OCA Investigation: Calls Made By Waterbury Public Schools to Local Police Regarding Students Attending Elementary and PreK through Grade 8 Schools During the 2018-19 School Year

September 1, 2020

BACKGROUND

During the 2018-19 school year, the Office of the Child Advocate (OCA) received multiple concerns related to Waterbury Public Schools' (WPS) delivery of services and supports to vulnerable students. Specific concerns were (1) the treatment of a very young student with disabilities who was receiving special education services, including the district's involvement of local law enforcement to address the student's behavioral issues: (2) suspension of young students and (3) arrests of young students. Due to the serious nature of the allegations, OCA determined that conducting a broader investigation of the WPS's practices as they pertain to seeking local police involvement for student behavioral concerns was warranted. OCA requested corresponding documentation from the Waterbury Police Department (WPD).

OCA is an independent state oversight agency tasked by state statute to investigate and publicly report on the efficacy of child-serving systems, review complaints of persons or entities concerning the actions of any state or municipal agency providing services to children, and issue reports and recommendations to the public.

METHODOLOGY

In March 2019, OCA requested the following records from the WPD and WPS for the time period: September, 2018- March, 2019:

1. Records of all calls made to the Waterbury Police Department by Waterbury Elementary Schools regarding student behavioral concerns.
2. Records of Waterbury Police Department responses to calls made by Waterbury Elementary Schools to address student behavioral concerns.
3. Records regarding all arrests at Waterbury Elementary Schools that resulted from student behavioral concerns.

OCA also reviewed the following:

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1. Records maintained by the Department of Children and Families (DCF) and Child Health and Development Institute of Connecticut (CHDI)[1] regarding the state's Mobile Crisis Intervention Services, formerly known as Emergency Mobile Psychiatric Services (EMPS) program.
2. Juvenile court referrals for children age 12 and under, disaggregated by municipality, gender and race.
3. State discipline data maintained by the State Department of Education.

OCA discussed data and information related to this review with Waterbury Public Schools', the Waterbury Chief of Police, CHDI, DCF, the State Department of Education, community-based mental health treatment providers serving children and families in Waterbury and other high-need urban communities in Connecticut, multiple members of the Racial and Ethnic Disparities[2] Waterbury team, and experts regarding positive school climate work.

The OCA shared a draft of this Report with of the state and local agencies identified herein. All agencies were given the opportunity to share with OCA any comments or concerns regarding the draft findings and recommendations. Efforts have been made to incorporate relevant feedback in the final Report. The OCA thanks all state and local agencies for their cooperation and responsiveness to this review.

INTRODUCTION

OCA's investigation found that in the six month period of September 2018 through March 2019, there were approximately 200 calls to police made by Waterbury elementary and Pre-K through Grade 8 schools as a result of a child's behavior, typically either a behavioral health crisis or an act of physical aggression by a child or multiple children, with children as young as 4 and 5 the subject of calls to police. OCA found that more than half of the schools called police to respond to children more often than they called community mobile crisis intervention teams.

A review of police records revealed that 18 percent (n= 36) of police calls resulted in a student arrest, typically associated with a child's act of physical aggression or threats, including nine (9) children age

[1] CHDI, under contract with DCF, operates the Mobile Crisis Performance Improvement Center, and coordinates all data analysis, quality improvement, and training activities for the statewide network of Mobile Crisis providers.

[2] The RED model, spear-headed by the Center for Children's Advocacy, a nonprofit legal advocacy organization for vulnerable children, creates a diverse roundtable of individuals who are key decision makers in the lives of youth in Bridgeport, Hartford, New Haven and Waterbury. Members of the RED team include juvenile probation supervisors, DCF regional administrators, Juvenile Review Board directors, judges, police, school officials, city and municipal staff, and key community-based program representatives, among others. Each committee engages in the effective examination of data at each decision point, disaggregated by race/ethnicity, gender and age, identifies areas of disparity and plans strategic interventions, including local and national best practices, to implement change. The committees have been in place in Hartford and Bridgeport since 2011, New Haven since 2013 and Waterbury since 2015 and have noted decreases in school based arrest, referrals to court and secure detention admissions in each of these cities.

11 and under.[3] The median age of a child subject to arrest was 12. All 36 arrests were for misdemeanor charges. When children are arrested, they are typically handcuffed and brought to the police station to process the arrest.

In Connecticut, where children as young as seven can be subject to arrest and detention, 141 Connecticut children under age twelve were referred to juvenile delinquency court in 2018. According to a recent data analysis from CT Voices for Children, "Since 2010 Waterbury has referred more children to the juvenile justice system than any other court in seven out of ten years [and] in 2018, 22.7 percent of all young children referred to court came from Waterbury."[4] More than two-thirds of children referred to court statewide were children of color.[5]

Research has long shown that the vast majority of youth referred to the juvenile justice system have witnessed traumatic events, experienced significant deprivation, have mental health treatment needs or suffered individual victimization.[6] OCA found that the majority of students who were the subject of a police report (with or without an ensuing arrest) lived in a family with a history of having been reported to the Department of Children and Families (DCF) due to concerns of child abuse or neglect.

Children who have traumatic life experiences are the most likely children to act out in school and be subjected to school suspension or arrest. Trauma has been shown to actually change the structure and functioning of a young child's brain through activation of the "flight or fight" response,[7] leaving a child to live in a constant state of emergency. Very young children, whose brains are still rapidly developing are understood to be "at particular risk" of harm as [trauma affects] memory, attention, thinking, language and consciousness… the ability to regulate emotions…. Unlike older children,

[3] Students attended the Waterbury PreK-8 and K-5 schools who were arrested ranged in age from 9 to 16 years old and the median age of arrested students was 12.

[4] CT Voices for Children *No Place for a Child*, pg. 12. https://ctvoices.org/wp-content/uploads/2020/02/No-Place-for-a-Child_Final-Report.pdf. For comparison purposes, according to CT Voices for Children's recent report *No Place for a Child,* the United States is an "outlier" compared to many other countries with regard to the arrest and prosecution of young children, with only 24/193 countries surveyed permitting criminal responsibility age 7, and the most common minimum age of criminal responsibility internationally is 14. In the United States, Voices found, more than half of states do not have any minimum age for criminal responsibility. Of those states that do set a minimum age, the majority (19) set that age higher than Connecticut. Two states, California and Massachusetts have raised the minimum of age of juvenile court jurisdiction to 12, thereby more closely aligning justice practices with those of other countries.

[5] According to Connecticut Judicial Branch data and a recent report from CT Voices for Children, 80% of charges for children statewide under age 12 were for misdemeanor offenses and "almost all of the children were not prosecuted, were discharged, or had their cases not accepted/dismissed during that time."

[6] Julian D. Ford, John F. Chapman, Josephine Hawke, and David Albert, *Trauma Among Youth in the Juvenile Justice System*, The National Center for Mental Health and Juvenile Justice Program Brief (June 2007). Found on the web at: https://www.ncmhjj.com/wp-content/uploads/2013/07/2007_Trauma-Among-Youth-in-the-Juvenile-Justice-System.pdf

[7] Bellis, M., Zisk, A., *The Biological Effects of Childhood Trauma*, Child Adolesc. Psychiatr. Clin. N. Am., Apr. 23 2014.

young children cannot express in words whether they feel afraid, overwhelmed, or helpless. However their behaviors provide us with important clues."[8]

The symptoms of trauma are often the very behaviors adults may aptly describe as "out-of-control." According to the National Child Traumatic Stress Network:

> Traumatic reactions can include a variety of responses, such as intense and ongoing emotional upset, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, problems relating to others or forming attachments, regression or loss of previously acquired skills, attention and academic difficulties, nightmares, difficulty sleeping and eating, and physical symptoms, such as aches and pains. Older children may use drugs or alcohol, behave in risky ways, or engage in unhealthy sexual activity.[9]

More than forty of the incident reports reviewed by OCA documented children, many as young as 7, 8 and 9 years old, banging their heads, tying things around their neck and expressing that they wanted to die. When police were called by the schools to respond, some of these children were handcuffed, per the police reports, for their own safety and the safety of others. Other police reports documented children threatening to harm others, hitting, punching and kicking students or school staff. Several incidents involved children fighting.

Often police reports described children as having disabilities or "special needs." A few children were the subject of several reports, and these children were all described as students with disabilities. The children with the most reports were identified in police records as children with Autism.

Concerned, overwhelmed and under-resourced school administrators may rely on police to respond to children's crises, seeing police intervention as a rapid way to address a child's spiraling behaviors, ensure a safe school environment, or as an effective strategy to access hospitalization and crisis support. Mobile crisis response times, which averaged just over 20 minutes in the Waterbury region (one of the lowest response times in the state)[10] may seem too long for school staff and administrators, and too few schools, and no Waterbury elementary schools, had dedicated school-based clinical staff[11] to help support children and educators.

Unfortunately, use of law enforcement as a behavioral health first response system is problematic and does not increase the likelihood of a child and their caregiver becoming well connected to community

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[8] Source: The National Child Traumatic Stress Network, *About Child Trauma*, found on the web: https://www.nctsn.org/what-is-child-trauma/about-child-trauma.

[9] Id.

[10] Mobile Crisis Intervention Services Performance Improvement Center (PIC) Annual Report Fiscal Year 2019. Found on the web at: https://www.empsct.org/wp-content/uploads/2019/09/Mobile-Crisis-Annual-FY2019-Report_FINAL.pdf.

