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THE CENTER FOR ELIMINATION OF DISPROPORTIONALITY AND DISPARITIES:

Spearheading Texas's Ongoing Fight Against Institutional Racism and Other Causes of Inequity

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EXECUTIVE SUMMARY

Institutional racism. It is a word that means many different things to different people. However, there is likely mainstream consensus on at least one thing concerning institutional racism: elimination. That is, right-minded people want to eliminate it wherever it exists, whatever it is.

This brief examines the Center for Elimination of Disproportionality and Disparities (CEDD), the institution that, over time, has become the primary mechanism for the elimination of institutional racism in Texas state agencies that serve families and children. In addition to providing the long history of CEDD and its predecessor institutions, this brief explores the meaning of institutional racism, particularly as it relates to CEDD's work to eliminate "disproportionality and disparities." Crucially, while assuming widespread goodwill amongst state agency employees, the brief uses various research and data to conclude—as the state's health equity efforts have, at least, strongly implied—that institutional racism, properly defined, exists in Texas state agencies. However, the brief also recognizes that institutional racism may not be the only cause of disproportionality or disparities.

Thus, this brief makes recommendations for CEDD to progress and succeed in its mission to eliminate disproportionality and disparities, whether caused by institutional racism or some other factor. Specifically, the recommendations call for Texas to 1) move CEDD from the Health and Human Services Commission (HHSC) to the Office of the Governor, with specific mandates for relevant state agencies to regularly report to CEDD and otherwise cooperate with CEDD; 2) pass legislation similar to House Bill (HB) 2038 (2013) in order to empower and require CEDD to address disproportionality across state systems; and 3) pass legislation to require CEDD and the Legislative Budget Board to conduct a comprehensive economic analysis of the impact disproportionality and disparities have on the state.

HISTORY OF THE CENTER FOR ELIMINATION OF DISPROPORTIONALITY AND DISPARITIES

Administratively established in 2010 and codified in 2011, CEDD aims to partner with health and human services agencies, other state systems, external stakeholders and communities to identify and eliminate disproportionality and disparities affecting children, families, and individuals (Center for Elimination of Disproportionality and Disparities [CEDD], n.d.). The Texas Department of Family and Protective Services (DFPS), within HHSC, defines "disproportionality" as the overrepresentation of a particular group of people in a particular program or system, and "disparity" as the unequal or inequitable treatment of one group as compared to another. CEDD has performed many training sessions and presentations, formed key partnerships, and generally informed Texans and others about combating disproportionality and disparities throughout this state and its governmental agencies. But Texas's official effort to fight against disproportionality and disparities affecting children and families is far older than CEDD; indeed, the effort is more than two decades old.

National Effort Becomes State Effort

In 1985, U.S. Secretary of Health and Human Services Margaret Heckler released a landmark task force report that called for the U.S. government and the public health community to address the significant health disparities the report had found affecting ethnic and racial minorities (Heckler, 1985). The report represented the first time the U.S. Department of Health and Human Services had consolidated racial minority health issues into one report. The U.S. Congress responded the next year by establishing the Office of Minority Health within the U.S. Department of Health and Human Services. During the next 20 years, as various research detailed disparities in health and other social service systems, 40 states followed the nation's lead by establishing state offices intended to work to eliminate health disparities affecting people of color (National Association of State Offices of Minority Health [NASMOH], 2006).

Texas was one of those states, establishing its Office of Minority Health via legislation in 1993 (HB 1510, 1993). Eight years later, Representative Garnet Coleman authored a bill that established a Health Disparities Task Force to help the state "eliminate health and health access disparities in Texas among multicultural, disadvantaged, and regional populations" (HB 757, 2001). The legislation required the task force to investigate and report on disparities issues, develop strategies to eliminate the disparities, and reorganize state health programs as necessary to strive for that elimination. The legislature also required the task force to consult with the renamed Office of Minority Health and Cultural Competency and the women's health office. The task force was required to report to the governor and legislative leaders, first annually and later biennially.

