. **Collaborating with community members to identify additional approaches** to public safety, and
3. Managing and **evaluating existing contracts and external partnerships** intended to advance public safety."[23]

So far, the department has established four crisis response teams that operate under the name of "HEART" (Holistic Empathetic Assistance Response Teams).

1. Crisis Call Diversion (CCD): CCD **embeds mental health clinicians in Durham's 9-1-1 call center**.
2. Community Response Teams (CRT): CRT **dispatches unarmed 3-person teams as first responders to non-violent behavioral health and quality of life calls for service**.
3. Care Navigation (CN): Care Navigators **follow up with people after meeting with one of our first responders** to help connect to the community-based care they need and want.
4. Co-Response (CoR): CoR **pairs clinicians with Durham police officers to respond to certain calls for service that pose a greater potential safety risk**.

Crisis Call Counselors embedded in the 911 call center serve eight major functions:

1. **Assess 911 callers' needs**, complete **safety plans**, and help **identify the appropriate response**.
2. **Divert non-emergent crisis calls** that do not require an in-person response.
3. **Connect people to resources** to support with future mental health-related needs.
4. **Dispatch Community Response Teams** as appropriate.
5. **Consult with 911 dispatchers**, providing information that can support better outcomes.

[23] "Department of Community Safety." Durham, NC. <https://www.durhamnc.gov/4576/Community-Safety>

6. **De-escalate situations prior to the arrival of first responders.**
7. **Support first responders in the field** as unanticipated mental health related issues arise.
8. **Follow up with callers after a crisis** to check in and help connect them to any services that might be needed.

Outreach

The second part of Step 2: Fact-Finding involved performing targeted engagement with all key stakeholders to establish all important facts **from their perspective** as a way to reach **more equitable community decisions** in this project. We followed a **consent-based** method of decision-making where everyone's opinion in the community matters, but **the opinions of the people whose lives are most impacted by a problem (key stakeholders) matter the most.**

After performing and documenting the Outreach stage, the Special Committee reviewed all stakeholder outreach testimony, **noting any recurring systemic problem indicators that emerged**, which are described in the Findings section. The Special Committee then sent the relevant quotes back to all stakeholders for their review, revision if necessary, and approval before including them in this Report.

Targeted Outreach

Following consent-based procedures of community outreach, the Special Committee focused its targeted outreach efforts on hearing from **those people who are the most harmed** by the local public safety system, including **those people who are statistically the least safe** in the community, based on **mortality, safety** and **justice** outcomes[24], and

[24] Due to the lack of local tracking of mortality rates and crime rates against various marginalized populations, we relied on national data which we assume roughly correspond to these local populations, and which are detailed in the Findings section. However, our Commission feels that relying on national data is not enough to dispel myths about which groups in our local community are the most under-served by the public safety system, due to the variations which may occur in our local community. We therefore recommend that the City of Bloomington begin to track these data points for our community in order to provide our community with a more evidence-informed understanding of public safety.

whose safety needs are therefore underserved. Besides the most marginalized and/or harmed stakeholders and **their advocates**, we also targeted important **operational, political and community stakeholders** whose active support is critical for the successful implementation of community solutions to these problems.

Public Outreach

We performed community-wide outreach at a **facilitated Public Safety Town Hall event**[25] that was open to the public both in person and online in order to solicit as much community feedback as possible. All key stakeholders were sent invitations to attend this event, and flyers were distributed at local places where safety-marginalized people gather. During this event, **Community Justice and Mediation mediators facilitated four breakout session** groups in which **event participants shared their experiences with and their perceptions of the systemic problems regarding public safety in the community**. Additionally, the Special Committee held one-on-one followup meetings with all interested community stakeholders following the facilitated event.

Findings

After uncovering all the relevant facts to the initial problem question that we could find, we moved to Step 3: Problem Definition. This is when the initial problem question was re-stated in a way that reflects all of the relevant information from our Research and Outreach.

Stakeholder Identification

Who are the most impacted by the public safety system in Bloomington?

In following a **consent-based** and **harm-reduction approach** to identifying the key stakeholders of public safety, the Special Committee prioritized identifying those who are the most harmed by the current approach to public safety according to statistical evidence. Because, to the Special Committee's knowledge, there does not exist local crime victim data

[25] "CAPS: Public Safety Town Hall, April 11, 2023." 2023. YouTube. https://www.youtube.com/watch?v=wsMmMTDQaCY.

using these categories of identification, we utilized national data to research the relative safety of **people who most directly experience harm from the three major threats to public safety** that were identified from initial research, who are victims of violence, unhoused people, people experiencing mental illness, and drug users.

Unhoused People

The data on the public safety impacts of being unhoused in the US is clear. Compared to 2% of the national population reporting experiences of violent criminal victimization, as many as **49% of individuals experiencing homelessness are estimated to be victims of violence**.[26] Furthermore, experts and advocates report that acts of violence against people experiencing homelessness have been on the rise in recent years.[27] Contrary to the common misperceptions that unhoused people are more likely to threaten public safety, studies demonstrate that **the public falsely perceives individuals experiencing homelessness as likely to engage in violent, criminal behavior**.[28]

People Experiencing Mental Illness

The statistical evidence from national data also confirms that people experiencing mental illness are some of the most harmed by our public safety system in several ways. **People with mental illness are 10 times more likely to be victims of violent crimes** than the general population.[29] Additionally, people with mental illness are more likely to be the victims of violent crime than the perpetrators.[30] Recent studies show that **people with**

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[26] Meinbresse, Molly, Lauren Brinkley-Rubinstein, Amy Grassette, Joseph Benson, Carol Hall, Reginald Hamilton, Marianne Malott, and Darlene Jenkins (2014). Exploring the experiences of violence among individuals who are homeless using a consumer-led approach. Violence and Victims, 29(1): 122-136. Truman, Jennifer L., and Michael Rand (2011). National crime victimization survey, criminal victimization. Washington DC: Bureau of Justice Statistics.
[27] Swenson, Kyle (January 2022). Serial murders, beatings and beheadings: Violence against the homeless is increasing, advocates say. The Washington Post.
[28] Link, Bruce G., Sharon Schwartz, Robert Moore, Jo Phelan, Elmer Struening, Ann Stueve, and Mary Ellen Colten (1995). Public knowledge, attitudes, and beliefs about homeless people: Evidence for compassion fatigue? American Journal of Community Psychology, 23,(4): 533-555.
Tompsett, Carolyn J., Paul A. Toro, Melissa Guzicki, Manuel Manrique, and Jigna Zatakia (2006). Homelessness in the United States: Assessing changes in prevalence and public opinion, 1993–2001. American Journal of Community Psychology, 37(1-2): 29-46.
[29] 8 Teplin, L. A., McClelland, G. M., Abram, K. M., & Weiner, D. A. (2005). Crime victimization in adults with severe mental illness. Archives of General Psychiatry, 62, 911-921.
[30] Watson A, Hanrahan P, Luchins D, Lurigio A. Mental health courts and the complex issue of mentally ill offenders. Psychiatr Serv. 2001 Apr;52(4):477-81.

mental illness are 16 times more likely to be killed by police officers, and that **over one-quarter of people killed by police and law enforcement officers exhibited signs of mental illness**.[31] The mentally ill also are **criminalized - arrested, charged, convicted and incarcerated - at much higher rates** than the general population, despite their not posing a greater safety threat.[32]

Drug Users

While there is no doubt that drug use increases the likelihood of people committing all kinds of crime, including violent crime, policing experts have found that **the current law enforcement approach to drugs**, which treats drug use as a crime in itself, **has not reduced crime rates despite massive spending** on drug policing efforts. Furthermore, drug treatment programs are reported to save cities money by reducing crime.[33] In fact, **access to drug treatment has been proven to reduce crime rates, especially violent crimes**.[34] The CAPS Commission has found overwhelming evidence that **removing all barriers** to access to **drug treatment,** improving access to **local socio-economic opportunities** and following **harm reduction** practices are the most effective response to drug use as a threat to public safety, while the ongoing **criminalization of drug users** results in **higher costs, higher crime rates** and **lower outcomes for safety, justice and racial equity.**[35]

Marginalization and Public Safety

The Special Committee found some disagreement among community members and key stakeholders about exactly who is a "marginalized person" in public safety, whether or not

[31] Ellis, Terry. 2022. "After the death of another mentally ill person in police custody, experts call for widespread training and health resources." CNN. https://www.cnn.com/2022/08/11/us/brianna-grier-mental-illness-police-response-reaj/index.html.
[32] Ghiasi N, Azhar Y, Singh J. Psychiatric Illness and Criminality. [Updated 2023 Mar 30]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK537064/
[33] Frakt, Austin. 2017. "Spend a Dollar on Drug Treatment, and Save More on Crime Reduction (Published 2017)." The New York Times. https://www.nytimes.com/2017/04/24/upshot/spend-a-dollar-on-drug-treatment-and-save-more-on-crime-reduction.html.
[34] Wen, Hefei, Jason M. Hockenberry, and Janet R. Cummings. n.d. "NBER WORKING PAPER SERIES THE EFFECT OF SUBSTANCE USE DISORDER TREATMENT USE ON CRIME: EVIDENCE FROM PUBLIC INSURANCE EXPANSIONS." National Bureau of Economic Research. Accessed June 13, 2023. https://www.nber.org/system/files/working_papers/w20537/w20537.pdf.
[35] Vitale, Alex. 2018. The End of Policing. London, England: Verso Books.

that term includes crime victims, and whether or not one's perceptions about their own level of safety are major determinants of one's status as a marginalized community member. In keeping with the principles of **human dignity** and **harm reduction**, the Special Committee views marginalized people as **those who are actively deprived by society of the basic resources required to sustain human life**, which include access to housing, drug treatment and mental healthcare.

This does not mean that crime victims are excluded or not considered in this work. As the evidence described above indicates, **safety-marginalized groups are much more likely to be victims of both crime and harm** by our public safety and justice systems. In fact, the Special Committee's work to promote a more evidence-based approach to crime prevention is expected to **benefit potential crime victims more than anyone** else by preventing those crimes from ever occurring. On the last topic of whether one's perceptions of safety determine one's level of safety-marginalization, one's feelings and perceptions of their safety may in fact be a potential determinant in their actual safety outcomes. However, using **statistical evidence to identify the groups most at risk of being victimized by crime and/or harmed by the safety, policing and justice systems** is the approach that the Standing Committee has taken in its work.

Root Cause Analysis

After reviewing the information and experiences gathered in the Research and Outreach stages, the Special Committee performed a root cause analysis to discern the **root causes, causal mechanisms** and **symptoms** around these issues for a deeper understanding of the system's dynamic processes.

Root Causes

Material	Growing and/or persistent deprivation of important resources needed to maintain the safety of our community, resulting in a lack of access to housing, mental healthcare and drug treatment by members of our community.
Psycho-Social	Negative stigmas and false perceptions about marginalized community members that are both externalized and internalized.

Economic	Market forces have steadily reduced economic opportunity for lower income wage-earners while increasing rates of economic inequality[36], an indicator that has been closely correlated to lower racial equity, public health, safety and justice outcomes, and increasing rates of homelessness, mental illness, drug use, violent crime, including gun violence. [37]

Causal Mechanisms

Material	Being deprived of access to important resources creates higher levels of stress, risks to physical and mental health, and other harmful effects, making it difficult to maintain good health, stable employment, secure housing and other important resources, creating feedback loops that make it increasingly difficult to gain access to the resources.
Psycho-Social	Being deprived of important resources needed to sustain human life, as well as being at the lowest ends of income and wealth distribution in a society, creates powerful psychological and social incentives for people to commit crime, including violent crime, to gain access to those resources. As marginalized people are perceived as themselves representing major threats to public safety, they are further deprived of resources through discrimination and marginalization, creating feedback loops that make it increasingly more difficult to obtain access.
Economic	Available housing stock is distributed in a way that creates perceptions of scarcity due to the growing divergence between prices and local wages. Local mental healthcare and drug treatment services are perceived to be scarce at all income levels. Being criminalized and marginalized makes it harder to secure stable income from employment, creating more harmful feedback loops.

Symptoms

Material	Rising or persistently high rates of homelessness, homeless mortality, housing insecurity, suicides, drug use, overdose deaths

[36] Piketty, Thomas. Capital in the Twenty-First Century. Cambridge Massachusetts :The Belknap Press of Harvard University Press, 2014.
[37] Pickett, Kate. Inner level: How more equal societies reduce stress, Restore Sanity and improve everybody's wellbeing. Penguin Books, Limited, 2018.

	and environmental pollution. High turnover and staffing shortages in public safety positions result in overwhelmed crisis response systems. Increasing visibility of safety-marginalized people and environmental pollution pose threats to local businesses and city-wide economic prosperity due to lower numbers of visitors, workers and employers coming to Bloomington.
Psycho-Social	Increases in crime, gang activity, violence, conflict, racism, hate crimes, anti-immigrant sentiments. Negative sentiments toward unhoused people, mentally ill people and drug users. Lower learning and developmental outcomes in children. Increases in mental illness and trauma. Lower levels of job satisfaction, higher rates of turnover and chronic staffing shortages in public safety agencies, whose employees perceive growing safety threats which lie outside of their control and/or expertise to prevent.
Economic	Employers and workers increasingly choose not to locate in Bloomington due to rising perceptions of lower community safety and resilience, leading to higher rates of job insecurity, unemployment, more precarious work, and lower economic development outcomes. Higher spending levels in all City departments responding to these ongoing problems, especially in law/code enforcement and public safety departments.

Key Problem Areas

What are the main systemic problems in public safety in Bloomington?

After performing a root cause analysis, the Special Committee identified three key problem areas that illustrate the **main structural barriers, conflicts in goals and interests, perceptual gaps** and/or **harmful feedback loops**.

Key Problem Area #1: Obstacles to Threat Prevention

Prevention of the main threats to public safety **is the most evidence-based strategy to reduce crime and improve community safety**, and the City's belief in this strategy is evidenced by its efforts to help ensure access to resources such as housing, secure employment, drug treatment and mental healthcare. However, this approach faces several **obstacles**, especially ongoing **staffing shortages** in public safety responder agencies, a **mismatch between local wages and housing prices** that is perceived to be worsened by the impact of Indiana University on the local housing market, and **Federal, State and**

County policies that have **systematically increased the scarcity of key safety resources** in the community.

Key Problem Area #2: Conflicts Among Institutional Goals

Despite **public safety responders' commitments to upholding safety and saving lives** as their top priority, there remains a **perception of a conflict between** the interests and goals of **law/code enforcement** and the interests and goals of **human safety**, especially for the **safety of unhoused people, drug users, mentally ill people, racial minorities, people who have been incarcerated** and other marginalized groups. This perception results in **worse safety outcomes for marginalized groups** who may hesitate to utilize the crisis response system in life-threatening situations, **leading to higher costs and lower health and safety outcomes** for the entire community. There is a similar conflict between the goals and interests of **housing**, **neighborhood development** and **sanitation departments** and public safety, where the **safety of marginalized people is sometimes excluded or even endangered**, such as when City housing departments issue citations to property owners due to the presence of debris in the non-traditional living areas of unhoused people who do not receive safe sanitation or waste disposal services from the city. Many of the neighborhood development programs of the city do not include the participation of unhoused and other safety-marginalized residents, resulting in **city-supported neighborhood organizations who actively work against the interests of their unhoused residents**[38] in important civic deliberations on housing and neighborhood policies.

Key Problem Area #3: Gap in Response Coordination

Despite the dedicated and innovative efforts by key stakeholders in public safety to connect marginalized people with available resources in the community, there remains a **systemic lack of access to resources like housing, mental healthcare and drug treatment**, resulting in higher crime rates, higher costs, and ultimately, worse public safety and social justice outcomes. This lack of basic safety resources is illustrative of **an institutional gap in ensuring a responsive approach** is taken to the changing safety needs of the community. This gap results in **perceptions by nearly all key stakeholders that it is not**

[38] Steve Volan. "An open response to CONA, about plexes in the UDO." 2019. Councilmanic. http://councilmanic.us/2019/11/13/an-open-response-to-cona-about-plexes-in-the-udo/."

explicitly within their governmental entity, organization, department or agency's purview to coordinate a community-wide strategic response to emerging safety needs.

Reformulated Problem Question

Following the design-centered entrepreneurship process, Step 3 Problem Definition, the Special Committee then **restated the initial problem question** from page 7 as a **synthesis of these main systemic problems**.

How might we design, fund and maintain a public safety system that:

- **Removes all barriers to access** of important resources needed for community safety, especially housing, mental healthcare and drug treatment,
- **Resolves all institutional conflicts** that arise between community safety and law/code enforcement, housing, neighborhood development and sanitation in the interests of human safety, and
- **Closes the institutional gap** in a way that enables the community to take a more responsive approach to resolving our safety needs?

Recommendations

After re-stating the problem question to better reflect all of the facts uncovered in the Special Committee's work, it moved to Step 4: Idea Finding. After considering and discussing all of the ideas compiled in the Research and Outreach sections of this Report, the Special Committee moved to Step 5: Evaluate and Select. Using the previously stated project objective, mission, goals and funding principles as guideposts, we selected the following ideas as the ones which are most likely to resolve the reformulated problem question above in ways that align with those values and which reflect the community's perceptions, goals and interests.

A More Responsive Approach

As the 21st Century Fire and Emergency Services report describes, the **public safety and crisis response needs of communities like Bloomington have changed dramatically** in recent years:

> As the role of the federal government shifts away from responding to everyday needs, local governments have also begun addressing such issues as climate change, **affordable housing, homelessness,** immigration, the **opioid epidemic**, and **behavioral health**. This reality has led local fire and emergency services to become the health and safety net for communities.[39]

Yet **most public safety-related departments** in Bloomington are tasked with **reacting to** the symptoms of **persistent or growing** levels of **violence, homelessness, mental illness** and **drug use**, while having **little control over the root causes**, or **even the causal mechanisms** that generate these symptoms. **Most City resources allocated to public safety** seek to address or resolve the individual manifestations of these symptoms once they have reached a crisis situation. While responding to individual needs is a valuable and necessary component of public safety, **this approach cannot strategically address the root causes driving these public safety threats.**

Alongside **rising rates of economic inequality both locally and nationally**, the institutional gap that exists around **ensuring a strategic and responsive approach to community safety** allows these symptoms to **worsen overall public safety outcomes**, through **no fault of the crisis responders or public safety agencies**. This lack of a strategic approach has led to **higher costs, more crime and lower social justice outcomes** for the community. Therefore, the recommendations in this Report are aimed at both **creating a more agile and responsive public safety system** that directly **addresses the root causes and mechanisms** which create these symptoms in order to reverse their rates of growth, and to **support and improve the ways the City reacts to the growing number of crisis calls** for **cost efficiency** and **greater safety, equity and justice outcomes**.

[39] "White Paper: 21st Century Fire and Emergency Services." 2020. ICMA. https://icma.org/documents/white-paper-21st-century-fire-and-emergency-services.

A Holistic and Evidence-Based View

An overly reductive view of the complex relationship between public health and public safety is a major psychological obstacle preventing our community from resolving problems which overlap into both areas. **Many key stakeholders in public safety view several indicators of threats to public safety as outside the purview of the City government to resolve or strategically reduce for the reason that they are also indicators of threats to public health -** and therefore, should instead be left to the County, State or Federal government to resolve. This view results in **blind spots** in the City's approach to public safety. A **more holistic view** that acknowledges the important ways in which **some threats to public health also pose threats to public safety** would better allow City stakeholders to **improve safety outcomes for all residents**. More specifically, public health indicators such as **income inequality, housing insecurity, rates of mental illness** and **overdose rates** are also important **indicators of public safety**.

In the view of the CAPS Commission, building **a safer and more resilient community** requires that City stakeholders take **a more holistic and evidence-based view of safety**. People who are deprived of the basic resources required to sustain human life are statistically **the least safe people in the community**, both in rates of crime victimization and in lower life expectancies. Moreover, modern science has established **clear causal links** between **violent crime rates, public health and safety outcomes** and **economic inequality** that are squarely outside of the purview of law or code enforcement agencies to address.[40]

Effective Provision of Resources and Services

Furthermore, the **perception** among some stakeholders **that the people who suffer from the lowest safety outcomes** themselves represent **an overall threat to the economic prosperity** of the city, and so there must be a limited economic "capacity" for the

[40] In *The Inner Level*, Wilkinson and Pickett demonstrate with economic and epidemiological evidence that rates of economic inequality are strongly correlated to rates of violent crime, drug use, mental illness, higher public costs and overall worse public health, safety and environmental outcomes. Pickett, Kate. Inner level: How more equal societies reduce stress, Restore Sanity and improve everybody's wellbeing. Penguin Books, Limited, 2018.

community to provide basic safety resources to all its residents, **does not reflect any evidence** we have collected. On the contrary, the **great majority of unhoused stakeholders** who participated in the Committee's Outreach reported that they **are employed**, at least part-time, with some working multiple jobs. Yet, **there is significant evidence** that the **economic growth** and vibrancy of any city **depends on the health[41], safety[42]** and **resilience[43]** of its **workforce**. Therefore, the Commission concludes that it is **not the human presence** of low-wage earners in the City who pose an overall economic threat, but the **systematic deprivation of basic safety resources and services** from low-waged, under-employed and economically precarious workers in our community which poses a growing threat to both public safety and prosperity.

For instance, a commonly cited belief among local stakeholders that the persistent problem of homelessness is caused by overall housing market scarcity is not reflected in the evidence our Commission has found. In fact, **vacancies of local housing units are reported to be 5-10 times greater than the number of unhoused people who are reported to be residents of Bloomington**.[44] The ongoing failure of the local community to

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[41] According to the High-Level Commission on Employment and Economic Growth of the World Health Organization, Figure 1, the causal pathways whereby community investments in health produce economic growth include: full-income growth, improved labor supply and productivity, economic output of health services and goods, reduced inequality, political stability, technological change and risk reduction for entrepreneurs, and greater health security leading to more overall commerce, trade and movement of people. Baldoz, Rosalinda. 2016. "WORKING FOR HEALTH AND GROWTH." World Health Organization (WHO). https://apps.who.int/iris/bitstream/handle/10665/250047/9789241511308-eng.pdf.

[42] A study on the economic effect of violent crime in US cities published by the Center for American Progress found that "Across five cities with the necessary data for our analysis, we found that a 10 percent reduction in homicides should lead to a 0.83 percent increase in housing values the following year, and a 25 percent reduction in homicides should produce a 2.1 percent increase in housing prices over the next year. Applying these results to all residential housing in the metropolita", Dowson, Douglas, Lisa Hamilton, and Matthew Jensen. n.d. "The Economic Benefits of Reducing Violent Crime." Center for American Progress. Accessed July 1, 2023. https://www.americanprogress.org/wp-content/uploads/sites/2/2012/06/violent_crime.pdf.

[43] The United States Economic Development Administration, a bureau of the US Department of Commerce, states that, "Building a resilient workforce that can better shift between jobs or industries when their core employment is threatened through job-driven skills strategies and support organizations" is an "example of a steady-state economic resilience initiative" that community economic development organizations should consider when building economic resilience. "Economic Resilience | U.S." n.d. Economic Development Administration. Accessed July 1, 2023. https://www.eda.gov/grant-resources/comprehensive-economic-development-strategy/content/economic-resilience.

[44] "HOUSING STUDY." 2020. City of Bloomington, Indiana. https://bloomington.in.gov/sites/default/files/2020-08/BloomingtonHousingStudy2020.pdf reports a

distribute available housing stock in a way that enables all residents to have access to public safety calls for **a more robust and safety-centered approach to housing, neighborhood and economic development** by the City. Similarly, the widespread reports by stakeholders of a city-wide scarcity of mental healthcare and drug treatment providers indicates the ongoing failure of the existing market forces and community organizations to provide access to these critical safety services**.** In the view of this Commission, **facilitating the effective provision of critical safety resources and services** in a way that **ensures minimum levels of public safety to all residents is the most fundamental obligation of a municipal government to the community** it serves.

As longtime Bloomington resident, Indiana University professor and Nobel prize-winning political-economist **Elinor Ostrom** wrote in regards to institutional governance of shared community resources, such as public safety:

> The most important lesson for public policy analysis derived from the intellectual journey I have outlined here is that **humans have a more complex motivational structure and more capability to solve social dilemmas** than posited in earlier rational-choice theory. Designing **institutions to force (or nudge) entirely self-interested individuals** to achieve better outcomes **has been the major goal** posited by policy analysts for governments to accomplish **for much of the past half century**. Extensive empirical research leads me to argue that **instead, a core goal of public policy should be to facilitate the development of institutions that bring out the best in humans.** We need to **ask how diverse polycentric institutions help or hinder the innovativeness, learning, adapting, trustworthiness, levels of cooperation of participants**, and the achievement of **more effective, equitable,** and **sustainable outcomes** at multiple scales.[45]

9% vacancy rate reported by the American Community Survey. Additionally, there were roughly 35,000 housing units reported by the US Census in 2020, or around 3,150 vacant and available housing units. While there is not an official count of unhoused people tracked by any of the City stakeholders who our Special Committee met with, there are roughly 300 homeless people living in Bloomington according to local stakeholders in public safety who work in housing insecurity.

[45]Ostrom, Elinor. 2010. "Beyond Markets and States: Polycentric Governance of Complex Economic Systems," American Economic Review, 100, 3: 24-25.

The Elinor Ostrom statue on Indiana University campus, outside Woodburn Hall. Photo by Jim Krause for Bloom Magazine. Ostrom was a political economist who established significant evidence

during her career that demonstrated that institutional governance of shared resources is more sustainable, equitable and effective using methods of strategic cooperation among many different types of community stakeholders rather than being left to market-based mechanisms of control.

1 - Department of Community Safety and Resilience (DCSR)

Key Recommendation #1

The most impactful intervention that we recommend is for the City to **create a new department that can coordinate the City's safety and resilience efforts** in a way that **explicitly prioritizes human safety** in all of its operations. This recommendation is contingent upon the results of **an independent study** to assess the **economic, statutory and organizational feasibility** of such a department to be carried out by a qualified firm. In addition to providing an economic, legal/statutory and organizational assessment of feasibility, the report should **identify existing City services that are currently provided by other departments which might be better provided by a DCSR**, and as well as develop an **incremental growth strategy**.

The DCSR should **report to the Mayor,** the **Common Council** and the **CAPS Commission**, and it should have the following responsibilities:

- **Collaborate with police, fire, emergency dispatch**, housing and neighborhood development, community and family resources, mental healthcare and drug treatment service providers and all **other key operational stakeholders** to conduct the following activities in ways that **prioritize human safety**:
    1. Identify and support **best practices** across all City departments,
    2. Design emergency dispatch **protocols** and crisis response **procedures,** and
    3. Identify and work to resolve conflicts between the goals of **community safety and resilience**, and all other City **goals**, **initiatives and programs**.
- Prioritize the **hiring of community members** who have recent or current **lived experience** of being **safety-marginalized**,
- Create and maintain **a crisis response team** of **community-based, peer responders** based on the **right-care/right-person** model[46] who are **trained, licensed** and **able** to respond **24 hours/7 days** to a wide variety of **low-level, non-violent crises** involving mental illness, drug use, unhoused people, domestic conflicts, people with disabilities, infants and elderly people,
- Monitor and **assess safety needs, capabilities** of service providers, and **stocks of** critical safety **resources,** and **remove all barriers** preventing the safety needs of City residents from being met, if necessary by **promoting local development** of needed service providers, **securing sufficient and sustainable flows of funding** and other resources, and **distributing those resources** in a way that **ensures the basic safety needs of everyone in the community are met**,
- Conduct stakeholder outreach and research national best practices to **identify opportunities** and **promote community-based solutions** to **mitigate ongoing human harm and environmental damage caused by existing gaps** in community safety and resilience, such as the provision of food, sanitation, hygiene and drinking water services to people in non-traditional living areas, environmental cleanup of non-traditional living areas and/or collection and proper disposal of drug syringes,

[46] "'Right Care, Right Person' is a model designed to ensure that when there are concerns for a person's welfare linked to mental health, medical or social care issues, the right person with the right skills, training and experience will respond." "'Right Care, Right Person' to be rolled-out from 31 January 2023." 2023. North Yorkshire Police. https://www.northyorkshire.police.uk/news/north-yorkshire/news/news/2023/01-january/right-care-right-person-to-be-rolled-out-from-31-january-2023/.

