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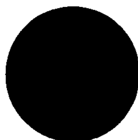
The Child Development-Community Policing Program

Program Replication Project

Final Report for the Office of Juvenile Justice and Delinquency Prevention



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CHILD DEVELOPMENT-COMMUNITY POLICING PROGRAM

PROGRAM REPLICATION PROJECT

REPORT TO OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION

The Child Development-Community Policing Program (CD-CP) is a partnership between the New Haven Department of Police Service (NHDPS) and the Yale University Child Study Center (CSC), which aims to address the psychological consequences of children's exposure to community violence through collaborative problem solving strategies of neighborhood police officers and mental health clinicians. The CD-CP Program began in New Haven in 1991. For the last three years, beginning in October 1994, the program has been involved in a multi-site program replication project, funded by OJJDP. Through this project, four other communities (Buffalo, NY; Charlotte, NC; Nashville, TN; and Portland, OR) have received training, consultation and technical assistance regarding their development of police/mental health collaborations based on the CD-CP model. New CD-CP programs have begun operation in Buffalo, Charlotte and Nashville, with initial promising results. Unexpected institutional and financial difficulties prevented successful development of the Portland program. Additional CD-CP sites are at various stages of program development, supported by funding sources other than the Department of Justice. This report is submitted to document the process of CD-CP program replication under the federally funded project, to describe the current status of CD-CP programs around the country and to make recommendations for modification and enhancement of future CD-CP program replication activities.

CD-CP PROGRAM HISTORY AND BACKGROUND

The CD-CP Program is a partnership that began in 1991 and was developed out of the shared concerns of New Haven police and mental health professionals regarding the experiences of children and adolescents exposed to and involved in community violence. The program aims to coordinate the efforts of community police officers and mental health clinicians to reduce the psychological burdens of violence on children and families, community members and the professionals themselves. The CD-CP Program is closely related to and dependent on the reorientation of the New Haven police to a community-based policing philosophy. Through the application of principles of child development and human functioning to the daily work of neighborhood police officers, the program provides officers with an expanded frame of reference and more varied options for intervening in the lives of children and families exposed to violence. Similarly, through a reorientation of their traditional relationships with police professionals, the program extends the roles that mental health clinicians play in the lives of the same children and families (Marans and Cohen, 1993; Marans, et al., 1995; Marans, Berkman and Cohen, 1996).

The CD-CP Program has become a foundation for officers, mental health professionals and now, juvenile probation officers and child protective service workers to broaden their roles as problem solvers. The process of consultation and collaboration with mental health and allied professionals breaks down barriers to the idea that complex problems require multiple solutions that involve new partners. As the burden and problem-solving tasks are shared, officers experience a greater sense of

effectiveness and are increasingly able to sustain their engagement in the lives of children. When problems can be assessed in the context of the CD-CP partnership, intervention can not only take place in a more timely fashion but also without the fragmentation of services that so often leads to a squandering of limited resources.

Beginning with three senior police supervisors from the New Haven Department of Police Service and three faculty members from the Child Study Center in 1991, the program in New Haven has now trained all members of the police department in principles and procedures involved in the CD-CP program. The Fellowship continues to grow for both supervisory and, increasingly, rank and file officers. Increased CD-CP demands have also required a greater number of clinicians to become involved in the program activities. This has included the development of an elective in the CD-CP program for psychology interns, post-doctoral level psychologists, child psychiatrists and adult psychiatrists. As part of this process, the Police Fellowship has become highly formalized and is now being developed into a manual for dissemination purposes.

From its experimental inception in 1991, the CD-CP program has become fully institutionalized in the practices and organizational structures of both the New Haven Department of Police Service and the Yale Child Study Center. In addition to the weekly planning and program conference meetings, on-call service contact, development and implementation activities of the new VAWGO and OVC projects, the leadership of the New Haven Department of Police Service and Yale Child Study Center meet on a weekly basis to coordinate and direct all aspects of the CD-CP program.

PROGRAM REPLICATION PROCESS

The CD-CP program replication project proceeded in four phases. The first year of the project was devoted to planning and preparation for a standardized approach to site selection and CD-CP training. During this phase, criteria for site selection were identified and articulated in a Request for Proposals (RFP) and a plan for disseminating the RFP was developed. At the same time, protocols for training and consultation to selected sites were developed. The second phase of the project took place in the first half of the second year and was devoted to selection of the four replication sites. This involved review of written applications and site visits to the strongest applicants. The third phase, which took place during the remainder of the second year, was spent finalizing the curriculum for training police/mental health teams from the replication sites and conducting an individual week of training meetings for each of the four sites. The final phase of the project, conducted during the third year consisted of program development and implementation activities in the replication sites, supported by regular telephone consultation with CD-CP staff. During this phase of the project, site visits were conducted to the developing programs in Buffalo, Charlotte and Nashville. CD-CP staff in New Haven also completed program evaluation protocols and began documenting the process of program replication in the other sites. All phases of the replication project involved close collaboration between NHDPS supervisors and CSC faculty who have been most involved in the development and implementation of the New Haven program. The three year replication project culminated with a multi-site conference, which brought together

representatives of the New Haven CD-CP Program, representatives of the federally funded replication sites, representatives of other CD-CP sites and representatives of sites that are currently in the process of program development.

The following sections of this report will describe and summarize the various stages of the overall replication process, the process and status of replication efforts in each of the four federally funded replication sites and the general findings and conclusions of the multi-site conference. Each section will include a brief analysis of the benefits and shortcomings of the process employed. Overall recommendations regarding the project and future replication activities will be presented in a separate summary at the end of the report.

Criteria for site selection/development of RFP

Criteria for site selection were developed by a committee consisting of New Haven police supervisors and Child Study Center faculty familiar with the CD-CP Program. The criteria were based on the committee's experience of the factors that had facilitated or inhibited development and implementation of New Haven's CD-CP Program, as well as our experience with pilot program replication efforts in Framingham, MA and Newark, NJ. The RFP committee met approximately twice monthly for the first eight months of the project's first year. Drafts of the RFP were also reviewed by New Haven's Chief of Police and by two senior police consultants prior to their submission to OJJDP.

The committee concluded that significant factors that would determine success of a CD-CP program included: (1) strong commitment from the highest leadership of both collaborating institutions to support the police/mental health partnership (this would require both setting an institutional tone of support for the project and making specific institutional resources available to the project's staff, e.g., time for training, time for collaborative meetings, compensation for on-call hours); (2) sufficient flexibility of the participating institutions to allow for the development and implementation of new approaches to police and clinical activities; (3) availability of sufficient resources to implement the program (e.g., funding for clinicians' time in non-fee generating CD-CP activities, police staffing levels that would permit regular engagement in additional activities with children and families and in interdisciplinary meetings); (4) availability of specific personnel in both the police and mental health agencies with sufficient interest in the collaborative process to develop the necessary interdisciplinary relationships and sufficient experience and expertise in their own field to serve as leaders and teachers, both for their own colleagues and across disciplines; (5) sufficient compatibility with the community policing approach employed in New Haven and with the developmental approach employed by the CSC faculty, on which the CD-CP Program is based, to support meaningful consultation between replication sites and CD-CP trainers.

It was difficult to articulate measurable criteria for such qualities as leadership commitment, institutional flexibility and level of staff interest. The collaborative investment of the participating agencies was addressed, in part, through a requirement that applications be submitted by a partnership of a police agency and a mental health agency, rather than a single institution, and that

each application include a formal agreement between the participating agencies. This would ensure that representatives of the participating agencies meet to discuss their common needs and strategies and their access to necessary resources, and that the executives of the applicant agencies formally commit themselves to the project.

When completed, the RFP addressed the following areas: (1) objectives and need for assistance (including a description of the specific local needs that could be addressed by a CD-CP program and a description of how the model would be adapted to benefit the applicant community); (2) qualifications of the participating police agency (including a description of the department's involvement in community-oriented policing activities, its plan for making time available to officers to participate in CD-CP training and its ability to provide training and observation opportunities for clinicians); (3) qualifications of the participating mental health agency (including a description of available clinical resources for police consultation, acute response and follow-up care, commitment to serve patients regardless of income, description of the professional qualifications of the identified clinicians who would staff the project and a commitment of clinical time to participate in CD-CP training); (4) commitment to collaboration (including written agreement between participating institutions and description of collaborative process to date); (5) budgeting (including specific plans of both agencies to make necessary resources available for training, consultation and direct response to children and families); (6) cooperation in evaluation efforts (including both commitment and demonstrated capacity to cooperate in standardized data collection for purposes of multi-site program evaluation). A copy of the RFP is attached to this report as Appendix A.

Development of training and consultation protocols

Parallel to the development of the RFP and selection process, a group comprised of clinical faculty and senior police officers involved in the CD-CP program met on a weekly basis to plan the curriculum for the replication training week. Based on our previous experiences training members of the New Haven police department, and police and mental health professionals from the Newark, NJ and Framingham, MA, pilot replication sites, we developed a four day training protocol. The training involved didactic, experiential, and facilitated seminar approaches to teaching all aspects of the CD-CP model and the ways that it would be applied to the specific locations. Sessions involving ride-alongs; how to teach seminars on developmental principles and policing strategies; issues in acute collaborative responses/on-call protocols; program evaluation; and, implementation strategies all aimed at providing information and actively facilitating the developing partnership between the police and mental health professionals from each of the sites. A copy of the training week outline is attached to this report as Appendix B.

Dissemination of RFP/development of applicant pool

In order to obtain a reasonably large and varied pool of applicants for the CD-CP replication project, efforts were made to disseminate the RFP as widely as possible within both the policing and mental health communities. In addition to the RFP, and prior to its completion, more general

information about the program and the possibility of support for replication was also disseminated through written materials and through presentations at a variety of professional meetings. It was hoped that the more familiar the CD-CP Program was in policing and child mental health circles, the more the announcement of available training and consultation for program development would be seen as an opportunity. (I.e., it was less likely that a police or mental health executive would undertake the necessary interagency planning to respond to the RFP if he or she had never heard of CD-CP or thought of the concept of police/mental health partnership prior to being presented with the RFP).

Initially, CD-CP staff and representatives of OJJDP had planned to publish the RFP in the Federal Register. This would have provided the greatest possible dissemination as well as the certainty that all communities throughout the country were fairly notified of the available training and technical assistance resources. Unfortunately, regulations regarding publication in the Federal Register did not allow inclusion of the CD-CP announcement due to the fact that the project was being conducted by a private entity rather than by the federal government. This required project staff to develop an alternate strategy involving direct mail, advertisement in professional publications and other modes of dissemination.

The final dissemination plan included direct mailing to a list of interested police departments and mental health providers that had been maintained by the CD-CP Program in response to inquiries about program replication, direct mailing to directors of mental health in all 50 states, to police departments in cities with populations between 100,000 and 900,000 and mailing to professional organizations in policing, mental health and child welfare, with requests that the organizations notify their members. In addition, police agencies throughout the country were notified of the RFP through a summary announcement through the National Crime Information Center.

Publication deadlines, advertising costs and limited advertising space complicated and limited the dissemination process. In addition, many inquiries regarding the replication project came from individuals who had only seen the summary announcement and not the full RFP, and whose applications were therefore delayed by the time it took for them to inquire and receive the complete information.

Initial response to the RFP was quite positive. The CD-CP Program received over 200 inquiries from interested parties beginning immediately following the mailing of the RFP and continuing until the published deadline for applications. CD-CP staff responded to inquiries by disseminating additional written material describing the program's work and the replication project, as well as by consulting with serious potential applicants by telephone. Despite the widespread interest in the program, only two completed applications were received by December 8, 1995, the first published deadline. The deadline was therefore extended to February 8, 1996, and an additional five applications were received. The applicants were Baltimore, MD, Brockton, MA, Buffalo, NY, Charlotte, NC, Nashville, TN, Portland, OR and Yonkers, NY.

The discrepancy between the number of inquiries and the number of completed applications can be attributed to several factors. First, we underestimated the time that potential applicants would require to complete the complex process of responding to the RFP, which itself entailed beginning to develop an interagency partnership. As noted above, for many agencies that were not previously familiar with the CD-CP concept, it was too much of a leap to receive written notice of the program, contact a potential institutional partner in the community and develop enough of a relationship and shared vision to submit a joint application within four months. In some cases there was an additional time constraint of securing special legislative authority for the police department to commit itself to an interagency agreement. Given the overall three year timeline of the replication project, it did not seem possible to provide more time for applicants to submit their applications. In our experience with other non-federally funded sites, however, there has typically been a much longer period between a replication site's initial inquiry regarding training and consultation opportunities and the site's commitment to CD-CP training, which has facilitated engagement between the collaborating agencies as well as the engagement between the other site and the New Haven CD-CP Program.

A second fundamental difficulty was presented by the absence of readily available funds to support the implementation of police/mental health partnerships in the replication sites, e.g., funding for on-call clinicians, funding for training. Applicants were thus faced with the need to develop funding strategies to support their engagement in the CD-CP process and to demonstrate the likely success of those strategies in their requests for training and consultation support. At the time that the replication project was initially conceived, we had hoped that funds to operate some developing CD-CP programs would be available through the Violent Crime Control and Law Enforcement Act of 1994. These funds did not materialize, however, and sites have funded the operation of their programs through private foundation grants or through reallocation of existing resources. The combination of short time lines and the need for creative funding plans likely deterred some applicants.

<u>Site selection process</u>

A site selection committee composed of police supervisors and Child Study Center faculty reviewed all seven completed applications. The Yonkers application was eliminated because it did not demonstrate the necessary involvement of the police department. Strengths and weaknesses were identified in the remaining six applications, with specific questions noted to be considered during a site visit. Each site was visited by a team composed of at least one clinician and one officer from the New Haven CD-CP program for two days. The visits consisted of meetings with those individuals slated to be involved in the replication of the program as well as a meeting with the chief of police and the director of the collaborating mental health agency, ride-alongs with supervisory and patrol officers and visits to the mental health agency's facilities. Teams visited Baltimore on April 14th-16th, Brockton on April 10th, Buffalo on April 21st-24th, Charlotte on April 17th-19th, Nashville on April 13th-16th, and Portland on April 22nd-23rd. Two meetings were held on April 24th and 26th in which reports from each site were presented and reviewed and selections were made. The selection process was a very difficult one as all sites demonstrated a

great deal of interest and enthusiasm for the CD-CP program. In the end Baltimore and Brockton were eliminated from the replication group. A brief report of each site follows.

1. Baltimore presented two extremes. On the one hand, the mental health agency is very sophisticated with direct ties and support from the Johns Hopkins School of Medicine. It provides an extensive array of services and had established collaborations with many organizations. On the other hand, the police were completely 911-driven and seemed overwhelmed by the amount of calls and activity in their district. There was not clear evidence of a move towards community policing and it was unclear if they had the time and energy to collaborate fully in the CD-CP replication. In the end, it was the concerns about the police department that eliminated Baltimore.

2. Brockton is a small city with little to no economic base. Police and mental health have been making due with very little. Police officers and clinicians volunteer a lot of time to various collaborative programs. However, there appeared to be a profound lack of resources available both to the police and the mental health agency. This led the selection committee to question how the Brockton group could manage the demands of the CD-CP Program and ultimately to its elimination from consideration.

3. Buffalo is a city in transition. The city's population has decreased substantially in the last 10 years, and policing moving from a traditional to a more progressive philosophy. The Chief of Police and supervisory officers were both knowledgeable and supportive of community policing philosophy in general and the CD-CP program in specific. There already existed a collaboration between the mental agency and the police department for the provision of crisis mental health services to adults with whom the police have concerns. They were very interested in expanding these services to include children and to extending their services to provide on-going treatment. There were concerns about resistance from the rank and file officers towards community policing and also about the mental health agency's ability to expand their array of services.

4. Charlotte is a dynamic and prosperous city with a 'can do' attitude. The police department is progressing rapidly towards full scale community policing and has become more and more child focused. The mental health agency was fully committed to the CD-CP program and to collaborating with the police department. Some concerns were raised about the level of expertise of the clinicians and the lack of clarity about the rank and file officers support for community policing.

5. Nashville applicants were full of optimism about their future. The police department had just embarked on the implementation of community policing and they saw a mental health/police collaboration as integral part of their new initiative. The mental health agency had an impressive amount of community services and were very excited about working together with the police to aid children. Concerns included the newness of community policing in Nashville, and the funding difficulties confronting mental health services in Tennessee.

6. Portland presented two very sophisticated and experienced partners. The police department was known as very progressive and a national leader in community policing. They already had established a collaboration with mental health clinicians regarding severely mentally ill adults. The mental health agency had identified several very experienced clinicians to staff the program and had a wide network of hospital based programs. Concerns focused on the lack of established outpatient child mental health facilities and a lack of a centralized mental health system.

PROGRAM REPLICATION PROCESS IN EACH REPLICATION SITE

The following summaries describe the experience of CD-CP replication in the four federally funded sites. Additional details regarding implementation in Buffalo, Charlotte, and Nashville and can be found in Appendix C.

Buffalo

Buffalo's application made a compelling case for the program based on the city's high crime statistics and thus need, and based on the clear commitment of the leadership in the participating departments. Commissioner Kerlikowske was direct in identifying the police department's historical lack of innovation and need for substantive change. He also noted the city's considerable fiscal, infrastructure, crime and social service problems. However, as a recently appointed commissioner of police services, he was convinced that the BPD was in a position to provide leadership in changing this picture.

Crisis services was described as an agency with an extensive history of providing crisis related services to children and adults. Although the clinical services tend to be time limited, they have worked with a range of patients in crisis including adult victims and witnesses of trauma, and they had extensive experience in running an acute clinical response service. Moreover, they came to the table with a history of collaboration with the BPD and considerable involvement in officer training.

The Buffalo application had a number of strengths and also important weaknesses. The objectives and need for assistance were clearly stated and consistent with the overall mission of the CDCP. They adequately documented the existence of two precincts with high rates of violent crime. Their application was strengthened by a clearly articulated intent to involve the Buffalo Public Schools as well as other key agencies. These intentions were backed by letters of support. The qualifications of the collaborating police agency were mixed. The BPD had no history of community policing or a clear institutional commitment to a community policing philosophy, although they had recently begun a special community policing services unit. They stood out in their commitment to training all officers in the participating districts and in their willingness to provide funding, assignment, and scheduling accommodations to ensure that this would happen. The qualifications of the collaborating mental health provider were also mixed, but overall favorable. Crisis Services had identified three experienced counselors with background in acute post-trauma debriefing with adults. All of these counselors also had experience with program administration and officer

training. Two were New York State Certified Police trainers. Crisis Services also noted great strength in coordinating and collaborating with other area services. Considerable collaborative skill and motivation were apparent throughout the application. Although premature, the clinicians had even included a proposed CD-CP officer training seminar. The leading agencies had a written memorandum of understanding committing both agencies to work together in a cooperative and mutually beneficial spirit. Their history of collaboration clearly supported the ability of both parties to engage in a significant expansion in their collaborative activities related to children and families. The application did not include a specific budget or commitment of dollars. However, both agencies identified the police resources and clinical resources that would be committed at each phase of program development. These plans were detailed and realistic and thus provided further support for the application. The application also provided the required commitment to cooperate in evaluation efforts.

Following the selection of Buffalo as a CD-CP replication site, Alice Colonna and Lt. Dean Runlett joined Lt. Verrelli and Dr. Schaefer to form the New Haven based training team. The team made several phone calls to the police and crisis services in preparation for the visit. We discussed changes in personnel, particularly the replacement of Lt. Paul Reinig of the Community Policing Division with Lt. David Mann of the Sexual Offense Squad. This change was reportedly based on David Mann's interest and reputation in the department and his freedom from union contract overtime restrictions which were likely to constrain considerably the freedom of other team members.

The police officers were most interested in learning about training techniques and the details of a collaborative response to crisis calls. The Crisis Services clinicians wanted to learn about child development and, particularly, how to provide clinical care to children on the scene of violent events. They and the police focused on the "service to traumatized children" aspects of the collaboration rather than other benefits of the collaboration that mutual consultation and coordination might have. The clinicians seemed to be aware that they had special expertise in crisis intervention but that they would benefit from a more in-depth understanding of the importance of understanding development and developmental context in providing crisis intervention services to children.

The CD-CP training team elected to present as much of the child development seminar as possible in the four-day training. It was assumed that the clinicians would struggle in conducting the training if their exposure to the seminar was primarily as a model without substantive content. By the same token, the team recognized that the primary goal of the training is to teach process rather than content. This was made explicit at the outset of training given the constraints of the four-day training model. It was recommended that if trainees felt they needed help with content, they should obtain additional consultation and possibly supervision locally from the State University of New York, Department of Psychiatry. The affiliated Erie County Medical Center reportedly had a child and adolescent psychiatrist on staff who was interested in exposure to trauma. However, this individual was not readily available to participate in the project at this time.

The early seminars dealt only with young children and then skipped school age to review adolescents. There was too little time to manage the many questions and the strong show of interest in basic developmental concepts. It was generally agreed that more time ought to have been allocated to discussion of adolescents. There was time to conduct one or two seminars on adolescents, but ultimately more time was needed (because the seminars were abbreviated) to discuss the implications for policing. Generally speaking, all trainers felt that more examples should have been presented that would highlight the significance of the child development content (i.e., implications for working with children and families as an officer). In addition, more than one of the trainers was left with the impression that the training should ordinarily extend for 5 days. Both of the New Haven officer trainers felt that there was not sufficient opportunity for them to provide input into the discussion of young children. In addition, they felt that there are few practical opportunities to apply knowledge of young children to policing. Consequently, they tended to be much more actively involved in the discussion of adolescence. This is not inconsistent with the observations of some clinicians in the New Haven based fellowship seminars.

Throughout the seminar there was a tension between several opposing forces. On the one hand, there was tension between the need to provide a basic survey of child development, child clinical services for trauma, community policing, and clinically informed police response versus a "training of trainers" approach in which the group is taught how to teach officers and clinicians at home and how to provide the leadership a new program will require. On the other hand, there was a need to balance the structured, sequenced, and, at times, didactic coverage of material with an unstructured, process based approach that emphasizes the development of strong collaborative relationships over content.

Overall, the trainers felt that the training was successful in fostering a significant collaborative bond, working relationships, and an investment in the program that would be critical in the first year of implementation. Although substantive content was conveyed in the course of the four day training, it was felt that much of what needed to be learned would occur in the context of collaboration around individual cases, the ongoing program conference, and through the involvement of local, interested clinical consultants.

Technical assistance was handled by the training team. Initially, New Haven consultants maintained monthly conference call contact with the Buffalo team. When this group contact became logistically infeasible, monthly or bi-monthly telephone calls to clinical and police leadership were substituted. In these phone calls, a variety of barriers to implementation were discussed, recommendations were made regarding hiring additional clinical personnel, and consultation was provided with regard to pilot cases. Barriers included issues of funding for police overtime to take part in training and to participate in ongoing program conferences, limitations on flexibility of assignment of police personnel to CD-CP activities due to strict seniority rules of union contract, and conflict with a preexisting victim advocate program run by the District Attorney's office.

A technical assistance site visit to Buffalo was conducted in March 1996, timed to coincide with the implementation of CD-CP training. Technical assistance telephone contacts continued through September 1997.

Despite some difficulties, the Buffalo team was successful in providing basic CD-CP training to over 200 officers assigned to the target police districts and, as of September 1997, had responded to 12 emergency referrals regarding children and families exposed to incidents of violence. All members of the Buffalo team have expressed a strong interest in continuing collaboration with New Haven. They have begun to implement the CAPERS tracking system and will be participating in the multi-site implementation evaluation. They have shown no signs of slowing their progress. The team is currently planning to submit a grant to extend the program citywide. This plan has received a clear endorsement from the Assistant Chief of BPD who oversees operations throughout the Department.

Charlotte

The replication process in Charlotte had a distinct advantage both from the police and mental health side of the partnership that was to develop. From the police side, Chief Dennis Nowicki had been familiar with the Child Development-Community Policing Program from early on in its inception. As the then Chief of Police in Joliet, Illinois, he had attended several meetings in which the developing CD-CP program was discussed. As a leading figure in the community policing movement, Chief Nowicki was an early supporter of CD-CP concepts. Shortly after assuming the position of chief in Charlotte, the RFP was issued and Chief Nowicki was eager to engage in the application and replication project.

Similarly, Mr. Peter Safir, the director of the Charlotte-Mecklenburg County Area Mental Health Center, had become familiar with the basic aspects of the CD-CP program a year prior to the RFP through previous contact with Chief Nowicki and Dr. Marans. Early discussions between Chief Nowicki and Mr. Safir were very successful and the beginnings of their partnership took shape. The additional partner was the Center for Mental Health, an organization that provides outpatient, emergency room, and in-patient mental health services under contract with the Area Mental Health Center. Each agency agreed to all aspects of the replication plan. Representatives from the three agencies met regularly both to familiarize themselves with services provided by each and to develop the application for the replication.

A seven member team from Charlotte came to New Haven for training during the week of May 20-23, 1996. The police were represented by Assistant Chief Robert Schurmeier, Captain Ken Williams, Sergeants Joey Neely and Tim Wilson. From the mental health side, Ms. Sarah McGeachy represented the Area Mental Health Center, Mr. John Gordon and Ms. Rita Brown represented the Center for Mental Health. The leaders for the New Haven training were Lt. Richard Randall, Sgts. Dawn Cathey and Stephanie Redding from the NHDPS and Drs. Steven Marans and Steven Berkowitz from the Yale Child Study Center.

In spite of the fact that all members of the Charlotte team had spent some time together in exploring the possibility of doing the replication and preparing the application, the remained very divided along professional lines in their experiences and perspectives of each others areas of work. In spite of the great enthusiasm that each group brought to the idea of developing the collaboration, the relative isolation of the two worlds of policing and mental health were as apparent at the beginning of the week with the Charlotte group as it has been with other groups with whom we have work. Both in and out of the formal seminars that began the week, the interaction between police and clinicians was somewhat stiff, if not wary. However, the highly interactive approach to the seminars and the use of ride-alongs with New Haven officers for the clinicians and officers from Charlotte served the desired function of increasing the engagement between the two groups very quickly. The stage was set in which each could begin the process of teaching the other about their areas of professional expertise. As each group came to appreciate what the other had to offer, the discussions about developmental/clinical and policing perspectives on human behavior began to converge. Similarly, each professional group could appreciate the central role that good observational skills serve in both areas of work and the extent to which they share concerns about the welfare of children and families caught up in the cycle of violence. By the end of the training week, interaction both formally and informally had replaced the beginning divide between professional group. (E.g., where police and mental health groups sat on opposite sides of the table the first two days, the last three days seating was mixed.) In the same vein, wariness and stereotyped preconceptions about the other's profession, views and perspective were replaced by a great deal of mutual curiosity and disclosure. At the end of the week, the Charlotte group had planned the ways in which their work would initially proceed from the week in New Haven, beginning roles and responsibilities were defined, and meetings were scheduled.

Technical assistance from New Haven was provided by Dr. Steven Marans and Sgt. Stephanie Redding. Contact was made, on average, four times a month and used for consultation about organizational problems, training issues and procedures as well as specific cases that were generated through the Charlotte CD-CP consultation service. In addition to the telephone contact, five site visits were made during the first year of the replication following the training week in New Haven.

During this first year, longstanding tension between the two mental health agencies about the scope of commitment, support and leadership roles in various community-based programs emerged as a rate-limiting factor in the developing CD-CP work in Charlotte. Where the police commitment has been unwavering throughout the process, in practice and fact, Area Mental Health commitment and participation in the work was far more consistent than that of the Center for Mental Health. From the police perspective, the Area Mental Health group, under the leadership of Ms. McGeachy, was viewed as the reliable and available partner in all spheres of the unfolding work. This split between the two mental health agencies created tensions that interfered in moving ahead with training and the on-call service at the rate that the core CD-CP group had intended. Unfortunately, the leadership of the two mental health agencies were unable to fully resolve the institutionally based disputes in a timely enough or definitive fashion.

Throughout the difficulties that emerged between the mental health agencies and their personnel, the police department took a primary leadership role both in efforts to resolve the issues and to insure that the CD-CP work continued to develop. The leadership of Chief Nowicki, Asst. Chief Schurmeier and Capt. Williams paved the way for all aspects of the program to move ahead. Over the course of the year it became clear that changes were required in order for the Charlotte program to reach its full potential. Personnel changes were made from the Center for Mental Health in a way that was acceptable to the other participants in order to decrease the barriers to effective interagency collaboration.

Nashville

Nashville's CD-CP program is a collaboration between the Metropolitan Nashville Police Department and Family and Children's Services, a large private non-profit mental health agency. The Police Department consists of 1146 sworn officers and covers an area of 533 square miles. The Department includes an internal victim advocacy and counseling program and domestic violence unit, both staffed by mental health professionals. Family and Children's Services provides a variety of outpatient and community-based services, and emphasized its community outreach programs, which involve extensive collaboration with other community services for families and children. The program is located in a high crime area in the downtown Enterprise Zone, which is also served by many other special programs, e.g., Cops Ahead, Cops More, Enterprise Community, Family and Children's Services outreach programs.

Prior to Nashville's selection for the replication project, an initial site visit was conducted by Anne Adelman, Ph.D. and Assistant Chief Douglas MacDonald from the New Haven CD-CP Program. Both in the written application and at the site visit, a very high degree of enthusiasm, energy and optimism about the project was expressed by both police and clinical administrators. It was also evident that Assistant Police Chief Deborah Faulkner, who had been identified as the project's leader from the police side, was a dynamic leader and well liked and respected by the officers in her command. The city also appeared to have a wealth of community resources available and a strong commitment to the principle and practice of collaborative program development. New Haven personnel did have some concerns regarding the fact that community policing was just in its beginning phase in Nashville, and had not been integrated throughout the police department (e.g., only 27 officers with special COPS funding were designated as community-based officers). While there might be some advantages in the concurrent development of community policing and CD-CP collaboration, there was also the risk that the CD-CP program would be marginalized within the police department if it was identified with a small and segregated community policing unit. There was also some concern that the police leadership on the project was stronger than the mental health leadership, and that mental health personnel identified to staff the project had more experience and expertise in community outreach services than in the developmental approach to clinical

intervention that was the basis for the CD-CP program. Overall, Nashville was chosen to participate in the replication based on the motivation and commitment of both agencies, the many existing resources in the community and the opportunity to investigate CD-CP program development in a context of newly developing transition to community policing.

Nashville's replication project training was facilitated by Anne Adelman, Ph.D., Lawrence Vitulano, Ph.D., Asst. Chief Douglas MacDonald and Lt. Bryan Kearney on July 22, 1996. Representing Nashville were Asst. Chief Deborah Faulkner, Sgt. David Williams, Sgt. Mark Steele, Officer Andrea Harakas, Ms. Heidi Bennett (Nashville P.D. crisis counselor), Ms. Donna Humbert (Nashville P.D. crisis counselor), Peg Leonard Martin, M.S.W., Tanya Gray, M.S.W., Kawema and Yasmin Dortche of Family and Children's Services.

The group worked very hard during the week, with all members obviously committed to making the Nashville CD-CP project a success. Though many of the week's discussions were difficult, and interpersonal tensions complicated the development of a cohesive working partnership, the group was able to confront and begin to address many of the complexities inherent in the CD-CP program, and to leave New Haven with their commitment to the project intact. New Haven trainers had attempted to prepare the group from Nashville for the process-oriented nature of the CD-CP training, and to explain the rationale behind our approach in the necessity of developing strong and open working relationships among the individual officers and clinicians who implement the program. Nevertheless, members of the group were obviously disappointed that the training was not more didactic, with clinicians particularly concerned that they were not receiving enough direct instruction in acute intervention techniques. This stance on the part of the Nashville clinicians made it somewhat more difficult for their Nashville police counterparts to perceive them as trusted mental health experts who would be available for emergency response. In addition, the development of relationships between police and clinicians was complicated by racial concerns, as the entire police team was white and most of the clinicians were black, and many members of the team were uncomfortable openly discussing issues of race as they impinge on both police and clinical work in their community. Finally, leadership issues were evident during the training week. The participating police had the clear presence ad backing of their department hierarchy, while the mental health team was unable to make decisions regarding on-call coverage, meeting times and data collection without going back to Nashville for approval. Despite these issues, the group remained energetic, proud of their agencies' commitment to serving children and families, excited by their involvement in a new model of intervention and determined to make their project a success.

Following the Nashville team's training in New Haven, consultants maintained bi-monthly telephone conference calls to provide technical assistance and monitor program progress. Initially, the project focussed substantially on training issues. A two day training curriculum has been developed and presented to 105 officers, most of whom are assigned to the targeted downtown three sector Enterprise Community. Much of the curriculum has been published in the form of a manual. The focus of training has been on educating officers about the reactions of children to traumatic experiences, within a developmental framework. Clinicians have also received

substantial training regarding basic police principles and practices, with all participating clinicians having attended the Nashville Police Citizen Police Academy. Members of the Nashville group have been eager to maintain contact with their New Haven consultants. They have always been cooperative in the national data collection efforts and also with supplying information for the CD-CP Newsletter. In telephone conference calls, they have been both proud of their accomplishments and open in their requests for advice and consultation.

A CD-CP team consisting of Asst. Chief MacDonald, Officer Rebecca Sweeney, and Drs. Anne Adelman and Larry Vitulano visited the Nashville program on February 1-4, 1997. It was an exciting time during which the team was proud to show off their accomplishments since our original visit. Most notably, a new community alert center had opened and the CD-CP clinicians would soon have offices together with their police teammates. The first CD-CP weekly case conference occurred while we were in Nashville for our visit. The police identified a child whom they had been unable to help after repeated attempts, and together with clinicians around the table, developed a plan to evaluate the child more thoroughly and connect him with after school services to provide more supervision. As the process unfolded, everyone was excited by the experience of sharing information and different perspectives to solve a difficult problem. During the visit, clinicians also showed videotaped sessions which they had conducted and presented for group discussion.

