# Community Policing for Mental Health Demonstration Project: A Report Brief

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**August 2016**

*This project was supported by Award No. 72897 from the Robert Wood Johnson Foundation. The opinions, findings, and conclusion or recommendations expressed in this publication are those of the authors and do not necessarily reflect those of the Robert Wood Johnson Foundation.*

## Introduction

The police have always been called upon to address general problems occurring in the community. However, as the availability of other social services avenues has declined, there has been a growing role of police responding to issues related to mental illness. Police are often the first and only community resource to respond to a situation where a person is having a mental health crisis, but they do not necessarily have the training and resources to properly respond to these encounters (Bittner, 1967; Franz & Borum, 2011; Husted, Charter, & Perrou, 1995). Law enforcement officers' response to calls for services involving someone with a mental health or substance abuse problem can have a number of consequences for the individuals and their family, communities, and the criminal justice system (Lamb et al., 2002; Lamb, Weinberger, & Gross, 2004; Police Executive Research Forum, 2012). Additionally, it can make police officers' job more challenging, frustrating, and risky (Borum, 1998; Reuland et al., 2009; Ruiz & Miller, 2004). Police are responsible for recognizing a need for treatment for an individual and connecting them with services, or identifying that there is illegal activity which becomes the primary issue. There is a great deal of discretion in how an officer responds to an encounter with someone who has a mental illness or substance abuse problem. The most appropriate response, such as transporting to a hospital or mental health facility, may not be clear or available resulting in arrest instead of treatment.

Across the country law enforcement agencies are recognizing the need for improvement on how they handle calls that involve persons with mental health struggles. There is a large movement towards implementing strategies to improve the police's response to mental health calls. These programs tend to fall into two general categories—Crisis Intervention Teams (CIT), which are the most common and the co-responder model. CIT provides officers with 40 hours of extensive training to respond to calls involving someone suffering a mental health crisis. The co-responder model partners a police officer and mental health professional as a response unit to respond to these calls. Agencies have adapted these programs to meet the needs of their jurisdictions, but generally aim to achieve a number of goals both directly and indirectly, such as immediate de-escalation strategies, diverting people to the mental health system over arrest, and connecting people to resources and services to receive treatment.

Initial research on these programs has demonstrated promising effects on repeat calls for service, time spent on calls, and diverting people from arrest and jail (Bower & Petit, 2001; Compton et al., 2008; Hanafi et al., 2008; Strauss et al., 2005; Steadman et al., 2000; Teller, Munetz, Gil, & Ritter, 2006; Watson et al., 2010). Officers have also reported being able to recognize symptoms of mental illness and feeling more prepared to work with this population (Compton et al., 2006; Compton et al., 2008; Dupont & Cochran, 2000; Hanafi et al., 2008; Watson et al., 2008; Wells & Schafer, 2006). These programs, however, follow the traditional reactive model of policing—responding to calls and crises after they occur, rather than solving the underlying issues and preventing such crises from occurring. One way the police can be proactive is to identify *where* the problems are occurring and be more present and active in those places.

In recent years there has been wide recognition of the importance of a proactive police focus on micro crime hot spots (Weisburd, 2015; Braga & Weisburd, 2010). A strong body of research has shown that crime is concentrated in a city in a very small number of micro-

geographic units such as street segments (intersection to intersection), or small groups of such segments. Data from cities such as Seattle, Boston, Minneapolis, and around the world have found that about 5% of the micro units in cities produce 50% of the city's crimes and about 1% produce 25% of crime (Braga & Weisburd, 2010; Weisburd, 2015; Weisburd, Groff, and Yang, 2012). Research has also shown that by focusing police efforts on hot spots of crime, a jurisdiction can decrease the level of crime in that area (Braga, 2005; Braga, Papachristos, & Hureau, 2014; Weisburd & Eck, 2004; Sherman & Weisburd, 1995). Overall, the past 30 years of research has shown that identifying hot spots and targeting police efforts in them is an effective crime control and prevention technique.