- Create and manage a **program that empowers neighborhoods to include safety-marginalized residents in civic decision-making** and **uses participatory budgeting** to improve neighborhood safety and resilience,
- **Make evidence-based assessments** about how the work of other City departments, procedures, policies interacts with community safety and resilience, and use these assessments to **make specific recommendations for attaining more equitable outcomes** in safety and resilience to the Mayor, Common Council and CAPS Commission.
- **Track, report** to other departments, and create a **public dashboard** with important **key performance indicators (KPI's) of our community's safety and resilience,** such as the ones recommended in Appendix A.

Initial Costs: $40-65,000

This figure is only the expected **cost of the feasibility study**, which is based on the actual costs of a 2020 organizational assessment of all existing City departments that was completed by an independent firm, whose costs ranged from $36-54,000 per city department or group of departments. A necessary requirement of completing the feasibility report is an **independent public audit** that should be conducted by a qualified firm, which is **expected to cost between $20-50,000**. The cost of creating the new department can only be determined after an independent public audit and a **full economic, statutory and organizational assessment** is conducted by a qualified firm to calculate the likely **upfront costs**, as well as the **expected long-term cost savings** of re-organizing the services currently carried out by existing departments into the DCSR.

Expected Benefits

The primary expected benefits of a DCSR are to **reduce rising rates of crime and violence, reduce overall municipal costs** and **improve social justice outcomes** using proven, community-led and evidence-driven strategies. Secondary benefits include **increasing economic prosperity for local residents** and **improving staffing levels in other existing safety-related departments**, such as the **police and fire** departments. The stakeholders in our outreach consistently reported that the main cause of the staffing shortages are lower workplace morale due to rising numbers of crisis calls, and employee's

perceptions of being unable to address the root causes driving the increases of those calls. For this reason, the Commission expects that the creation of a DCSR would **improve cost efficiency, safety outcomes and staffing levels** in other safety-related departments.

The main benefit of a feasibility report is to allow the CAPS Commission to make its future recommendations on improving public safety in a way that is informed by all relevant evidence. The Commission's analysis reflected in this Report indicates that **most safety-focused crisis response programs in the US have net economic benefits to cities**. Furthermore, initial analysis of the City's police service call data in Figure 1 indicates that **up to 54% of the currently police-dispatched calls for service may be responded to by community responders**.

2 - City-Wide Incorporation of Key Safety Indicators

Key Recommendation #2

To ensure a consistent and strategic City-wide approach to addressing these public safety threats, we recommend that the Mayor's Office and Common Council work to **incorporate the key performance indicators (KPI's) of public safety identified in this report into both departmental assessment metrics and reports delivered to the public and Common Council.** This will **create structural incentives** in all City departments to work toward more higher and **more equitable outcomes** in community safety and resilience, as well as improve **public transparency** and allow the City to **promote more evidence-based perceptions** about the threats to public safety, which can lead to **greater consensus among key stakeholders** about the best strategic response to these threats.

The Commission also recommends that the City of Bloomington regularly **utilize the expertise of local experts in community facilitation, organizational design and innovation** from the Community Justice and Mediation Center, Indiana University, Ivy Tech Community College and other community-based organizations to find ways to better **incorporate the perceptions, interests and goals of the most safety-marginalized community stakeholders directly into all existing City innovation, design and assessment processes**, especially in the departments of police, fire, emergency management, housing and neighborhood development, economic and sustainable

development, parks and recreation, community and family resources, planning, and others directly related to maintaining community safety and resilience.

Expected Costs: $30,000-$50,000

This cost is a rough calculation of 30-50% of the salary and benefits of a City staff member who is sufficiently qualified in social data analysis to identify reliable sources of data for tracking these indicators, recommend methods of incorporating them into important City departments and to recommend strategies for measuring any indicators that are not currently tracked in a reliable way.

Expected Benefits

The expected benefits of tracking and incorporating important safety KPI's in a way that ensures a consistent approach to improving safety outcomes include **more equitable outcomes in public safety**, **more evidence-based perceptions** and **wider agreement among community members and key stakeholders** about public safety. For instance, a recent study on homelessness in California has disproven some of the negative stigmas and perceptions of unhoused people that also exist in Bloomington, around which cities or counties they were last housed and/or whether they are employed.[47]

3 - Promote Inclusion and Awareness

Key Recommendation #3

To guide the CAPS Commission's future work on the topic of alternative public safety, the Special Committee makes the following recommendations:

1. **Create a standing committee of the CAPS Commission** that can continue the community innovation process begun in this Report. The next steps are 6 - Plan, 7 - Gain Acceptance and 8 - Take Action. Key Recommendations #1 and #2 are part of the planning stage.

[47] Levin, Sam. 2023. "Who's unhoused in California? Largest study in decades upends myths." The Guardian, June 20, 2023. https://www.theguardian.com/us-news/2023/jun/20/california-affordable-housing-crisis-homelessness-study-myths-older-black-residents.

2. The CAPS Commission should support the implementation of Key Recommendations #1 and #2 by **collaborating with the City of Bloomington to design a request for proposal or a request for qualifications**. The CAPS Commission should also **support the hired firm in acquiring access to all needed information** to perform an evidence-based assessment, including all relevant local data regarding law/code enforcement, crime, public health, emergency response, fire or other public safety data. The Commission should work to **ensure that a public audit is completed in a timely way** that allows the hired firm to conduct its work.
3. The Commission should continue its important civic role as a City liaison for under-served groups in public safety by **performing systematic outreach with safety-marginalized community members at the places where they gather**, including unhoused people, drug users, mentally ill people, disabled people, racial minorities and people who have experienced incarceration, and where **recruitment of safety-marginalized people to fill open City Commission and Board seats** is a secondary goal.
4. The Commission should undertake partnerships with local news, radio, media, art, education and cultural organizations to **promote an evidence-based awareness campaign on the community's threats to public safety**, including a holistic understanding of the root causes, the causal mechanisms and the symptoms. For instance, the CAPS Commission's recent efforts to partner with the Indiana University Cinema to host film screenings that provide evidence-based information about community safety is one such partnership that can improve the Commission's overall effectiveness.

Expected Costs: $3,000-$6,000 per year

These costs are calculated based on the expected annual costs of performing an evidence-based awareness campaign on public safety with local media, news and arts organizations. The other Commission efforts can be performed without incurring any costs to the City.

Expected Benefits

The benefits of improved and more systematic outreach with marginalized residents by the CAPS Commission include **improved participation by marginalized people in the City's existing democratic decision-making mechanisms**. This will **improve overall community resilience and safety outcomes for all residents**, as well as **improve perceptions of equity** in local democratic institutions.

The benefits of promoting a more holistic and evidence-based understanding of public safety includes **generating wider consensus in the community about how to address threats to public safety**. Furthermore, a more evidence-based understanding of the threats to community safety and the specific mechanisms that undermine community resilience may **help dispel harmful beliefs that blame our community's threats to safety and resilience on the most safety-marginalized residents,** including racial minorities, religious minorities, immigrants, unhoused people, drug users, previously incarcerated people and people experiencing mental illness.

Appendix

A. Important Key Performance Indicators of Community Safety and Resilience

Many of these metrics may already be tracked by City, County or State governmental entities, local service providers, college and university public safety-related initiatives, like the Indiana University Crisis Technology Innovation Lab, or community advocacy organizations. We have noted the known sources of this information and **recommend that the DCSR should start tracking any indicators which are not yet reliably tracked.**

Dept of Community Safety and Resilience KPI's

- Ratio of all community members who feel their priorities are reflected and whose needs are served by DCSR according to surveys
- Ratio of unhoused, mentally ill and drug using community members who feel their priorities are reflected and whose needs are served by DCSR according to surveys
- Number of partnership agreements made with local service providers
- Dollars distributed to local service providers
- Rates of crime, violent crimes, arrests, criminal prosecutions, incarceration
- Crime victim demographics, including age, race, disability status, income, employment status, drug use and housing status

Crisis Response KPI's

- Ratio of traditional public safety responders dispatched vs community responders dispatched
- Ratio of arrests, incarcerated, probation, court cases resulting from community responses compared with traditional response programs
- Costs of operating DCSR compared with traditional spending approach
- Total overdose deaths (County Health Rankings)

- Number of conflicts successfully resolved using restorative justice
- Total heat, cold or flood-related deaths
- Violent crime, overdose deaths, homicides and suicides (County Health Rankings)

Housing KPI's

- Total number of unhoused population
- Total number of vacant rental housing units for 6 consecutive months or longer (Housing and Neighborhood Development)
- Unhoused mortality rate [48]
- Housing insecurity rate (County Health Rankings)
- Unhoused population demographics, including age, race, disability status, employment status, the last County and State where they were housed

Community Resilience KPI's

- Total participation in community resilience program
- Total number and ratio of unhoused, drug using and/or mentally ill community members in the resilience program
- Dollars spent using participatory budgeting
- Ratio of City budget spent using participatory budgeting
- Public transit use and/or walkability index improvement
- Number of green spaces improved or preserved
- Access to care (County Health Rankings)
- Access to healthy food (County Health Rankings)
- Access to exercise opportunities (County Health Rankings)
- Food insecurity (County Health Rankings)
- Housing insecurity (County Health Rankings)
- Child poverty (County Health Rankings)
- Income inequality (County Health Rankings)

[48] Tracking of homeless mortality rates, demographics and cause of death is recommended by the National Healthcare for the Homeless Council in their Homeless Mortality Data Toolkit: <https://nhchc.org/wp-content/uploads/2020/12/Homeless-Mortality-Toolkit-FULL-FINAL.pdf>

B. Stakeholder Outreach Documentation

Public Safety Town Hall Outreach

The items below are documentation of the presentation, perceptions, experiences and views around public safety in Bloomington that we collected from the community members who participated in the Public Safety Town Hall that was held in the Monroe County Public Library on April 11, 2023. This two-hour hybrid online (Zoom) and in-person event included an opening presentation by CAPS Commission members, breakout sessions that were facilitated and documented by Community Justice and Mediation mediators and note-takers, and a closing session where some of the information gathered from the pre-event survey and from the breakout sessions were shared.

The information gathered in this public event has been studied by the CAPS Commission, utilized in our Findings, particularly in the root cause analysis, and it has been operationalized in the Recommendations of this Report. The direct quotes gathered by the CJAM notetakers and facilitators are in quotation marks, while any contextual words, phrases or additional information added by CAPS Commission members has been placed in brackets.

Opening and Closing Session

The opening and closing session of the Public Safety Town Hall that was presented by the Special Commitee can be viewed on the City's YouTube page.[49]

Breakout Session Question 1

From your personal experience, how do you relate to the issue of public safety in Bloomington? How have you been affected, or you and your family been affected? Others you know?

[49] "CAPS: Public Safety Town Hall, April 11, 2023." 2023. YouTube. https://www.youtube.com/watch?v=wsMmMTDQaCY.

Community Responses to Question 1

1. “Individuals experiencing **homelessness**” [are associated with] “**disruptive behavior**, clean-up of **vacated camps.**”
2. “**Feelings of unsafety** [due to lack of] lighting in the community.”
3. “**Lack of 24/7 help**, community resource officers.”
4. “Sidewalk repairs, lack of signage, **pedestrian safety**.”
5. “Community **resources for low-income individuals** and individuals with substance use/mental health concerns. Where to put funding? What is most important? **Scarce resources.**”
6. “Language barriers, **income disparities**.”
7. “**Discrimination** against marginalized individuals.”
8. “**Stigma** against mental illness”
9. “Gender and racial **discrimination**”
10. “Theft”
11. “**Substance use**”
12. “**Drug** houses”
13. “Public transportation”

Breakout Session Question 2

What steps are needed to move our community forward to ensure safety for all in Bloomington?

Community Responses to Question 2

1. “I feel safe [but] others say they don’t.”
2. “I’m not allowed to assess my own safety.”
3. “Positive, helpful interactions with law enforcement comparatively.”
4. “I’m **not getting the help I want**.”
5. “Who do I call to get **help that is not police**? Is my person white or black?”
6. “How do I get help but avoid bringing the police? **Mistrust**.”

7. “Devastated that **resource options perpetuate harm**.”
8. “Wanting **better options to intervene**.”
9. “Where does a person go to get safe? The **most vulnerable [go to] jail**.”
10. “Training on de-escalation for police”
11. “**Power** dynamics”
12. “Presence of **weapons**”
13. “Police - **think about uniform**”
14. “More appropriate **resources to the need**, more services to address the **root cause**”

Breakout Session Question 3

From your perspective, what might be some potential benefits and/or challenges in establishing a city-wide, unarmed, crisis-response team to respond to emergency calls which do not require the presence of law enforcement?

a. **What would it take to do this? What resources exist in our community that might support such efforts?**
b. **What might we have to give up to make this happen?**
c. **Who might be made safer? Less safe? What are some ways to reduce or mitigate safety risks to these people?**

Community Responses to Question 3 and Follow-Up Questions 3 abc

1. “Public **education on how/who to call**? 911/988”
2. “Stride center - **who can refer**? Access, **no bans** at shelters.”
3. “**Identify service gaps** - understaffed [public safety] shifts, transportation, uncovered neighborhoods, de-escalation”
4. “Transportation to resources”
5. “More **alternative intervention officers**, after-hours ambassador”
6. “**Listening to** those we are claiming to protect (ie. **unhoused**)”
7. “Utilization of community’s self-organized assets”

8. “Permit and **support safe outdoor living options** [with] bathrooms [and] dedicated camping zones”
9. “Interventions” by **responders who are “knowledgable” and “understand addiction**”
10. “Safety for whom?” **Identify “who is vulnerable**,” and “**believe them**”
11. “**Prolonged [drug] treatment** for those who need it”
12. “**Active participation**” by marginalized/vulnerable groups “to make changes” in our public safety system
13. “All people, but especially those who make decisions from places of power or privilege, would benefit greatly from actually getting to know homeless people.”
14. “Better lighting and other utility type improvements that can make a physical environment feel more safe including openness”
15. “Wealthy people who are very much oblivious to the realities experienced by homeless people fear them because they haven’t met or genuinely made acquaintance with these people.”
16. “Primary intervention: Why do people lose their homes, commit crimes, do drugs? We can **prevent violence by keeping people in good health** and situations where they are less likely to commit crime in the first place.”
17. “Policy changes to **lessen discrimination** - MCCSC policy change in their handbook”
18. “Education for community members on **how to intervene** in issues of public safety”
19. “**Cap enrollment** for Indiana University”
20. “**Reprioritizing resources** in the community, **allocate based on need**”
21. “Community discussions all around the community, especially including diverse populations”
22. “**Wealth inequality**”
23. “Organization (not police), **work with police**”
24. “Use **mental health professionals**”
25. “Safe spaces”
26. “Trusted adults”
27. “**Violent crime prevention**”
28. “**Collaboration with unhoused**”
29. “Holding treatment facilities accountable”
30. “Who manages [community responders]? Are they linked in to 911?”

31. “Putting [community responders] in violent situations, unarmed”
32. [Community responders might] “**provide more services and resources** than a typical [law enforcement] officer”
33. “How would we fit [community responders] into other resources?”
34. [Community responders] “would **have to be 24/7**.”
35. “Advertise this group as **non-police**”
36. “When would you send [community responders] vs [law enforcement] officers?
37. “**Cost savings of using cheaper first responders**”
38. “PR around [dispelling] perceived mishaps”
39. “Training of dispatch”
40. “How to measure and convey: **less harm, disrupting cycle** of harm”
41. “Where is [community responders] housed administratively? [It should have] **training, resources, accountability**. Public or private? City or county? “

Targeted Stakeholder Outreach

To **gain the consent of those most impacted by our decisions**, targeted outreach with key stakeholders in public safety prioritized outreach with the people who are most safety-marginalized according to statistical evidence regarding who is the least safe, or most at risk of becoming victims of crime, and those people whose safety is put at risk by our public safety system. In addition to meeting with the **safety-marginalized stakeholders** whose lives are most impacted by our community's public safety system, we also met with **dozens of institutional stakeholders**. In collecting these responses, members of our Special Committee visited three local service providing locations, including **two homeless shelters** and **one soup kitchen**, presented the people there with the information about our project and asked them the same three questions from the Public Safety Town Hall.

For the purpose of maintaining all stakeholders' anonymity in participating in this project, we sorted institutional stakeholders into the following descriptive categories: **operational stakeholders** (City officials and department heads), **advocacy stakeholders** (nonprofit service providers), **community stakeholders** (business and real estate organizations), and **political stakeholders** (individuals campaigning for public office). See the section entitled Stakeholder Identification on page 20 in Findings for a more detailed description of how our Commission identified important key stakeholders in our work.

The questions we asked institutional stakeholders closely resemble the three questions that were asked in the Public Safety Town Hall, except that they were customized to apply to the work of each organization. For instance, instead of asking about their personal experiences with public safety, **targeted stakeholders were asked to identify what they view as the main threats to public safety in Bloomington and how their organization works to prevent these threats**. Besides questions about an alternative crisis response program, targeted stakeholders were also asked to **identify the greatest benefits and challenges that may arise from implementing other alternative public safety programs that we identified in our work, such as creating a safe and supervised injection area for drug users or performing regular sanitation services in non-traditional living areas.** In some cases, the CAPS Commission members performing

outreach also asked extemporaneous or clarifying questions that followed up the initial questions.

While we have redacted all directly identifying information included in the quotes below, some stakeholders communicated to our Special Committee performing this outreach that they preferred to include the full name of their organization in our Report. We have made notations indicating this preference where this request was made. **These statements are organized according to the general themes uncovered in our work, or Key Problem Areas, that they best illustrate.**

There were several safety-marginalized stakeholders present during those outreach meetings, and more than one stakeholder speaking at some of the targeted institutional outreach meetings, so these statements were sometimes made by a group of people. The statements from institutional stakeholders have been reviewed and approved by both the CAPS Commission member and the stakeholders who were present in those meetings. The CAPS Commission has carefully studied all the perspectives, experiences and views shared below, **we have utilized this information in our Findings, particularly in performing the root cause analysis, and operationalized it in our Recommendations**.

Safety-Marginalized Stakeholders Location A

1. "When someone is experiencing a **mental health crisis**, people need help. So **who is supposed to help them**?"
2. "I know a woman who had a stalker, and [local law enforcement] didn't do anything [to protect her safety.] We need **conflict resolution**" [resources in our community.]
3. "With BPD, if they don't have drugs, they aren't interested in investigating" [crisis situations]
4. "**Police should care more about violence** and **domestic abuse** crimes."
5. "**Police see domestic disputes as opportunities to make arrests**. When [police] run their names [through their criminal database and recognize a person in a crisis situation has a felony record], **they put their hands on their guns**. This is intimidating. [My partner is] a Black man, and they are going by statistical information" [to determine whether he might be dangerous to them, instead of treating him in a manner appropriate to his current behavior.]
6. "Once [a bystander] called 911 because my [unhoused partner] and I were arguing in the Kroger parking lot, and they saw us arguing and called the police. When the officers arrived, the first thing they did was run our names [through a criminal database] and when they saw my partner's [criminal] record, they all **put their hands on their guns**. This made us both **feel less safe**."
7. "When we lost our Section 8 housing assistance and were evicted, we lost all our possessions. It was during winter, and we needed our heaters for our tent, so we broke in [to our old house] to get our things. The neighbors recognized us and called 911 to report [our presence there.] Eight [law enforcement] officers showed up and **silently entered the home with their guns drawn**, walking while crouching down a hallway to the back bedroom we were in. I finally saw about four of them out of the corner of my eye in a mirror standing in the hallway staring at us with their guns out. They never announced themselves or said a word to let us know who they were or that they were in the house with us. [The law enforcement responders] **made it a dangerous situation** [because they ran my partner's criminal record and followed procedures]."
8. [My unhoused partner and I] "**always feel [too] intimidated [to utilize the local 911/crisis response system**.] "Most of the time, **we don't want to call** [911 crisis

responders.] We just try to help [people we see experiencing crisis situations] ourselves."

9. "Having a **team of highly trained people** will help take the pressure off" [of law enforcement agencies.]
10. "Marginalized people need someone to call with **lived experience, peer responders**."
11. "**Property crimes** and **violent crimes should be** [responded to under] **separate** [protocols or agencies.] There are situations where [law enforcement officers] need to be."

Safety-Marginalized Stakeholders Location B

1. "**Pedestrians** are not always given the right of way"
2. "Local emergency rooms treat us [unhoused people] like shit. When I had an epileptic seizure and a blood infection, I was taken to IU Health emergency room, and I was refused treatment because they knew I was unhoused and uninsured."
3. [People who experience] "drug addiction **do what you have to do" [to survive]**.
4. [Unhoused people] "are **discriminated** against in public transportation."
5. [Indiana] "**University is engulfing the town**. It's all getting gentrified."
6. "**You never know which agencies** [law enforcement or other public safety responders] **will be sent**" [to a crisis situation in which a person has called 911.]
7. [The presence of] "**weapons** [introduced into crisis situations by law enforcement responders] **changes things entirely**."
8. [Law enforcement officers in our community] "**search** and **harass** [unhoused] **people just for existing**"
9. [Public safety officers in our community] "don't want to go into certain neighborhoods"
10. "**People shouldn't need to be perfect" [to access basic safety resources**.] "During a Christmas-time cold snap, I called 911 and requested help because I was experiencing hypothermia. [The **public safety responders] would not pick me up**" [because I was known to be unhoused.]
11. "Having actual **responders trained in dealing with mental illness**" [would be an improvement to our public safety system]
12. [Community responders] "would **do less harm. You wouldn't be criminalized** for [experiencing] a crisis situation."
13. [Community responders would allow] "people to **get the help they need** instead of the help they get."
14. [To reduce homelessness, our community should] "make it easier for people to expunge eviction notices from their records"
15. "More low-cost, single-family housing" [is needed in our community]
16. [A drug treatment center with safe and supervised injection site would allow drug users] "to **be safe and to not get arrested**."

17. [A drug treatment center with safe and supervised injection site would result in] "**less littering of needles**."
18. [Some unmet public safety needs of unhoused people are] "**the same services they offer at rest stops**. A place to poop, shower, maybe a camp site."
19. [A legal camp site in the City] "could be located at Seminary Square. It should be **located near downtown** [to meet the safety needs of unhoused people.] It could utilize community volunteers to maintain it."
20. [Local service providers who offer services to unhoused people] "should have a menu" [of available resources and services]. [Unhoused people] shouldn't have to guess what is available. Do they have soap, writing paper, tampons, vitamins? Right now, to find out, you have to ask specifically for each item before you can know if it is available."

Safety-Marginalized Stakeholders Location C

1. "Especially when I read it in the paper, **most of the shootings, stabbings, killings–the major stuff–is happening on campus and not out on the street where the homeless are**. Now in the past, that wasn't quite true. But this time around with me here, it pretty accurate."
2. "**I think we do need more police. And they're trying. I know quite a few quit, but… when it comes to the homeless, police do not–or did not, at one time–care whether we got hurt or not.** I know myself and someone else who got hit by a car and it wasn't our fault. In both situations, the person went through the stop sign–didn't even stop. And I was laying on the ground and **the cops were just laughing their heads off. They thought it would be really funny because I was homeless**."
3. "When it comes to stealing, **I've seen a lot of college kids steal. I know that some homeless do it, but not this time around-it isn't as bad on stealing as it was when I was homeless before**. So in that respect, and on the homeless part, that's better than it was. Now I've seen a lot of college kids steal like crazy in stores. So you know, that **they need protection from that, and to stop blaming it on the homeless**. Because we know we get the brunt of it."
4. "All of these electric scooters and bikes–some homeless use them, too. But mostly the colleague kids I have seen so many just go right through stop signs and not even stopped; not even looking for a car or anything. Four or five days ago. I was on the sidewalk and I was going to cross the street. **A car stopped at the stop sign and there were two college kids on two scooters who went around the car and went straight through the stoplight. They almost hit me and another car almost hit them.** So I mean, there's a lot of issues going up and going on whether you want to talk about being safe."
5. "Most of the major crime that I hear about is on campus. Whether it's killings, stabbing at a party. They had someone get stabbed and someone got killed in one of the parties, and another one got really badly injured. But there's so many–**so much is happening on the campus itself–than on the streets**."
6. "Now there are shootings. Someone got shot. I think it was a homeless shooting and another homeless person a few days ago. But that's a rarity. Very rare."

7. “I’m tired of [cops] coming to Shalom and where the homeless hang out, because a lot of it is frivolous. They come when someone is having a seizure. But **we need more people who know about medical issues so that people don't get all upset and you'll call the cops**. Well, I think maybe Shalom has to–if someone is having a seizure or something, it might be a requirement.”
8. “So that's why I keep going back-and-forth. The mental health issues, the mental issues. **I can notice there are more and more people that really do have true mental issues this time around than before**. I don't know if it’s all the drugs they’re taking or they were just born that way. I don't really know. I have no idea. But it is more prevalent, and I know that I see it and hear it.”
9. “If you don't have those kinds of [mental health] issues, and this is the only place you can go to get help–whether it's housing or whether it's food or a shower or whatever–it gets on your nerves. **I think there needs to be more places that they could go to to get the help that they need. That would help Shalom kinda calm down. But I don't know if that will ever happen**. Even if it needs to be an actual place to put people–like an institution or semi-institution or in-between place for them to go to get help and make sure they're taking their medicines and not selling them medications–**that would help greatly if if they could someone could get the money to get that started**.”
10. “**If more people and organizations would work together, including the churches–instead of complaining about the homeless or those with mental issues, it would do more to help**. Instead of throwing money away on frivolous stuff within the church organization itself, **do what Jesus said: take care of each other; help each other; and help your brothers or sisters.** And he wasn't talking about helping brothers and sisters in the faith: **Humanity is your brothers and sisters.”**
11. “With Rapid Rehousing, if you don't have a job or can't find a job or something like that, you lose it. They *are* helping: you have a place here. You're not on the street. You have a place to go to lay your head down. **When you're homeless, there's no quiet time to rest or anything.** And if you're trying to sleep on the street, which I've been lately, you know, the cops want to move you around here and there, and we can stay here. You can't sleep here. **With the homeless or the housing**

situation, there needs to be more money. They need to help people at least a little bit longer than one year."

12. "When I was homeless before, I was only like five or six communities. They hand-picked a few homeless people to be on some committees with church members and city council members. And even some of the people at the college were on these committees. And we were talking about the issue with money and helping the homeless. But we've talked about this issue that I'm trying to bring up: **Why don't [businesses] try to hire the homeless?** I mean, some of them you wouldn't want working for you, but there are many, many that would be really good at whatever job that was offered to them. I mean, there are homeless they have working at fast food restaurants and stuff like that. **Sometimes I know they're homeless, or sometimes I don't know they're homeless, but it's a back-and-forth situation there**."
13. **"When your money runs out and you have to either get back on the street or find something else to do to make money,** that's a great issue right there. Just responding to the way people say, 'Getting a job.' Yeah. It's kind of responding the same, '**Give us a job–a good job. Give us a chance. And, you know: if we mess it up, we mess it up. But at least you got a chance**.'"
14. "**There may be a collaboration with different organizations to try to help the homeless obtain work**. I mean, in my case, I don't see that happening. I mean, **if it's happening, I don't hear it, you know, and I don't see it**."
15. "**Most of the people that were on the committees are not homeless, but they are ready to learn**. I really enjoyed working with them. And then I'll motion. I'm really truly wanted to help that they had the committees I was on. They had some other people to go to. And so they had other people to where they wanted to use us. Collaborate with maybe. But like I said, most of them I really enjoyed. And **one of the ladies was the one that was totally, completely over the college... Every time she saw me, she said, 'You're sitting with me.'"**
16. Collaborate with the places that help the homeless. Go to Beacon, Centerstone, or whatever else is out there. **Help us get to learning that we need the education that we need. If we need an education on that–maybe even going to help you keep going to Ivy Tech because they have a lot of Trade trade programs**. Even if they just do like one or two or maybe three for a year–however many they can

actually help to go. And if they need somewhere to stay, either get them housing or have someone bring them into their house–into their Home.