During the visit, New Haven representatives got a sense that both the community-based police officers and the outreach clinicians involved in the project experienced themselves as relatively unsupported or marginalized within the larger bureaucracies of the police department and Family and Children's Services, and that increased institutional support would greatly benefit the project (e.g., increasing the staffing of the alert center to include evening coverage as well as day staffing). Nevertheless, the project appeared to be developing strongly and individual participants appeared pleased with their work. A stronger bond between the New Haven and Nashville team also seemed to develop during the site visit and continued into the following months of collaboration through e-mail and telephone contact.

As of September 30, 1997, 16 cases had been seen by the CD-CP team. Program conferences take place weekly. There is a significant degree of informal consultation between police and clinicians, both around the meetings and at the alert center. The on-call service is up and running, but there have been ongoing administrative difficulties with the beeper service, which was scheduled to begin in October. There has been a request for continued telephone contact and another site visit by the New Haven team, and funding for our continued involvement is being explored.

Portland

The Portland CD-CP collaboration is a partnership between the Portland Police Bureau, in collaboration with the Child and Adolescent Behavioral Health Program at Legacy Emanuel Hospital. As noted above, during the application process, both agencies presented themselves as fully committed to developing a joint program based on the CD-CP model. The proposal stated

that the project would be implemented in the Northeast section of the city and would involve the Portland public schools, the Inner Northeast Neighborhood Association, Multnomah County Children's Mental Health Unit, State of Oregon Children's Service Division, and children's mental health advocacy groups. Project Network, a program serving primarily African-American drug-addicted mothers and their children, was also named as a collaborator. Preliminary plans for staffing the program were presented in the application, along with assurances that necessary resources would be made available by both collaborating institutions.

The site visit prior to the final selection of Portland as a replication site took place on April 22 and 23, 1996. New Haven Police Chief Nicholas Pastore and Jean Adnopoz of the Child Study Center were the site visitors. The site visitors met with the leaders of both police and mental health agencies and were provided with tours of the relevant institutional facilities and the Northeast Precinct, where the program was to be implemented. As in the written application, police and mental health administrators assured the CD-CP team of their philosophical and practical commitments to the program. CD-CP personnel were somewhat concerned, however, when they learned that Sgt. Karl McDade, who had written the grant for Portland to participate in the replication project, had been transferred to another area of police work and would no longer be involved in the project, and that other central police supervisors had been informed of the program, but had not been involved in planning for its implementation. Unfortunately, the site visit was not long enough for the New Haven personnel to get a clearer sense of the nature of either institution's organization or the depth of commitment to the CD-CP project.

Overall, it appeared to the site visitors that both the Portland Police Bureau and the CATP possessed the necessary resources and were prepared to make the necessary commitments to participate successfully in the CD-CP replication project. Their only reservations included concerns about the implication for the program of Sgt. McDade's transfer, general concerns about the availability of clinical resources through a for-profit managed care agency, and Chief Pastore's concern about the potential incompatibility of the Portland approach to community policing with the approach of the New Haven consultants (i.e., Portland police take a more aggressive approach as demonstrated in their more frequent involvement in shootings of civilians).

A six member team from Portland came to New Haven for training during the week of June 13, 1997. Police representatives included Lt. Rod Beard, supervisor of community programs for the Northeast Precinct, Lt. Michael Bell, day shift commander, and Lt. James Ferraris, evening shift commander. Mental health representatives included Pamela O'Keefe, M.S.W., and Tammy Lambert, R.N., both of the CATP inpatient unit, and Wendy Jenson, M.S.W., an outpatient therapist. The New Haven consultants included Jean Adnopoz, M.P.H. and Miriam Berkman, J.D., M.S.W. of the CSC and Lt. Michael Sweeney and Sgt. Anthony Griego of the NHDPS. Of the four New Haven staff, only Ms. Adnopoz had been to Portland for the site visit. Of the six Portland personnel, only Lt. Beard and Ms. Lambert had been present at any of the site visit meetings, and neither had taken a substantial role in planning Portland's involvement in the CD-CP replication project.

It was evident as soon as the team arrived in New Haven that there was a significant discrepancy between the level of interest and commitment expressed through Portland's written application, statements of both police and mental health leadership during the site visit and the expectations of the team members sent to New Haven for training. From the police side, two of the three lieutenants were relatively new to the district and had had no exposure to the CD-CP program prior to their assignment to come to New Haven for training. Though Lt. Beard had been present at a meeting with the New Haven site visitors, he had not been involved in planning the project, had not seen the grant application and had not been given any written program description prior to his assignment to the training team. All three lieutenants stated in the opening session of the training that they believed they had been assigned to observe and evaluate the New Haven program in order to make recommendations to their department about its possible implementation in Portland. Police supervisors made clear that all of their assignments are transient and that important decisions are made above them, often without their input. Though all three of the police participants were obviously knowledgeable, experienced and thoughtful about their work, their description of their department's organizational structure raised obvious questions about how a program like CD-CP, which depends on personal relationships, can be implemented in Portland. More fundamentally, the lack of communication between the department administration that submitted the grant and the individuals identified to implement it raised serious concerns about the commitment of police leadership to the project.

On the mental health side, there was some confusion during planning of the New Haven training regarding who would attend, with last minute substitution of clinicians. Individuals who did attend were experienced line clinicians with responsibilities to the in-patient unit or outpatient services and much expertise in working with adolescents. Two also had some experience as juvenile probation officers. Clinicians were generally knowledgeable about child development and interested in prospect of working with police, but had not had much previous information about program. No one with administrative authority was present and all clinicians were uncertain what resources they would have to work with (e.g., compensation for on-call, organization of follow-up service). During the site visit, several administrators had expressed their commitment to the CD-CP model and appeared to be enthusiastic about the selection of Portland as a replication site. However, the absence of high level clinicians and/or administrators made it difficult to obtain any serious commitments while the group was in New Haven.

Discussions during the first two days of training were difficult, with Portland participants contributing less than we hoped. Seminars were particularly difficult, with police taking the stance that they already had training about child development and didn't need more, and with clinicians also expressing some impatience with going back to basics. Police participants expressed skepticism that the CD-CP program would be useful in Portland, and spent much time discussing all the resources they already had in place, most particularly a volunteer response team made up of local community leaders and ministers, which is currently called out in crises, including fatalities witnessed by children and civil disturbances. This volunteer team was not mentioned in either the written application or the site visit. Particularly during the first two days of the training, New Haven group leaders talked more than we would have liked, and as the meetings took on a more

didactic tone, the New Haven clinicians rather than the police took on the leading role, perhaps making connections with the Portland police all the more difficult.

Despite difficulties and questions regarding the commitment of the participating Portland institutions, there were some positive indications. All of the mental health and police participants in the New Haven meetings were obviously bright, experienced and competent professionals. As they became more familiar with each other and with the CD-CP model, they were more open in the discussions and able to drop some of their posturing. By the end of the week, we felt that the personnel identified to implement the program would have the capacity to do so if they had (1) adequate time to develop their beginning relationships; and (2) adequate institutional support (in terms of time, resources and signals from superiors that their institutions would value their collaborative work).

Subsequent to the New Haven-based training, contacts between New Haven consultants and the Portland collaborators were few and, unfortunately, confirmed our concerns that the program would not succeed in Portland. Despite an agreement at the end of the training week that New Haven consultants and Portland team members would maintain contact through telephone conference calls, calls were difficult to schedule, calls from the New Haven consultants were not returned and only one conference call was completed. The defensive tone of the police participants during this call led to concerns on the part of the New Haven consultants that our attempts to provide ongoing consultation contacts were perceived as intrusive and demanding. We considered making an early site visit in order to assess the potential of the site to get back on track, but elected to wait and allow the Portland team to try to come together on their own rather than to provide a target for their resistance and resentment.

For approximately six months we had no contact at all with Portland police, but did maintain some telephone or written communication with mental health administrators. Through these limited contacts we learned that some but not all Portland team members had followed through with their plans to visit each other's institutions, and all three participating clinicians went on at least one ride along with police. As planned, Lt. Beard met with the police coordinator of the volunteer crisis response team and engaged her in planning meetings with mental health representatives, however the remaining police lieutenants who had come to New Haven ceased participating in the group. As planned, participating clinicians met with their administrators and developed a system of on-call coverage, however the police did not call for any clinical response. Interagency team planning meetings took place once a month. Representatives from Legacy Emanuel Hospital were asked to present five hours of police in-service training on issues related to child development, responses to trauma and police interactions with children. Clinicians who had been involved in the project were frustrated and discouraged by the lack of engagement by their police counterparts and mental health administrators were frustrated by their unreciprocated commitment of resources (e.g., paying stipends to clinical staff to carry a beeper that police never called).

In February 1997, Lt. Beard was transferred to another unit within the Police Bureau and Lt. Tammy Jones was assigned to the Northeast Precinct in his place. Mental health representatives were initially pleased that Lt. Jones appeared more interested and excited by the prospect of developing a police/mental health collaborative program. She expanded the collaborative planning group to include representatives of a department-wide domestic violence unit. She also facilitated the development of a formal protocol for referral of police cases to the on-call clinical service. Within three months, however, she too was transferred out of the Northeast Precinct. Moreover, despite the existence of the written protocol, there continued to be no requests for clinical involvement in cases involving children's obvious exposure to traumatic violence. Upon hearing of Lt. Jones's transfer, New Haven consultants, who had been planning a site visit to Portland in May, cancelled our visit, based on our conclusion that there was little active collaboration possible given the level of commitment by the Portland Police Bureau.

As one of the federally supported replication sites, representatives from Portland were invited to attend the CD-CP Multi-site Conference in September. At that time, a series of telephone conversations with police and mental health administrators made clear that the Portland program would not participate either in the conference or in the network of CD-CP sites. As Chief Moose explained, financial cutbacks had made it impossible for the Portland Police Bureau to commit the level of staffing to the CD-CP program that had been originally contemplated. Loss of funding had also necessitated a reorganization of the Bureau's supervisory staff and had resulted in the multiple transfers that had plagued the project. Mental health administrators decided at that time to terminate their funding for the on-call service, but to maintain a looser link to the police that would facilitate referrals to existing clinical service.

The experience in Portland emphasizes the importance of ongoing and involved high level institutional support for successful development of a CD-CP collaboration. Although the top administrators of both institutional partners in Portland committed themselves in principle to the replication project, what appears to have been missing was either an ongoing relationship between the police chief and the director of the mental health agency that could have facilitated interagency problem solving when the project began to founder or delegation of sufficient authority and resources to the supervisors who were charged with the responsibility of implementing the project. It appeared that none of the many police supervisors involved in the project received a clear message from the police leadership that the CD-CP program was important enough to be protected from personnel transfers or that they would be recognized or rewarded for their engagement in a difficult program of institutional change.

PROGRAM EVALUATION

The CD-CP program is currently conducting research in three areas. The first of the three areas relates to the national replication of the CD-CP model. In order to track the clinical and collaborative activities of replication sites, CD-CP has developed a windows based computer application referred to as the Case, Activity, and Patient Electronic Recording System (CAPERS).

Version 1.0 of this program was completed in February 1997 and has since been field tested in New Haven and at several replication sites. The field testing led to the identification of several problems with the original program and with ideas for enhancing and streamlining this program. A pilot Version 2.01 was developed in June 1997, and tested in New Haven in August. This program improves on the prior version by eliminating extraneous information, combining screens, and addressing the need for the recording of police follow-up activities after the acute event. Version 2.01 was distributed to OJJDP replication sites at the Multi-Site Conference in September 1997. Charlotte, Nashville and Buffalo are scheduled for full implementation by late September. CD-CP will be collecting MIS data from each site on a bi-annual basis. These data will be compiled into a single data repository at the Yale Child Study Center where descriptive statistics will be generated for reporting. In addition to providing feedback to individual sites, reports will be prepared for OJJDP and for broader publication where appropriate. See Appendix D for the latest version of the CAPERS 2.01 User's Guide.

The CD-CP research division has recently completed the CD-CP Officer and Clinician Surveys (attached as Appendices E and F respectively). Several versions have been field tested extensively during the past year. This has led to the omission of items that do not distinguish trained officers and the rewriting of items that are poorly worded. The current version of the Officer Survey has 99 items which tap such areas as knowledge of child development, insight into psychological functioning, dogmatism, awareness of children, social desirability, contact with youth, understanding of mental health, and appreciation for the therapeutic value of structure and police authority. Test-retest reliability testing is partially completed. Three of the four replication sites have agreed to administer the surveys to officers in a CD-CP target district and matched control district. The survey administration will be repeated every six months for 2 years. The Charlotte police department will begin the first wave of survey administration in August 1997. Buffalo and Nashville are scheduled to begin the survey administration in the fall. The data collection will allow us to assess change in officer knowledge and attitude over time, and to assess the effect of involvement in CD-CP program activities using the non-CD-CP district control as a comparison. An evaluation proposal that summarizes the use of the CAPERS system and Officer and Clinician Surveys can be found in Appendix G.

The final component of our current research program involves a follow-up study of children and adolescents who have been served by the CD-CP collaboration. The primary aim of this research is to determine the rate of Post-traumatic Stress Disorder and the relationship of this disorder to various aspects of the traumatic event and characteristics of the children and families. Information will also be collected regarding the individual's subjective experience of involvement in the CD-CP program. This investigation at the level of individual outcome will also be coordinated with concurrent tracking of outcomes at the service system and community levels (e.g., tracking of referral patterns, monitoring of crime rates, truancy and school performance data and community survey data). An overall discussion of issues in evaluating the CD-CP program is contained in Appendix H.

MULTI-SITE CONFERENCE

On September 14 and 15, 1997, the CD-CP Program hosted a two day meeting of police, mental health and other professionals actively involved in collaborative programs based on the CD-CP model. 73 participants attended. These included representatives of the federally supported projects in Buffalo, Charlotte and Nashville, representatives of additional CD-CP projects in Baltimore, Framingham and Newark, representatives of several new sites that are in various stages of CD-CP program development and representatives from the New Haven CD-CP Program. The conference provided an opportunity for representatives of the replication sites to share information about their work with others engaged in similar collaborative activities and to compare the different ways in which the CD-CP model has been adapted to meet the needs and resources of the particular communities in which it is being implemented. The conference also provided a forum for open discussion of some of the difficulties that have faced the developing programs across the country. The first morning of the conference consisted of welcoming and introductory remarks, followed by summary reports from the replication sites. During the afternoon of the first day and the morning of the second day, the conference broke into smaller work groups focussed on several different areas of concern across the sites: administration, collaborative response, training, juvenile justice, domestic violence and new site development. Each working group reported its general findings and recommendations to the full conference. The conference then concluded with a keynote address by OJJDP Administrator Shay Bilchik and general discussion among participants and Mr. Bilchik.

Overall, participants in the conference expressed enthusiasm and excitement for their involvement in police/mental health collaborative projects, with many police and mental health professionals describing newfound optimism for their work with troubled children and families as a result of their engagement in the CD-CP programs. Conference participants from the various sites appreciated the opportunity to share information across sites and were interested to find that many of the same barriers to program development had been experienced by other communities. Consistent themes emerged relating to the need for high level institutional commitment and support for the collaborative process, the complexity and slow pace of institutional change, the need for new and more flexible funding sources, the professional burdens associated with exposure to chronic violence and trauma and the gratification of involvement in open working relationships between police officers and mental health professionals, significant interest in maintaining and deepening the contacts among personnel from the various sites and significant interest in becoming involved in disseminating the model more broadly throughout the country.

A full report of the conference proceedings will be disseminated separately. Appendices to this report contain the following material from the conference:
Appendix I: conference agenda
Appendix J: list of conference participants
Appendix K: summary reports from the replication sites
Appendix L: summary reports from the conference working groups

CONCLUSIONS AND RECOMMENDATIONS

1. In order for the replication of CD-CP to occur, there needs to be significant guarantees of engagement with and support from top leadership within the police, city, mental health and other involved agencies. Those sites that had this level of continued support (i.e., from the time of the application through the period of implementation) were most successful. It was clear in other sites that the depth of support was not substantial enough for the project to move ahead at the pace with which the key personnel were willing and able to assume. In these sites, it became apparent that in spite of paper support for the replication, issues such as inadequate support for key personnel, changing staffing assignments, lack of active planning for program funding, limited dissemination of information about the program within departments/institutions, significantly interfered with the full potential for implementation of the CD-CP model. This was especially demonstrated in our attempts to work with the Portland initiative.

It is recommended that more extensive discussions/preliminary work be completed between potential partners within possible replication sites prior to the initiation of extensive formal training by existing CD-CP consultants. These initial discussions will provide the basis of the developing local partnerships. During this period, existing CD-CP personnel can be available for consultation to the nascent projects. This beginning back and forth contact allows everyone involved to learn more about the CD-CP activities (including visits to existing CD-CP sites) as well as opportunities for CD-CP consultants to get a better sense about the viability of continuing the replication process (i.e., developing memoranda of agreement; engaging in CD-CP training; establishing local training, call service, case conference, etc.) This early phase in establishing institutional relationships most closely mimics the establishment of the New Haven-based CD-CP and has proved to be one of the most important contributions to endurance and further development of the program. In addition, this broader approach to familiarization with the potential site can decrease the wasted energy and false hopes that occur with insufficient information/understanding the realities of the local organizations, politics, and resources.

2. In order for CD-CP programs to develop optimally, both participating police and mental health institutions require financial support for staff to engage in essential training, relationship building, and collaborative intervention activities. Those sites that were most successful were those that had access to relatively flexible funding sources in order that existing resources could be redeployed and those that were able to obtain additional grant funding to support the activities of central CD-CP personnel. In many of the sites, mental health agencies found an acute need for operational funds presented by the requirements of managed health care. Because agencies ordinarily will not be reimbursed for the time CD-CP clinicians spend in interagency meetings, training, community outreach, or on-call hours, alternate sources of funding are essential if clinicians are to be able to be available when needed by the police. Similarly, police departments must have sufficient personnel available in order to provide adequate police coverage on the street while also protecting the time officers spend in CD-CP training and regular attendance at meetings.

It is recommended that greater assistance be provided by the federal government to enable CD-CP replication sites to obtain the level of financial support required to begin new programs. While it is expected that successful programs will be able to develop their own solutions to the issues of long term support, newly developing interagency collaborations would be greatly strengthened if they experienced start-up expenses as less of an overwhelming barrier. There are several ways in which federal support would be invaluable.

a. Greater support for CD-CP as an emerging national model of service delivery could be obtained through a coordination of the efforts of the many federal agencies that are attempting to address the effects of exposure to violence on children and adolescents. In addition to the support being provided by the Department of Justice, increased coordination of funding for violence prevention, victim and witness services and community-based developmental intervention available through such agencies as Department of Education, Department of Health and Human Services and Department of Housing and Urban Development would greatly simplify the task of funding a developing CD-CP program.

b. In addition to increased direct funding from federal sources, it would greatly assist developing CD-CP programs if technical assistance were available from the federal government regarding the identification and application for funds for CD-CP work from a range of public and private sources.

c. Increased federal support for newly developing programs ought to be made available in a form that encourages nascent programs to think through the institutional requirements of the CD-CP model and requires at least some investment of participating agencies' own resources. Federal funding that requires a commitment of local matching funds and/or various kinds of in-kind support would serve the dual purposes of supporting and encouraging program development consistent with a new federal model, while at the same time discouraging applications for funds that are not based on a serious commitment to exploring institutional change.

3. In order for the CD-CP model to be effectively disseminated more broadly throughout the country, it is necessary to expand the pool of trainers, presenters and consultants beyond the current personnel based in New Haven. Ideally, trained and experienced CD-CP consultants should be based in all regions of the country, with the ability to support an expanding number of CD-CP sites in various stages of program development and with the ability to conduct a range of local and regional training meetings. Early experience in CD-CP program replication has demonstrated that working relationships between CD-CP consultants and developing programs are facilitated by ease of contact and a perception that support is available as needed. More frequent site visiting back and forth between training sites and developing sites would be possible if travel were not prohibitively expensive and time consuming. Regionally based CD-CP consultants would also be in a better position to become aware of local and regional issues that might affect the success of a growing collaborative program. In addition, greater involvement of police and mental health personnel from existing and future replication sites in the training and dissemination activities of the CD-CP network will strengthen existing

replication programs by providing opportunities for experienced professionals to demonstrate their own acquired expertise.

The current group of replication sites offers the potential for expansion of the CD-CP training pool. Ongoing contact with personnel from those sites through the CD-CP network and sharing of training and presentation material will begin a process of broader dissemination of the model as well as a process of deepening the engagement of existing sites.

4. Increased replication of the CD-CP model would be facilitated by expanded dissemination of information about the collaborative model and the experiences of CD-CP programs in the various sites to a range of professional and lay audiences. As noted above, our experience has been that successful CD-CP program development is a lengthy process that involves two groups of professionals in familiarizing themselves with each other's work and the potential benefits of joining forces in the interests of children at risk. A first essential step in that process is exposure to the idea that, contrary to traditional stereotypes, police and mental health professionals have interests in common and that both groups might benefit from greater interaction. Acceptance of the intervention model will be enhanced by greater awareness of the basic ideas underlying the model and broader dissemination of the program's successes. In order to reach the widest audience possible, a range of dissemination strategies should be designed, including use of print, video, audio and computerized media. These expanded dissemination efforts are part of current CD-CP activities, supported by OJJDP.

5. Current and future replication activities would be supported by greater communication between the replication sites and New Haven program staff as well as communication among the replication sites themselves. More active communication among the sites will provide avenues for sharing information, experiences, innovations, training materials, modifications of the basic CD-CP model, etc. Expanded communication within the CD-CP network will also decrease professional isolation and solidify the experience of being an essential part of a developing model program. Development of the network has begun through the establishment of a CD-CP newsletter and the experience of the multi-site conference. These efforts will continue and should be expanded through the greater use of technologies. A CD-CP website is currently under development.

6. CD-CP training would be enhanced by the collection and integration of training materials from all current CD-CP sites and the development of a comprehensive training manual. The manual would contain both conceptual material describing and explaining the CD-CP approach to training and more detailed lesson plans and that could be used by CD-CP trainers in different sites and with different specific audiences. The integration of training materials would make available to all current and future sites innovations developed by the first replication sites. Dissemination of detailed materials and greater manualization would also facilitate the expansion of CD-CP trainers which we recommended above. The process of collecting and integrating training materials has already begun and will continue with current OJJDP support. Additional government support would be helpful with regard to the development of materials that can be

more broadly disseminated, e.g., training films, computerized training materials.

7. With the spread of the CD-CP model to many communities nationally, the question of how to measure program impact has frequently arisen. Numerous obstacles complicate the application of standard models of program evaluation to CD-CP programs. These include features inherent to this innovative intervention and to the people and communities served. For example, the context of the intervention is one of human and neighborhood crisis, and it is activated at the point when children and youth are exposed to serious, often criminal, forms of violence. Clearly, in such circumstances many uncontrolled factors impinge on the situation and affect to whom, to what extent, and in what form CD-CP services are delivered.

Notwithstanding the methodological challenges, it is essential to develop a comprehensive strategy for evaluating and documenting program utility and effectiveness. It is recommended that an integrated approach to evaluation be employed, which includes examination of outcomes at the individual, service system and community levels. Through the convergence of finding from different types of longitudinal studies, the most convincing case can be stated regarding effectiveness of CD-CP interventions. Such a comprehensive approach would include the following areas of investigation.

a. At the individual level, development of a means for tracking cases over time provides summative descriptive data to explore short and long term outcomes for children and families who receive CD-CP services. In this context, individual and family status are documented and also perceptions of the utility of CD-CP intervention.

b. Another set of individual level outcomes involves the knowledge and attitudes held by police officers and clinicians who train in the CD-CP intervention. Both the CD-CP training and ongoing experiences in implementing the program should change and reinforce awareness of their potential roles in traumatic situations and in more routine aspects of their work with children and families in the community.

c. A third area for evaluation involves the extent to which systems and services -- both police and mental health -- actually change through the implementation of CD-CP.

d. In terms of community level outcomes, comparison of rates of youth involvement in violent activities and rates of trauma related symptoms in communities with and without CD-CP programs is a useful population based approach. Such a design is considerably strengthened when comparisons can be made across a number of communities with similar initial crime rates, but with different degrees of CD-CP implementation at subsequent points in time.

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Appendix A: RFP

Appendix B: CD-CP Replication Training Schedule

Appendix C: Program Implementation Reports from CD-CP Replication Sites

Appendix D: CAPERS Users' Guide

Appendix E: CD-CP Officer Survey

Appendix F: CD-CP Clinician Survey

Appendix G: CD-CP Evaluation Research Proposal

Appendix H: Memorandum re: Issues in Evaluating Child Development-Community Policing Programs

Appendix I: CD-CP Multi-site Conference Agenda

Appendix J: CD-CP Multi-site Conference List of Participants

Appendix K: CD-CP Multi-site Conference Reports from Replication Sites

Appendix L: CD-CP Multi-site Conference Reports from Working Groups

TRAINING AND TECHNICAL ASSISTANCE FOR DEVELOPING POLICE/MENTAL HEALTH COLLABORATIONS -- CHILD DEVELOPMENT-COMMUNITY POLICING PROGRAM MODEL

REQUEST FOR PROPOSALS

The purpose of this program is to provide training and technical assistance to developing collaborative programs between police and mental health professionals based on the Child Development-Community Policing (CD-CP) Program model, developed in New Haven, Connecticut. The model program to be replicated is outlined below, along with the rationale for the model's approach to intervention with children exposed to community violence.

Background:

The Child Development-Community Policing Program developed in New Haven, Connecticut, is a model for a powerful new collaboration between law enforcement and mental health professionals. Police officers and mental health clinicians are learning together to intervene on behalf of those children and families who are most affected by exposure to community violence. In this Program, both law enforcement and mental health professionals have recognized that --while their separate efforts to interrupt the cycle of violence have been limited--thinking and acting collaboratively yields a broader range of perspectives on shared problems and a greater chance or resolving those problems successfully.

For police officers, the Program offers an array of strategies for responding to community violence and leads to an increased sense of effectiveness, personal safety and better law enforcement. The collaboration allows mental health professionals to deliver psychological services more directly and immediately to those members of the community who are most vulnerable and for whom traditional mental health services have been least accessible. The partnership between police and mental health professionals provides a unique opportunity to investigate the relationship between violence, traumatic stress symptoms and antisocial behavior, as well as to develop more effective ways of delivering better police and mental health services to our communities. The Child Development-Community Policing Program reflects smart policing, smart mental health services and smart partnerships.

Children's Exposure to Violence

For too many children in America, exposure to violence is a common experience, both in their homes and in the larger community. Unfortunately, many children also lack the supports of family or the coherence of the community and its institutions to help them deal with the psychological

consequences of their experiences.

The United States has the highest rate of violence of all industrialized nations. Studies of rates of children's exposure to scenes of violence are equally alarming.

* At Boston City Hospital, it was reported that 1 out of every 10 children seen in the primary care clinic had witnessed a shooting or stabbing before the age of 6; half in the home, half on the streets (Taylor, 1992).

* In New Haven, CT, 41% of a sample of 6th, 8th and 10th grade students reported having seen someone shot or stabbed in the preceding year (New Haven Public Schools, 1992).

Such exposure to violence was associated with increased feelings of depression and anxiety, higher levels of antisocial and aggressive activities, greater alcohol use, lower school attainment and increased risk taking. Of particular concern is youth involvement in violent crime, which has continued to rise at a rate of 36% in the last five years and 5% from 1992-93. While there is no one-to-one correspondence, studies have repeatedly shown that violent criminal behavior is frequently associated with a childhood history of physical abuse and exposure to adult violence.

These connections between exposure to violence, experience of psychological symptoms and engagement in violent activity require new and creative interventions that bridge the gap between policing and mental health approaches to children and adolescents who are exposed to and involved in community violence.

<u>A Collaborative Response</u>

The Child Development-Community Policing (CD-CP) Program emerged out of the shared concerns of Yale Child Study Center faculty and New Haven police leadership regarding the potential psychological casualties of community violence, including those children and adolescents who perpetuate the cycle of violence by becoming participants themselves.

Since the inception of the CD-CP Program in New Haven, both police officers and mental health professionals have assumed new and expanded roles in relation to the children, adolescents and families exposed to and engaged in community violence.

* The entire police force has been trained in the use of

the CD-CP Consultation Service, which provides back-up for officers responding to scenes of violence, including both operational support for officers' own containment of crises and the availability of immediate clinical intervention for children and families. As a result, officers have been less burdened by their own exposure and more effective in their response to traumatic events.

* Officers have increasingly applied psychological principles learned through the CD-CP seminars to their daily police activities to increase their own safety and effectiveness in a range of situations, e.g., crowd control and civil disturbances, interviewing youthful offenders and witnesses, and establishing an authoritative presence that is supported by the community.

* Formal linkages have been established for the first time among police, juvenile probation, public schools, child welfare and mental health agencies, which provide opportunities to share information and to coordinate and streamline the various institutions' responses to children and adolescents involved in juvenile delinquency.

* Officers and clinicians have worked together on hundreds of cases since the CD-CP collaboration began. Children and adolescents seen through the Consultation Service (see below) have included many who had previously experienced multiple exposures to violence and significant psychological and behavioral difficulties but who had never before been referred to any mental health service.

* Clinicians have expanded their activities in community settings and have increased their appreciation of the need many children have for the control of external authority, including police and probation.

Program Outline

The CD-CP Program, as developed and implemented in New Haven, consists of several inter-related educational and clinical components which aim at sharing knowledge and reordering the relationship between police officers and mental health clinicians.

A. Clinical Fellowships for Supervisory Officers

* The Fellowship aims to provide supervisory officers with special psychological expertise to lead

neighborhood-based officers in a variety of crime prevention, early intervention and relationship building activities involving children, families and the larger community.

* Fellows spend several hours a week over the course of several months in the Child Study Center engaged in observations, case conferences and discussions which familiarize them with developmental concepts, as applied both in clinical settings and in the daily work of police officers.

* Through the Fellowship, ongoing collaborative relationships are established among the police Fellows and the mental health professionals involved in the Program.

B. Police Fellowships for Clinical Faculty

* Clinicians spend time with police colleagues, in squad cars, in police stations and in the streets, observing officers' day to day activities.

* Mental health professionals become familiar with police operations, local neighborhoods and the realities of officers' interactions with children and families.

* Basic familiarity with the concerns and practices of police officers allows clinicians to develop trusting collegial relationships with officers and explore collaborative intervention strategies.

C. Seminar for Police Officers

* A 10 week seminar, jointly developed by police supervisors and Child Study Center faculty, is co-led by a team of supervisory officer and clinician.

* The seminar exposes officers to principles of child development and human behavior in the context of case examples drawn from the experience of seminar members and leaders, and applies psychological principles to policing strategies.

* The seminar provides officers with the experience of working alongside mental health professionals and with concepts and methods for working cooperatively with other social services on behalf of children and families.

D. Consultation Service

* Neighborhood-based police officers come in frequent contact with children and families who are in danger or distress, e.g., victims or witnesses of violence, truants from school, or teens involved with gang activity, and therefore require clinical support for their expanded roles.

* The Consultation Service is staffed 24 hours a day by a team of clinicians and specially trained police supervisors who respond to officers' immediate needs for guidance in crises, especially following children's traumatic experiences.

* In urgent cases, a clinician may meet immediately with a child in acute distress, either at the police station, the family's home or elsewhere in the community.

* Consultation may also lead to a later meeting with a clinician, a supportive intervention by a neighborhood officer or to a referral to another available clinical program.

E. Program Conference

* Police officers and clinical faculty meet weekly to discuss difficult cases that arise from the officers' direct experience and from the Consultation Service.

* The Conference provides a forum for CD-CP staff to examine cases from a variety of perspectives in order to understand better the experience of children and families exposed to violence, to explore the limits of current intervention strategies, and to develop improved methods of collaboration and response.

* The Conference also addresses systemic, institutional and administrative issues.

The CD-CP Program provides neighborhood-oriented officers with the clinical knowledge and operational support they need to assume expanded psychological roles in the lives of the children and families they serve, and provides clinicians with opportunities to affect the lives of children who previously would not have come to the attention of mental health services. Working together, both officers and clinicians are broadening their perspectives on the children and families they serve and are developing new strategies for the streets, the classroom and the consulting room for interrupting the cycle of community violence in which youth are involved as witnesses, as victims and as perpetrators.

Training and technical assistance provided under this program will support the development of police/mental health collaborations based on the general program model described above. Replication of each of the program elements described above is recommended but not required. It is expected that the program model will be adapted to meet the particular needs of the applicant community.

Program Strategy:

Agencies interested in applying for training and technical assistance under this program must be willing to accept major program planning and implementation responsibilities. Also, given the experimental nature of this replication program, agencies must be willing to implement required management and operational changes as defined by the program. The sites must design and fully execute a strategic plan of action in support of the CD-CP Program replication, and must be willing to make periodic modifications in the plan as requested during the program replication cycle. Strategic plans must also include methods for ensuring continued support for the program.

Organizational Commitments:

At a minimum, the following commitments are necessary: (1) creation of a core police/mental health provider team to coordinate development of the collaborative program; and (2) development and maintenance of a strong and meaningful partnership between the police and mental health agencies.

Key Program Elements:

Elements to be addressed in the application include the following:

* Flexibility of management attitudes and behaviors: to ensure compatibility between established agency management styles and practices and the requirements of this program.

* Established organizational structure: to ensure that the current organizational structures can facilitate the successful replication of the CD-CP Program as embodied in community policing ideas and practices.

* Expanded role of patrol officers supported by consultation and collaboration with clinicians: to ensure the necessary expansion of the operational role of patrol officers and to identify approaches for facilitating the integration of all sectors of the

police and mental health agencies.

* Awareness of systems, policies and practices requiring change: to identify the level of change in internal police and mental health systems (e.g., training, managing calls for service, career development) that will be required to support the management and operational goals of the program. Also, to ensure that existing organizational policies and practices are compatible with the CD-CP Program.

* Supportive role of political leadership: to ensure the existing and sustained support of the local political leadership.

* Expansion of measures of success: to identify and test the qualitative measures of police and mental health provider performance as well as the quantitative measures.

Review Process

A. Eligible Applicants

Before applications are reviewed, each application will be screened to determine that the applicant organization is eligible as specified below. Applicants that do not meet the eligibility requirements will not be considered and will be so informed.