Next, in 2003, Representative Arlene Wohlgemuth authored a bill that consolidated the state's health and human services system under the oversight of HHSC and its executive commissioner (HB 2292, 2003). The bill laid the groundwork for Representatives Dawnna Dukes and Garnet Coleman to further the state's health equity aims with 2007 legislation (HB 1396, 2007). The 2007 legislation officially gave the Office of Minority Health a more apt statutory title: Office for the Elimination of Health Disparities. However, the Office of Minority Health continued administratively and today serves within CEDD as a grant-receiving information resource. The 2007 legislation moved the newly named office from the Department of State Health Services to the parent HHSC agency, so that the office could carry

out its mission across all of the state's health and human services system. The bill also specified that the five-year-old Health Disparities Task Force should focus on race and ethnicity, in addition to other, more generally termed demographics.

State of Texas Timeline: Addressing Racial Disproportionality and Disparities

1990s

- 1993 - Texas establishes state Office of Minority Health (House Bill [HB] 1510, 73rd Regular Legislative Session)

2000s

- 2001 - Texas establishes state Health Disparities Task Force (HB 757, 77th Regular Legislative Session)
- 2003 - Texas consolidates state health and human services system into five agencies, including parent agency, Health and Human Services Commission (HHSC), headed by executive commissioner (HB 2292, 78th Regular Legislative Session)
- 2005 - In the midst of a Child Protective Services (CPS) crisis, Texas requires CPS data analysis on racial disproportionality (Senate Bill [SB] 6, 79th Regular Legislative Session)
- 2005 - Texas requires cultural competency training for CPS's child welfare staff and recruitment of appropriate foster and adoptive families and diverse child welfare staff (SB 6, 79th Regular Legislative Session)
- 2006 - CPS reports that it takes disproportionate action, particularly against Black or African American and Native American children, and that it has started remediation, including "Undoing Racism" training

2010 - Present

- 2010 - CPS reports that, since 2005, it has moderately reduced disproportionate action against children of color and racially diversified its staff
- 2010 - HHSC executive commissioner administratively establishes Center for Elimination of Disproportionality and Disparities (CEDD), citing successes during CPS disproportionality reform
- 2011 - Texas codifies CEDD, establishes Interagency Council for Addressing Disproportionality (IC), and eliminates decade-old Health Disparities Task Force (SB 501, 82nd Reglar Legislative Session)
- 2012 - IC releases legislative report, adopting Texas Model for addressing disproportionality and disparities and making policy recommendations
- 2013 - HB 2038, 83rd Regular Legislative Session, aims to implement IC recommendations and continue IC, but bill fails in Senate
- 2013 - HHSC Rider 87, SB 1, 83rd Regular Legislative Session, calls for CEDD to spearhead steps to address disproportionality and disparities across state systems and report to legislature
- 2013 - IC officially expires
- 2015 - HHSC and CEDD release Rider 87 report that identifies new Texas Model and highlights the lack of formal legislative mandate to address disproportionality and disparities, except in Department of Family and Protective Services
- 2015 - New State Budget expected to be signed into law (HB 1, 84th Regular Legislative Session) retreats from previous legislative sessions' efforts to make CEDD truly cross-systems and largely limits CEDD's role to health and human services

Meanwhile and relatedly, the Texas Legislature in 2005 took another key step to addressing health and human services equity by passing Senator Jane Nelson's Senate Bill (SB) 6 (2005), coauthored by Kyle Janek, the current HHSC executive commissioner who was then a state senator. The bill was a response to then-Governor Rick Perry, who had sought systemic reforms of the state's troubled child and adult protective services with executive orders and a declaration of an emergency legislative item. The governor's actions came after several news reports on injuries to and deaths of children involved in Texas Child Protective Services (CPS), overseen by DFPS (Mann, 2007).

In relevant part, SB 6 required HHSC and DFPS to analyze 2004 and 2005 data on child removals and other child protection enforcement actions to determine whether such actions, when accounting for all relevant factors, were taken disproportionately against any racial or ethnic group. If the agencies found such disproportionate action, the legislation required the agencies to 1) evaluate policies and procedures on child protection enforcement actions, 2) develop and implement a remediation plan to prevent disproportionate action based on race and ethnicity, and 3) report back to the legislature.