17. “I have an ex-minister I was staying with who took me in the first time I was homeless and helped me get myself back on my feet. And I've had a house. I was always paying. The first house I had was at $1,200 a month, not including utilities. And the second house was $1,000, not including utilities. So I was doing pretty well. Yeah. And it was because I had help, you know. She took me in. And **we would do better if we had more people who would take people in, or help them with housing–with housing vouchers**.
18. It's so hard. **There's so many people still on the street working. And you've got to be cleaned up and nice-looking going into certain job**s. And it's not easy. People don't understand that we need a place to clean up. And what we know. We can take the showers [at Shalom], but only a few people can take showers each day. Everyone can't because they're only open 8-4, you know. So people don't understand that. **It’s not just the money, it's the hygiene just to be real**.”
19. “I'm looking for **a safe place to sleep for the night where they won't see me**."

Operational Stakeholder A

This operational stakeholder, the Bloomington Fire Department, preferred that their organization's identity not be hidden in this Report.

1. "Last year we almost broke 6,000 calls for service, which the year prior was a the largest single increase in our call volume year over year in our entire history. I think it went up 37%, which is **unsustainable and insanely busy** for us."
2. "We don't try to justify our existence by the number of calls we run. We run a lot of prevention programs. I tell a lot of people if I was the best fire chief we'd never run another call again. So I'm failing being the best fire chief, but **we are doing our best to try to prevent calls** as much as we can."
3. "October of last year, we started our **mobile integrated health (MIH) care program**. This is another response to the major call volume increase and the types of calls we're seeing over and over and over again. Simply put, it is the **before and after 911**. Our MIH's job, including two more people online this year. If we go to someone and they need **continuity of care**, they follow up with that. So it could be an overdose or as we're finding it's a lot of elderly folk that don't have good support systems or medical care, that type of thing."
4. "So a lot of our world that we are getting into is someone who **if they had medical checkups, fluids, or someone that cared before the 911 call, it would've never triggered into the emergency world**. I've now had an issue of dehydration for five days and now it's a vital one issue, right? So I think that's a good example. The other thing you get into is the after 911 is like an overdose or what we're seeing is a lot of elderly care which we go and help pick someone up. It's a non-emergency call for us. We picked up that just this last year because the ambulance is kind of overloaded. So we go out, we pick them up. We don't want to pick them up 100 times. That's where the MIH team comes in. We pick them up and then we say, well, what are you missing? Why did a 911 response get triggered to come pick you up? So that that's what I mean by the before and after. We're looking at how can we eliminate 911 calls by either taking care of someone before, we're taking care of someone after, so that it's not just always hitting the 911 system."
5. "**We focus a lot on the preventative effort**. If I had unlimited resources and had to rebuild the department from day one. We will probably be a lot more prevention focused than operational focus."
6. "When we just did our report for the end of the year, **we had coordinated care with 18 separate agencies** and we just started in October."
7. "As far as other equipment, this program generally progresses to what they call **community paramedicine**. So EMTs are very limited into the type of medical interactions they could do. So you could get into a community paramedic working with a Dr. starts getting the ability to administer a lot of different medications, doing things like Intravenous fluids or medications. So we go to people in the park all the

time during the summer because they're passed out and they are just really low in fluids. They had nowhere to go cool off. So, you know, there's these things that we're looking at progressing towards that paramedic model. But we're also slowly tip toeing that way because it's very expensive to get into that advanced life support level of service (ALS)."

8. "If there's any one answer, on the mental health side, **having a crisis response team available 24 hours a day**. But again, you can't just have one because we have more than one of those types of calls going on at the same time. That that to me is where you start bridging out of the traditional public safety model and you start **sending the appropriate resource**. We've all been kind of cross trained to mental health issues, but **we're not mental health experts.**"
9. "We actually looked at a **community-based software** that will allow us to start looking at the continuity from beginning to end. The one thing that I think is lacking in Bloomington is there's so many resources, there's no coordination between them and there's no information sharing between, right? So I think that we had to talk about a tool or we had to talk about a way of bringing this all together, something like that community-based software. That that to me seems to where we can start making some headway on this issue. Then again, automating some of our workflow."
10. "But I think if there was **one system tracking all the Public Service entities**, they're maybe a lot of useful information to come out of that. As far improvements. I want to be very clear that the community service coordination- based software system was talking about is more of a social service side, is not really built for public safety. Public safety can be a player. We're doing social service and we could be the person that buys it, making it available to the community."
11. "You've got to talk to the people on the ground (**Emergency medical personnel**) because they're pulling their hair out, trying to figure out why there's not enough EMTs, there's **not enough paramedics, there's not enough ambulances**. If we don't fix something before it gets to them. **They're at the point of breaking**."
12. "I told you we ran almost 6,000 calls, but somewhere in the realm of another 10,000 to 12,000 calls a year for medical calls that an ambulance goes to that we don't, that's the stubbed toes. or 'I've been sick for four or five days and I just decided I needed to go the hospital.' Now, even something as simple as a broken arm, that's a primary care or an urgent care. Ambulances are not needed to handle those. These kinds of calls don't need to have an emergency room trip by ambulance. Sending ambulances on those calls just takes away valuable resources from the community when we already have limited resources."
13. "I'm very lucky in the fact that **all the people involved in this department really want to improve the quality of life** for Bloomington residents. "
14. "The biggest change in crisis response that I think may benefit our community is starting to look at having a **medical provider, like a nurse, available in our crisis response system**. So that lower-level, acuity calls, the non-critical - not the 'My arm's cut off and I'm going to die' - but **first aid needs would move from being**

responded by the Emergency Medical (EMS) and it would be kicked down to a nurse for triage. That nurse could then triage the call and ask questions like, Can you drive yourself to your primary care or to an urgent care? No. Can I send you a medical Uber? San Bernardino County in California started this program. There's a lot of other communities that are doing things similar to my awareness."

15. "The police (BPD's) social workers wear a **police-looking uniform** with the Bloomington badge on it. And it just says 'social worker.' And I asked them **'Does that shirt stop people from wanting to work with you?'** And they said, **'Absolutely**. '"
16. "There were so many calls we'd go on in overdose situations, for instance, where we'd say, 'Look, **I am not an officer, I'm not going to arrest you**. I just need to know what you took. **I'm just here to take care of you.** I need to know what you took so I can give you the right treatment.' And **we in the fire department have that public trust pretty quick**. The police seem to start from the side of no trust and have to earn it, right, which goes well or doesn't go well and it adds or takes away from the public safety outcomes."
17. "I don't know that I have a particular one-off answer to how to address the problem of marginalized groups being hesitant to utilize our crisis response system, other than we probably should **review the calls the police are going on**. "
18. "I know if you do your research nationally, they're starting to show that, even with things like a **domestic violence call, police sometimes inflame that situation**. So I think it's every call is going to be different, but I definitely know that's a thing, and that I've seen it. I've seen attitudes completely changed when a police officer walks on the scene, even if they don't interact with someone, right? Just the attitude sometimes changes when that person was afraid of them, there is just a different attitude when there's an armed officer there. "
19. "I would say the biggest concern [in responding to calls from marginalized groups like unhoused, mentally ill people and drug users] we have from our people is their own safety. I've had more requests for our firefighters to get body armor in the past year-and-a-half, two years, because of some of the clientele that we're starting to deal with and see. We've made conscious efforts to make sure that they are safe. But the day you put body armor on a firefighter is a day that you're changing the feel of your department within your community. "
20. "**Police running dispatch is a problem**. 911 dispatches, the core center of all of our services, police, fire and emergency medical. It running under the police does not work for all the other crisis responding organizations. That's not state mandated. It generally starts out where a police or fire run their own dispatch. And at some point, a community decides, this is too hard or the calls for service become too great so they consolidate. The police, have a stranglehold on it because of the data in the criminal database system, that they say they have to control the dispatch. There are plenty of communities across the US and in Indiana in which police do not control the dispatch. The police might also say that, well, we run 90% of the calls, so that's why it should be run by the police. But I don't know why it's that way. Anyway, if I

had to make one improvement to this community to start making a ripple and improvement across the community it is that **dispatch would be run as an all-hazards dispatch center. Perhaps you make dispatch its own entity** with its own director. Then it still serves all those crisis responding agencies, but it is not under any of them. The county is not as large of a government system as the city is, which is why the city runs it. It is a collaborative unit run by the county and the city, but the city has the responsibility to actually run it. I would argue that either it should be run at a higher level above both city and county, which is not a very effective model to stand up all that support it needs, or the other option is that it should be equal to police or fire. They wouldn't answer to any one of us. They are equal to us. "

21. "Especially here in Indiana where **there seems to be a lack of medical resources from just primary care physicians,** so on and so forth. **The Mobile Integrated Health unit fits very well to what this community needs.** "
22. "We're dealing a lot with **elderly**. That was something when I took this position, I wasn't I didn't not be honest with you. I didn't realize the elderly population right? And they are falling through the cracks. We're getting to respond to people who need some respite care. **They're only taking care of each other. Their quality of life is not good.** If we can improve that quality of life by 1%, that's huge. Sometimes we respond to **make sure people have food**, make sure they have **heat**. So it's so much more than just the basic health assessment. We really get to help coordinate care.
23. "We knew that we had some options to start looking for what we call super users of 911. Those that use it a lot. Within that group, we have **four main program areas**. The first one that we got to attack, are **falls and lift assists**. So those were our people (firefighters) that were responding to help pick them up and many times responding three or four times. And how can we prevent falls? This was where we started tracking **mental health and substance use**. So those are our people that might have overdosed or have, you know, they might have responded and somebody might have been in crisis and they got crisis help. But they needed to make sure that long-term after they got that initial crisis help. How do we make sure they're getting the things that we need? Alright, The next is what we term **healthy living**. And that was where the goal is to help prevent hospital readmission and to help deal with chronic conditions and that sort of thing. So since we are EMTs, we can do the health assessments, right? So we can we're like, "Hey, your baseline is this but your blood pressure is high" or "You've not been feeling good." So healthy living really encompasses a lot of things. We're just trying to improve the overall well-being and health of somebody, right? The last one is **maternal and infant health**. And the goal there ultimately is to help prevent infant mortality and just keep people safe. "
24. "**On average, we [in the Mobile Integrated Health unit] see somebody four-and-a-half (4.5) times** according to our numbers. So **we're never a one and done**. Sometimes they only needed two times. And we've made that first initial and

then we get to follow up and we know now they're engaged in services, their back involved with the resources and healthcare professionls who they're supposed to be involved with. Specifically with our **mental health patients**, when we first showed up, many hadn't been to their provider in a long time. So then, **we made sure they got back into their provider** and then once we followed up with them, they're back in to engage in services and it's not something they really need us to check in on anymore because they're already done. For our elderly, sometimes we're seeing them 6-7 times."

Operational Stakeholder B

This operational stakeholder, the Bloomington Police Department, preferred that their organization's identity not be hidden in this Report.

1. "It's **difficult for a police department to be able to prevent a domestic violence** situation or a bar fight. Arguments that escalate and turn into abusive fights happen and many times there are other factors at play such as alcohol. Gun crime prevention is also difficult but we are starting to use evidence collected at the scenes of these incidents and compare it to national data bases to link gun crimes here to those in other communities. This allows us to link the evidence from these crimes to evidence from other crimes to see if there is a link. That allows us to build a case and hopefully identify a suspect."
2. "We are funded for four social workers. We have one opening. We also are allocated six Downtown Resource Officers. We currently have one. **The overall staffing shortage of the department has had a significant impact on these units.**"
3. "We were **one of the first agencies in the country to hire social workers**. We have had so many people inquiring about our program we've had two national conferences where we had over 100 people representing over 25 states attend. It's a beneficial program where we take calls that we may not be the best to respond to like **mental health** or **housing issues**, and have social workers intervene to **make sure people get the right resources** to handle the problems they may be having."
4. "Certainly incidents of police brutality have happened nationally and people are concerned about it. Many **departments are painted with the big brush and labeled bad**. When in reality, if you call 911, it is the police who can arrive the fastest. Ambulances and fire units are dispatched from fixed locations. The Police are on patrol and may be much closer to the call when it is happening. If you take an overdose, officers carry Narcan. We can usually arrive on scene before fire or ambulance and can administer it. **I don't know how we convince people that it's safe to call 911**. One thing we do to build trust Is our officer have body cameras to record their interactions. If there are allegations of misconduct, the video can be pilled and reviewed and appropriate actions can be taken if an officer does something out of policy."

5. “**We have really good people working for us. They are very caring and really want to do the right thing and help people**. Since COVID, we’ve not been able to do much community outreach. I believe it is really important for a department to do outreach. We usually interact with people when they are not having their best day. So every opportunity we get to interact with people in a positive way, is a good thing.”
6. “The Board of Public safety is our civilian oversight board. They are independent citizens appointed by the Mayor to oversee Police and Fire. If there are allegations of misconduct, they have investigative authority. People can bypass us and file complaints directly with them.”
7. “We have multiple ways we track officer’s behavior. Body cameras, we use a red flag warning system. It tracks complaints on officers and alerts supervisors when problems arise. The State of Indiana has passed legislation that deals with decertification and maintaining a database and information sharing amongst departments. The hope is this will prevent a bad officer from hopping around to different departments.”
8. “There are **a lot of times people may see a problem on the street and not know who to call so they call 911.** All of public safety is dealing with staffing shortages. We can’t send an ambulance to every welfare check call. So the police go. Many times ae are familiar with the person. We know who they may have been seeing for help, we know what resource can help them. **The problem we have is there are not enough resources** to go around. That’s probably the biggest struggle we have is finding resources.”
9. “We started the downtown resource officer program around 10 years ago. It was started **due to the increase in calls and crimes with people experiencing homelessness** or those struggling with **mental health issues or substance use issues.** We had experienced a spike in those types of calls. So we started this new program. We had six officers volunteer. We didn’t force anyone to be part of it. **We wanted to try to break the cycle.** To try to **help people resolve their issues**. We partnered with social service agencies. We got the city to commit money we used to provide grants to those who worked with us. We wanted to get services to people who needed it the most. We had a lot of success the first several years. Then we hit this plateau. That’s when we came up the idea of hiring social workers. We started

with one and then added two more. We thought they could take what we were doing to the next level and better provide services. We wanted to reduce the interactions people were having with us. That program has been very successful. **We were able to get those who needed the most services what they needed so we had fewer contacts with them.** Stride was a spinoff of what do we do with people at 2am. There is nothing available in the middle of the night so Stride filled that void."

10. "Stride used to accept only police referrals. Now they accept walk-ins as well. Because of those early interactions, people are more comfortable returning on their own when they need help."
11. "I think **the lack of treatment providers or services leads to crime.** We have a lot of mental health issues involving the groups of people you're talking about. **We just don't have enough mental health services. We have no providers, there aren't a lot of psychologists or psychiatrists that can help with the mental health crises we're experiencing. That's probably the biggest thing, a lack of treatment options and providers.**"

Operational Stakeholder C

This operational stakeholder did not reply to our requests to approve the direct quotes from their outreach in time to be included in this Report.

Operational Stakeholder D

This operational stakeholder preferred that the direct quotes from their outreach with our Special Committee not be included in this Report.

Operational Stakeholder E

1. "In my role as [REDACTED]. I feel it is my job to try to ensure public safety to the best of my ability. The things that come through our office, I think some of the biggest threats that we face, it's very place-specific to Bloomington, I think a lot of the things that we deal with right now are distracted driving and intoxicated driving. We also have a lot, I feel there's been an **uptick in the last few years of violent crimes**, so whether that be with firearms, or knives or other weapons, we've seen seen a lot more of those kinds of crimes. Fortunately, they haven't all resulted in a homicide, but they have, they're still very threatening to people who are around those gunshots. Those are probably some of the things that cause me the deepest concern. "
2. "I think one of the biggest struggles that we have is that when we do end up getting like grant funding or something to start a new program. For example, take the Stride Center, or the mobile crisis unit, getting the funds in place and getting things in place, is one thing, but actually drawing people to do the work and to stay and manage the program: It's a real challenge. So I think we have to do something to foster people wanting to do that work and stay with it for a while. **It's not particularly high-paying work**. **There's a lot of secondary trauma** associated with it. There tends to be a lot of bureaucracy and oversight that people have to deal with. So I think there's a lot of different things that make it challenging. But I don't know that that's necessarily even unique to those programs. I think that it's kind of something that employers are struggling with across a lot of different sectors. And I'm not sure how to fix that problem. But in order to be a licensed care provider for these things, you have to have a significant amount of education, too, and that's not, you know, usually free or easy. And so I think it's also something where people are looking to make more money, and to move up in their [career] ladder too. But yeah, I think that really **the best thing the City can probably do is try to make connections across a lot of different sectors and then provide [employee benefits] programs to try to help incentivize those that work** and [provide promotion] options."
3. "I think that **there's a lot of folks who are saying things like we need to be considering alternatives** [to law enforcement and criminal justice] for [addressing

the problems of] **substance use and mental health from the police.** And I think honestly, **the police and I would agree with you**. At least I would. **We** [law enforcement and criminal justice providers] **are not equipped to deal with some of the significant mental health problems that we see**. But the unfortunate truth is that they don't a lot of people don't end up getting mental health treatment for a variety of reasons. I think some of it has to be with **access**, like they don't have **health insurance**, or **means to get themselves into treatment**. But I think a lot a large part of it is that **a lot of folks who are experiencing mental illness [do not] realize or recognize that they are experiencing mental illness**. And so they won't necessarily engage with it voluntarily. I wish we could find a way for that to be **destigmatized**, or, like **more accessible**, more normalized, for people to to get connected with and feel okay about checking in with our mental health. Because what ends up happening with us is we get people who have committed batteries [violent crimes] or other kinds of [crimes] as a result of mental health outbursts, but **we just don't have a very effective means**, **we do our best to try to get people treatment** and get them to a place where they're not going to hurt people again, **but [the criminal justice system] is not the best way to to get that done.** I would say I think that any efforts that can be made to destigmatize and increase access to mental health and substance use [drug treatment] is going to be a huge effort. But again, I really do love the idea of trying to do some community-based violence preventionwork, and I don't know how I can foster or support those efforts, but I would be happy to do it if I can. “

4. “I was talking about just **not having enough, or the right, resources for certain mental health and substance use challenge**s. I do think one of the things I found most interesting about some of the stuff that you were presenting at the [CAPS Commission’s Public Safety] Town Hall was the idea of trying to come up with **violence prevention initiatives**, and something [based] in the community, because the truth is like **making it illegal, sending the police** bringing them to [the criminal justice system]. **It's not going to convince people to avoid this behavior**, and it's much preferable to avoid violence. Then than to try to get justice for somebody who's lost a family member. It's much **more cost effective** as well. “
5. “I know that the **police department has its social workers**, and I do think that **they're doing some really good work** with the social workers. But I also think that

it's healthy to keep criminal justice and treatment providers, for them to have some separation. Because **you don't want the law enforcement piece to have that much of an outsized influence on this treatment**. I always think it's a good idea to to pay attention to [critical assessments] people are putting out about criminal justice and the things that I do, just because, if you don't challenge yourself to hear what other people have to say you're never, you're not really improving right? So I try to do that, and some of it I agree with, and some of it, I don't."

6. "**We obviously have a lot of folks who are dealing with mental health and substance use challenges that cause them to come into the [criminal justice] system over and over again**. And so that's obviously a big issue that **we're trying to address root cause** through treatment and other referrals. But **there's never enough for of the right resources** to deal with that that huge problem. I have no idea [how to resolve this lack of resources]."
7. "I don't think that the City can do everything and be all things to all people, and i'm not sure that's advisable, anyway. But I think it's important to foster an environment through incentive programs to draw developers into providing low-income housing and draw treatment providers to want to live and work here."
8. "If we're talking about [the City resolving the lack of access to] housing, I feel like that makes the most sense in like HAND, or the Bloomington Housing Authority, or somewhere that already kind of deals with housing issues and landlord issues. If you're talking about [drug] treatment, maybe the department of Community and Family Resources. I think that [they are] doing some initiative on preventing violence [from a community-based perspective] that I was talking about. So maybe that's like that's a good home for it."
9. "I think you're always gonna run into the NIMBY [Not In My BackYard, or when residents of a community support providing more access to resources for marginalized residents, but they do not support having those resources provided in their own neighborhoods] problem with that. **People don't want to be around those kinds of resources.** I mean, you see that with when we were trying to locate the Shalom Center [Beacon Inc.] or the Stride Center. We were looking at a place that was kind of near this one somewhere on the south side, and well basically just the neighbors weren't having it. They didn't want to have that kind of resource down there. So you're always gonna have that where businesses and neighborhoods like

folks just aren't gonna want to have people using drugs in their vicinity because **they're seen as being unstable, and unhealthy and threatening, even if they're not**. I just think they are **seen as being kind of menacing**. So I think that's really going to be your biggest problem with [providing drug treatment resources more widely available in our community, including safe injection sites]. I think the research suggests that you have fewer overdoses, or the overdoses that you do have can be reversed very quickly and keep people alive."

Operational Stakeholder F

1. "I think I would say, the greatest threat to public safety are in a couple of dimensions. One dimension to me is **guns and weaponry, and the means of violence that are pervasive and increasing**. We're seeing more weapons more frequently around our community, and in incidents that we deal with, and you know any time a firearm is involved there's so much more danger than if one is not involved. So that's one dimension of what I would say is a great threat to public safety, and I would urge our elected representatives in the State House to let us do more to try to manage those issues. So we care deeply about that. I mean having a lot more firearms in the community is a direct threat to our public safety officers, as it is a real concern for our residents."
2. "I think the second dimension i'd talk about, I suppose, is **in terms of threat to public safety** would be the kind of the **underlying public health challenges, mental health, substance use disorders, that drive a lot of kind of street stress**. And I think you know the **state of Indiana is among the very lowest per capita investments in public health**. I think **we need to do a lot more locally on that issue** in terms of **prevention and dealing with threats to our public safety**. You can have **public health challenges with mental health that can result in public safety challenges, same with substance use disorder**. I think the **lack of affordable housing and homelessness can also cause public safety challenges**. I would reiterate that at a very fundamental level the weaponry and the danger of guns creates an order of magnitude risk that we really need to deal with. It's very difficult in a state like this with the laws that we have. But I do agree that **both the reality and the perception of public safety are affected by all three of those categories [the problems of homelessness, mental illness and drug use]**."
3. "And then I guess I maybe i'd mentioned a third, which is having as much opportunity for people as possible, is very important in terms of **making people feel connected to the community with the future with a lot of opportunity** to live a good life. So that means **jobs and good education and a good quality of life**. But that's at a really high level, too. **Public safety is fundamental to any successful city**, and **any risks or threats or deterioration of public safety is a threat to the success of the city**. "

4. “The public health is, of course, a very, very broad topic. but I was just saying personal choices [are important] too. You know we try to encourage people to be active and to walk and use our parks and have an active, healthy lifestyle. And that's part of public health, too.”
5. “The **lack of public health investment [by the federal, state and county governments**] means that we spend a lot of time dealing with **situations that are fundamentally medical and health situations, but they manifest themselves on the streets** and in street homelessness, or behaviors that are challenging. So **we end up kind of paying that the back end for what should be a front end, healthcare issue**. “
6. “I think the overall criminal justice system is a critical part [of improving the city’s public safety outcomes]. We haven't really talked about that much, but I think you know **America is extremely over-incarcerated** when you look at our relationship to other developed countries that's got a deep and long legacy, and I think, reflects the fact that **we're not doing enough to invest in services and prevention and opportunit**y. And indeed, in our community in particular, our incarceration system, our jail, is an abomination and it has been for many years. It has been left to deteriorate in a way that's really a stain on our community. I know there are a lot of people who work very hard and do a lot of good things in the criminal justice system, but that particular component is in desperate need of improvement, and I would also say the whole component of **prevention and mental health services and substance use disorder, counseling, and job placement and opportunity creation is under resourced and should be invested in more**, and that all trickles down. It all affects public safety.”
7. “You know public safety is affected by a lot of things. You know the road infrastructure making sure we do the best we can to **protect pedestrians**, bicyclists, and vehicle occupants that they're safe. That is a big deal working on suicide that if you really look at the big picture of mental of public safety. **Suicide is a big challenge.** And how do we address that issue? We don't have good public health [in Bloomington] compared to the wealth of our country and our community. So that's a whole level of question about public health, exercise, and lifestyle. Choices are really important in public health. So doing all **we don't have good public health compared to the wealth in our community**.”

8. "It's complicated. On the one hand, a [key operational stakeholder in public safety] and **a city [government] are of course, interested in all aspects of life**. And what how they affect us. On the other hand, [ensuring access to resources like **mental healthcare and drug treatment] are areas that we don't directly do a lot about**. You know, medical health, for example, is one I you know I don't run a hospital or an ambulance service or doctors offices. **Mental health is similarly not really an expertise or responsibility that we have**. You know our state is set up with a public health system that's based at the county level. It covers all counties, including all the city residents of a county. So that **basic public health system is really rooted in county government**, which doesn't mean I as a [key operational stakeholder in public safety] don't care about it. **I do care a lot because it affects all the 85,000 Bloomington residents, but in terms of that language of "taking overall accountability," that's just not something we're likely to do on mental healthcare and drug treatment.** Now we want to work very closely with the experts in that area, whether they're public experts or nonprofit, or even private experts to try to improve that. But, like the funding generally comes to the county, and so **the direct responsibility for public health is with the County Health Department** and a health board that oversees it. So **we're kind of a partner** in that."
9. "On affordable housing **I do feel like the City of Bloomington feels overall accountability for doing everything we can with affordable housing** inside city limits where **we directly and manage resources and opportunities**. And we work really hard at that. So I guess if the question is, "How can we allow the City of Bloomington to take overall accountability for access to safe and affordable housing?" You know we need more funding from the Federal Government, and we have rules that we have to deal with from the Federal and State Government, both on Housing support, but **we certainly do embrace that mission of affordable housing for all of our residents** very seriously, and **pursue it aggressively every day in city government**."
10. "Well, so let's split this into the different categories on this, on **the subject of affordable housing**. You know our major department is **housing and neighborhood development**, and they are very active. Of course we have a Bloomington Housing Authority. So I think that the combination of the housing

authority and the housing and neighborhood development would be the the two key [city departments critical to resolving the city's lack of] affordable housing. They're more with the **economic, sustainable development** and the **planning department and legal department**, and the Controller and others that get involved. But HAND would be the center [of the coordination of city programming to resolve housing insecurity.] We do work very closely with lots of community organizations on housing, from housing producers to homeless service providers and others things like that on the mental health and drug treatment. "

11. "Well, we certainly care deeply about that lack of access [to mental healthcare and drug treatment]. But inevitably **we're going to be dealing primarily with the County Health Department, and the healthcare system overall to make advances on that**. We don't have a health department in the city government. We, the closest we have, I think, right now would be the **Community and family resources department which deals with a lot of varied issues around a welcoming community, a safe and civil community**, a community of robust nonprofits and volunteers and well engaged people. Some very large cities do have a health department, and that would be a different animal if we did, I think. But I don't know how that funding would work related to the County Health Department, which you know gets the direct state money, and if the state's gonna, I hope very much that they will, add investments in public health, it will generally come through the County Health Department."
12. "**Indiana is extremely under invested in public health per capita**, which mostly funds our county health system, and **I think we should do more locally**, and we need more help from the State Government, too. But **I think we can step up and should step up locally**. And again, that's basically at a county finance level. We have tens of millions of dollars of American Rescue Plan Act money that should be significant, parts of which should be dedicated to public health. In my view. the county received 12 million dollars annually in new local income tax revenue this year, and I think a significant chunk of that should be dedicated to public health. It appears the decision is mostly to move that into the criminal justice jail part, and I think that's not appropriate. so I think we can do more locally. I also think we need help from the State and Federal Government. It appears that the 12 million dollars of new local income tax money that the county received this earmarked just for the

jail when, in my view, it ought to be significantly invested in prevention, services, and and healthcare, and all those things have a separate source of funding than for a jail, which we're allowed to do as a community. We can create a criminal justice tax for the jail."