1. To be eligible to apply for training and technical assistance under this program, an applicant must fall within one of the following categories:

a. A police department or other mandated law enforcement agency engaged in or in the process of implementing community policing;

b. A mental health provider (as defined below); or

c. A governmental entity responsible for providing mental health services to children and adolescents, either directly or by contract; and

may represent a jurisdiction with population between 100,000 and 900,000.

(For purposes of this program, "mental health provider" includes any public mental health agency, private nonprofit mental health agency, university, or consortium of licensed mental health clinicians in private practice who provide mental health services to children, adolescents and families. Private clinicians must have the capacity to serve patients regardless of income.)

2. In order to be eligible, each applicant must include a

written agreement to participate in the program signed by the chief executive officers of the participating police agency and the participating mental health provider as well as the chief executive of the city, town or county government for the area to be served by the proposed project.

In submitting applications that involve the cooperative efforts of more than one organization, the relationship among the parties must be set forth in the application. As a general rule, organizations that describe their working relationship in the program replication process as cooperative or collaborative will be considered co-applicants. In the event of a co-applicant submission, one organization must be designated as the lead agency and be responsible for coordinating the activities of the other co-applicant. Under this arrangement, each organization would agree to be jointly and severally responsible for accomplishing all program goals and objectives. Each co-applicant must sign the application and indicate its acceptance of the conditions of joint and several responsibility.

B. Review Process and Funding Decisions

Proposals will be reviewed based on a two tier site selection process consisting of written applications followed by site visits to the top scoring applicants.

1. An original and two copies of the application are required. There are no formal page limits, but applicants are encouraged to be as concise as possible. Applications should be sent to the following address:

Child Development-Community Policing Program
47 College Street, Suite 218
New Haven, CT 06510.

Applications must be postmarked by February 8, 1996.

2. Written applications will be reviewed by a panel of police and mental health professionals who are familiar with the Child Development-Community Policing Program model. Review of written applications will be completed by February 14, 1996. Applicants will then be informed whether they will be included in the site visit portion of the review process.

3. Site visits will be conducted for the applicants receiving the highest scores on their written applications. Site visits will be conducted by police/clinician teams drawn from the panel that reviewed the written applications. Site visits will be conducted during the period between Febraury 19 an February 29, 1996.

4. Following the completion of site visits, reviewers will make recommendations to the Office of Juvenile Justice and Delinquency Prevention regarding the sites to receive training and technical assistance. Final notification of site selection will be made no later than March 4, 1996.

5. A total of four sites will be selected for training and technical assistance under this program.

C. Evaluation Criteria

Reviewers will evaluate each application based on the extent to which they meet the following criteria:

1. Objectives and Need for Assistance (25 points)

This section of the application should:

a. Describe the collaborating institutions and identify the location of the project and area to be served by the proposed project;

b. Describe relevant policing, child welfare, mental health and/or general social issues in the applicant community that indicate a need for collaboration between police and child mental health providers;

c. Describe the ways in which training and technical assistance would facilitate the development of a collaboration between police and mental health providers in the applicant community and the ways in which the proposed collaboration would address the issues of local concern identified in section 1.b;

d. Identify any organizations that will be formal participants in the proposed collaboration in addition to the local police agency and participating mental health provider. (Additional collaborators might include a child welfare agency, juvenile probation agency or other agency that provides mandated services to children and families.); and

e. Provide letters of support from interested members of the community.

2. Qualifications of Collaborating Police Agency (20 points)

This section of the application should demonstrate that the participating police agency has the following characteristics:

a. Commitment to a model of neighborhood-based police service. Applicants should give evidence of their involvement in community-oriented policing.

b. Commitment and capacity to provide significant time for officer training. The police agency must be committed to provide 20 to 40 budgeted hours of training time for each participating officer. Issues regarding the scheduling, funding and assignment of officers to CD-CP training should be addressed.

c. Commitment and capacity to provide training for clinicians from the participating mental health provider regarding basic policing principles and operations. Possible opportunities for clinician training should be described.

3. Qualifications of Collaborating Mental Health Provider (20 points)

This section should demonstrate that the participating mental health provider has the following characteristics:

a. Comprehensive clinical capacity. This includes:

1. capacity of the clinicians most involved in the CD-CP Program to provide consultation to officers and clinical response.

2. capacity to provide rapid access to outpatient and other mental health resources for the evaluation, treatment and follow-up of children and families upon referral from the CD-CP Program following acute clinical response.
(a) In the case of large, integrated mental health facilities, the range of services within the mental health agency should be documented.
(b) In the case of mental health providers that do not themselves encompass a variety of evaluation and treatment resources, information should be provided regarding the available resources elsewhere in the community and the linkages among them that will facilitate rapid referrals.

3. capacity to serve patients regardless of income.

4. clinical staff with experience in the assessment and treatment of children, adolescents and families, including those exposed to violence and other traumatic situations. Vitae of the clinicians who will lead and staff the proposed program should be submitted with the application.

b. Training capacity.

1. Clinical staff of the mental health provider must include persons who have:
(a) familiarity with developmental principles, ability to apply developmental concepts to understand human behavior and commitment to working with police partners to apply developmental principles to policing strategies; and
(b) experience teaching and training other professional staff.
Vitae of the staff who will be primarily responsible for training activities should be submitted with the application.

2. Describe the range of possible training experiences for senior officers that may be available within the mental health agency.

3. The mental health provider should be able to provide clinicians involved in the CD-CP Program with adequate time to observe and discuss police activities with their police colleagues as part of their own training.

4. Commitment to Collaboration (10 points)

This section of the application should demonstrate a commitment by both the participating police agency and participating mental health provider to the development of a collaborative program, as indicated by
(1) a written agreement between the collaborators; and
(2) a description of the process by which the inter-agency collaboration has begun to develop.
Applicants may also describe any previous efforts at interagency collaboration by either the law enforcement agency or the mental health provider.

5. Budgeting (20 points)

Applicants must be able to make resources available to operate their proposed programs. These resources include:

a. Police resources:

1. time for officers to participate in CD-CP training, i.e., 20 to 40 budgeted hours of training per participating officer;

2. time for senior officers to co-lead CD-CP training seminars;

3. time for senior officers to meet regularly with CD-CP clinicians for discussions of cases and program development.

b. Clinical resources:

1. time for clinicians to provide consultation to officers and acute clinical services;

2. time for clinicians to co-lead CD-CP training seminars;

3. time for clinicians to participate in training activities regarding basic policing principles and operations;

4. time for clinicians to meet regularly with police colleagues for discussions of cases and program development.

This section should describe a plan to make the listed resources available on an ongoing basis.

6. Cooperation in Evaluation Efforts (5 points)

A comprehensive evaluation system is in development at the New Haven CD-CP Program. Accordingly, selected sites need not develop their own evaluation systems. Applicants should provide evidence that they have the capacity to support program evaluation activities, including data collection and entry. Research faculty of the Yale Child Study Center will facilitate coordination of data collection across sites and conduct site specific and cross-site statistical analyses.

This section of the application should demonstrate that the participating police agency and mental health provider currently collect routine descriptive data regarding their activities and that one or more personnel, employed by either of the participating agencies, will be available to implement and oversee on-site data collection activities required for the CD-CP Program.

Scope of OJJDP Support

Support provided under this program will cover all aspects of training and technical assistance. These include:

A. Training and consultation provided by the New Haven CD-CP Program staff;

B. Training manuals and other written materials;

C. Costs of travel and lodging for core staff of the developing program site (approximately three officers and three clinicians) to visit New Haven for training observations, seminars and consultation meetings;

D. Costs of travel and lodging for New Haven CD-CP staff to conduct site visits as appropriate during the development of the new program;

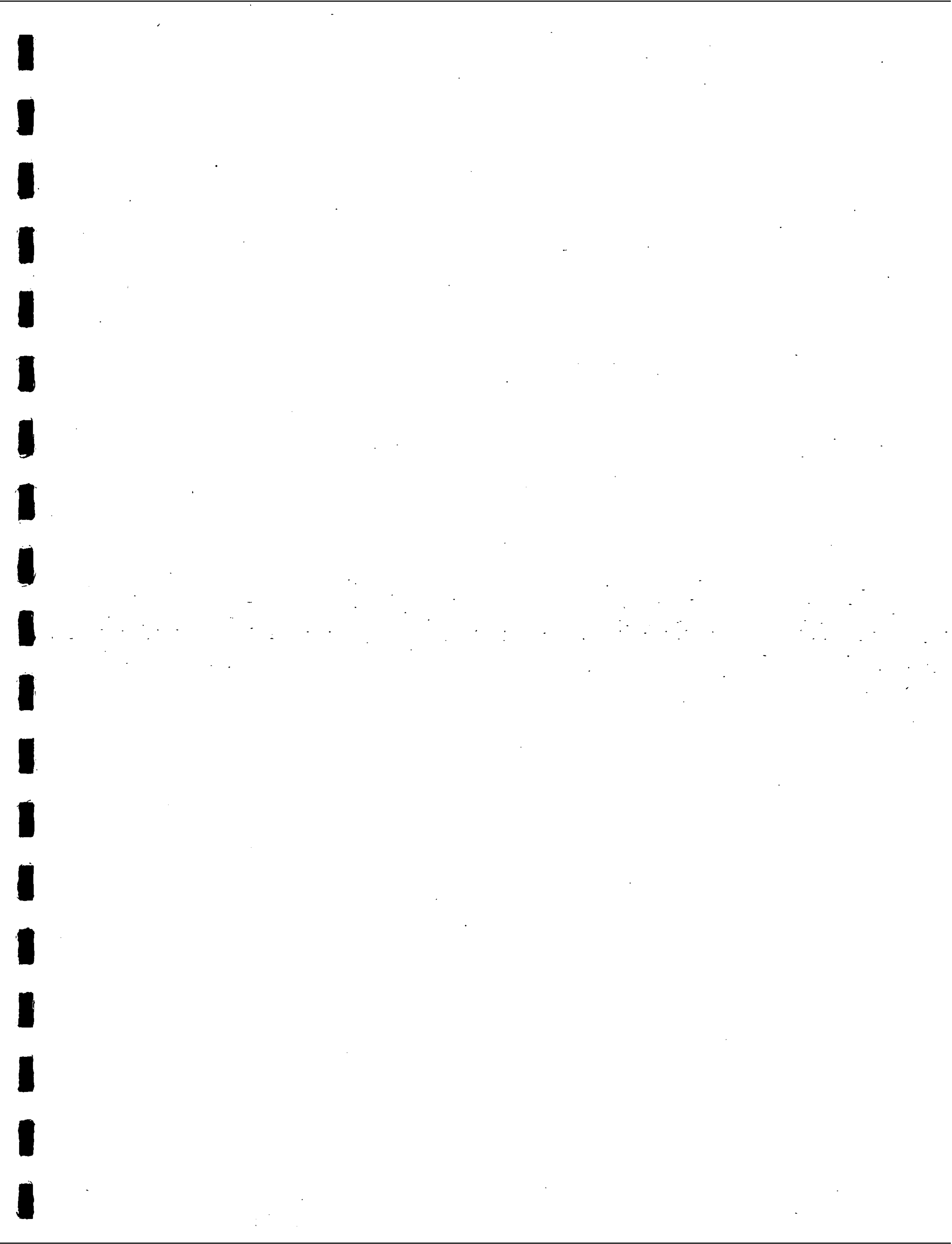
E. Costs of telephone, postage and fax consultation as needed; and

F. Technical support for participation in standardized CD-CP evaluation and research.

This program will not provide funding for the day to day operation of developing collaborative programs (e.g., salaries for officers participating in seminars, salaries for clinicians and senior officers leading seminars, salaries for clinicians' training or responding to emergency calls.)

Inquiries

For further information regarding the CD-CP Program model and its implementation in New Haven, the requirements for applications submitted under this program, or the status of any application after submission, contact Ms. Colleen Vadala, Administrative Assistant, Child Development-Community Policing Program, 47 College street, Suite 218, New Haven, CT 06510, (203) 785-7047.



Child Development-Community Policing Program Replication Project Training Schedule for Charlotte, North Carolina May 20-23, 1996

Facilitators for the week are the following:
Steven Marans, Ph.D., Steve Berkowitz, M.D.,
Lt. Rick Randall and Sgt. Dawn Cathey.

Monday, May 20, 1996 (Yale Child Study Center-Senn Room)

8:00-9:30	Breakfast
9:30-12:00	Introductions, history and orientation, overview of policing and mental health issues
12:00-1:00	Lunch
1:00-2:30	CD-CP Seminar and Fellowship-Introduction and infancy
2:15-3:45	CD-CP seminar -- Young children-movie"John"
3:45-4:15	Break
4:15-6:45	Ride-alongs (Lt.Mike Sweeney-Assistant Chief Bob Schurmeir; Lt.Steve Verrelli-Captain Ken Williams; Sgt.Tony Griego-Sara McGeachy; Sgt.Stephanie Redding-Sgt.Joe Neely; Lt.Dean Runlett-Dave Verhaagen; Lt.Manny Diaz-Sgt.Tim Wilson; Sgt.Denise Blanchard-John Gordon; and Lt.Bill Tinker-Rita Brown.)
6:45-?	Dinner-Elm City Brewery-Grand Avenue

Tuesday, May 21, 1996 (New Haven Department of Police Service)

8:30-9:00	Breakfast
9:00-10:30	Consultation Service
10:30-10:45	Break
10:45-12:00	Consultation Service
12:00-1:00	Lunch continue discussion of consultation service)
1:00-1:15	Break
1:15-2:30	CD-CP seminar -- Toddlers and preschool children
2:30-4:00	CD-CP seminar -- School age children
4:00-4:30	Assign tasks for day three: officers and clinicians to discuss and identify questions about and/or potential barriers to implementation of CD-CP program in their city
4:30-6:00	Cocktail hour-295 Congress Street, The Boyer Center

Free evening

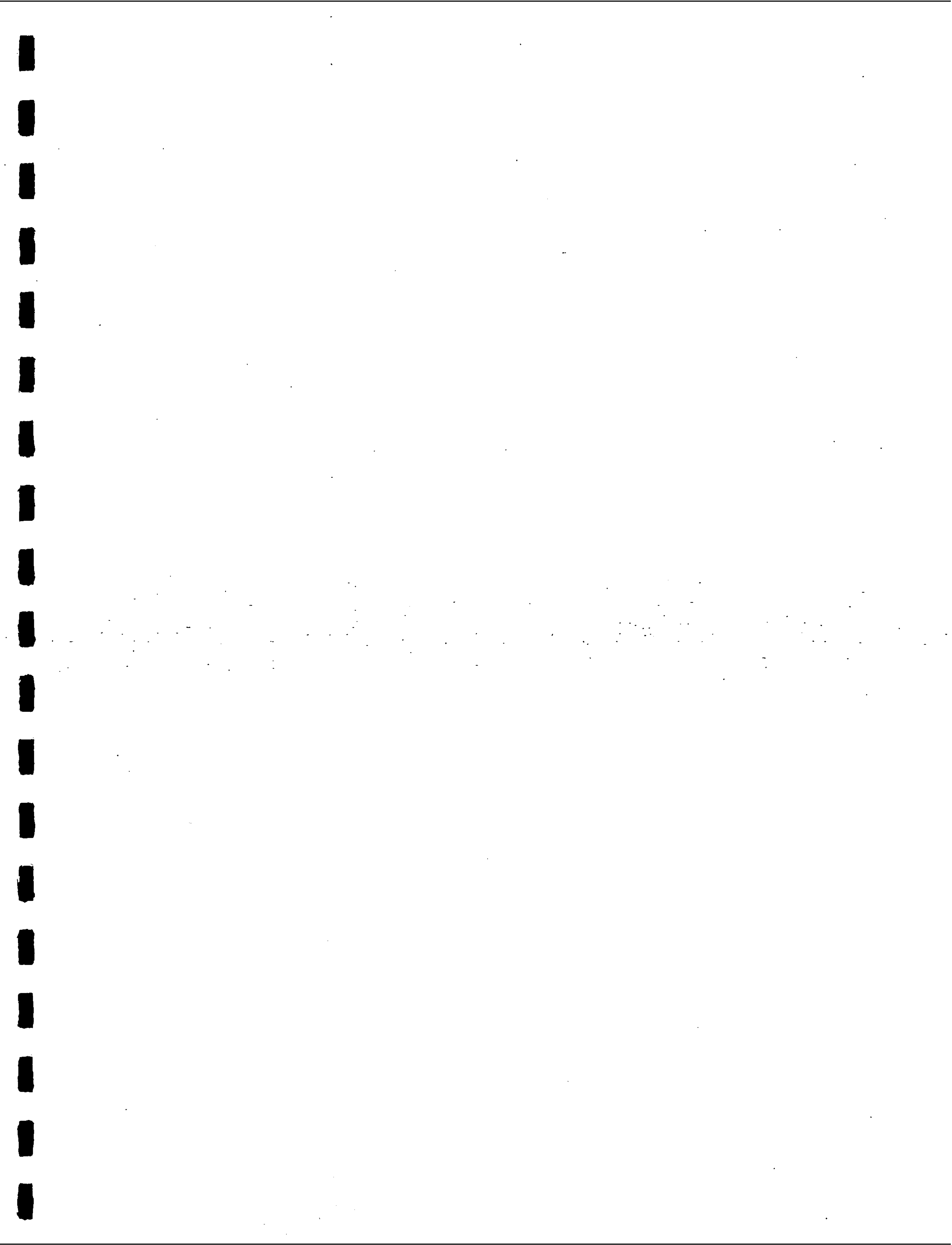
Wednesday, May 22, 1996 (Yale Child Study Center-Senn Room/Beaumont Room)

8:00-8:30	Breakfast
8:30-9:45	Site implementation
9:45-11:00	CD-CP Program Conference
11:00-11:15	Break
11:15-12:00	Discussion of Program Conference
12:00-1:00	Lunch
1:00-1:15	Break
1:15-2:30	CD-CP seminar -- Puberty and early adolescence
2:30-2:45	Break
2:45-4:00	Adolescence and set up for "Boyz 'n the Hood"
4:00-6:00	Film -- "Boyz 'n the Hood"
6:00-7:30	Pizza and discussion

Thursday, May 23, 1996 (Yale Child Study Center-Senn Room)

9:00-10:30	Breakfast and continue discussion of site implementation issues
10:30-10:45	Break
10:45-12:00	Evaluation
12:00-1:00	Lunch
1:00-2:30	Technical assistance
2:30-3:30	Wrap-up

C:CDCP\replication\charsch



Crisis Services - Buffalo Police Department
Child Development - Community Policing Program

Report to

The Office of Juvenile Justice and Delinquency Prevention

1. Police/Clinical Training Model

The police officers did not receive overtime for the clinical training presented by Crisis Services. Therefore the training was provided during the participating officer's shift. Given the time constraints the training program was reduced to a two to four hour presentation.

The officers targeted for training were C District (Precinct 3) of the Lower West Side of Buffalo and D District (Precinct 11 and 12) of the East Side of Buffalo. These areas have been identified as having the majority of 911 response calls for community/domestic violence. We provided 13 training programs (four day -trainings. one training beginning at 4:00 p.m. and eight trainings beginning between 8:00 p.m. to 9:30 p.m.) to 25 lieutenants and 180 patrol officers for a total of 205.

The training was provided by the three senior clinicians and three senior police officers of the collaborative project.

2. Clinical Consultation Service.

In January, 1997 we initiated a 24 hour a day, seven day a week on call consultation service. Police on the scene or at their precinct can directly access the clinical consultation service through a digital beeper. Currently this consultation coverage is provided on a weekly rotation basis by the three senior clinicians. Upon review of the situation a decision is made for an immediate visit or followed up by the responding clinician on the next day. Due to the funding requirements of the United Way Grant the case sub types received as of September 1, 1997 are as follows:

Sub Type	Requests	Case Opening	Visits	People Seen
Community	31	22	48	68
CD-CP	12	6	14	16
Total	43	28 (65%)	62	84

Of the 28 cases 20 are closed and eight are currently actively.
Of the six case openings through the CD-CP project two resulted in an immediate and on site intervention.

3. Police Protocol or Practice Changes.

To date there have been no changes.

4. Clinical Protocol or Practice Changes.

Given the nature of the trauma cases received to date (where the family may be temporarily relocate) or the financial situation (when the family does not have a phone) we have initiated the following:

> Write a brief and simple letter of introduction accompanied by handouts and initiate a "drop by" with the goal of engaging the family or leaving the above in their mail box.
>
> When the geographic location of the trauma is judged to be unsafe police will drive us to the scene and the above is implemented.

5. Ongoing collaborative forums/meetings/conferences.

To date we have had one case conference attended by 25 lieutenants. We are planning to schedule a minimum of one per month. The participating lieutenants are paid overtime. There may be additional dollars, through a police grant, that will allow us to increase these meetings to two per month.

We have contacted the Buffalo Municipal Housing Authority Division of Peace Officers and provided training to 35 peace officers. This was completed in August and, to date, we received one case.

Other collaborations;

*The remaining police districts A, D and E of the Buffalo Police Department. We will be contacting these districts in October.
*Two Coalitions on Domestic Violence. In progress
*Erie County Medical Center's Violence Prevention Project. In progress. To date we received one case from them.
*Family Support Center of the Buffalo Municipal Housing Authority. First meeting is scheduled for late October.
*City of Tonawanda Police Department. This is a small suburb in Erie County and training is planned for late October.
*Towns of Amherst, Cheektowaga and West Seneca Police Departments. In progress.

Attachment A: Training Schedule and curriculum

Training Schedule

March 18, 1997	9:00 a.m. to 2:00 p.m.
March 26, 1997	5:00 p.m. to 9:00 p.m.
March 31, 1997	4:00 p.m. to 8:00 p.m.
April 2, 1997	9:00 a.m. to noon
April 10, 1997	9:00 p.m. to midnight
April 15, 1997	9:00 p.m. to midnight
April 25, 1997	9:00 a.m. to noon
June 2, 1997	9:00 p.m. to midnight
June 4, 1997	9:00 p.m. to midnight
June 12, 1997	9:00 p.m. to midnight
June 24, 1997	7:30 p.m. to 9:30 p.m.
June 24, 1997	10:00 p.m. to midnight
July 2, 1997	8:30 a.m. to 10:30 a.m.
Total	13 Training Programs

Training Curriculum

I. Introduction and history of the CD-CP Project by police trainer.
Introduction of Crisis Services and history with police by clinician trainer.

II. Pass out Officer Survey

III. Introduction and Definition Trauma.

Emphasis placed on examples
Emphasis placed on impact and attendant difficulties for adults.

IV. Child / Adolescent Developmental Stages and impact of trauma on each stage

Emphasis on examples
Handouts provided

V. Crisis Services Trauma Intervention Model

Emphasis on examples
Emphasis on barriers of race, class, age, police uniform

VI. CD - CP Protocol by police trainer

VII. Training Evaluation Form completed by police trainees.

Evaluates trainer knowledge/presentation style
Evaluates appropriateness of handouts
Evaluates length of training program
Evaluates police willingness to use the CD-CP Collaboration
Evaluates police willingness to received follow up call by clinician

2969 Main Street, Buffalo, New York 14214-1003
(716) 834-3131 - TTY/TDD - FAX (716) 834-9881

Dr. Joseph P. Lyons
President
Board of Directors

Dennis C. Walczyk
Executive Director

Crisis Phone Counseling Kids' Helpline 834-1144

Advocate Program
for victims of rape, sexual assault and domestic violence

Emergency Outreach Program

Outreach to the Homeless Program

Homeless Hotline

Mobile Outreach for Children and Adolescents

Community Crisis Response Team

Police/Mental Health Coordination Project

September 29, 1997

Dr. Steven Marans, Ph.D.
Harris Assistant Professor
of Child Psychoanalysis;
Coordinator, Child Development
Community Policing Program
Yale Child Study Center
47 College Street, Suite 212
New Haven, Connecticut 06510

Dear ~~Dr. Marans~~ Steve:

Per your request I have attached the following program report for the CD-CP Collaboration program between Crisis Services and the Buffalo Police Department.

On behalf of our CD-CP participants please accept our thanks for your on going support and assistance to us as well as a host that is without peer.

We look forward to your conference summary and recommendations. We also plan to forward to you our summary of activities for the first nine months of 1997 followed by quarterly reports

As I mentioned at the initial group presentation this is the most exciting, challenging and proactive-change program that I have had to privilege to participate in.

Please call if questions arise. Our best wishes for continued success to you and your project participants.

Sincerely,

Vern Saeger

Vern Saeger, Coordinator
Trauma & Crisis Services

Certified by the American Association of Suicidology

Funded through Erie County Department of Mental Health, NYS Office of Mental Health, City of Buffalo, NYS Health Department
United Way Member Agency

CHARLOTTE, NORTH CAROLINA CD-CP

1. Describe your model for training officers and/or clinicians. How was the training scheduled and paid for? Who was targeted for training and why? How many trainings have been held and how many individuals were trained? Who were the trainers? (Please attach training schedule and curriculum.)

The CD-CP Project is currently being used as a pilot project in the David Two District alone. Clinicians are selected for the program based on an application and selection process. All officers and sergeants are trained together in groups of no less than ten and no more than fifteen. All sergeants and clinicians are trained under the fellowship requirements that consist of 24 hours of classroom training and other required activities. Some of the activities for the clinicians include ride-alongs with different officers, observing a violent crime scene, and observing the execution of a search warrant. During the training the clinicians are given a police partner to serve as a contact person to give assistance to the clinician and to make orientation into the police society easier.

Compensation for training the clinicians is taken care of through the mental health agency. Employees are salaried, so no overtime is paid, but compensation time is given when possible. The police department handles officer's compensation and the site location and amenities. The officers are given the option of taking the training as overtime, on duty or compensation time, within reason. The officers may also choose to apply the training toward in-service training or credit for the Senior Police Officer Program that allows officers to receive pay increases through off duty training. There are two training sessions offered at the same time, one at 7:00 a.m. on Tuesday and 7:00 p.m. on Wednesday to accommodate officers on different shifts. The goal of the training staff is to make the training environment as pleasant as possible to attain maximum involvement in the training and participation in the program. All sergeants receive compensation time or attend on duty. All amenities are paid for through a special police fund.

We are currently in our fourth and fifth training sessions with 67 officers and clinicians either in training or have been trained by Charlotte trainers. The trainers consist of clinicians and sergeants that have prior training experience or were selected by the Steering Committee. A lesson plan was written based on the New Haven Model that fits the approved Charlotte-Mecklenburg Police Department Training Academy model. This lesson plan has been reviewed and accepted as an approved lesson plan curriculum.

After all the officers and sergeants have been trained in the David Two District, the long-term plan for this training is to be department-wide. The rest of the David Districts will be trained next and then it will reach the other three service areas. We are currently considering the depth of training that we want to give to recruits in the Academy.

2. Describe the program's clinical consultation service. What are the mechanisms for referral to the clinical consultation service (i.e., 24/7 beeper, next day call, weekly complaint review, etc.)? How many cases have been seen as of September 1, 1997? If your site distinguishes between case sub-types, please provide sub-types and number of cases seen (e.g., clinical assessment and intervention, consultation to police re: investigation, etc.). However, sub-types are not necessary.

The Charlotte-Mecklenburg CD-CP began operating a 24 hour/7 day on-call system on July 1, 1997. Sergeants use the beeper to call clinical fellows whenever a violent or traumatic event occurs involving a child. Clinicians respond on the scene immediately, provide telephone consultation, and/or may follow up later. Referrals may also be made in the weekly Program Conference. Approximately 56 children were referred in the first year (June '96-July '97). The total number of children referred since July '97 is not currently available. We are just beginning to make our record keeping more efficient, so the types of cases seen in not currently compiled. Most cases involved assessment of children and referral. Children have been referred for obvious traumatic incidents(i.e. drowning or vehicular death of sibling, witnessing of domestic violence in the home, home invasions, assaults, etc.), but have also been referred due to reactions to police interventions (searches) or incidents of neglect (being left unsupervised).

3. Have there been changes in police protocol or practice resulting from the collaboration? If so, please describe.

The police still respond to calls for service as usual; however, the officers are learning to be aware of cases that may merit referral and when they encounter these, to notify the on-duty sergeant (a CD-CP Fellow). The sergeant responds and determines if there is a need to contact an on-call clinician. Our officers and sergeants are becoming much more attuned to the needs of the children that may have witnessed the crime and are attempting to provide guidance, advice, or referral as needed.

4. Have there been changes in clinical agency protocols or practices resulting from the collaboration? If so, please describe.

There are no notable changes in clinical agency protocols or practices resulting exclusively from the CD-CP Program. Prior to the implementation of the project, Charlotte was already moving towards increased collaboration and improved community service delivery, which have both continued to expand with support from the CD-CP program. For instance, a mental health clinic has recently opened in one of the neighborhoods in the district where the CD-CP is piloted, and more clinical services are available in the schools. The police are now more often at the table with human service agencies discussing community child protection.

5. What ongoing collaborative forums/meetings/conferences exist? What is the structure, format, frequency and duration of regularly scheduled meetings? How are these meetings paid for? Which agencies (child protection, mental health, probation, police, etc.) and personnel (patrol officers, supervising officers, psychologists, social workers, etc.) typically attend?

CD-CP Case Conference

When: Wednesday
Frequency: Weekly
Duration: 2 hours
Funding: Time donated by represented agencies
Structure: Roundtable discussion
Format: Rotation of Facilitation on a weekly basis between police/clinical Fellows
Minutes recorded by civilian volunteer
Previous meeting minutes distributed, corrected, and accepted
Active cases discussed
New cases presented/assigned
Administrative issues discussed

Represented Agencies: Charlotte-Mecklenburg Police Department
Health, Mental Health and Community Services, Mecklenburg County
Center for Mental Health, Carolina HealthCare Systems

Personnel Attending: Police Supervisors and case referring officers
Psychologist(s)
MSWs, CCSWs

CD-CP Steering Committee

When: Thursday
Frequency: Every other week
Duration: 2 hours
Funding: Time donated by partner agencies
Structure: Round table discussion
Format: Facilitation by Sarah Stutts (back-up Sarah McGeachy)

CHARLOTTE, NORTH CAROLINA CD-CP

Please also provide any additional comments or observations you wish regarding your site's experience of developing a police/mental health collaboration with special attention to barriers, facilitators, and future plans. Comments regarding the work with the New Haven CD-CP consultants are also appreciated.

The biggest barriers to providing services are the lack of resources. The CD-CP requires doing our work in new ways, some of which are not immediately seen as "productive" or conducive to "managing resources". Because Charlotte received no additional resources when the decision was made to replicate the project, everyone involved already had a full-time job and the CD-CP is an additional responsibility. Charlotte has had unique difficulties due to the structure of our Mental Health system, but hopefully this will become less complicated due to recent decisions.

Our biggest successes have been due to the hard work of the professionals who have been the most enthusiastic about the collaboration and therefore have dedicated extra time and energy to the project. Our consultants from New Haven CD-CP have been most helpful due to their having already been through the tough early days of trying to create a new program that requires new thinking and innovative interventions. Without their help, some of the barriers would have been insurmountable.

Yale Child Study Center - New Haven Police Department

Child Development-Community Policing Program

Report to the Office of Juvenile and Delinquency Prevention

— Nashville, Tennessee Site —

1. *Describe your model for training officers and/or clinicians. How was the training scheduled and paid for? Who was targeted for training and why? How many trainings have been held and how many individuals were trained? Who were the trainers? (Please attach training schedule and curriculum.)*

   Our model of training has three major components:

   A. Police Supervisory Staff (Sector Sergeants) attend a full day orientation at Family & Children's Service. The supervisors meet the Executive Management Staff, Program Managers and selected clinicians. Expertise is shared, including the demonstration of clinical interventions, participation in a group experiential exercise and other didactic forums. We will be repeating this orientation process for all new supervisory staff in the police Department.

   B. Front Line Officers are offered monthly, two-day intensive training workshops. The operating model is interactive, encompassing both normal and abnormal childhood development. Special emphasis is placed on educating the officers about trauma reactions in children within a developmental framework. (Please note the training curriculum left at Yale with Dr. Larry Vitulano. Trainees requested that material be documented in layperson's terminology.) During November and December we will be offering this training to Command Staff. Ms. Peg Leonard-Martin (F&CS) will co-facilitate with one of the Community Policing Sergeants.

   C. Other Staff Development Opportunities – Training Co-facilitators in the Police Department as well as any interested front-line officer are welcomed to participate in F&CS clinical staff development seminars and workshops. The more extensive training workshops occur quarterly for full day events.

   Training was scheduled after lively debates as to the length and accessibility of the material. The Police Department currently reports liking the two-day format and incorporate the seminars into regular Police Department in-service requirements for the officers. The clinicians from F&CS are full time in this program and therefore co-facilitation is part of their job description. The clinicians from the Police Department donate their time with supervisory cooperation and approval. All materials used are part of program budgets at F&CS (Program specific and general staff development funds.)

   Our first priority was training all officers who work in the Enterprise Community in

Nashville, an area divided by three (3) police sectors all of which are in the heart of neighborhoods representing the highest crime rate as well as the highest density of children under 18 years of age. Training lists then are comprised of community police officers as well as police staff from Patrol, Youth Services and the Domestic Violence Division of the Metro Nashville Police Department.

To date we have conducted nine two-day training sessions, attended by a total of 94 officers. Moreover, clinician-police partners have attended 15 roll-call orientations (to be repeated in the next four months.) The training teams consisted of one police sergeant or front-line officer and two master level clinicians (F&CS and either Victim Intervention clinician or Domestic Violence Division clinician.)

2. *Describe the program's clinical consultation service. What are the mechanisms for referral to the clinical consultation service (e.g., 24/7 beeper, next day call, weekly complaint review, etc.)? How many cases have been seen as of September 1, 1997? If your site distinguishes between case sub-types, please provide sub-types and number of cases seen (e.g., clinical assessment and intervention, consultation to police re: investigation, etc.). However, sub-types are not necessary.*

   Consultation Service – During the past year officers who are familiar with (or trained specifically about) the CD-CP Program refer the cases directly to the clinical team. When officers are not clear about the appropriateness of a case, especially regarding the less severe referrals, he or she refers the case through their sergeant. Most often the clinicians responded within 24 hours. (Please note that our 24/7 beeper service begins October 1, 1997.) Officers are requested to call the clinical team with the referral, as well as complete a referral sheet for our records. Sixteen cases and referrals since September 1, 1996.