Furthermore, the bill added a cultural awareness section to the child welfare chapter of the Texas Family Code, which applies to CPS. The section—unamended since—requires DFPS to 1) develop and deliver cultural competency training for service delivery staff; 2) target recruitment efforts for appropriate foster and adoptive families and diverse staff; and 3) partner with community organizations "to provide culturally competent services to children and families of every race and ethnicity."

After conducting SB 6's mandated analysis, HHSC and DFPS did find disproportionate child protection enforcement actions that affected children of color, particularly Black or African American and Native American children (Texas Health and Human Services Commission & Department of Family Protective Services [HHSC & DFPS], 2006). In the resulting 2006 remediation plan and report to the legislature, HHSC and DFPS listed the first major remedial achievement as staff training, including "Undoing Racism" training for CPS management and later DFPS staff. In 2007, with CPS still mired in controversy because of more child deaths, Senator Nelson's SB 758 furthered the reform process of DFPS, particularly CPS, by calling for an overall improvement plan (Department of Family and Protective Services [DFPS], 2007). The December 2007 improvement plan report to the legislature noted that DFPS was in the process of establishing a statewide network of disproportionality specialists to serve the community and CPS staff. The report mentioned that the legislature funded the specialists network, in addition to "undoing racism" training.

During the five years after SB 6's 2005 passage, several thousand Texas CPS staff, other agencies' staff and community members throughout the state participated in undoing racism and other cultural competency training, as DFPS implemented its remediation and improvement plans. Meanwhile, CPS slightly reduced disproportionate child protective actions while making the CPS staff more racially diverse (DFPS, 2011).

In September 2010, then-HHSC Executive Commissioner Tom Suehs administratively created CEDD, appointing Joyce James to head the institution (HHSC, 2010). James, who had provided testimony regarding CPS disproportionality during hearings on 2005's

SB 6, worked in CPS as an assistant and deputy DFPS commissioner from 2004 till taking over CEDD. Part of the announcement of CEDD quoted Suehs: "At the heart of all our programs and services, we're about people. And we want to make sure that every person is treated with respect and dignity. Joyce has been a pioneer in helping improve equity in our protective services programs, and we want to put that same focus on all our services."

Cross-Systems Elimination of Disproportionality and Disparities

With passage of Senator Royce West's SB 501 (2011), the legislature made CEDD official in law during its 20ll regular legislative session. The bill officially replaced the Office for Elimination of Health Disparities with CEDD, which now encompasses the state Office of Minority Health and Health Equity, the Office of Border Affairs, and the statewide network of regional equity specialists first established in CPS.

The legislation also created an Interagency Council for Addressing Disproportionality (IC) and eliminated the decade-old Health Disparities Task Force statute. In a move to a more cross-systems approach to the problem, the legislation required the IC to include agency and community representatives from various education, health and human services, juvenile justice, and criminal justice backgrounds. The bill named CEDD's representative presiding officer of the IC. SB 501 explained that the IC was to examine, investigate, and then report to the legislature on any disproportionality or disparities affecting racial or ethnic minorities in the state's juvenile justice, child welfare, mental health, education or health system.

Just ahead of the December 2012 deadline, the IC, led by James, released a 222-page report that found that disproportionality and disparities affected racial and ethnic minorities in all of the systems examined (Interagency Council for Addressing Disproportionality, Texas Health and Human Services Commission, Center for Elimination of Disproportionality and Disparities, 2012). The report outlined components of a "Texas model" for addressing the disproportionality and disparities. The model had been used during the CPS disproportionality remediation and guided CEDD's work. In addition to a focus on data-driven strategies, community engagement, and cross-systems collaboration, two elements featured prominently in the model: 1) "anti-racist" training and principles and 2) "an understanding of the history of institutional racism and the impact on poor communities and communities of color" to "develop common analysis of racism and history that led to current outcomes."

The report, in relevant part, recommended to the legislature that: 1) CEDD assist HHSC in developing cross-systems performance measures based on the Texas model; 2) the state implement the Texas model in all of the systems examined in the report; 3) the IC continue till December 2015 and submit a status report on the implementation of the Texas model to the legislature in December 2014; and 4) CEDD monitor and report to HHSC executive commissioner on implementation plans to address disparities in health and human services agencies.