[11] Dedicated solely to one school.

supports.[12] Ample research shows that early involvement with the justice system, always a heightened risk when law enforcement is involved, is strongly correlated to student arrest, student discipline, student disengagement and dropping out. A 2019 report from CT Voices for Children, *Policing Connecticut's Hallways: The Prevalence and Impact of School Resource Officers in Connecticut* (April 2019),[13] found that the presence of police officers in Connecticut schools did not lead to improved public safety outcomes, but did lead to greater risk of student suspension and arrest for Latino students. In fact, CT Voices found that "the average arrest rate of Latino students at schools with a [School Resource Officer (SRO)] was six times greater than the average arrest rate of Latino students without an SRO," while schools with SROS also reported "higher levels of school policy violations, such as skipping class, insubordination, or using profanity."[14]

Of course, police are obligated to respond to crises when called, and Waterbury police reports reviewed by OCA were typically thorough, describing the circumstances leading to the police being called, detailing efforts the police made to engage with a child, connect with a parent/guardian, arrange for ambulance transport, or ensure that local authorities such as DCF were contacted as needed. OCA met with a representative from the Waterbury Police Department during the course of this review and reviewed the report's findings with the Waterbury Police Chief, both of whom expressed the Police Department's commitment to engaging with youth, establishing more relationships in the elementary schools and moving more children into community diversion programs.

Yet, as the Waterbury Police Department acknowledged, law enforcement officers generally are not trained in children's behavioral health or how to work with children who have disabilities, and they are not responding to schools with support from or as part of a coordinated community mental health response. According to the U.S. Substance Abuse and Mental Health Services Division (SAMHSA), a Division of the U.S. Department of Health and Human Services, *National Guidelines for Behavioral Health Crisis*:

> In many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the de facto mental health mobile crisis system. This is unacceptable and unsafe… [While] the role of local law enforcement in addressing emergent public safety risk is essential and important. … unfortunately, well-intentioned law enforcement responders to a crisis call often escalate the situation solely based on the presence of police vehicles and armed officers that generate anxiety for far too many individuals in a crisis.[15]

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[12] United States Substance Abuse and Mental Health Services Administration, *National guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, pg. 33. Found on the web at: https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[13] Connecticut Voices for Children, *Policing Connecticut's Hallways: The Prevalence and Impact of School Resource Officers in Connecticut*, (April 2019), found on the web at: https://ctvoices.org/publication/policing-connecticuts-hallways-the-prevalence-and-impact-of-school-resource-officers-in-connecticut/.

[14] Id. at 16.

[15] United States Substance Abuse and Mental Health Services Administration, *National guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, pg. 33 (emphasis added).

SAMHSA noted that good mental health crisis services and teams must be in place, and where public safety requires, the crisis team should collaborate with law enforcement.[16] SAMHSA referenced research showing that strategic alliances between law enforcement and mental health professionals can be effectively implemented to reduce unnecessary hospitalization, arrest and incarceration.[17]

OCA's investigation found that the elementary and Pre-K through Grade 8 schools in Waterbury that had the highest number of police calls also had the highest number of student suspensions.[18] Two schools that purport to have specialized resources for children with behavioral health treatment needs[19] accounted for a combined 370 school suspensions and police calls in the 2018-19 school year alone, persuasive evidence of a lack of effective support structure, including adequate special education services, in place for students and educators.[20]

Today a national conversation is taking place regarding the role of police in schools and how reliance on law enforcement in our schools to provide security and behavior management has overtaken investment in children's mental health, mentorship, support for teachers and other educators, and investment in human services, a lack of investment that most harshly impacts children and communities of color, often children with disabilities. It will be essential to reverse this trend to further the public health goals of supporting children's wellbeing and combatting the impact of systemic racism on vulnerable children.

REPORT FINDINGS AND DISCUSSION

[16] Id. at 33-34.
[17] Id. at 34.
[18] State Department of Education discipline data, broken down by district and school, maintained on Ed Site. Available on the web at: http://edsight.ct.gov/SASPortal/main.do. National studies have demonstrated that children who are subjected to exclusionary discipline (suspension; expulsion) at some point in his/her academic carrier are less likely to graduate from high school. Students who are expelled are at a higher risk of ending up in the school-to-prison pipeline. National Conference of State Legislatures, *School Discipline,* Colleen Brooks and Benjamin Erwin (6/24/2019), available on the internet at: https://www.ncsl.org/research/education/school-discipline.aspx; see also EdJustice, National Education Association, *Ending the School-to Prison Pipeline*, available on the internet at: https://neaedjustice.org/ending-the-school-to-prison-pipeline.
[19] Two of the schools that were part of OCA's review have embedded Behavioral Disorder Learning Centers (BDLC). According to the WPS website, "within each middle school there are two BLDC classrooms and one BDLC classroom at each high school. A set of guidelines has been established that should be considered prior to referral of a student into the BDLC program. The average number of students per class is approximately 10. Each classroom is assigned a Special Education teacher and a paraprofessional. Students in the BDLC classrooms participate in a weekly group counseling session with the school psychologist or school social worker. Issues addressed may include anger management, self-esteem, and socialization. Individual counseling is also provided depending on a student's IEP." https://www.waterbury.k12.ct.us/Content2/248.
[20] In one school, police reports noted that the complainant was often the special education staff.

12/11/18 Police Report-- excerpt

Police were dispatched for a "four year old female out of control." Maria (pseudonym) was "calm at this time." Per the report, the school social worker explained that this was the third incident in the past two weeks where Maria had been "belligerent" in school. She was reportedly "kicking and pushing staff" and would "then knock books off a bookcase." It was reported to by school personnel that the "child was having behavior issues, suffers from mental illness and is on medication to control her behavior." An ambulance was call to transport Maria to St. Mary's Hospital Behavioral Health Division for treatment. It was learned that this child was in DCF foster care; her case worker and foster mother responded to the hospital.

1. **From August 2018 through March 2019, there were 198 police reports provided by the WPD corresponding to calls from WPS elementary schools and PreK - Grade 8 schools regarding student behavioral concerns.**

OCA sought data from both the District and the police department regarding the number of calls by District personnel to local police about young students exhibiting behavioral concerns in District schools.

"Behavioral concerns" as defined by OCA for purposes of this review were instances where police responded to a request for intervention at a school serving children Pre-Kindergarten through 8th Grade due to a student attempting to harm themselves or others or otherwise described as out-of-control.

The WPD provided OCA with incident reports and call logs.[21] Per police data, there were a total of 198 incidents in Pre-K through Grade 8 schools involving a "behavioral concern" that resulted in a district call to police. The total number of individual students involved in the incidents, without duplication was 162.[22] The most frequent Call Types as documented in the police reports were:

- Mental Illness/Psych, Medical Assist or Suicide Attempt (Medical Assist Calls included here corresponded to calls about children's mental health): 81
- Disturbance: 43
- Assault or Fighting: 17

[21] Not all reports forwarded by WPD to OCA involved a student with a "behavioral concern." WPD reported to OCA that they erred on the side of providing more information and allow the OCA to determine what calls to the police would constitute "behavioral concerns." Of the 297 reports provided by WPD, OCA determined that one hundred and ninety-eight (198) of the police reports met the OCA's criteria of relating to student "behavioral concerns."

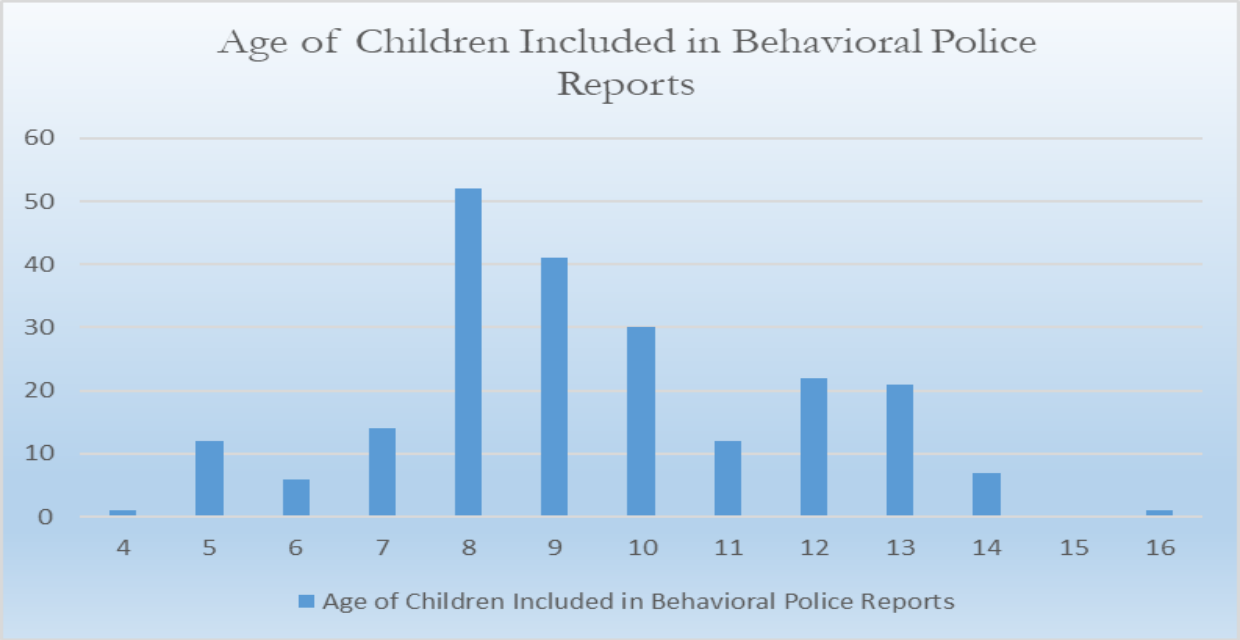
[22] There were 34 students who had two or more reports throughout the school year.

Police incident reports typically, though not always, identified a "complainant." The complainants varied and included, among others, teachers, often special education staff, other school staff and administrators. A few complainants were identified as parents or guardians.

Data provided to OCA by the school district regarding calls to police was inaccurate when compared to police data

The school district reported that during the six month period under review (September 2018 – March 2019) there were 61 calls to the police by WPS elementary and Pre-K through Grade 8 schools, of which 48 were determined by OCA to meet the OCA criteria of a behavioral incident. The data provided by the district reflected about 150 fewer calls to the police than is seen in the data provided to OCA by the police department. School district administration later acknowledged the data discrepancy. The Superintendent told OCA that the District was looking to improve the reliability of its police-call and school-based arrest data going forward.

