PROVIDENCE POLICE DEPARTMENT

Behavioral Health Response Team (BHRT)

FINAL PROJECT REPORT

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The Providence Police Department's "Behavioral Health Response Team (BHRT):" Final Project Report

Executive Summary

Background

Like most other communities across the United States, the Providence Police Department (PPD) has experienced significant challenges associated with effectively responding to calls for service and other incidents involving individuals with significant behavioral health problems. As early as 2004, PPD began a pilot program that partnered behavioral health specialists with patrol officers to more effectively meet the needs of individuals in crisis, experiencing trauma, or otherwise facing significant challenges associated with substance use or mental health problems. The "Go Team," as the effort has been known locally, has been informed by early pioneering work done as part of Yale University's "Child Development-Community Policing Program" (U.S. Senate Committee on the Judiciary, 2010). The Go Team has served as a strategic partnership between the PPD and two key behavioral health agencies, The Providence Center and Family Services of Rhode Island, for much of the past 15 years. These partnerships ensure at least one civilian behavioral health specialist is on patrol with a uniformed police officer on nearly all shifts to provide clinical support across the City of Providence related to incident-driven police encounters.

Using these partnerships as a framework, the PPD and The Providence Center (TPC) proposed the Behavioral Health Response Team (BHRT) in 2017 as an extension of the existing co-responder model. The intent of the BHRT was to supplement existing programing by proactively identifying individuals with demonstrated histories of contact with local first responder systems due to unmet behavioral health problems, and to provide case management

support intended to connect people with services. The project team proposed a framework for identifying "high rate utilizers" of both police and emergency management services resources. High rate utilizers, or HRTs, represent individuals with extensive contacts with police for public order type offenses such as public intoxication, loitering, trespassing and similar call types.

The findings from this report are timely and important as many across the public safety landscape question the role of police in community-based collaborations focused on innovative solutions to behavioral health and substance use problems. The nexus between these problems, and, at times, both crime and disorder make the timing of these findings important.

Early Challenges to Program Model

The BHRT project almost immediately had implementation barriers that were, to a large part, unexpected or not fully understood. The longstanding collaboration between the Providence Police Department and behavioral health agencies such as The Providence Center was well known across the local community. As the implementation team moved forward with early operational plans in 2018, it became readily apparent that the enhanced program model and partnerships proposed were substantively different and could impact the larger program in unexpected ways.

Prior to the implementation of the BHRT initiative, behavioral health specialists from The Providence Center co-responded with the patrol officers to 911 calls for service. From a co-responding perspective, 911 calls are generally considered "exigent circumstances" which provide wide latitude for information sharing between police and behavioral health specialists. Traditional barriers related to privacy, consent, and information sharing that often discourage collaboration between police and clinicians generally take a back seat in these circumstances.

The BHRT initiative was different in that it adopted more of a "case management" approach where most of the program-client encounters were proactive and not pursuant to emergency calls for service. The implications of this difference was not fully anticipated in the early stages of the project and it nearly stopped the program in its tracks early on. Ultimately, representatives of the Providence Police Department and The Project Center were able to develop standard operating procedures that found an effective balance between public safety and privacy in ways that were focused on getting at-risk individuals access to help.

Impacts and Results

The BHRT used a variety of strategies to identify program clients. Police personnel with support from the local research partner developed strategies to monitor police contact data, particularly contacts involving low level disorder calls. Police personnel also collaborated with the city fire/EMS department to identify individuals characterized as high-rate utilizers of their response systems. These two data sources provided the starting point to identify clients. These lists would then be "round-tabled" with staff from TPC. In many cases, the short list of potential clients was already well known to behavioral health specialists. These combined data were then be used to identify individuals that would be approached by the BHRT for proactive support and engagement.

The BHRT documented proactive outreach to 30 individuals identified as being in need for comprehensive behavioral health support. For these 30 individuals, staff documented over 600 client contacts. "Contacts" are proactive staff-client engagements that typically occur in informal settings such as on the street or in shelters. Some of the contacts took place at individuals' homes if they had stable housing and residential address information was known.

Contacts were not coercive engagements but were intended to build rapport and trust between staff and potential clients. For those 30 individuals, 26 were ultimately "enrolled" in the BHRT program. "Enrollment," at a minimum, meant willingness to sign a waiver permitting information sharing and a general agreement to program support. The average age for clients was 45 years, and 62% were men (n=16) and 38% women (n=10). Forty-six percent (n=12) of clients were identified as "white," and the remainder minority including African American (n=seven), Asian (n=one) and Native American (n=one). The remainder were characterized as "other" or missing. Not surprisingly, clients had demonstrated histories of chronic health problems, mental health problems, and substance use.

Analysis of contact data indicates potential clients were typically supportive of BHRT outreach efforts. For the 609 documented contacts, staff characterized clients as having "no interest" in program support in only 16% of contacts (n=97). In contrast, staff classified clients as having "moderate interest" or "a lot of interest" in 66% of all contacts. It became apparent, however, that "interest" is a somewhat dubious word that does not often translate into full-blown program engagement. It is safe to say that clients preferred "arms-length" support. That is, clients appreciated the genuine concern by program staff and maybe even appreciated staff checking-in with them, but they didn't want to be enrolled in "a program." The BHRT project focused efforts on high-risk individuals typically with long, complicated histories. Most were no strangers to the services, service providers, and often the BHRT staff. Program "engagement" and "enrollment" are complicated terms that often lack clear meaning, particularly from the viewpoint of BHRT clients. It became evident that BHRT staff had to come to terms with this reality and quickly. That is, *real* behavioral health work with high-risk clients requires patience and a willingness to meet clients where they are and on their terms.

From an evaluation point of view, interventions with individuals with complicated life histories are often similarly complicated stories to tell. Sadly, three BHRT clients died during the course of the project period; two from apparent overdoses and one from a hit/run while presumably sleeping on a public road. These heartbreaking stories not only complicate "evaluations," but are, more importantly, devastating to program staff and others. However, for each of these tragic outcomes there were cases with significant improvements in life outcomes. After long and sustained periods of program engagement, several clients were able to secure stable housing and critical medical care for those clients who were, quite frankly, on the verge of succumbing to long-untreated medical problems. Program staff helped stabilize another individual with a 20+ year history of negative encounters with police and housing and mental health treatment. These complex stories often defy aggregation into an "outcomes" table. Effective "treatment" entails building relationships and trust, meeting people where they are, and stabilization. Stabilization is the key to longer term treatment and support. But just as importantly, communities wishing to implement a BHRT-like program must be willing to accept "stabilization" as the primary outcome measure. Success must be defined on individual client terms and must be reflective of client starting points.