Center for Elimination of Disproportionality and Disparities: 2013 to Present

During the 2013 regular legislative session, Representative Dawnna Dukes authored HB 2038 (2013) to implement the IC's recommendations. The bill passed in the House with bipartisan support, but only after it was amended to give the HHSC executive commissioner more control over CEDD's contract-based partnerships and the substance of the Texas model. The legislation died in the Senate, leaving the

IC to officially expire in December 2013. HHSC Rider 87 of the state budget, however, contained some key provisions from HB 2038, including a requirement that CEDD advise various state systems on cultural competency training and partner with community to help deliver culturally competent services to children and families (SB 1, 2013). The rider also called for CEDD and the IC to develop and recommend to the HHSC executive commissioner policies for addressing disproportionality and disparities across several state systems, and to report back to the legislature on implementation of those policies (assuming the executive commissioner's approval).

Since the 2013 regular legislative session, at least five key things have occurred in the story of CEDD. First, leadership at CEDD changed hands, with Sheila Sturgis Craig taking over from James. Second, the IC officially dissolved in December 2013. Third, on January 6, 2015, HHSC and CEDD released to the Institute for Urban Policy Research & Analysis a report in response to Rider 87 (R. Patterson, personal communication, January 6, 2015). The Rider 87 report was 17 pages and contained no information regarding whether any of the state systems examined by the December 2012 report had made any progress in eliminating disproportionality or disparities; instead, the report highlighted that "only the Department of Family and Protective [*sic*] has a formal legislative mandate to address disproportionality and disparities within their agency." Fourth, CEDD has altered the Texas model, which was approved by the IC and reported to the legislature in 2012. While the Rider 87 report indicates that CEDD continues to refine the Texas model, which includes "[p]romoting anti-racist or race equity principles … ," CEDD's website explanation of the Texas model, as of the publication of this brief, includes no mention of anti-racist work. Furthermore, neither the Rider 87 report nor the website uses the term "institutional racism." Fifth, HHSC Rider 64 of the new state budget expected to be signed into law retreats from the legislative effort of the two previous regular sessions to carry out CEDD's mission across systems (HB 1, 2015). Instead, Rider 64 limits CEDD's advice on cultural competency training and development of and recommendation on policies to health and human services agencies, excluding key systems that 2013's Rider 87 included. Also, Rider 64 makes the first legislative mention of the "CEDD and the HHS Statewide Coalition on Addressing Disproportionality and Disparities." CEDD officials have said this coalition is intended to replace the IC. However, the names of the two groups tell the fundamental difference—the IC or *Interagency* Council was a cross-systems entity, while the "CEDD and the HHS Statewide Coalition" is limited to health and human services. As legislation on CEDD moves away from a cross-systems effort, the Center seems to be moving away from explicitly addressing "institutional racism."

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INSTITUTIONAL RACISM

Institutional racism has been defined as those established laws, customs, and practices that systematically reflect and produce racial inequities in American society (Jones, 1972; see also Knowles & Prewitt, 1970). While the practice of institutional racism has a long-standing history in the United States, the term was coined in 1967 by Kwame Ture and Charles Hamilton in the book Black Power: The Politics of Liberation (Ture & Hamilton, 1967). Institutional racism is different from individual racism, or the prejudice acts and attitudes of individuals against a member or members of an oppressed minority (Sears, Henry, & Kosterman, 2000). Institutional racism is "less overt, more subtle, less identifiable in terms of individuals committing the acts. But it is no less destructive to human life" (Ture & Hamilton, 1967).

It is important to understand that institutional racism does not necessarily result from intent. It can occur even when the institution or its agents—individuals—do not intend to make distinctions on the basis of race. Often, institutional racism occurs without any awareness that it is happening (Schafer, 2000). Cultural bias in standardized testing is an example of unintentional institutional racism. The results of such biases contribute to the "Black White test score gap" and have a wide-ranging effect on the educational opportunities of African American children. (Hilliard, 1979; Jencks & Philips, 1998).