3. *Have there been changes in police protocol or practice resulting from the collaboration? If so, please describe.*

   There have been many changes in police practice as a result of this collaborative:

   - Training has been expanded to include not only Community Police but Patrol, Domestic Violence and Youth Services officers as well. Command Staff has been supportive and approved CD-CP training for official in-service training credit.
   - Supervisory officers now encourage other front-line officers in their sectors to attend our weekly meeting, as well as becoming training facilitators.
   - Referrals – front-line officers are beginning to <u>routinely</u> refer cases to this program. There appears to be a direct correlation between recent training of officers in Domestic Violence and a subsequent, dramatic increase in reporting cases involving children to the clinicians assigned to this division.
   - We have recently received reports from officers that they used concepts from their training experience when conducting a community intervention.
   - Currently, Command Staff is writing the Directive regarding necessary protocol for 24/7 beeper service.

4. *Have there been changes in clinical agency protocols or practices resulting from the collaboration? If so, please describe.*

   - Review of all liability issues and coverage
   - Exploration re: need for training on legal issues vs. confidentiality, especially critical in homicide cases.
   - Development of 24/7 on call structure and funding requirements of same.
   - Unique chararactistics of this collaborative necessitated that clinicians acquire in-depth education re: the hierachy of Police Department, as well as attending issues of communicaiton channels, political realities and the impact of ranking and discipline within the Police Department. We are more accustomed to working in collaborations with agencies whose missions and practices are similar to our own.

5. *What ongoing collaborative forum/meetings/conferences/exist? What is the structure, format, frequency and duration of regularly scheduled meetings? How are these meetings paid for? What agencies (child protection, mental health, probation, police, etc.) and personnel (patrol officers, supervising officers, psychologists, social workers, etc.) typically attend?*

   Weekly two-hour CD-CP meeting of *clinicians and police personnel. This meeting takes place at F&CS. Cases are staffed first with subsequent follow-up assigned as needed. Both "new" and "old" business is addressed and training needs are routinely attended to. Command staff attend as needed.
   Each F&CS clinician is assigned to attend pertinent community meetings in one of each three sectors. (Two hours monthly per clinician.) Moreover, the clinicians rotate responsibility for attending advisory board meetings of local Family Resource Centers in one of the sectors as well as attending council meetings at United Way (two hours bi-monthly per clinician).
   Again, F&CS staff have 100% time allotment in the CD-CP program so all meetings, community activities and clinical time is a part of their routine job assignment.

*F&CS clinicians, Victim Intervention clinician and Domestic Violence clinician.

Child Development Community Policing

USER'S GUIDE

Case, Activity, and Patient Electronic Recording System (CAPERS)

Developed by:
Yale Child Study Center
Child Development-Community Policing Program

Version 2.01
September, 1997

Child Development - Community Policing

Case, Activity, and Patient Electronic Recording System (CAPERS)

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I. Introduction to Version 2.01

The CD-CP Case, Activity, and Patient Electronic Recording System (CAPERS) was developed to capture and track demographic, clinical, and administrative data for the Child Development-Community Policing program. (It will be referred to throughout this manual as "CAPERS," "the application," or "the system.") The use of this automated, centralized, and standardized mode of data collection will facilitate cross-site data analysis and program evaluation.

The application was developed for a Windows environment using the Microsoft Access PC-based relational database tool. This tool was chosen because it is widely available in standard pre-installed software constellations, and because of the notable flexibility offered by a relational database as compared to a traditional, hierarchically organized database.

Those who are familiar with CAPERS v1.0 will notice marked improvements in CAPERS v2.01. This latest version is significantly more streamlined than the previous version, allowing the most critical information to be entered in the fewest windows possible. In addition, version 2.01 is far more flexible than is its predecessor. Users can navigate from window to window with fewer keystrokes or mouse-clicks, and with minimal restrictions as to the order in which information is entered. The new version is also smaller, and occupies less space on the hard drive than did the previous version. Lastly, the installation procedure has been automated.

II. Who Should Use this Guide

The CD-CP CAPERS has a single accompanying manual, with a special section entitled "System Administrator's Supplement". The User's Guide proper is intended for "end-users" of the application. "End-users" (or simply "users") are those who will use the application to look up data, enter data, and run pre-written queries or reports. Users do not typically perform more technically sophisticated tasks such as writing queries, compacting the database, and backing up the data. Such technically sophisticated tasks will be performed by the system administrator, and are described in the System Administrator's Supplement.

The remainder of the User's Guide assumes basic keyboarding skills, as well as "point-and-click" knowledge of Microsoft Windows applications, including the ability to use drop-down menus. Basic knowledge of Microsoft Windows terminology (e.g., "window," "combo box," "list box," "radio button," "text box," etc.) is also assumed. If you do not have these skills, please return to this Guide after completing the Microsoft Windows Tutorial.

III. System Requirements

The CD-CP CAPERS will run with reasonable speed and efficiency on an IBM computer with a Pentium 90Mhz processor and 16 megabytes of RAM (random access memory). The application was designed to run on Windows version 3.11 and Microsoft Access version 2.0, but we have been told that it is upwardly compatible with all later versions of Windows (including Windows 95) and later versions of Microsoft Access. The application has not been tested with these later versions.

We have not determined the absolute minimum system requirements, but the application should run with adequate speed on a 486 machine with as little as a clock-doubled 66Mhz processor. In addition, it may be possible to run the application on Windows 3.11 with only 12 megabytes of RAM, provided there are no other applications running simultaneously. Subsequent versions of Windows require considerable RAM, which leaves less for CAPERS.

There are no special requirements with regard to computer monitors or peripherals. The size of the hard drive depends on what other software programs and associated files will reside on the hard drive. However, as a general guideline, if Windows, Microsoft Access, and CAPERS were the only programs residing on the hard drive, one would probably want no less than a 300-megabyte hard drive. Beginning in 1996, most new computer buyers have opted for no less than a 1-gigabyte hard drive.

The application is not Macintosh compatible.

IV. Installation Procedure

Before you attempt installation of the application, be sure that Microsoft Windows and Microsoft Access are both installed and functional.

Important note: The following installation instructions apply for the *initial installation* of the CD-CP CAPERS, before any data has been entered. If, at some later date, there is a need to re-install the application, you must contact your system administrator. The system administrator will follow special instructions for re-installing the application without over-writing any of your existing data. **If you attempt a *re-installation* of the application by following the steps below, you will lose all of your existing data.**

The following steps will allow you to create a CAPERS sub-directory and load the program into that directory. In addition, directions are provided for creating a CD-CP CAPERS icon in the program manager. There are many ways to accomplish this installation. The following steps outline one approach. If you are familiar with the Windows environment, you may use whatever approach seems most straightforward and familiar. In the end, you should have a single CAPERSv2 sub-directory off of the C:\ root directory. The creation of the subdirectory and loading of the program can be done in Windows 3.1 File Manager or Windows 95 Explorer. You can start the program by clicking on the CDCPAPP2 application file within File Manger or Explorer or you can create an icon or desktop shortcut.

The MS-DOS approach on a Windows 3.1 or Windows 95 machine is as follows:

Step 1
Go to the DOS prompt. Insert the CAPERS diskette in your floppy drive. At the C:\ prompt in MS-DOS, type the following commands:

C:> md CAPERSv2 {ENTER}
C:> cd CAPERSv2 {ENTER}
C:\CAPERSv2> copy a:*.* {ENTER}

Step 2 (Windows 3.1)
Return to the Microsoft Windows environment (type Exit). In the Program Manager of Microsoft Windows 3.1, choose "New..." under the "File" menu. Select the radio button next to the words "Program Group" and click the "OK" button. You will be prompted to enter two different fields. Enter them as follows:

Description: CD-CP
Group File: CD-CP

Then click the "OK" button.

Still in Program Manager, again choose "New..." under the "File" menu. This time, select the radio button next to the words "Program Item" and click the "OK" button. You will be prompted to enter four different fields. Enter them as follows, noting that these commands assume the default setup of Microsoft Office. If your setup differs from the default, you will need to modify the pathnames.

Description: CD-CP
Command Line: C:\MSOFFICE\ACCESS\MSACCESS.EXE C:\CAPERSv2\CDCPAPP2.MDB
Working Directory: C:\MSOFFICE\ACCESS
Shortcut Key: None

Click the "Change Icon..." button. Select the icon you wish to represent the CD-CP application, and click the "OK" button. You will be returned to the "Program Item Properties" window. Click the "OK" button.

The CD-CP CAPERS is now completely installed. From this point forward, you may start the application by double-clicking the icon you just created, or by single-clicking it and then choosing "Open" under the "File" menu.

Step 2 (Windows 95)

Close all applications. Go to Explorer and fine the CDCPAPP2 file in the CAPERSv2 sub-directory. Point to the file with the mouse pointer and push the right mouse button. Highlight "Create shortcut" and click. This will create a shortcut file. Drag the shortcut file to the desktop. You will now have a shortcut icon for the CAPERS program.

When you wish to start the program, click the CDCPAPP2 icon or go the File Manager or Explorer and click directly on the CDCPAPP2 file.

V. Overview of the Application

A. Words You Should Know

Case
A screen in the application where preliminary information is gathered about a particular referral or request for consultation, and how the CD-CP Program came to be involved.

Collateral Contact
Any professional (see definition of *professional* above), other than a clinician, who provides consultation to the CD-CP Program.

Defensive Aggressor
A participant in an event who is *not* a perpetrator, but who takes aggressive action in protection of self or others.

Event
The particular discrete occurrence that precipitated the involvement of the CD-CP Program. For example, in a case of chronic truancy, the *event* may be the most recent occasion on which the police picked up the truant child.

Group
Two or more individuals from different families who share a need for similar interventions, and are therefore brought together for joint therapy sessions. Note that *group* therapy is distinct from family therapy.

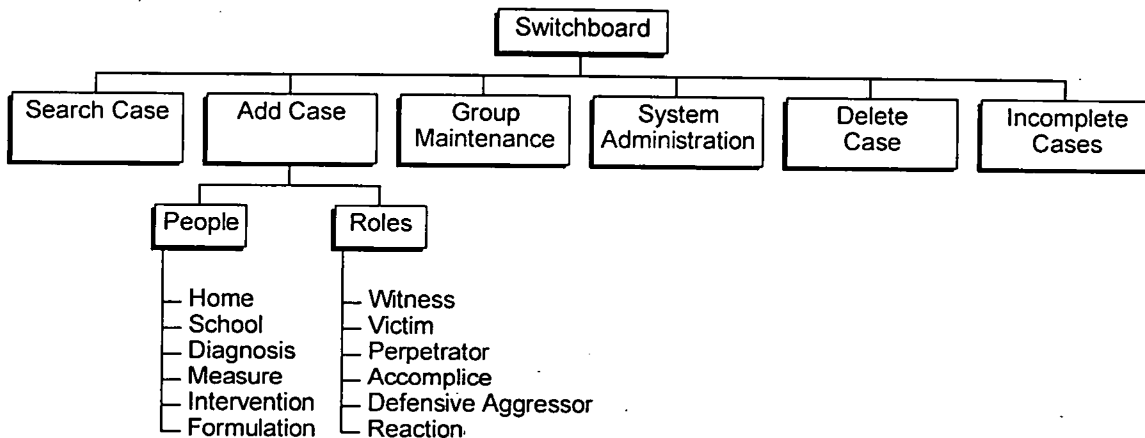
Professional
Any individual who participates directly or indirectly in the work of the CD-CP Program, such as police officers, clinicians, child and family protection caseworkers, probation officers, school officials, etc.

Switchboard
The "main menu" of the application, and the first screen that a user sees after entering the application.

System Administrator
A single individual, appointed at each CD-CP site, who is responsible for the more technically sophisticated tasks involved in maintaining the application.

B. Window Flow

The following diagram illustrates the window flow of the CD-CP CAPERS. A window flow is like a road map of the application. Each box represents a particular window, or destination, in the application. A line between two boxes indicates a route by which the user can navigate between the two windows represented by those boxes. In addition, the sub-points below a box indicate what categories of information can be entered in the window represented by that box.



C. One-to-Many: A Key Concept

In order to understand the CD-CP CAPERS and use it effectively, users should understand a key concept called a "one-to-many relationship." To illustrate the need for one-to-many data relationships, imagine that you are asked to fill out a form. The form provides three blanks, one for your name, one for your address, and one for your telephone number. But you happen to have a home telephone number, a work telephone number, and a beeper number. The form does not accommodate your needs because it is assuming a one-to-*one* relationship: that is, that one person has exactly one telephone number. In reality, however, since one person can have many telephone numbers, a one-to-*many* relationship is required.

The CAPERS accommodates a variety of one-to-many relationships. For example, one case can have many people associated to it. Each of those people, in turn, can have many homes, many diagnoses, and many roles in an event. A user of the application is alerted to a one-to-many relationship in two ways: 1) by the design of the window, and 2) by the presence, in a number of different places in the application, of a button that says, "Add another...".

Certain windows in the application are specifically designed to accommodate one-to-many relationships. These windows, namely the "People" window and the "Role"

window, identify a particular person in the top portion of the screen, and display a number of file-folder-like "tabs" in the bottom portion of the screen. Suppose you are in the People window, and the name at the top says, "Jane Doe." If you click on the School tab, you will be entering school information *for Jane Doe*. If you then click on the Diagnosis tab, you will be entering diagnosis information *for Jane Doe*. As long as Jane Doe's name appears in the top portion of the window, all information in the bottom portion of the window applies strictly to her. The same logic applies to the "Role" window. The design of the window means that Jane Doe can have multiple roles. She can at once be a witness to an event, a victim of the event, and have a reaction to the event, for example.

Notice that almost every tab in the bottom portion of the "People" and "Role" windows has an "Add another..." button. This button allows you to enter multiple homes, diagnoses, witness rows, etc. for a particular individual. For example, if you are entering a diagnosis for a child, clicking on the "Add another..." button will allow you to enter an additional diagnosis *for that same child.* Similarly, if you are entering data on an injury witnessed by a particular person, you can click on the "Add another..." button to enter data on an additional injury witnessed *by that same person.* Therefore, not only can Jane Doe have multiple roles (i.e. witness, victim, and one who reacts to the event), but she can also have multiple occurrences of each role (i.e. she can witness multiple injuries, be victim to multiple injuries, and react in multiple ways all to the same event).

Once you understand the concept of a one-to-many relationship, the other tasks you perform with the CAPERS will be easier. When you click on the Formulation tab, for example, you will always know clearly for whom you are entering a formulation. When you choose to delete information, you will understand that you have the option of deleting an entire person along with all of the associated information, or simply deleting one particular tab's worth of information on that person. Detailed instructions for functions such as adding, updating, and deleting data are provided below, but successful use of these functions depends on a solid understanding of one-to-many relationships.

VI. How To...

The following instructions provide a high-level look at how to perform the different functions in the application. For low-level, detailed information on specific fields in the application, please refer to the Field Reference section of this user's guide.

A. Start the CD-CP CAPERS

Double-click your "CAPERS2" icon. (In Windows 95, you can also start the application via the shortcut on your desktop, or via the Programs… list under your Start menu.) Microsoft Access will automatically start up, the application will be opened, and you will be prompted for a password. The password is the same for all users of the application, and is printed on the index card enclosed with this manual.

If you are using the application for the first time, then after the password has been correctly entered, you will be prompted to enter the name of your site (i.e. the city where you have implemented the CD-CP program). Each subsequent time you use the application, you will be brought directly to the Switchboard after you enter the password. The Switchboard is the starting point for all other application functions, described individually below.

B. Add a New Case

<u>The Case Window</u>

To add a new case, you first have to get to a blank Case window. From the Switchboard, click the button that looks like a notebook and is labeled "Add a New Case." You will be brought directly to the Case window, where a blank case will be displayed for you to enter.

On the Case window, you enter basic information about what happened, under what circumstances, where, and when. You also indicate the urgency of the case, and the CD-CP program's response to it. Consult the Field Reference for detailed assistance in entering the case information on this window.

The bottom portion of the Case window provides space in which to record information about all persons with whom program clinicians had contact. In addition, information should be entered for all victims and perpetrators, whether or not clinicians had contact with them.

For each person, enter the name, birth date or age, ethnicity, etc. For each person you enter, the application will automatically check to see if the name you entered matches any name that already exists in the database. If no matches are found, the person will be

added immediately. If matches are found, the application will list the matches, and prompt you to indicate whether any of these matching names are actually the same person as the one you just entered.

Consider an example. Suppose you add the name "John Doe" because he was a witness in the assault case you happen to be working on. The application searches the database and finds two other "John Does," one who was involved in a firesetting on Main Street, and one who was kidnapped by his uncle. You must determine whether the "John Doe" you are entering is the same as either of the two "John Does" who are already in the database. Suppose you determine that your "John Doe" is, in fact, the same one who was kidnapped by his uncle. Then you would select the kidnapped "John Doe" from the list, and click the appropriate button to indicate that your "John Doe" is indeed the same as the kidnapped "John Doe." If, on the other hand, you determine that your "John Doe" is not the same person as either of the other two, then you would not make a selection in the list. You would instead click the appropriate button to tell the application that your "John Doe" should be added as yet a third separate person with the same name.

If you are working on a case that is strictly a one-time consultation requiring no clinical follow-up, then you do not need to enter detailed information about the people involved in the case and you have finished your work on this case. Return to the Switchboard by clicking the "Switchboard" tab at the top of the screen.

If, on the other hand, you are working on a case that requires any evaluation, direct assessment, or clinical follow-up of any kind, then you must enter additional information about the people involved in the case, and the roles played by different people in that event.

The order in which you enter the People and Role information is up to you, but for the purpose of illustrating a typical flow through the system, we will address the People window first.

<u>The People Window and its Sub-Windows</u>

To navigate to the People window, click the "People" tab at the top of the Case window. The People window will appear. Note that the People window is one of the windows referred to above in the section entitled "One-to-Many: A Key Concept." You may wish to review that section before proceeding with entering information on the People window.

Notice that the People window has two sections: a top section that identifies a particular person, and a bottom section with file-folder-like tabs. Whatever information you enter in the bottom section of the window applies to the person named in the top section.

When you first arrive at the People window, the top section of the window will display one of the names you previously entered on the Case window. You will probably want to enter more detailed information about the person named in the top section of the screen.

You may enter the detailed information in any order you like, simply by clicking the appropriate tab in the bottom section of the window, and filling in the fields.

Here again, the concept of a one-to-many relationship is worth noting. Suppose you wish to enter detailed information about a child's diagnoses, and suppose further that this child is conduct disordered and mildly mentally retarded. This is one child who has many diagnoses. Click the Diagnosis tab. To enter the first diagnosis, you enter the date, select Axis I from the list of axes, and select Conduct Disorder from the list of diagnoses. Now you wish to enter the child's second diagnosis. To do this, you click the "Add another..." button. You are presented with blank fields. You enter the date again, and this time you select Axis II from the list of axes, and select Mild Mental Retardation from the list of diagnoses. In order to double-check that you have indeed entered both diagnoses, click the left arrow button (located under the "Add another..." button). If you click the left arrow button repeatedly, you will see all diagnoses previously entered for this child.

Notice that in the previous example, you entered multiple diagnoses for the same child. Suppose you now wish to enter diagnoses for a different child. You use the "Name:" combo box to navigate from person to person. Select a person from the list, and as before, click the Diagnosis tab to enter this child's diagnoses.

The other tabs in the bottom section of this window work similarly, but with important notes regarding the Home tab and the Intervention tab. The Home tab has a special feature that is designed to save time when multiple people on a case live in the same home. Suppose a family has three children, and all three children have the same two homes: one that they lived in before the event happened, and one that they live in after the event. You can enter the two homes for one of the children, and then, instead of re-entering this information for the other two children, just click the "Model after..." button for the remaining two children. You will be prompted to select the name of the child whose homes you wish to model for this child. A copy of the homes will automatically be created, saving you the time of re-keying them.

The Intervention tab requires some additional explanation. Click the intervention tab to record therapy sessions.

When you want to record a therapy session, select the appropriate case from the combo box at the top of the window. (This is done because a given person may have been involved in multiple cases, and you will want to record which case is relevant to this intervention.) Fill in the date, session type, location, and duration of the session, and then record the attendance at the session.

Recording the attendance at a session is a multi-step process. The goal of the process is to build a complete Attendance List, including the names of all patients and clinicians who were expected at the session. You may enter the patients first or the clinicians first, whichever you prefer. For the sake of illustration, we will first describe the process of entering patients.

In the radio button option group in the lower left corner of the window, click "List patients." Notice that there are two combo boxes to the right of this radio button option group. One of the combo boxes is labeled "Patient:" and the other is labeled "Attendance:." The "Patient:" combo box lists all of the members of the group for which you are logging a session. Select one of the members from the list, and then indicate in the "Attendance:" combo box whether that member attended the session, cancelled, or no-showed. Now click the right arrow button to officially add this patient to the Attendance List. Repeat this procedure for each patient who was expected to attend the session.

Now click "List clinicians" in the radio button option group in the lower left corner of the window. Notice that the combo box, which was previously labeled "Patient," is now labeled "Clinician." In addition, the contents of the combo box have changed, and the list now shows all clinicians. Just as you did for the patients, select a clinician from the list, indicate in the "Attendance:" combo box whether that clinician attended the session, canceled, no-showed, or provided consultation, and then click the right arrow button to add this clinician to the Attendance List. If the clinician you need is not in the list, simply type the clinician's name in the combo box. When you attempt to leave the combo box, you will be prompted through the process of adding this clinician to the list. Repeat this procedure for each clinician who was expected to attend or provide consultation for the session.

The Attendance List should now be complete. If you wish to remove someone from the list, click the person's name to highlight it in the list, and then click the left arrow button. If you wish to change the attendance status of someone on the list, simply remove the person from the Attendance List and then re-add the person with the new attendance status.

If you would like to log another session for this same person, click the "Add another..." button, and repeat the procedures described above. If you would like to look at other sessions that have already been logged for this same group, use the left and right arrow buttons directly under the "Add another..." button to scroll through previous sessions.

<u>The Role Window and its Sub-Windows</u>

Once you have finished entering detailed information regarding some or all of the people involved in the case, you will want to enter information about the roles those people played in the event that precipitated the case. In every case, role related information should be entered for all victims, perpetrators and **child** witnesses. It is not necessary to enter role information for other adults who were involved in the event or are related to the children.

To navigate to the Role window, click the "Role" tab at the top of your screen. You should now be on the Role window, which is somewhat reminiscent of the People

window. The top section of the window displays the name of a person whose role is to be described, and the bottom section of the window has file-folder-like tabs that allow you to enter detailed information about the role of this person in the event.

To indicate which person's role you would like to describe first, select that person's name from the combo box in the top section of the window, and use the radio buttons to the right to indicate whether this person was present at the event. You will only be permitted to enter detailed information about a person if that person was actually present.

You may enter the detailed information in any order you like, by clicking the appropriate tabs in the bottom section of the window. Remember that a single person can have multiple roles, and also, that a single person can have *multiple instances* of the *same* role. For example, suppose a boy and his family are caught in the crossfire of a gang-related shooting. The boy, his mother, and a stranger are all shot. When you enter detailed information about the boy, you might click first on the Victim tab, and record the details of his being shot, such as the severity of his injury. Next, you will want to record the boy's role as a witness by clicking on the Witness tab. Here, you need to record *two instances* of his role as a witness, since he witnessed both his mother's shooting and the stranger's shooting. To do this, you first enter the detailed information about his mother's shooting. Then, you click the "Add another..." button, and enter the detailed information about the stranger's shooting. Just as you saw earlier on the People window, you can use the small left and right arrow buttons just below the "Add another..." button to navigate from one instance to the next.

If you wish to enter detailed information about another person's roles, select that person's name from the combo box in the top section of the window and proceed just as you did earlier.

At this point, presuming that you completed the People window before navigating to the Role window, you have entered all of the information relevant to this case. Click the "Switchboard" tab at the top of your screen to save your work and return to the Switchboard. Alternatively, you may return to a window you have already worked on by clicking its tab at the top of your screen.

C. Update an Existing Case

The process of updating an existing case is almost identical to adding a new case, except that, instead of starting with a blank Case window, you start with one that you have already entered in the past.

From the Switchboard, click the button that looks like a pair of eyeglasses and is labeled "Search for an Existing Case." Cases in the CD-CP CAPERS may be identified either by the address at which the precipitating event occurred or the name of a person involved in the case. Select the search strategy--either name or address. Then click the "Search for an Existing Case" button. You will be prompted to enter the name or the address of the

case for which you are searching. If you do not recall the entire name or address, you may enter just a portion of either and the system will call up all cases containing that portion.

If only one match is found for the address you enter, you will be brought directly to the Case window, where the matching case will be displayed.

If multiple matches are found, you will be prompted to select the one you want from a list of the matching cases, and you will then be brought to the Case window where the selected case will be displayed.

From the Case window, you may 1) correct or update case information, or, 2) navigate to the People window, the Role window, or back to the Switchboard.

1) To correct or update case information, simply position the cursor in the field you wish to change, and make the change. Your changes will be saved automatically when you leave this window to go to another window, or, if you wish, you can choose "Save All Work" under the "File" menu. Consult the Field Reference if you require information about specific fields.

2) To navigate to the People or Role windows, click the appropriate tab at the top of the window, just as if you were adding a new case. Notice that you will not be permitted to navigate to either of these windows unless you have entered at least one person involved in the case. In other words, you cannot go to People or Role if the grid at the bottom of the Case window is blank.

   Once you arrive at the People window or the Role window, you can add or edit information, or navigate to other windows, just as if you were adding a new case. In addition, you can add new information to the existing information. For example, suppose you have been working since January 1, 1996 with a child who lived with her grandmother on Main Street. Now, six months later, she has moved on to Easy Street. You can go to the People window, select the girl's name from the "Name:" combo box, and then click the Home tab in the bottom section of the window. Here, you can click the "Add another..." button and enter the girl's Easy Street address as of June 1, 1996, and the other pertinent information about her new home. As always, you can use the small left and right arrow buttons below the "Add another..." button to navigate from one of this girl's homes to another.

   To navigate back to the Switchboard, click the "Switchboard" tab at the top of your screen.

D. Work with Groups

The "Create and Maintain Groups" function allows you to group together any number of individuals from any number of cases for the purpose of conducting and logging

interventions with all of the individuals in the group. For example, if the CD-CP Program has received a number of arson-related referrals, the team may decide to create an Arson Group and conduct group therapy sessions with all of the children who have been referred for arson.

From the Switchboard, click on the button that looks like a handshake and is labeled, "Create and Maintain Groups." The Group window will appear. From here, you can create a new group, call up an existing group, add people to groups, remove people from groups, navigate to the Group Session window, or return to the Switchboard.

The layout of the Group window is quite simple. In the combo box at the top, you specify which group you would like to work on, by selecting that group from the list. If you are adding a new group, type the name of the new group into the combo box. When you attempt to leave the combo box, you will be prompted to confirm that you wish to add this as a new group.

The body of the Group window contains two large list boxes with arrow buttons between them. One of the large list boxes shows all of the people in the database who are *not* members of the group you have specified, and the other large list box shows all of the people who *are* members of the group you have specified. You use the arrow buttons between the two list boxes to add someone to the group (i.e. move someone from the non-member list to the member list) or remove someone from the group (i.e. move someone from the member list to the non-member list). For example, if you click and highlight the name "Jane Smith" in the non-member list, and then click the left arrow button, you will see Jane Smith's name disappear from the non-member list and appear in the member list. Similarly, if you decide to remove Jane from the group, you can click and highlight her name in the member list, and then click the right arrow button to move her name back to the non-member list.

When you want to record group therapy sessions, select the group you want from the combo box at the top of the window, and then click the "Log Session..." button. A blank Group Session window will appear. Fill in the date, location, and duration of the session, and then record the attendance at the session.

Recording the attendance at a session is a multi-step process. The goal of the process is to build a complete Attendance List, including the names of all patients and clinicians who were expected at the session. You may enter the patients first or the clinicians first, whichever you prefer. For the sake of illustration, we will first describe the process of entering patients.

In the radio button option group in the lower left corner of the window, click "List patients." Notice that there are two combo boxes to the right of this radio button option group. One of the combo boxes is labeled "Patient:" and the other is labeled "Attendance:." The "Patient:" combo box lists all of the members of the group for which you are logging a session. Select one of the members from the list, and then indicate in

the "Attendance:" combo box whether that member attended the session, cancelled, or no-showed. Now click the right arrow button to officially add this patient to the Attendance List. Repeat this procedure for each patient who was expected to attend the session.

Now click "List clinicians" in the radio button option group in the lower left corner of the window. Notice that the combo box that was previously labeled "Patient:" is now labeled "Clinician:." In addition, the contents of the combo box have changed, and the list now shows all clinicians. Just as you did for the patients, select a clinician from the list, indicate in the "Attendance:" combo box whether that clinician attended the session, canceled, no-showed, or provided consultation, and then click the right arrow button to add this clinician to the Attendance List. Repeat this procedure for each clinician who was expected to attend or provide consultation for the session.

The Attendance List should now be complete. If you wish to remove someone from the list, click the person's name to highlight it in the list, and then click the left arrow button. If you wish to change the attendance status of someone on the list, simply remove the person from the Attendance List and then re-add the person with the new attendance status.

If you would like to log another session for this same group, click the "Add another..." button in the top right corner of the window, and repeat the procedures described above.

If you would like to look at other sessions that have already been logged for this same group, use the left and right arrow buttons directly under the "Add another..." button to scroll through previous sessions.

If you have finished working on sessions for this group, click the "Done" button to return to the Group window. Then, you click the "Switchboard" tab to return to the CAPERS Switchboard.

E. Perform System Administrator Functions

Only the appointed administrator at each site will typically perform system Administrator Functions.

From the Switchboard, click on the button that looks like a hammer and is labeled, "System Administrator Functions." You will be prompted for a special System Administrator password. This password is different from the password used to gain access to the application, and can be found on a second index card enclosed with this manual. After the password is correctly entered, a message box will appear, informing the system administrator how to proceed. More details regarding system administrator functions is available in the "System Administrator's Supplement" at the end of this manual.

F. Deleting

The method for deleting information in the CD-CP CAPERS depends on what level of information you would like to delete. Let us make the distinction between three different levels at which information can be deleted: the sub-window level, the window level, and the case level.

Suppose a family's house has burned, and a child named Jane has been a victim of the fire, and has also witnessed the injury of her father and her sister in the fire. You enter all of this information into the application. A week later, you learn that in fact, Jane only witnessed the injury of her father, and not her sister. You need to delete only one instance of Jane's role as a witness. This is sub-window level information because it is information that exists under one tab of a multi-tabbed window.

Now suppose, on the other hand, you learn a week later that Jane was, in fact, not even present at the event at all, and is not even part of this case. Now you wish to delete Jane altogether, with all of the detailed sub-window information associated with her. This is window-level information because it comprises an entire window, including all of that window's sub-windows.

This time, suppose you learn that the entire case never should have been entered. For example, the fire actually happened in a different county, and your local police department should not have even been notified in the first place. Now you wish to delete the entire case - the house fire, and all the people involved, and all the detailed information pertaining to those people. This is case-level information because it applies to the entire case, not just one particular window, and not just one particular instance of a given sub-window.

Now that we have clarified the three levels of information you may wish to delete, let us look at the steps involved in actually deleting them.

<u>Deleting Sub-Window Level Information</u>:
Since only the People window and the Role window have tabbed sub-windows, you will only delete sub-window level information from one of these two windows. To do it, navigate to the appropriate window, click the proper tab, and use the small arrow buttons so that you can see the specific instance of the tab you wish to delete. Then, click the "Delete..." button in the bottom right-hand corner of the window. You will be prompted to decide whether you wish to delete the window-level information or the sub-window level information. Select the sub-window level information by clicking the appropriate button.

<u>Deleting Window Level Information</u>:
As is true of sub-window level deletions, you will only delete window level information from the People window or the Role window. To do it, navigate to the appropriate window. Since you are deleting window level information, you need not worry about

which information is displayed in the bottom section of the window. Click the "Delete..." button in the bottom right-hand corner of the window. You will be prompted to decide whether you wish to delete the window level information or the sub-window level information. Select the window level information by clicking the appropriate button.

Deleting Case Level Information:
Deleting a case is something you will do only very rarely. The only reason to delete a case would be if the entire case had been added in error. If a particular piece of information on a case is erroneous, you would simply update that piece of information, and there would be no need to delete the case. You would only delete a case if the entire case never should have been added. For example, if you add a case and later discover that you had already added that exact same case, you must delete one of them so you will not have duplicates in the database. However, since the application checks for duplicates each time you add a new case, the need to delete a case should genuinely be a rare one.

From the Switchboard, click the button that looks like a waste-paper basket and is labeled, "Delete a Case." You will be prompted for the address of the case you wish to delete. The application will confirm that you indeed wish to delete the entire case, and will then return you to the Switchboard.

VII. Minimum Data Requirements

CAPERS permits each site to enter extensive information regarding all individuals present at an event or otherwise related to a case. However, it is anticipated that many sites will limit their data entry activities to the minimum necessary to permit cross-site comparisons. (The application will be implemented in Baltimore, Maryland; Buffalo, New York; Charlotte, North Carolina; Nashville, Tennessee; New Haven, Connecticut; Newark, New Jersey; Portland, Oregon; and other sites to be determined.)

The recommended minimum data entry requirements for police/mental health collaborative cases are outlined below. Individual sites may wish to establish supplemental data requirements depending on local needs and interests. The outline below refers to two of the three primary windows including the Case window and the People window. Each of these windows is described in more detail elsewhere in the User's Guide.

Case

- Record each case in which a clinical referral or consultation was considered necessary by a police officer (on the scene or upon review in the weekly program conference) whether or not clinical follow-up subsequently occurred.

- Record all fields in the Case window for every case. The only exceptions are Police Case Number, which might not be available, and the Auxiliary fields, which are optional.