13. "**We have very substantial local resources available today to invest in public health** in particular. Mental health and substance use disorder at the county level, both with the American Rescue Plan Act and with the new local income tax. **and I strongly believe, as a community and as a County, we ought to do that.** The City is investing substantially in affordable housing with local resources. We just put another a 1 million dollars a year of local taxes into affordable housing. And we're spending a lot on transit which helps make housing more affordable and climate response. And all which we're doing [the City's] part. But we are not generally a public health funder that's done at the County level, and I think if [City, County and State governments] each take our part in addressing these components, we can really make progress, but I think at the County level we need to see a lot more investment in that public health side. "

Operational Stakeholder G

This operational stakeholder did not reply to our requests to approve the direct quotes from their outreach in time to be included in this Report.

Advocacy Stakeholder A

1. “First of all, we are wrapped around in **a system that is inherently capitalistic that cares nothing for the person**. I think people understand that we live in this kind of dual lives where we're told one thing, but the other thing is going on, and we live with it on such a daily basis that **we kind of like internalized it**. I think that, like poverty, low access to housing. I mean, most drug use doesn’t start as a systemic problem. It's usually like a reaching for something to feel better or reaching for something to augment your personality, augment your feelings.”
2. “If you don't feel good because of the way the world is, though no fault of your own, or through a fault of your own, you will seek out some way to feel better about yourself or to ease the pain. It is a natural function in the human body as well as in human nature. And **drugs provides that [mechanism to feel better], but it also provides harm** inherent **both in the illegality** as well as the **drugs themselves**. “
3. “We live in an environment of **white supremacy that is ingrained into our culture** so deeply that it makes us all racist. even if we don't, even if we don't think we are. We have a two-party [political] system. That's really a one-party system. All of these [structural problems] that are going on, that are poorly addressed, and if they are, They're usually bad in a ways that **make the person feel generally unsure and untrusting of the system**, and those that do trust the system have to do it blindly, because they doubled down so hard. “
4. “We started out as a harm reduction focused organization. The services we provide are protecting people from blood-born pathogens by **giving out clean syringes and clean, safer smoking supplies, sniffing supplies** and anything that whatever drug you're using, **whatever harm might come, or whatever disease, anything you can get from that drug** or from the use of that drug. **We try to prevent that with simple evidence-based strategies.** Nothing we do doesn't have like 8 miles of evidence behind it because, unfortunately, **drug users are not trusted** very well. So we have to do double the data [gathering and research.] When someone comes into our [REDACTED] for the first time. What's the what's going on in my head is, ‘I have this person in there. They're there for 5 min, 10 min, 1 min, or whatever. As soon as they walk out that door **they may die**. I may never see them again. **They may be locked up**. Any of these **horrible things that happen to people in America who**

use drugs.' [We provide] love and care, as well as many services or referral to services that are trusted by drug users. "

5. 'I would say that the [REDACTED] offers **harm reduction focused strategies and principles to give bodily autonomy and resources to people in use [drugs]** in [our community], and to **strive to give them** whatever **positive change** we can provide for them. "
6. "The problem that happens is, we talk about categories [of the causes of drug use]. Categories like lack of education as a child or poor family situation, **no help from the public [safety] sector** at all, and **what help there is is all punitive in nature**. The punitive nature [of the public safety system] that leads to **shame and stigma that [drug users] then internalize and then throw back out**. So, even though, like we receive this stigma jam, the worst part is what [**drug users] give back out [to other people], which is doubled down stigma and shame, and ends up, being a recycling board of shame**. "
7. "I would say that there's **not one positive thing about [Bloomington's policing system]. I couldn't find a positive.** What do [the police-embedded social workers] do? It's like saying, 'Here's your science teacher. He's an ecclesiastic priest.' **It's contradictory**. [**Police-embedded social workers] are only there to serve a purpose to a politician**. Any help that we have right now [from police] is not for true care of the person. "
8. "[**BPD] haven't asked drug users what they want.** They may have asked a couple recovering addicts what they want, but they're **not asking people who are scared for their lives**. "
9. "Once, for instance, [**when they first opened] Stride Center. I was really psyched** with it, for I know it sounds weird. Normally, you think i'd be totally [skeptical], but I was actually kind of like excited when [the idea] first got brought to me, when I was heard about it. [My original] idea of [how it would operate was] they [drug users] could just hang out. People could just go and chill [without the police] fucking with them. They were talking about private rooms, you know, like utilitarian rooms where [drug users] can spend the night. And **we see what happened. No one can go there without a police referral until just recently**. "
10. "I would say that **90% of the problem [causing contradictions between the goals of law enforcement and the public safety of drug users in our community is]**

around the felony possession of a syringe. If you have a Narcan kit, and you take out that syringe out of the Narcan Kit, and you're in Brown County, and get pulled over, you will get a felony for a syringe made to save people's lives. [The law views possession of Narcan kits as] possession of a syringe that is to be used for [illegal] drug use. So guess who gets to decide if it's going to be used for drug use or not? The police. And you know that they're gonna say it was used for drugs. We're lucky here that [the Monroe County prosecutor] all on her own [addressed this problem in Monroe County], so anyone that comes to [court in Monroe County on] the [syringe possession] charge, they bounce right out now. **They still get** fucking **arrested**, which is shady, but, like we have to stop that mark because they shouldn't even be getting arrested. But at least they don't [get convicted.]"

11. "I would say that another [contradiction between the goals of law/code enforcement and public safety] is the idea of how we treat our homeless. The idea of **ripping these camps down without providing solutions**. We always are quick to tear down a camp or to tell [unhoused people] to leave, but **we're never quick to say, 'Here, this is an alternative [place for you to live].'** [The city could] **help** [unhoused people] **with some coding issues, and help the** [property owners] **avoid having to evict them.**"
12. "We can take the entirety of **drug use** out of [the realm of law enforcement]. **It is not a problem for the law [to solve]. It's a problem for health care**. We could take out every, **instead of police responding with to someone who's choking, or maybe having an overdose. We could have a lay responder** and pay for them to respond or pay for. You know, there are people out there [who would] probably volunteer to do it. I would, you know, if you tell me that they're going there. It'll need [to operate in] shifts. They can help them right then, you know they can, and traverse them to whatever care [facility] they choose. **[Drug users] should be protected from going into the legal system.** "
13. "**Any overdose, and anybody helping with that overdose**, regardless of calling 911, regardless of anything else, **should be protected by law against search and seizure** against [legal prosecution]. **No one should have to wake up from an overdose to a charge**. No one should have to help someone [recover from] an overdose and get charged if they don't call 911."

14. “If they think that they have a [community-led, safety-based crisis response] group [that is] entirely peer ran in Tacoma, Washington. So when the EMS goes out, it rings them, and they get paid by the State to go with EMS to overdoses, so that [if] they show up, and it's just a [non drug-induced] heart attack or something else, and that's fine. They don't care [if they get dispatched to non-drug related 911 calls], but right now they're showing up to like at least 10 to 20 overdoses a day in one of these municipalities. Here [in Bloomington] we have, **we get reported for one month about 100 reversed overdoses. This is all peer-reversed** overdosed right now, if someone OD’s what happens if I call the police right now, and I say, ‘There's a man on the sidewalk outside my house who's having seizures, and he has a syringe stuck in his arm.’ The first thing I would say to you is why are you wasting time calling the police when you could be saving his life first, and then calling the police. [But if you were to call 911 in Bloomington for an overdose situation,] the police [being dispatched] is going to be their advice. Whatever time they take, they're going to get there. What we've seen is either they come with do they send the EMS right away, or **they all show up, Fire [department] shows up. It's** fucking **stupid. Yeah, it's crazy [waste of resources].** i'm serious, like I watched somebody once, he ws overdosing, and [our organization] came in. **By the time we'd given them Narcan and and brought them back [from overdosing]. They had [Fire department response]. 3 or 4 cop cars, you know an ambulance, and it was disgusting that, like the amount of resources not needed and wasted**, so that the cops could check [the situation to find out if] there might be a bust there, you know, because that's what it's all about. **It doesn't make sense that you would send a police officer period in that situation, because this because it's a medical situation**. But like. [**police are not needed to respond to 911 calls] except for a violent crime**. [Or if you need a responder to] fill out a report. If someone stole some shit from you, and you don't know who it is. [Law enforcement and **police should] have no jurisdiction over your health or your body, you know at least if you have done nothing violent**. Intervening in **currently committed violent crimes and solving past crimes, that's what [law enforcement agencies] should be doing.** “
15. “If we look at [public safety response system in Bloomington] currently right now, **there are people who would rather die than deal with the system.** They would just rather die, you know. So I mean they don't have an overdosing [crisis

responder] because the [public safety response] system is at such odds [with the safety needs of drug users]. If we could get another [crisis responding agency], it have to be true, **it would have to be separate and above from police that can say [to responding police], "You have to leave." There has to be [legal and institutional] power behind it.** They need to be able to tell [responding police officers], if we had a group of these independent responders, they have to have the power to tell the officer to leave. which will be really hard to do, you know, but that's something that they'd have to have. "

16. "[Local public safety responders] they'll send [drug users] to [a local mental healthcare provider for drug treatment.] So [our organization] don't say that. **We don't go to [this local mental healthcare provider] because we've just been treated like shit there.** Here are some alternatives. Now, [this local mental healthcare provider] is changing, I've heard, but i'll have to see it to believe it. You know we operate. **They play in the reduction stuff when they don't even hire drug users**, or **if you do work there, they fire you if you use drugs**, so it's kind of like, [**this local mental healthcare provider] is responsible for enough of its own shaming [of drug users in our community]** for me not to have to itemize it. "
17. "But that's one of the things that I would say we do differently is [that] we **don't shame [drug users].** We let people come as they are, and get the care that they see they need. So we provide resources. If they need resources or money, or whatever it may be, whatever they see as a positive change. We will work with them some days it might be spending the whole day get their [drivers] license back. Some days, it might be, we have a a participant who comes in a lot who has nowhere to go that he feels safe. Literally. He has [drug-induced] psychosis, and he has nowhere else that he feels safe. So, after a couple of days being out in the non-traditional living situations, he will come and sleep on the couch sometimes for like 8 hours. We just let him sleep. He's not bothering no one. He's not hurting no one. He just needs a place where he feels safe and mostly that's what we are, is a sanctuary for drug users."
18. [The reason why drug users may not feel safe in our community's overnight shelters] is, first of all, there's [a local overnight shelter for unhoused people]. That is phase-based. i'm getting this [information] from my participants. I haven't stayed in these shelters. I would not. I was not [unhoused when] these shelters [existed]. They

were around when [my experience of being unhoused] was over. **The [local overnight shelter] is religious by nature, and lots of bad things happen there**. Plus you have to be there by a certain time, same as [another overnight shelter] where, like, for instance, might be a little bit better. But **you have to be there by a certain time, and then, like they can't have their drugs there. They can't be intoxicated there.** Sometimes **they're using these drugs to [treat] a mental problem.** You know what I mean, [I'm] not saying it's the best thing, but what I heard once heard someone from like a homeless coalition in a New York say is that the idea of a shelter was never meant to be cyclical. It was meant for, like you've got a a problem right this second. It's cold outside. I don't want you to die. Come in here, and then we'll give you warm food in the morning, and you go. I mean [the practice of providing overnight shelter to unhoused people] originally started out in the churches, but I mean after it left the churches, [secular non-profit organizations] did the same model. **The idea of putting people in a huge room, it's dormitory style that when the lights go out there's one guard, and he doesn't give a shit. He's not policing around, there have been assaults there. There's been huge racial problems there. So I mean, I would say that going to the shelters is the shittiest option [unhoused drug users] have**. "

19. "Well, [to resolve the problem of drug users who hesitate to call 911 in emergency situations out of fear of law enforcement being dispatched], **ideally, the [law enforcement] officer wouldn't be [dispatched to an overdose situation] in the first place.** I think there if is a police officer in any situation, no one can tell him what to do. That's how law enforcement works. They used to not be that, like the medical field could tell [police not to interfere in health emergencies], like early EMS in the seventies and eighties. The county health department should be able to. So **if we did [create a safety-focused crisis response system], we would have to have double advisory boards. We'd have to have [an advisory body] that [would be] made up of the constituents of our community, and one made up of drug users. I mean, we would have to incorporate all of [least safe and marginalized groups into the oversight structure** of the program], because **what tends to happen [in municipal public safety design] is people with great intentions build these systems without talking to drug users or people who have lived**

experience, or they'll go to somebody who's in a 12-step abstinence-based recovery program and that looks a lot different [than the] harm reduction [model]."

20. "If we were to have [a drug treatment center including a safe injection site] in Bloomington, **we would need to have more than one [location].** How could we address the concern that everyone would have, which would be, 'Not in my backyard,' like where to put it. This is the main [obstacle to] something like that. But you have to understand that **these things would drastically reduce all those [harms and injustice** experienced by the drug using community]. People can't, they're not going to be hanging around the site, and even then, we can place the site, **it needs to be quickly accessible to people who use drugs**, so that people can get this [treatment]. It also **needs to be close to the [other] services [drug users may need], because people are walking** a lot. [Local residents and business owners] would be like, "Oh, don't put it near [my neighborhood], put it somewhere else. Of course that's what they do. Nobody wants like, **we have such a little love for the drug user [in our community] that the people [here don't] want drug users to be around them**. What we don't understand [in Bloomington] is things like that. That the more we normalize drug use as just [being a] health care problem that some people have, the more we're going to climb out of those ways of thinking that [a] person is inherently bad or wrong for using drugs."
21. "And of course there's probably legal [reforms] we need to do to make [a walk-in drug treatment with safe injection site] happen. If we would give police [legal protection from] their liability, **if we'd say [to] police, 'you're not liable.'** But really until we get that syringe [law reformed], [making arrests of drug users for syringe possession] is always going to be what [law enforcement officers] do. It just comes down to like, **that's how the system is set up**. **I'm sure if I [was] a cop, I'll get promoted and get more awards if I arrest more people with felonies. I'm just sure that's how it works.** "
22. [The benefit of a safety-based crisis response system] is **if the drug user knows that he can call this [alternate phone number to 911] and the [peer responders] are gonna come and save him, or if they know that no police will ever be [dispatched], [if there was a] phone number to call that did not bring the police, [then drug users would be more likely to ask for help in crisis situations]. And so that's a pro**. The other pro is that you You can see these

relationships being built, like right now, like with [our organization] and the [Bloomington] Homeless Coalition and Beacon, and we've built these relationships between the people that work in the [organizations]. So if [one of those organizations] go and see a guy that he's over[dosing or if] someone's got some drug related [crisis situation]. They're gonna call [my organization] and in the same turn, if I see something that's more of a housing issue, or this person just needs [some other resource], I'll send them to somewhere else. You know I mean, the pros are that **one of these systems can serve in that capacity as a liaison to other [service providers]**."

23. "I would say that [key performance indicators the City might use for gauging success in community safety] would be **overdose rates** and **homeless mortality rates**. I would also use **increases in money** [secured by the City for] **harm reduction** services and **increases in access to alternatives for homelessness and drug use**. That's a problem that we only have one thing you can do. **There's no good rehabs around here. More money [secured by the City and] funded towards homelessness. and [empowering] autonomous decision-making [by] homeless people. [Marginalized] people [should] be able to make their own decisions for themselves**. Another key indicator would be [the City securing and] funneling a lot more money into things like **domestic violence [organizations]. Can they be reducing the mortality rate of drug users?** Increased money [toward] **getting people out of poverty** [would result in a] drastic cut in Hepatitis C and in the blood-borne pathogens. Also increased funding into things like emerging new technologies running through like **drug checking**. We should be having a **machine to check all drugs on the spot**, as many as we want. So that people can see like. For instance, I was in North Carolina [where someone had] one [of the drug-checking machines] and a guy found out that he had drugs in which the horse [tranquilizer] was that can kill you and **he threw away one of the largest bags of drugs I have ever seen. So people will do that if they find out that it's ba**d."

Advocacy Stakeholder B

1. "**One of the biggest structural causes of homelessness in Bloomington is a lack of affordable housing**. In addition, when there is affordable housing, many times landlords don't accept rental assistance vouchers due to the **stigma or false perception of people** who use the program being more likely to be bad renters."
2. "The current data tracking system of unhoused residents in the City is a **coordinated entry program that is required by HUD [Federal department of Housing and Urban Development.] Case managers who provide services to unhoused people** enter information about their clients into a common database where case managers assess clients on a vulnerability index. Then when housing becomes available, the most vulnerable people are at the top of the list. One challenge is that **not every agency is part of this process**. In short, **we need a way to start counting unhoused people who are not in the database**. "
3. "The coordinated entry system will give us good idea [of a monthly count of unhoused residents in the City]. Region 10 [of the coordinated entry system] includes Monroe and 5 other counties. [Our organization] has a target goal to launch a public dashboard by June 30, 2023. We've been entering data for 7 months internally see how it looks. It's not a public database. **We are working towards pulling that into a public like a page on our website that would be updated monthly**. We're we haven't done that yet, because the data is incomplete, because [a local overnight shelter], which is the biggest shelter and has the most direct [homeless data in Bloomington], they are not, they use a separate database for their management. And so we're working to export their data into the database that everybody else uses. When that happens, it'll be a more accurate description. It is a challenge for us to figure out what the [systemic] gaps are, and how we can build a more comprehensive, more timely database [for tracking homelessness in our community.]"
4. "I know that the County feels like they need to [conduct environmental mitigation] when they clear an encampment. They need to basically do like bio-hazard remediation of some sort. But there, **as far as I know, there is no ongoing effort [by either the City or County governments] to keep encampments clean [for the health and safety of unhoused residents]. Clean-up happens after a**

decision has been made to clear the encampment by the [County] Health Department. "

5. "A community collaborative is working on a set of guidelines for encampment closings. The goal is to have the agencies that provide direct services to unhoused [residents] come to a consensus on best practices. And then from there try to align the City and the County with those recommendations, which is a pretty heavy lift, because the City and County have separate operating processes. We are just hoping to provide some guidance that will result in - and this is really not addressing the question of should encampments continue to exist - this is, if a decision is made to close an encampment, here is a humane way to go about it. I think **we also need to develop a policy about the existence of encampments**, and but the city and county, and **what are the things that make them decide to close encampments or not**. And this is specifically on public property, because it's different for private property. I mean, if an owner says they want people off their property, that's the law. So there's less flexibility. [However,] **there is flexibility about the [the City or County departments issuing] citations [to private property owners due to debris caused by the presence of unhoused residents living on their properties]**. That's a decision. So we're still kind of early days on [this effort]. But I think that **there needs to be a more of a community consensus** on, let's **not just like randomly have our [City or County law enforcement agencies] just go and suddenly there's an encampment closing**. **Let's think about what that [human] impact is, and how we can address the needs of people who are in the encampments because they're there for a [systemic] reason**."
6. "I feel like it's not any one [City department that could resolve the homelessness crisis in Bloomington], it's not just the City of Bloomington [government] who should be held responsible for resolving the lack of access to housing. **We should also include the [Monroe] County government and other nearby municipalities**. For instance, Bedford doesn't have a year-round shelter. The City and County both contributed ARPA [American Rescue Plan] funding to [our organization]. Additionally, **transportation, infrastructure, park resources such as public bathrooms**, all of these **impact the health and safety of unhoused people**."
7. "Within the City of Bloomington, **CFR [Community and Family Resources department**] - [**resolving the homelessness crisis] is within their purview more**

than HAND [Housing and Neighborhood Development department]. But [if the City decided to take accountability to resolve the homelessness crisis], also HAND would play a big part, **Parks and Rec, BPD [police], BFD [fire] should be involved. You want everyone involved, the Mayor, the City Council, they all need to be communicating that message and implementing a compassionate community response."**

8. "If we wanted to **calculate an economic assessment of ending homelessness?** We would take cost of housing one person, add the cost of case management, take into account the in-flow and out-flow rates, the costs of preventing homelessness, which involves [providing access to resources such as] childcare, healthcare, etc. maybe universal income, eviction prevention. **It seems doable**."
9. "I think the challenge on [providing trash removal and other basic services equally to unhoused residents in our City] is that from what I understand of current political leadership, **there's a reluctance to basically say, "We're okay with the encampments.**"
10. "[On whether any government office in our community tracks homeless mortality rates,] I don't know the answer to that. I think that [in] the [coordinated entry system] database there is a column for when people exit homelessness, [and] death is one of those one of the ways. But **it's not [tracked at] the [County] Coroner's office, and so it wouldn't be comprehensive**. No, the number wouldn't be accurate at all. And sometimes there are gaps. So if nobody knows what happened to that person, they might just be - suddenly, they're not around, [identifying the cause of their disappearance from our community] that sometimes [is] hard to know. Like did they leave the community? Did they find housing on their own? So as far as I know, **that specific category [homeless mortality], isn't [tracked by government officials in our community**.]"

Advocacy Stakeholder C

1. "There was a statistic that was brought up [in the CAPS Commission presentation at the Public Safety Town Hall] that caught my attention. It was about housing. There was a data point or a comment made about vacancies and vacancy rates, [citing the 2020 Bloomington Housing Study on the City of Bloomington website, which states the vacancy rate of rental housing as reported by the American Community Survey is 9%] and something about **how there are enough empty beds or enough vacancies to house everybody. I'm interested in having more information as this seems high** and the percentage that I heard is closer to 4%. Do those vacant units cost $1,200 a month or more? Are they in apartments complexes like Smallwood that are marketed to IU undergraduate students? Would a family with children be welcome there, or want that to be their home environment because of lifestyle differences? If you've got young kids, you may be more of an morning person and concerned about early morning noise. If you work an evening shift or have a late-night lifestyle, there could be a conflict with recreational noise and guests because you're awake when others are sleeping. **I'd also like to know if there is a possibility of empty beds or unleased rentals that aren't being reported.** I also think that [Mayoral Candidate] Don Griffin made the point in one of the candidate forums that there are two-acre lots where, if zoned differently, could accommodate additional units. I've had a brief conversation with Don on the reporting of vacancies. **'Well, where are they? That's not what my experience is. So where are those units?'**
2. "I think **the underlying [cause of crime and threats to public safety in Bloomington] is substance use, bias and racism.** I think that not understanding other cultures or being uncomfortable around certain groups is underlying a lot of the violence that's happening. Many of the altercations that are happening might not escalate or might not even be initiated if there wasn't this misunderstanding and fear of others. That's not really what's being talked about right? Most people want to focus on the increase in the ability of people to open carry [guns in public]. **The amount of weapons readily accessible contributes to [crime and threats to safety]** and I also think there has been an influx of people coming from outside the community, not here to do any other business than drug trade. You're seeing an

increase in gun activity in some [drug-related] turf wars, in that wasn't there before. I think that is part of it, too."

3. "Around 2020, 2019. **There seemed to be more people moving here from out of state due to opportunities for income-based housing and porting section 8 housing vouchers.** I'm not sure if this was due to suggestions from the out-of-state housing authorities or from friends/family members [telling housing-insecure people] to come to Bloomington. It's just hard to tell. When I first heard people talking about, 'Blacks from Detroit, and Blacks from Chicago come here and take advantage of public housing.' I'm like,' Whoa! 'Wait a minute, are you - that sounds pretty racist.' Are you saying that there's more crime because there's more Blacks? I have noticed an increase of people contacting my program for services that recently moved here from the Chicago and Detroit area. [I do not get] information on why people left their prior housing unless they choose to share why they did. **A lot of people said they needed to leave an unhealthy environment related to domestic violence issues, drug activity, gang activity, and things like that.** So it seems that in some instances that [perception] may have some credence."
4. "I don't know if I would say [Bloomington is] a healthy environment, since this depends on the individual's circumstances/habits and socio-economic status. It seems that **in past years more people were considering moving here due to having social services and medical and other supports available.** There seems less options for lower income families based on the increase of those in need. **You can't easily find Section 8 housing just because you have a voucher and temporary shelter options are wait-listed. Even "workforce" housing is in high demand."**
5. "It's hard for me to know [what causes housing insecurity in Bloomington] other than a lack of available units, because I'm not part of the community serving the unsheltered population. I have many conversations [with housing insecure people] focused on their challenges finding stable housing, but **that is different than direct experience**. I'm as objective as I can be, but I'm talking to 25-30 people in a week, hearing about their struggles and conflict in finding housing, when **the units they can afford aren't there or for some they aren't able to get rental applications approved due to bad credit or prior evictions**."

6. “There are different levels of housing insecurity. One is financial insecurity where you temporarily can't pay your rent or your mortgage due to unforeseen circumstances or the **landlord/bank raises the amount which is outside of your budget**. If you **lose your job, if your hours get reduced, or if your industry goes away**. That, of course, happened all through the **COVID-19 pandemic,** where there's **financial insecurity based on [unemployment**, under-employment or precarious employment]. That is not just in Indiana. The US Treasury allocated funds for mortgage and rental assistance because this is a national issue and it is still happening. **People are still not able to work because of Covid or financial setbacks that happened in 2020. Many have never recovered,** because either their industry went away or their mortgage/apartment unit was bought at and the new owner is increasing the payment. **That has a lot to do with the way that our economy and workforce is structured** and people are [living] paycheck-to-paycheck. For most people that means getting a second job or even third job. **The costs are going up and the wages aren't matching** so it’s not enough to stay housed. “
7. “Another level of housing insecurity is that if you have a lease, it’s housing for only 12 months. Some people don't know if they’ll be able to get the next lease because everybody has raised their rent. If someone can afford $900 a month, but now the rent in a similar unit is $1,200 a month, how are they going to find housing since they are already living within their budget. **They may budget well, but the cost of food, gas for their vehicle and everything else has also increased, except for their wages.**”
8. “I’m receiving complaints from some of the larger low-income apartment complexes where it seems like there are **residents that are racist, making multiple complaints to their leasing office about the “Black kids”**. It appears to be easier to ask that family to leave or come up with an alleged lease violation versus confronting whomever is making the complaints to property management. “
9. “Then depending on your **perceptions and bias**. It might be like, ‘He's sitting on public property outside of my house – I bet he is seeing if he can break-in.’ It's just a kid sitting there, but maybe he is skinny and white with bad teeth and neck tattoos so he is **perceived as being on meth**. There's certain aspects [of negative

stereotypes of housing insecure people] that **may not be true, but they are powerful due to stereotyping**."

10. "How do we shift the public [perception of unhoused people]? I have friends that dress a certain way, spend a lot of time outside or maybe don't shower as much as others, and they're like, 'I was going in to buy whatever, and they were acting guarded and watching me.' I'm like, 'Well **that [business owners may expect] you're going to come in and cause trouble or make customers uncomfortable**. "because **you fit their stereotype of what a homeless person looks like**."
11. "I've noticed an **increased response of [health and public safety] services from the fire department in situations related to substance use** and calls for people that might need Narcan for overdose treatment and there have been **more social workers on staff with the police department**. **The BFD mobile [integrated health] unit and BPD social workers should definitely be involved [in resolving these threats to public safety] because they provide that service as municipal and county employees interacting with the public in a different way than what has traditionally been provided."**
12. "That was one of the things that I wanted to do with, brought up in some of the discussions [in the breakout session of the Public Safety Town Hall] is helping to **improve public awareness of what happens if you call [911] to get assistance from a social worker** for someone while an [crisis] incident is happening versus requesting an armed officer response. My understanding is that the [police] department has an armed officer arrive first to assess that it's safe for their social workers. **I don't think there's been full transparency when it comes to the [police-embedded] social workers involvement and follow-up services.** A better understanding of what the process is for the public would be helpful. **You may see somebody in potential crisis, not be correctly perceiving their need and want to do something to assist but not "call the police on them"**. Let's say there's an argument going on, and you don't want to have an armed officer show up to escalate the situation. **If you call BPD for social worker assistance, you may understand why what you were wanting to prevent [still] happened.** Informing the public of how that happens in a broad way [about the emergency dispatch protocols] would be helpful."