Institutional racism looks beyond the maliciously motivated model of individual racism. In doing so, it stresses how past policies result in current inequalities and focuses on outcomes, as opposed to actions (Lopez, 2014). For example, the infant mortality rate for African American mothers is more than twice that of their White counterparts (Centers for Disease Control and Prevention, 2014). Maternal health, nutrition, and access to prenatal care contribute to pregnancy and childbirth outcomes (Centers for Disease Control and Prevention, 2014). African American women are more likely to live in a food desert and receive lower quality medical care than their White counterparts (Trehaft & Karpyn, 2010; IOM Unequal Treatment, 2002). Another example is the wealth gap. In 2013, the median wealth of Black households was $11,000, compared to $141,000 of White households (and $13,000 for Hispanic households) (Kochhar & Fry, 2014). Researchers have identified possible factors including, intergenerational inheritance, differing unemployment rates, differing rates of and policies on homeownership (including redlining, race covenants, and housing segregation), and college education (Desilver, 2013).

The policies and practices of institutions operate in a way that produces systemic and ongoing advantages and disadvantages based on race (Zatz & Mann, 1998). As a result, it creates and maintains racial and socioeconomic inequalities in communities across the United States (Fong, Dettlaff, James, & Rodriguez [Eds.], 2015, pp. 21-22). Institutional racism is reflective of the dominant group's cultural assumptions and leads to the systematic disadvantage of minorities (Anderson & Taylor, 2006; Knowles & Prewitt, 1970). As a result, minorities face overrepresentation in adverse outcomes (disproportionality) and unequal treatment or services as compared to the dominant group (disparity). Disproportionality and disparities exist across systems, in every societal sector that individuals have contact with, including health, education, criminal justice, and employment (Fong et. al. [Eds.], 2015).

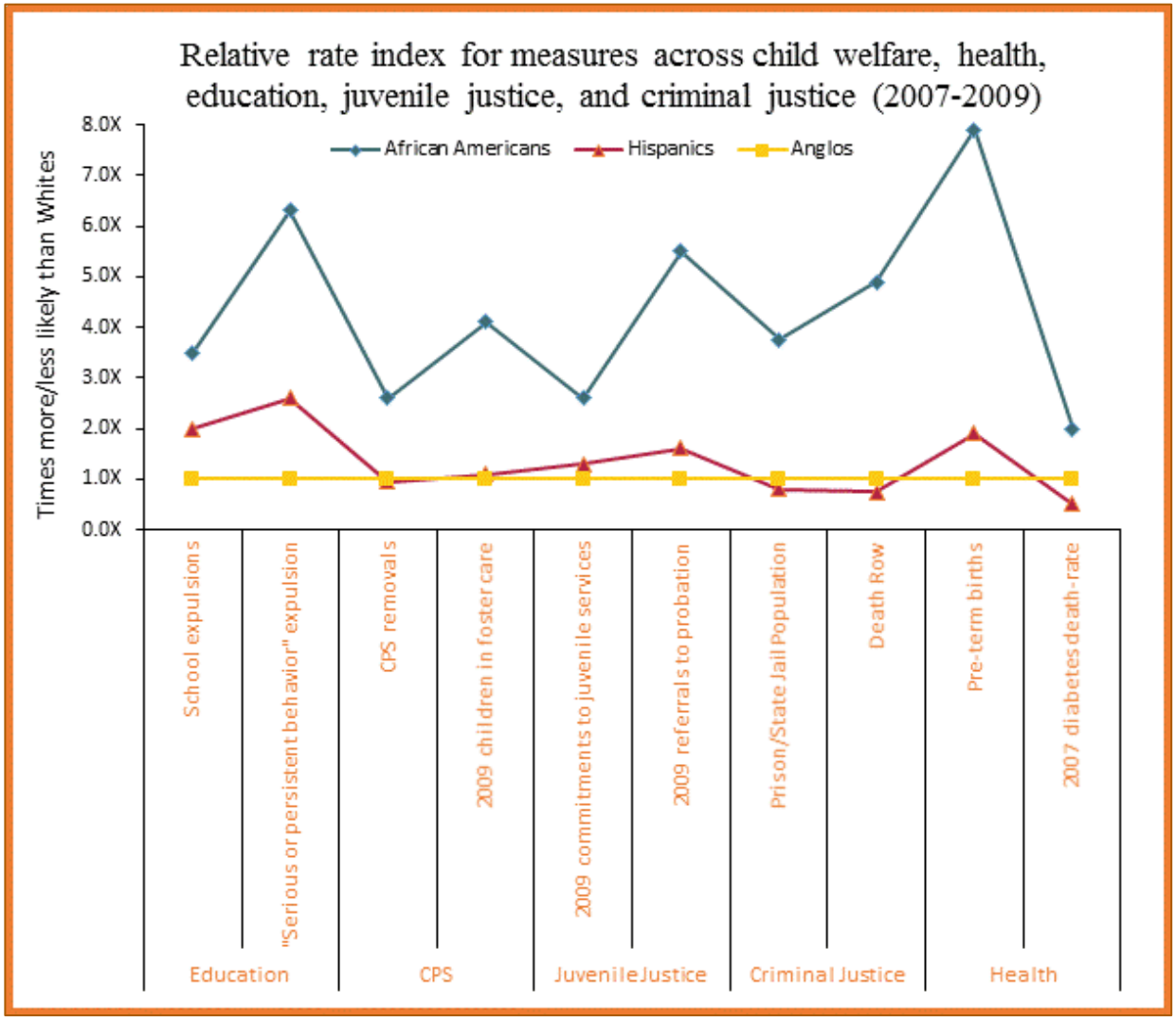
Key Terminology		
Term	**Definition**	**Most commonly used in:**
Disproportionality	The overrepresentation or underrepresentation of a particular race or cultural group in a program or system	Child welfare
Health Disparity	Preventable differences in the burden of disease or disability or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.	Health
Disproportionate minority contact (DMC)	The disproportionate number of minority youth that come into contact with the juvenile justice system	Juvenile justice
Achievement gap	The observed disparity on a number of educational measures between the performance of groups of students	Education
Equality	The concept that everyone should be treated in exactly the same way	Systems
Equity	The concept that everyone should be treated in a way that meets their specific needs so they have a fair opportunity to attain their potential	Systems