- Record the name and approximate age (or date of birth) of all ***persons associated*** with a CASE in which clinical services or consultation was provided. Consultation includes cases discussed at the weekly program conference but for which there was no follow-up activity. ***Persons associated*** with a case are defined as follows:

  1. All persons contacted by the mental health professional in the course of the acute clinical service, consultation, or follow-up.

  2. All victims and perpetrators, whether or not they had contact with a program clinician.

People

- In the Intervention sub-window, record all acute and follow-up interventions provided to person identified in the Case window.

VIII. Glossary of Fields

Case

Referral Date - Provide the date that the referring individual successfully reached a program member and requested a referral or consult. This may or may not be the date of the event. It also may or may not be the first attempt by the referring party to initiate contact. You may either type the date directly into the field, or alternatively, you may click on the calendar icon next to the field. A calendar will appear, and you can select a date by double-clicking on it.

Event Date - The date on which the precipitating event took place. This date may or may not be the same as the referral date. You may either type the date directly into the field, or alternatively, you may click on the calendar icon next to the field. A calendar will appear, and you can select a date by double-clicking on it.

Police Case Number - All cases referred by an officer should have a corresponding number from the police report. This should be available from the referring officer or supervisor.

Auxiliary Fields - These are optional "extra" fields. Users can define these fields if they have data needs beyond those accommodated elsewhere in the application. For example, a particular site may wish to use Auxiliary Field #1 to record the initials of the responding officer or the precinct in which an event occurred.

What happened? - Provide a brief (one line) description of the event. Single key words that capture, e.g., who saw whom do what with what to whom, are sufficient to help identify a case.

Where? - Provide the address where the event occurred. If there is no number, the street or cross streets should be entered. This information allows the user to crosscheck with other entries at the same location.

Category (1 and 2) - There are two Category fields with their respective Types and Sub-types. You should enter at least one Category, Type, and, if applicable, Sub-Type. The second Category and Type should be entered if more than one Category or Type applies to a given case. Generally speaking, the most salient or serious event category should be entered first in Category 1. For example, in the event of a natural disaster and criminal misconduct, these terms should be selected for Categories 1 and 2. In the case of a murder/suicide, the user should select criminal misconduct for both Category 1 and Category 2. Type 1 would then be murder while Type 2 would be suicide (or visa versa). The "social/family problem" category is used to refer to a broad range of incidents and crises that result in calls to the police, but are not described by any of the other categories.

For example, if the police were called because a child is refusing to return to her foster home, the Category would be recorded as "social/family problem."

Type (1 and 2) - Choose the code that best describes the particular nature of the Category you selected. For example, if the Category is criminal misconduct, choose the incident code that best describes the crime.

Sub-type (1 and 2) – In some cases, there may be Sub-type options that will qualify the selected Type. Thus if the user selected the criminal misconduct Category with "murder" as the Type, one of the Sub-types, e.g., "criminally negligent homicide," needs to be selected. In many cases, e.g., "burglary," there will be no Sub-types listed so nothing can be entered in the Sub-type field. Most Sub-types are self-explanatory. However, in the criminal misconduct Category, some Sub-types warrant more detailed definitions. These particular Sub-types are as follows:

Arson – The actor starts a fire or causes an explosion with intent to destroy or damage a building and/or place another person at risk for injury. *(Note: Fire-play without intent to cause damage or harm should be coded under the Category Juvenile Matters).*

Assault – With intent to cause serious physical injury to another person, the actor causes such injury to such person or to a third person. *(Note: An assault resulting in a death should be coded under the Sub-type Murder).*

SUB-TYPES

- Simple Physical Assault (no weapon)
- With a firearm
- With a deadly instrument or dangerous instrument (non-firearm)

Burglary – The actor enters or remains unlawfully in a building with intent to commit a crime therein.

Child abuse/neglect – A child or youth who has been abandoned, denied proper care and attention, or abused under the following circumstances:

SUB-TYPES

- Abandonment – Actor has charge of child and exposes child in any place with intent to wholly abandon her.
- Physical abuse – Child is physically but not sexually abused.
- Sexual abuse/assault – Actor has sexual contact or sexual intercourse with a child 15 years old or under. *(Note: If sexual contact involves a child 13-15 years of age and is consensual, code as Statutory which is a sub-type of Sexual Assault).*

- Denial of proper emotional/physical care – Child is denied physical, educational, emotional or moral care.

Criminal mischief – The actor intentionally or recklessly damages property of another, e.g. vandalism.

Custodial interference – Knowing that he has no legal right to do so, the actor takes or entices from lawful custody, a child from her lawful custodian.

Driving Under the Influence – The actor is operating a motor vehicle while under the influence of alcoholic liquor or narcotic substance.

Drugs – *(Note: Child/adolescent drug use should be coded under the Category Juvenile Matters, in the Sub-type Drug/Alcohol use).*

SUB-TYPES

- Possession
- Possession with intent to sell
- Possession of paraphernalia

Kidnapping – The actor abducts another person.

Larceny – With intent to deprive another of property or with intent to appropriate property of another to oneself or a third person, the actor wrongfully takes, obtains, or withholds such property from an owner. Larceny includes, but is not limited to: obtaining property by false pretenses, extortion, theft of services, shoplifting, conversion of motor vehicle, library theft.

SUB-TYPES

- Under $50
- Between $50-$500
- Between $500-$5000
- Over $5000

Murder – The actor causes the death of another person.

SUB-TYPES

- Murder with Intent – With intent to cause the death of another person, the actor causes the death of such person or of a third person.
- Manslaughter 1 – With intent to cause physical injury to another person, the actor causes the death of such person or of a third person.
- Manslaughter 2 – The actor recklessly causes the death of another person.

- Criminally Negligent Homicide – With criminal negligence, the actor causes the death of another person, e.g. with criminal negligence in the operation of a motor vehicle. Actor was not considered reckless.
- Attempted Murder – With intent to cause the death of another person, the actor fails to cause the death of such person.

Prostitution – The actor engages or agrees or offers to engage in sexual conduct with another person in return for a fee.

Reckless Endangerment – The actor recklessly engages in conduct that creates a risk of physical injury to another person.

Riot – Simultaneously with two or more other persons, the actor engages in tumultuous and violent conduct and intentionally or recklessly causes or creates a grave risk of causing public alarm.

Robbery – In the course of committing a larceny, the actor uses or threatens the immediate use of physical force upon another person.

SUB-TYPES
- With a Weapon
- Without a Weapon

Search Warrant Execution – Officer executes warrant to search a particular location; property may be seized at this time for evidence, e.g. drug raids.

Sex Offense, Other – Sub-type includes Public Indecency, Stalking and Voyeurism.

SUB-TYPES
- Public Indecency – Actor performs an act of sexual intercourse in a public place; Actor lewdly exposes his body in a public place with intent to arouse or satisfy sexual desire of the person; Actor lewdly fondles or caresses the body of another person in a public place.
- Stalking – The actor recklessly causes another person to reasonably fear for his physical safety by willfully and repeatedly following or lying in wait for such person.
- Voyeurism – The actor observes unsuspecting individuals, usually strangers, who are naked, in the process of disrobing, or engaging in sexual activity. The act of looking ("peeping") is for the purpose of achieving sexual excitement, and generally no sexual activity with the observed person is sought.

Sexual Assault – Crimes involving sexual contact or intercourse.

SUB-TYPES
- Sexual assault (forcible) – Sexual assault with force or threat of force.
- Sexual assault (unable to consent) – Applies to persons unable to give consent due to acute or chronic defect in mental state.
- Statutory sexual assault – Actor has sexual intercourse with a child 13 to 15 years of age (with consent and without threat of force). Actor must be more than 2 years older.

Suicide – Actor causes her own death with the intent to cause such death.

SUB-TYPES
- Completed
- Attempted

Threatening – The actor intentionally places or attempts to place another person in fear of imminent serious physical injury, e.g. a bomb scare.

Trespassing – Knowing that he is not licensed or privileged to do so, the actor enters or remains in a building, or any other premises.

Unlawful Restraint – The actor restrains another person.

Weapon – Actor uses or possesses a weapon.

SUB-TYPES
- Unlawful discharge of firearm
- Possession of firearm
- Possession of deadly weapon or dangerous instrument (non-firearm)

Circumstances - Build a list of the circumstances surrounding this case by selecting one descriptor from the list and then clicking the right arrow. The circumstance you selected will appear in the rectangle to the right. Now, if applicable, select a second circumstance from the list, and again move it to the rectangle by clicking the right arrow. Repeat these steps until the list of circumstances in the rectangle is complete. If you add a circumstance to the list in error, you can remove it from the list by clicking on it, and then clicking the left arrow. The definitions of the circumstances in the list are as follows:

Acute psychiatric - Child - When a child on the scene is experiencing an acute psychiatric crisis, this circumstance descriptor should be selected. Acute psychiatric refers to an adult's behavior that is due to a psychiatric condition. This would include psychotic symptoms such as delusions (e.g., paranoid) or

hallucinations, homicidal or suicidal behavior, irrational fears and phobias, obsessions, etc. that appear to be due to a psychiatric condition. Odd, bizarre, or dangerous behavior that is a result of substance use should not be included here.

Acute psychiatric - Adult – When an adult on the scene is experiencing an acute psychiatric crisis, this circumstance descriptor should be selected. Acute psychiatric refers to an adult's behavior that is due to a psychiatric condition. This would include psychotic symptoms such as delusions (e.g., paranoid) or hallucinations, homicidal or suicidal behavior, irrational fears and phobias, obsessions, etc. that appear to be due to a psychiatric condition. Odd, bizarre, or dangerous behavior that is a result of substance use should not be included here.

Children at scene - Select this circumstance if a child or adolescent was at the scene of the event. The child can be present during the event itself or be present in the aftermath. He or she does not need to witness the event directly, e.g., the child can be on the front porch or can enter the scene after the fact

Custody dispute - This circumstance applies to those situations in which caregivers (living together or apart) are in conflict over the care and custody of a minor child.

Domestic conflict (child perpetrator/non-violent) – This is the first of four categories of four categories of domestic conflict/violence. The categories differ with respect to the primary perpetrator (child or adult) and whether or not the event involves physical violence (physical aggression or property destruction). This category includes family conflict in which a child is the primary instigator of a conflict that does not involve physical aggression or property destruction.

Domestic partner conflict (non-violent) – In this case, adults are the primary instigators of or participants in a conflict that does not involve physical violence.

Domestic partner violence - In this case, adults are the primary instigators of or participants in a conflict that involves physical violence.

Domestic violence (child perpetrator) - This category includes family violence in which a child is the primary instigator of a conflict that does involve physical aggression and/or property destruction.

Drug dealing - This circumstance relates to those events that in some way are related to the buying, selling, stealing, or acquisition of illegal drugs or drug

money. Thus, if a prominent drug dealer is robbed at home and it is believed he was targeted because of large quantities of drug money, this circumstance should be selected. In contrast, if a drug dealer assaults his wife in front of the children over issues unrelated to drugs, this circumstance should not be selected. Incidents related to active substance abuse should be addressed in the *Drug/alcohol Intoxication* circumstance only.

Drug/alcohol intoxication - This circumstance includes incidents in which a person is using substances at the time of the incident and for whom substance use was believed to contribute to the occurrence of the incident or its effect on children on the scene.

Gang involvement - This circumstance applies only to situations in which gang tensions, gang affiliation, or gang activities were a significant factor in the event. If persons with gang affiliation are present on the scene but gang issues were not related to the event, then this circumstance should not be selected.

Program Response - Build a list of the actions the CD-CP program will take in response to the case. Do this by selecting a group (e.g. police, clinicians, or whole program) from the first list, and a response from the second list, then clicking the right arrow. The group/response you selected will appear in the rectangle to the right. Now, if applicable, select a second group and response from the lists, and again move the response to the rectangle by clicking the right arrow. Repeat these steps until the list of program responses in the rectangle is complete. If you add a response to the list in error, you can remove it from the list by clicking on it, and then clicking the left arrow. The "whole program" choice refers to those activities, which involve both officers and clinicians. For example, "whole program" should be selected if an officer/clinician team meets with children in a classroom or holds a community meeting.

Urgency - Enter the urgency of the event. If *immediate* clinical assessment was indicated, the response should be immediate (the clinician responds to the scene within 2 hours of the call). *24-hours* should be entered if the situation is urgent rather than emergent and a clinical assessment needs to be conducted within 24 hours. If the referral is not urgent, as is the case with many standard outpatient referrals, the user should enter *eventual.*

Response Time - Regardless of the urgency of the event, enter the actual response time of the clinical service.

Explain - If the clinical service response time did not match the urgency of the event, provide an explanation why. A user can add an explanation to this list by typing it in the box and then pressing the <TAB> key.

Clinical Service Mode - Indicate whether the clinical response was provided by *telephone* or *direct-in-person. Direct-in-person* includes direct contact with officers or other persons on the scene or at any other site).

People - The grid at the bottom of the Case window is for recording information about the people involved in the case. Each person corresponds to one row in the grid. You use the <TAB> key to navigate from cell to cell in the grid. Notice that if you enter a person's birth date, the application will automatically calculate the age by subtracting from the Event Date. Notice, too, that the application does not permit you to navigate to the People window or the Role window until you have entered at least one person in this grid.

People

Name - Should contain all names previously entered for this *CASE* in the Gather Names window. To navigate to a particular name, simply select it from the combo box.

Birth date - If you entered the birth date in the "people grid" at the bottom of the Case window, it will already be filled in here on the People window. Otherwise, it will be blank.

Status - Click to indicate whether this person is active with the program, or has been discharged ("D/C'd") from the program. If you click D/C'd, you will be prompted to specify the circumstances of the discharge. If you wish for some reason to change how you have recorded the circumstances of the discharge, simply click Active, and then click D/C'd, and you will be prompted again to enter the circumstances.

Home - This window allows the user to enter information about each child's living environment. Information on adults is optional. The user can enter characteristics of the child's living environment for any period of time and for as many time periods as desired. Use the "Add another..." button to add additional homes at previous or subsequent periods in time, or when the child has an additional home at the same time (e.g., alternates between homes of divorced parents). This window allows one to track placement changes over time, a feature which is particularly important when describing the lives of children living in high risk communities.

> As of.... - The user enters the date when the child began living at the home described in the fields that comprise this window. The user can use the broad categories (pre-event or post-event) or an exact date can be specified when the new living arrangement became active. If Specific Date is selected, the user will be prompted for the exact date which may be estimated if not known for certain.
>
> Home type - The user should specify what kind of home using one of the general categories provided. Immediate family includes parents of whatever type,

whether step, adoptive, or biological. Extended family involves any other household led for example by a grandparent, aunt, uncle, etc.

Home address - Address of home noted above.

How many adults live in the home? - Adults are 18 years or older. "Live in the home" can be broadly construed as using the home as the primary place of residence.

How many of these adults are employed? - This includes part-time or full-time employment but does not include employment to conduct illegal activities.

How many children live in the home? - Include the total number of children under 18 years of age including any the child whose home is being described.

Is this a placement change? - Indicate whether this placement represents a change from a previous known placement.

Reason for change - If this is a change in placement, select the category that best describes the circumstances of the change. Child protection means that the local child protection agency was involved in determining a suitable placement. A family agreement does not involve the child protection agency even if the move was prompted by safety concerns.

Child has 2nd home? - Check here if the child has another home where he or she resides for a significant period of time each week.

Primary caregiver - Indicate the caregiver in the home who is the child's primary attachment and who, for all practical purposes, is the primary provider for this child. If the two more significant caregivers are roughly equal in importance to the child and in terms of responsibility for providing care, either may be selected and the other indicated under Secondary Caregiver. Scroll down for additional options.

Secondary caregiver - Indicate the second most significant caregiver/provider for this child in this home if any. Scroll down for additional options.

Tertiary caregiver - Indicate the third most significant caregiver/provider for this child in this home if any. Scroll down for additional options.

Educational level of primary caregiver - This is a required field. Indicate the highest educational level completed by the primary caregiver.

Model After - **Use this button before entering home information if home information has already been entered on siblings or other residents of the**

same home. This button allows the information that describes other children's homes to be copied to the current child. This avoids the need to reenter data on siblings and other family members. Click "Model after...", select the individual whose home data you would like copied. All entries will be copied to the current child. Once copied, they may be deleted or modified as necessary.

School - The user may enter the child's previous schools and current school placement. Again, this window allows one to record placement changes as they occur in order to better describe areas of instability.

As of.... - The user enters the date when the child began attending the school described in the fields that comprise this window. The user can use the broad categories (pre-event or post-event) or an exact date can be specified when the new school became active. If Specific Date is selected, the user will be prompted for the exact date which may be estimated if not known for certain.

School name - The school name should be entered in freeform text.

Grade - The grade should be selected from the combo box.

Placement type - Categories in this field correspond to the Scale for Assessing the Restrictiveness of Educational Settings (SARES). Placement restrictiveness can be quantified and used in statistical analyses.

Special Ed? - Indicate whether or not the child is eligible for special education services.

Reason for special ed. - Indicate the eligibility classification under which the child is eligible. If the child is eligible under more than one designation, pick the uppermost in the combo box. If local categories do not match the categories in this box, select the most appropriate of the choices.

Diagnosis - Allows the entry of any number of DSM-IV diagnoses based on functioning at various points in time. Diagnosis should be entered after the evaluation, but before treatment begins and then again every 3 months until discharge.

Date - Enter date that the diagnosis is made.

Axis - The user should select each of the five axes one at a time and enter corresponding diagnostic information after each one, clicking the "Add another..." button between each diagnosis. If there is more than one diagnosis for any axis, that axis can be selected again by using the "Add another..." button. After clicking on "Add another...", the user should select the axis again and then select the second or third diagnosis.

Diagnosis - This combo box is different for each axis. The box for Axis I contains all current DSM-IV, Axis I codes. The user can get to any diagnosis quickly by typing the first few letters of that diagnosis. The box for Axis II contains all DSM-IV Axis II codes. The boxes for Axis III and IV also contain basic descriptive categories from DSM-IV. For Axis V, the user is asked to select the functional measure of choice (GAF vs. CGAS) and the applicable period (current vs. maximum in the past year). The score itself is entered in the Comment field. The user can complete all four if desired by using the "Add another..." button. **At a minimum, the GAF (Current) and GAF (max. in past year) should be entered for every child seen for a clinical evaluation.**

Comment - Comment allows the user to enter freeform text to qualify any of the diagnostic entries. It is in this space that one should enter the terms *provisional* or *rule out (R/O)* if the diagnosis has not been established with any certainty. The comment box allows the user to enter a digit numeric score for Axis V.

Measures - The measure window allows all sites to enter periodic adjustment information on children treated. Scores should be entered every three months and at discharge for all children treated clinically.

Date - Enter the date that the measure was administered. If the "Add another..." button is clicked so that an additional measure can be entered, the date will default to the prior measure unless the user specifies otherwise.

Measure - Select the measure whose score will be entered. Additional measures can be added to the combo box (e.g., Trauma Symptom Checklist by Briere) or factors of particular measures (e.g., CBCL (INT), CBCL (EXT), CBCL (TOT)) can be added if one wishes to follow progress and gather outcome data. To enter a new measure, just type in a brief title for the new measure or factor and then press the <TAB> key.

Score - This field will accept numeric scores of up to 50 digits including decimal points.

Intervention - This window allows the recording of appointments including patients who attended, clinicians who attended, and whether or not scheduled appointments actually took place. Each annotated field presents information necessary for entering a single session for a single patient and single clinician. If multiple entries, patients or clinicians are necessary, see Notes 1 and 2 at the end of this section.

Case - This combo box presents all the cases with which the named individual is associated. The user should select the case about which the session has been scheduled.

Date - Enter the date upon which the session was scheduled to take place.

Session type - Select the category that best characterizes the session. Evaluation - acute response should only be selected for those initial visits in which the response was immediate or within 24 hours. Visits subsequent to the acute response should be recorded as Evaluation visits. Visits that are scheduled in advance with more than 20 hours notice, even when initial visits, should be recorded as standard Evaluation visits. Other visit categories should be used after the final evaluation visit is completed.

Location - Select the location category that best describes the location of the visit.

Duration - Enter the duration of the visit in minutes. The default is set to 60 minutes for the standard office visit.

List patients - Click this radio button in order to enter the names of patients who were scheduled to attend the session.

Patients - The combo box should present all individuals associated with the case selected above. In order to record the visit of a single individual, click on that individual's name, then go to the Attendance box.

Attendance - This combo box presents options regarding the patient's attendance, ranging from *attended* to *no show*. Select the correct option. Notice that there is also a "Not applicable" option. If a clinician cancels or no-shows, then the patient's attendance is not applicable.

Blue arrow (pointed right) - Click on this arrow to enter this patient and attendance record to the Attendance List on the right. Once the Attendance List contains the names of all patients scheduled to attend the session, you may go to the List Clinicians radio button.

Blue arrow (pointed left) - Click on this arrow to remove a patient or a clinician and attendance record from the Attendance List on the right. If more than one patient or clinician is on the list, be sure to highlight the person to be removed before clicking the blue arrow.

List Clinicians - Click this radio button in order to enter the names of clinicians who were scheduled to attend this session.

Clinicians - The combo box should present all program clinicians. In order to record the presence of a single clinician, click on that clinician's name, then go to the Attendance box.

Attendance - This combo box presents options regarding the clinician's attendance, ranging from *attended* to *no show*. Select the correct option. Notice

that there is also a "Not applicable" option. If a patient cancels or no-shows, then the clinician's attendance is not applicable.

Blue arrow (pointed right) - Click on this arrow to enter this clinician and attendance record to the Attendance List on the right. If this is the only clinician who was scheduled, you have completed the entry for this session.

Blue arrow (pointed left) - Click on this arrow to remove this patient and attendance record from the Attendance List on the right. If more than one patient is on the list, be sure to highlight the patient to be removed before clicking the blue arrow.

Note 1: More than one patient may be entered as follows. After the first patient and attendance classification have been added to the Attendance List, return to the Patient combo box. Follow the same steps noted above for each additional patient to be added to the list. The Attendance classification must be selected before a patient can be added to the list. **When more than one patient is entered, this session information will automatically be added to the record of each patient listed. Thus, the user does not need to repeat this procedure for other patients.** Additional clinicians can be added using the same procedure after first clicking the List Clinicians radio button.

Note 2: In order to enter another session, click on the "Add another..." button.

Formulation -

Date - Enter the date of the formulation.

Formulation - The user can enter a lengthy narrative description/formulation for every child seen clinically beyond the acute response.

Roles

Name - This combo box contains all of the names entered in the "people grid" on the Case window. After entering all role data on the first person listed, the user should select and enter data on each of the other names in the box for whom role data is required.

At event? - Check whether or not the person listed was *present* or *not present*. A child or adult should be considered present if he or she was present at the scene during the event or during the immediate aftermath. The aftermath of the event can be a period of relatively short or long duration. When a child discovers a parent dead of a drug overdose several days after the incident proper (the parent's death), the child is present in the aftermath. When the scene has essentially been restored to normal, cleaned, etc., this would not constitute the aftermath. Generally speaking, when a person has been injured or killed, the aftermath continues until they have been removed from the scene and evidence of injury has been cleared (bloody floor). If the damage is exclusively to

property, a child's arrival on the scene after, e.g., a fire has been put out or a hurricane has ended should not be considered present at the event or aftermath unless injured persons remain.

Note: For any of the categories listed below, the user may specify multiple instances or combinations as it seems necessary to capture any individual's role *vis a vis* the event. Additional layers/combinations are added by clicking on the "Add another..." button.

Witness

Witness to - Allows the user to specify what the person witnessed, whether the event, the aftermath, or both. Which options are selected depends in part on the *Witness type* variable as noted below.

Witness type - On occasion, a child or adult will be traumatized by an event they never saw but did hear. In this field, one can specify whether the event was seen or heard or both. **It may be necessary to enter various combinations using the "Add another..." button**. For example, If the child heard the event but visually witnessed the aftermath, both combinations should be entered. This requires several steps. First, one must enter Event under Witness to... and then Auditory under Witness type, and complete the remaining information. Second, the user must enter *Aftermath* under *Witness to...* and then *Both* (visual and auditory) under *Witness type*. This ensures that one can reconstruct elements of exposure that correspond to level of post-trauma risk.

Injury Witnessed - Select the option that best defines the most serious injury witnessed by the selected individual. (Do not include the person's own injuries.)

Weapon - Select the weapon that was witnessed.

Weapon Used for... - Indicate how the weapon was used. For example, a gun may be used to threaten, or it may be used to shoot or hit someone.

Relationship to victim. - Select the category that best describes the relationship of the child or adult named in the top section of the window to the victim.

Relationship to perpetrator. - Select the category that best describes the relationship of the child or adult named in the top section of the window to the perpetrator.

Victim - this information should be completed on those who were victims of a threat of violence whether or not they were actually injured.

Weapon - Identify the weapon that was used.

Weapon Used for... - Indicated how the weapon was used. For example, a gun may be used simply to threaten, or it may be used to shoot someone, or it may be used to beat someone.

Injury sustained - Identify the seriousness of the injury sustained by this victim, whether or not the weapon caused this particular injury.

Relationship to perpetrator. - Select the category that best describes the relationship of the child or adult named in the top section of the window to the perpetrator.

Perpetrator

Weapon - Identify the weapon carried or used by this perpetrator, whether or not it was used to inflict injury.

Weapon used for - Indicate how the weapon was used. For example, an accomplice who has a gun may shoot the gun, threaten with the gun, or beat someone with the gun (as in a pistol-whipping).

Injury inflicted - Identify the level of injury this perpetrator was responsible for inflicting. If the perpetrator inflicted multiple injuries, use the "Add another..." button to record details of additional injuries inflicted.

Criminal status - Indicate whether the perpetrator was jailed or otherwise detained shortly after the incident.

Accomplice - Includes persons who were involved in a criminal incident but who were not involved in threatening or perpetrating violence.

Weapon - Identify the weapon carried by the accomplice if any.

Weapon used for - Indicate how the weapon was used. For example, an accomplice who has a gun may shoot the gun, threaten with the gun, or beat someone with the gun (as in a pistol-whipping).

Criminal status - Indicate whether the perpetrator was jailed or otherwise detained shortly after the incident.

Defensive Aggressor

Weapon - On occasion, the target of an assault or other incident will pick up a weapon for self-defense or retaliation. This should be recorded here. For example, a local restaurant owner was robbed at gunpoint. He responded by

attacking the perpetrator with a knife. He thus was a defensive aggressor (in this case the perpetrator did nothing more than threaten with a weapon).

Weapon used for - Indicate how the weapon was used. For example, an accomplice who has a gun may shoot the gun, threaten with the gun, or beat someone with the gun (as in a pistol-whipping).

Injury inflicted - Indicate the nature of the injury inflicted by this defensive aggressor, if any.

Description - This field allows the user to enter a brief narrative description of the circumstances of the defensive aggression.

Action Taken - This is primarily of interest for children and adolescents.

Where? - Did the child remain on the scene or leave the scene in order to obtain help or protect him or herself?

Reaction - What category of action best describes the child's response? If the child took more than one action, use the "Add another..." button provide information on each significant action taken.

Group

Group name - Select a group from the combo box. If you are adding a new group, simply type its name in the combo box and then press the <TAB> key. You will be prompted accordingly.

Non-members - This rectangle lists all of the people in the entire database who are *not* members of this group. To add someone to the group, select a name in this list and then click the right arrow button. The name will disappear from the non-members list and appear in the members list.

Members - This rectangle lists all of the people who are members of this group. To remove someone from the group, select the appropriate name in the non-members list and then click the left arrow button. The name will disappear from the members list and appear in the non-members list. Note that a person cannot be removed from a group if he or she has ever attended a session for that group. (This is for data integrity purposes.)

Log a session... - Click this button to log a group session. You will be brought to the Group Session window. Since this window is almost identical to the Intervention sub-window of the People main window, please consult that section of the Field Reference if you need guidance.

IX. Getting Help

There are three forms of Help documentation available to you: this paper-based User's Guide, the Microsoft Access online Help facility (which you reach via the Help menu), and online comments in the Status Bar.

When you are just in need of a quick reminder regarding the use of a particular field, you can always look to the Status Bar. The Status Bar displays a single line of text at the very bottom of your screen. The text in the Status Bar changes, depending on the position of the cursor. Therefore, if you need a quick reminder about a certain field, you can simply position the cursor in that field and then read what the Status Bar says.

IX. System Administrator's Supplement

As the designated system administrator for your site, you will be responsible for the more technically sophisticated tasks involved in operating and maintaining the CD-CP CAPERS. From site to site, system administrators are likely to vary widely in their skills and level of computer experience. However, some combination of the following skills will be helpful for a system administrator to have:

- facility with point-and-click, Windows-based applications
- familiarity with Microsoft Access
- experience with a relational database
- basic programming skills, such as writing macros
- broad-based knowledge of file management principles, such as backing up data, copying files, etc.
- trouble-shooting skills
- patience with less-experienced end-users of the application
- exposure to object-oriented systems or programming

Technical Overview of the Application

The system consists of two main pieces: 1) the application itself, and 2) the database. The application includes the windows described elsewhere in this manual, the Access Basic programming code, etc. The database includes the CAPERS table structure, table relationships, and the data housed by those tables. Special "attachments" act to link the application to the database. These attachments are said to "point" the application to the database.

Each of the two main pieces of the system consists of two files, an .mdb file and an .ldb file. The application files are called cdcpapp2.mdb and cdcpapp2.ldb. The database files are called cdcpdat2.mdb and cdcpdat2.ldb. Note that cdcpdat2.mdb is the file that actually contains the data you have entered into CAPERS. **Therefore, if you ever need to re-install the application, you should answer "No" when asked if this file should be overwritten. Otherwise, you will lose your data.**

Unlike other PC-based database packages you may be familiar with, Microsoft Access stores all of the components of an application in a single file. Therefore, cd-cpapp.mdb contains windows (called "forms"), queries, table pointers, reports, and programming code all in one. You can only refer to a particular query, form, or report from *within* the application.

Responsibilities

In order to perform most system administrator tasks, you will need to bypass the protective limitations the system places on typical users, and gain access to the behind-the-scenes inner workings of the application. You do this by clicking the "System Administrator Functions" button on the Switchboard of the application, and then entering

the system administrator password supplied with this manual. A message box will appear, notifying you that full menus and functionality will be restored as soon as you click the "OK" button. The System Administrator also has the ability to change the contents of the various combo boxes. These changes can be made by clicking the "Maintain system lookup codes" button and entering the system administrator password.

At that point, you have free reign over the system. The following two sections address important points for preventing your free reign from going awry, and for giving you a sneak preview of what your responsibilities as system administrator are likely to include.

What Every System Administrator Should Know

Regarding Modifications. The application is designed to facilitate cross-site comparisons of data. For these comparisons to be valid, it is essential that each site have the exact same application. As a system administrator, you will have access to the Access Basic code that runs "behind the scenes." However, you must refrain from making any unauthorized changes to this code, even if the proposed change seems like a "quick fix." Making such unauthorized changes would not only invalidate cross-site comparisons, but would also impede the trouble-shooting process, should problems arise.

Vestiges of Development. Those who are familiar with the systems development process know that many designs and decisions continually change as the developing application evolves. Some vestiges of these changes remain in the application. For example, a "case" was initially called an "intake," and then a "first contact," before it came to be called a "case." The particular table of the CAPERS database that stores cases, and the form used to enter cases, are still called "First Contact." A handful of other, similar examples exist in the application. System administrators who familiarize themselves with such vestiges of the development process will potentially save themselves some confusion.

Recommended Reading. Two books that system administrators will probably find helpful are, Understanding Microsoft Access 2 and Microsoft Access 2 Developer's Handbook. The first of these is a good guide for someone who is new to Access, but is ready to start dabbling in queries and macros. The second book is a more technically sophisticated book, focusing on the Access Basic language and syntax.

A Sampling of Responsibilities

Backups. Depending on the volume of cases at your site, you will want to make periodic backups of your CAPERS database. Making a backup is as easy as saving off a copy of the file called CD-CPDAT.MDB. You can make the copy in File Manager or DOS, whichever you are most comfortable with.

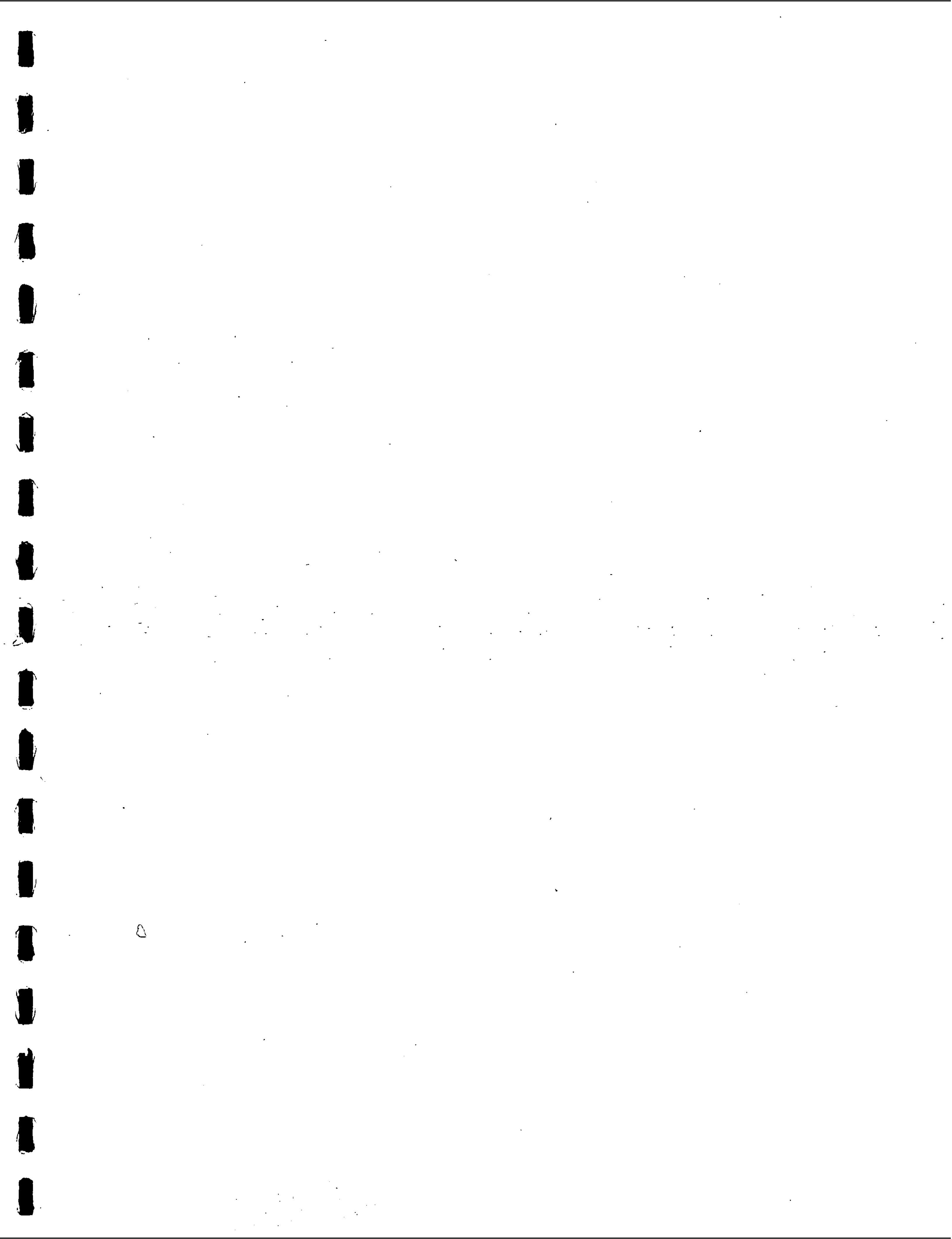
Maintenance/upgrades. As system administrator, you will be the designated person for performing system maintenance and installing upgrades. If a very minor change to the

application is necessary, it may happen that each site is notified of the change and given specific instructions on how to implement it. When a more significant change is required, the change will be programmed at a single site (most likely New Haven), and then distributed for re-installation to the system administrators at all other sites.