13. “I've had a couple of different incidences with the police because of my daughter’s father. **I tried to get assistance to request some type of well check and mental health resources for him. He was going through some type of mental health/emotional crisis** and showed up at my house late at night. He had permission from me to be in the garage, because he was storing some of his stuff there, but showing up so late, acting erratically and some of the things he was saying made me worried that it could be a self-harm/suicide situation. I was not comfortable going into the garage not knowing if the situation was going to be volatile, and **I called dispatch to see if they could take him to the hospital for care hoping that [my call could be diverted] right to the behavioral health [experts] or something. It ended up being three armed officers showing up, beating him up and pointing a gun at him**. It was very **traumatic and unecessary** and definitely carried over into the ongoing relationship [I have with him]. How do you trust somebody who you think called the cops on you? Could there have been a different approach had I known better? But I did not know. This is a long time ago. This is before there were any kind of public safety social workers. I thought I was doing what I needed to do, because I thought he was going to commit suicide in my garage. “
14. “So I have had other negative experiences [with local law enforcement agencies] through my relationship with him. **Why are we getting pulled over again? How come this doesn’t happen when I'm with my white boyfriend and/or friends? Oh, maybe because they are Black** and we live in Bloomington. I've had direct experiences here, and also growing up depending on which cousins I was hanging out with and what they look like. I realize that I have my own biased perception [of local law enforcement] and **we all have different perspectives based on experiences. I think that it's important to note that.“**
15. “**HAND’s [housing and neighborhood development department] jurisdiction is limited to title 4 and title 16 which is related to building structure/safety and habitability** and the number of people in the rental based on zoning ordinance type. They've hired in **a new position focused on Affordable Housing efforts** which is a full time staff position. They’ve been requesting additional staff for I think two or three years. **CFRD [community and family resources department], is**

hiring for a special projects coordinator that would focus on strategies for reducing homelessness and provide services to the unsheltered/unhoused. "

16. **"My preference is to have [the City] put more effort "higher up the stream" with focus and services to people who are on the edge of losing their existing housing**, and work to support them **so they won't need the [temporary shelter] services later**."

Advocacy Stakeholder D

This operational stakeholder did not reply to our requests to approve their direct quotes in time to be included in this Report.

Community Stakeholder A

1. “We know that **violent crimes rates, gun crimes**, those kinds of things **are increasing**. We know that our **public safety staffing levels are decreasing**. And so we're seeing a deficit. Police officers, we're seeing a deficit of firefighters and dispatch personnel. Those are all concerning, too, because that affects response times and response rates. “
2. “We've got far fewer public safety personnel working in the city. All the research has demonstrated from the experts who look at these things that you know we need more firefighters. We need more police officers. **We need more people. You know, responding to certain types of events and crises that are occurring in the community**. And so the final **crime rates are going up**, and **that's really a a big concern**, too. “
3. “I think there's a lot of the illicit behaviors that lead to **a perception among people in the community that moving to Bloomington is not as safe as it was before**. And you know, I think **when we talk about public safety, we also need to be talking about public health** and a lot of this, since a lot of these behaviors, whether it's violent crime or or nonviolent or just, you know kind of illicit things that people are, seeing that that they feel like are degrading the quality of life in our community are **rooted in severe addiction and severe mental illness**, and a lot of times. I think there's some overlap there as well, too. and so that's the challenge I think is addressing in a large, meaningful way, **how do we get people to help they need, so that they don't act out**. And that our members don't have these perceptions of Bloomington does not say that the community doesn't have these perceptions that Bloomington is less safe, and so they avoid certain parts of town. At certain times they don't want to take their families there for whatever reason, because **they just don't feel the safe**. So those that, I think, is a huge threat to our members, just **the perceptions that Bloomington is not safe**. But I think that is backed up by some data that we saw on the recent Public Safety Report. The **violent crime rates are increasing**, as well as the staffing levels of our police and fire are decreasing in a concerning way. We hear a lot about **syringes in the community**, when the Boys and Girls Club must have their staff scatter the grounds for an hour each morning collecting syringes, so that the kids don't come across those. That's

time spent by hose staff members picking up dirty syringes instead of serving our youth. I think everyone would much rather those staff members rather than be paid by a nonprofit who, on a shoestring budget to be paid, going around collecting needles. Let's invest that staff time and those resources in programming for the kids so that they have, you know, enriching programs. They can't do that when they're out collecting needles. A lot of these distractions **get in the way of our business owners** and members. We're having to deal with certain behaviors or for things that are happening around their business when they really need to be focused on their business and doing everything they can to get customers in the door and providing the services that they're there to do."

4. "The capacity issue of the town is one thing I hear a lot about, when do we reach that saturation point of being able to help. We are very generous community, which is great. But when does that generosity gets zapped? You know we Bloomington and the [REDACTED] membership as well. Very compassionate place. You know, we have 870 members. 80% of which are small businesses and nonprofits, locally owned, you know, businesses that we all patronize and love that make this community such a great place. The [REDACTED] **is a compassionate organization. I think we want to be known as a community, and I know that if you need a second chance you can come to Bloomington and get a second chance**. I don't think we want to be known as an enablement here. Where this is a place that you can come to get access to things that are going to continue to cause problems for you personally, or for your relationships. "
5. "Looking at the inflow of folks needing services who aren't necessarily Monroe County residents, but **maybe coming from other counties** surrounding Monroe County. One of the things that I learned the other day was the Department of Corrections is when is convicted of a felony. they send you to the State Prison rather than the county jail, and then the department of corrections releases those folks here in Bloomington without any real housing or anywhere to go. That is something to look into. How can we identify those folks who are coming here that have some backgrounds that they need help with getting jobs. They need help with getting housing. They need help with probably substance use disorders, but just having them kind of come into the community with no real plan or even knowledge about our community that is a big burden on our residents. I don't know why Bloomington

is one of those drop off places. It looks like the State Legislature needs to put a new law in place. They're considering some legislation that would prevent the Department of Corrections from doing that in the future, so that they must return people to their home counties. "

6. "**I think it's a good idea to give people help. The problem is, it can be exploited by other communities, too.** We hear the city of Columbus, for example, the police there will arrest somebody for a possession of a syringe which is a felony in Indiana, and they say, Look. if you don't want to go to jail if you don't want to go through detox and withdrawal, and all that stuff that's what's gonna happen to you. You want to stay here in Columbus, otherwise we'll give you a 125 bucks, and we'll put you on a bus to Bloomington and they've got all the needles that you could ever want and they have safe injection site. You can do all that. That's Columbus, but there is Green County, Owen County, Orange County, Brown County, Morgan County. "
7. "I think [public safety providers in communities outside Bloomington] see Bloomington as a place where they can send their folks who are desperately in need of help to get them help. At some point the community is going to be way over capacity on the help that we can provide. And we're just not going to have the resources to really do it again. We want to be a compassionate community. **We want to be a second chance community. But you know, for people who really don't really want help. You know it's becoming a place that you know. They're thriving**, I think, in a lot of ways. "
8. "[**The city government] is not overall accountable for these things like affordable housing, mental healthcare, drug treatment,** and all of that is way too big. Some of that is also a county issue. Since the Health Department is a County function, **it's going to take real collaboration with the city and the county with nonprofits**. But it's not the city can take over every person within its city limits, or to make sure they have treatment. That is not among their purview is, they don't have the personnel, nor the resources to sort of handle a situation like that. Now **they can help with that and make sure that they're providing some resources**. They do a lot of different grant programs to a lot of the nonprofits. They have a lot of those measures that they do to help the nonprofits and deal with some of these things, **but they cannot, I don't believe, take overall accountability to ensure**

that these things are maximized, and I don't know that we would want them to. I would be much more interested in giving overall accountability to other provider group, I don't know that we would want that to be the city administration or the city council. They kind of lead the community. I would much rather see subject matter experts that, you know, really understand mental health. really understand the housing market, and what all is involved and who really understand addiction. The challenges and issues, and understand the criminal justice system as well, too. That is, hugely dependent on the county government. And yeah, they have complete control over the criminal justice system here locally, just not with BPD, but with jail and the courts. **It would require a tremendous amount of collaboration. And I don't think we would want to do that unilaterally for just the city. The state is also needs to be involved.** This session has been public health, and it is kind of a regional approach. It needs to be a collaborative, an expert-needed endeavor that does not fall under the municipality. And we don't want it to fall under the city. I's not under their purview. They can NOT handle all those entities when **their essential services are trash pick up and public safety on the streets. All of those are really what they are accountable for. And we've seen deficits there with the essential services**. It would be difficult to add more item on to the plate of the city right now, considering that they're having a hard time keeping up with everything that they've already planning or implementing. This is why we talk about housing and constructing new housing units that we desperately need in Bloomington and Monroe County. You have to go through the planning and permitting process to do all of that, and we can't even get the planners over there to issue permits in under a 6-month timeframe. I mean it's just incredible. You go over to Brown County, and they issue it the same day. These are real challenges they need to work out before they take overall accountability. You know a lot of these are very high-level issues.

9. "The **housing is a market and the city can't control the prices** of land. They can't control building costs, and a lot of those things are just out of their control. It's a market, and Bloomington is just an 80,000-person municipality. To think [the city government] can have a real effect on that is not reasonable. You can work on what they've been doing, which is on the margins. But I don't think you can hold them accountable for the price of housing. **They cannot manipulate the market.** The

one area that they can kind of manipulate is that it's been brought up is a land trust to buy land where they can kind of make it a little bit more affordable, based on putting up some of the housing that they want. But even that is just a small portion of the market. The City does not have a lot of undeveloped land they buy up, it has to be available. And even then, let's just say they have this Land Trust you're still looking at a very small amount of housing that they can feed into where you're not going to achieve the goal of affordable housing or access to workforce housing. You're just working on the perimeters. **I think [providing housing to all unhoused people in our community] is a great goal to have. And I would hope that it's realistic.** it's a good goal to have. I don't know that any community is ever going to have 100% of their residents housed, and there may be some residents who don't want to be housed or cannot actually take care of themselves. It's one thing to give housing; but if people are not mentally or physically able to handle that responsibility. There are a lot more factors in there, than just providing housing. "

10. "I heard a good podcast the other day with the Wheeler Mission in Indianapolis, and this is something that they are really concerned about, and they've got all of these different constituents that they work with, the people who are suffering from housing insecurity, and they've got lots of options, and they want to help them all. But he said his biggest challenge is he's got a subset of folks who simply don't want any help, and they don't want to be housed, and there's nothing that he can do to help them, despite his best efforts. **They would rather, you know, stay in a tent and camp for example, than live in shelter housing**. So I think you know that's probably got to be taken into consideration."

Community Stakeholder B

This institutional stakeholder, the Bloomington Board of REALTORS®, preferred that their organization's identity not be hidden in this Report.

1. "REALTORS® have a high-risk job. They are entering vacant properties, alone and meeting clients at properties who may not be thoroughly vetted. **There have been increased incidences of REALTORS® entering vacant properties where an unhoused, mentally ill, or intoxicated person has broken an entry and is squatting in the property. This can be a very dangerous situation for all parties**. "
2. "When you drive on walnut and college you quickly realize **we have a homeless epidemic in our community**. Many of the unhoused struggle with mental illness and/or addictions. **Untreated mental illness and addictions impact not only the individual struggling but the community as a whole**. There is an **increase in violence, theft, property damage, and pollution when people are left to struggle through these conditions without support**. "
3. "We need to be **focusing resources on our school system** and making sure they have the services they need, and our teachers have the support that they need. Teachers are leaving the profession at alarming rates. If we don't want to add to our pool of people with untreated mental illness and addiction issues, then we need to work preventatively with the schools. **Mental health issues and drug use among children are increasing drastically** and there are very few resources to address it. These children will be adults very soon and living in our community. We need to be doing everything possible to prevent a school shooting in our community. As we all know, no community is immune, but the impact of such an event is devastating to not only the victims and their families but the community as a whole. The quality of the school system has a dramatic impact on the value of an individual's home. How easy would it be for you to sell your home if it was known nationally as being in the community of a school shooting? "
4. "**Elected officials could provide grants, low-interest loans, and/or other incentives to help property owners rehabilitate blighted properties in our**

community. This would be **more inventory in our market while reducing the damage that vacant and blighted properties cause** for cities."

5. "Our elected officials need to take a very hard look at how they can **minimize regulations, red tape and increase efficiencies** that would enable builders to increase our housing supply. They need to be **actively seeking funding sources** to build infrastructure and seek tax incentives for developers to invest in housing in our community. **When supply is increased cost is reduced.** Our **elected officials can have a huge impact on their constituents' ability to have quality, affordable homes and reduce the number of unhoused** in our community."
6. "The **elected officials need to seek the expertise of professionals in both the private and public sectors** to address the issues at hand. They need to **respect the data** and the advice from those who know their specialty areas the most. **They need to focus on doing the hard work, that** may not be popular, but **is best for the community**. The work they should be doing is not work to get themselves re-elected, but the work should be to **increase the quality of life of us all**."

Political Stakeholder A

1. "The major threats that I see is a significant increase in gun violence in the city, and I think that our residents are not hearing about that a lot, possibly because of where they're happening. **There were 70 shots fired at people last calendar year**, and that is quite significant for the city of Bloomington. The other threat to public safety that I see is **an increase in street drugs especially Fentanyl.** Fentanyl is killing people, and causing people [to behave in ways] that can be erratic and sometimes violent. I would also note that our lack of ability to retain our police and firefighters is, puts [our community] at greater risk."
2. "I think [our city's threats to public safety] **pose challenges at all levels [of city government] frankly, but particularly in our in our police and fire**. These public servants don't know what they're walking into on any given day. That may have always been true, but this increase in gun violence, and increased street drug threat is, putting them at greater risk. As I have done ride-alongs and talked to them directly, they really feel like they have - the illustration I've been using is there's this big avalanche coming at them, and **no matter how hard they work, the avalanche is actually getting bigger instead of smaller as a result of their work - and that does seem to be a core piece of the morale issue in the police and fire departments**."
3. "[The City's lack of access to housing, and sufficient mental healthcare and drug treatment] these three issues are at the top of my agenda, and they're all, of course. inextricably entwined. **The city can convene us and bring all of these stakeholders together.** Allowing the nonprofits to do what they do best, and to create those added services. **The City's role is as convener, and then potentially as the applicant for government funds that serve to address these issues and then filtering them to nonprofits.** If it is the case that the nonprofits cannot apply directly. There are some of those [Federal or State] government funds that have to go directly to the municipal [City] governments. In that way, **the city could understand what the best practices and priorities are, and further equip the nonprofits to do their work.** We need our Parks department involved, our HAND department involved, our Planning department involved, in helping to ensure communication around public safety and housing needs so they are better met.

They are very much the eyes and ears on the ground, and they understand things about how our residents are living, and want to live, better than any other single department could understand on their own. When we're trying to tackle these complex issues, **it's really important that we're doing outreach to all of our city departments to have them play a role in at least inputting into the solutions**. "

4. "I really don't know [if the City has the economic resources to sustainably resolve these three issues], because **the City hasn't published a public independent audit that's up to date. It's very hard to track what funds the city has available, and what they can be used for** as a resident. You have to be an insider to be able to answer that question. I think that **we need local solutions, and there may be Federal funds**, and I think that there are, when it comes to housing. We know there are [Federal] HOME dollars available. There are CDBG [community development block grant] dollars available that we can leverage. We can and should be leveraging those things. **A local municipality's [city government's] role is to access those funds and deploy them** for use in these kinds of projects. But I think that we need to have local solutions that are potentially funded with assistance from elsewhere. In addition to [being funded] locally.
5. "**Many [city] departments are going to need to be involved [to sustainably resolve these three issues]**. You don't think of the Parks Department as being involved in mental health, or substance use. Most people don't, but I understand that they are involved. I think if you were to make the mistake of pigeon-holing it into one department, you would not get the comprehensive approach that we really need as a community. **What you are asking about, frankly, are several components of social determinants of health.** And we have learned over the past decade-plus that **you can't expect a Health Department to deal with all of the social determinants of health. If you shoe-horn it there, you're going to get doctors and nurses that are trying to solve housing issues [and] that's not where they're solved**. **If we create a priority in the city that these three issues are the core issues. We may need a position that helps coordinate that work and navigate the intersectionality of it all to ensure that our plan stays. Our plan first of all gets written, but then stays on track. But I think, it has to be very strategic.** But if you pigeonhole it into one department rather than **engaging**

your whole city team, or at least your city leadership team, then we will certainly leave out assets that we could be bringing to the table. "

6. "Well, we have already a team working at **Heading Home**. And there's also the **South Central Indiana Housing Network**. They are working on housing. I would like a team that's sort of similar to the Stride coalition that used to exist to come back to the table to at least look at in a comprehensive way mental health and substance use disorder. That was a team of tens of different organizations and community leaders that came together, and the main output of that work was the Stride Center. They had mental health providers from **Centerstone**. We had the **Indiana Recovery Alliance, Health Net, IU Health** was there, we had **all kinds of health providers and housing providers**, all through the spectrum [of public safety], the **police chief** came. The **sheriff's office** usually sent somebody. I was there from the [REDACTED]. There were lots of people involved in that coalition. We may not need it to be as broad but frankly, it was a really good team. "
7. "**If we really want to look at how we're solving [these three issues of lack of housing, mental healthcare and drug treatment] as a city, we need some transparency in our finances to understand where we might be able to go**. We have a shortage of police and firefighters, and part of their problem is that they're not being paid highly enough. That may or may not be solvable. And without the public audits, we just don't know. I think **that piece is really key. If we want our commissions to be empowered to solve these issues. We have to know what [economic resources] we're working with**. "
8. "How we do government is my number one [campaign issue], and then housing and **public safety, especially as it pertains to substance use, and mental health**. "

Political Stakeholder B

This political stakeholder did not reply to our requests to approve the direct quotes from their outreach in time to be included in this Report.

Political Stakeholder C

This political stakeholder preferred that the direct quotes from their outreach with our Special Committee not be included in this Report.

Passed:

CAPS Commission Members:

Community Advisory on Public Safety Commission Resolution 23-01:
Protection of LGBTQ Rights & Freedom

Community Advisory on Public Safety Commission Resolution 23-01 expresses concern of the Community Advisory on Public Safety Commission over the slate of legislation passed during the 2023 Session of the Indiana General Assembly restricting the rights of transgender youth, their families, their medical providers, and their educators.

WHEREAS, the Indiana General Assembly (IGA) has passed and Indiana Governor Eric Holcomb has signed into law several bills within the 2023 Session that restrict or infringe on the rights of transgender youth; and

WHEREAS, on April 5, 2023, Indiana Governor Eric Holcomb signed into law Senate Bill 480 (S.B. 480), which bans gender-affirming medical care for all minors under the age of eighteen within the State of Indiana; and

WHEREAS, on May 4, 2023, Indiana Governor Eric Holcomb signed into law House Bill 1608 (H.B. 1608), which bans instruction on human sexuality in public schools from kindergarten through the third grade and requires public school educators to notify the parents of a student who requests to go by a different name or pronoun of this change; and

WHEREAS, on May 4, 2023, Governor Holcomb signed into law House Bill 1447 (H.B. 1407), which opens public school educators to liability for disseminating educational materials alleged to be harmful to minors; and

WHEREAS, in response to H.B. 1608 and H.B. 1447, the Community Advisory on Public Safety Commission recommends the City of Bloomington (City) foster a welcoming and safe environment for transgender youth in schools and honor the decisions of public school educators to develop curricula without fear of liability from state-sanctioned punishment of speech; and

WHEREAS, according to the American Civil Liberties Union of Indiana (ACLU Indiana), the effect of these laws is to censor books and educational topics by and about LGBT people and other marginalized groups, which has a chilling effect on the availability of educational materials for students[1]; and

WHEREAS, the American Civil Liberties Union of Indiana filed a lawsuit[2] on June 9, 2023, seeking a declaration that H.B. 1608 is unconstitutional and an injunction against its enforcement because it is, according to ACLU Indiana, unconstitutionally overbroad, to the point where educators will not be able to determine what can and cannot be said to students, and it infringes on constitutional First Amendment rights of educators to express themselves as private citizens outside of the classroom[3]; and

WHEREAS, according to ACLU Indiana, H.B. 1608 also requires teachers to forcibly "out" students who wish to go by a different name or pronoun by sending a note home to their parents or guardians, which increases the risk of parental rejection and negative emotional well-being when students do not feel ready or safe to come out at home[4]; and

WHEREAS, such forced disclosures will make school become yet another "closet" for transgender and gender diverse youth who may not ever feel safe enough to explore their identities when there is no longer any safe space at school to do so; and

WHEREAS, it is necessary and appropriate to exercise the authority vested within the City to protect public school educators lawfully engaged in developing meaningful and effective coursework for students within the municipality, and to protect gender diverse students within the municipality from forced disclosures that could negatively impact their well-being; and

WHEREAS, in response to S.B. 480, the Community Advisory on Public Safety Commission recommends the City honor the rights of transgender youth, their parents or guardians, and their medical providers to make well-informed medical decisions without government interference; and

WHEREAS, access to medical transition and hormone blockers has been known to significantly decrease the risk of suicide in populations of transgender youth ages 13-20, including 60% lower odds of moderate or severe depression and 73% lower odds of suicidality over a 12-month follow-up[5]; and

WHEREAS, according to the Human Rights Campaign, as of March of 2023, more than half of transgender youth ages 13-17 in the United States have lost or are at risk of losing access to life-saving gender-affirming medical care[6]; and

WHEREAS, as of June of 2023, at least twenty states have passed bills restricting or criminalizing access to gender-affirming healthcare, five of which make it a felony crime to provide best practice medical care for transgender youth[7]; and

WHEREAS, Indiana joined this list on April 5, 2023 by the passage of S.B. 480, which prohibits health care practitioners from providing any types of medical gender-affirming healthcare to minors under the age of eighteen, including cross-sex hormones and puberty blockers, even with parental consent; and

WHEREAS, under S.B. 480, health care practitioners who assist another health care practitioner in providing gender-affirming care to a minor violate the standards of practice for health care professions and can be subject to discipline under their respective health care profession board; and

WHEREAS, S.B. 480 creates a private cause of action for a minor or their parent or guardian against a health care professional who provided or assisted another health care professional in providing the minor with gender-affirming care; and

WHEREAS, S.B. 480 does not provide exemptions for Hoosier transgender youth currently being prescribed gender-affirming medical care, and the bill gives transgender youth until the end of this year to receive care until it is prohibited across the board; and

WHEREAS, under the mandate of S.B. 480, Hoosier transgender youth who have previously been prescribed puberty blockers or cross-sex hormones with parental consent will, by January of 2024, be required to detransition (reverse, or go through the puberty that does not align with their preferred gender identity) or move out of state in order to continue receiving a continuum of gender-affirming medical care; and

WHEREAS, the vast majority of major medical organizations support gender-affirming care in populations of transgender youth, including the American Academy of Pediatrics[8], Endocrine Society[9] and Pediatric Endocrine Society[10], American Medical Association[11], American Psychiatric Association[12], and American Academy of Child and Adolescent Psychiatry[13]; and

WHEREAS, national and international guidance exists on age-appropriate treatments for transgender youth, including suppression of puberty in prepubescent adolescents and cross-sex hormone treatment in youth of at least sixteen years of age[14]; and

WHEREAS, because the risk of depression and suicide among transgender youth decreases as access to gender-affirming medical care increases[15], transgender youth depression and suicide rates will increase with state-legislated forced detransition and assigned-sex puberty that must legally occur until the patient can access or re-access gender-affirming care at the age of eighteen; and

WHEREAS, while policy rationales behind state-legislated gender-affirming care bans concern protecting minors from making semi-irreversible decisions that they may later come to regret, gender-affirming care is statistically associated with low levels of regret[16] and blanket gender-affirming care bans will not protect transgender minors from undergoing semi-irreversible changes that they may later regret, notably a forced puberty that does not align with their known experience of gender identity;

WHEREAS, medical doctors, minor patients, their consenting parents or guardians, and all other health care professionals who provide or assist in providing gender-affirming medical care enjoy a basic right to privacy and a confidential relationship between patient and physician that should protect them from criminal punishment, civil liability, administrative penalty, or any professional sanction related to decisions made within the healthcare provider-patient relationship so long as those decisions occur without coercion, force, or negligence; and

WHEREAS, the American Civil Liberties Union of Indiana filed a class action lawsuit[17] on April 5, 2023, alleging violations of U.S. constitutional rights, including Equal Protection, and federal law, including the Medicaid Act and Affordable Care Act and seeking injunctive relief against enforcement of S.B. 480[18]; and

WHEREAS, the U.S. District Court for the Southern District of Indiana granted the Plaintiffs in the case a partial preliminary injunction on June 16, 2023, blocking the effect of S.B. 480 during the pendency of litigation as it applies to minors seeking gender affirming care (but not surgeries), and speech that would “aid or abet” the provision of gender affirming care to a minor[19]; and

WHEREAS, the preliminary injunction will remain in effect until the case is fully litigated, which could take several months, if not longer; and

WHEREAS, while the litigation in this case is pending, it is important for the City to declare itself a safe haven for its LGBTQ+ youth; and

WHEREAS, the Council for Kansas City, Missouri declared, by Resolution No. 230385[20], the municipality to be a Safe Haven for Gender-Affirming Healthcare in the wake of proposed but not yet passed executive and legislative initiatives to ban gender-affirming medical care; and

WHEREAS, the Council for Kansas City adopted a Gender-Affirming Healthcare Policy which declared, within the extent of what is required by law within its jurisdiction, that the municipality would make enforcement of any state-sanctioned ban on gender-affirming care the lowest priority, including the enforcement of penalties, other jurisdictions’ laws and requests for information, and collection of any judgment; and

WHEREAS, the City of Bloomington should follow this model of adopting a policy that declares the City a Safe Haven for transgender youth, their parents or guardians, treating healthcare professionals, and educators within the municipality to the extent permissible by state and federal law; and

WHEREAS, the City has a responsibility to protect its residents from violations of their human rights and any criminalization of the free exercise thereof;

NOW, THEREFORE, BE IT RESOLVED BY THE COMMUNITY ADVISORY ON PUBLIC SAFETY COMMISSION THAT THE FOLLOWING POLICIES AND ACTIONS BE RECOMMENDED TO THE MAYOR AND COMMON COUNCIL FOR ADOPTION BY THE CITY:

Section 1. That the City of Bloomington formally condemns any action intended to abrogate the fundamental liberties of its people and affirms its commitment to protecting the right of its residents to make private health decisions regarding gender-affirming care.

Section 2. That the City of Bloomington formally condemns any action intended to ban and censor educational materials about marginalized groups in schools within the municipality, as well as any action intended to make schools within the municipality a less safe space for transgender and otherwise gender diverse students to exist as their authentic selves without fear.

Section 3. That the Mayor and Common Council declare the City of Bloomington a Safe Haven for Transgender Youth and adopt a policy or policies consistent with the principles set forth above.

PASSED by the Community Advisory on Public Safety Commission of the City of Bloomington, Monroe County, Indiana, this ___ day of ________________, 2023.

______________________________ Co-Chairs, Community Advisory on Public Safety Commission

Synopsis:

This Community Advisory on Public Safety Commission Resolution asks the City of Bloomington Common Council and the Mayor to declare the City a Safe Haven for Transgender Youth in response to recent state legislation that bans gender-affirming health care for minors, restricts educational materials with LGBTQ+ themes in municipal schools, and requires parental notification of nomenclature and pronoun change requests from students in municipal schools. The Commission asks the City to create a policy or policies consistent with the principles set forth in the resolution.