2. **The Median Age of Children Who Were the Subject of a Police Call was 9 Years Old, and the Youngest Child was 4 Years Old.**[23]



The age range for children who were the subject of a police call in a Pre-K through 8th Grade was 4 years old to 16 years old.

[23] Four years old=1; Five years old=12; Six years old=6; Seven years old=14; Eight years old=52; Nine years old=41; Ten years old=30; Eleven years old=12; Twelve years old=22; Thirteen years old=21; Fourteen years old=7; Fifteen years old=0; Sixteen years old=1.

3. **There were 85 children age 8 and under who were the subject of a police report**

Forty-three percent of the reports reviewed by OCA involved children age 8 and under, and the behaviors documented in police reports included tantrums, running out of the school, hitting and scratching themselves or staff, head banging, and making threats to harm themselves or others.

> Police were dispatched to Waterbury elementary school for what was coded in the police narrative as a "mentally disturbed child." The student, 8 year old Brandon (pseudonym), was standing in the hallway with "his shirt off. Brandon was calm but breathing heavy." The school social worker and the boy's mother were present and said that the student was "kicking and screaming and then began to undress himself" as he entered the school. The student was not identified as having an official diagnosis and does not take any medications. The student was transported to St Mary's Hospital for "behavioral health treatment." Two school days later, the police responded again to the school about Brandon. He was "aggressive to his mother and [the school social worker] because he did not want to go to school." Brandon was "pulling away from them and pushing them." The mother wanted Brandon to go for evaluation at St Mary's Hospital and the student was eventually transported there by ambulance.

4. **Many reports documented that the subject child had a disability or was known to have "special needs" or mental illness.**

The majority of police reports reviewed by OCA included documentation that a child was known to school staff as a child with a disability. Indeed, at one school, the police reports frequently identified the "complainant" as a special education teacher.

> Officer was dispatched to SCHOOL in regards to a suicidal attempt complaint. Upon arrival, I met with the complainants, the school principal and the special education teacher. TEACHER stated one of her students was being uncooperative in class and he was not following directions. TEACHER told child many times to stop acting this way, and he became agitated, by yelling and waving his arms around aggressively. CHILD stated he was going to go home and write a suicide note, and he was not going to come back to school because he was going to kill himself. TEACHER stated CHILD began slapping himself in the face repeatedly when police were called for assistance. I then spoke with CHILD. CHILD was crying in the corner of the classroom and he would not answer any questions. AMR Ambulance EMTs were on scene and placed CHILD into an ambulance without incident. I spoke with CHILD'S mother and made her aware of the incident. MOTHER stated she was leaving work and would respond to HOSPITAL.
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> Officer dispatched to SCHOOL on a medical assist for an out of control student. Upon arrival, I met school staff outside of the school on the side of the building. They were restraining a student, CHILD, age 8. CHILD did not want to go back inside the school after recess. CHILD was trying to run away and had to be restrained. CHILD was aggressive and

swinging his arms. I placed handcuffs on CHILD and placed his arms in front of him, just to deter him from swinging at staff and myself. CHILD was able to calm down a bit and we were able to place him on a stretcher and eventually the ambulance. CHILD was not talkative, he did not want to explain what was bothering him to myself or school staff. He was transported to Waterbury Hospital by AMR without incident. … Staff stated that nothing happened during the day for CHILD to react this way, but that he was just more quiet than normal during the school day. CHILD is on medications but he takes his medications at home and not at school."

Officer dispatched to SCHOOL on a mentally ill person complaint. Upon arrival to the school, this Officer was able to hear a student screaming all the way outside. … As I entered the classroom, I saw a female student, 8 years old CHILD, being restrained by school staff because they were stopping her from hurting herself and others. As soon as they let CHILD loose, she began to scratch her wrist with a [sic] nails. When her teacher attempted to stop CHILD from scratching herself, CHILD attempted to scratch TEACHER with her nails. Due to CHILD'S assaulting and self-injury behavior, I immediately placed her in handcuffs, in an attempt to stop her from injuring herself or others. As soon as I placed CHILD in cuffs, she immediately calmed herself down. As soon as Ambulance arrived, CHILD sat on the stretcher and I removed the cuffs. I spoke to teacher, who stated that during class, CHILD was misbehaving, so she decided to take away the recess time. When CHILD found out that she had lost recess, she became very agitated and combative. She then began to slam her head on a table and then grabbed a pencil to stab herself. When CHILD heard TEACHER telling me about the pencil incident, CHILD stated "because I lose my recess, so I don't want to live anymore." Based on the statements and from what I observed, I believe CHILD to be a danger to herself and others and in immediate need of medical evaluation. … at HOSPITAL I met with CHILD's MOTHER. … MOTHER stated that CHILD is Autistic.

OFFICER was dispatched to SCHOOL regarding a complaint of a 9 year old student who was acting out and hitting teachers. Upon my arrival, I spoke with the complainant who is a special education teacher employed here. TEACHER said that one of her students suffers from autism. She said that CHILD was not listening to directions and she was in a crisis. That CHILD was throwing things around the classroom and said that she can be violent. She said that this was the third time that CHILD has become irate in school and that on two previous occasions she has threatened suicide so she removed the shoelaces from CHILD'S shoes. She said that CHILD had banged her head on the wall, causing a bruise on her forehead and that she had also bit herself on the arms. TEACHER said that she had called CHILD'S mother numerous times, but she did not answer and did not call back as of yet. She said that she feels that the mother is not answering because she is tired of coming here to the school to pick up her daughter. This Officer observed a small bruise in the center of CHILD'S forehead and numerous old bruises all over both of her arms. CHILD was yelling and screaming at times while I was here and she refused to speak to this Officer. CHILD finally calmed down and AMR ambulance placed her on a stretcher without violence, and CHILD was later transported to HOSPITAL for evaluation. The Vice Principal also rode in

the ambulance to the hospital with CHILD, and she would stay at the hospital until the mother could notified and also respond there.

Officer DISPATCHED to school regarding a complaint of a student with mental illness issues. Upon my arrival, I spoke with the complainant who is the principal. PRINCIPAL said that an 8 year old student was out of control, refusing to listen to staff and that he had been kicking and hitting, refusing to calm down. She said that he suffers from ADHD and takes medication. She said that he was disrupting his entire class and he was taken to her office. She said that she had notified CHILD'S father, but that FATHER was not at home … this officer attempted to speak with CHILD, but he was whimpering, crying, moaning and sobbing, curled up in a ball and would not calm down. There were no injuries to anyone. Ambulance personnel responded here to the scene and later transported CHILD to HOSPITAL for evaluation.

Officer responded to SCHOOL to see Principal regarding an incident with third grade student. CHILD is severely mentally handicapped. She is in therapy and counseling in the school as well as outside the school and she sees a neurologist on a regular basis for her condition. Upon arrival at the school I also met her parents. Earlier today in class CHILD had an episode which included a loud verbal outburst where she said she would kill everyone in class. She also took a pencil and made stabbing motions towards her classmates and staff. This is not the first time CHILD had done something like this. After the episode she actually passed out briefly and her parents were called. They responded immediately. Both parents reiterated what principal said regarding CHILD'S mental condition and treatment. During my visit CHILD was crying and appeared to not understand the results of her actions and was being consoled by her mother. She was scheduled for a doctor's appointment today after school. Based on the aforementioned information no police action would be taken other than documentation of the incident.

5. **Outcomes of Police Calls Varied.**

Eighty-four (84) of the police reports indicated that the student was sent from school to the hospital for evaluation. Sixteen (16) reports indicated parents refused a hospital visit for the student. Six (6) of the reports indicated the DCF Careline was contacted by the WPD as a result of the incident. Thirteen (13) of the reports indicated that the responding officer searched the student's home or belongings at school for weapons, as a result of a threat made at school, though in twelve (12) of those cases no weapon was found and in one search police noted that the home had a weapon, but it was properly secured by adult/s. A couple of incident reports referenced police referring a child to a community diversion program in lieu of arrest. Thirty-six (36) children were arrested.

6. **Incidents involved a range of children's behaviors, including physical aggression, threats, and statements of intent to self-harm.**

Incidents that led to police calls frequently included fighting, other incidents of physical aggression, verbal threats to students and staff, some made by very young children, and suicidal statements and self-harming behaviors.

More than 40 police reports reviewed by OCA documented children engaging in suicidal or self-harming gestures such as tying a shoelace around their neck, tying an extension cord around their neck, writing a suicide note, or telling a teacher or police officer that they wanted to die. Most of these children were age 10 or younger.

8-year-old restrained outside of school building by staff after running away at the end of recess. Officer handcuffed student's arms in front of his body to avoid swinging at staff members.

8-year-old stated he wanted to kill himself and attempted to take his shoelace off and tie it around his neck. Teacher confiscated sneakers and student told officer that he did not want to live anymore. Student said he wanted to be "with his dad," who had passed away.

9 year-old lost a point in class, swung headphones around room and almost hit staff. Brought to another room designed for escalated children. Began biting his arm and was being restrained by staff when officer arrived. Kicking and screaming in restraint.

9 year old hit another student, two began fighting. Police called. 9 year old handcuffed by police. Brought to hospital for evaluation. Suspended from school.

9 year old. Asked classmates for knife, saying he wanted to stab the lunch lady. Arrested and charged with Breach of peace and Threatening.

8 year old. Overheard by teacher threatening to kill a classmate. Student said he didn't mean to say kill, said he was talking about a Spiderman villain.

10 year old. A classmate told teacher that child had threatened to kill her. Child then told teacher he wanted to kill himself when he was asked about the incident. Student was angry that classmate had turned off his computer.