Forcing data. End-users at your site may sometimes need to manipulate data in an out-of-the-ordinary way that is not accommodated by the CAPERS windows. If this happens, the system administrator can "force" the data by going into the Design View of the relevant tables, and manually inserting, updating, or deleting information.

Troubleshooting. Part of the system administrator's job will be technical support of the end-users. When a problem arises, an end-user will come to you as the system administrator for help in troubleshooting the problem. You should first see if you could re-create and then solve the problem yourself. If that does not work, consult the available documentation. If you are still unable to solve the problem, contact any of the system administrators at other sites for assistance.

Queries/Reports. When a particular site is seeking data from other sites, it is likely that the requesting site will supply the other sites with the necessary query and/or report for culling and presenting the relevant data. This means that if your site would like to request data from other sites, you will be the one responsible for writing the query and/or the report. Consult the books in the *Recommended Reading* section above for basic instructions on how to create queries and reports. You will also want to familiarize yourself with the CAPERS data model, so you will know how the different tables in the database are related to one another.



Child Development-Community Policing: Officer Survey

PIN: ______

Today's date: ____/____/____

Which of the following CD-CP trainings have you had?
___ 1 or 2 day training(s)
___ 4 - 5 day training(s)
___ Multi-week training(s)

How many CD-CP meetings have you attended? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16+

How many children/families have you referred to CD-CP? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16+

Do you have children? ☐ Yes ☐ No

District or precinct: ______

Years on the force: ______

Post-high school degree: ☐ Assoc. ☐ Bachelors ☐ Masters ☐ Doctorate

Optional Questions:

How old are you? ______

What is your gender? ☐ Female ☐ Male

What is your race? ______

Directions: *Using the scale below, please indicate how much you agree or disagree with each of the following statements.*

1	2	3	4	5
Agree	*Somewhat Agree*	*Neither Agree Nor Disagree*	*Somewhat Disagree*	*Disagree*

1. Occasional nightmares are a normal part of childhood. 1 2 3 4 5
2. Personality is pretty much set by 3 years. 1 2 3 4 5
3. In domestic violence, the arrest may be the most important vehicle for providing help to the family. 1 2 3 4 5
4. Unless there are enforceable consequences for delinquent kids, mental health treatment is likely to be useless. 1 2 3 4 5
5. It is not normal for a young child, in angry moments, to harbor a wish to be rid of or destroy a loved one. 1 2 3 4 5
6. Collaborating with a mental health professional is not likely to lessen the frustration many officers feel when handling difficult adolescents. 1 2 3 4 5
7. If a teenager is made to feel ashamed when confronted, the teenager is more likely to back down. 1 2 3 4 5
8. I have a positive relationship with some of the kids on my beat even after I have arrested them. 1 2 3 4 5
9. Mental health professionals tend to make excuses for criminal activity. 1 2 3 4 5
10. Some kids worry that their angry, aggressive wishes will come true. 1 2 3 4 5
11. Mental health professionals just get in the way when they show up at crime scenes. 1 2 3 4 5
12. A temporary placement in foster care will not have much effect on a child under the age of 2. 1 2 3 4 5
13. Angry adolescents should be presented with choices. 1 2 3 4 5
14. Children under the age of 6 can be difficult to interview because they may talk about things that never happened. 1 2 3 4 5
15. A family that tolerates too many differences of opinion among its own members cannot exist for long. 1 2 3 4 5
16. There is not much a police officer can do to lessen a child's emotional distress from exposure to violence. 1 2 3 4 5
17. I have reported to violent crime scenes where I never considered the impact on the children who were present. 1 2 3 4 5
18. When young kids are depressed, they often complain of aches and pains. 1 2 3 4 5
19. I often stop kids on the street to check in and see how they are doing. 1 2 3 4 5

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1 Agree	2 Somewhat Agree	3 Neither Agree Nor Disagree	4 Somewhat Disagree	5 Disagree

20. Kids who are anxious may become quiet and withdrawn or have trouble with eye contact. 1 2 3 4 5

21. Most abused 7 year olds will simply be relieved to be placed in foster care. 1 2 3 4 5

22. Sometimes young kids may believe that they witnessed something even if they did not. 1 2 3 4 5

23. Children from violent backgrounds grow accustomed to violence and so are less affected by it. 1 2 3 4 5

24. Sharing the details of a child's therapy sessions with parents can interfere with the treatment. 1 2 3 4 5

25. The problem with delinquent kids today is that their parents fail to use strict physical discipline. 1 2 3 4 5

26. In the therapy of some children who have been exposed to a violent event, the event may never be discussed directly. 1 2 3 4 5

27. In many situations, mental health consultation can help officers better enforce the law and protect the community. 1 2 3 4 5

28. I can relate to the fact that some parents get angry enough to abuse their kids. 1 2 3 4 5

29. After age 10, there is not much that can be done to help kids change. 1 2 3 4 5

30. Mental health professionals have little to offer to control the criminal behavior of delinquent kids. 1 2 3 4 5

31. I never fail to protect every child I encounter at work. 1 2 3 4 5

32. Without considerable structure (i.e., firm limits, authority, consequences, clear expectations), therapy with delinquent kids is likely to fail. 1 2 3 4 5

33. Often it is not until after leaving a violent crime scene that I have distressing thoughts or memories about kids on the scene. 1 2 3 4 5

34. It is encouraging to see an 18 month old look to an unfamiliar adult to be held or taken with them. 1 2 3 4 5

35. I am pretty good at taking the perspective of a child I meet in the course of my work. 1 2 3 4 5

36. The main reason that people who live in crime-ridden communities are hostile toward the police is that they have something to hide. 1 2 3 4 5

37. Many delinquent kids will not benefit from therapy unless they live in a home or other setting with firm, enforceable limits, expectations, and consequences. 1 2 3 4 5

38. There is little I can do to help children cope when they have been victims of or witnesses to violence. 1 2 3 4 5

39. It is normal for kids to have some sorts of homosexual ideas or behaviors in the course of puberty. 1 2 3 4 5

40. Four, five, and six year olds are normally curious about sex and may show this curiosity in play with their bodies. 1 2 3 4 5

41. I know many of the kids on my beat. 1 2 3 4 5

42. Although they face many new problems, kids on my beat struggle with some of the same issues my friends and I did when we were growing up. 1 2 3 4 5

43. Adolescents on my beat never really get to me. 1 2 3 4 5

44. By the time someone is a teenager, the main thing in life they should want is to do something important. 1 2 3 4 5

45. Officers in this department feel supported by their immediate supervisors and colleagues. 1 2 3 4 5

46. For the most part, an abused 2 year old would not be upset about being placed in a foster home. 1 2 3 4 5

47. Sometimes I am not in the mood to talk with the kids on my beat. 1 2 3 4 5

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1 Agree	2 Somewhat Agree	3 Neither Agree Nor Disagree	4 Somewhat Disagree	5 Disagree

48. There are times when even good parents may feel like abusing their kids. 1 2 3 4 5

49. When young children do not tell the truth, you can usually assume that they are lying or psychotic. 1 2 3 4 5

50. In a crime with children present, the disadvantages of having a mental health professional at the scene outweigh the benefits. 1 2 3 4 5

51. To police a neighborhood well, you need to have some relationship with the people on your patrol. 1 2 3 4 5

52. If a 4 year old boy engages in play with sexualized content, it must mean he has experienced sexual abuse. 1 2 3 4 5

53. Many people, without being aware of it, react to police officers as they did to their own parents when they feared being found out and punished. 1 2 3 4 5

54. Young people should not have access to books and other media that will expose them to radical ideas. 1 2 3 4 5

55. When a young child is terrified, you can always expect that he or she will scream, run around, or get agitated. 1 2 3 4 5

56. Most adolescents "don't give a damn" about anyone but themselves. 1 2 3 4 5

57. When dealing with domestic violence situations involving kids, I sometimes worry about the decisions I made and whether I did right by those involved. 1 2 3 4 5

58. The content of a therapist's work with children should be readily available to an investigating officer. 1 2 3 4 5

59. When I have to decide whether to arrest a parent for abuse or neglect, I consider the emotional bond between the parent and child. 1 2 3 4 5

60. I'm reluctant to talk to adolescents on my beat because most of them are unreceptive or they cop an attitude. 1 2 3 4 5

61. When interviewing a child with marks or bruises from punishment, it is important to ask the child whether he or she did something to justify the punishment. 1 2 3 4 5

62. Officers in this department feel supported by the administration. 1 2 3 4 5

63. If children regularly receive harsh physical discipline, they are much more likely to be aggressive when they are older. 1 2 3 4 5

64. I usually do not make a special effort to avoid having a child see his parents taken away in handcuffs. 1 2 3 4 5

65. Even though I value freedom of expression, it is important to restrict the freedom of many adolescents to express themselves. 1 2 3 4 5

66. An officer can often shame an adolescent into cooperating. 1 2 3 4 5

67. Some of the delinquent kids that I see probably have a psychiatric disorder or a learning disability that makes it tough for them to succeed in school. 1 2 3 4 5

68. My emotional reactions never affect the judgments I make as a police officer. 1 2 3 4 5

69. The behavior problems I see in kids on my beat are due to what they see in the media. 1 2 3 4 5

70. There are some kids that I feel are beyond help. 1 2 3 4 5

71. Foster care is a positive, uncomplicated solution to problems of neglect and abuse. 1 2 3 4 5

72. Cops should develop more of an appreciation of the effect of their interventions on children at the scene of a police action. 1 2 3 4 5

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1 Agree	2 Somewhat Agree	3 Neither Agree Nor Disagree	4 Somewhat Disagree	5 Disagree

73. An 18 month old who was deprived or abandoned will be more vulnerable to emotional problems as an adult. 1 2 3 4 5

74. The world is basically a lonesome place for most kids to grow up. 1 2 3 4 5

75. Young people should not have easy access to books that are likely to confuse them. 1 2 3 4 5

76. In my work, it is helpful to remember what it was like to be a kid. 1 2 3 4 5

77. A child who witnesses a shooting should not be permitted to play with toy guns. 1 2 3 4 5

78. Mental health professionals are quick to make excuses for irresponsible and negligent parents. 1 2 3 4 5

79. Regardless of their initial reaction, most kids get used to multiple changes in foster parents. 1 2 3 4 5

80. It is unusual for a 3 year old child to give different stories to different interviewers during a sexual abuse investigation. 1 2 3 4 5

81. I always follow up with children on my beat who have been exposed to violence. 1 2 3 4 5

82. Masturbation is normal in children. 1 2 3 4 5

83. Many kids act cocky or defiant because they feel powerless and inadequate. 1 2 3 4 5

84. My blood boils whenever a teenager refuses to admit he or she is wrong. 1 2 3 4 5

85. When children see cops as the "bad guys" during a domestic dispute, the officers can not have a positive role with the children afterwards. 1 2 3 4 5

86. After an aggressive police action (e.g., drug raid) with young children on the scene, police should not have follow-up contact with the family regarding the children. 1 2 3 4 5

87. Many children in our inner cities live in circumstances that leave them feeling fearful and ashamed on a regular basis. 1 2 3 4 5

88. Teenagers only listen to police when threatened with punishment. 1 2 3 4 5

89. Children who have been sexually abused by a family member often have both positive and negative feelings about the perpetrator. 1 2 3 4 5

90. After dealing with a domestic violence call, I often leave the scene thinking about how little I've done. 1 2 3 4 5

91. For most kids the present is all too often full of unhappiness; it is only the future that counts. 1 2 3 4 5

92. Most teenagers have no idea what's good for them. 1 2 3 4 5

93. I sometimes feel aggravated and exhausted after managing domestic disputes involving children. 1 2 3 4 5

94. There are some groups of kids I have come to hate simply because of what they stand for. 1 2 3 4 5

95. Caring and loving parents regularly discipline their children. 1 2 3 4 5

96. Regardless of the circumstances at a crime scene, I am always aware of the impact of my actions on the children. 1 2 3 4 5

97. Some kids are born easy going and easy to soothe, others may be temperamental and hard to soothe. 1 2 3 4 5

98. Kids who are defying authority will often calm down in front of an audience of their peers. 1 2 3 4 5

99. Many children model themselves after caring adults who are confident, powerful, and well regarded. 1 2 3 4 5

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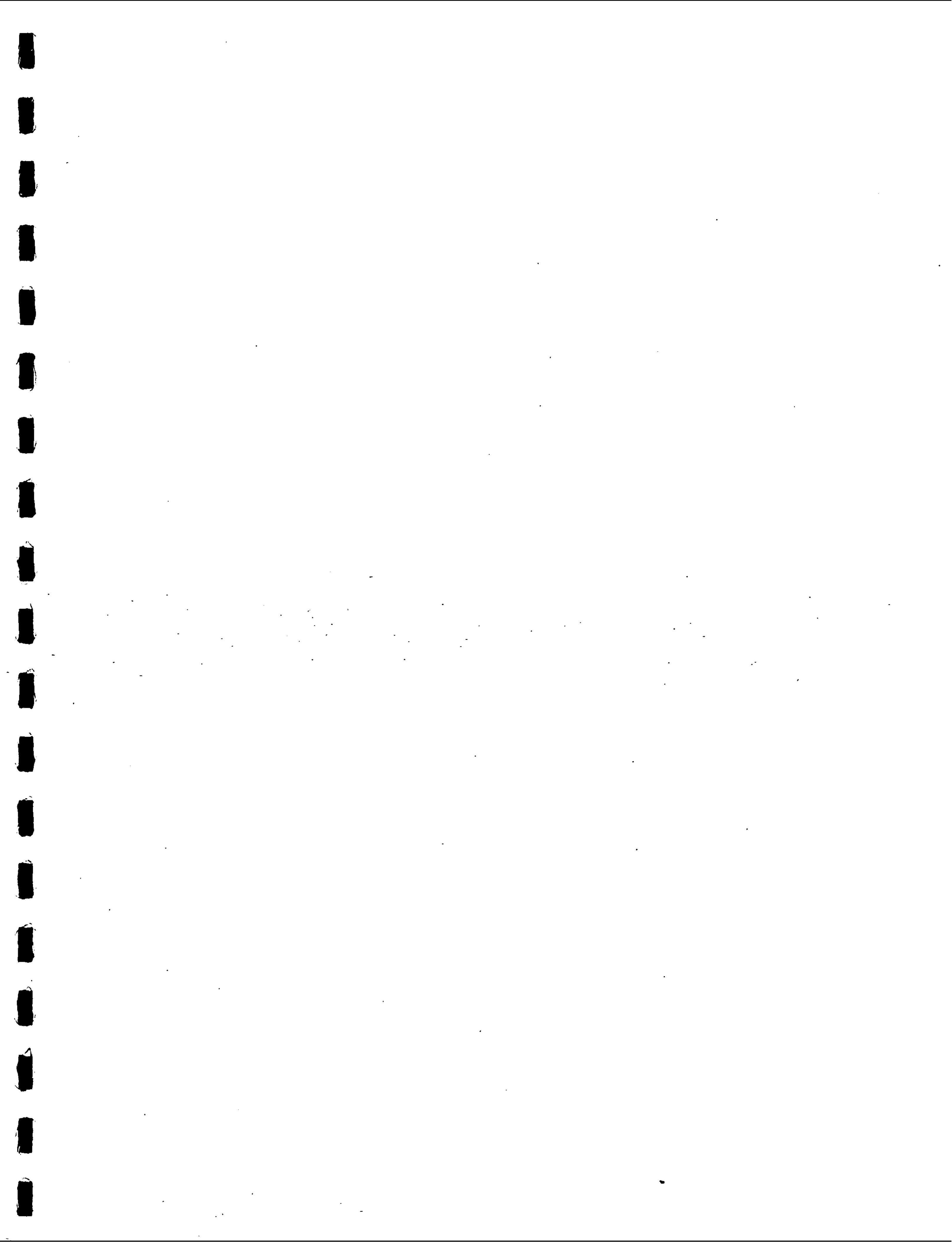

Child Development-Community Policing: Clinician Survey

PIN: Appendix F

Today's date: ______/______/______

How many of the following CD-CP seminars have you had? ___ 1 or 2 day training(s) ___ Multi-week course(s)

How many CD-CP meetings have you attended? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16+

What degrees have you earned? ____________

What is your current position? ____________

After earning your first clinical degree, how many years of clinical experience have you had? ____________

Do you have children? ☐ Yes ☐ No

Optional Questions:

How old are you? ____________

What is your gender? ☐ Female ☐ Male

What is your race? ____________

Directions: *Using the scale below, please indicate how much you agree or disagree with each of the following statements.*

1	2	3	4	5
Agree	*Somewhat Agree*	*Neither Agree Nor Disagree*	*Somewhat Disagree*	*Disagree*

1. The only reason kids act cocky or defiant is because they feel powerless and inadequate. 1 2 3 4 5
2. Unless there are enforceable consequences for adolescents engaging in delinquent behavior, mental health treatment is likely to be useless. 1 2 3 4 5
3. In domestic violence, the arrest may be the most important vehicle for providing help to the family. 1 2 3 4 5
4. Only disturbed or bad parents feel like abusing their children. 1 2 3 4 5
5. A mental health referral from a police officer at a crime scene is nearly certain to fail. 1 2 3 4 5
6. Children from violent backgrounds grow accustomed to violence and so are less affected by it. 1 2 3 4 5
7. Sharing the details of a child's therapy sessions with parents can interfere with the treatment. 1 2 3 4 5
8. In the therapy of some children who are exposed to a violent event, the event may never be discussed directly. 1 2 3 4 5
9. In many situations, mental health consultation can help officers better enforce the law and protect the community. 1 2 3 4 5
10. When the subject of an arrest is injured in the process, it is clear that excessive force has been used. 1 2 3 4 5
11. Many delinquent or pre-delinquent kids will not profit from therapy unless they are in a home or other setting with firm, enforceable limits, expectations, and consequences. 1 2 3 4 5
12. A child's perseverative play about a traumatic event suggests the need for clinical intervention. 1 2 3 4 5
13. There are times when even good parents may feel like abusing their kids. 1 2 3 4 5
14. Clinical neutrality is compromised if I collaborate with juvenile authorities in the treatment of conduct disordered adolescents. 1 2 3 4 5
15. Kids often become more criminalized in detention. 1 2 3 4 5
16. If a 4 year old boy engages in play with sexualized content, it must mean he has experienced sexual abuse. 1 2 3 4 5
17. Many people, without being aware of it, react to police officers as they did to their own parents when they feared being found out and punished. 1 2 3 4 5
18. Young people should not have access to books and other media which will expose them to radical ideas. 1 2 3 4 5

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1 Agree	2 Somewhat Agree	3 Neither Agree Nor Disagree	4 Somewhat Disagree	5 Disagree

19. In most cases when a child or adolescent commits a crime, the officers should refer the child for mental health intervention rather than make an arrest. 1 2 3 4 5

20. The content of a therapist's work with children should be readily available to an investigating officer. 1 2 3 4 5

21. Many officers become involved with the aim of helping children and families live in a just society. 1 2 3 4 5

22. Children taken away by the State should not be returned to their parents. 1 2 3 4 5

23. Most of the hard-core delinquent teens, were destined to be criminals since they were little kids. 1 2 3 4 5

24. A police officer is likely to be less stressed in dealing with child witnesses to violence if child mental health professionals are available on the scene . 1 2 3 4 5

25. I can not understand how some parents get angry enough to abuse their kids. 1 2 3 4 5

26. Competition is a healthy outlet for aggression. 1 2 3 4 5

27. Many kids are naturally curious about or excited by fire. 1 2 3 4 5

28. Some of the parents I meet in my work may be rough with their kids or show little affection, but I think they care and make an effort nonetheless. 1 2 3 4 5

29. Most kids get used to multiple changes in foster parents without suffering significant psychological consequences. 1 2 3 4 5

30. There are some kids that I feel are beyond help. 1 2 3 4 5

31. If there is not a direct discussion of the traumatic event that brings a child to psychotherapy, the therapy will probably be ineffective. 1 2 3 4 5

32. The world is basically a lonesome place for most kids to grow up. 1 2 3 4 5

33. Most adolescents "don't give a damn" about anyone but themselves. 1 2 3 4 5

34. It is only natural for most adolescents to be fearful of what the future holds. 1 2 3 4 5

35. For most kids, being sent to detention or jail does little or nothing to curb their involvement in criminal activities once they're back on the streets. 1 2 3 4 5

36. Even though I value freedom of expression, it is important to restrict the freedom of many adolescents to express themselves. 1 2 3 4 5

37. My blood boils whenever a teenager refuses to admit he or she is wrong. 1 2 3 4 5

38. Kids who are resilient and succeed despite poverty, uncaring parents, and neighborhood violence do so in part because of genes and heredity. 1 2 3 4 5

39. Every nine- or ten-year-old child who sets an illegal fire should be arrested. 1 2 3 4 5

40. Young people should not have easy access to books that are likely to confuse them. 1 2 3 4 5

41. A child who witnesses a shooting should not be permitted to play with toy guns. 1 2 3 4 5

42. When children perceive officers as the "bad guys" during domestic disputes, the officers can not have a positive role with the children afterwards. 1 2 3 4 5

43. When responding to a crime scene, I anticipate that I will be in the way or isolated from officers. 1 2 3 4 5

44. Many police officers enter the profession to satisfy a wish for excitement and adventure. 1 2 3 4 5

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1 Agree	2 Somewhat Agree	3 Neither Agree Nor Disagree	4 Somewhat Disagree	5 Disagree

45. I am always able to take the perspective of a child I meet in the course of my work. 1 2 3 4 5

46. After dealing with situations involving domestic violence, I sometimes worry about the interventions that I make and whether I did right by those involved. 1 2 3 4 5

47. When interviewing a child with marks or bruises from punishment, it is important to ask the child whether he or she did something to justify the punishment. 1 2 3 4 5

48. The behavior problems I see in kids are due to what they see in the media. 1 2 3 4 5

49. Most teenagers have no idea what's good for them. 1 2 3 4 5

50. All children who are abused should be removed from their families. 1 2 3 4 5

51. Treatment of a child exposed to violence requires talking directly about the incident. 1 2 3 4 5

52. One reliable way to recognize false allegations of sexual abuse is if a child tells different stories to different interviewers. 1 2 3 4 5

53. Neurobiology cannot be influenced by psychotherapy or other external environmental stimuli. 1 2 3 4 5

54. Since uniformed police officers are often frightening to children, officers should not wear their uniforms in schools unless absolutely necessary. 1 2 3 4 5

55. Of police calls for service, responding to domestic disputes poses the greatest risk to an officer's physical safety. 1 2 3 4 5

56. Children who are witness to a violent crime should always be seen by a clinician before speaking to an investigating officer. 1 2 3 4 5

57. When clinicians respond to a crime scene, they should avoid contact with the police in order to maintain neutrality with the family. 1 2 3 4 5

58. Police officers can be particularly effective in referring children and families for mental health services because they are likely to be perceived by many as caring authority figures. 1 2 3 4 5

59. When officers don't engage young children at the scene of a violent event, it is often because they are uncomfortable talking to children and don't know what to say. 1 2 3 4 5

60. It is necessary for police authority to be feared in some police actions involving adolescents. 1 2 3 4 5

61. In the absence of collaboration with juvenile authorities, clinical work with conduct disordered adolescents is frequently frustrating and ineffective. 1 2 3 4 5

62. Police officers that I work with are quite receptive to a psychological perspective in police matters involving children and families. 1 2 3 4 5

63. When children have witnessed a seriously traumatic event involving a caregiver, it is unlikely that they will be receptive to the intervention of a clinician in the immediate aftermath. 1 2 3 4 5

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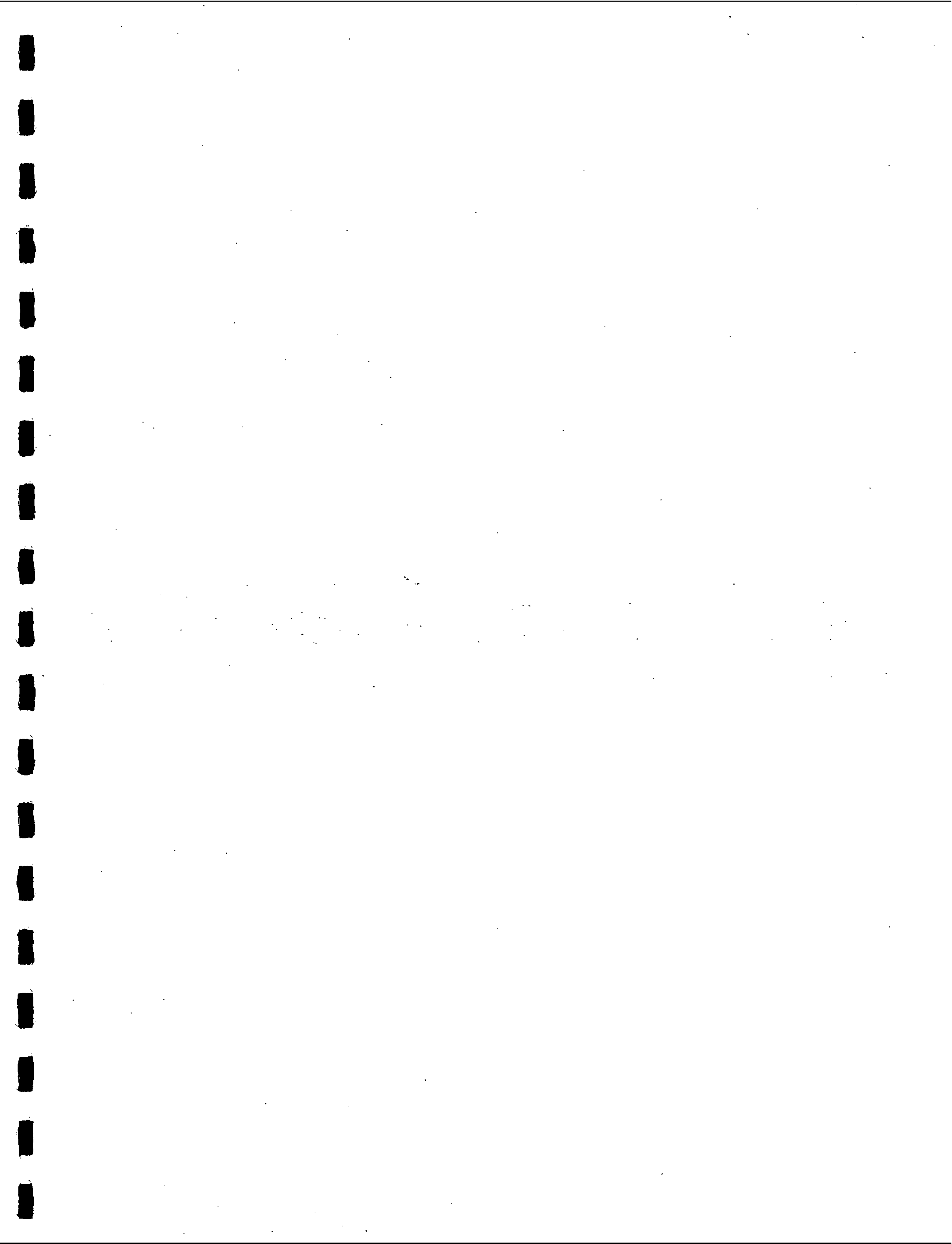


Child Development-Community Policing Replication Evaluation

Specific Aims

The Child Development - Community Policing (CD-CP) Program is a collaboration between the New Haven (Connecticut) Department of Police Service and the Yale Child Study Center. The program was initially designed to address the effects of urban violence on children, their families, and the community by providing acute clinical services to children and families exposed to violence. The program also sought to help officers recognize the effects of violence on child development and to appreciate the therapeutic impact that officers can have when children and families are in distress as a consequence of violence.

The focus of the program has expanded to include a variety of child related problems with which police are confronted on a regular basis. Mental health professionals and police officers collaborate on cases ranging from delinquency to domestic conflict to psychiatric crisis. The collaboration is designed to provide a broader repertoire of coordinated interventions which are believed to lead to more favorable therapeutic and/or law enforcement related outcomes.

Under the auspices of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the U.S. Department of Justice, a manual of the CD-CP Program was developed. This manual has served to guide the replication of the New Haven CD-CP program in Nashville, Tennessee; Baltimore, Maryland; Buffalo, New York; Portland, Oregon; Newark, New Jersey; and Charlotte, North Carolina. Technical assistance to four of these six sites has been supported by OJJDP. Other cities are also attempting replication but have not yet committed to be part of the proposed evaluation.

The widespread implementation of this program necessitates the development of an evaluation protocol in order to ensure that new programs are accomplishing their objectives, and in order to provide feedback for further refinement of the model. Thus, the purpose of this research is to evaluate the implementation of the CD-CP program in the above sites and additional sites as replication proceeds.

The proposed evaluation has two objectives. The first objective is to evaluate changes in officer knowledge and attitudes as a function of police district or departmental implementation of the Child Development-Community Policing Program. The second objective is to document the collaborative activities that occur within each replication district as a measure of program implementation.

Specific Location of Study:

The investigation will be undertaken concurrently in five CD-CP replication sites: Buffalo, New York; Newark, New Jersey; Charlotte, North Carolina; Nashville, Tennessee; Baltimore, Maryland; and Portland, Oregon. The survey will be administered in the participating police district(s) and a control district(s) at each site.

Probable Duration of Project:

The survey will be administered to officers in each participating district and control district in five waves taking place every six months for 2 years. Although the study will be implemented concurrently at each site, each wave of survey administration will be staggered across sites. Staggered administration will be necessary due to practical constraints at the coordinating site (Yale Child Study Center) and the need to tailor the administration to the needs of each locality.

The Case, Activity, and Patient Electronic Recording System (CAPERS) will be implemented for two years, beginning at the same time that the baseline survey administration is conducted. Sites will have the option to continue using CAPERS at the end of this two year period.

Research Plan:

The following methodology will be implemented concurrently in the five CD-CP replication sites. The procedure is outlined for a single site. Each site will be asked to select a convenient start date from which time the data collection procedures will be conducted in accordance with the outlined timeline.

The survey study will employ a repeated measures quasi-experimental design in which all officers in the participating district and a control officers will be evaluated at baseline and then again every 6 months for two years.

The baseline administration will be conducted in the early stages of program implementation (sometime during the first year) before most officers have received program training. Some officers will have been trained prior to the baseline administration; however, it is expected that the effect of this training will be negligible due to the small number of officers involved. In addition, it is believed that most of the change in officer attitudes and knowledge will occur as a function of the district's ongoing participation in the collaboration, rather than the initial training in-service or course.

CAPERS will be implemented by the clinical services agency.
They will record all cases, collaborative activities, and the collaborating district. The data will provide a measure of implementation to compare against other replication sites. It is assumed that the control districts will not be involved in making referrals or other mental health/police collaborative activities. Each site will download a copy of their database and send it to the New Haven CD-CP program every six months until the end of the 2 year study period.

Respondents/subjects

The survey respondents will include all police officers in the patrol division of the district(s) in which the replication is being conducted and all officers in an additional control district in which the replication is not being conducted. The control district will be selected based on its similarity to the replication district. At least fifteen percent of the officers will be ranking officers of Sergeant or higher.

CAPERS data will be collected for all cases involving children on whom the police and mental health agency collaborate. Because the system will serve a clinical management function in addition to data collection for this study, the database will contain the names of all children and families served. The names will be purged from the database copy, which is sent to the New Haven site for data analysis. Consequently, the confidentiality of patients will be protected.

Procedure

The following survey procedure has been developed and tested to ensure the anonymity of participating officers. Each respondent will be given a copy of the CD-CP Officer Survey by his or her immediate supervisor. Each survey will contain an instruction sheet and a 1/4-inch by 3/4-inch self-adhesive label. The respondent will be directed to select a personal identification number of his or her choosing consisting of four numbers and two letters (e.g., 5544-xe). The respondent will be asked to write the number on the survey and on the label included with the survey. Finally, the respondent will be asked to post the label on his or her driver's license or other identification card for use in subsequent administrations. The respondent will be instructed to return the survey to the New Haven Child Development-Community Policing Project using an attached pre-addressed and stamped envelope.

Every six months the survey will be readministered with a different set of instructions. The instructions will direct the respondent to locate the adhesive label from the initial administration and record his or her identification number on the current survey.