An ongoing study in Baltimore entitled "Community health, anti-social behavior and safety at street segments" supported by the National Institute on Drug Abuse of the National Institute of Health (hereafter referred to as the NIDA project), has found that these crime hot spots also tend to be streets with higher rates of self-reported mental health problems. In other words, residents living on crime hot spots are more likely to report mental health problems and recent drug use than residents living on streets with little crime. While more research is needed to examine this overlap, it has provided the groundwork for developing a new innovative program that targets mental health problems at the street segment level.

Through collaboration with the Baltimore City Police and Behavioral Health System Baltimore (BHSB), we developed a program that combines three policing strategies: 1) the co-responder model and CIT, 2) hot spot policing, and 3) community-policing. The innovation of this approach is that it provides police and mental health professionals the opportunity to prevent mental health crises from occurring. It also improve access to services by using community-policing strategies to proactively reach out to residents in high crime areas. Rather than spread efforts across an entire neighborhood or community, teams of police officers and mental health professionals can target resources more efficiently to these small areas and strengthen ties with residents in these high crime areas. Not only does this program aim to prevent mental health crises and prevent individuals from ending up in the criminal justice system, the community-policing approach aims to improve relations between the police. When people see officers walking around the street, talking to their neighbors, and showing a genuine concern for the community, they are more likely to have a positive perception of the police (Gill, Weisburd, Telep, Vitter, & Bennett, 2010). Finally, the program has the potential to also reduce crime and victimization in the long run as mental health problems get treated, police presence deters and disrupts criminal activity, the police develop ties in the community, and the community and police work together to solve problems on the streets.

**Demonstration Project**

In August 2015, efforts began to develop a new program and pilot test it in a small number of crime hot spots in Baltimore. We partnered with officers from the Community Collaboration Division at the Baltimore City Police Department (BCPD) and staff from Behavioral Health System Baltimore (BHSB) to specify the goals of the program, identify the program protocols including activities and procedures in the field, and develop training materials. Each agency was responsible for their respective role on the project and helped in identifying the police officers and service provider to work on the project. This section will

describe the various components of the demonstration project including staffing, the goals of the program, the sites of the pilot, the program protocols and roles of the officer and clinician, and data collection efforts.

*Staffing*

A Lieutenant in the Community Collaboration Division was assigned to supervise this project. He was responsible for helping develop the program with the research partners and mental health partners and selecting the officers. The two officers had different positions and roles within the department which allowed the project team to identify strengths and weaknesses associated with each position and inform the department as to how to staff a program like this in the long term. One of the officers had over 20 years of experience and worked in the Community Collaboration Division, but did not work patrol and had no formal training in working with mentally ill residents. The other officer received mental health training while in the academy, but was younger with 8 years of experience at the department and was working in patrol when she was assigned to this project. The officers were both assigned to this project part-time and had to maintain their other responsibilities.

The selected service provider was Baltimore Crisis Response, Inc. BCRI is a private non-profit that specializes in community-based psychiatric crisis intervention and addictions treatment services. BCRI has worked with the BCPD in a limited capacity through BCRI's involvement in the mental health training at the police academy know as Behavioral Emergency Services Team (B.E.S.T.). BCRI has a number of services including a telephone crisis line, a mobile crisis unit, medical detox, in-house and community case management, residential crisis services, and in-home support. BCRI was a good fit for the program because it is the only community crisis program in the city and can get people into services rather quickly, such as detox or case management. They also work with a large number of providers in the city so they know about many other services. Two clinician with years of clinical experience and interest in working in Baltimore communities were selected to work on this project part-time.

*Goals*

The goal of the demonstration project was to develop the program and test the program model on a small number of sites. For a process evaluation, we collected data through a number of sources to assess the implementation of the program, clarify logistical issues, and identify strengths and challenges of the program which could be used to inform the program protocols for expansion of the program. As previously mentioned, the program draws from multiple policing strategies and aims to achieve a number of goals:

- Proactive response to mental illness in violent crime hot spots
- Build policing/community trust
- Build policing/mental health/community relations- collaboration and information sharing
- Provide resources and access to treatment
- Prioritize treatment over arrest when appropriate, divert people to treatment
- Crisis de-escalation strategies during interactions with people with mental illnesses; immediate mental health assessment
- Reduce time spent on calls for service with mentally ill
- Reduce repeat calls for service by improving access to services early on

- Helping to solve other crime and disorder problems on the street

Given the scope of the demonstration project, we did not empirically assess these outcomes, but qualitative data provided promising support for the program to meet a number of these goals in a short amount of time. We will discuss these initial findings with examples from contacts with citizens in subsequent sections.