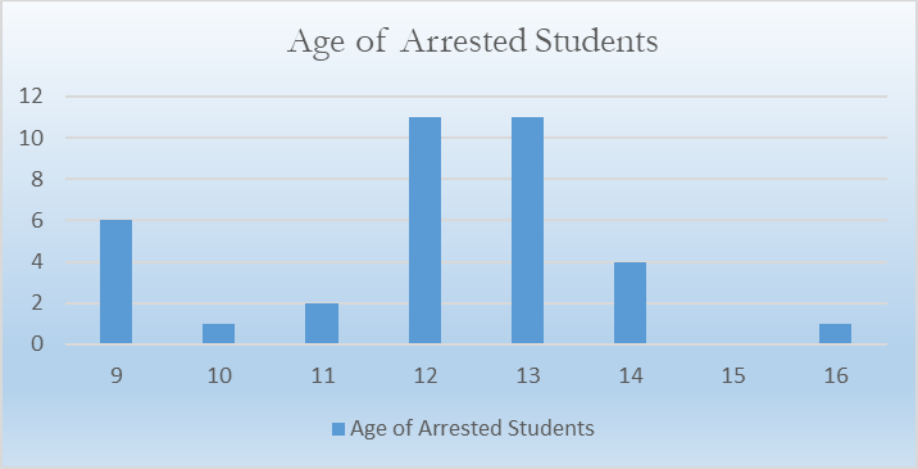
7. **<u>Documentary Data Regarding the Race/Ethnicity of Children Who Were the Subject of Policy Reports was Not Reliable</u>**

Police reports often listed a subject student's Race, noting that the child was either Black or White. There was no differentiation in police reports between White and Hispanic students. Forty incident reports listed Race as "Unknown."

ARRESTS AND SCHOOL SUSPENSIONS ARISING OUT OF REPORTED INCIDENTS

<u>Just under 20% of police responses resulted in a student arrest.</u>

Out of the 198 incidents resulting in a call to police and a police report, there were thirty-six arrests of students.



- Police reports documented that of the 36 arrests, 14 students were identified as Black and 17 were identified as White. Five of the students arrested did not have their race identified in the report. Again, race/ethnicity data was listed as either Black or White, and did not include information about whether a child was Hispanic. The majority of students in Waterbury, per SDE data, are identified as Hispanic.

- Students who were arrested ranged in age from 9 to 16 years old, and the median age of arrested students was 12.

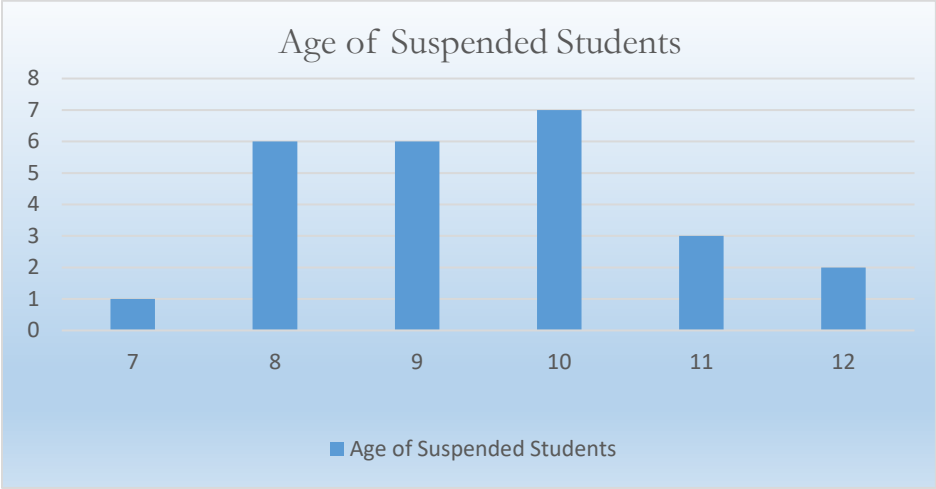
Four of the incidents leading to a student arrest involved a child hitting, punching, pushing or threatening school staff. Two of these children were 9 years old, one was 12 and the other 13. The remaining thirty-two arrests involved physical fights or attacks between children, verbal threats of harm made by children, and one trespass charge for a student who came to school despite being

suspended. All thirty-six arrests were for Misdemeanor charges.[24] Incident reports that detailed assaultive behavior by a student age 12 and older more often resulted in an arrest. Nine (9) children age 11 and under were also arrested. Younger children were more likely to also express a wish to self-harm and were more likely to be transported by ambulance to a local hospital.

According to 2018 data from the Connecticut Judicial Branch Court Support Services Division regarding the arrest of children age 12 and under throughout the state, the City of Waterbury led all municipalities with 61 delinquency referrals. By comparison, there were 20 delinquency referrals for young children in Bridgeport and 9 in Hartford during the same time period.

13% of incidents resulted in a documented student suspension.

Of the 198 incidents leading to a police report, 25 resulted in a documented student suspension.



Students ranged in age from 7 to 12 years old and the median age of suspended students was 9 years old. Students were reportedly suspended for physical violence and threats of physical violence.

Connecticut law does not permit the out-of-school suspension of a student in Pre-K through second grade unless an informal hearing "determines that an out-of-school suspension is appropriate for such pupil based on evidence that such pupil's conduct on school grounds is of a violent or sexual nature that endangers persons."[25] Most students who were suspended appeared to be in third grade or above.

District Data Regarding School-Based Arrests was Inaccurate

Similar to the data disparity OCA found between data provided by the police department and school district with regard to police calls, the list of arrests provided by the district for these schools

[24] Charges included Third Degree Assault, Breach of Peace, Disorderly Conduct, Threatening, Harassment, Trespass, Criminal Mischief, Reckless Endangerment, and Sexual Assault 4th.
[25] Conn. Gen. Stat. Section 10-233c(g).

significantly understated the number of arrests arising out of the district's request for police intervention.

MOBILE CRISIS INTERVENTION SERVICES UNDER-UTILIZED BY THE DISTRICT DURING THE PERIOD UNDER REVIEW, THOUGH UTILIZATION VARIED BY SCHOOL

OCA reviewed the number of police reports as well as the number of calls to 211 Mobile Crisis between August 2018 and March 2019. According to the program website, Mobile Crisis services are funded by DCF and "are for children and adolescents experiencing a behavioral or mental health crisis."[26]

> [I]n partnership with the United Way of Connecticut and the Child Health and Development Institute (CHDI), [Mobile Crisis Services] comprises a team of nearly 150 trained mental health professionals across the state that can respond immediately by phone or face to face within 45 minutes when a child is experiencing an emotional or behavioral crisis. The purpose of the program is to serve children in their homes and communities, reduce the number of visits to hospital Emergency Rooms, and divert them from hospitalization if a lower level of care is a safe, effective alternative.[27]

The program is accessed by calling the state's 2-1-1 information line and is available 24 hours per day, seven days per week to all children, up to age 18., regardless of health insurance status.[28]

In 2013, the Connecticut General Assembly passed Public Act 13-178, *An Act Concerning the Mental, Emotional and Behavioral Health of Youth*, which Act included the requirement that Mobile Crisis providers collaborate with, among others, local boards of education to strengthen the referral process from school districts to community providers regarding children with mental, emotional or behavioral health needs.[29]

OCA reviewed the Memorandum of Understanding between the City of Waterbury, Waterbury Public Schools and Wellmore, Inc., regarding the provision of Mobile Crisis Services, which Memorandum was signed in summer of 2016. The Memorandum provides that Wellmore, a non-profit community-

[26] https://www.empsct.org/about/
[27] Id.
[28] https://www.cga.ct.gov/2013/rpt/2013-R-0082.htm
[29] Public Act 13-178, Section 1(b): "Emergency mobile psychiatric service providers shall collaborate with community-based mental health care agencies, school-based health centers and the contracting authority for each local or regional board of education throughout the state, utilizing a variety of methods, including, but not limited to, memoranda of understanding, policy and protocols regarding referrals and outreach and liaison between the respective entities. These methods shall be designed to (1) improve coordination and communication in order to enable such entities to promptly identify and refer children with mental, emotional or behavioral health issues to the appropriate treatment program, and (2) plan for any appropriate follow-up with the child and family."

based provider of mental health services will deliver Mobile Crisis Services as needed, and that the district will contact Mobile Crisis "when a student is determined to be experiencing a psychiatric or behavioral health crisis and can benefit from in-person psychiatric stabilization services."

Many of the Police Call Types reviewed by OCA were coded as Mental Health Psych/Medical Assist or Suicide Attempt. Only a few reports mentioned calls to Mobile Crisis or use of a Mobile Crisis social worker. OCA compared the number of calls per school that resulted in a police response versus the number of calls by the same school to Mobile Crisis for the same period. The number of police reports in the chart below is the number of reports that were considered by OCA to be related to a child's behavior. The 211 Mobile Crisis calls reflect the number of times that a school contacted the 211 crisis line about a child's behavior. OCA also listed the reported number of in-school and out-of-school suspensions for each school for the 18-19 school year.[30] **While most schools used Mobile Crisis, half of schools made more calls to police than to Mobile Crisis/211.**

SCHOOLS WITH HIGHER NUMBER OF POLICE CALLS ALSO HAD HIGHER NUMBER OF SCHOOL SUSPENSIONS

OCA examined data regarding student suspensions in all of the Waterbury Elementary and PreK through Grade 8 Schools during the 2018-19 school year. Four out of five schools with the highest number of police reports during the period under review also had the highest number of school suspension for the academic year. Two of these schools (Bunker Hill and Woodrow Wilson) have embedded Behavioral Disorder Learning Centers (BDLC),[31] separate classrooms created to provide more structured intervention and support to high need children. Notably, these two schools had some of the highest numbers of police calls and suspensions combined, totaling more than 370 police responses and suspensions for the school year.