Source: Myers, S. L. (2010). Definitional Clarity. Presented at the Alliance for Racial Equity in Child Welfare Research Symposium on Racial Disparities in Child Welfare: What Does the Research Tell Us about Racial and Ethnic Disproportionality and Disparities in the Child Welfare System? Baltimore: MD. July 27-28, 2010.

Well-established empirical research has confirmed the pervasive existence of institutional racism, as well as the resulting disproportionality and disparities. African American and, to a lesser extent, Hispanic children are more likely to be taken out of the home and placed into foster care than Whites, even when families have the same characteristics and problems. (Department of Health and Human Service [DHHS], 1997; Fluke, Harden, Jenkins, & Ruehrdanz, 2010). For example, a child welfare study found that hospitalized Black and Hispanic children were five times more likely to be evaluated for child abuse and three times more likely to be reported than White children hospitalized for similar injuries (Lane, Rubin, Monteith, & Christian, 2002). Racial and ethnic minorities tend to receive lower quality health care and are less likely to receive needed care than Whites, even when controlling for access-related factors (IOM Unequal Treatment, 2002). Nationally, Black students are suspended and expelled three times more than White students and represent 31% of school-related arrests (Dept. of Education, 2013). Black men are given, on average, nearly 20% longer sentences than those served by White men for similar crimes (U.S. Sentencing Commission, 2013). The Texas populace is no exception to the widespread documented disproportionality and disparities.

Disproportionality and Disparities in Texas

Patterns of inequity are prevalent in the Texas health, child welfare, education, juvenile justice, and criminal justice systems. That is to say, disproportionality and disparities exist across systems. These systems are intertwined and often compound negative outcomes for people of color.



Source: (James & Love, 2013)

In 2007, the HIV infection rates for Texas adolescents were 0.8% for Whites, 1.4% for Hispanics, and 7.1% for African Americans. In 2009, the infant mortality rate of African Americans in Texas was twice that of Whites and Hispanics in the state. African American Texans, on average, live four years less than the state's average life expectancy (Lakey, 2013). African American and Hispanic Texans are five times more likely to die from diabetes. African Americans Texans are also more likely to die from heart disease, cancer, and stroke (James & Love, 2013).