*Sites*

The streets used for the pilot sites were drawn from a large basic research project funded by the National Institute of Drug Abuse of the National Institutes of Health. In that study three types of crime hot spots (violent crime, drug crime, and combined sites) and "cool" and "cold" spots were examined using official information on crime and survey data collected at the street segment level. We randomly selected eight sites from a sample of violent crime hot spots and using June 2014- June 2015 calls for service to ensure the streets were still met the threshold for a hot spot. We also calculated rates of mental health problems on the streets based on survey data collected during two waves of survey data collection to determine whether there was service need on the streets. Based on these eight randomly selected streets, four were selected with the assistance from the BPD to ensure there were no major safety concerns on the street.

While the four streets met the criteria for hot spots and had self-reported mental health problems, the physical layout and context of these streets greatly differed. For example, one street was a predominately residential in the northwest area of the city, with row homes along both sides and was located near a school. There was not a lot of street activity during the day and the residents seemed to be mostly working class or retired. Properties were generally maintained and there was not a lot of trash. The population appeared to be mostly White and Hispanic residents, many were home owners that had been on the block since it was built, but there is an influx of young Hispanic families moving in and renting.

In contrast, one of the other streets was located off a busy cross-street, around the corner from a methadone clinic. There was a high amount of street activity from people who did not live on the street, predominately young black men selling drugs openly on the corner. At least 2/3 of the row houses on the street were burned/abandoned and boarded up, there were many vacancies, trash along the sidewalks and curbs, and a fast-food restaurant on the corner. The few residents that lived on this street were predominately Black and owned their homes. In regard to the other two streets, one was on a busy road with warehouses and businesses on one side of the street, and the other had three apartment buildings. Therefore, it is evident that the street environment varied across the four streets which influenced how the teams spent their time and worked on the street.

*Team Approach- Program Protocols and Activities*

The Community Policing for Mental Health Program utilized a team model – pairing a police officer and a licensed mental health clinician. This aspect of the program allowed for teams to be able to handle a wide variety of scenarios and situations with their varied skill sets and backgrounds. While the activities of the team followed the program protocols, each team worked differently due to different personalities—in one team the officer took more the of leadership role, knocking on doors and introducing the project, while in the other team the

clinician took this role. The pilot demonstrated the ability of the officer and clinician to work well together and their expertise and skill sets complimented one another. That being said, the roles of officer and the clinician were distinct and defined below.

The Role of the Police Officer

- Public safety expert on the team
- Working directly with mental health clinician to engage with individuals on the streets
- Work proactively with residents to help resolves safety, crime, and disorder issues
- Provides pertinent information, resources, and referrals
- Work with clinician to engage community providers
- Provide a presence in hot spot neighborhoods that deters criminal activities
- Give advice to residents about public safety concerns
- Connect residents with various public works such as those involved in trash pickup, street lights, and parking
- Provide backup to clinician if necessary
- Perform any police activities that come up such as making arrests

The Role of the Mental Health Clinician

- Behavioral health expert on the team
- Works in partnership with the officer to engage individuals in their hotspot
- Working proactively with individuals to help resolve issues and address behavioral health concerns before it turns into a crisis
- Provides behavioral health information resources and referrals
- Helps break-down stigma and provides psycho-education as needed
- Provides regular support to individuals in behavioral health crisis (by phone and in-person)
- Engaging community providers in the hotspot
- Completes psychiatric assessments as needed
- Provides short-term solution based therapeutic interventions
- Provides individual and family conflict resolution
- Acts as a case manager advocate navigating resources and entitlements.
- Completes Emergency Petitions when necessary
- Provides screening and crisis intervention

The program protocols proceeded in five main steps:

1) Arrive on the street- drive around the block to make presence known and assess potential risks.
2) Assess the street by walking up and down the street, engaging with people on the street and getting an overall sense of the street environment. Depending on the street, these activities may take place during one visit or over multiple visits.
3) Begin door to door contacts- once the team feel comfortable on the street, they began knocking on residents' doors to explain the program and offer any information for or assistance with mental health and behavioral health problems, as well as crime and disorder problems on the street. The teams filled out daily activity longs and contact information to track their contacts (and needs) with individuals during visits to the street.
4) Proactive problem-solving- with assistance from residents, the teams identify problems,

research solutions to the problems, and implement the solutions. Teams are encouraged to take ownership of the street, meaning that they should be focused on figuring out ways to improve the lives of those who live on that street – whether it is through getting people the services they need or ensuring that all of the street lights are functioning properly so people feel safe.

5) Follow-up- the teams return to the streets weekly over the pilot. This allowed the teams to follow-up with individuals trying to get services. Problem solving strategies typically require follow-ups with individuals and problems on the street to ensure issues are addressed.

*Research and data collection*

In order to understand the program development and monitor program implementation a process evaluation was conducted, consisting of a variety of data collection methods. Participant observations took place during project meetings, semi-structured interviewers with the officers and clinicians before, during, and after the pilot intervention, weekly ride alongs with the program teams, and semi-structured interviewers with residents who had contact with the program teams. Daily activity logs were also completed by the program team to capture the time spent on the street and the number and type of contacts the teams had with individuals on the street. These data provided a great deal of information about the program and its potential to meet the desired program goals if implemented on a larger scale. The next section will present findings from the pilot, followed by lessons learned and recommendations for future work in this area.

**Findings**

The pilot began in early December, 2015. The teams spent a total of 14 weeks visiting their two assigned streets. The first week the teams spent canvasing or "scanning" the street and surrounding area. They walked on the street segment, engaged with business owners and other individuals on the street, but did not actively pursue contacts with residents in their home. After the initial visit, the teams started knocking on residents' doors to engage with citizens about issues on the street and their service needs.

It is important to emphasize that due to the innovativeness of this program, there was a great deal of uncertainty in terms of what the teams would encounter when visiting these streets, knocking on residents' doors, and trying to connect people with services. Given the climate of Baltimore following the aftermath of the death of Freddie Gray Jr. and the riots in the spring of 2015, the police department was initially apprehensive about people's willingness to speak with officers in general, much less about their mental health. Despite these concerns, the teams had success implementing the program and working with residents and individuals on the street. We will now discuss some of the key findings, providing examples from the program teams' feedback and experiences in the field.

*Daily Activity*

The teams completed a daily activity log for each visit to each street in order to track the amount of time spent on the street, number of contacts, and the nature of those contacts. On average the teams spent 1.5 hours on the street and had contact with an average of 6 individuals

during each visit to the street. The teams initiated the contact in approximately 90% of the contacts and about 2/3 of these contacts took place at the individual's residence with the remaining taking place on the street.

During the initial first contact, almost 20% of the individuals that the team came into contact with reported having a mental health or substance use problem or displayed symptoms of a problem that the team noted. About half of these individuals reported they were receiving services for their mental or substance use problem. The clinician provided on-scene counseling to 20 individuals during the initial contact (11%) and conducted a psychological evaluation for 2 individuals. The teams provided information about getting specific services to 60% of individuals and made a direct referral for service for one individual during the first contact. The most common type of services the teams gave information for was outpatient mental health, followed by inpatient drug treatment and then outpatient drug treatment. The teams also provided information for housing, medical care, legal and a number of other services.

In subsequent visits to the streets, the teams made a total of 97 follow-up visits across 25 individuals. In over half of these follow-up visits, the individual had a mental health or substance use problem. Furthermore, in 25% of these visits, the individual was receiving services before having contact with the team. This demonstrates that the teams spent most of their follow-up visits checking on individuals who had ongoing issues, but were not receiving services. The clinician provided on-scene counseling in 34% of these visits and conducted 3 psychological evaluations. The teams provided information about services in 66% of the visits, helped an individual call the Information/Referral line in four of the visits, and made a direct referral for services in six of the visits. Again, outpatient mental health services was the most common type of service the teams provided information for, followed by inpatient drug treatment and outpatient drug treatment, but during 2 visits the individual was transported to the Emergency Room for immediate care.