[30] Source: Connecticut State Department of Education Ed-Site, found on the web at: http://edsight.ct.gov/SASPortal/main.do.

[31] BDLC is an abbreviation for a separate classroom called the Behavioral Disorder Learning Center. There are 17 such classrooms at the elementary school level, three primary BDLC classrooms which encompass grades K-2, and four Intermediate classrooms which encompass grades 3-5. According to the WPS website, "within each middle school there are two BLDC classrooms and one BDLC classroom at each high school. A set of guidelines has been established that should be considered prior to referral of a student into the BDLC program. The average number of students per class is approximately 10. Each classroom is assigned a Special Education teacher and a paraprofessional. Students in the BDLC classrooms participate in a weekly group counseling session with the school psychologist or school social worker. Issues addressed may include anger management, self-esteem, and socialization. Individual counseling is also provided depending on a student's IEP." https://www.waterbury.k12.ct.us/Content2/248

School	Police Reports 8/25/18 to 3/26/19	Calls to 211 Mobile Crisis 8/15/18 to 3/29/19	Suspensions ISS[32]/0SS[33] 18-19 school year
B.W. Tinker School	22	13	16/41 total: 57
Bunker Hill School	33	37	64/69 + 47 (BDLC) total: 180
Carrington School	6	2	*/31 total: 31
Chase School	8	0	33/45 total: 78
Driggs School	13	9	59/87 total: 146
Duggan School	4	1	*/48 total: 48
F.J. Kingsbury School	1	12	*/23 total: 23
Gilmartin School	18	6	141/119 total: 260
Hopeville School	9	9	*/18 total: 18
Maloney Interdistrict Magnet School	1	3	0/*
Margaret M. Generali Elementary School	6	11	19/42 total: 61
Reed School	14	10	66/57 total: 123
Regan School	6	9	39/19 total: 58
Rotella Interdistrict Magnet School	2	2	8/0 total: 8
Sprague School	9	15	14/8 total: 22
Walsh School	13	4	13/23 total: 36
Washington School	5	3	6/* total: 6
Woodrow Wilson School	28	81	*/48 + 84 (BDLC) total: 132
Bucks Hill	0	0	6/19 total: 25
Wendell Cross	0	0	0/*
Total	**198**	**227**	

For Bucks Hill (Pre-K through 5) and Wendell Cross Elementary School (Pre-K through 5), there were zero police reports that were flagged as due to "behavioral" incidents by the OCA and zero calls to Mobile Crisis.

* Data suppressed by SDE to ensure confidentiality.

[32] In School Suspensions.

[33] Out of School Suspension

MEETING WITH WATERBURY SCHOOL OFFICIALS AND WATERBURY POLICE, AND DISTRICT REPONSE TO OCA REPORT

In November 2019, OCA met with WPS Superintendent, Dr. Verna Ruffin, and senior District administrators along with a representative from the Waterbury Police Department. District officials acknowledged that historically the district's data management of the issues addressed by OCA's review were unreliable. The district strongly affirmed its commitment to improving school-based behavioral support for young children, and pledged to reduce reliance on law enforcement and school-based arrests and suspensions of young children.

Superintendent Ruffin noted that her administration and leadership were still relatively new but that she strongly believes in the need to improve supports for young children and emphasize social-emotional learning and engagement with families. The Superintendent stated that her team is addressing the issue of out-of-school suspensions with individual schools and that school officials were meeting weekly to monitor data and implement improvements, as needed. The Superintendent's team spoke to OCA about the district's efforts to improve positive behavioral supports district-wide and its endorsement of restorative practices. They pointed to strengthened partnerships with community-based mental health providers such as Wellmore Behavioral Health and Family & Children's Aid as part of the district's effort to create linkages for children and families in need. The district spoke to the often "overwhelming needs of children and families," and noted that they lacked the optimal resources truly required to help staff meet those needs while children are in school.

The Waterbury police representative discussed the need to improve relations between police and the children in the elementary schools and noted that there is now a roving School Resource Officer who goes to different elementary schools establishing relationships with staff and students. The police officer also spoke to the need for more tools to assist children having a significant behavioral health crisis.

District officials pointed to a recent reduction in school-based arrests, noting an improvement, but acknowledged that they are still not "where they'd like to be." OCA's review of 2019 data regarding school-based delinquency referrals for young children statewide did show a drop in school-based arrests in the City, though referrals remained higher in Waterbury than in other major cities in Connecticut.

Waterbury School officials spoke of their participation in local Racial and Ethnic Disparities (RED) meetings, attended by various community stakeholders and advocates and intended to reduce the over-representation of youth of color at key decision-making points throughout the juvenile justice and educational systems.[34] These RED meetings historically have not examined police intervention with younger children.

[34] The RED model, spear-headed by the Center for Children's Advocacy, a nonprofit legal advocacy organization for vulnerable children, creates a diverse roundtable of individuals who are key decision makers in the lives of youth in Bridgeport, Hartford, New Haven and Waterbury. Members include juvenile probation supervisors, DCF regional administrators, Juvenile Review Board directors, judges, police, school officials, city and municipal staff, and key community-based program representatives, among others. Each committee

After reviewing OCA's final report, the District provided additional information regarding its efforts to improve supports for children and educators. WPS administrators are in discussions with DCF to increase preventative and collaborative support for students who are in DCF care. The District is working with the Waterbury Police Chief, Fernando Spagnolo, to host a series of local forums to discuss these issues using a community roundtable format. The District continues to talk with community partners to identify protocols for offering supports to the most at-risk students. The District reported to OCA that "Since the time frame of this report, the district has adopted an Equity Policy and began a professional development rollout on the topic of race and education with all staff in the comprehensive middle schools, central office staff and all building administrators." The District is also working to begin a roll out of CBITS for certain students and is "partnering with Community Mental Health Affiliates (CMHA) to work with students in person and/or virtually. The partnership will begin with a pilot serving 5-10 students in 2 schools to support students with trauma and behaviorally related issues. "

The District also reported that "To better address de-escalation techniques and provide appropriate professional development, Waterbury is shifting its crisis prevention model from SUPPORT to Safety Care intervention with 300 staff members being trained on September 1 and 2, 2020. The Safety Care Crisis Prevention model is nationally recognized and is grounded in PBIS and Applied Behavioral Analysis. By making this shift, Waterbury is placing a strong preventive focus designed to be an active part of restraint prevention and elimination initiative. Because Safety Care is based on positive reinforcement principles, it can be readily adaptable to the communication abilities of any individual. Waterbury previously had one SUPPORT training provider and it will now have 3 full time contracted trainers in district with long term goal of training district staff to become trainers. Through the efforts of the Safety Care initiative Waterbury will have more focus on the disengaged student to re-engage them in the educational process."

Waterbury also directly addressed concerns in OCA's report about the need to strengthen supports for students with disabilities. The District reported that "Waterbury recognizes the need to provide a robust and preventative model for its BDLC program. Under the new administrative structure, the Waterbury Pupil Services department is actively redesigning the BDLC program to better meet the needs of students. In the Summer 2020, a Professional Learning Community (PLC) composed of SPED Supervisors and Principals began re-writing the entrance protocols for the BDLC program. In the redesign of the BDLC, programs will be rebranded to focus on more positive aspects of supporting students. The programmatic and curricular redesign work will begin in fall 2020 with teachers joining the PLC."

Finally, Waterbury stated it is committed to a districtwide approach to SEL for ALL students, not specific to only special education students. The District reported that in March, 2020, trauma training

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engages in the effective examination of data at each decision point, disaggregated by race/ethnicity, gender and age, identifies areas of disparity and plans strategic interventions, including local and national best practices, to implement change. The committees have been in place in Hartford and Bridgeport since 2011, New Haven since 2013 and Waterbury since 2015 and have seen significant decreases in school based arrest, referrals to court and secure detention admissions in each of these cities.

was provided to paraprofessionals and training is being provided to behavior technicians, prevention specialists, school psychologists, Social Workers, and Speech/Language Pathologists on August 25, 2020. In addition, WPS reported that the districtwide BCBA will be stationed at Wilson School in close proximity to BDLC classrooms to have more direct contact with students and classroom staff.

MEETING WITH DCF

In January 2020, OCA met with Waterbury DCF officials to discuss the issues and data regarding school district reliance on law enforcement to respond to children's behavioral crises and unmet needs. DCF is both the state's lead mental health agency for children and a funder of Mobile Crisis Services and other targeted therapeutic supports for young children and their caregivers.

Of the 162 individual students who were the subject of a police report, 88 of these students lived in a household previously reported to DCF for suspected child abuse or neglect and 46 of these families had open cases with DCF in the 12 months prior to OCA's records examination.

During OCA's meeting with DCF regional administrators, officials affirmed their commitment to assisting with positive outcomes for high need children in the Waterbury area. DCF participates in local RED meetings along with public school officials but DCF regional staff observed that the RED meetings have not historically addressed issues related to younger children in school. DCF agreed that getting these issues on the RED meeting agendas would be an important step for improving outcomes for these children.

DCF's Regional Advisory Council for Waterbury had recently hosted an official from Waterbury Public Schools who met with advisory council members, including local mental health providers, to discuss the needs of students and families and strategies for strengthening linkages between community organizations and local schools. DCF expressed its commitment to continuing this dialogue and emphasized the importance of bringing data regarding the needs and experiences of young children in school to the table with providers and school officials.

DCF officials recommended the development of a school-based or community-based process for engaging with high-need children and their families to discuss their access to care and supports. DCF emphasized the need to increase positive engagement between police, schools and families as mistrust and misperceptions haunt and undermine what should be productive alliances between community stakeholders. Concerns about race-based assumptions and implicit bias were openly discussed by DCF and OCA and both agencies agreed that strategies to address these concerns must continue to take center-stage in community conversations.

DCF staff recommended that it work to ensure out-posting of social workers in high need schools where data shows more frequent utilization of law enforcement and school suspensions.