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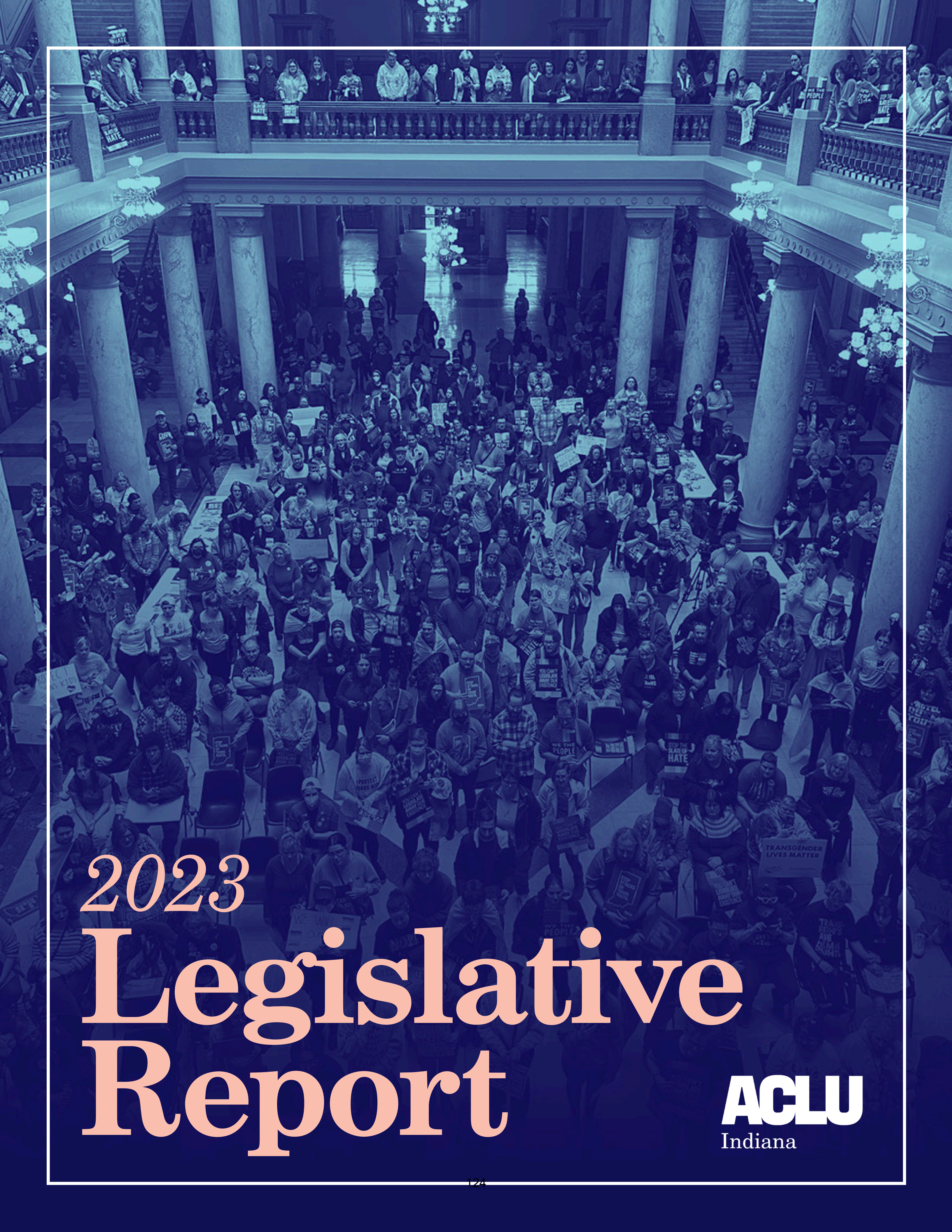


2023 Legislative Report

ACLU
Indiana

A NOTE FROM OUR DIRECTOR OF ADVOCACY & PUBLIC POLICY, KATIE BLAIR

Katie Blair (she/her)
Director of Advocacy and Public Policy,
ACLU of Indiana

The 2023 legislative session will go down in Indiana's history as a session fraught with hate and misinformation. But it can also be remembered as a session where Hoosiers from every corner of our state **showed up like never before** to support their rights, and the rights of their neighbors.

ACLU of Indiana supporters sent more than 78,000 messages to their elected officials to speak up against bills that threaten our rights and freedoms. To put that in perspective, that is nearly **three times** the number of messages sent last year!

But I won't sugar coat it, this session was hard. More than 20 bills were filed that **targeted LGBTQ Hoosiers** and singled out trans kids. The rhetoric surrounding this legislation was not grounded in reality. It was propped up by cherry-picked studies, fringe "experts," a handful of political operatives from outside of Indiana, and fearmongering.

And while three of those bills passed, **the ACLU of Indiana is not done fighting,** and neither are our supporters. Read more below about the bills we defeated, the bills that passed, and how we will continue to make an impact.

BY THE NUMBERS

78,000+
MESSAGES SENT TO LEGISLATORS

18,000+
HOOSIERS TOOK ACTION

264
BILLS TRACKED

16
BILLS SUPPORTED BY ACLU

24
BILLS OPPOSED BY ACLU

80
DAYS IN SESSION

1,250+
ACLU SUPPORTERS RALLIED AT THE STATEHOUSE

SLATE OF HATE

Protecting LGBTQ Rights at the Statehouse

This year, Indiana legislators launched an **unprecedented attack on LGBTQ Hoosiers.** More than 20 bills introduced were part of a coordinated, hate-driven campaign to push LGBTQ people, particularly trans youth, out of public life.

Many of these bills were offered under the guise of "protecting parental rights," but parents who support their LGBTQ kids are **having their rights stripped away.**

Whether it's a parent's right to access gender-affirming care for their kid, or to request a teacher refer to their child by the name and pronouns aligned with that child's gender identity — these anti-LGBTQ bills only aimed to protect parents whose ideologies align with certain politicians and out-of-state extremists.

GENDER AFFIRMING CARE

WE'RE SUING!

Every reputable medical organization has found that some transgender people need gender affirming care, which is often life-saving medical care. The courts have agreed, finding gender dysphoria to be a serious medical issue, requiring appropriate treatment. A dangerous bill passed by the Indiana legislature, SB 480 **prohibits families and doctors from providing age-appropriate, evidence-based care** for youth who require it.

Despite intense opposition from families of trans youth here in Indiana, as well as warnings from medical professionals, some lawmakers chose to **risk the lives of young people** by forcing their way into family decision-making, a fundamental right which has traditionally been protected against government intrusion.

Young people who are trans need support and affirmation, not to be a political target. Just hours after SB 480 passed, the **ACLU of Indiana filed a lawsuit** on behalf of four families and a medical provider, and remains dedicated to overturning this blatantly unconstitutional law in court.

HB 1569 is another gender-affirming care ban that denies access to care for people housed in the Department of Correction simply on the basis that they are transgender. This will **deny necessary medical care** that the State is required to provide, and we will do everything in our power to defeat this blatantly unconstitutional law.

Photo: AJ Mast

RIGHT TO LEARN

Multiple bills introduced in the 2023 session attempted to control what youth can and cannot read, what they can and cannot learn, and—**most troublingly**—who they can and cannot be. HB 1608 is an atrocious "don't say gay" bill that bans conversation about "human sexuality" in public schools, an undefined term which could be used to broadly censor discussions about sexual orientation and gender identity in pre-K through third grade. This bill also **forces teachers to out students** who request to be referred to by a different name or pronoun, by sending a note home to parents.

More than 13,000 Hoosiers spoke out against this bill, and while it still passed, **several amendments were made to lessen the blow.** In its original form, HB 1608 banned teachers from using the correct pronouns and names of trans kinds without their parent's permission. Now, while a school administrator must notify a parent of the request, teachers do not have to gain consent from a parent to use the student's requested pronouns and name. In addition, if a parent wished for a school to affirm their child's gender identity, pronouns, and changed name they could only make that request once a year but that request could be ignored by school staff. That language was also eliminated from the bill.

ACLU of Indiana attorneys are assessing this law and we will do everything in our power to protect the rights of LGBTQ students.

In another attempt to filter LGBTQ content from schools, SB 12 was a book banning bill that died in the House, but was resurrected within the last two days of session. Legislators quickly and quietly amended and passed HB 1447, which will strip away protections for material that is disseminated for educational purposes and **opens schools, teachers, and librarians up to penalties if a parent disagrees with any part of material available in a school library.**

As we have seen across the country, when books are censored, it is mostly books by and about LGBTQ people, people of color, and other marginalized groups that are the first to be banned. Students have a right to learn about all types of people and histories. This bill will have **a chilling effect on the availability of books** for students to read and explore.

PROTECTING TRANS YOUTH

VICTORY!

HB 1407 **would have made it illegal** for child services to consider failure to provide a safe and affirming environment to a trans youth when looking into abusive home environments. Like all the bills that were part of the Slate of Hate, this bill attempted to capitalize on unfounded public fear that parents will be "forced to accept" trans youth. There simply aren't examples of Indiana agencies removing children from homes for the sole reason that parents didn't provide trans-supportive care.

* = Photos by Lee Klafczynski + = Photos by AJ Mast

CRIMINAL LEGAL REFORM

ELIMINATION OF COSTS AND FEES IN JUVENILE COURTS

VICTORY!

Too often in our criminal legal system, Hoosiers are faced with the burden of excessive fines and fees. HB 1493 will ensure that **parents do not have to pay for the defense of their child** in juvenile court unless the judge finds that they are financially able to.

NONCOMPLIANT PROSECUTORS

DEFEATED!

Prosecutors have the power to flood jails and prisons and deepen racial disparities with the stroke of a pen. **But they can also use their legal discretion to do the opposite.** Every year, Indiana legislators attempt to stop prosecutors who use their power to reduce racial and economic inequalities in the criminal legal system. SB 284 would not only have undermined the prosecutor's authority but also the voter's power to hold county prosecutors accountable. SB 284 died in the House.

LIMITATION ON RIGHT TO BAIL

Originally, bail was supposed to make sure people return to court to face charges against them. But instead, the money bail system has morphed into widespread wealth-based incarceration. SJR 1 seeks to amend the Constitution of the State of Indiana to add language that would **eliminate access to bail** for someone deemed a "risk to society," while failing to fix the broken cash bail system. All this bill does is ensure that **even more people stay behind bars,** languishing in Indiana's overcrowded jails.

This is the first step of a multi-year process to amend the State Constitution, and we will continue working with legislators to push for reform that will limit pretrial detention to the rare case where a person poses a serious, clear threat to another person.

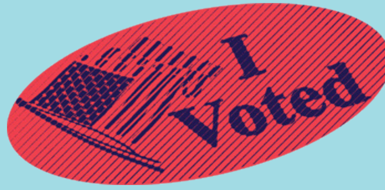
POLICING

Over the last several years, Indiana communities have increasingly called for more police accountability and transparency. In blatant disregard to those requests, Indiana legislators passed HB 1186 which would **make it a crime** for a person to come within 25 feet of a police officer performing duties if the person is told by the officer to move away. While this bill does not mention recording, it is clear that this threatens a citizen's ability to observe and record police interactions in their communities.

Whether it's at a rally, a traffic stop, or during a police response to a mental health crisis, **community members cannot hold police officers accountable if they cannot observe what is going on.** The ACLU of Indiana testified in opposition to this bill and will continue our work within Indiana communities to hold police accountable.

VOTING RIGHTS

ABSENTEE VOTING RESTRICTIONS



We owe it to Hoosiers to eliminate barriers to the ballot box, but year after year, some Indiana legislators attempt to pass legislation that pushes voting access out of reach. HB 1334 adds **unnecessary rules to the absentee voting process** that will lead to confusion and greater difficulties for Hoosiers attempting to vote absentee, ultimately increasing the risk of voter disenfranchisement. HB 1334 has been signed into law, and as a result, absentee voters will be required to provide an extra layer of identification on their absentee ballot application this November. In addition, applications will no longer be able to be sent out without a request or by an assisted living or nursing home employee for their residents.

VOTING RIGHTS FOR PEOPLE WHO WERE PREVIOUSLY INCARCERATED

VICTORY!

A section of HB 1116 would have denied suffrage to a person convicted of felony voter fraud for 10 years following the date of their conviction. The restoration of the right to vote upon release back into the community gives individuals an opportunity for reengagement and a chance to be full members of our democracy. **HB 1116 was defeated, and these voting rights remain intact.**

MISSED OPPORTUNITIES

IN-STATE TUITION

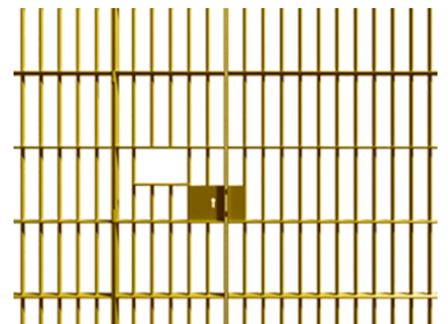
Two bills, HB 1043 and SB 135, were introduced to allow undocumented Hoosier students who attended high school, graduated from a public school in Indiana and have a pending DACA case to pay in-state tuition at Indiana's public colleges and universities. 92,000 undocumented immigrants call Indiana home and 60% have lived in Indiana over 10 years. Bills recognizing the value that these young people bring to our state are introduced every year. But this year, some progress was made. SB 135 received a committee hearing. We are hopeful that legislators will take the important next step toward equality next session and pass in-state tuition for these young Hoosiers.

MARIJUANA DECRIMINALIZATION

For the first time ever, Indiana legislators heard a bill that would decriminalize marijuana in our state. The enforcement of marijuana laws generates some of the justice system's starkest racial disparities. In Indiana, Black people are more than 3.5 times more likely than white people to be arrested for marijuana possession. We are glad the Indiana General Assembly took a step by giving this legislation a hearing, but we hope next session they will move forward and pass marijuana legalization bills that prioritize racial justice and equity.

SENTENCE MODIFICATION

As we see all too often in Indiana, jail overcrowding inherently leads to conditions that the Supreme Court has found unconstitutional, as well as serious health and safety concerns. HB 1648 would have created a system of medical and geriatric reprieve to support safe, evidence-based pathways to release for the elderly and those with terminal, costly, life-hampering or life-threatening medical conditions. We will continue to support legislation that aims to reduce overreliance on the mass incarceration system.



ACLU
Indiana

2023 LEGISLATIVE SCORECARD

The ACLU of Indiana works hard to keep Hoosiers informed on key issues at the Statehouse and legislative votes on civil liberties. We constantly seek ways to hold politicians accountable to protecting your rights and supporting public policy that creates a more just and equitable state for all Hoosiers.

Within the 80 days of the 2023 legislative session, we tracked a variety of bills that would have advanced or threatened civil liberties in our state. We the People can use this information to hold our elected officials accountable. A number of key civil liberty issues arose this session and we fought with our activists to ensure the protection of Hoosiers' rights at every turn.

As you know, direct communication with your elected officials is a valuable way to encourage them to stand up for freedom and protect civil liberties. We encourage you to use this scorecard to give your legislators feedback on their votes in the 2023 legislative session and their stances on the issues impacting your rights and freedom.

ABOUT THIS SCORECARD

HOW WE CHOSE THE SCORED BILLS

We make sure legislators know the ACLU's position on important civil liberties issues prior to voting. We then select a range of key civil liberties votes by the full House or Senate to include in our scorecard. The following votes cover a range of issues facing Hoosiers today.

PURPOSE OF THE SCORECARD

The purpose of this scorecard is to inform our supporters and the public of where their legislators stand on civil liberties issues. Legislators may promise many things while running for office, but there is no substitute for an actual vote. The scorecard is in no way meant to be construed as an endorsement of legislators who score well, or a statement of opposition against those who do not.

ADDITIONAL NOTE

The lifecycle of any given bill may have several rounds of votes. The most recent vote is recorded in this scorecard and represents how each state senator and state representative last voted. To research all legislative votes on a bill, visit www.iga.in.gov, and search for legislation by its bill number.

1 HB 1608: “DON’T SAY GAY” & FORCING OUTING

This bill would effectively ban discussion or acknowledgment of LGBTQ people in schools under the guise of banning conversations around “human sexuality.” This language is incredibly vague and would chill discussions around sexual orientation and gender identity in grades Pre K-3. This bill would also force teachers to out students who request to be referred to by a different name or pronoun. These types of forced outing bills expose youth to the threat of additional violence at school and at home.

ACLU OPPOSED

2 SB 480: GENDER AFFIRMING CARE BAN

This bill would prohibit families and doctors from providing age-appropriate, evidence-based care for youth who require it. By banning nearly all forms of gender affirming care available to trans youth, this bill would forcibly deprive some youth of life-saving care that they are already receiving. Bills such as these violate the rights of parents and families to make decisions about their children’s health.

ACLU OPPOSED

3 HB 1186: ENCROACHMENT ON AN INVESTIGATION

This bill would make it a crime for a person to come within 25 feet of a police officer performing duties if the person is told by the officer to move away. Whether it’s at a rally, a traffic stop, or during a police response to a mental health crisis, community members cannot hold police officers accountable if they cannot observe what is going on. The overbroad nature of this bill also makes it ripe for abuse and misinterpretation.

ACLU OPPOSED

4 SJR 1: LIMITATION ON RIGHT TO BAIL

SJR 1 seeks to amend the Indiana Constitution to add language that eliminates access to bail for someone deemed a “risk to society.” While the ACLU of Indiana is opposed to the cash bail system, this bill only ensures that even more people stay behind bars, languishing in Indiana’s overcrowded jails. Opening up the right to bail more broadly to a judge’s discretion will only further increase the risk of bias, continuing to enforce racial disparities in the criminal legal system.

ACLU OPPOSED

5 HB 1334: ABSENTEE VOTING RESTRICTIONS

This bill would require absentee voters to provide an extra layer of identification on their ballot application. That proof of ID could be in the form of a photocopy of a driver’s license or state-issued ID, or the written-out digits of various types of identification numbers. House Bill 1334 would require the voter or a family member to request an application. Applications could no longer be sent out without a request or by an assisted living or nursing home employee for their residents.

ACLU OPPOSED

2023 LEGISLATIVE SCORECARD

Fields with Liberty Torch voted with the ACLU

Fields left blank opposed the ACLU

Fields with the letter "A" indicate absent or no vote

1 HB 1608: "Don't Say Gay" and Forced Outing

2 SB 480: Gender Affirming Care Ban

3 HB 1186: Encroachment on an Investigation

4 SJR 1: Limitation on Right to Bail

5 HB 1334: Absentee Voting Restrictions

	SENATE	1	2	3	4	5
R	Alexander, Scott					
R	Alting, Ron	✓	✓			
R	Baldwin, Scott					
R	Bassler, Eric	✓		A	✓	✓
R	Becker, Vaneta	✓	✓		✓	✓
R	Bohacek, Mike					
R	Bray, Rodric					
D	Breaux, Jean	✓	A	✓	✓	✓
R	Brown, Liz					
R	Buchanan, Brian					
R	Buck, Jim					
R	Busch, Justin					
R	Byrne, Gary					
R	Charbonneau, Ed			A		
R	Crane, John					
R	Crider, Michael					
R	Deery, Spencer					
R	Dernulc, Dan					
R	Donato, Stacey					
R	Doriot, Blake					
D	Ford, J.D.	✓	✓	✓	✓	✓
R	Ford, Jon					
R	Freeman, Aaron					
R	Garten, Chris			A		
R	Gaskill, Mike			A		
R	Glick, Sue				✓	
R	Holdman, Travis			A		
D	Hunley, Andrea	✓	✓	A	✓	✓
R	Johnson, Tyler					

	SENATE	1	2	3	4	5
R	Koch, Eric					
R	Leising, Jean					
D	Melton, Eddie	✓	✓	✓	✓	A
R	Messmer, Mark					
R	Mishler, Ryan		A	A		A
R	Niemeyer, Rick					
D	Niezgodski, David	✓	✓	✓	✓	✓
R	Perfect, Chip			A	✓	
D	Pol, Rodney	✓	✓	✓	✓	✓
D	Qaddoura, Fady	✓	✓	✓	✓	✓
R	Raatz, Jeff					
D	Randolph, Lonnie	A	✓	✓	A	✓
R	Rogers, Linda					
R	Sandlin, Jack					
D	Taylor, Greg	✓	✓	✓	✓	✓
R	Tomes, James				✓	
R	Walker, Greg				✓	✓
R	Walker, Kyle		✓			
D	Yoder, Shelli	✓	✓	✓	✓	✓
R	Young, Michael			✓		
R	Zay, Andy					

	HOUSE	1	2	3	4	5
R	Abbott, David	A				
D	Andrade, Mike	✓	✓			✓
R	Aylesworth, Mike					
R	Baird, Beau					A
R	Barrett, Brad					
R	Bartels, Stephen					
D	Bartlett, John	A	A	✓	✓	A
D	Bauer, Maureen	✓	✓		✓	✓
R	Behning, Bob				A	
R	Borders, Bruce					
D	Boy, Pat	✓	✓		✓	✓
D	Campbell, Chris	✓	✓	A	✓	✓
R	Carbaugh, Martin					
R	Cash, Becky					
R	Cherry, Bob	A				
R	Clere, Ed	✓	✓			
R	Criswell, Cory					
R	Culp, Kendell					
R	Davis, Michelle					
D	DeLaney, Ed	✓	✓			✓
D	Dvorak, Ryan	✓	✓	✓		✓
R	DeVon, Dale					
R	Engleman, Karen					
D	Errington, Sue	✓	✓			✓
D	Fleming, Rita	✓	✓		A	✓
R	Frye, Randall				A	
D	Garcia Wilburn, Victoria	✓	✓		A	✓
R	Genda, Mark					
D	GiaQuinta, Phil	✓	✓	✓	✓	✓
R	Goodrich, Chuck					
D	Gore, Mitch	✓	✓			✓
R	Greene, Robb					
R	Haggard, Craig					
R	Hall, Dave					
D	Hamilton, Carey	✓	✓	✓		✓

	HOUSE	1	2	3	4	5
D	Harris Jr., Earl	✓	✓	✓	✓	✓
D	Hatcher, Ragen	A	✓	✓	✓	A
D	Hatfield, Ryan	✓	✓	✓		✓
R	Heaton, Bob					
R	Heine, Dave					
R	Hostettler, Matt			✓	✓	
R	Huston, Todd	A	A	A	A	A
D	Jackson, Carolyn	✓	✓	✓	✓	✓
R	Jeter, Chris					
D	Johnson, Blake	✓	✓			✓
R	Jordan, Jack					
R	Judy, Christopher			A		
R	Karickhoff, Michael					A
R	King, Joanna	A				A
D	Klinker, Sheila	✓	✓			✓
R	Lauer, Ryan					
R	Ledbetter, Cindy					
R	Lehman, Matt					
R	Lindauer, Shane					
R	Lucas, Jim			✓	✓	
R	Lyness, Randy					
R	Manning, Ethan					
R	May, Christopher					
R	Mayfield, Peggy					
R	McGuire, Julie				A	
R	McNamara, Wendy					
R	Meltzer, Jennifer					
R	Miller, Doug					
D	Miller, Kyle	✓	✓	✓	✓	✓
D	Moed, Justin	✓	✓			✓
R	Morris, Bob				A	
R	Morrison, Alan					
D	Moseley, Chuck	✓	✓	✓	A	✓
R	Negele, Sharon		A		A	
R	O'Brien, Tim					

	HOUSE	1	2	3	4	5
R	Olthoff, Julie					
D	Pack, Renee	✓	✓	✓	✓	✓
R	Patterson, Lindsay					A
R	Payne, Zach			✓	✓	
D	Pfaff, Tonya	✓	✓	✓		✓
R	Pierce, Kyle					
D	Pierce, Matt	✓	✓		✓	✓
D	Porter, Gregory	✓	✓	✓	✓	✓
R	Prescott, J.D.					
R	Pressel, Jim					
D	Pryor, Cherrish	✓	✓	✓	✓	✓
R	Rowray, Elizabeth				A	
R	Schaibley, Donna					
D	Shackleford, Robin	✓	A	✓	✓	✓
R	Slager, Hal					
R	Smaltz, Ben					
D	Smith, Vernon	✓	✓	✓	✓	✓
R	Snow, Craig					
R	Soliday, Ed					A
R	Speedy, Mike					
R	Steuerwald, Gregory					
D	Summers, Vanessa	✓	✓	✓	✓	✓
R	Sweet, Lorissa					
R	Teshka, Jake			A		
R	Thompson, Jeffrey					
R	Torr, Jerry		✓			
R	VanNatter, Heath					
R	Vermilion, Ann		A			
R	Wesco, Timothy				A	
R	Zent, Denny			A		

Healthcare Laws and Policies:
Bans on Best Practice Medical Care for Transgender Youth

No updates required since July 3, 2023

What's in this document (click to jump to that section):

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Background

Bans on best-practice medical care represent one of the most extreme and coordinated political attacks on transgender people in recent years. These bills target transgender youth by blocking their access to best-practice medical care, care that is backed by decades of rigorous research and endorsed by the American Academy of Pediatrics, the American Medical Association, and every leading health authority in the country. These bills not only display a fundamental lack of understanding of transgender children, but they also ban access to medical care often by criminalizing either the doctors or even the parents of transgender youth seeking to provide best-practice medicine for children in their care.

Equality Map & Additional Resources

- See our Equality Map: Bans on Best Practice Medical Care for Transgender Youth, which is updated and maintained in real time alongside this document.

- For more on these attacks, including how these bills are becoming more extreme over time and expanding to include transgender adults' access to health care, read MAP's 2023 spotlight report.

- For more information about "shield" or "refuge" laws that protect transgender people's access to healthcare, see our Equality Map: Transgender Healthcare "Shield" Laws (updated and maintained in real time) and its corresponding citation sheet, which contains additional state-by-state information, links, and analysis.

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Summary Tables

Table 1: Legislation/Regulations and Exceptions

Category	Number	List	Source Link	Exceptions
States that ban medically necessary surgery and medication for transgender youth	19 states	Alabama	SB184	-
		Arkansas	HB1570 (2021) SB199 (2023)	- -
		Florida	Admin. Code 64B8-9.019 SB254	Grandfather Grandfather, with rules TBD
		Georgia	SB140	Grandfather
		Idaho	HB71	-
		Indiana	SB480	Weaning
		Iowa	SF538	-
		Kentucky	SB150	Weaning
		Mississippi	HB1125	-
		Missouri	SB49	Grandfather; Ban will expire in 4 years
		Montana	SB99	-
		Nebraska	LB574	Grandfather
		North Dakota	HB1254	Grandfather
		Oklahoma	SB613	Weaning
		South Dakota	HB1080	Weaning
		Tennessee	SB1/HB1	Weaning
		Texas	SB14	Weaning
		Utah	SB16	Grandfather
		West Virginia	HB2007	New Rx allowed under restrictive conditions
States that ban surgery only	1 state	Arizona	SB1138	-
States with no bans or restrictions	30 states, D.C., and 5 territories	All others		

"Grandfather" exceptions refer to those that allow minors currently receiving prescriptions to continue that care, typically (though not always) so long as that prescription begins before the effective date of the bill.

"Weaning" exceptions refer to those that allow minors currently receiving prescriptions to continue that care, but only for a limited amount of time with the expectation they will "wean off" the prescribed medication.