Besides bringing support to high-risk individuals, the BHRT initiative was intended to increase the organizational capacity of the Providence Police Department to better respond to individuals in crisis. It was intended to build on existing co-responder program model by providing other avenues for police officers to help people in their community access the support many so desperately need. Findings from surveys of officers from the Providence Police Department and interviews with program staff suggest overwhelming success. Officers reported that they feel unprepared to handle incidents with individuals with serious mental and behavioral

health problems. An overwhelming 76% of respondents (n=95) indicated they are "very supportive" of the BHRT initiative, and 76% reported making at least one referral to the program. Officers expressed high levels of support for this and related partnerships between police and behavioral health specialists. In short, these types of collaborations expand the options and resources police officers have to get people with chronic problems access to care. There is a need for tangible program that can be mobilized quickly to stabilize individuals who are often in crisis. This report makes it clear that police officers in the Providence Police Department see programs such as the BHRT mission critical.

Lessons Learned and Strategies for Moving Forward

The Behavioral Health Response Team initiative implemented in the City of Providence represents a viable approach to addressing the needs of high-risk individuals who are at a disproportionate and often unnecessary risk for coming into contact with the criminal justice system and other "front-line" community resources such as emergency departments. This represents an important evolution a "tier one" co-responder models that partner clinicians and police to collaboratively respond to emergency calls for service. The BHRT initiative provides a roadmap for creating more comprehensive case management approaches for some of the most chronic problems. Communities deciding to move forward with a similar program model are encouraged to consider the following recommendations and lessons learned from the Providence experience:

1. Establish Ground Rules Early On: Communities are encouraged to recognize that "case management" partnerships between police and clinician staff require special attention to

"ground rules" related to data sharing and what collaboration looks like. Clear agreement on ground-rules is essential to early implementation and sustainability efforts;

2. Staffing Decisions Matter: Behavioral health program models, particularly those using case management strategies, require selecting the "right people" on both the police and clinical sides of the house. This type of collaborative work is difficult and prone to conflict. Police departments are encouraged to move beyond the "who wants overtime?" approach and be intentional and deliberate about staffing decisions. Clinicians need to understand police work and police culture, and be willing to adapt, where possible, to both. Collaborative partnerships require patience, a willingness to understand the others' role, and even "thick skin" to weather the difficult or uncertain times.
3. Partnerships are Not Enough: Communities must realize it is essential to couple strategic partnerships with a net increase in social capacity to actually treat or support high-risk clients. Creating strategic partnerships where co-responder teams are better able to make referrals to community providers matters; community partners must be present and willing to roll up their sleeves and provide support.
4. Creating Shared Agreement about Key Outcomes: Defining "success" is often elusive and difficult in behavioral health program models, particularly those geared toward high-risk populations with chronic and co-occurring disorders.

Finally, the policymakers at both the state and federal levels are encouraged to give serious attention to challenges associated with privacy and information sharing that make collaborations between public safety and clinicians difficult. As the nation considers questions about the future of policing, there is little doubt this conversation will focus on the

role of police in supporting access to treatment, and hopeful partnerships with non-traditional partners such as behavioral health specialists, social workers, recovery coaches, etc. Any such partnerships are ripe with concerns related to HIPPA and 42 CFS Part 2 which restrict information sharing. We offer two specific recommendations as it relates to both:

1. Clarify the Existing Rules: Local experience from the BHRT program indicates there is often a lack of clarity about what information can be shared, among whom, and under what circumstances. Moreover, different "experts" often have incredibly different views on the nature of all of the above. Finally, shifting political agendas can further complicate these questions especially when the ground rules are not clear. There is a need for clear and unambiguous guidance from state and federal regulators and legal experts about what can and cannot be done. This guidance has to be clear and consumable by non-legal experts. There is a need to establish a universal set of guidelines that all can reference for much needed guidance.
2. Enabling Legislation/Rules: State and federal regulators are also encouraged to consider new legislation or rules that permit collaboration between professionals in the criminal justice systems and behavioral health experts. While many of these rules were created in the spirit of protecting individual rights and privacy, they might also hamper the necessary collaboration that could improve serious negative life outcomes for some of the most at-risk individuals living in our communities.