MEETING WITH COMMUNITY MENTAL HEALTH PROVIDERS

OCA staff met with mental health providers who work with families and children who attend school in Waterbury. Providers noted that Mobile Crisis is a free service for schools and children, and that the program successfully diverts most children from local emergency departments, while 911 calls typically lead to more hospitalization and often, more trauma and less effective support for children.

Providers discussed the need for greater integration of therapeutic and trauma-informed supports in the academic structure of schools. Waterbury had previously considered one promising therapeutic tool for schools, the CBITS program (Cognitive Behavioral Intervention for Trauma in Schools), which according to the model's website is "a school-based, group and individual intervention designed to reduce symptoms of Post-Traumatic Stress Disorder, depression and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills."[35] Per providers, WPS struggled to implement CBITS throughout the district. School social workers are often moving between two and three schools, and dedicated resources to support implementation of the CBITS model were hard to come by. Meanwhile the academic pressures on teachers and administrators are intense, as Waterbury works to make and sustain performance gains. WPS reported to OCA that is recently began conversations with local providers regarding bringing CBITS to buildings with the highest needs.

Providers also spoke to the increasingly acute needs of young students and how rising housing insecurity and instability in the City exacerbate children's needs and complicate service delivery for the children who often do not finish the academic year in the same school they began.

Discussing available services, providers noted that resources are thin even for the therapeutic programs with proven records of success. For example, evidence-based programs that work with very young children like the ECCP (the State's Early Childhood Consultation Partnership Program) and Child First, a two-generational model that works with higher need young children and families, providing intensive, home-based services,[36] are small and, in the case of Child First, typically waitlisted.[37] At the time of OCA's discussion with providers in February of 2020, the Child First program in the Waterbury region had 46 families on the waitlist.

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[35] https://cbitsprogram.org/. CBITS is used with students from 5th to 12 grade who have witnessed or experienced traumatic life events such as community and school violence, accidents and injuries, physical abuse and domestic violence, and natural and man-made disasters. CBITS used cognitive-behavioral techniques (e.g., psychoeducation, relaxation, social problem solving, cognitive restructuring, and exposure).

[36] https://www.childfirst.org/.

[37] ECCP is a statewide, evidence-based, mental health consultation program designed to meet the social and emotional needs of children birth to five in early care or education settings. The program builds the capacity of caregivers at an individual, family, classroom, or center-wide level. It provides support, education, and consultation to caregivers and educators in order to promote positive outcomes for young children. ECCP is evidence-based and has undergone three random control trial evaluations with demonstrated effectiveness—after one month of participating in the ECCP service, 99% of young children at risk of suspension or expulsion in early childhood education settings were not suspended or expelled. The state should fund expansion of this model to elementary school age children.

Providers strongly recommended that the school district have robust partnerships with community agencies that can help support school staff, students and families, and that the district adopt and stick with a Social Emotional Learning (SEL) curriculum and program. Providers described the District as having "just scratching the surface" with SEL work, and not yet able to embed trauma-informed work in its practices and school communities. Providers recommended that state and local leaders elevate the social emotional wellbeing of children to a critical public health priority, the same as has been done for childhood asthma or obesity. Such prioritization could bring not only resources but targeted training, pre-certification and evaluation criteria for teachers and administrators to empower and support their developmental work with children.

MEETING WITH WATERBURY POLICE DEPARTMENT

The OCA reviewed the findings of this report with the Waterbury Chief of Police, Fernando Spagnolo, whose tenure as Chief began in May 2018 only a few months prior to the period under review for this Report. The Police Department was very responsive to OCA's review, providing complete data and records promptly upon request and meeting with OCA staff during and at the conclusion of this review.

Chief Spagnolo stated that police recognize that the developmental and mental health needs of children necessitate a unique response from officers. He stated that when police are responding to a 911 call from an elementary or PreK though 8 school in Waterbury that they try to "use the right officer," one more familiar with the school and with children, and whenever a situation appears likely to result in an arrest, a supervisor responds to the school to ensure appropriate protocols are followed and that school district personnel and families are aware of what is taking place.

OCA and Chief Spagnolo discussed the types of behaviors that children, particularly young children, were described as having in police reports reviewed by OCA: self-injury and threats of harm to self and others, expressions of anger and despair. Chief Spagnolo discussed the Crisis Intervention Team (CIT) training that officers receive, noting that some officers receive longer doses of training than others and maintain a CIT certification. But the Chief acknowledged that the CIT curriculum is not geared towards working with children, and there is no specific training for community officers regarding childhood behavioral health or children and trauma.[38] The Waterbury Police Department does have a partnership with licensed mental health care providers that works with police and comes onto a secured scene to assist, but the Chief acknowledged that this partnership has focused on adults, not children.

The Chief also lamented the loss of what he felt was a "great program"-- a pilot designed to bring a supportive response to children outside of school who may have been exposed to a traumatic arrest or family violence that resulted in an arrest. While the Chief said that this program, available a few years ago in the City, was helpful, the funding did not continue.

[38] The District reported to OCA that school-based officers previously participated in CIT-Youth under the School Based Diversion Inititative, which addressed child and adolescent development and mental health.

With regard to the elementary and PreK-Grade 8 schools' utilization of police to respond to children's behavioral incidents, the Chief stated that the Department assumes that by the time the schools are calling the police that someone has assessed the child's mental health and gone through graduated steps of crisis management and de-escalation. He was supportive of the idea that dedicated clinical staff within the school environment would help to reduce reliance on police by school staff and ensure appropriate assessments of children in crisis.

Chief Spagnolo discussed the various diversion efforts the Department has been implementing in recent months, including the KIDS (Keeping Individuals Driven for Success) program, and mentor and workforce development programs, often coordinated with the local Police Activity League. The Chief acknowledged that Waterbury had suffered without adequate youth programming and diversion models in recent years. He referenced meeting with the non-profit law firm The Center for Children's Advocacy and Gary Roberge, Director of the Judicial Branch's Court Support Services Division, to discuss Waterbury's high rate of school-based arrests, and that after doing his own research, recognized that a lot of work needed to be done to correct this trend and offer more support to young people. The Chief noted that the City had lost a Juvenile Review Board and that the Department had lost touch with some of the available programs in recent years. The Chief stated that the Department really wanted to outreach and support youth who he described as having "one foot on the ledge," and help connect those youth to job opportunities, violence prevention and mentoring. But the Chief also noted that these are programs geared towards teenagers, typically age 14 to 18, and that the Waterbury RED meetings are also typically looking at data about older youth, not students in elementary schools. OCA and the Chief agreed that bringing more school and community-based supports for younger children and their families, and a focused data review regarding utilization of police in the elementary schools would be important to address children's needs and reduce police involvement in the schools.

Chief Spagnolo described the Department's practice of having a roaming school resource officer for the Waterbury elementary schools with the intent being to develop relationships between the police and school communities, particularly middle school students. The Chief did state that while he understands the push to remove police from schools altogether, he does feel that embedding or even having roaming SROs in schools provides a valuable opportunity for relationship building and mentorship between the police department and students, particularly critical in communities of color where families and children have distrust of police generally and bridges need to be built. The OCA referenced research showing that contrary to having a positive impact, embedded police in schools often lead to increased suspensions, expulsions and school-based arrests, disproportionately and negatively impacting children of color. The OCA raised the possibility of alternative strategies to build relationships and positive encounters between children and families and police that would not require embedding officers in schools.

MEETING WITH THE STATE DEPARTMENT OF EDUCATION

OCA met with representatives from the State Department of Education regarding the findings from this review. The group collectively discussed historical concerns regarding racial disparities in school

discipline and school-based arrests in Waterbury. SDE indicated that improving school-based climate and SEL supports for students and teachers is an agency priority and that they have been working directly with the Waterbury District regarding a number of related systems issues, including reducing reliance on exclusionary discipline and improving school climate.

An SDE administrator noted that while the children's needs may be complex, that the number of 911 calls seen in the Waterbury schools' data raises concerns of a problem in certain schools' culture, an acceptance or belief that it's okay to routinely call 911, and that building leadership has to turn that culture around and support crisis prevention and de-escalation work in the school.

SDE administrators stated that there has been a positive shift in the District's culture and commitment to addressing concerns under the tenure of new Superintendent, Verna Ruffin. SDE administrators described Superintendent Ruffin as a leader who is committed to positive changes and who "gives no excuses" and does not "shy away from tackling the big issues." SDE noted that Superintendent Ruffin had also made numerous administrative and leadership changes within the District over the last year.

SDE acknowledged that work remains to be done in Waterbury and that additional decreases in exclusionary discipline numbers and student school removals are still needed. SDE emphasized the importance of focusing on equity in all aspects of the District's positive school climate work, including any work done to implement a Social Emotional Learning curriculum. SDE stated that they would explore how to use allocated Alliance district funding to support the changes needed to address equity challenges and school removals for children of color and children with disabilities. SDE also indicated it would follow up with the OCA regarding relevant data trends in the Waterbury schools.

DISCUSSION AND STRATEGIES TO REDUCE RELIANCE ON LAW ENFORCEMENT IN SCHOOLS

It's important to understand the issues driving utilization of police as a response to young children in crisis. Districts sometimes report to providers and to the OCA that they feel police can respond more quickly when a child is in crisis. Schools may be concerned about their capacity to support a child in extreme distress safely. Teachers worry about children's escalating and acute behaviors. Administrator worry about liability in case the child is harmed. Some building administrators are looking for someone outside the school to come and remove the child from that setting and believe that connecting the child with the hospital system is the quickest way to get mental health care for the child and family. Conversely, Mobile Crisis's goal is to stabilize the child, *divert them* from the hospital and send them back to class whenever possible. Waterbury elementary schools usually do not have dedicated clinical staff on site and lack the multi-tiered systems needed (training, therapeutic and special education resources, mental health services) to adequately support students and teachers.