CAPERS will be available at each program conference for the recording of cases discussed. At each conference, a trained clinician or police officer will be designated to enter the data. Cases that are not discussed and entered during the program conference will be entered by the clinical services agency using available case information before the end of each week.

Instrumentation

Officer Survey. The CD-CP Officer Survey consists of several demographic questions and 99 items rated on a 5 point Likert scale. The demographic questions relate to participation in the program, program training, rank, years on the force, and several optional questions including gender and ethnicity. The 99 questions inquire about officer knowledge, attitudes, and perception of the program. It consists of approximately 10 factors which assess such areas as knowledge of child development, insight into human behavior, affective expression, program satisfaction, awareness of children in police actions, and circumspection. The factor structure is currently being established empirically. Psychometric properties are also being evaluated. In a recent field trial of the survey, approximately 80% of police officers completed the measure within 20 minutes. More than 95% complete the survey within 25 minutes.

Clinician Survey. The CD-CP Clinician Survey consists of several demographic questions and 63 items rated on a 5 point Likert scale (see Appendix C). The demographic questions relate to participation in the program, program training, level of education and degree(s) earned, and several additional questions including gender and ethnicity. The 63

questions inquire about clinician knowledge, attitudes, and perception of the program. The survey items tap eight content areas (see Appendix D for annotated list) including knowledge of child development, insight into human behavior, therapeutic value of structure, value of mental health to law enforcement, understanding of mental health intervention for child victims of trauma, circumspection, social desirability, and knowledge of policing. The factor structure is currently being investigated. Psychometric properties are also being evaluated.

Case, Activity, and Patient Electronic Recording System (CAPERS). CAPERS is a computer application that was developed to capture and track demographic, clinical, and administrative data for the Child Development-Community Policing program. CAPERS is designed to facilitate paperless case tracking and event recording for child mental health and police collaborative programs. Unlike most existing outpatient mental health clinic management information systems, the CAPERS application provides a format for recording information that is uniquely designed for police/child mental health collaboration. Thus, the system allows the recording of detailed case information, including the nature of the precipitating event, police non-enforcement related response, clinical response, demographics, intervention, and other basic clinical information. The use of this automated, centralized, and standardized mode of data collection will facilitate cross-site data analysis and program evaluation.

The application was developed for a Windows environment using the Microsoft Access PC-based relational database tool. This tool was chosen because it is widely available in standard pre-installed software constellations, and because of the notable flexibility offered by a relational database as compared to a traditional, hierarchically organized database.

The following diagram illustrates the window flow of the CD-CP CAPERS. Each box represents a particular window in the application. A line between two boxes indicates a route by which the user can navigate between the two windows represented by those boxes. In addition, the sub-points below a box indicate what categories of information can be entered in the window represented by that box.

Issues in Evaluating Child Development-Community Policing Programs

With the spread of the Child Development-Community Policing (CD-CP) Program to many communities nationally and internationally, the question of how to measure program impact has frequently arisen. To begin with, it is important to note that the theoretical base for the development of the CD-CP intervention is grounded in results from numerous research efforts that have documented the relationship between exposure to violence and later risk for participating in violent and non-violent delinquent behavior (Thornberry, 1994; other references; Schwab-Stone et al.). CD-CP programs respond to these consistent findings of a cycle of violence in order to reduce later risk for traumatized individuals and also to diminish the perpetuation of a climate of violence at the community level.

Numerous obstacles complicate the application of standard models of program evaluation to CD-CP programs. These include features inherent to this innovative intervention and to the people and communities served. For example, the context of the intervention is one of human and neighborhood crisis, and it is activated at the point when children and youth are exposed to serious, often criminal, forms of violence. Clearly, in such circumstances many uncontrolled factors impinge on the situation and affect to whom, to what extent, and in what form CD-CP services are delivered.

Three standard approaches are frequently used to evaluate programs such as CD-CP. Within community comparisons based on follow-up of comparably exposed groups, one receiving the intervention and the other not, would provide relevant information on program effectiveness in minimizing later symptoms and detrimental impact on the development of violence exposed children. However, ethically it is not possible to randomize this intervention once the capacity to do so has been developed within a community. Across community comparisons (one community with the CD-CP

intervention versus another without) can be useful but, of course, there are many factors across communities that cannot be controlled (e.g. varying patterns and types of crime activity, variations in social service and social network resources) and that confound the meaning of the comparison.

Another approach is based on follow-up of families to examine outcomes for those who were offered but refused CD-CP intervention to those who agreed and participated in it. Again, numerous background factors involving the psychological and behavioral characteristics of those refusing services, especially factors on which it may not be possible to gain information (e.g. illegal involvements), strongly reduce the value of this approach for establishing control groups. In summary, numerous issues inherent to the real world, crisis context of the CD-CP intervention seriously limit the ability to assess its impact using traditional evaluation models.

Notwithstanding these methodological challenges, there are a number of worthwhile approaches, and there is some available evidence bearing on the important questions of program utility and effectiveness. By integrating findings on both broad-based and specific effects of CD-CP activities, program impact can be documented. These approaches examine outcomes at the individual, service system and community levels and together give the fullest sense of program effects. At the individual level, development of a means for tracking cases over time provides summative descriptive data to explore short and long term outcomes for children and families who receive CD-CP services. In this context, individual and family status are documented and also perceptions of the utility of the CD-CP intervention. Special populations, such as children and women in domestic violence cases, can be of particular interest in these respects. Similarly, on the police side, perceptions of the intervention experience are also tracked to allow comparisons vis a vis intervention recipients.

In addition to behavioral and symptom outcomes in those exposed to violence, another set of individual level outcomes involves the knowledge and attitudes held by police officers who train in the CD-CP intervention. Both the CD-CP training and ongoing experiences in implementing the program should change and reinforce awareness of their potential roles in traumatic situations and in more routine aspects of their work with children and families in the community. It can also be hypothesized that acquisition of knowledge and increased competency in police work involving children and families would enhance job satisfaction and feelings of efficacy at work. Such changes can be tracked using attitude surveys in relation to CD-CP training and length and intensity of experience in applying the CD-CP model on the job.

Another area for evaluation involves the extent to which systems and services --both police and mental health services-- actually change through the implementation of CD-CP. A set of indicators (e.g., referral patterns), followed over the stages of initiation and development of the CD-CP program in a community, provides valuable information on the key elements of police and mental health service functioning, and on changes in functioning, with respect to violence exposed children.

In terms of community level outcomes, comparison of rates of youth involvement in violent activities and of rates of trauma related symptoms in communities with and without CD-CP programs is a useful population based approach. Such a design is considerably strengthened when comparisons can be made across a number of communities with similar initial crime rates, but with different degrees of CD-CP implementation, at subsequent points in time. Settings where delivery of CD-CP services involves greater coordination among officers, parents, schools, courts, child protective services, and clinical facilities would be expected to show the greatest diminution in relevant youth outcomes.

In New Haven, community level changes are being documented through examination of rates of juvenile violent crime and through collaborative efforts with the school system whereby the population of 6th, 8th and 10th grade students is surveyed biennially. The assessment, the Social and Health Assessment, is conducted as a classroom administered questionnaire that inquires about a range of student behaviors, background experiences, and perceptions of school and community climate. An important focus of this assessment has been student exposure and involvement in community violence. Over the period from 1992 (when the survey was first administered) to 1996, there have been substantial changes in the levels of violence exposure reported by New Haven's youth. For example, from 1992 to 1996 there was a 15% drop in the percentage of 6th and 8th graders who reported having seen someone shot or stabbed in the past year. Involvement in gang fights declined by 11% for 8th graders over that period, and reports of carrying a weapon in school declined by 9% for 8th and 10th graders. Dramatic increases in the perception that neighborhoods and schools are safe places is evidenced by a 20% increase in reports of feeling safe in one's neighborhood and a similar increase in 10th grade reports of feeling safe at school. Overall, findings from this survey, which taps the perceptions of 2500 New Haven teens, lends strong support to the conclusion that New Haven has become a safer place over the years of CD-CP development and expansion.

An evaluation of a specific CD-CP program, the Gateway Offenders Program, has also yielded preliminary results supporting the effectiveness of this promising approach. the Gateway Offenders Program is a collaborative venture operated by the CD-CP of the Yale Child Study Center and the New Haven Offices of Juvenile Probation and Alternative Sanctions. It is designed to reduce legal recidivism and improve social functioning among adolescents with a history of relatively modest criminal offenses (e.g., auto theft, truancy, etc.) Adolescents, generally ranging in age from 12 to 16 years, are mandated to attend the Gateway program as a component of juvenile probation. The program has community and milieu based components with

opportunities for community service, psychoeducational and psychotherapeutic group counseling, academic support, and structured recreational activities. These specific interventions are augmented through regular family contact and support and through liaison with educational and judicial systems. Preliminary evaluation of 23 youth who are at least six months beyond discharge from the program indicate significant decreases in the rates of felonies during the six months following discharge relative to the six months prior to their admission. A trend toward decreases in misdemeanors was also evident, suggestive of beneficial results.

In summary, the very nature and context of CD-DP service delivery poses unique challenges for the evaluation of its impact as an intervention addressing the psychological and behavioral consequences of children's exposure to community violence. Innovative models of evaluation are required; these must consider multiple levels of impact and utilize complementary types of data (e.g. survey methodologies, in- depth interviews, analysis of system changes, etc.) Through the convergence of findings from different types of longitudinal studies, the most convincing case can be stated regarding effectiveness of CD-CP interventions.

Child Development-Community Policing Program
Multi Site Conference

Sponsored by:
The United States Department of Justice,
Office of Juvenile Justice and Delinquency Prevention,
New Haven Department of Police Service, and
Yale University, Child Study Center

Baltimore, Maryland
Buffalo, New York
Charlotte, North Carolina
Framingham, Massachusetts

Guilford, Connecticut
Nashville, Tennessee
Newark, New Jersey
New Haven, Connecticut

Saturday, September 13, 1997-New Haven Hotel

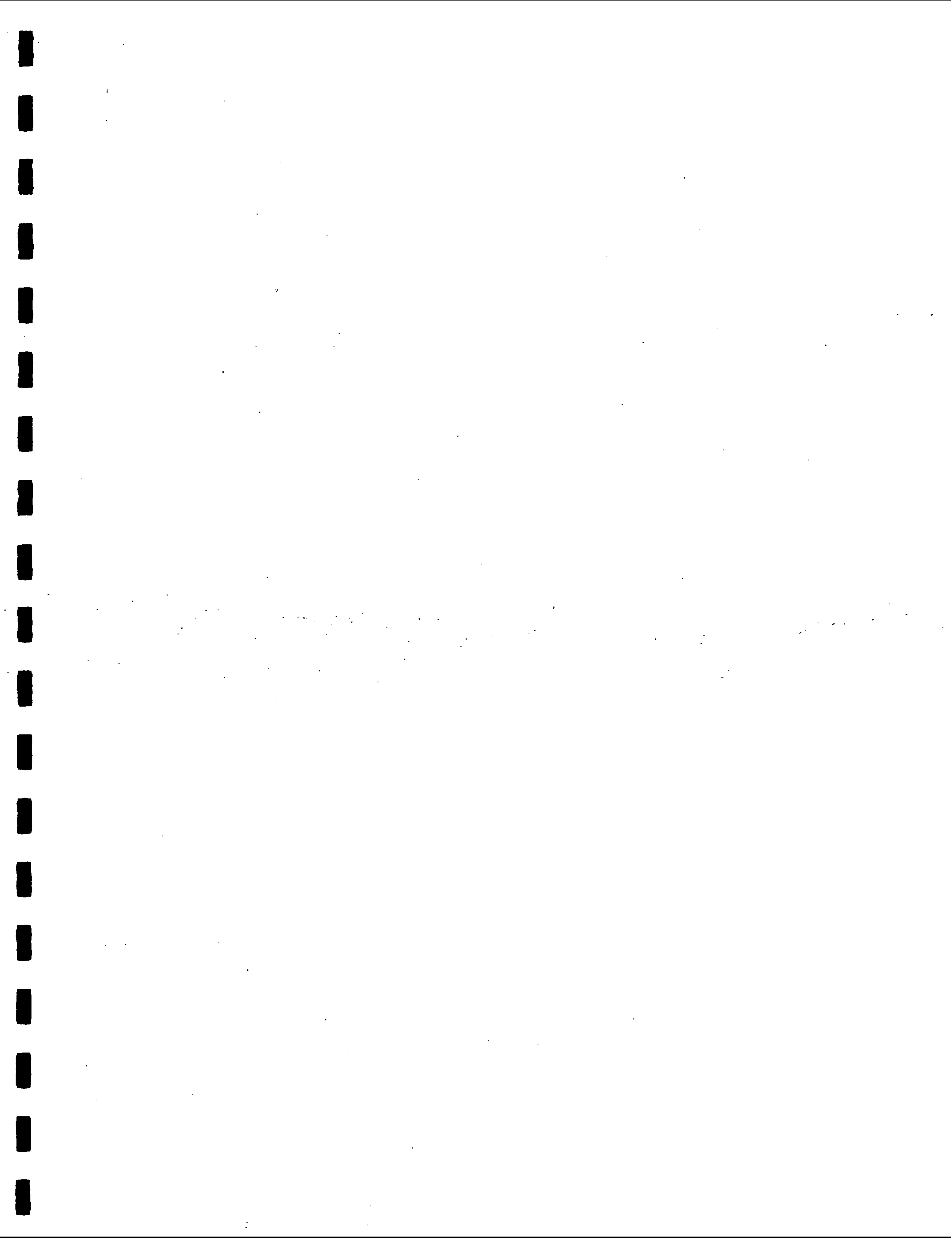
6:00-8:00 p.m.	Welcoming reception for conference attendees and New Haven CD-CP Program participants

Sunday, September 14, 1997-Slifka Center

9:00-9:30 a.m.	Breakfast
9:30-10:00 a.m.	Welcoming remarks
10:00-10:30 a.m.	Present Experience and Future Directions for CD-CP Programs, Steven Marans, Ph.D., Coordinator, Yale-New Haven CD-CP Program
10:30-10:45 a.m.	Break
10:45-12:45 p.m.	Round table discussion of Police/Child Mental Health Collaboration with representatives of each program site: Successes, Barriers, Current Developments, and Summary of Evaluation
12:45-2:00 p.m.	Lunch (Concurrent Evaluation Lunch Meeting)
2:00-4:15 p.m.	Working Groups-Day I (1) Administration: Funding, systems collaboration and public relations (2) Training: Curriculum development, resources and training materials (3) Police/Mental Health Response: On the scene collaboration and follow-up (4) Family Violence: Domestic violence and child abuse (5) Juvenile Justice: Prevention and intervention with victims and perpetrators (6) New Sites
4:15-4:30 p.m.	Break
4:30-5:30 p.m.	Site Consultants meet with representatives of individual replication sites
5:30-6:30 p.m.	Moderators of working groups to meet
6:00-?	Happy Hour-Hennessey's, College Street

Monday, September 15, 1997-Slifka Center

8:00-8:30 a.m.	Continental Breakfast
8:30-11:00 a.m.	Working Groups-Day II (1) Administration (2) Training (3) Police/Mental Health Response (4) Family Violence (5) Juvenile Justice (6) New Sites
11:00-11:30 a.m.	Break
11:30-12:30 p.m.	Reports and discussion of working group recommendations
12:30-1:30 p.m.	Luncheon-President's Room, Woolsey Hall
1:30-2:15	Keynote Address: Shay Bilchik, Administrator, Office of Juvenile Justice and Delinquency Prevention
2:15-3:30 p.m.	Reports and discussion of working group recommendations (continued)
3:30 p.m.	Conference wrap-up



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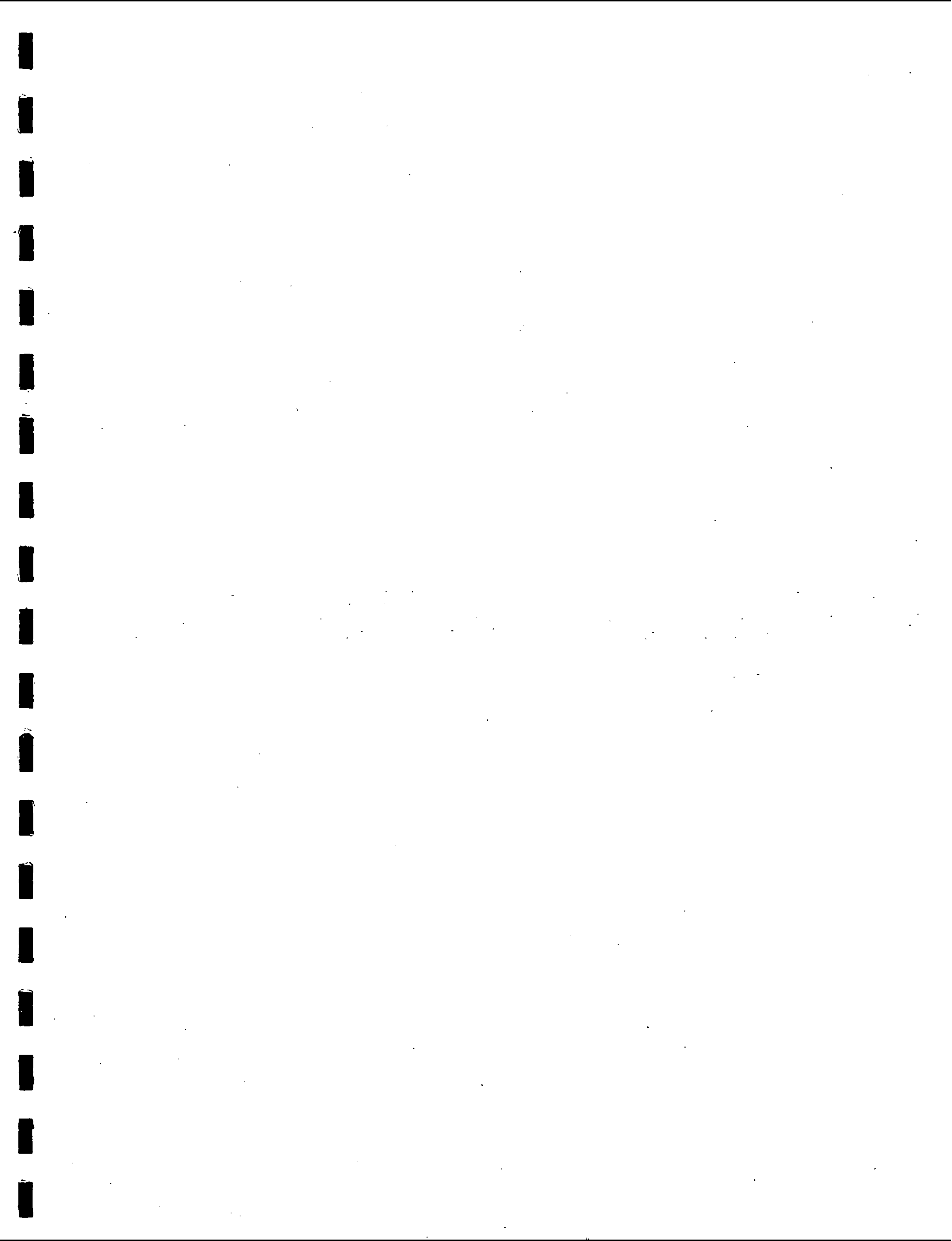


The following reports were presented by personnel from each CD-CP site represented at the CD-CP Multi-site Conference on September 14, 1997.

1. Nashville:
Assistant Police Chief Deborah Faulkner presented the following report.

Nashville is a large city encompassing 533 square miles and a population of 560,000. It is the capital of Tennessee and houses major institutions such as the Grand Ol' Opry and more than 20 colleges and universities. The police force includes 1300 sworn officers and 300 civilians. Community policing came to Nashville about two years ago under the leadership of Chief Emmett Turner. The police department began its collaboration with Children and Family Services about 1 1/2 years ago. They chose to locate the Nashville CD-CP program in the city's Enterprise Community so as to capitalize on other resources also targeting the area (COPS Ahead, COPS More, Byrne grant). This area covers 3 square miles and includes businesses, residences, the Music Hall of Fame and Vanderbilt University. 33% of the population is under 18 years old. Crime rates are high (e.g., 17 of the city's 91 homicides took place there last year). The area has therefore been targeted to receive the city's first wave of 27 community-based officers through COPS Ahead. In response to the change in police approach, the public housing units in this area have moved from reporting the fewest calls for police service to the most calls for service. Homicides in the area have also decreased from 17 last year to 7 so far this year.

The Nashville Police Department has a 20 year history of involvement in counseling services (e.g., victim services, domestic violence services) but these services have a history of leaving children out. That is why the CD-CP program was so appealing to them. Children and Family Services is now their best friend. The Nashville group is proud of their achievements. They now have a community alert center staffed by police and clinicians. This has just recently increased its hours from just days to day and evening police shifts. 105 officers have been trained -- the 27 community officers and others from patrol who come into the Enterprise area. Officers feel a sense of success when they are now able to follow-up and provide service to children who witness violent events.

The process has also been difficult at times. Space was an issue before the alert center opened. Time was an issue. Spending time engaged with children and families takes time away from other police activities. Trust of the officers was also an issue. Officers need buy in from the top and that is why she, as Assistant Chief, has remained involved and visible in the program. "Burn out" is also an issue, and workers in the program need support. The program also needs increased financial and community support. To address this need, she is always seeking other partners throughout the city, e.g., Rotary groups, United Way, wife of the Mayor, who was herself a victim of crime.

2. Framingham
Jack Hagenbuch of MetroWest Mental Health Center gave the following report.

Framingham is a small city in the Boston area with a population of about 75,000. The collaboration between the Framingham police and MetroWest Mental Health was the first CD-CP replication effort. The program has had much difficulty in the last few years. The mental health

agency has felt a lot of pressure from the advent of managed care and has experienced two recent transitions from non-profit to for-profit and back to non-profit. At the same time, two of the original clinicians trained in the project have left the agency, and Jack remains as the only CD-CP clinician. The program has $8300 annual funding. Currently, he responds to 2 or 3 high profile violent cases and about 50 domestic violence incidents. This immediate response results in better social service contact for battered women and their children and also assists the police. Jack also runs a group for batterers and finds that concern for their children is one area of leverage for therapeutic work with batterers. In his many conversations with police, he believes that officers see the same things that he sees. The collaboration helps both to tolerate the horrendous tragedy they are exposed to and to experience some gratification. Currently the Framingham program is primarily focussed on domestic violence, with close collaboration among police, probation and court advocates as well as clinical response.

3. Baltimore

Major Wendell France of the Baltimore Police and Raymond Crowell, Ph.D. of the East Baltimore Mental Health Partnership gave the following report.

The East Baltimore Mental Health Partnership provides integrate services for children and families, including mental health programs, collaborative services and intensive outreach services. The Partnership has full time clinicians in all of the public schools in its area. The Partnership covers an area of 20 square blocks in a section of Baltimore characterized by high poverty, high unemployment, public housing and many resources (e.g., Johns Hopkins Medical School, Empowerment Zone and a politically active community). Police have seen the same children that clinicians see, but haven't known where to turn. The police/mental health collaboration makes a lot of sense.

Early efforts of the Baltimore CD-CP program have included adjustments in the training curriculum, development of response protocols and ride alongs, which have been eye opening. Early barriers the group has faced have included suspicion on both sides, which has led to some frank and edgy dialogue. Issues of reputation have arisen, including conflicts between police and the community and Hopkins and the community. Managed care has also increased the demands on the clinical staff. Positive developments include interest and support for the project from the Mayor's office and involvement from the community. Community members have been included in their training seminars and have provided both critical input and requests for more training for community members.

Major France described his own police career as centered in the detective bureau, in homicide, sex offenses and child abuse. He initially wondered what he had done wrong when he was transferred to head patrol in the Eastern District. The police district covers 2.76 square miles and 60,000 population. It is an impoverished area with high drug use. It also includes Johns Hopkins University, which expects a safe haven. His initial experience of the CD-CP program was that it was taking five people he needed off the street and sending them to New Haven for a week, just one after he arrived in the Eastern District. At the time he was not impressed. Later it made sense.

Early barriers have included lack of funding, e.g., to pay for police overtime. Police in the district are willing to do the work, but their contract demands that they be paid. Cumbersome processes

within the mental health institution have also been a barrier. Police just get things done and worry about process later. Clinicians don't operate like that. Lack of understanding between police and clinicians has also been a barrier in the beginning. Getting to know what each other does takes time. The reputation of Johns Hopkins as a bully in the community has also had to be overcome. A big effort is now being made by Hopkins, including East Baltimore Mental Health Partnership. It is a good match for the community.

4. Charlotte
Sgt. Joey Neely gave the following report.

He is a sergeant in the street crimes unit of the David 2 district in Charlotte. The area is 5.5 square miles and is a small pilot for the Charlotte CD-CP program.

Early barriers to the development of the Charlotte program included delays in training. They are currently in the process of the first round of training. 46 officers and 15 clinicians are being trained. For the first year, the only personnel who had been trained were the eight who had come to New Haven (4 officers and 4 clinicians), and so the whole burden of the program fell on their shoulders. A second barrier the group faced was cultural. Charlotte has a large Laotian community, which has been closed to the police. The CD-CP program was called to respond to an accidental death of a Laotian boy, and as a result, the community's relations with the police have greatly improved. Now that the door is open, police have been more successful in investigating crime within the Laotian community. A third barrier is that officers have understandably questioned what is in it for them. two officers were recently killed in Charlotte, one on his way to take a subject to jail and one after asking a subject to leave the property. Officers are increasingly seeing the CD-CP program as a potential way of turning around kids' attitudes toward the police, and thereby increasing officers' safety. The organization of the mental health agencies involved in the project has also been a barrier. Coordination between the two mental health agencies has been complicated. Clinicians have also had full caseloads in addition to CD-CP, and have to do CD-CP follow-up on their own time. The program is in the process of looking for more funding for clinical time. The group has struggled with the question of how to involve the child protection service, whether to view child protection as a tool for the CD-CP programs work or an opponent. They need to have regular representation in the group. The program has challenged those involved to find a way make decisions collaboratively rather than to have one person in charge. The program needs the support of the top administrators of both agencies. That support has been there from the Police Department from the beginning. More support is needed from the mental health administration. More coordination is also needed to be able to track children after traumatic events. Current involvement with the schools has been limited.

Since January 1997, the Charlotte CD-CP program has seen 56 children. The mental health agency has opened a satellite clinic in the D2 district. The program is moving ahead and participants are excited about their ability to provide more for the children in the district.

5. Buffalo
Lt. David Mann of the Buffalo police and Vern Saeger of Crisis Services provided the following report.

Buffalo is the second largest city in New York. From the police side, the beginning CD-CP program has successes and has faced barriers. On the positive side, Crisis Services had previously been providing 24 hour crisis response services and most police officers were already familiar with the Crisis Services program and personnel. The biggest barriers were police union contracts that made it difficult to provide training to officers and officers reluctance to support anything that carries a community policing label. Training was shortened to a 5 hour block in order to make the training available to all officers in B and C districts, where the program is being piloted. The shorter version of the training also eliminates detail that will not interest officers and emphasizes what officers need to know, e.g., when an how to call the clinical service. The first case conference for police supervisors was held the proceeding Friday. Though many of the participants did not want to act interested in public, they approached the presenters afterwards, indicating their positive response.

Vern Saeger began by stating that his involvement in CD-CP is the best thing in his 20-year career.

So far, the program has provided CD-CP training to officers on all three shifts -- during their shifts. This has gained the clinicians respect of officers. The program has been involved in 26 cases. Clinicians have made 70 visits to 80 people. 3/4 of the clients were children. 3/5 were minority group members. 3/4 were witnesses to traumatic events. They do not consider their visits in the community to be psychotherapy, but opportunities t listen. It is essential to go out in the community. If you make clinic appointments, many of these clients won't come in.

An example of the program's work was a case in which three children, 12, 10 and 8 witnessed their father's murder by his psychotic son. The mother was not present, but was later located by police through flyers handed out in the neighborhood. A call from the mother led to a meeting between her and Vern. During the meeting she gave permission for him to call the children's school and make a link for the children with the program.

Some cases are particularly hard for the team to handle. For example, in a situation in which a 2 year old was killed by a car, the randomness of the event was worst for the team. Other especially difficult cases have involved homicide or suicide. These are situations that call on team members to provide a lot of support for each other.

6. Newark

Gerry Costa, Ph.D. provided the following report.

Newark has a population of 275,000. The police department has between 1200 and 1300 officers. The department has a history of commitment to community policing. The department receives about 700,000 calls for service annually. Money Magazine reports that Newark is the most violent city in the U.S., including about 100 homicides per year. The Newark police and University of Medicine and Dentistry of New Jersey ha their first contact with the CD-CP program in 1992. The group obtained a grant from the Prudential Foundation to develop their own collaborative program, and they came to New Haven to begin a process of consultation in January 1995. At the time, as he listened to officers and clinicians in the CD-CP program conference, he thought the officers sounded like clinicians and vice versa.

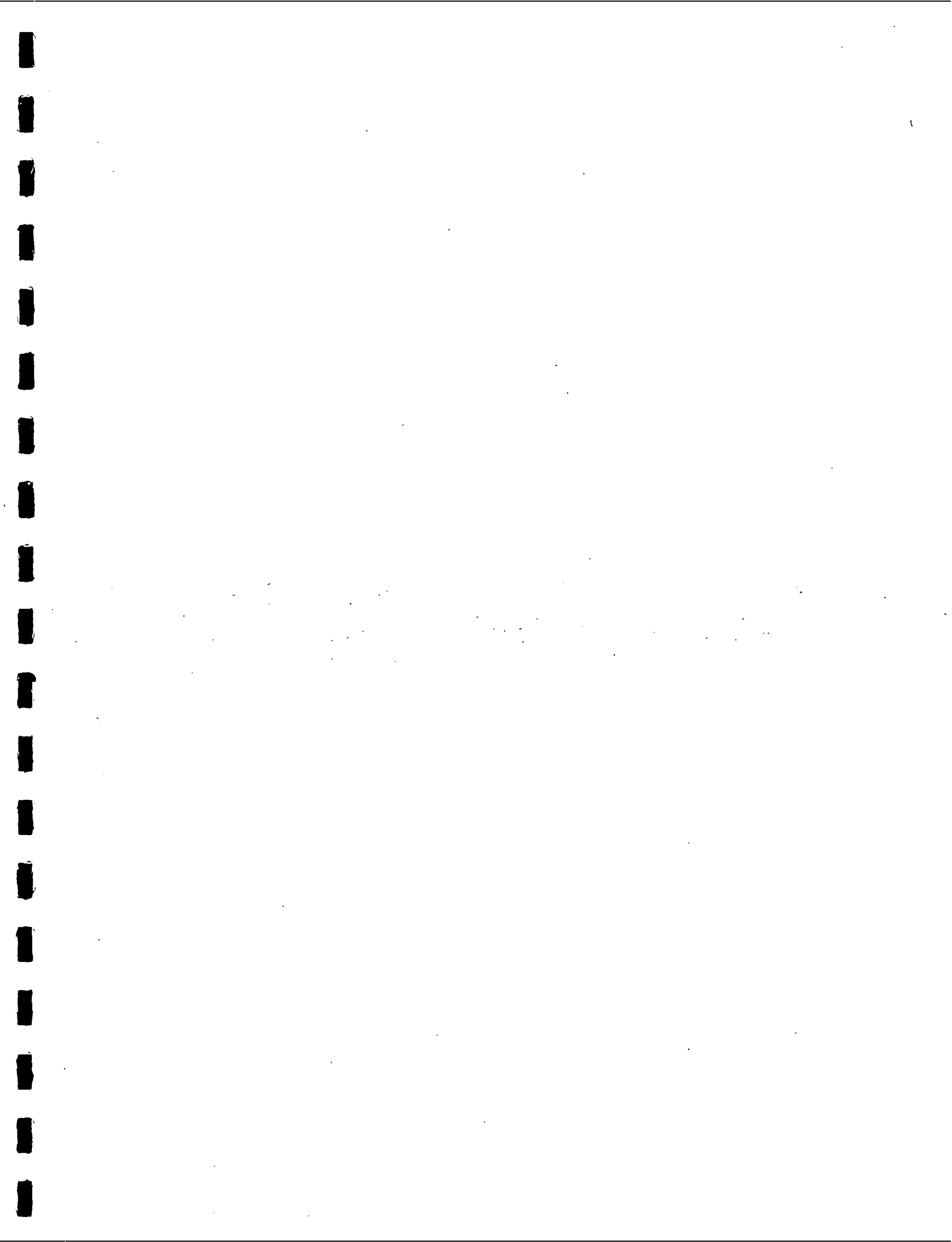
The CD-CP program philosophy immediately meshed with the clinical experience of the Newark group. For example in a clinical service for children under six, the children seen have remarkable histories of exposure to violence. Most have heard shots and/or seen shootings. Last year, 6 children under six were referred because their fathers were killed violently. In Newark, there has been similar suspicion between police and mental health clinicians. There is suspicion and distrust of the University within the midst of the poor community, and general distrust of mental health professionals. Within the Newark CD-CP program, a remarkable camaraderie has developed. Clinicians have come to recognize that police see many more traumatic situations than clinicians do and also see people at their very worst moments. Police have gotten beyond their stereotypes of clinicians as only interested in evaluating cops.

The Newark team came to New Haven for training in October 1995. During the training, both police and mental health professionals realized the impact of trauma on their own lives. They saw in the CD-CP program an opportunity to share their experiences. They developed a greater understanding of violence as a symptom of disordered relationships. Police know a lot about this, but don't often have an opportunity to talk about what they know.

Back in Newark, the team developed a 20 week fellowship training program, which provided training for both officers and clinicians. The team's efforts stalled there. The police department has experienced three changes in leadership in a year. Simultaneously, managed care has put a lot of pressure on the delivery of mental health services and the hospital has reorganized. No police representative from Newark is attending this conference and the program is currently inactive.