Evaluation of Providence Police Department's Behavioral Health Response Team

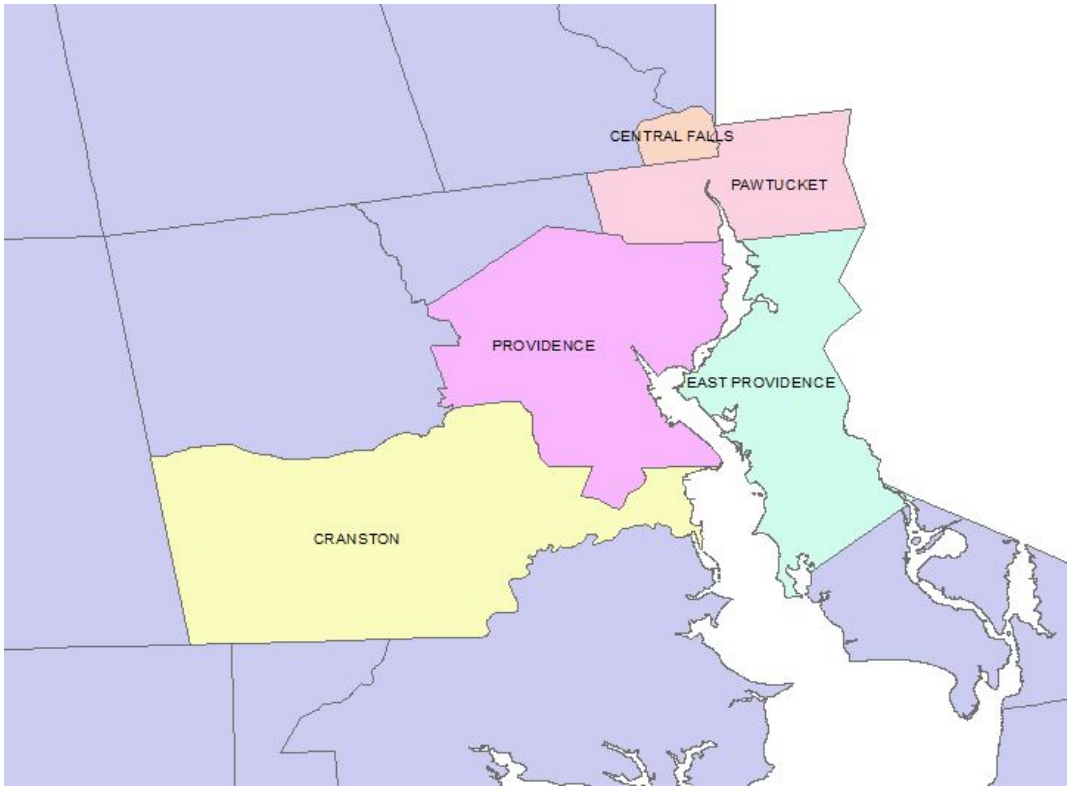
Background

The City of Providence is the largest municipality in the state of Rhode Island, with a 2019 estimated population of approximately 179,000. Providence is part of a larger metropolitan area with the contiguous cities of Cranston (2019 population estimate 81,456), Pawtucket (2019 population estimate 72,117), East Providence (2019 population estimate 47,618), and Central Falls (2019 population estimate 19,586). Providence is the third largest municipal government in New England, behind both Boston and Worcester, Massachusetts. Its proximity to both (approximately 50 miles) and New York (approximately 182 miles) results in its importance as a regional hub with significant cultural, political and economic importance (see Figure 1).

As the capital city and the most populous city in Rhode Island, Providence accounts for nearly 17% of the total state population. The city's population has risen slightly in recent years, increasing by approximately 1.2% between 2019 and 2020 (see Table 1). This growth is double that of the entire state which saw a .6% population increase during the same period. Compared to other cities and towns in Rhode Island, Providence is generally a younger and more racially/ethnically diverse community (see Table 1). For example, approximately 29% of Providence is age 18 or younger compared to 24% of the state. Nearly 18% of the residents are aged 65 and older compared to almost 11% of Providence. Providence has a substantially larger percentage of residents classified as Black/African American (16.8% compared to 8.5%) and/or Hispanic (43% compared to 16.3%).

Unfortunately, Providence also experiences the largest volume of the state's violent crime, substance abuse treatment admissions, and the greatest number of overdoses. Approximately 21% of the adult, Rhode Island population reports having a mental illness.

Figure 1. Providence metropolitan area.



Providence and Rhode Island as a whole have experienced a host of economic challenges associated with it struggles assimilating to the "new economy." With a long history as a manufacturing hub of the Northeast, Providence has not been able to adapt to the increasing presence of the healthcare, education, science, and financial economies that dominate the region. This inability to adapt has been felt more acutely in Providence which still lags behind measures of socioeconomic status as well. Although the percentage of individuals holding a bachelor's degree or higher in Providence, is similar to the remainder of the state (30.1% compared to 34.2%), the median household income between 2015-2019 are very disparate ($45,610 compared to $67,167). Providence also has a substantially larger percentage of its residents living in poverty (25.5%) compared to the remainder of Rhode Island (10.8%).

Table 1. Demographic data, Providence and State of Rhode Island.

Fact	Providence	Rhode Island
Population Totals		
Population estimates (July 1, 2019)	179,883	1,059,361
Population, percent change (2019 to 2020)	1.20%	0.60%
Age		
Persons under 5 years	6.30%	5.10%
Persons under 18 years	22.40%	19.30%
Persons 65 years and over	10.80%	17.70%
Female persons	51.60%	51.30%
Race/Ethnicity		
White alone	55.10%	83.60%
Black or African American alone	16.80%	8.50%
American Indian and Alaska Native alone	1.00%	1.10%
Asian alone	6.00%	3.70%
Native Hawaiian and Other Pacific Islander	0.10%	0.20%
Two or More Races	4.70%	2.90%
Hispanic/Latino	43.30%	16.30%
Education		
High school graduate or higher (2015-2019)	81.60%	88.80%
Bachelor's degree or higher (2015-2019)	30.10%	34.20%
Economic/Poverty Measures		
Median household income (in 2019 dollars), 2015-2019	$45,610	$67,167
Persons in poverty	25.50%	10.80%
Other Socio-Demographics		
Foreign born persons, percent (2015-2019)	28.70%	13.60%
Owner-occupied housing unit rate (2015-2019)	36.10%	60.80%
Median value of owner-occupied housing units (2015-2019)	$200,300	$261,900
Living in same house 1 year ago (2015-2019)	80.70%	87.40%
Language other than English spoken at home (2015-2019)	50.30%	22.40%

Source: www.census.gov

Crime Trends

The City of Providence Part I crimes, which include homicide, rape, aggravated assault, burglary, motor vehicle theft, drug/narcotic violations, and weapon violations for the years 2016-2020 are detailed in Table 2. Providence experienced, on average, 13 homicides a year between 2016-2020 with a high of 18 in 2020 and a low of 11 in 2018. There was a 27% and 29% increase in total homicides between the years 2018-2019 and 2019-2020, respectfully. These

Table 2. City of Providence, Part 1 Crime Counts (Percentage Change) 2016-2020.

Crime Type	2016	2017	2018	2019	2020
Homicide	11	13 (+18%)	11 (-15%)	14 (+27%)	18 (+29%)
Rape	114	127 (+11%)	133 (+5%)	124 (-7%)	71 (-43%)
Agg Assault	612	592 (3%)	512 (-14%)	563 (+10%)	590 (+5%)
Burglary	1,253	1,089 (-13%)	997 (-8%)	765 (-23%)	692 (-10%)
Motor Vehicle Theft	698	592 (-15%)	583 (-2%)	526 (-10%)	585 (+11%)
Drug/Narcotics Violation	871	907 (+4%)	890 (-2%)	802 (-10%)	414 (-48%)
Weapon Law Violations	403	401 (0%)	321 (-20%)	338 (+5%)	310 (-9%)

Source: Providence Police Department, 2021.

increases in homicide correspond to a smaller increase in aggravated assault over the same periods including a 10% increase between 2018-2019 and a 5% increase between 2019-2020. There were decreases in recorded rapes from 7% between 2018-2019 and 43% between 2019-2020. It is likely the large drop in reported rapes was somehow related to change in social patterns related to the COVID-19 pandemic. In terms of motor vehicle thefts, the 11% increase between 2019-2020 reversed a steady decline from 698 in 2016 to 526 in 2019. Of notable interest were substantial declines in reported incidents related to both drugs/narcotics.

Table 3. City of Providence, Public Order Offenses (Percentage Change) 2016-2020.