The teams, particularly the officer, never had to use force when interacting with someone during a visit to the street, or make an arrest over the course of the pilot.

*Responsiveness of citizens*

One of the main obstacles associated with this type of program is whether the people the teams reach out to will be responsive and receptive to the presence of the police and clinician on their street and knocking on their door. Overall, if people were home, they opened their door and talked to the team on their door step, received some information and brochures, indicated they "were fine" and the team moved on. The officers and clinicians all responded that the people they had contact with were "very responsive" and expressed that they were surprised about the willingness of individuals to talk with the police officer and clinician about their mental health problems.

One clinician provided the feedback that people were "very responsive for the most part. They're at least willing to have a brief conversation with us. I think one of the reasons they are responsive is that the officer is there and they're happy to see him." A number of people did openly disclose problems they had been having with mental health or drug use during the initial visits. One officer noted how shocked he was that one of the residents was so open about having mental health issues and needing help. He was very sure that no one would be that open with

them and it gave him a boost in confidence. Others were skeptical of the teams, but gradually opened up about issues over time. The team had to spend more time building rapport with these individuals and gain their trust. And there were still others, although few, that did not want to talk to the team at all and asked them not to come back.

It is also important to note that over time, word of mouth about the program and the police officer and clinician being on the street started to spread throughout the neighborhood. One of the clinicians expressed how she felt like the residents were watching them, waiting to see whether they were there to sweep the street for criminals and drugs or to help. On multiple occasions, people on the street approached the team and started engaging with them, asking why the cops were there and what kind of services they could provide. In some instances, it was homeless people, passing through and had heard of the "cops out here trying to help people." The weather also started to improve as winter ended so people were outside more and it was easier to engage.

*Building trust*

This type of program takes time and patience to build rapport with individuals so they feel comfortable talking about problems they are dealing with, whether it is issues of crime and disorder on the street or personal problems with mental health. Returning to the streets weekly is a key component of the program because it demonstrates commitment and concern from the team. One of the officers said that a strength of the program is that "you are building a relationship with people in the area over time and more likely to get them to get to into services with the follow up."

During a focus group with the staff from BCRI, one of the staff discussed how the relationship between the public and the police has been destroyed and that nothing will really matter until the relationship is improved, and that police should spend more time in the community, "playing basketball with kids and stuff like that." In fact, during one of the initial visits, the police officer turned on his lights and sirens for a little boy and his grandmother waiting at a bus stop on the street. One officer lamented about how police engagement with the community in non-crime related ways (such as handing out information, events for kids and families to learn more about the police, etc.) have gone by the wayside as crime control has taken a front seat. He added how important little things like that are for good community relations. This officer took the lead in one instance where the team purchased toilet paper and some food for one of the women they had been trying to help get into detox and another case where they bought pet food for a couple who was having trouble feeding their pets.

One of the clinicians explained how most of the interactions these residents had with the police prior to the program was negative and related to law enforcement such as drug busts, but this program put the police in "a different light, especially in those neighborhoods." She thought that this program allowed residents to see police in a different way, where they were there to offer support and not immediately judge. The other clinician said that a lot of people they encountered would say things like, "Wow, we never have police come to our door and ask how things are going." I think the police presence makes residents feel safer and promotes the police in a positive light.

From interviews with residents that had contact with the team, much of the feedback was positive. One respondent that struggled with mental health and drug issues expressed that it took a couple of weeks for them to get my trust and to realize the team was not "B-S-ing" him. When asked about calling the police in the future he responded, "They restored my faith in the police in actually helping people. It's nice to see that they do more than write tickets and lock people up. I would never have thought of them helping with mental health stuff." Other people described how personal the officer and clinician were more caring and easy to talk to, and it showed that someone actually cared about them [drug addicts].

*Service Needs*

The teams came across a number of people with mental health problems and substance abuse problems, but reported that substance abuse problems were more common among people they had contact with during visits to the streets. One of the clinicians attributed this to the stigma associated with mental illness—people were much "more open to talking about substance abuse than mental illness because there is more stigma and they don't want a label." Some of the common mental illnesses the teams came across were bi-polar, schizophrenia, and depression, and the most common substance used was heroin.