African American children in Texas are twice as likely to be removed from their families and four times as likely to be placed in foster care when compared to their White and Hispanic counterparts

(James & Love, 2013). Hispanic children are twice as likely as their White counterparts to be expelled from school, while African American children are three times as likely as White children to be expelled (Governments Justice Center [CSGJC], 2011). Controlling for other variables, African American students have been found to be 31% more likely to receive discretionary disciplinary action when compared to otherwise identical White and Hispanic students (CSGJC, 2011). These systems are interconnected and have many points of overlap (Nicholson-Crotty, Birchmeier, & Valentine, 2009). Students suspended for a discretionary violation are nearly three times more likely to be in contact with the juvenile justice system (CSGJC, 2011). African American children are twice as likely to be committed to a juvenile detention center in Texas (James & Love, 2013). This pattern of disproportionate detention is carried throughout the larger criminal justice system in Texas. While African Americans make up only 12% of the Texas population, they account for roughly 36% of the prison population in Texas (Texas Department of Criminal Justice, 2012).

All of these statistics illustrate racial disproportionality and disparities that exist because of institutional racism in Texas. Arguably, the most clear and comprehensive research implicating institutional racism in this state came in 2011's "Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Student's Success and Juvenile Justice Involvement." The Council of State Governments Justice Center and the Public Policy Research Institute at Texas A&M University produced the study. Remarkably, the study followed all students in Texas public schools who began seventh grade in academic years 2000, 2001, or 2002 (CSGJC, 2011). Of the nearly one million students whose records were reviewed, 14% were African American, 40% were Hispanic, and 43% were non-Hispanic White.

Generally, the study found mandatory discipline for serious violations was relatively rare and nearly equal across racial groups during the secondary school years overall. However, when controlling for 83 factors—including sex, low-income status, special education status, at-risk status, attendance rate, limited English proficiency, immigrant or migrant status, campus teacher racial demographics, and a variety of academic performance factors—race was still a predictive factor for whether a student would be disciplined, especially for discretionary disciplinary actions. African Americans suffered the most from disproportionate discretionary disciplinary actions of school officials. In fact, in ninth grade, African American students were 23% *less likely* than White students to commit serious offenses that required *mandatory* discipline, yet school officials were 31% *more likely* to subject African American ninth-graders to *discretionary* discipline when compared with their White counterparts. The authors found this astounding disproportionality even after factoring in all other measurable student and campus attributes; race still dictated.

DISCUSSION

Nearly 22 years after Texas began formally striving for racial equity in its health and human services system, the Rider 87 and December 2012 IC reports make absolutely clear that there is still much work to do. Disproportionality and disparities in Texas, as throughout the country, are pervasive. They profoundly affect not just the children and families served by Texas's health or child welfare services and systems, but also the state's education, mental health, and juvenile justice systems. Black or African American children and families face particularly dire disproportionality and disparities, though many other Texas residents of color also suffer from disproportionate outcomes or disparate service or treatment.

Research shows that institutional racism—regardless of the intention of those working in the relevant institutions—has caused and continues to cause disproportionality and disparities in this country and this state. Understanding this fact requires that, amongst other things, one appreciates the differences between institutional and individual racism. A recent book on addressing disproportionality and disparities in human services quotes a White scholar in this regard: "I was taught to recognize racism only in individual acts of meanness by members of my group, never in individual systems conferring unsought racial dominance on my group from birth" (Fong et al. [Eds.], 2014, p. 251).

The main reason CEDD—and institutions like it—must train, present, and discuss institutional racism is not to place blame on any individuals within the relevant institutions; rather, it is because the opportunity to eliminate something within an institution is obviously greater when all stakeholders have a robust and common understanding of exactly what they seek to eliminate. That fact is why the Texas model formerly referred to "an understanding of the history of institutional racism." The former model was used for years, with some success during the CPS disproportionality remediation (Interagency Council for Addressing Disproportionality, Texas Health and Human Services Commission, Center for Elimination of Disproportionality and Disparities, 2012).