Crime Type	2016	2017	2018	2019	2020
Disorderly Conduct	810	943 (16%)	982 (4%)	1,058 (8%)	721 (-32%)
Liquor Law Violations	71	125 (76%)	122 (-2%)	38 (-69%)	9 (-76%)
Trespass of Real Property	172	167 (-3%)	123 (-26%)	110 (-11%)	58 (-47%)
All other Offenses	2,404	2,486 (3%)	2,346 (-6%)	2,470 (5%)	1,705 (-31%)

Source: Providence Police Department, 2021.

laws violations and weapon laws (e.g., firearms). After experiencing a small increase in narcotic police incidents between 2016-2017, there were corresponding declines in recent years. There was, for example, a 10% decline between 2018-2019 and then a corresponding 48% decline between 2019-2020. There is little doubt COVID likely upset local drug markets and was in part responsible for significant declines in drugs and illicit firearms on the streets. In terms of firearms, there was a substantial decline in the number of weapon law violations between 2016-2020. The largest decreases occurred between 2017-2018 (20% reduction) and 2019-2020 (9% reduction).

Table 3 displays crime data related to public order type offenses in Providence between 2016-2020. These incident types are of particular interest as it relates to the current program. There was an increase in disorderly conduct incidents in Providence between 2016-2019, increasing almost 31% across the period. The largest portion of that increase occurred between 2016 and 2017, representing a 16% increase. There was a corresponding increase in liquor law violations between 2016-2017, while trespass and "all other" public order offenses remained relatively flat. These figures indicate a slight increase in public order offenses over the time period, driven mostly by disorderly conduct.

The History of the Providence Police Department and Clinical Partnerships

The Providence Police Department (PPD) has a long history of implementing and supporting co-responder model programs involving police and behavioral health specialists. Informed by important work in Yale University's "Child Development-Community Policing Program," the Providence Police Department implemented the "Go Team" in 2004 as a partnership between police officers and behavioral health support specialists from a local service provider, Family Services of Rhode Island, as an innovative approach to bringing support to children and their families experiencing trauma related to crime. This effort has been recognized as an important advancement in the city's efforts to make real, long-term impacts on crime and trauma (Liberman, 2009). This effort made Providence one of the few departments in the nation at that time to have formal partnerships with external behavioral health partners to support co-responder models. Then Chief of Police chief Dean Esserman, when testifying before Congress in support of the reauthorization of the federal funding to support local policing, explained that such partnerships are essential to the future of policing. Esserman stated "And so the future of innovative and cost-effective crime reduction strategies must be focused on the twin pillars of prevention and partnership with the communities" (U.S. Senate Committee on the Judiciary, 2010, p. 11). Current Chief of Police Hugh Clements has also identified these specific partnerships as central to the core mission and success of the Providence Police Department. PPD leadership has recognized and embraced the linkage between disorder, violence, trauma, and negative life outcomes, including future involvement in crime. These partnerships, according to Chief Clements, help "…improve the quality of life in the city. No question we are a better police department and better agency because of [these] partnership[s]"[1].

[1] https://www.providencejournal.com/article/20141125/NEWS/311259971.

The Yale Child Study Center from the early 1990's (U.S. Senate, 2010) is a collaborative approach to policing focused on creating real and meaningful partnerships between police and external partners such as behavioral health, mental health, and substance abuse specialists. Recognizing the comorbidity between crime and these risk factors, Yale's Child Development-Community Policing (CD-CP) partnership emphasized the need to break cycles of generational problems by helping police facilitate access to much needed and neglected mental health support (U.S. Senate Committee on the Judiciary, 2010). Police/clinical partnerships have been piloted to address numerous public safety issues, with domestic violence one of the earliest applications of these collaborative approaches. Early evidence about the efficacy of such partnerships to increase overall levels of safety (Davis, Maxwell, & Taylor, 2006) suggests these partnerships have the potential to increase safety and reduce calls for service (Casey et al., 2007). These and similar efforts across the country were consistent with the then emerging trend of innovative partnerships between police and community partners that offered the promise of reducing problems associated with at-risk populations by better connecting them to treatment, services, and/or support.

In 2012, PPD again expanded the use of trauma-informed approaches to policing by expanding their partnerships with non-policing behavioral health specialists to include The Providence Center, a regional service provider that focuses on the co-morbid problems of mental health, behavioral health, and substance misuse issues. These partnerships with treatment and behavioral health experts have allowed the PPD to think more holistically and comprehensively about the needs of individuals and their families living across their various neighborhoods. The PPD has been a national leader in the use of innovative partnerships built on creating and implementing long term solutions to long term problems. A significant percentage of police

officers currently working within the Providence Police Department have spent a large proportion of their policing career working in an organization with such partnerships.

The Formation of the BHRT Initiative in Providence

The Providence Center (TPC) (https://www.providencecenter.org/) first opened its doors to the City of Providence in 1969 as a one-of-a-kind community resource center that co-located numerous community resources under one roof. Currently, TPC services include a wide variety of mental health, behavioral health, and addiction recovery support services. The PPD-TPC partnership works by embedding a behavioral health clinician within PPD. The clinician has a multi-pronged role, and is responsible for: 1) Riding with officers to conduct on-scene assessments to divert individuals to treatment or hospitalization, as appropriate, and avoid arrest; 2) Following up on referrals from officers and community partners to intervene with individuals who might be at risk for additional arrest; and 3) Providing training to PPD officers on scene and in formal training settings, to increase officer knowledge and awareness of behavioral health issues and their ability to respond effectively to those experiencing a mental health or substance use crisis. This collaborative policing model draws on the unique skills, experiences, and even "powers" relevant to each partner. In the State of Rhode Island, for example, licensed clinicians have expanded legal authority beyond that of law enforcement to initiate involuntary commitments for individuals with substantial impairments.

The early successes associated with the partnerships between the Providence Police Department and The Providence Center created the background for the Smart Policing Initiative (SPI) grant application submitted in 2017 by the Providence Police Department. Police leadership recognized the impacts of the co-responder programs and envisioned that as a new

Table 4. Arrest Summaries to Identify "High Rate Utilizers" (2016-2017).

Number of 'Arrests'	# of Individuals	Total Arrests Associated with Group	# of Individuals Within Groups (1)	# of Individuals Within Groups (2)
1	10,021	10021		
2	2,584	5168		
3	814	2442		
4	369	1476		
5	209	1045	**N=480 Individuals**	
6	97	582		
7	65	455		
8	29	232		
9	24	216		
10	17	170		**N=56 Individuals**
11	14	154		
12	9	108		
13	6	78		
14	5	70		
15	2	30		
16	1	16		
17	1	17		
19	1	19		
	14,268	22,299		

Source: Providence Police Department (2018).