People also had co-occurring disorders, often suffering from drug addiction, particularly heroin, and mental health problems, which often added an additional challenge of getting these individuals into services. One of the officer's comments highlights this, "One thing I learned is that a lot of these people have co-occurring issues and that the detox has to come before the mental health treatment, it is a hoop to go through. If it is strictly mental health issues we can just refer to outpatient treatment." There were also a number of people who were in services, but not happy with their services, or wanted to add counseling to taking medications.

The service needs of these individuals also extended beyond mental health and substance abuse, such as insurance issues, housing, dental health and general health. A few individuals did not even have basic identification and the teams were able to help with this; in one case the individual went to BCRI for medical detox and they helped him get identification, and in another situation the team helped a man access to his Veteran Assistance benefits, which helped him get identification. Overall, the teams provided a number of referrals to case management at BCRI because it is better suited for individuals with multiple needs that cross over different systems of care and agencies.

*Prevention*

It is difficult to determine whether crises are prevented with outreach programs like this one. Particularly with a short pilot intervention, we cannot know if the program prevented crises, but some of the feedback we received from individuals who had contact with the teams, the police officers, and the clinicians suggests the program has potential to prevent crises and other problems like crime and victimization. This is especially true if the program was implemented over a longer period of time. When asked about how this program is different from other work they have done, one of the officers responded "we're going head on to try and get problems under control before they turn into something big." And one of the clinicians described how, in her work as a social worker, she works with people who have "identified themselves or someone

else has identified them as needing help, and then they come with a referral or refer themselves and many are actively in crisis." She believed that this program was "more proactive than reactive because we are engaging them prior instead of a point where they are in severe crisis." Both of the teams agreed that the program could prevent crises and expressed that they thought this program will help people access resources, particularly individuals whose "primary care is the ER," and prevent them from cycling in and out of the hospital.

During one visit to the street, the team was following up with a couple where the woman had PTSD and some other mental health issues. Within a couple of minutes of talking with the team, the woman got upset and started crying. The man said he was very glad the team showed up when they did because they had been fighting a lot the night before and the woman was not doing okay. The clinician and woman spoke in private for a few minutes, and the woman looked much better and was smiling when they returned. When we interviewed this couple later, the male partner expressed that he liked how often they team came by because the female really needed counseling, but "needs a nudge."

One of the individuals the teams visited multiple times had mental health, substance abuse, and other health problems. He discussed with the team that he often felt very agitated when he is off his meds and was concerned about what he might have done had the team not started coming around. Another individual who was in detox when we interviewed him described how the team was a "life saver" and "it was an answer to prayers as literally that morning I prayed for help and there she was." He said that if it wasn't for the team, he would still be out there using.

These examples highlight how unstable some of these individuals were before the team had contact with them and their increased risk of having a crisis due to their mental health and substance abuse problems. It appears the program was able to help them at a critical time by connecting them to services, but also visiting frequently and being available to talk.

*Connecting people to services*

One of the primary goals of the program was connecting people to services. As previously discussed, the teams made a number of referrals, helped individuals schedule appointments, and got people into medical detox. Both of the teams expressed how people knew little about services available to them—"they were open to getting treatment, but didn't know how to go about it". The teams also came across a number of people who had been in services for mental illnesses and substance use in the past, but had since stopped going, were back on drugs, and/or off their prescribed medications. In some ways, these were the individuals who were most open about their problems with the team and expressed wanting to get better again, but were difficult to follow-up with because they were often more transient.

The teams discussed how initially they tried to encourage people to make the first step by providing information and phone numbers, some people said they would call, but never did, which is not unusual. After a few weeks of the pilot and establishing contacts with individuals that actively wanted treatment, the teams spent more of their time helping these individuals navigate the system and get connected to treatment. In one case, a clinician sat with a resident on numerous occasions to help him make phone calls and go through the admission process as he tried to get mental health care, even letting him use her phone as he didn't have access to one at

the time. Numerous residents reported feeling that the system was confusing or hard to navigate on their own and that they appreciated the help from the teams.