7. Guilford
Chief Kenneth Cruz provided the following report.

Guilford is a small town about 15 miles east of New Haven. It has a population of 22,000 and a police force of 35 officers. Chief Cruz was a 18 year veteran of the New Haven police before he became Chief in Guilford. He used to be disturbed as he walked away from children and later saw them involved in the juvenile justice system. He had followed the CD-CP program from a distance until recently, when he joined with the Director of Guilford Youth Services, Mike Regan, in a partnership to replicate the program in Guilford. They agreed that Guilford has similar problems to larger cities, though the numbers are smaller and the intensity is less. Cruz and Regan attended a training with a group of New Haven officers in July. Chief Cruz recently met with his police officers to inform them of his efforts to get a similar program going in Guilford, and the general response was "It's about time."



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Key Issues

1. Role of Media
2. Funding (who should fund; long term vs. short term)
3. Marketing
   a. Internal
   b. External
4. Role of political leadership, if any
5. Sustainability of the program
6. Separate responsibilities
   a. municipal unions
   b. FLSA compensation issues
7. Relationship to community based problem solving
8. Changes in Health Care Industry
   a. Managed Care and its uncertainties
9. Other partners and how they can help
10. Evaluation; problems and opportunity

training

The training group consisted of 8 individuals from 5 locations. Each of us drew on the experience in our own city as well as the replication training as a basis of discussion. The discussion was sometimes lively and sometimes heated, and covered the following issues:

1. Administrative issues- In setting up training for the police officers, each location had to deal with a different set of administrative problems. Every one was unique. The locations represented each had its own labor agreement or department rules to deal with. Some of the departments had strong unions while others had none.

2. Curriculum- Each of the sites has based its curriculum on the development model from New Haven. Just as in New Haven, constant adjustment are made. The use of site visits and the case conference by New Haven was explained and well received by the others.

3. Training materials- There was a lot of discussion about training materials used in the different sites. Such things as movies, TV news clips, and other materials have been used in the training. It was suggested and universally agreed upon that all the sites exchange information on what training materials they have been using and how those materials have been effective.

4. Selection- The question of who should be trained, both from the police and clinician side changes with each site, depending on how the program is developing. Some sites for officer training are training the entire department (Charlotte), while others just that area that is participating. Non-officer training varies depending on who is involved in the collaboration at each site. Baltimore has added community training, thereby bringing the community into the loop. There was discussion about issues of confidentiality around community involvement which were not resolved.

5. Goals- While it was agreed that am important goal of police officer training is to give the officer a greater understanding and awareness of children. The major goal of training for everyone involved in the collaboration, police, clinician, probation, and child protective worker is for each to gain an empathy and understanding of the others role, so that they may than work toghther more effectivly.

Police Mental Health Response Group 2

Moderators: Lt. Mike Sweeney and Sara Stutts, MSW

I Promoting Referrals

A. Academy training – The group generally agreed that academy training should routinely incorporate CD-CP training. The training should include an overview of child development and children's response to trauma, the nature and purpose of a 24-hour clinical service, and criteria for referral. This basic training should be tailored to the program characteristics specific to each program. Although this exposure is unlikely to have a substantial impact on knowledge and attitude, the program will benefit because it will be perceived as a standard institutionalized aspect of police services.

B. Recognizing referrals - Criteria should be clearly established and made available to officers. Currently, officers in most participating departments are likely to refer only highly violent cases with children present. In most sites, this is one of the circumstances under which referral is expected but there are a host of other situations in which the need for referral may be less obvious and thus should be stated explicitly. These criteria should be posted in communications, reviewed in academy and CD-CP training seminars/inservices, and distributed to officers on laminated business cards. The supervisors may also use written criteria as a guide when discussing indications for referral with patrol officers on the scene or in follow-up case review.

C. Mechanisms for promoting trust – Mutually held suspicions and mistrust between officers and clinicians is seen as an essential barrier to referral and mutual consultation. Conversely, the development of relationships and mutual trust are seen as facilitators. There are a number of ways to develop trust between officers and clinicians who traditionally have worked independently. Intensive week long seminars or extended seminars (15 week) can be used to develop relationships that enhance trust and facilitate referral and case conferencing. In addition, the program conference is an essential ongoing vehicle for developing these relationships. In the latter case, it can be particularly helpful for officers to present their cases at the program conference where they can receive support and recognition for their use of the program and where they can work directly with a range of clinical personnel. Finally, a number of sites emphasize that ride-alongs should occur routinely and on an ongoing basis. Ride-alongs tend to encourage the development of positive collaborative relationships and to increase mutual comfort in discussing approaches to working with families and children.

D. Referral Prompt – A cue system shortly after the incident would be useful. There were several notable possibilities for this:

- For departments with Mobile Data Terminals (MDT), the dispatcher could, in cases of violent crime, activate an on onscreen prompts which asks whether a child is on the scene (or alternatively whether a CD-CP referral is warranted).

- A checkbox could be added to the end of the police report requiring the officer to indicate whether he or she made a referral to CD-CP.

Either of these approaches would increase the rate of referrals. However, they raise the risk of producing a major increase in referrals that would otherwise be screened by supervising officers. It was noted that supervising officer should always be notified before the referral is made in order to ensure that the referral is appropriate and that it is not contraindicated by other factors such as the investigation or security considerations. Clinicians noted that they are interested in receiving more calls, but that they too made need to screen and/or triage in the event of a deluge. New Haven has some experience in doing this as New Haven clinicians have gotten multiple calls

within minutes of one another. In these cases, the referring officers are contacted and the cases are triaged or additional backup clinical personnel are brought in as needed.

E. Feedback – Feedback to the referring officer is considered essential for fostering referrals. Officers are more likely to make referrals if they learn that there was a positive outcome (i.e., successful delivery of clinical services and resolution of problem) related to the referral or that it in some way improved the effectiveness of their policing (e.g., reduced calls for service). It is recommended that there be a follow-up call to officers in every case, regardless of whether there is a need for further action on the part of the officer.

F. Involving the whole department – Although most sites are not yet prepared to extend CD-CP citywide, doing so is considered an advantage with regard to enhancing the profile of the program and overall officer awareness. For example, this would allow it to be incorporated into academy training and department wide protocol communications, neither of which is possible when implementation is limited to one or two target districts.

G. General orders – In New Haven and elsewhere, the question has repeatedly been raised about whether or not to incorporate CD-CP protocols into the general orders. The advantage is that general orders are enforceable and they would lend a certain legitimacy to collaborative mechansims. Unfortunately, it was the opinion of this group that general orders or other rule-based approaches to fostering referrals carry the risk of being an affront--something that will be resisted. All members of this group agreed that it is best to encourage referrals through other mechanisms such as those discussed above.

II. **Police Response –**

Across implementation sites, there is considerable variability with regard to the involvement of officers in clinical assessment and intervention. In New Haven, officers are always involved in the initial introductions to parents. Beyond this, officers may be asked to play a role in a clinical assessment or intervention with children, depending on the child's needs as assessed by the clinician. Thus, officers have responded to children's questions about what happened or what is going to happen, and at times the officer will spontaneously offer his or her own observations. On some occasions, officers have been invited to sit down with the clinician and child to discuss how the child feels about what happened. What did the child perceive? How does he/she feel about the police? In these situations, the clinician supports the child in talking with the police about for example, why they had to break down the door of the house, rummage through the rooms, or take a parent away. This can sometimes be helpful when children are confused or frightened by an event and the police's involvement in the event. How and whether the child can use the officer's input depends very much on the child and the individual circumstances. Officers also sometimes observe from a distance, remaining in the room in order to ensure the safety of the clinician. In the post-acute phase, officers may work alone or with a clinician in order to assess the family's adjustment and needs. Thus far, however, officers typically have not been involved for the clinical assessment of the child.

Charlotte routinely involves officers in the assessment phase. They have established standing clinician/officer teams who do the follow-up together. On occasion, a clinician may be paired with an officer at the time of the event. According to the current protocol, when a referral comes in, a clinician volunteers to take the case and a first and second shift officer is assigned. The assigned officers may or may include the referring officer (i.e., this is preferred but not always possible). The clinician and officer go the home to get consent from the parent and then make arrangements to see the child. The officer may or may not make comments or ask questions in the course of the assessment. If it is not contraindicated, the officer may participate in some of the treatment visits.

A case in Charlotte provides a useful illustration. Andrew, a 6-year-old, had been abandoned for several days by a drug abusing mother and physically abusing live-in boyfriend. The state child

protection agency removed the child and placed him in the care of his biological father. It was clear from the initial visit, that there was an immediate rapport between the officer and the child. The officer easily engaged the child, not necessarily in a therapeutic alliance, but with a rapport that served therapeutic ends. In this case, the child drew free drawings and included the officer and clinician in the drawings. Andrew explained the pictures. When the officer asked questions, Andrew elaborated further. It quickly became apparent that the officer was seen as an ally rather than an intruder or punitive authority. According to the clinician, this officer was exceptionally qualified to be involved in this way, demonstrating considerable skill and sensitivity. In addition, this officer was particularly interested and actively involved in the program. All the sessions occurred in the school. The officer participated in 6-8 sessions as it became apparent that the child would require ongoing therapy to address issues related to chronic abuse and neglect. Time was taken to transition the officer out of the therapeutic work, although he continued on occasion to check in with the child at home.

The team noted that there a number of points to be considered when deciding whether to involve officers in this way:

- Officers may better appreciate the value of the therapeutic intervention when they are present and can see directly its effect on the child. This appreciation will support future referrals.

- Officers may develop a broader repertoire of child interviewing skills by observing the approach to working with children modeled by the clinician.

- Children often have ambivalent feelings toward the officers who responded to the incident. This of course depends on the circumstances. However, officers may be perceived as aggressors, ransacking the house, disturbing the peace, and arresting a loved one, or they may become the target of rage displaced from a father or mother, quite apart from their actions. When an officer participates in the post-event assessment and responds with caring and understanding, or at the very least, a non-defensive tone in response to angry accusations, the child can less easily split officers and other adults into camps of "good" and "bad." A child will have difficulty relegating the officer and others like that officer to the realm of those who hurt or punish unfairly and meanly. Simply, stated children may benefit from having present the authority toward whom they have mixed feelings. They can develop a relationship that does not so easily allow the externalization and/or displacement of rage onto the police authority. This is seen as being adaptive in the short term and over the long term.

- How and whether sites opt for a team based follow-up and whether this will serve as the only clinical child assessment (in lieu of one-to-one) will depend on the circumstances of the event, the child's initial response, and the theoretical frame applied to this work.

- It is possible that the presence of an officer may have a disruptive effect on the therapeutic assessment. Areas of conflict or other worries can arise that have little or nothing to do with police authority. In these instances, the police officer may serve as a distraction, may diffuse the intimacy of the clinician/child relationship, and may lead to heightened fears of internal (conscience) and external (parental/police authority) punishment.

- The possibility of counter-therapeutic officer involvement is heightened when the officer is anxious, defensive, or awkward. Consequently, it is important whenever possible that the selected officer be someone who is known to the clinician and/or police fellow.

III. Safety of Clinicians

Clinicians are at risk. In a variety of ways, clinicians may be in jeopardy in the course of their work as part of this collaboration. The risk may occur in the context of an acute response, follow-up home visit, or ride-along. Although many clinicians are inclined to be cautious, even clinicians

who are cautious have found themselves in frightening and potentially dangerous situations. For example, a clinician from Charlotte was on a ride-along with an inexperienced officer. This officer responded to a scene with an angry and somewhat intoxicated crowd. When one member of the crowd became provocative, made threats and ran, the officer proceeded to chase him down, leaving the clinician alone and unprotected in the midst of this crowd. Back-up was called but took some time to arrive.

In another incident in which a clinician went to a housing project as part of a follow-up call, the clinician called ahead to meet an officer escort. The exact meeting location was vaguely specified so the clinician and officer missed one another. The clinician, who was unfamiliar with the layout of the project, proceeded down a dead end street in search of the officer when his car was surrounded by a band of threatening youths and young adults. Although the youths let the clinician pass when he said he was with the police, several of the youths began making angry threats and one suggested that they were being conned. The clinician managed to drive away without harm and later returned with the police escort without further incident.

Both of the above events could have had much more serious consequences, and in both cases, the danger could largely have been avoided. Interestingly, it is the clinicians who are more likely to fail to assess or incorrectly assess the dangers related to a particular location or incident. They may overestimate their degree of safety by virtue of their association with the police, forgetting their basic vulnerability due to a lack of experience, legitimate authority, knowledge, and basic essential safety equipment (i.e., vest, weapon, and radio). The group acknowledged that some slight risk is inevitably associated with this work, but that steps to minimize the risk should be taken within each program. It was recommended that each program implement its own safety policy and protocol. Several specific suggestions were offered as follows:

Ride-Alongs

- Clinicians should only ride with seasoned officers. The decision about who to ride with should go through a supervising officer. In most cases, riding with a supervisor is preferred because the supervisor will have the experience and judgment necessary to minimize clinician risk and because the supervisor is likely to be able to expose clinician to a wide range of incidents. Patrol officers are more likely to get stuck managing the details of a particular scene.

- Clinicians should always defer to the supervising officer regarding what to do upon arrival at the scene. When time permits, the officer and clinician should have a "safety briefing" in which the protocol for ensuring safety at the destination is discussed in advance. Safety considerations should be as explicit as possible. Officers should not make the mistake of assuming that the clinician will know how to stay out of harms way and out of the officers way. Clinicians should remain in the car unless directed to do otherwise. On walking beats, the clinician should remain on the street unless invited to enter the premises. Clinicians need to remain attentive to signals from the officer about what to do.

Acute Response

- Calls need to be considered on a case by case basis. Before responding to the scene, *the clinician should routinely ask* the referring officer about the level of safety in the neighborhood. In many cases, it may be necessary for the supervisor to make this assessment. If safety is an issue, arrangements should be made to meet with an officer at a safe location. The clinician can then either join the officer or drive to the scene with the officer as escort. In exceptionally dangerous situations, the officer and clinician may elect to do the acute clinical response at the substation or police headquarters.

- An officer should remain on the scene or at the acute response location until the clinician completes the clinical work. If the supervisor is not going to remain on the scene, he or she should ensure that the officer is aware of the need to do so.

- Clinicians are less likely to inquire about safety or request an escort if the officer leads the clinician to believe that the clinician is overly fearful or that it is a hassle to make the arrangements. Safety protocols need to be taken seriously by all involved.

- Bullet-proof vests are not currently in use by clinicians at any of the implementation sites. In many cases, extra vests are not available so it is not a realistic policy. Generally speaking, vests are not recommended standard protocol at this time provided the safety precautions noted above are in place. In departments where vests are available for clinicians, the decision to wear one should be left to the discretion of the clinician.

Follow-up Assessment

- Experience in New Haven suggests that clinicians are less inclined to be cautious about follow-up visits. However, safety considerations are equally important in the follow-up contact. Many of the visits are conducted in homes characterized by a high level of domestic violence, drug involvement, or neighborhood violence and, as such, the risks are likely to be greater than those that characterize traditional social casework. In every case of follow-up contact, the clinician should ensure that he or she is familiar with the overall safety of the neighborhood and risks or safety considerations related to event that necessitated police involvement. Typically, district supervisors or senior officers are a reliable source of this information. Supervising officers are also more likely to be aware of factors related to the ongoing investigation, which may or may not be compromised by clinical work at the scene.

- In general, the same procedures noted in the **Acute Response** section apply here. An officer should accompany clinicians when the home or neighborhood are unsafe. If the home is unsafe, the officer should be present in the home during the visit or arrangements should be made to follow-up with the family elsewhere. If the neighborhood is unsafe, the officer may remain outside of the home but in the immediate vicinity.

IV. On-call protocols

Each site has developed its own written or unwritten protocols for managing the on-call service. The group agreed that it would be beneficial to have core or comprehensive protocol that could be used as a reference for new and existing implementation sites. This protocol would summarize the range of options used across sites for various aspects of running the service. Alternatively, it could identify practice standards. The development of such a protocol was beyond the scope of this workgroup. However, a number of points were made about what areas such a protocol should cover as well as specific ideas for protocol content. The categories and contents are outlined below:

Program Referral

- Supervising officers should review referrals before they are made as they have the perspective and experience necessary to determine fit with the program and implications for investigation and security. Supervising officers are responsible for the overall management of the scene and may, e.g., consult with investigations before making the referral.

- The police should ensure that level of safety and security of those on the scene is addressed before allowing clinicians to enter the scene. If the scene is not yet secure, the clinicians can be paged and asked to report to a local substation. They will then proceed to the scene when they get a briefing and security Ok from the supervising officer.

- Practically speaking, the officers will need to locate a caregiver or guardian if none is available, and/or contact the local child protection agency.

- The officer should given the identified caregiver/guardian an overview of the program and obtain verbal consent for a clinician to speak to them and/or their children. This consent must be given in order for a clinician to make direct contact with a child and/or family. Consent is not required if the clinician will solely be acting as a consultant to the police. This would be the case if, for example, the clinician is asked to interview a family member as part of the investigation or in order to guide police management of the case.

Acute Clinical Response

- The clinician should be briefed prior to beginning the work. This can typically occur at one or more points in the process including 1) on the phone before arriving at the scene, 2) when the clinician is being escorted to the scene, and 3) on the clinicians arrival at the scene. At some point, the clinician should determine whether language will be a barrier and how to accommodate this.

- Upon arrival, the clinician might benefit from a brief overview or "walk through" with regard to the event sequence and where various individuals were on the scene as the event unfolded.

- Either immediately upon arrival, or after the walk through, the clinician should be introduced by the supervising officer (or his or her designee) to the caregiver/guardian when such is available.

- During the introduction, the clinician may wish to review the nature of the CD-CP program so that the caregiver understands the service that is being provided. When more than one clinician is available, it is oftentimes helpful for one clinician to take more time with the parent while the other begins work with the child or children.

- Among the first things that the clinician needs to decide is who should be seen, when they should be seen, where they should be seen, and how the case will be divided among the clinicians. In some cases, the children and the caregivers can be interviewed together. In other cases, children may be seen together but separately from the caregivers.

- A standard assessment form is used by some program clinicians to ensure that a range of items are covered in the assessment. The assessment should be conducted in a way that is as comfortable as possible for the child.

- After the children have been assessed, the clinician should talk with the parents and consider whether there is a need for follow-up. Arrangements may be made at that time.

Follow-up Response

- The follow-up should be done by the responding clinician whenever possible. It may be necessary to bring on additional clinicians if more than one child is especially symptomatic and needs to be seen individually. If the work is likely to be sustained, the program avoids having a single clinician work individually with more than one family member (except perhaps to provide parent guidance).

- The site of service is an important consideration. Some families will not be receptive to follow-up regardless of the location of the appointment. Other families are likely to participate in a home-based follow-up, but would not make a special trip (or trips) to the outpatient clinic. If the initial evaluation work suggests that ongoing psychotherapeutic work

is necessary, it is usually necessary to arrange for this to happen in a clinic or school where there is sufficient space, privacy, and play materials.

- Officers should follow up with the child within a few days of the event when indicated. This follow up can be done at the home, sub-station, or school. This follow up should be done with the clinician. The clinician runs the show, with the officer in the background in order to lend support and be a presence.

- Canvassing can be used to raise awareness of children's needs and the program's services in cases with a *high community impact*—cases where it is obvious that many children and families are likely to be affected by an incident. This would include violent or disastrous events in which many children were on scene, or in which children were not present but are likely to be affected. Incidents would include fires, shootings, gang fights, and community disasters, to name a few. This section of the protocol would outline the mechanisms by which the community can be mobilized to attend to the needs of and developmental risks to its children. Techniques might include leafleting, community meetings, or personal contact with community leaders such as community members on boards of finance, elected officials and unofficial leaders of the community.

  Examples:

  1. A family's house burned down. The four children (ages 2, 6, 9, & 13) and mother were home. All were safe after a narrow escape. The clinician entered the home of a relative where the family went after the fire. The clinician introduced himself to the extended family, but asked to meet with the family alone. Since no child was known in advance to be more traumatized than the others, the clinician met with all members of the family with the children seated around the kitchen table, and the parents sitting just behind. The clinician asked the children what happened ("I understand that your house caught fire. Tell me what happened.") He encouraged the 2 and a ½ year old to go first because this child was most likely to be influenced by the experience of the others.. He told a brief but articulate story about what happened, surprising even his parents. The others then naturally followed suit, each highlighting a different aspect of how the event felt to them. When asked "what was the worst part about it?" they each volunteered a unique take on what was most upsetting to them. From the start, they were invited to draw and paper and crayons were available on the table. As they talked, they drew and later talked about their drawings. A single follow-up visit was scheduled in which it was determined that none of the children were symptomatic. The case was then closed.

  2. A family living on a second floor apartment awakened suddenly to the sound of gunfire coming from the 3rd floor apartment. Upstairs, a man well known to the family was shot in the chest 6 times. His wife sobbed hysterically as the paramedics transported him downstairs and to the hospital. The shooter escaped. The children on the second floor were quite distressed. In addition to the parents, there were 21, 16, 9, and 7-year-old boys and a 13 year old girl. Upon arriving at the scene, the officers briefed the clinicians, who then proceeded into the house where they introduced themselves to family. The officer and parents made clear that the 16-year-old was close friends with the man upstairs, that he saw his friend on the floor, and that he was visibly shaken. The other children were distressed, but they had not seen the body and were reasonably composed. After talking with the parents, one clinician immediately met alone with the 16 year old boy in a room adjacent to the kitchen. The other clinician met with the younger children together on a bed in the master bedroom. Although meeting on a bed in the bedroom is not ideal, most adults entered through this room and were gathered in an open access, adjacent living area. The clinician said "I understand that something terrible happened" in response to which the children recounted the event and drew a variety of pictures. All of the children talked easily about the event and it was unclear to what extent it would affect them. The clinicians met briefly with the parents and arranged for a follow-up

visit. The oldest boy was seen in the outpatient clinic office because the consulting room was felt to be the most appropriate place to explore the complicated and unsettling feelings that the event brought about. For practical purposes, the other children were seen in the home. The two who were markedly symptomatic were each seen alone for about ½ hour by one of the original responding clinicians and an additional clinician who was brought into the case for the follow-up. After several additional meetings, the case was closed as the symptoms of all children had resolved.

CD-CP Multi Site Conference
September 13-15, 1997

Juvenile Justice Working Group Report

Attendance: Richard Aldridge (Co-chair), Cisco Ortiz, Mike Zuccarelli, Bonnie Frazer, Gordon Howey, Alan Bozman, Phillip Harrison, Maria Knight, Karen Eaddy, Direk Rogers and Larry Vitulano (Co-chair)

It was an exciting and stimulating working group that felt there wasn't enough time to do much more more than to begin to address the major issues which were identified during out two sessions. The following six issues were discussed and presented to the plenary session:

1) The value of police authority as a therapeutic intervention:
-Treatment is seen too often as punishment by kids
-Kids need and want limits from all caring adults
-Goals of authority: Be consistent, caring and tough
-Caring means hanging in there with tough kids for a long time
-Teach kids to be responsible for themselves: A leads to B - consequences
-We don't have all the right treatments for all kids
-Mandatory attendance in treatment is where you start!

2) Police/mental health partners must work effectively with many other institutions by forming both formal and informal relationships with each other. For example, schools, social services, child community agencies, probation, churches, etc.

3) How we understand juvenile delinquency and the cycle of violence:

First, it's a long term cycle: victims become perpetrators.
We must differentiate hard-core from workable kids. Workable kids have clearer values, are more engageable and more respectful.
We must work with families and neighborhood resources
Poverty and isolated neighborhoods must be addressed
Have realistic expectations
Learn everything you can about gangs and substance abuse
Earlier intervention is better
Kids need **Someone Special**- Be straight with kids

4) Issues in dealing with psychiatrically disturbed perpetrators:
Arrest for the crime first, then get psychiatric treatment with more leverage for support.
Follow-up is more difficult but also more important
Be sensitive to kids not wanting psychiatric label: "Crazy"
Institutional racism often causes unfair treatment of minority kids who are not encouraged to get psychiatric treatment

5) Confidentiality: Laws
Relationships
Rights

We just began to address the issues of confidentiality in our partnerships. It is sometimes unclear as to the roles of the different partners within systems.

6) Juveniles should be treated differently than adults; some are very different!

CHILD DEVELOPMENT-COMMUNITY POLICING PROGRAM
MULTI-SITE MEETING

September 13-15, 1997
New Haven, Connecticut

Working Group for New Sites: Summary of discussions

The working group for new sites was attended by representatives from Chelsea, MA, Louisville, KY, Philadelphia, PA and St. Louis, MO. The group was facilitated by Lt. Richard Randall of the New Haven Department of Police Service and Miriam Berkman, J.D., M.S.W. of the Yale Child Study Center. Discussions centered on general principles and recommendations regarding the process of starting a police/mental health collaboration in the CD-CP model and specific questions and issues currently facing the working group participants. The following is a summary of the status of program development efforts in the four new sites and some general recommendations regarding the replication process.

Chelsea:

The town of Chelsea has a population of approximately 30,000 and a police force consisting of 50 officers and 25 supervisors of various ranks. The Chief of Police is Edward Flynn. Chelsea is a separately governed municipality contiguous with the City of Boston and utilizing many of the same city services. Massachusetts General Hospital maintains a satellite community health clinic in Chelsea, which includes a mental health department. MGH and the Chelsea Police Department have been involved in discussions for at least several months regarding the development of a CD-CP Program. Other collaborative efforts between the hospital, MGH and other community agencies have been ongoing for more than a year. Both police and mental health agencies appear to be committed to developing better and more coordinated services for children and families. Collaborative efforts are partially driven by a state requirement that MGH, as a non-profit hospital, contribute a certain level of voluntary service to its community, and the hospital's identification of youth violence as one of its target concerns.

Two rank and file Chelsea police officers attended the CD-CP conference -- Roger Digaetano and Rosalba Melendez. Both are involved in the department's domestic violence unit in addition to serving as general community-based officers. They described their department as thoroughly committed to a community policing philosophy and already engaged in substantial activities with children. For example, the department produced a series of "baseball cards" featuring 48 community-based officers and offered prizes to children who collected all 48. This required children to approach officers in their neighborhoods to ask for their cards and facilitated relationship building. Officer Digaetano also described several cases in which he was involved, as part of his patrol activity, in regular informal monitoring of adolescents on the edge of juvenile delinquency. Captain Donald Robitai has been the police department's liaison to the collaborative planning committee with MGH. He was described as Chelsea's "grandfather of community policing." Captain Robitai had previously stated that he wanted to

attend the conference himself, but was unable to do so due to previous commitments. In contemplating a partnership with child mental health clinicians, officers were particularly concerned about improving their response to domestic violence and about finding some ways to intervene with children and young adolescents beginning to be involved in criminal activity.

Sue Thompkins, a clinical child psychologist, attended the conference on behalf of MGH. She described the mental health unit at her clinic as consisting of three psychologists, four psychologists and 20 social workers. Most of the staff has limited experience with children, however, Dr. Thompkins and a few others do have extensive training and experience. Dr. Thompkins would be designated the clinical coordinator of the project and appeared excited to move forward. She is particularly interested in having earlier access to the children who are affected by chronic exposure to violence but rarely present to mental health services until they are seriously symptomatic and/or involved in delinquent activities.

Both police and mental health representatives from Chelsea were anxious to move ahead with the development of a CD-CP Program, and it appeared both from the discussion at the conference and from previous telephone contacts with agency administrators (Margaret Oakes in MGH Community Development Office and Capt. Robitai in police department) that senior administrators are on board. Initial program activities and consultation with New Haven CD-CP staff would be funded by MGH community benefit funds. The next step in developing this project is for New Haven CD-CP staff to propose a schedule and fee for training, consultation and technical assistance. This should be done soon, since Chelsea staff are ready to go, want assistance from us and have been waiting for us to have time to work with them.

Louisville:

The developing police/mental health partnership in Louisville involves the police and Bingham Child Guidance Clinic, which is affiliated with the University of Louisville. Two representatives of Bingham Child Guidance and one from the police department attended the CD-CP conference. Child Guidance representatives included Anne Arnsberg, a senior clinic administrator and David Causey, M.D., an experienced child psychiatrist whose primary duties include inpatient and outpatient treatment, a group treatment program for fire setters and trainee supervision. Officer Constance Jones is a special assistant to the Assistant Chief of Police. Of the Louisville representatives, only Dr. Causey attended this working group. Anne Arnsberg attended the administrative group and Officer Jones attended the police/mental health response group.

Dr. Causey described his interest in the project as stemming from his clinical experience with younger and younger children who have been exposed to violence and deprivation and who are involved in violent activities themselves. (E.g., he reported that more than 30% of admissions to his inpatient unit are precipitated in part by fire setting, and that admissions have been for younger and younger children). Dr. Causey reported substantial support within his institution for the collaboration with the police. As a senior clinician, he was interested in discussing issues of clinical staffing and the potential use of clinical trainees to provide less costly direct service. Facilitators from New Haven emphasized the importance of developing continuous

relationships between police officers and the clinicians with whom they will work, particularly at the beginning of the project, as well as the importance of staffing the project with clinicians of sufficient experience to feel comfortable taking their knowledge out into the street and applying it to new and complex situations.

Dr. Causey had not been significantly involved in previous contacts with the police department and did not know much about the organization of the police department or its commitment, at higher levels, to the collaboration with his clinic. He reported that the police had an existing relationship with a group of chaplains, whom were called to intervene in domestic violence cases. These individuals are community volunteers and have no particular clinical or child-related training. We discussed the importance of securing a commitment to support the project from the Chief of Police and his senior staff, as well as the designation of individuals to implement the project. Based on previous contacts between CD-CP staff and individuals from Louisville, it appears that the mental health group is significantly more committed to and further along in planning their end of the program. The group from Louisville was aware that they needed to discuss this imbalance and work first on securing the commitment of their police leadership before any further planning could be effective.

Philadelphia:

Two representatives from Philadelphia attended the CD-CP conference: Mimi Rose, an assistant district attorney who prosecutes family violence, child abuse and sexual assault cases and who is also is in training, on an academic track, at the Philadelphia Association for Psychoanalysis. and Rachel Manson, a senior social worker from the Philadelphia Child Guidance Clinic. Both women are representatives of a collaborative group that is planning a small pilot project located in a single housing project. The impetus form the project came from Mimi Rose and others at the Association for Psychoanalysis. Given Philadelphia's large population (>1,000,000) and their evaluation of the city police department as too big (>6,000), too bureaucratic and too difficult to work with, they decided to begin with a single housing project and a partnership with the housing police, who are independent of the city police. The target project has a population of 600 and some resident services located in a community center. The organizing committee obtained a $15,000 grant to conduct a feasibility study, and as part of that study, interviewed residents of the project, members of the housing police, and social service personnel who work there. Philadelphia Child Guidance Clinic agreed to be the clinical partner and is already providing some community-based family support services in the designated project. The local Housing Authority (including housing police?) is headed by John White, who is currently running for Mayor, and has been very supportive of the project. Because no representative of the housing police attended the conference, it was impossible to get a more detailed sense of their administration's commitment to the project, the interest or openness of the individual officers assigned to the target housing complex or the issues that might arise as a result of overlapping jurisdiction with the city police. Presumably, these issues have been explored in the feasibility study.

The Philadelphia representatives were anxious to proceed with their project and seemed excited about moving ahead. They believe they are ready to bring a team to New Haven for training

and would like to do so as soon as possible. The next step is for us to talk with Mimi Rose more specifically about the results of the feasibility study and for someone in New Haven to have some direct contact with a representative of their housing police. Assuming they are in fact ready, the New Haven CD-CP Program needs to propose a schedule and a fee for training. The very small target area of this pilot and the careful planning that seem to have been in progress should make it an interesting project.

St. Louis:

Dean David Cronin of the Washington University School of Social Work attended the CD-CP conference from St. Louis. There was no representative from the police department. Dr. Cronin described his efforts to develop a police/social work partnership program in St. Louis, including several grant applications that are pending. The motivation behind the program appears to be coming from a mayor who is interested in building community partnerships and supports this project and from leadership in Washington University, which is trying to provide more service to its community and build more positive relationships with community residents and institutions. Dr. Cronin has taken the lead in developing a project proposal and has worked with personnel in the police department's planning department. There appears to be little ongoing involvement from the police in designing or developing the project, and it is significant that no police representative could be identified to attend the conference. It was Dr. Cronin's feeling that the police leadership would be very interested in the project if it is funded, but that until he could deliver at least start-up funding, the police department would not be motivated to invest in the planning process.

The planned project would place social work interns in a district police substation to provide crisis intervention and social service linkage to community residents who request police service. The project is based on the idea that many calls for police service concern social service needs that might be better addressed by social workers, thereby freeing up police officers to do other things and improving connections between community members and social service institutions. The project seeks to team up police officers and social workers to apply an interdisciplinary problem-solving approach to cases that are presented to the police. The goals are to provide better services to individual community members and to improve the local service delivery systems.

This project is related to the CD-CP model in that it brings together police and mental health professionals to address the needs of community residents, particularly children. The project is not specifically targeted to addressing issues associated with exposure to violence. It is organized very differently than the CD-CP model, with a much less central focus on the development of ongoing relationships between officers and clinicians and between a police department and collaborating mental health institution. The next step for the St. Louis project is to hear the results of their grant applications. If the project is funded and if its leadership wants any consultation from CD-CP, Dr. Cronin will contact us.

General Considerations:

All of the new sites raised questions concerning the process of developing an inter-agency collaboration between police and mental health agencies, with lots of specific questions related to the organization of our consultation service (e.g., criteria for referral, handling of confidentiality, selection of personnel, integration of this service with existing clinical services, mechanics of beeper rotation, etc.). Everyone (except St. Louis) also raised questions about the level of consultation and training that could or would be provided by the New Haven staff. As it becomes clearer that each replication site is developing a very different program, determined by the needs and resources of the participating agencies, we need to rethink the nature and intensity of our training and consultation to individual sites. The New Haven CD-CP Program needs to determine what resources we have to act as paid consultants to other individual developing sites and how to allocate those resources, and to consider what alternative training and consultation models could be developed. For example, we might develop a training program that could be attended by representatives of more than one site at a time. This strategy would spread our resources, but would lose the more process- or relationship-oriented approach to training that seems to have been somewhat successful with the existing sites.