"starting point" for thinking more strategically about how these partnerships could be a framework for proactive policing efforts. The team was specifically motivated by a vision to develop a co-responder initiative focused on individuals who suffer from chronic mental health, behavioral health, and substance use problems that bring them into disproportionate contact with the full range of first responder systems, including police, EMS, and other emergency departments. The team recognized the presence of a small but notable number of individuals with unmet behavioral health needs who also live on the margins of communities (e.g., chronically experiencing homelessness), and are chronic utilizers of first responder systems (e.g.,

police, EMS, and emergency departments). Unmet behavioral health needs place these individuals at disproportionate risk for unnecessary contact with the criminal justice system, and also result in them being an undue burden on other first responders, including the healthcare system. Early planning stages were focused on developing strategies for understanding the prevalence of individuals at an elevated risk for coming into unnecessary contact with the criminal justice system and might be ripe for proactive outreach intended to connect them to services/support.

To illustrate the point, Table 4 comes from the Providence Police Department's strategic action plan for the SPI effort. These data reflect an analysis of police arrest reports between 2016-2017 for "90" series codes; 90 series codes include a range of public order type incidents including public intoxication, disorderly conduct, and being a public nuisance. The data presented in Table 4 illustrate the number of individuals with the total number of documented police arrests during the analysis period. For example, 10,021 individuals had one arrest for 90 series offenses between 2016-2017; 2,584 individuals had two arrests, and 814 individuals had three arrests. The analysis shows 480 individuals had between five and 19 arrests during the analysis period and 56 individuals had between 10 and 19 arrests. The 56 individuals falling in the last group accounted for 662 arrests in total. Anecdotal evidence also indicated that many of these individuals resulted in a disproportionate number of unnecessary EMS transports and emergency department visits. PPD's SPI program was developed specifically to leverage the partnership between PPD and TPC in an effort to create a more systematic approach to treatment and services to decrease the overreliance on police and EMS services.

Police Officer and Clinician Selection

The initial grant application called for the BHRT to include a Project Coordinator, one Clinician, two Case Managers, and eight self-selected police officers who would participate on an overtime basis. It was expected that these officers already had some crisis response training and showed an interest in serving the target population.

Police Officer Selection

On the police side, the first Program Director was Captain Dean Isabella, a 30-year veteran of the PPD. He served as the commander of the department's Special Projects Unit and played a key role in formulating the SPI program design, the implementation plan, and the program evaluation. Midway through the grant Captain Isabella retired and Captain Henry Remolina, a 23-year veteran of the PPD, inherited the project. Captain Remolina, having been mentored by Captain Isabella, was aware of the SPI Project and went through a short acclimation period.

Sergeant Paul Zienowicz from the Office of Professional Responsibility, joined the BHRT after working with Jessica Zira from The Providence Center. Ms. Zira went on call-outs with police officers before the formal grant started and was with Sgt. Zienowicz one evening when they responded to a call for a woman who purposely locked herself in a bathroom and refused to unlock the door. Sgt. Zienowicz succeeded in talking the woman out of the bathroom and Ms. Zira commented on what a great job he did. Once the grant was funded, Ms. Zira sought the sergeant out and told him he would be an asset to the team so he volunteered.

In 2013, Officer Mark DeCecco took interest in autism and mental health issues after an incident with a 10-year old autistic girl who had her tablet stolen. Officer DeCecco and another PPD officer replaced the tablet with their own money and created a bond with the

family. It was at that point that he realized how ill-equipped police officers were at handling individuals with similar issues. Following the incident, Office DeCecco spoke to Captain Isabella and was able to receive crisis intervention training. This training was ultimately rolled out into a 4-hour training block, department wide. Although there was initial push back from some officers, they came to see that the skills they learned were an extra tool for them to use.

Captain Dean Isabella asked Officer Jose Pineda, a 16-year veteran of the PPD, to be a part of the SPI project because of his involvement in the community. Officer Pineda created a camp for children in town and always involved himself as much as possible in the community. Officer Pineda is also bilingual (English-Spanish), something that is critical to the program's ability to respond to the needs of the Latino population.

Officer Derek Ardito, a 17-year veteran of the PPD, also learned of the project from Ms. Zira and saw it as an opportunity to really help someone. "As a housing police officer, it could be frustrating without having opportunities to do more and get people help," Officer Ardito stated. He went on to say, "For the average post-car cop - - these types of clients can be difficult. You want to chase bad guys. These individuals become so frustrating. Some street cops don't have the time or temperament to handle these calls." Officer Ardito saw the work as cutting edge and that SPI, as a program, needed to be done.

For a short period of time, Officer Tracy Miller completed several shifts as a member of the BHRT but she was transferred to the police academy. The BHRT attempted to recruit a bilingual female but due to COVID-19 that never came to fruition. All-in-all, at its peak, the PPD had only four officers assigned to the BHRT in an overtime capacity. It is important to note that the PPD is authorized at 494 sworn members but throughout this project they operated at an

approximate 10% deficit with only 443 sworn members. The fact that the PPD was not fully staffed impacted the department's ability to have eight officers in the program.

Clinician Selection

On the clinician side, Jessica Zira, MA, QMHP served as the initial Project Coordinator for this grant. Fifty percent of the clinician's time was to be spent coordinating the project, providing officer training, and supervising the case managers. The remaining 50% of the time focused on clinical responsibilities within the department, for example, diverting individuals experiencing mental health and substance use crises away from further criminal justice involvement and toward treatment when that was the most appropriate response. Before the first BHRT shift commenced, Zira left The Providence Center and was replaced by Jacqueline Mancini-Geer, LMHC, CRC, QMHP, Director of Acute Care at The Providence Center. Although she inherited the project, Mancini-Geer was interested in participating in the BHRT; she had been doing police liaison work with the PPD and Warwick Police Department for years on crisis care.

Rachel Caruso was hired by Jacqueline Mancini-Geer to serve as a case worker for the BHRT. Nicole Vadnais was hired by the PPD in 2017 to serve as a Clinical Police Liaison on the second shift. In this capacity, she rode along with patrol officers and assisted as needed to calls for service related to mental health and/or substance abuse (often crisis in nature). When she found out about the SPI program during its development phase, she was excited to have the opportunity to be brought on board.