*Crime*

Since the program is focused on hot spots of crime, it also has the potential to reduce crime and disorder on the street in a number of ways. The proactive police presence on the streets can deter criminal activity by being visible and spending time on the street that is not responding to calls. When the team visited the street with high drug activity, the street cleared within minutes of the team arriving, and the team reported that "they never know when we're coming." Over time, if the teams are successful visiting the streets on various days at different times of day, certain kinds of criminal activity may subside and decrease, and research suggests it will not just "move around the corner" (see Weisburd et al., 2006).

The teams may also have an effect on crime through building trust with residents who may be more willing to share information about criminal activity on the street and problem solve strategies to address the issue. For example, on one street residents complained about a house that had a lot of people coming and going, related to drug use and prostitution. The officer talked with other officers that patrolled the district to get their sense of the house, where he learned that it was not a major source of drug trafficking, but just a flop house. Rather than take a law enforcement approach, the officer felt it was best way to approach the house was from a treatment perspective—reaching out to individuals at the house and trying to get them into services.

This presents another way the teams can affect crime—by getting individuals with substance use problems into treatment (who by nature of their disorder are committing crimes to support drug addiction). This may reduce the demand for drugs on the street and decrease related crime. The teams expressed that people with untreated mental illnesses and drug problems are often the victims of crime and thought this program could help prevent victimization by connecting people to services. Finally, the teams can facilitate communication among residents, plan block meetings, and foster relationships with other community organizations, which improves collective efficacy on the street and the ability of the residents to prevent crime.

*Follow-up*

In their typical positions, officers and clinicians often have little time to follow-up with people and in most instances only have contact with individuals because the individual initiates the contact such as calling the police during a crises or setting up an appointment for treatment. In response to a question about how this program was different, one of the officers emphasized the ability to follow-up with individuals. He said, "We continue to monitor and follow up with people. In the past we go up and give brochures and that is it. Or it is someone who keeps having crisis that we respond to, but we don't have the resources and services to really help them."

The examples presented above highlighted the type of follow-up the teams engaged in during the pilot and the teams expressed that they would often spend part of their shifts following-up with anyone with pending issues, "to see where they're at and what's going on with them." The clinicians would also spend time making phone calls to service providers, requesting medical files, and checking on individuals if they were receiving treatment at BCRI. The police

followed up on issues related to crime and disorder. On another street the team was successful in getting a new street light installed.

**Summary**

Throughout the project it was clear that this program was innovative and has great potential to make an impact on law enforcement, the mental health system, and the lives of residents living in high crime areas. Very few programs have police officers or mental health clinicians initiate contact and offer help in a proactive way—as stated by one mental health clinicians, *"*This is different because normally people come to the mental health provider and not the other way around. Also going with the police adds another layer of uniqueness to it."

These findings come from limited implementation of the program on four streets over a 4-month period and are not exhaustive of all the experiences of the teams, but highlight some of the key experiences and contacts with a few specific individuals. There were also a number of interactions that did not have a "successful" result. For example, some individuals reported that the team did not come and follow-up with them as expected, but it is difficult to say whether the team did not follow-up or the individual was not home when they did follow-up. Additionally, some of the assistance the residents wanted involved a greater length of time, in one instance a resident wanted a blue light to be installed on the corner to deter the drug dealers and he was disappointed that this had not happened when we interviewed him. There were also individuals who did not engage with the team at all and wanted them to stop knocking on their door. It is difficult to say whether this could have changed over time and the individuals would eventually open up to the team. And there were still others who were disenchanted with the police and government in Baltimore and did not express much optimism in the team being able to do anything to change that.

Despite these negative outcomes or "failures" of the program, the feedback we received from the officers, clinicians, stakeholders, and residents from the streets was overwhelmingly positive and supportive. The program fostered a stronger collaborative relationship between the BCPD and BHSB, it demonstrated the ability of police officer to work together and their skill sets and knowledge complemented one another, and they were successful reaching out to residents and individuals in hot spots. The next section we will discuss some of the key lessons we learned from the pilot that will inform implementation of the program in the future. It is important to note that many of the limitations of the program were a result of the limited scope of the pilot and could be addressed with a larger program.