It is important to recognize that disproportionality and disparities likely can exist without institutional racism being the cause. Most researchers believe that the causes of disproportionality and disparities are complex and multiple. Thus, the best way to approach an effort to eliminate disproportionality and disparities is to appropriately address all causes to the fullest extent possible (Fong et al. [Eds.], 2014). This brief focuses on institutional racism because it is *one* widely misunderstood and profoundly pervasive factor that causes immense disproportionality and disparities.

CONCLUSION & RECOMMENDATIONS

Texas has been fighting to eliminate disproportionality and disparities affecting children and families for nearly a quarter-century, but they stubbornly persist across state systems. The state must make a concerted, robust, cross-systems effort to eliminate or, at least, minimize institutional racism, because research shows that it is a widespread cause of disproportionality and disparities. The Center for Elimination of Disproportionality and Disparities—an institution Texas should be applauded for creating—is the state institution best positioned to do that as part of its effort to rid this diverse state of inequity. Therefore, Texas should do three things to support and grow CEDD in the most efficient and effective way:

Recommendation #1: Transfer the Center for the Elimination of Disproportionality and Disparities from the Health and Human Services Commission to the Office of the Governor, while requiring relevant agencies within state systems—including health, mental health, juvenile justice, education, and child welfare—to regularly provide data to and otherwise cooperate with CEDD in identifying, tracking, and eliminating disproportionality and disparities.

Rationale: Instead of having each system address disproportionality and disparities issues in its own way, without a legislative mandate, CEDD can more comprehensively, efficiently, and consistently work with these interconnected systems to carry out its mission wherever it is necessary. This cross-systems approach was the reason SB 501 (2011) established the Interagency Council for Addressing

Disproportionality, in addition to codifying CEDD. It makes sense that an effort involving so many different state agencies comes from the Office of the Governor.

Recommendation #2: Pass legislation similar to HB 2038 (2013) reestablishing a statutory, cross-systems body similar to the IC and requiring each relevant agency to address disproportionality and disparities together with CEDD. The legislation should establish new duties for CEDD regarding a) officially adopting a Texas model to achieve equity and address disproportionality and disparities and all of their causes, b) implementing the Texas model in HHSC and other relevant state systems, and c) advising relevant state agencies regarding cultural competency training for staff and partnering with community to deliver culturally competent services.

Rationale: The December 2012 legislative report produced by CEDD and the IC indicated that significant disproportionality and disparities exist in every examined state system (Interagency Council for Addressing Disproportionality, Texas Health and Human Services Commission, Center for Elimination of Disproportionality and Disparities, 2012). The CEDD and IC report produced in response to HHSC Rider 87 of SB 1 (2013) gave no indication whatsoever as to whether any improvement had been made in any of the state systems examined by the December 2012 report (R. Patterson, personal communication, January 6, 2015). In fact, the report required by Rider 87 points out that "only the Department of Family and Protective [*sic*] has a formal legislative mandate to address disproportionality and disparities within their agency." Presumably, the "mandate" the report refers to is Section 265.004 or Section 264.2041, Texas Family Code. Recommendation #2, together with Recommendation #1, would ensure that all relevant agencies address disproportionality and disparities with the guidance of CEDD.

Recommendation #3: Pass legislation to require CEDD and the Legislative Budget Board to collaboratively produce an economic analysis on the cost of disproportionality and disparities to the State of Texas.

Rationale: The issue of disproportionality and disparities is a moral issue concerning equity for the future and foundation of the state—children and families; however, it is also an economic issue. For example, research indicates that dropping out of the education system is linked to a greater likelihood of involvement in the juvenile justice system, and, in turn, is linked to greater likelihood of involvement in the criminal justice system, which, of course, costs Texas taxpayers dramatically (Texas Appleseed, 2007). Similarly, the impact of health disparities comes at a substantial cost to the State of Texas. The years of potential life lost, time or days away from work, and additional costs to the health care system all contribute to an excess cost or loss of economic value for Texans. A number of states have developed a method of measurement for health disparities using one or more of these metrics (HCUP, 2011). In Texas, these costs will likely increase given the state's growing population of color. It would be hugely beneficial to understand just how economically impactful disproportionality and disparities are to Texas.

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