Early Problems and Strategies to Address Them

The proposed effort between PPD and TPC was well positioned to be translated into action because of their longstanding partnership once BJS provided final approval of their

efforts. Both organizations also understood the importance of selecting the "right people" on both the law enforcement and clinical sides of the collaboration to best ensure the staff selected fully embraced the project goals and understood the nuances of working in these types of cross-disciplinary collaboration models. This type of collaborative work can be difficult to operationalize under ideal circumstances, but it becomes that much more difficult when it involves organizations with strong professional cultures and tradition, and disciplines that are bound by impactful legal and policy frameworks that can function as impediments to collaboration. Police work, for example, is often shrouded in secrecy that is, at least in part, based on the privacy rights of individuals and legal concerns related to active and open investigations. These factors are further exacerbated by a general sense of distrust of "outsiders" not familiar with the unique demands and challenges associated with police work. Behavioral health specialists, both licensed and non-licensed professionals, also operate in professional cultures that similarly discourage collaborative working partnerships, particularly involving those from outside clinical/treatment/healthcare environments. Privacy concerns have a tendency to discourage and even activity prohibit information sharing and programmatic cooperation (see Shepherd, 2001).

The Providence Police Department and The Providence Center's existing partnership led them to propose an enhanced program model focused on instituting long term change, i.e. better facilitation of helping individuals get access to treatment. As will be described below, substantive differences between the existing co-responder model and the proposed Behavioral Health Response Team (BHRT) program caused unanticipated implementation barriers.

Crisis Response versus Case Management: Impacts and Consequences

The Providence Police Department sought funding under the 2017 *Smart Policing Initiative* (SPI) funding stream that was announced by the Department of Justice's Bureau of Justice Assistance (BJA). This competitive funding program encouraged police to develop creative frameworks including community collaborations that would be problem-focused, and have longer-term impacts on crime. The focus was on an analysis-driven, evidence-based program model that created sustained partnerships, and the Providence Police Department was one of seven nationally funded projects. The collaborative partnership was intended to build on this important strategic partnership between PPD and TPC to engage high-rate utilizers of public safety services in treatment. Specifically, the project focused on the following goals and objectives:

1) Reduce the number of arrests for low-level crimes in the targeted catchment areas; 2) Reduce arrests for high-risk offenders with behavioral health needs; 3) Increase access to comprehensive case management for low/at-risk offenders with behavioral health needs; and 4) Increase PPD's capacity to effectively respond to individuals with chronic substance use and/or mental health problems.

The BHRT members were positioned to begin the BHRT program model once funding was formally approved by BJA in early 2018. As part of the process, program managers from the Providence Police Department and The Providence Center began to identify prospective staff, make hiring decisions, and develop additional administrative structures in the weeks following the announcement of the award and then eventual approval of the final project plan. Unexpectedly however, it soon became apparent the project roll-out would be complicated by unexpected problems associated with confidentiality, privacy, and even establishing protocols

related to BHRT client encounters. The program team who developed the original grant proposal largely assumed the existing legal and professional frameworks that were in place prior to the initiation of the BHRT program were sufficient and appropriate to the enhanced program model.

The implementation team began to come to terms with the difference between "crisis response" versus "case management" approaches to behavioral health/police partnerships. Of proximal concern were "brick and mortar" issues related to issues such as privacy, confidentiality, and standard operating procedures that all too often hamper interdisciplinary partnerships between police and non-traditional partners. Employment sectors typically approach their work through a professional lens for good reason as they are informed by training, policy, and even occupational culture. The professional lens adopted in any given profession is also influenced by laws, particularly laws protecting privacy rights. Information sharing on the part of police, for example, is often influenced by state laws which govern the dissemination of criminal history information and these laws can vary by state. Police partnerships with education professionals can be shaped by protections afforded under the Federal Educational Rights Privacy Act (FERPA)[2]. In similar ways, police partnerships with hospital personnel, other medical staff and even behavioral health specialists can be hampered by privacy rights provided under the Health Insurance Portability and Accountability Act (HIPAA)[3]. Finally, protections provided under federal legislation referred to as "42 CFR, Part 2"[4] often creates challenges to

[2] https://ucr.fbi.gov/office-of-partner-engagement/active-shooter-incidents/ferpa-guide.

[3] https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf

[4] https://www.thenationalcouncil.org/wp-content/uploads/2020/01/Justice-and-Health-Connect-42-CFR-Part-2-final.pdf?daf=375ateTbd56

police partnerships with a variety of both clinical and non-clinical specialists providing substance use recovery support.

Clients Intake Summary

The BHRT used a multi-step process for identifying and enrolling clients into the program. These steps illustrate two important parts of the client identification process. The first step involves using data to help identify viable candidates, and the second step illustrates the need to gain consent from potential program participants. The non-crisis nature of the program requires staff to deemphasize or even eliminate "forced treatment" or coercion-based approaches typically used when managed by criminal justice professionals in legal settings (e.g., post-arrest or pre-release frameworks). In crisis-based responses, public safety goals supersede clinical goals when the two are seen to be in conflict. This non-crisis framework recalibrates this balance whereby clinical goals associated with voluntary consent and privacy are flipped and can be envisioned as superseding public safety priorities. While the balance between public safety and clinical goals are more nuanced and usually situationally based, these observations are intended to yet again illustrate the implications of non-crisis based co-responder relationships.

Table 5. Gender and age characteristics for SPI/BHRT clients (n=26).

Gender	Total	Average Age
Male	16 (62%)	46
Female	10 (38%)	45
Total	26	45

The BHRT team was able to secure consent to complete a formal intake form for 26 clients during the project period, all of whom were associated with the 609 program contacts documented previously in Table 4. Sixty-two percent (n=16) of the clients were male and the remaining 38% (n=10) were females (see Table 5). Client ages ranged from 30 to 61, with an

Table 6. Racial characteristics for SPI/BHRT clients (n=26).

Race	Total	Percent
White	12	46%
African American	7	27%
Asian	1	4%
Native American	1	4%
Other	2	8%
Missing	3	12%
Total	24	100%

average age of 46 years for men and 45 years for females. From a race perspective, 46% (n=12) of the clients were classified by project staff as White, 27% (n=7) as African American, and the remaining as Asian (n=1), Native American (n=1), or other (n=2). Race classification was missing for three of the 26 clients. Three of the 26 clients (13%) were classified as being of Latino/Latina ethnicity (Table 6). As a whole, analysis of program intakes indicates the program clients were disproportionately male, middle-aged and white.