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Table 2: Enactment vs. Effective Dates, Age Applicability, and Lawsuits

State *(bill linked)*	**Enactment date** *(date of governor signature, veto override, or administrative filing)*	**Planned effective date** *(ban may not go into effect on this date due to lawsuits)*	**Age applicability** *(does not reflect state funding (e.g., Medicaid) or other provisions)*	**Lawsuit**	**Notes on lawsuit status** *(see state-by-state section below for more detail)*
Alabama	April 8, 2022	30 days later	<19	*Walker et al v. Marshall et al* (2022), joined by federal Department of Justice	Temporarily blocked by court order. Block applies to ban on medication, but not ban on surgical care or other provisions (e.g., forced outing).
Arizona	March 30, 2022	March 31, 2023	<18	ACLU of Arizona and NCLR have stated they will sue	
Arkansas	April 6, 2021 (overriding governor's veto)	90 days after legislature adjourned	<18	*Brandt et al v. Rutledge et al* (2021)	Permanently blocked as of June 2023, though the state is appealing the ruling.
Florida (Board of Medicine regulation)	February 24, 2023	March 16, 2023	<18	*Doe v. Ladapo* (2023)	Temporarily blocked by court order
Florida (legislation)	May 17, 2023	May 17, 2023	<18* *with provisions obstructing access to adult care	*Doe v. Ladapo* (2023)	Temporarily blocked by court order
Georgia	March 23, 2023	July 1, 2023	<18	*Koe v. Noggle* (2023)	Filed
Idaho	April 4, 2023	January 1, 2024	<18	*Poe v. Labrador* (2023)	Filed
Indiana	April 5, 2023	July 1, 2023	<18	*K.C. et al. v. Individual Members of the Medical Licensing Board et al* (2023)	Temporarily blocked by court order. Block applies to ban on medication and "aiding and abetting," but not ban on surgical care.
Iowa	March 22, 2023	March 22, 2023	<18		
Kentucky	March 29, 2023 (overriding governor's veto)	June 29, 2023	<18	*Doe v. Thornbury* (2023)	Temporarily blocked by court order
Mississippi	February 28, 2023	February 28, 2023	<18		

(Table continued on next page)

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(Table continued from previous page)

State *(bill linked)*	**Enactment date** *(date of governor signature, veto override, or administrative filing)*	**Planned effective date** *(ban may not go into effect on this date due to lawsuits)*	**Age applicability** *(does not reflect state funding (e.g., Medicaid) or other provisions)*	**Lawsuit**	**Notes on lawsuit status** *(see state-by-state section below for more detail)*
Missouri	June 7, 2023	August 28, 2023	<18		A related lawsuit, *Southampton Community Healthcare et al. v. Bailey* (2023), earned a temporary block on the attorney general's earlier attempted ban, which he then terminated.
Montana	April 28, 2023	October 1, 2023	<18	*van Garderen v. State of Montana* (2023)	Filed
Nebraska	May 22, 2023	October 1, 2023	<19	*Planned Parenthood of the Heartland v. Hilgers et al* (2023)	Filed
North Dakota	April 19, 2023	April 19, 2023	<18		
Oklahoma	May 1, 2023	May 1, 2023	<18	*Poe et al. v. Drummond et al* (2023)	State's attorney general has signed a binding agreement to not enforce the law during the ongoing lawsuit.
South Dakota	February 14, 2023	July 1, 2023	<18		
Tennessee	March 2, 2023	July 1, 2023	<18	*L.W. et al. v. Skrmetti et al* (2023), joined by federal Department of Justice	Temporarily blocked by court order. Block applies to ban on medication, but not ban on surgical care.
Texas	June 2, 2023	September 1, 2023	<18	ACLU of Texas and Lambda Legal have stated they will sue	A related lawsuit, *Doe v. Abbott* (2022), earned a temporary block on the governor's attempted investigations of transgender children's families.
Utah	January 28, 2023	January 28, 2023	<18	ACLU of Utah and NCLR have stated they will sue	
West Virginia	March 30, 2023	January 1, 2024	<18		

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Chronology

Order of Laws and Vetoes

Order of Laws
(by date of governor signature, veto override, or administrative filing; not by effective date)

2021 (1 this year)

1. Arkansas – HB1570 – April 6, 2021 (overriding governor veto)

2022 (2 new states this year)

2. Arizona – SB1138 – March 30, 2022
3. Alabama – SB184 – April 8, 2022

2023 (17 new states and counting this year)

4. Utah – SB16 – January 28, 2023
5. South Dakota – HB1080 – February 14, 2023
6. Florida – Administrative Code 64B8-9.019 – February 24, 2023
7. Mississippi – HB1125 – February 28, 2023
8. Tennessee – SB1/HB1 – March 2, 2023
   Arkansas – SB199 – March 13, 2023
9. Iowa – SF538 – March 22, 2023
10. Georgia – SB140 – March 23, 2023
11. Kentucky – SB150 – March 29, 2023 (overriding governor veto)
12. West Virginia – HB2007 – March 30, 2023
13. Idaho – HB71 – April 4, 2023
14. Indiana – SB480 – April 5, 2023
15. Missouri – "Emergency Rule" 15 CSR 60-17.010 – April 13, 2023 (withdrawn May 16, 2023)
16. North Dakota – HB1254 – April 19, 2023
17. Montana – SB99 – April 28, 2023
18. Oklahoma – SB613 – May 1, 2023
    Florida – S254 – May 17, 2023 (building on earlier administrative ban)
19. Nebraska – LB574 – May 22, 2023
20. Texas – SB14 – June 2, 2023
    Missouri – SB49 – June 7, 2023 (replacing earlier "emergency rule")

Order of Governor Vetoes

1. Arkansas – HB1570 – April 5, 2021 (later overridden)
2. Kentucky – SB150 – March 24, 2023 (later overridden) (read veto statement here)
3. Kansas – SB26 – April 20, 2023
4. Louisiana – HB648 – June 30, 2023 (read veto statement here)

Note: the Montana governor initially issued an "amendatory veto," meaning he would sign the bill if the legislature approved his suggested amendments. The legislature did so and the bill was later signed into law.

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State-by-State Sources & More Detail

Alabama

- State bans best practice medical care for transgender youth (ages <19). See SB184/HB266/Public Act 2022-289 (April 2022; effective 30 days later).
  - This law defines minor as "The same meaning as in Section 43-8-1, Code of Alabama 1975." That section of Alabama code defines minor as individuals under the age of 19.
  - Law makes providing such care a felony crime, and requires school officials to out children to parents. This is the first state with both such provisions.
- In May 2022, a federal judge temporarily blocked the part of the state's law that bans medication for transgender youth, though the rest of the law remains in effect for now, including the ban on surgical care, felony punishment and provisions that require school staff to tell parents if a child expresses thoughts that they might be transgender. See *Walker et al v. Marshall et al* (2022), joined by the federal Justice Department.

Alaska

- State does not ban best practice medical care for transgender youth

Arizona

- State bans best practice medical care for transgender youth (ages <18). See SB1138 (March 2022, effective March 31, 2023).
  - Law bans gender-affirming surgical care for minors, though it does not ban non-surgical forms of care (e.g., hormone-related medication).

Arkansas

- State bans* best practice medical care for transgender youth (ages <18). See HB1570/Act 626 (April 2021).
- *In June 2023, a federal judge permanently blocked the ban, ruling the law unconstitutional. However, the state is appealing this ruling. The permanent block builds on an earlier temporary block (July 2021) that prevented the law from going into effect. See *Brandt et al v. Rutledge et al* (filed May 2021).
- See also SB199/Act 271 (March 2023). This law is not a ban on medical care, but it does create obstacles and deterrents to care, including by allowing lawsuits against medical providers of gender-affirming care and encouraging burdensome obstacles to care that do not reflect best practice medical standards.

California

- State does not ban best practice medical care for transgender youth

Colorado

- State does not ban best practice medical care for transgender youth

Connecticut

- State does not ban best practice medical care for transgender youth

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Delaware

- State does not ban best practice medical care for transgender youth

District of Columbia

- State does not ban best practice medical care for transgender youth

Florida

- State bans best practice medical care for transgender youth
    - See FL Administrative Code 64B8-9.019 (filed February 24, 2023; effective March 16, 2023).
        - Rule allows exception for minors who were "being treated with puberty blocking, hormone, or hormone antagonist therapies prior to the effective date of this rule" (March 16, 2023) to continue that medical care.
        - In March 2023, a lawsuit was filed challenging this ban. See *Doe v. Ladapo*.
    - See also S254 (May 2023)
        - Law also makes providing such care a felony crime.
        - Law also bans state funds from covering best practice medical care for any transgender people, regardless of age.
        - Law also places obstacles to accessing healthcare for transgender adults, including the requirement that best-practice medical care only be provided by physicians—excluding other medical professionals such as nurse practitioners or physicians assistants—thereby reducing the number of available providers of medically necessary care to transgender adults.
    - On June 6, 2023, a federal judge temporarily blocked the state's ban from being enforced against the plaintiffs in the lawsuit. Both legal precedent and legal advocates say this ruling effectively blocks the state from enforcing the law against anyone. This map and information will be updated as the case continues to unfold.

Georgia

- State bans best practice medical care for transgender youth ("minors," undefined). See SB140 (March 2023, effective July 1, 2023).
    - Law allows exception for minors who are, prior to July 1, 2023, receiving "hormone replacement therapies" (undefined) to continue receiving that medical care.
- In June 2023, a lawsuit was filed challenging this ban. See *Koe et al. v. Noggler*.

Hawai`i

- State does not ban best practice medical care for transgender youth

Idaho

- State bans best practice medical care for transgender youth (ages <18). See HB71 (April 2023, effective January 1, 2024).
    - Law also makes providing such care a felony crime.
- In May 2023, a lawsuit was filed challenging this ban. See *Poe v. Labrador*.

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Illinois

- State does not ban best practice medical care for transgender youth

Indiana

- State bans best practice medical care for transgender youth (ages <18). See SB480 (April 2023, effective July 1, 2023).
    - Law also bans any health care professional from "conduct that aids or abets" the provision of best practice medical care for transgender youth.
    - Law includes a "weaning off" clause that allows minors receiving prescription/medication prior to effective date to continue that care, but only through 12/31/23. See Section 13(d), page 5.
- In June 2023, a federal judge temporarily blocked the parts of the state's law that ban medication for transgender youth and "aiding and abetting" the provision of this medically necessary health care. The rest of the law is scheduled to go into effect July 1, 2023. See *K.C. et al. v. Individual Members of the Medical Licensing Board et al* (filed April 2023).

Iowa

- State bans best practice medical care for transgender youth (ages <18). See SF538 (March 2023, effective immediately).
    - Law also bans any health care professional from "conduct that aids or abets" the provision of best practice medical care for transgender youth.

Kansas

- State does not ban best practice medical care for transgender youth

Kentucky

- State bans best practice medical care for transgender youth (ages <18). See SB150 (March 2023; effective June 29, 2023, 90 days after legislature adjourns).
    - Law includes a "weaning off" clause that allows minors receiving prescription/medication prior to effective date to continue that care, but only for an unspecified period of time with the explicit goal of "systematically reduc[ing]" the medication. See Section 4(6), page 9.
- In June 2023, a federal judge temporarily blocked the state's ban. See *Doe v. Thornbury* (filed May 2023).

Louisiana

- State does not ban best practice medical care for transgender youth

Maine

- State does not ban best practice medical care for transgender youth

Maryland

- State does not ban best practice medical care for transgender youth

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Massachusetts

- State does not ban best practice medical care for transgender youth

Michigan

- State does not ban best practice medical care for transgender youth

Minnesota

- State does not ban best practice medical care for transgender youth

Mississippi

- State bans best practice medical care for transgender youth (ages <18). See HB1125 (Feb 2023, effective immediately).
    - Law also bans the use of public funds for any provision of best practice medical care for transgender youth, and bans any person from "conduct that aids or abets" the provision of best practice medical care. This extends the scope of the ban from doctors and medical providers to parents and *any other individual* who might help or participate in getting a transgender minor access to best practice medicine. This is the first state ban on transgender youth medical care that includes the "aids or abets" language.

Missouri

- State bans best practice medical care for transgender youth (ages <18). See SB49 (June 2023, effective August 28, 2023, but expires in four years on August 28, 2027).
    - Law also bans state funds from covering best practice medical care for any transgender people, regardless of age, specifically in the Medicaid program, and bans gender-affirming surgical care for anyone incarcerated by the state of Missouri.
- Previously, state effectively banned best practice medical care for all transgender people, regardless of age. See "Emergency Rule" 15 CSR 60-17.010 (issued April 13, 2023; intended to go into effect April 27, 2023 with expiration of February 6, 2024; rule terminated by attorney general May 16, 2023).
    - The rule was initially set to go into effect April 27, 2023. A court case delayed the effective date to at least July 24, 2023, with a further injunction possible at that time.
    - On May 16, 2023, the state's attorney general filed to withdraw/terminate the emergency rule as a result of the legislative ban passed by the legislature.
    - While the regulation was presented as allowing medical care if patients/providers meet certain requirements, these requirements were extraordinarily burdensome if not effectively impossible to meet. While there was language about exceptions for those who already have prescriptions, it was unclear whether individuals who already had prescriptions would still need to meet these requirements in order to renew or continue those prescriptions.

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Montana

- State bans best practice medical care for transgender youth (ages <18). See SB99 (April 2023, effective October 1, 2023).
  - Law also says "state property, facilities, or buildings may not be knowingly used to promote or advocate the use of social transitioning or the medical treatments prohibited" by this law. See Section 4(7). This is the first state to issue any sort of restrictions targeting social transition.
- In May 2023, a lawsuit was filed challenging this ban. See *van Garderen v. State of Montana*.

Nebraska

- State bans best practice medical care for transgender youth (ages <19). See LB574 (May 2023, effective October 1, 2023).
  - Law allows those with hormone prescriptions prior to the effective date of the bill (October 1, 2023) to continue those prescriptions.
  - If/when the law goes into effect, it explicitly bans surgical care for those <19, and bans new prescription medications for those <19 unless the individual can meet requirements to be determined by the state's chief medical officer. The bill specifies these requirements must address numerous elements, including but not limited to a minimum number of hours in therapy, a required waiting period, and other items likely to create significant obstacles to this medically necessary care.
- In May 2023, a lawsuit was filed challenging this ban. See *Planned Parenthood of the Heartland v. Hilgers*.

Nevada

- State does not ban best practice medical care for transgender youth

New Hampshire

- State does not ban best practice medical care for transgender youth

New Jersey

- State does not ban best practice medical care for transgender youth

New Mexico

- State does not ban best practice medical care for transgender youth

New York

- State does not ban best practice medical care for transgender youth

North Carolina

- State does not ban best practice medical care for transgender youth

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North Dakota

- State bans best practice medical care for transgender youth (ages <18, including emancipated minors). See HB1254 (April 2023, effective immediately).
    - Law also makes providing surgical care a felony crime, and providing medication a misdemeanor crime.
    - Law allows exception for minors who are, prior to April 19, 2023, receiving medication to continue receiving that medical care.

Ohio

- State does not ban best practice medical care for transgender youth

Oklahoma

- State bans best practice medical care for transgender youth (ages <18). See SB613 (May 2023, effective immediately).
    - Law also makes providing such care a felony crime.
    - Law allows minors who have a hormone prescription prior to the effective date of the bill (May 1, 2023) to continue that prescription but only for six months, "solely for the purpose of assisting the minor with gradually decreasing and discontinuing the use of the drugs or hormones."
- On May 18, 2023, the state's attorney general signed a binding agreement to not enforce the state's ban pending further legal challenge. This was a development of the lawsuit filed challenging the state's ban, *Poe et al. v. Drummond et al* (May 2023).
- Previously, SB3 (Oct 2022) provided over $108 million in federal COVID-relief funding to the University of Oklahoma medical system, with the requirement that the system stop providing best practice medical care for transgender youth. The medical system agreed to this requirement. This did not ban best practice medical care statewide, but did reflect a clear effort to limit access to this medically necessary care.

Oregon

- State does not ban best practice medical care for transgender youth

Pennsylvania

- State does not ban best practice medical care for transgender youth

Rhode Island

- State does not ban best practice medical care for transgender youth

South Carolina

- State does not ban best practice medical care for transgender youth

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South Dakota

- State bans best practice medical care for transgender youth (ages <18). See HB1080 (Feb 2023, effective July 1, 2023).
    - Law allows minors who have a hormone prescription prior to July 1, 2023, to continue that prescription but only through Dec 31, 2023. Medical providers are expected to "systematically reduce" the prescription over that time period.

Tennessee

- State bans best practice medical care for transgender youth (ages <18). See SB1/HB1 (March 2023, effective July 1, 2023).
    - Law also bans "a person" (i.e., not only medical providers) from providing hormones or puberty blocking medication to minors, and further specifically bans medical providers out of state from providing care via telehealth to minors in the state.
    - Law allows minors who have a hormone prescription prior to the effective date of the bill (July 1, 2023) to continue that prescription but only until March 31, 2024.
- In June 2023, a federal judge temporarily blocked the state's ban. See *L.W. et al. v. Skrmetti et al* (filed April 2023)
- Previously, SB126 (2021) prohibited medical providers from providing hormone-related medication to "prepubertal minors" (emphasis added). Best practice medical care for transgender youth can (though does not always) include hormone-related medication, but only once a youth has entered puberty, not prior to it. In other words, this law banned something that did not happen, but it set a dangerous precedent for further restrictions of medical care for transgender youth.

Texas

- State bans best practice medical care for transgender youth (ages <18). See SB14 (June 2023, effective September 1, 2023).
    - Law allows minors who have a hormone prescription prior to June 1, 2023, to continue that prescription but only over a limited amount of time (unspecified) with the expectation they will "wean off" the prescription.
- Previously, and as reported by Equality Texas, "On February 18th [2022], in the middle of early voting for the Texas primary elections, Attorney General Ken Paxton released a non-binding opinion grossly mischaracterizing medically necessary, best-practice healthcare for transgender children as child abuse. Shortly after, Governor Abbott sent a letter to the Department of Family Protective Services (DFPS) directing them to enforce Paxton's opinion." These actions did not change the law in Texas and are not legally binding (in fact, their very legality is being directly challenged in court), but they have nonetheless caused harm and even initiated investigations into families of transgender children in the state. These investigations were temporarily halted by a statewide injunction, until a Texas Supreme Court ruling in May 2022 ended that injunction. However, the Texas Supreme Court also ruled that the governor had no authority to order such investigations. For more information and resources, see the Transgender Education Network of Texas (TENT) and Equality Texas.

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Utah

- State bans best practice medical care for transgender youth (ages <18). See SB16 (Jan 2023, effective immediately).
    - This law provides a limited exception for hormone treatment for youth who were “diagnosed with gender dysphoria” prior to the bill’s passage, but the law also allows individuals to later retroactively revoke their consent.

Vermont

- State does not ban best practice medical care for transgender youth

Virginia

- State does not ban best practice medical care for transgender youth

Washington

- State does not ban best practice medical care for transgender youth

West Virginia

- State bans best practice medical care for transgender youth (ages <18). See HB2007 (March 2023, effective January 1, 2024).
    - Law allows limited exception for minors to receive hormone medication under a burdensome set of conditions, but this exception does exist. Requirements include an official diagnosis of “severe gender dysphoria” from at least two medical providers, one of whom must be a mental health provider or adolescent medicine specialist, and both with “relevant training.” The conditions also require that the medication is “limited to the lowest titratable dosage necessary to treat the psychiatric condition and not for purposes of gender transition,” among other requirements/conditions on such care.

Wisconsin

- State does not ban best practice medical care for transgender youth

Wyoming

- State does not ban best practice medical care for transgender youth

U.S. Territories

American Samoa

- Territory does not ban best practice medical care for transgender youth

Guam

- Territory does not ban best practice medical care for transgender youth

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Northern Mariana Islands

- Territory does not ban best practice medical care for transgender youth

Puerto Rico

- Territory does not ban best practice medical care for transgender youth

U.S. Virgin Islands

- Territory does not ban best practice medical care for transgender youth

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Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2022 Regular Session of the General Assembly.

SENATE ENROLLED ACT No. 480

AN ACT to amend the Indiana Code concerning professions and occupations.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 25-1-22 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 22. Gender Transition Procedures for Minors

Sec. 1. As used in this chapter, "gender" means the psychological, behavioral, social, and cultural aspects of being male or female.

Sec. 2. As used in this chapter, "gender reassignment surgery" means any medical or surgical service that seeks to surgically alter or remove healthy physical or anatomical characteristics or features that are typical for the individual's sex, in order to instill or create physiological or anatomical characteristics that resemble a sex different from the individual's sex, including genital gender reassignment surgery or nongenital gender reassignment surgery knowingly performed for the purpose of assisting an individual with a gender transition.

Sec. 3. As used in this chapter, "gender transition" means the process in which an individual shifts from identifying with and living as a gender that corresponds to his or her sex to identifying with and living as a gender different from his or her sex, and may involve social, legal, or physical changes.

Sec. 4. As used in this chapter, "gender transition hormone therapy" means:

(1) testosterone;

(2) estrogen; or

(3) progesterone;

given to an individual in an amount greater than would normally be produced endogenously in a healthy individual of that individual's age and sex.

Sec. 5. (a) As used in this chapter, "gender transition procedures" means any medical or surgical service, including physician's services, practitioner's services, inpatient and outpatient hospital services, or prescribed drugs related to gender transition, that seeks to:

(1) alter or remove physical or anatomical characteristics or features that are typical for the individual's sex; or

(2) instill or create physiological or anatomical characteristics that resemble a sex different from the individual's sex, including medical services that provide puberty blocking drugs, gender transition hormone therapy, or genital gender reassignment surgery or nongenital gender reassignment surgery knowingly performed for the purpose of assisting an individual with a gender transition.

(b) The term does not include the following:

(1) Medical or surgical services to an individual born with a medically verifiable disorder of sex development, including an individual with:

(A) external sex characteristics that are irresolvably ambiguous;

(B) forty-six (46) XX chromosomes with virilization;

(C) forty-six (46) XY chromosomes with undervirilization; or

(D) both ovarian and testicular tissue.

(2) Medical or surgical services provided when a physician or practitioner has diagnosed a disorder or condition of sexual development that the physician or practitioner has determined through genetic or biochemical testing that the individual does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action.

(3) The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of gender transition procedures.

(4) Any medical or surgical service undertaken because the individual suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician or practitioner, place the individual in imminent danger of death or impairment of major bodily function unless the medical or surgical service is performed.

(5) Mental health or social services other than gender transition procedures as defined in subsection (a).

(6) Services for a disorder or condition of sexual development that is unrelated to a diagnosis of gender dysphoria or gender identity disorder.

Sec. 6. As used in this chapter, "genital gender reassignment surgery" means a medical procedure knowingly performed for the purpose of assisting an individual with a gender transition, including the following:

(1) Surgical procedures, including a penectomy, orchiectomy, vaginoplasty, clitoroplasty, or vulvoplasty for a male sex patient or hysterectomy or ovariectomy for a female sex patient.

(2) Reconstruction of the fixed part of the urethra with or without a metoidioplasty.

(3) Phalloplasty, vaginectomy, scrotoplasty, or implantation of erection or testicular prostheses for a female sex patient.

Sec. 7. As used in this chapter, "minor" means an individual who is less than eighteen (18) years of age.

Sec. 8. As used in this chapter, "nongenital gender reassignment surgery" means medical procedures knowingly performed for the purpose of assisting an individual with a gender transition, including the following:

(1) Surgical procedures for a male sex patient, including augmentation mammoplasty, facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation, hair reconstruction, or associated aesthetic procedures.

(2) Surgical procedures for a female sex patient, including subcutaneous mastectomy, voice surgery, liposuction, lipofilling, pectoral implants, or associated aesthetic procedures.

Sec. 9. As used in this chapter, "physician" means an individual who is licensed under IC 25-22.5.

Sec. 10. As used in this chapter, "practitioner" means an individual who provides health services and holds:

(1) an unlimited license, certificate, or registration;

(2) a limited or probationary license, certificate, or registration;

(3) a temporary license, certificate, registration, or permit;

(4) an intern permit; or

(5) a provisional license;

issued by a board regulating the profession in question.

Sec. 11. As used in this chapter, "puberty blocking drugs" means:

(1) gonadotropin releasing hormone analogues or other synthetic drugs used to stop luteinizing hormone and follicle stimulating hormone secretion; or

(2) synthetic antiandrogen drugs used to block the androgen receptor;

when used for the purpose of assisting an individual with a gender transition.

Sec. 12. As used in this chapter, "sex" means the biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles.

Sec. 13. (a) Except as provided in subsections (c) and (d), a physician or other practitioner may not knowingly provide gender transition procedures to a minor.

(b) Except as provided in subsection (c), a physician or other practitioner may not aid or abet another physician or practitioner in the provision of gender transition procedures to a minor.

(c) This section does not prohibit a physician or other practitioner from providing any of the following to a minor:

(1) Services to individuals born with a medically verifiable disorder of sex development, including an individual with external biological sex characteristics that are irresolvably ambiguous, including individuals born with forty-six (46) XX chromosomes with virilization, born with forty-six (46) XY chromosomes with undervirilization, or having both ovarian and testicular tissue.

(2) Services provided when a physician or practitioner has diagnosed a disorder of sexual development that the physician or practitioner has determined through genetic or biochemical testing that the individual does not have normal sex chromosome structure, sex steroid hormone production, or sex steroid hormone action.

(3) The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of

gender transition procedures.

(4) Any medical or surgical service undertaken because the individual suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician or practitioner, place the individual in imminent danger of death or impairment of major bodily function unless the medical or surgical service is performed.

(d) A physician or practitioner within the practitioner's scope of practice may continue to prescribe to an individual, who was taking a gender transition hormone therapy on June 30, 2023, as part of a gender transition procedure, gender transition hormone therapy until December 31, 2023. This subsection expires January 1, 2024.

Sec. 14. Health care services furnished in the following situations may not include gender transition procedures to a minor:

(1) By or in a health care facility owned by the state, a county, or a municipality.

(2) By a physician or other practitioner employed by state, county, or local government.

Sec. 15. A physician or practitioner that takes any action that aids or abets another physician or practitioner in the provision of gender transition procedures for a minor violates the standards of practice under IC 25-1-9 and is subject to discipline by the board regulating the physician or practitioner.

Sec. 16. An:

(1) individual who has received gender transition procedures in violation of this chapter; or

(2) individual's parent or guardian;

may assert an actual or threatened violation of this chapter as a claim or defense in a judicial or administrative proceeding and may seek to obtain compensatory damages, injunctive relief, declaratory relief, or any other appropriate relief.

Sec. 17. (a) Except as provided in subsections (b) and (c), an individual must bring a claim for a violation of this chapter not more two (2) years after the day the cause of action accrues.

(b) A minor, through a parent, guardian, custodian, or next friend, may bring an action for a violation of this chapter.

(c) If an individual was less than eighteen (18) years of age when the cause of action for a violation of this chapter accrued, when the individual is eighteen (18) years of age or older, the individual may bring a cause of action at any time until the individual reaches

twenty-eight (28) years of age.

Sec. 18. (a) Notwithstanding any other law, an action under this chapter may be commenced, and relief may be granted, in a judicial proceeding without regard to whether the person commencing the action has sought or exhausted available administrative remedies.

(b) In an action or proceeding to enforce a provision of this chapter, a prevailing party who establishes a violation of this chapter is entitled to recover reasonable attorney's fees.

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: ____________________ Time: ____________________

SEA 480

First Regular Session of the 123rd General Assembly (2023)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~
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Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2022 Regular Session of the General Assembly.

HOUSE ENROLLED ACT No. 1447

AN ACT to amend the Indiana Code concerning education.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 20-23-18-3, AS AMENDED BY P.L.125-2022, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 3. (a) Except as provided in subsection (c), the Muncie Community school corporation is subject to all applicable federal and state laws.

(b) If a provision of this chapter conflicts with any other law, including IC 20-23-4, the provision in this chapter controls.

(c) Notwithstanding subsection (a), to provide all administrative and academic flexibility to implement innovative strategies, the Muncie Community school corporation is subject only to the following IC 20 and IC 22 provisions:

(1) IC 20-26-5-10 (criminal history).

(2) IC 20-26-21 (personal analyses, evaluations, or surveys by third party vendors).

~~(2)~~ **(3)** IC 20-28-5-8 (conviction of certain felonies or misdemeanors; notice and hearing; permanent revocation of license; data base of school employees who have been reported).

~~(3)~~ **(4)** IC 20-28-10-17 (school counselor immunity).