Training school staff regarding what works when preventing and responding to children's behavioral health crises is imperative. According to a state mental health systems administrator OCA interviewed as part of this review, "when you dial 911, you know you are getting police. If the intent is to get the child to the Emergency Department, educators need to know that this is not helpful to the child, and is often traumatizing. These children are very young, they need to stay in school and get support."

Police records at times reflected that law enforcement personnel and school staff made efforts to address concerns about safety in myriad ways, moving a child out of the classroom, talking to a child, or bringing the child to a time-out room, though these rooms had varying names in police reports. Incident reports did not typically reference the presence of therapeutic or clinical support staff, and police did not arrive at schools with support staff or as part of a mobile mental health response team. Police reports document officers resorting to handcuffing young children in distress as part of their effort to ensure everyone's safety, a traumatizing experience for any child, much less one in acute distress and who has already been exposed to trauma.

While school district administrators that OCA spoke with pledged greater efforts to reduce reliance on law enforcement and exclusionary discipline for young children, multiple mental health professionals emphasized to OCA that reforms must start with supporting teachers. As one professional stated:

> We must recognize the secondary trauma that educators are experiencing. Start there and help them. From there, you introduce the concepts of trauma and children, and then you can give the strategies to the school. School climate, [Social Emotional Learning] curriculum and student mental health-- these areas are always secondary but they need to be primary, particularly now, particularly post COVID. We need to be much better with all of this, and schools need direct linkages to mental health systems. Otherwise we are dead in the water. The only way is leadership, both at the building level and the district.[39]

An examination of special education resources available to programs that serve high need children or who have higher rates of exclusionary discipline and 911 calls is a necessity. The fact that so many police reports referenced children who the district identified as having disabilities speaks to a likely dearth of adequate special education services to support children and teachers. Multiple children with Autism, for example, were the subject of repeated calls to police, a convincing sign that the children's needs were either poorly understood or poorly addressed in the school environment. Strengthening special education supports for children with more complex disabilities, be they psychiatric or neurodevelopmental in nature is critical. Special education overseers at the State Department of Education and local leadership may need to secure outside technical assistance for schools that struggle to meet the needs of children with trauma-based behavioral or neurodevelopmental disorders.

Multiple stakeholders OCA interviewed acknowledged the importance of district and principal leadership in supporting reforms for children and their teachers. Implementing a multi-tiered system of support for a school community takes a durable commitment and often several years of work. And yet stakeholders noted that school leadership positions have high turnover rates, and when things change, as one professional noted, "You are back to square one." Everyone interviewed by OCA acknowledged that a social emotional learning curriculum is now fundamental to being an educator.

[39] State mental health systems administrator, Department of Children and Families, discussion with OCA.

Schools must have the resources, training and evaluation frameworks in place to support implementation of a school-wide behavioral support system. Teachers need their own supports, trauma-informed and compassionate. Teachers who are working daily with many high-need, often trauma-exposed children cannot continue to be pressure-cooked by current evaluation criteria, unduly weighted exclusively towards student academics rather than children's healthy development.

As seen in the dozens of police reports reviewed by OCA, mental health professionals strongly cautioned that suicidality in young people must be on everyone's minds. Suicide is now the second leading cause of preventable death in children age 10 and older.[40] Untreated behavioral health needs is a leading cause of suicidal risk and ideation. In Connecticut, the age of children engaging in suicidal behavior and even dying by suicide has trended younger and younger, with four (4) children age 12 and younger (one 11 year old) dying by suicide between 2017 and 2020.[41]

As children's needs go and up and resources stay static, the implications for children's mental health and special education are alarming. As the State moves through the COVID-19 pandemic and the simultaneous social and racial justice protest movement, the support needs for children, families and educators is higher than ever. State and local government must make a meaningful and sustained commitment to health care supports (including mental health care) and equitable education for children and families. Teachers and other educators must be supported with training and self-care. Families must be engaged and heard.

Schools are now a frequent setting for delivering health care, including mental health care, to children. Connecticut is home to multiple evidence-based models of intervention for young and school-age children with greater support needs, including models of intervention described earlier in this report such as ECCP and Child First, and school-based models such as CBITS and BounceBack (an adaptation of the CBITS model for elementary school age children.) Like CBITS, BounceBack is provided to elementary school-aged children at no cost to districts,[42] and is designed to assist younger students experiencing traumatic stress by helping them develop coping skills and relaxation strategies and enhance social problem solving skills.[43]

> **Data shows a 93% completion rate among children who begin BounceBack, a significantly higher rate of completion than exists for families attending community-based outpatient care and who grapple with workplace, family and transportation challenges.[44] Children who received Bounce-Back showed a 75% reduction in symptoms of PTSD following program participation.[45]**

[40] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention National Center for Health Statistics, Death Rates Due to Suicide and Homicide Among Persons Aged 10–24: United States, 2000–2017, available at: https://www.cdc.gov/nchs/data/databriefs/db352-h.pdf.
[41] OCA co-chairs the state's Child Fatality Review Panel and issues annual public reports containing child fatality review data.
[42] DCF funds BounceBack.
[43] Bounce Back includes ten group sessions, one to three parent sessions, and up to three individual child sessions. Bounce Back helps children to understand, cope with, and recover from trauma exposure.
[44] https://www.chdi.org/publications/issue-briefs/helping-students-recover-trauma-bounce-back/
[45] Id.

Connecticut has also seen promising results from another program geared towards middle school and high school students: the School Based Diversion Initiative (SBDI). Recognizing that schools are one of the primary referral sources to the mental health and juvenile justice systems and that many children in the justice system have unmet mental health needs, SBDI was developed to provide training to school personnel, revise school discipline policies where needed, and help build connections between schools and community-based mental health services, thereby diverting students from arrest and reducing rates of exclusionary discipline.[46] SBDI has worked in 48 schools, effectively reducing court referrals for students by 34%.[47] The program is now jointly funded by the Judicial Branch Court Support Services Division, SDE and the Department of Mental Health and Addiction Services.[48] A new version of SBDI, adapted for elementary school-age children was developed in recent years but has never been piloted.

Connecticut also has multiple innovative public-private partnerships between community-based providers and local school districts, designed to identify and provide consultation to schools, as well as intensive services or case management to high need students, and where appropriate, their families. One such program, run by Clifford Beers in New Haven, has demonstrated success in reducing student absenteeism and suspension rates as well as improving children's clinical symptoms and academic test scores. Clifford Beers' program is grant funded by DCF and the Dalio Foundation. In Hartford, through a partnership with the school district, the Village for Children & Families also provides a constellation of services at the student, family, classroom, and school levels. An evaluation of The Village's work at one school demonstrated a significant decrease in absences and reduction of trauma symptoms among students.

Like ECCP and Child First, CBITS and BounceBack, the SBDI diversion models and the public-private partnership models, are not funded to scale in Connecticut, leaving many children and school districts without needed services.

In addition to school and community-based diversion and intervention models already discussed, effective crisis management programs are essential to support educators and students. As recommended by the U.S. Substance Abuse and Mental Health Services Administration, a strategic plan and well-developed infrastructure for crisis prevention and response, inclusive of "strong partnerships between crisis care systems and law enforcement," are essential "for public safety, suicide prevention, connections to care, justice system diversion, and the elimination of psychiatric boarding in emergency departments. The *absence of comprehensive crisis systems has been a major 'front line' cause of the criminalization of mental illness.*[49]"

While providing resources is essential, districts must also be accountable for their utilization of law enforcement and exclusionary discipline practices, practices that are often shown to have harsher

[46] https://www.chdi.org/our-work/mental-health/school-based-mental-health/sbdi/
[47] Id.
[48] See also https://www.chdi.org/publications/reports/impact-reports/improving-outcomes-children-schools-expanded-school-mental-health/.
[49] SAMHSA Guidelines, supra n. 16 at 34 (emphasis added).

impact for children of color,[50] and the State should require reporting not only on suspensions and expulsions by school, but on calls to police, and what resources each school has dedicated to SEL and teacher supports. As most of the incidents that led to arrest of a child involved youth-on-youth aggression and fights, incorporation of restorative justice practices into the school community will be essential in driving down police calls and school-based arrests.

Finally, though an examination of the specific root causes and circumstances leading to children's behaviors in Waterbury elementary schools is beyond the scope of this investigation, policymakers' attention must be focused on addressing the unmet needs of children and families in communities struggling with chronic deprivation: housing and food insecurity, lack of employment opportunity, and lack of access to community mental health supports.

RECOMMENDATIONS

- **Increase Transparency And Accountability For School Districts' Utilization Of Police**

  - **The legislature should prohibit the use of embedded police officers in schools**. While certain communities may and do value the role of local police in their schools, the disproportionate and harsher impact on students of color from schools' reliance on or utilization of police resources cannot be ignored. Police should have no role in maintaining school climate or school discipline.

  - **The state should track schools' utilization of 911 and reliance on police**. The State should require school districts to report to the State Department of Education (SDE) and the Connecticut Legislature regarding districts' utilization of 911, 211/Mobile Crisis, in addition to exclusionary discipline and student arrests. Given the racial justice issues implicated by the school-to-prison pipeline, the data must be disaggregated by age, grade, race, and *disability status* (this should include some information about disability classification as well) and include information regarding where students were arrested and the type of officer conducting the arrest. The data measures should be built into state measures of districts' annual progress and performance.

  - **The state should require reporting regarding implementation of SEL supports for teachers and students.** Reports from schools must also include a description of SEL curriculum, associated resources utilized by the school, utilization of restorative justice practices, and dates of applicable in-service trainings for staff and students, along with other school climate and crisis prevention resources available to school staff.