Not surprisingly, the BHRT clients had demonstrated risk factors that are often correlated with unmet and chronic behavioral health problems, substance misuse, and increased contact with the criminal justice system (see Table 7). For example, 46% (n=12) of the clients had less than a high school education at the point of intake, but just as important, 19% (n=5) had at least some college. These two data points together indicate that experiencing chronic homelessness and unmet behavioral health problems often touch a wide cross-section of individuals within our communities. Not surprising, nearly two-thirds (65%) of those identified as BHRT clients were classified as experiencing homelessness or otherwise lacking a stable housing situation, and 77% (n=20) self-described themselves as unemployed and not seeking employment at the time of program intake. Although the intersection between experiencing homelessness, behavioral

Table 7. Intake risk factors (n=26).

Domain	Category	Total	Percent
Education	Less Than HS	12	46%
	HS Grad	3	12%
	Some College	3	12%
	College Grad	2	8%
	Missing	6	23%
	Total	26	100%
Housing Status	Experiencing Homelessness	17	65%
	Stable Housing	5	19%
	Missing	4	15%
	Total	26	100%
Employment Status	Unemployed Not Seeking	20	77%
	Missing	6	23%
	Total	26	100%

health problems, and employment are complicated, the finding that many individuals are not even seeking employment should not be surprising. Actively looking for employment is an unlikely goal for individuals who do not even have their most basic needs met.

Client intakes also indicated a significant presence of physical disease. Among the 26 clients with a formal intake, 92% reported chronic health conditions (see Figures 2 and 3). All who reported chronic health conditions reported more than one, and the most common were seizures (42%), hypertension (17%), and both asthma and chronic pain (13

The co-morbid nature of behavioral health, substance use, and physical disease is important as each often plays into the other. Undertreated behavioral health problems, for example, can result in both exacerbated physical health problems and illicit substance use. Chronic and persistent substance use problems such as addiction can also be a barrier from getting access to needed medical attention. Behavioral health specialists and their policing

partners by extension often find it difficult to find the right access point to individuals as both the intensity and co-morbidly of these issues are elevated.

Figure 2.

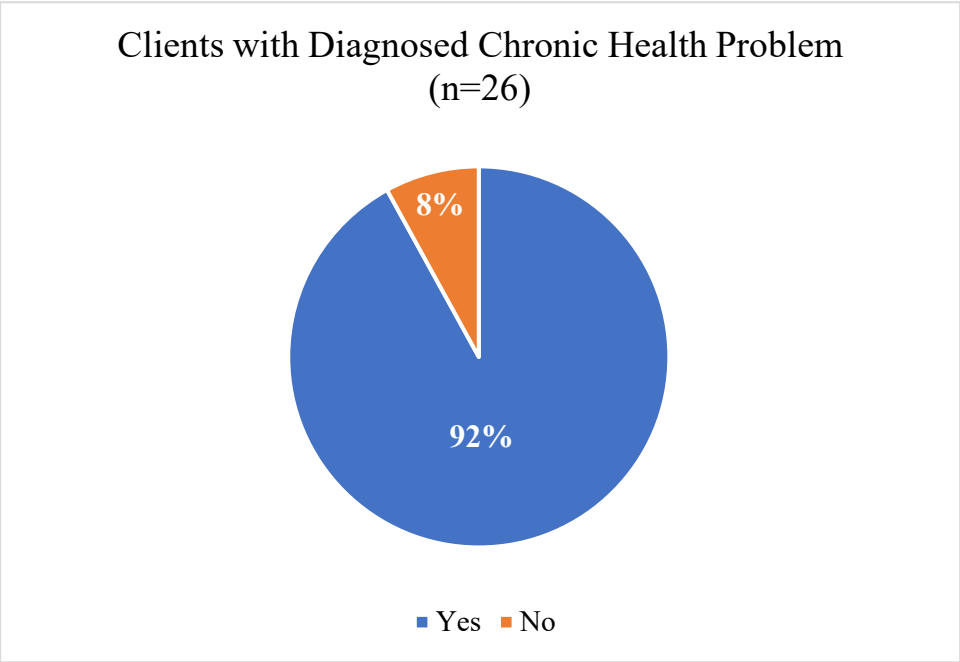


Figure 3.

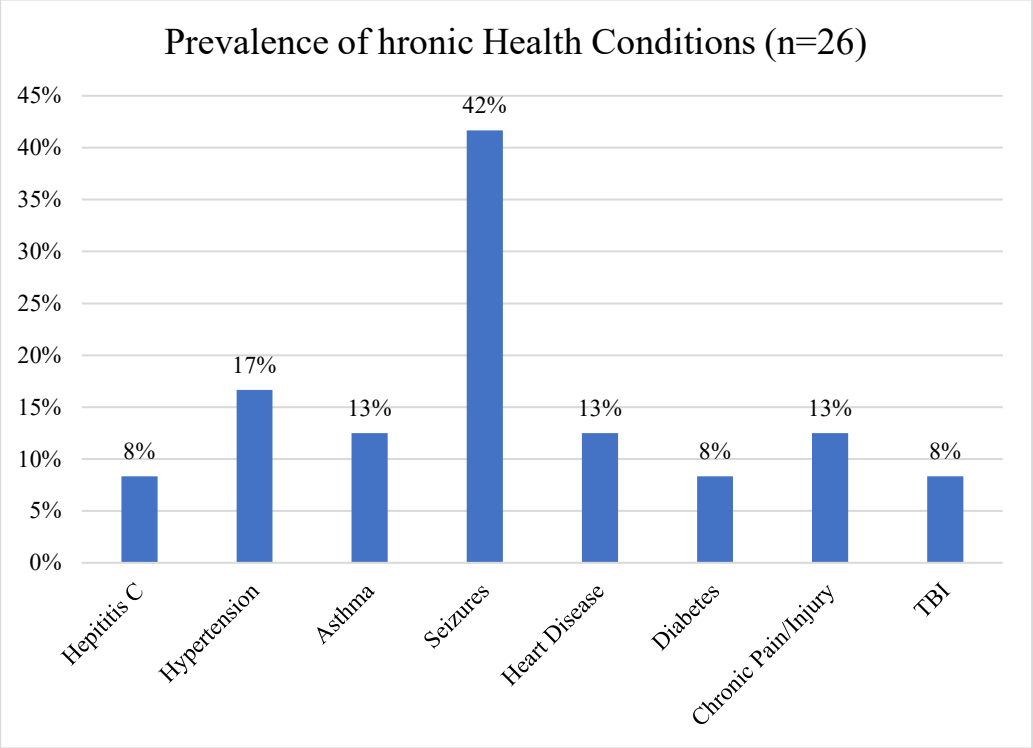


Table 8. SPI Overtime Activity Reports. Totals and Shift Averages.