~~(4)~~ **(5)** IC 20-29 (collective bargaining) to the extent required by

subsection (e).
~~(5)~~ **(6)** IC 20-30-3-2 and IC 20-30-3-4 (patriotic commemorative observances).
~~(6)~~ **(7)** The following:
(A) IC 20-30-5-0.5 (display of the United States flag; Pledge of Allegiance).
(B) IC 20-30-5-1, IC 20-30-5-2, and IC 20-30-5-3 (the constitutions of Indiana and the United States; writings, documents, and records of American history or heritage).
(C) IC 20-30-5-4 (system of government; American history).
(D) IC 20-30-5-5 (morals instruction).
(E) IC 20-30-5-6 (good citizenship instruction).
~~(7)~~ **(8)** IC 20-32-4, concerning graduation requirements.
~~(8)~~ **(9)** IC 20-32-5.1, concerning the Indiana's Learning Evaluation Assessment Readiness Network (ILEARN) program.
~~(9)~~ **(10)** IC 20-32-8.5 (IRead3).
~~(10)~~ **(11)** IC 20-33-2 (compulsory school attendance).
~~(11)~~ **(12)** IC 20-33-8-16 (firearms, ~~and~~ deadly weapons, **or destructive devices).**
~~(12)~~ **(13)** IC 20-33-8-19, IC 20-33-8-21, and IC 20-33-8-22 (student due process and judicial review).
~~(13)~~ **(14)** IC 20-33-7 (parental access to education records).
~~(14)~~ **(15)** IC 20-33-9 (reporting of student violations of law).
~~(15)~~ **(16)** IC 20-34-3 (health and safety measures).
~~(16)~~ **(17)** IC 20-35 (concerning special education).
~~(17)~~ **(18)** IC 20-39 (accounting and financial reporting procedures).
~~(18)~~ **(19)** IC 20-40 (government funds and accounts).
~~(19)~~ **(20)** IC 20-41 (extracurricular funds and accounts).
~~(20)~~ **(21)** IC 20-42 (fiduciary funds and accounts).
~~(21)~~ **(22)** IC 20-42.5 (allocation of expenditures to student instruction and learning).
~~(22)~~ **(23)** IC 20-43 (state tuition support).
~~(23)~~ **(24)** IC 20-44 (property tax levies).
~~(24)~~ **(25)** IC 20-46 (levies other than general fund levies).
~~(25)~~ **(26)** IC 20-47 (related entities; holding companies; lease agreements).
~~(26)~~ **(27)** IC 20-48 (borrowing and bonds).
~~(27)~~ **(28)** IC 20-49 (state management of common school funds; state advances and loans).
~~(28)~~ **(29)** IC 20-50 (concerning homeless children and foster care children).

~~(29)~~ **(30)** IC 22-2-18, before its expiration on June 30, 2021 (limitation on employment of minors).

(d) The Muncie Community school corporation is subject to required audits by the state board of accounts under IC 5-11-1-9.

(e) Except to the extent required under a collective bargaining agreement entered into before July 1, 2018, the Muncie Community school corporation is not subject to IC 20-29 unless the school corporation voluntarily recognizes an exclusive representative under IC 20-29-5-2. If the school corporation voluntarily recognizes an exclusive representative under IC 20-29-5-2, the school corporation may authorize a school within the corporation to opt out of bargaining allowable subjects or discussing discussion items by specifying the excluded items on the notice required under IC 20-29-5-2(b). The notice must be provided to the education employment relations board at the time the notice is posted.

SECTION 2. IC 20-26-5.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2024]:

Chapter 5.5. School Library

Sec. 1. (a) The governing body of a school corporation or charter school shall establish a:

(1) procedure for each school to prepare a catalogue of materials available in the school library;

(2) procedure for each school to allow a:

(A) parent or guardian of a student enrolled in the school; or

(B) community member:

(i) within the school district; or

(ii) within the school district in which the charter school is located;

to submit a request to remove material from the school library that is obscene (as described in IC 35-49-2-1) or harmful to minors (as described in IC 35-49-2-2); and

(3) response and appeal procedure for each school to respond to a removal request submitted by a parent, guardian, or community member described in subdivision (2).

(b) The response and appeal procedure established under subsection (a)(3) must require the governing body to review the request at the next public meeting.

Sec. 2. The governing body of a school corporation or charter school shall:

(1) publish on the website of each school; and

(2) make available in hard copy for an individual upon request;

the catalogue of material available in the school library and each policy established under this chapter.

Sec. 3. A school corporation or charter school may not make available materials that contain:

(1) obscene matter (as described in IC 35-49-2-1); or

(2) matter harmful to minors (as described in IC 35-49-2-2);

within the school library.

SECTION 3. IC 20-26-21 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 21. Personal Analyses, Evaluations, or Surveys by Third Party Vendors

Sec. 1. As used in this chapter, "qualified school" means the following:

(1) A school maintained by a school corporation.

(2) A charter school.

(3) A laboratory school established under IC 20-24.5-2.

(4) The Indiana School for the Blind and Visually Impaired established by IC 20-21-2-1.

(5) The Indiana School for the Deaf established by IC 20-22-2-1.

Sec. 2. This chapter does not apply to the following:

(1) An academic test or academic assessment, scoring keys, or other tools directly related to measuring a student's academic performance in understanding a particular curricular subject matter, as prescribed by the department.

(2) A career aptitude or career interest survey.

(3) An assessment or screening instrument administered by a third party employed:

(A) psychologist licensed under IC 25-33; or

(B) social worker, clinical social worker, marriage and family therapist, or mental health counselor licensed under IC 25-23.6;

if the third party provider described in clause (A) or (B) is referred by school personnel in a crisis situation in which the school personnel and the third party provider reasonably believe that the student is in immediate danger of self harm, harming another person, or experiencing harm resulting from abuse or neglect.

(4) An assessment, screening instrument, or evaluation survey

administered by a third party employed:

(A) psychologist licensed under IC 25-33; or

(B) social worker, clinical social worker, marriage and family therapist, or mental health counselor licensed under IC 25-23.6;

who has received a consent for services from a student, if the student is an adult or emancipated minor, or parent of a student, if the student is an unemancipated minor.

(5) A survey or evaluation administered to a student of a school by a third party vendor that gauges or attempts to gauge student satisfaction with or participation in the school's programming, technology platform, or approved curriculum.

Sec. 3. If a school corporation or qualified school uses a third party vendor in providing a personal analysis, evaluation, or survey that reveals, identifies, collects, maintains, or attempts to affect a student's attitudes, habits, traits, opinions, beliefs, or feelings, the third party vendor and the school corporation or qualified school may not record, collect, or maintain the responses to or results of the analysis, evaluation, or survey in a manner that would identify the responses or results of an individual student.

Sec. 4. (a) This section does not apply to a personal analysis, evaluation, or survey for which consent is required under IC 20-30-5-17(b).

(b) Before a school corporation or qualified school may administer a personal analysis, evaluation, or survey described in section 3 of this chapter, the school corporation or qualified school must provide the parent of the student or the student, if the student is an adult or an emancipated minor, with a written request for consent for administration. A consent form provided to a parent of a student or a student under this subsection must accurately summarize the contents and nature of the personal analysis, evaluation, or survey that will be provided to the student and indicate that a parent of a student or an adult or emancipated minor student has the right to review and inspect all materials related to the personal analysis, evaluation, or survey. The written consent form may be sent in an electronic format. The parent of the student or the student, if the student is an adult or an emancipated minor, may return the consent form indicating that the parent of the student or the adult or emancipated student:

(1) consents to the personal analysis, evaluation, or survey; or

(2) declines the personal analysis, evaluation, or survey.

If a student does not participate in the personal analysis,

evaluation, or survey, the school corporation or qualified school shall provide the student with alternative academic instruction during the same time frame that the personal analysis, evaluation, or survey is administered.

(c) If the parent of the student or the student, if the student is an adult or an emancipated minor, does not respond to the written request provided by the school corporation or qualified school under subsection (b) within twenty-one (21) calendar days after receiving the request under subsection (b), the school corporation or qualified school shall provide the parent of the student or the student, if the student is an adult or an emancipated minor, a written notice requesting that the parent of the student, or the student, if the student is an adult or an emancipated minor, indicate, in a manner prescribed by the school corporation or qualified school, whether the parent of the student or the adult or emancipated student:

(1) consents to the personal analysis, evaluation, or survey; or

(2) declines the personal analysis, evaluation, or survey.

A notice provided to a parent of a student or a student under this subsection must accurately summarize the contents and nature of the personal analysis, evaluation, or survey that will be provided to the student and indicate that a parent of a student or an adult or emancipated minor student has the right to review and inspect all materials related to the personal analysis, evaluation, or survey. The notice may be sent in an electronic format. If the school corporation or qualified school does not receive a response within ten (10) days after the notice, the student will receive the personal analysis, evaluation, or survey unless the parent or the adult or emancipated student subsequently opts out of the personal analysis, evaluation, or survey for the student.

(d) Each school corporation or qualified school shall:

(1) post a copy of a personal analysis, evaluation, or survey described in subsection (b) on the school corporation's or qualified school's website; and

(2) send with each notice an explanation of the reasons that the school corporation or qualified school is administering the personal analysis, evaluation, or survey.

(e) The department and the governing body shall give parents and students notice of the parents' and students' rights under this section.

Sec. 5. A parent of a student or a student, if the student is an adult or emancipated minor, who is enrolled in a qualified school

may submit a complaint for a violation of this chapter under the grievance procedure maintained by the qualified school in accordance with section 6 of this chapter.

Sec. 6. Each qualified school shall establish and maintain a grievance procedure for the resolution of a complaint submitted by a parent of a student or student, if the student is an adult or emancipated minor, under section 5 of this chapter.

Sec. 7. The department shall:

(1) develop guidance materials for school corporations and qualified schools to assist school corporations and qualified schools in implementing this chapter; and

(2) post the guidance materials on the department's website.

Sec. 8. Nothing in this section prohibits qualified schools from administering state or federally required assessments.

Sec. 9. After June 30, 2023, if a school corporation or a qualified school contracts with a third party vendor to provide a personal analysis, survey, or evaluation described in section 3 of this chapter, the contract must include a provision stating that if the third party vendor does not comply with the requirements described in section 3 of this chapter, the third party vendor has committed a breach of contract.

SECTION 4. IC 20-33-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 1.5. Neutrality Regarding Certain Activities

Sec. 1. As used in this chapter, "qualified school" has the meaning set forth in IC 20-26-21-1.

Sec. 2. As used in this chapter, "state agency" has the meaning set forth in IC 4-13-1.4-2.

Sec. 3. If a state agency, school corporation, or qualified school or an employee of a state agency, school corporation, or qualified school requires, makes part of a course, awards a grade or course credit, including extra credit, or otherwise incentivizes a student to engage in:

(1) political activism;

(2) lobbying; or

(3) efforts to persuade members of the legislative or executive branch at the federal, state, or local level;

the state agency, school corporation, or qualified school or the employee of the state agency, school corporation, or qualified school shall not require the student to adopt, affirm, affiliate, or take any action that would result in favoring any particular

position on the issue or issues involved without offering an alternative option for the student to complete the assignment or receive extra credit or other incentivization that allows for the favoring of an alternative position.

SECTION 5. IC 35-49-3-3, AS AMENDED BY P.L.158-2013, SECTION 648, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2024]: Sec. 3. (a) Except as provided in subsection (b) **and section 4 of this chapter,** a person who knowingly or intentionally:

(1) disseminates matter to minors that is harmful to minors **(as described in IC 35-49-2);**

(2) displays matter that is harmful to minors in an area to which minors have visual, auditory, or physical access, unless each minor is accompanied by the minor's parent or guardian;

(3) sells, rents, or displays for sale or rent to any person matter that is harmful to minors within five hundred (500) feet of the nearest property line of a school or church;

(4) engages in or conducts a performance before minors that is harmful to minors;

(5) engages in or conducts a performance that is harmful to minors in an area to which minors have visual, auditory, or physical access, unless each minor is accompanied by the minor's parent or guardian;

(6) misrepresents the minor's age for the purpose of obtaining admission to an area from which minors are restricted because of the display of matter or a performance that is harmful to minors; or

(7) misrepresents that the person is a parent or guardian of a minor for the purpose of obtaining admission of the minor to an area where minors are being restricted because of display of matter or performance that is harmful to minors;

commits a Level 6 felony.

(b) This section does not apply if a person disseminates, displays, or makes available the matter described in subsection (a) through the Internet, computer electronic transfer, or a computer network unless:

(1) the matter is obscene under IC 35-49-2-1;

(2) the matter is child pornography under IC 35-42-4-4; or

(3) the person distributes the matter to a child less than eighteen (18) years of age believing or intending that the recipient is a child less than eighteen (18) years of age.

SECTION 6. IC 35-49-3-4, AS AMENDED BY P.L.266-2019, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JANUARY 1, 2024]: Sec. 4. (a) It is a defense to a prosecution under section 3 of this chapter for the defendant to show:

(1) that the matter was disseminated or that the performance was performed for legitimate scientific ~~or educational~~ purposes;

(2) that the matter was disseminated or displayed to or that the performance was performed before the recipient by a bona fide ~~school,~~ **college, university,** museum, **college library,** or public library that qualifies for certain property tax exemptions under IC 6-1.1-10, **or university library,** or by an employee of such a school, **college, university,** museum, **college library,** or public library, **or university library** acting within the scope of the employee's employment;

(3) that the defendant had reasonable cause to believe that the minor involved was eighteen (18) years of age or older and that the minor exhibited to the defendant a draft card, driver's license, birth certificate, or other official or apparently official document purporting to establish that the minor was eighteen (18) years of age or older; or

(4) that the defendant was a salesclerk, motion picture projectionist, usher, or ticket taker, acting within the scope of the defendant's employment and that the defendant had no financial interest in the place where the defendant was so employed.

(b) Except as provided in subsection (c), it is a defense to a prosecution under section 3 of this chapter if all the following apply:

(1) A cellular telephone, another wireless or cellular communications device, or a social networking web site was used to disseminate matter to a minor that is harmful to minors.

(2) The defendant is not more than four (4) years older or younger than the person who received the matter that is harmful to minors.

(3) The relationship between the defendant and the person who received the matter that is harmful to minors was a dating relationship or an ongoing personal relationship. For purposes of this subdivision, the term "ongoing personal relationship" does not include a family relationship.

(4) The crime was committed by a person less than twenty-two (22) years of age.

(5) The person receiving the matter expressly or implicitly acquiesced in the defendant's conduct.

(c) The defense to a prosecution described in subsection (b) does not apply if:

(1) the image is disseminated to a person other than the person:

(A) who sent the image; or

(B) who is depicted in the image; or
(2) the dissemination of the image violates:
(A) a protective order to prevent domestic or family violence or harassment issued under IC 34-26-5 (or, if the order involved a family or household member, under IC 34-26-2 or IC 34-4-5.1-5 before their repeal);
(B) an ex parte protective order issued under IC 34-26-5 (or, if the order involved a family or household member, an emergency order issued under IC 34-26-2 or IC 34-4-5.1 before their repeal);
(C) a workplace violence restraining order issued under IC 34-26-6;
(D) a no contact order in a dispositional decree issued under IC 31-34-20-1, IC 31-37-19-1, or IC 31-37-5-6 (or IC 31-6-4-15.4 or IC 31-6-4-15.9 before their repeal) or an order issued under IC 31-32-13 (or IC 31-6-7-14 before its repeal) that orders the person to refrain from direct or indirect contact with a child in need of services or a delinquent child;
(E) a no contact order issued as a condition of pretrial release, including release on bail or personal recognizance, or pretrial diversion, and including a no contact order issued under IC 35-33-8-3.6;
(F) a no contact order issued as a condition of probation;
(G) a protective order to prevent domestic or family violence issued under IC 31-15-5 (or IC 31-16-5 or IC 31-1-11.5-8.2 before their repeal);
(H) a protective order to prevent domestic or family violence issued under IC 31-14-16-1 in a paternity action;
(I) a no contact order issued under IC 31-34-25 in a child in need of services proceeding or under IC 31-37-25 in a juvenile delinquency proceeding;
(J) an order issued in another state that is substantially similar to an order described in clauses (A) through (I);
(K) an order that is substantially similar to an order described in clauses (A) through (I) and is issued by an Indian:
(i) tribe;
(ii) band;
(iii) pueblo;
(iv) nation; or
(v) organized group or community, including an Alaska Native village or regional or village corporation as defined in or established under the Alaska Native Claims Settlement

Act (43 U.S.C. 1601 et seq.);
that is recognized as eligible for the special programs and services provided by the United States to Indians because of their special status as Indians;
(L) an order issued under IC 35-33-8-3.2; or
(M) an order issued under IC 35-38-1-30.

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: ____________________ Time: ____________________

First Regular Session of the 123rd General Assembly (2023)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2022 Regular Session of the General Assembly.

HOUSE ENROLLED ACT No. 1608

AN ACT to amend the Indiana Code concerning education.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 20-28-10-17, AS ADDED BY P.L.1-2005, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 17. (a) Except as provided in **IC 20-33-7.5 and** IC 31-32-11-1, a school counselor is immune from disclosing privileged or confidential communication made to the counselor as a counselor by a student.

(b) Except as provided in **IC 20-33-7.5 and** IC 31-32-11-1, the matters communicated are privileged and protected against disclosure.

SECTION 2. IC 20-28-12-5, AS ADDED BY P.L.1-2005, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 5. A school psychologist who is endorsed under this chapter may not disclose any information acquired from persons with whom the school psychologist has dealt in a professional capacity, except under the following circumstances:

(1) Trials for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide.

(2) Proceedings:

(A) to determine mental competency; or

(B) in which a defense of mental incompetency is raised.

(3) Civil or criminal actions against a school psychologist for malpractice.

(4) Upon an issue as to the validity of a document.

(5) If the school psychologist has the express consent of the client or, in the case of a client's death or disability, the express consent of the client's legal representative.

(6) Circumstances under which privileged communication is lawfully invalidated.

(7) Disclosures required by IC 20-33-7.5.

SECTION 3. IC 20-30-17 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 17. Prohibited Instruction

Sec. 1. As used in this chapter, "school" means any of the following:

(1) A public school, including a charter school.

(2) A laboratory school established under IC 20-24.5-2.

(3) The Indiana School for the Blind and Visually Impaired established by IC 20-21-2-1.

(4) The Indiana School for the Deaf established by IC 20-22-2-1.

Sec. 2. A school, an employee or staff member of a school, or a third party vendor used by a school to provide instruction may not provide any instruction to a student in prekindergarten through grade 3 on human sexuality.

Sec. 3. Nothing in this chapter may be construed to prohibit a teacher from providing instruction on academic standards developed by the department under IC 20-31-3-2 or instruction required under IC 20-30-5-5.7.

Sec. 4. Nothing in this chapter may be construed to prevent a school employee or a school staff member from responding to a question from a student regarding the topic described in section 2 of this chapter.

SECTION 4. IC 20-33-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 7.5. Parental Notification Regarding Identification

Sec. 1. As used in this chapter, "school" has the meaning set forth in IC 20-30-17-1.

Sec. 2. (a) A school shall notify in writing at least one (1) parent of a student, if the student is an unemancipated minor, of a request made by the student to change the student's:

(1) name; or

(2) pronoun, title, or word to identify the student.

(b) Not later than five (5) business days after the date on which

a school receives a request described in subsection (a), the school shall provide notification to a parent as required by subsection (a).

Sec. 3. This chapter does not:

(1) change an individual's duty to report child abuse or neglect, as required under IC 31-33-5; or

(2) permit a school to establish a policy described in IC 20-26-5-35.5.

Sec. 4. Nothing in this chapter may be construed to require a school psychologist, a school nurse, a school social worker, or a school counselor to violate a federal law or regulation.

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: ____________ Time: ____________

HEA 1608 — Concur

CLINICAL PRACTICE GUIDELINE

Gender Dysphoria/Gender Incongruence Guideline Resources

September 01, 2017

Full Guideline: Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline
***JCEM* September 2017**
Wylie C. Hembree (Chair), Peggy T. Cohen-Kettenis, Louis Gooren, Sabine E. Hannema, Walter J. Meyer, M. Hassan Murad, Stephen M. Rosenthal, Joshua D. Safer, Vin Tangpricha, Guy G. T'Sjoen

The 2017 guideline on endocrine treatment of gender dysphoric/gender incongruent persons:

- Establishes a framework for the appropriate treatment of these individuals
- Standardizes terminology to be used by healthcare professionals
- Reaffirms the role of the endocrinologist
- Emphasizes that a broader healthcare team is needed to provide mental health services and other treatments, such as gender-affirmation surgery

- **Clinical Education** (Free CME) | Endocrine Society

- **Educational Slide Deck** | Endocrine Society
- **Guideline Pocket Card** | Guideline Central
- **Interview with the Chair** | Endocrine News
- **Patient Resources** | Endocrine Library
- **App and point of care tools** | Endocrine Society
- Executive Summary Translations | Endocrine Society
    - **Español**
    - **Português**

Endocrine Treatment of Gender Incongruent/Gender Dysphoric Persons: An Endocrine Society Clinical Practice Guideline

Essential Points

- Diagnosing clinicians, mental health providers for adolescents, and mental health professionals for adults all should be knowledgeable about the diagnostic criteria for gender-affirming treatment, have sufficient training and experience in assessing related mental health conditions, and be willing to participate in the ongoing care throughout the endocrine transition
- Gender-dysphoric/gender-incongruent persons should receive a safe and effective hormone regimen that will suppress the body's sex hormone secretion, determined at birth and manifested at puberty, and maintain levels of sex steroids within the normal range for the person's affirmed gender.
- Hormone treatment is not recommended for pre-pubertal gender-dysphoric /gender-incongruent persons;

- For the care of youths during puberty and older adolescents, an expert multi-disciplinary team comprised of medical professionals and mental health professionals should manage treatment;
- For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient;
- All individuals seeking gender-affirming medical treatment should receive information and counsel on options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy in both adolescents and adults;
- Removal of gonads may be considered when high doses of sex steroids are required to suppress the body's secretion of hormones, and/or to reduce steroid levels in advanced age; and
- During sex steroid treatment, clinicians should monitor, in both transgender males (female to male) and/or transgender females (male to female), prolactin, metabolic disorders, and bone loss, as well as cancer risks in individuals who have not undergone surgical treatment

Summary of Recommendations

- 1.0 Evaluation of Youth and Adults

1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender

incongruence and conditions that have similar features (e.g., body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (e.g., body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕OO)

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 | ⊕⊕⊕O)

- 2.0 Treatment of Adolescents

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕OO)
2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |⊕⊕OO)
2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕OO)
2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |⊕⊕OO).
2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕OOO)
2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 | ⊕⊕OO)

- 3.0 Hormonal Therapy for Transgender Adults

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕O)
3.2. We recommend that clinicians evaluate and address medical conditions that

can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 |⊕⊕⊕O)
3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕OO)
3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕OOO)
- **4.0 Adverse Outcome Prevention and Long-Term Care**

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 | ⊕⊕○○)
4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 |⊕⊕OO)
4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕OO)
4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕OO)
4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 |⊕⊕OO)
4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕OOO)

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

- 5.0 Surgery for Sex Reassignment and Gender Confirmation

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 |⊕⊕OO)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 |⊕OOO)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 |⊕⊕OO).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 |⊕OOO)

File #: 230385

RESOLUTION NO. 230385

Declaring the City of Kansas City a Safe Haven for Gender-Affirming Healthcare through adoption of a Gender-Affirming Healthcare Policy.

WHEREAS, as of the date of this legislation, Missouri law does not restrict access to gender-affirming healthcare or ban insurance exclusions for gender-affirming healthcare; and

WHEREAS, in 2023, members of the Missouri state legislature have introduced a record number of bills criminalizing access to gender affirming healthcare across Missouri; and

WHEREAS, some of the states bordering Missouri have proposed bills restricting or criminalizing access to gender-affirming healthcare and passed other legislation limiting the rights of transgender youth, and local clinics and advocates have heard from families living all over the continental United States who are considering moving away to access gender-affirming healthcare for their children; and

WHEREAS, other states may adopt or expand laws that impose criminal punishment, civil liability, administrative penalties, or professional sanctions on health care professionals who provide gender-affirming healthcare and on persons who seek, receive, or assist another in receiving gender-affirming healthcare in the City of Kansas City; and

WHEREAS, gender-affirming healthcare has been proven to be evidence-based, medically necessary, and lifesaving by the American Medical Association, the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatricians, the Endocrine Society, the American Psychiatric Association, and the World Professional Association for Transgender Health, amongst other institutions; and

WHEREAS, studies have shown that gender transition, including access to gender-affirming healthcare, improves the overall wellbeing of transgender people and that access to gender-affirming healthcare for youth is associated with better mental health outcomes and lower risks of suicide; and

WHEREAS, over 94 percent of LGBTQ+ youth surveyed by the Trevor Project in late 2021 said recent politics have negatively impacted their mental health, and 93 percent of transgender and nonbinary youth surveyed by the Trevor Project in 2022 said they have worried about transgender people being denied access to gender affirming medical care due to state or local laws; and

WHEREAS, multiple healthcare institutions across the country, including in Missouri, have scaled back or have considered scaling back gender-affirming healthcare services in response to legal challenges, perception of legal risk, harassment, or threats of violence; and

WHEREAS, a large number of the institutions providing gender-affirming healthcare in the State of Missouri are located in Kansas City, and local advocates already report long waitlists and difficulty accessing medically necessary gender-affirming healthcare; and

WHEREAS, the City of Kansas City has consistently declared its commitment to furthering transgender equity and supporting its growing transgender community; and

WHEREAS, healthcare professionals providing as well as persons seeking, receiving, or assisting another individual who is seeking or receiving gender-affirming healthcare in the City of Kansas City should be protected from attempts to impose criminal punishment, civil liability, administrative penalties, or professional sanctions based on the laws of other states when gender-affirming healthcare is lawful in the State of Missouri and meets standards for good professional practice; and

WHEREAS, a majority of U.S. adults agree that transgender minors should have access to gender-affirming care; and

WHEREAS, it is necessary and appropriate to exercise the authority vested in the City of Kansas City Charter, including the coordinated and integrated direction, supervision, and control of all City of Kansas City departments, boards, commissions, and other agencies, to protect healthcare professionals and persons lawfully seeking, receiving, and assisting another individual in seeking or receiving of gender-affirming healthcare in the City of Kansas City; NOW, THEREFORE,

BE IT RESOLVED BY THE COUNCIL OF KANSAS CITY:

Section 1. That the Mayor and Council hereby declare the City of Kansas City a Safe Haven for Gender-Affirming Healthcare.

Section 2. That the City of Kansas City hereby adopts the following Gender-Affirming Healthcare Policy:

1. City personnel shall not criminally prosecute or impose administrative penalties on an individual or organization for providing, seeking, receiving, or assisting another individual who is seeking or receiving gender-affirming healthcare.

2. In the event any law or regulation is passed in the State of Missouri which imposes criminal punishment, civil liability, administrative penalties, or professional sanctions, on an individual or organization for providing, seeking, receiving, or assisting another individual who is seeking or receiving gender-affirming healthcare, City personnel shall make enforcement of said law or regulation their lowest priority.

3. City personnel shall not enforce laws of other jurisdictions that impose criminal punishment, civil liability, administrative penalties, or professional sanctions, on an individual or organization for providing, seeking, receiving, or assisting another individual who is seeking or receiving gender-affirming healthcare and shall decline any request to stop, arrest, detain, continue to detain, or transfer into out-of-state custody individuals on the basis of such conduct being criminalized, penalized, or prosecuted in said jurisdiction.

4. Except as required by lawful authority, City personnel shall not respond to any request for information from another jurisdiction if the request is related to that jurisdiction's laws, rules, or regulations imposing criminal punishment, civil liability, administrative penalties, or professional sanctions, on an individual or organization for providing, seeking, receiving, or assisting another individual who is seeking or receiving gender-affirming healthcare.

5. Except as required by lawful authority, City personnel shall not enforce or facilitate the collection of any judgment of another jurisdiction to the extent the judgment arises out of a cause of action in that jurisdiction based on providing, seeking, receiving, or assisting another individual who is seeking or receiving gender-affirming healthcare.

6. That the Kansas City, Missouri Police Department is hereby encouraged to adopt a similar Gender-Affirming Healthcare Policy.

Authenticated as Passed

Quinton Lucas, Mayor

Marilyn Sanders, City Clerk

MAY 11 2023

Date Passed

KANSAS CITY
MISSOURI

KANSAS CITY
MISSOURI

Resolution #230385 is Proactive & The First Step

- This is an example of harm reduction to minimize violence towards trans people accessing gender affirming care.
- The resolution is critical for protecting health outcomes & access for trans people.
- Many trans communities of color & trans youth without supportive guardians also don’t have access to current gender affirming care options.

Call to Action / Next Steps

- Vote to pass Resolution No. 230385 to show support & active commitment to KC's trans and nonbinary communities.

- Encourage an amendment added to encourage Jackson, Clay & Platte Counties not to prosecute those seeking or providing gender affirming care.

- Kansas City needs to continue to financially invest in trans communities and identify the barriers to health access, as well as uplift services & sustainable programs that serve trans communities.