  - **The state should review data regarding disability classification and exclusionary discipline and police reports to understand how to support districts' special**

[50] Riddle, T., and Sinclair, S., *Research Disparities in school-based discipline actions are associated with county-level rates of racial bias.* Proceedings of the National Academy of Sciences of the United States of America (April 23, 2019), on the web at: https://www.pnas.org/content/116/17/8255.

education programming needs. Some of the children in Waterbury subject to the highest number of police responses were students with Autism, raising concerns that the particular schools had an inadequate educational program to support those students and their teachers.

- **Address the School to Prison Pipeline For Young Children**

  - **The legislature should prohibit the arrest and detention of young children.** Consistent with the recommendations of the state's Juvenile Justice Policy and Oversight Committee, the Legislature should raise the minimum age of arrest to 12.

  - **The legislature should prohibit suspension of young children.** Given the sharp and persistent racial disparities in school discipline, the connection between school suspension and justice system involvement, and the civil rights concerns these disparities give rise to, the legislature should amend state law, Conn. Gen. Stat. §10-233c, to ban of out-of-school suspensions for elementary school age children and instead provide resources to implement therapeutic classroom interventions that take place in the school building.

- **Create Crisis Prevention And Response Partnerships In Districts And Municipalities.**

  - **State statute should require municipalities, local districts and local police departments have agreements with community mental health service providers** that include specific protocols for managing school-based behavioral health crises, utilization of 911, and which require regular meetings and collective review of data regarding mobile crisis calls, police calls, percentage of youth stabilized and returned to the community, connections to ongoing care, and school based arrests. Current state law only directs *mobile crisis providers* to engage with school districts. The directive should be recrafted to create an obligation for municipalities to ensure a comprehensive crisis response system of care that does not place the onus on law enforcement to manage children's behavioral health.

  - **State statute should require that law enforcement and emergency medical services have specific crisis prevention teams trained in how to respond to emergencies involving children**, whether in school or the community, which includes specific training regarding child development, childhood trauma, childhood mental illness, engagement with children who have disabilities, and strategies for identifying and responding to a mental health crisis, including partnership with local mental health providers. Training should include specific curriculum around implicit bias and children. Local mental health providers should actively participate in law enforcement and EMS training. Clear protocols regarding limitations on the use of mechanical restraint with young children must be developed.

  - **The Racial and Ethnic Disparities Groups should review data regarding younger children relevant to understanding and preventing the school to prison pipeline**. Data and information reviews could include, exclusionary discipline, police calls, mobile

crisis calls, in-service trainings for first responders, school staff and administrators, and resource allocation for SEL and positive school climate supports.

- **Address Unmet Special Education Needs For Children With Disabilities**

  - **The SDE must strengthen its IDEA oversight activities** with regard to districts that are heavy users of exclusionary discipline and law enforcement.

  - **The SDE must insist on special education turnaround plans where districts have high rates of school removal for children with disabilities**. Turnaround plans must include incorporating outside technical assistance, where needed, to improve service delivery and supports for students with disabilities and their teachers and related service providers.

  - **The SDE should pay special attention to the utilization of police and school removal practices for children with neurodevelopmental disorders**, in addition to trauma-based disorders, and corrective action plans should address related programmatic needs for these students and their educators.

- **Require Behavioral Health Reinvestment to Support Children and Educators**

  - **State and local leaders must elevate the social emotional wellbeing of children to a critical public health priority**, the same as has been done for childhood asthma or obesity. Such prioritization must bring not only resources but targeted training, pre-certification and evaluation criteria for teachers and administrators to empower and support their developmental work with children.

  - **Sustainable funding streams and incentives must be created to support embedding crisis prevention and clinical personnel in local schools**. Mental health intervention needs to be co-located where children are. An entirely community-based mobile crisis model may be too stretched to accomplish the sought after diversion and engagement goals for which it was created. Schools need professionals on-site that can develop relationships with school staff, children and families, and through consultation, direct service provision and connection to community supports and care coordination, prevent crisis and improve developmental outcomes for children. A portion of Mobile Crisis resources should be co-located in schools that have higher rates of police calls, arrests, expulsions and suspensions.

  - **The legislature should require all school districts/local Boards of Education to create and submit to the SDE a Behavioral Health Reinvestment Plan** that will outline how resources will be allocated away from law enforcement contracts and personnel and towards professional and therapeutic supports for students, teachers and classrooms, inclusive of restorative justice practices and special education supports. This mandate cannot be unfunded.

- **The legislature must expressly require and fund adequate support staffing**: counselors, social workers, behaviorists, and mentors, and create minimum staffing requirements based on national best practices and informed by student population, including the percentage of children in a district who are low-income and the percentage of children with special education needs. Funding should also support districts' capacity to consult with community-based providers regarding disciplinary policies, instructional strategies, restorative practices, and self-care for educators.

- **The legislature should require and fund districts' utilization of specific evidence behavioral health and SEL interventions**, such as

    - Mental health consultation and support for teachers, school staff, and administrators.
    - Cognitive Behavioral Intervention for Trauma in Schools (CBITS).
    - BounceBack (an elementary school version of CBITS).
    - Restorative justice practices.

- **The state should pilot CHDI's School-Based Diversion Initiative (SBDI) Elementary school model.** SBDI has been serving primarily middle and high schools since 2009, impacting over 32,000 students in CT, demonstrating increased connection to behavioral health services and decreases in juvenile court referrals ranging from 17-78%. An adaptation of this model, SBDI-Elementary (SBDI-E) was developed, but has not yet been piloted. Funding should be identified to support implementation of SBDI-E pilots for elementary schools with high utilization of law enforcement and exclusionary discipline.

Clifford Beers Clinic, New Haven

Clifford Beers runs a comprehensive, whole-school "system of care" funded by DCF and the Dalio Foundation, that connects students to mental health services and creates an interdisciplinary collaboration between mental health providers and educators. The Clifford Beers partnership consists of identifying high-need students through screenings and assessments, providing personalized treatment, linking students and their families to community services, coordinating care management, and professional development for school and community around impact of trauma, and offering early intervention and prevention services.

The outcomes of this intervention have included significant reduction of students' chronic absenteeism, suspensions, and clinical symptoms of Post-Traumatic Stress Disorder, as well as an increase in student grades and test scores. The cost of a 12 month child/family intervention is $9.00 per day.

The state should support expansion of successful public-private partnerships such as the DCF and Dalio Foundation-funded program run by Clifford Beers in New Haven (see out-take). The State's Medical Assistance Policy and Oversight Committee, the Behavioral Health Policy and Oversight Committee or the Juvenile Justice Policy and Oversight Committee should review current public-private partnerships between school districts and community-based providers, examine the cost-benefit data regarding such partnerships, and make recommendations to the legislature that will help bring successful innovations to scale with sustainable funding and reimbursement strategies.

Cost Effective Programs for Children

Community providers like the Village for Children and Families in Hartford and Wellmore Inc in Waterbury, and Wheeler Clinic (among others) run early intervention and clinical programs like the Early Childhood Consultation Partnership Program and Child First, that are evidence-based for improving outcomes for young children and increasing parental capacity. These economical programs need to be brought to scale across the state.

ECCP works with early childhood classrooms and provides up to 12 weeks classroom-based consultation, direct support with social/emotional interventions, staff training on managing disruptive behaviors, and support visits to help implement a plan of action in the classroom and at home.

Child First provides services to pregnant women or families with a child from birth through five years of age, Children who have behavioral problems or delays in their development or learning (such as anger, sadness, risk of being expelled from childcare, or language delays), Families with multiple challenges or stresses (such as not enough income, feeling alone or hopeless, not able to meet your needs or the needs of your child, fighting in the home, drug use, homelessness, or involvement with the child welfare agency).

The State should fund an expansion of the State's Early Childhood Consultation Partnership Program (ECCP) into Elementary Schools and Increase Funding for the Child First Program and other Home Visiting Services.

ECCP is a statewide, evidence-based, mental health consultation program designed to meet the social and emotional needs of children birth to five in early care or education settings. The program builds the capacity of caregivers at an individual, family, classroom, or center-wide level.[51]

According to a 2019 report, the ECCP provided assistance to 438 children, and their parents, and teachers in the previous year and successfully reduced the use of school exclusion for young children.[52] This program, is currently funded by DCF ($ 2.2 million) and the state's Office of Early Childhood ($ 750 thousand). ECCP requires strategic support so that more children, including those in early elementary school, and their teachers can reap the benefits.

Child First is one of the only clinical and evidence-based two-generational programs for parents and young children in the state. Child First is now a national model being replicated by other states, and is shown to reduce the effects of trauma in adults and children, resulting in an improvement in children's social skills and language development and reducing maternal depression.[53] Child First is not available statewide and has lengthy wait lists. Child First is relatively low cost (particularly compared to the costs associated with police intervention, hospital transport and Emergency Department services) but is not available at the scale needed in Connecticut, even for children and families affected by significant trauma.

[51] ECCP is evidence-based and has undergone three random control trial evaluations with demonstrated effectiveness—after one month of participating in the ECCP service, 99% of young children at risk of suspension or expulsion in early childhood education settings were not suspended or expelled. The state should fund expansion of this model to elementary school age children. A pilot is already underway in Hartford.

[52] https://ctmirror.org/2019/07/26/program-aims-to-reduce-the-suspension-of-connecticuts-youngest-students/

[53] Child First, 2018 Outcome Report, on the web at: https://www.childfirst.org/our-impact/evaluation.

Home visiting programs are cost-effective *non-clinical* supports that work with parents and young children and are evidence-based for reducing risks associated with child maltreatment, improving developmental outcomes for children and increasing parental capacity.[54] Despite their cost-effectiveness and evidence-base, home visiting services are still not available at the scale needed in Connecticut.

- **That state should examine strategies under the federal Family First Act to draw down additional dollars** to support school-based mental health and care coordination programs and home visiting programs.

[54] Connecticut Office of Early Childhood, *Connecticut Home Visiting Plan for Families with Young Children* https://www.ct.gov/oec/lib/oec/familysupport/homevisiting/workgroup/home_visiting_plan_2014.pdf