**Lessons learned**

*Staffing and support*

Since the program was only implemented on 4 streets with two teams, all of the intervention staff were part-time and had to balance the program with their existing responsibilities. This made it challenging to schedule the teams to go out on various days and times of the week. The teams both acknowledged the limitations this placed on their ability to devote all their time and resources to the streets and connecting people with services, and that dedicated staff to this project would make the program more effective.

Furthermore, the police department was not widely informed about the project, which resulted in conflicting orders from the officers' supervisors about work assignments and how the officers should prioritize their time, adding to the scheduling challenge. Patrol officers should also be aware of the project, so that they know which officers are working on the program, where they are working, and be an additional resource for problem-solving and emergencies. A long term, sustainable program may have hot spots flagged in the dispatch system, so when a call for service is received on one of program streets, the assigned officer that works on that street can be notified and respond if available. Patrol officers would be encouraged to cooperate with the team officers on any ongoing crime and safety issues on the street in the area would provide more resources and ability to problem solve. This also speaks to the broader issue of community policing and the organizational support needed to be successful.

*Exposure on street*

Due to the scheduling issues mentioned above, one of the teams visited their streets during the week, predominately during the middle of the day (between 9am and 2pm). This limited their "exposure" on the streets and access to different residents living on the streets, such as those working during the day. This was problematic for one street in particular, which was composed of predominately retired residents and working class residents; many of the contacts the team had on this street were with the retired residents as they were the only ones home. The team reported to us that it did not "feel" like a hot spot and they did a lot of knocking on doors with not much contact, but many residents expressed concern about drug use, dealing and unsupervised youth on the street. A number of residents we spoke with expressed that the team should have come at different times, like the evenings when children were out of school. One resident said "They [the team] come at the wrong time. They come during the day and most of these kids are in school and the parents are at work." Another individual said they liked the amount the team came to the street but "they should come more in the afternoon. If they come between 8 and 4, it's just retired people like me." And finally, the individual whom the team secured detox services expressed that "the area may seem residential with kids and stuff, but there is so much dope there. It's a great area for the program." This feedback highlights the importance of visiting a street at various times, including nights and weekends, because people with different needs may be around at different times, and will be missed if the team visits the street at the same time every week.

*Community Partnerships and Streamlining Services*

Prior to the pilot intervention, we did not reach out to a large number of service providers to inform them of the program, but it became clear that this would be essential for a large program implemented across a large number of streets. This should be done at the planning stages of the program by the supervisory project staff so that service providers are aware of the outreach efforts to high crime and need areas and can be prepared for new clients they may obtain through the program. The teams of officers and clinician should also become familiar with resources in the areas they are working, introduce themselves to service providers, exchange phone numbers with community leaders, so they have networks to help connect people to services. One team referred a majority of the individuals they had contact with directly to the

services at BCRI, while the other team made referrals to different service providers. This team also spent time looking up various providers around the two streets they were working to learn about what services they provide and the best way to refer someone. The officer suggested that having better connections and clearer directions for funneling people to the appropriate services would be helpful and thought that "building a relationship or agreement with different types of service provides can help streamline the process of getting people into services." Building these community partnerships is critical for a program to sustain over time and be effective.

**Conclusion**

Across the country, the police are called upon to deal with a number of social problems beyond the realm of typical law enforcement duties, including calls for service involving citizens with mental health issues, while also facing a difficult time with trust and legitimacy. This program offers the police an innovative strategy for improving the mental health of the residents in the community it serves as well as rebuilding trust with citizens. More research is needed to understand the lives of individuals living in high crime areas and the unique challenges they face when it comes to their well-being. Based on the success of this program, efforts are ongoing to implement the program on a larger scale and test its effectiveness in addressing a number of outcomes including reducing unmet mental and behavioral health service needs, preventing mental health crises and confrontational interactions between mentally ill and the police, improving community relations with the police, and reducing crime and disorder in the future. Given that research has found that hot spots of crime are relatively stable and produce a large percent of a city's crime, it is important to develop programs that can disrupt the stability of crime, ameliorate other related social problems, and improve the lives of people in these places.

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