Year. Month	Total Shifts	Targeted BHRT Clients	BHRT Clients Contacted	Non-BHRT Clients Contacted	ED Visits for BHRT Clients	Client Advocacy Contacts for BHRT Clients
2018.11	7	42 (6.0)	8 (1.1)	8 (1.1)	0 (0.0)	0 (0.0)
2018.12	0	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
2019.01	14	53 (3.8)	16 (1.1)	6 (0.4)	3 (0.2)	3 (0.2)
2019.02	9	29 (3.2)	18 (2.0)	5 (0.6)	3 (0.3)	9 (1.0)
2019.03	8	25 (3.1)	20 (2.5)	5 (0.6)	0 (0.0)	3 (0.4)
2019.04	4	14 (3.5)	7 (1.8)	1 (0.3)	0 (0.0)	0 (0.0)
2019.05	5	15 (3.0)	4 (0.8)	0 (0.0)	0 (0.0)	0 (0.0)
2019.06	3	14 (4.7)	3 (1.0)	1 (0.3)	0 (0.0)	1 (0.3)
2019.07	4	21 (5.3)	8 (2.0)	0 (0.0)	0 (0.0)	0 (0.0)
2019.08	2	8 (4.0)	5 (2.5)	0 (0.0)	1 (0.5)	1 (0.5)
2019.09	18	90 (5.0)	48 (2.7)	9 (0.5)	1 (0.1)	3 (0.2)
2019.10	21	108 (5.1)	53 (2.5)	3 (0.1)	4 (0.2)	11 (0.5)
2019.11	17	115 (6.8)	49 (2.9)	7 (0.4)	3 (0.2)	3 (0.2)
2019.12	15	98 (6.5)	25 (1.7)	3 (0.2)	0 (0.0)	0 (0.0)
2020.01	11	62 (5.6)	29 (2.6)	2 (0.2)	0 (0.0)	3 (0.3)
2020.02	3	28 (9.3)	8 (2.7)	0 (0.0)	0 (0.0)	0 (0.0)
2020.03	5	29 (5.8)	8 (1.6)	0 (0.0)	0 (0.0)	1 (0.2)
2020.04	0	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
2021.05	0	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
2020.06	1	5 (5.0)	2 (2.0)	1 (1.0)	0 (0.0)	0 (0.0)
2020.07	17	121 (7.1)	46 (2.7)	6 (0.4)	1 (0.1)	5 (0.3)
2020.08	19	123 (6.5)	50 (2.6)	7 (0.4)	0 (0.0)	4 (0.2)
2020.09	16	91 (5.7)	44 (2.8)	7 (0.4)	1 (0.1)	8 (0.5)
2020.10	11	75 (6.8)	27 (2.5)	0 (0.0)	0 (0.0)	1 (0.1)
2020.11	5	46 (9.2)	19 (3.8)	0 (0.0)	0 (0.0)	0 (0.0)
2020.12	5	28 (5.6)	14 (2.8)	0 (0.0)	0 (0.0)	0 (0.0)
2021.01	9	79 (8.8)	26 (2.9)	0 (0.0)	1 (0.1)	2 (0.2)
2021.02	0	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
2021.03	5	32 (6.4)	10 (2.0)	0 (0.4)	2 (0.0)	1 (0.2)
Total	234	1,351 (5.7)	547 (2.3)	73 (0.3)	18 (0.1)	59 (0.3)

Analysis of Overtime Reports

The research partner developed a series of data collection tools to document the processes and outcomes of the BHRT response. The BHRT overtime shift report is provided as

Table 9. Description of Overtime Shift Report Measures.

Shift Measure	Description
Targeted BHRT Clients	Represents the total number of BHRT clients targeted across reported shifts. Does not necessarily represent unique clients.
BHRT Clients Contacted	Represents the total number of BHRT client engagements each month. Similar to above, this does not necessarily reflect unique individuals.
Non-BHRT Clients Contacted	Represents the total number of non-BHRT client engagements each month. These engagements represent self-initiated engagements deemed appropriate and necessary during the normal course of shifts.
ED Visits for BHRT Clients	Visits to the emergency department specific to the needs and/or transports for BHRT clients.
Client Advocacy Contacts for BHRT clients	Client advocacy events specific to BHRT clients. These advocacy events might be in person or electronic means and often represent efforts to get clients connected to services.

documentation in the Appendix. Table 8 presents monthly shift summaries for the overtime shifts conducted as part of the SPI funding, and a description of the overtime data collected is provided in Table 9. The BHRT conducted 234 total overtime shifts between November 2018 and March of 2021 or an average of nine shifts per months. For purposes of this report, an overtime shift is defined as the deployment of a BHRT co-response team. Overtime tracking forms were not necessarily used to track every single shift worked by police or clinical partners, but specifically those shifts where the BHRT teams were deployed specifically to conduct outreach. There are instances where two BHRT units were deployed on the same shift, and in these cases, they would be tracked as unique overtime shifts. The average number of monthly shifts ranged from a low of one in June 2020 to a high of 21 in September of 2019 (already mentioned above). No BHRT overtime shifts were conducted during the months of December 2018, April and May of 2020, or February 2021. There were no overtime shifts in April and

May of 2020 due to the COVID-19 epidemic. Despite COVID-19, BHRT overtime shifts were still conducted during 10 of the 13 months between March 2020 and 2021 for a total of 93 total shifts.

The project team maintained a list of approximately 50 BHRT clients based on identification as "High Rate Utilizers" of emergency/police services. That number, 50, could be adjusted accordingly based on several factors, including how many clients were actively engaged with the BHRT, the number of "prospective" or intended program participants, and new clients that emerged as priority for engagement. Each BHRT co-response unit approached shifts with an identified list of clients who were the subjects of proactive engagements. Approximately 3-6 clients were typically targeted during an average shift. During the initial months, however, the primary goal was to outreach to as many BHRT individuals as possible to identify those who were most at-risk and most likely to engage. Engaging high risk individuals with histories of undertreated behavioral health problems can be challenging to say the least. There is often a subset of these individuals with chronic and unmet behavioral health challenges who also demonstrate high levels of resiliency in terms of living "on the streets" and in the spaces between the systems intended to provide support. Making contact with individuals who are experiencing homelessness or living in fluid housing arrangements is both difficult and time consuming.

The data presented in Table 8 indicate the BHRT teams, on average, were able to make contact with one to two intended clients per shift, and occasionally non-BHRT contacts that were sufficiently noteworthy to justify documentation. "Contacts" are typically defined as a prolonged engagement between program staff and clients with an extended "engagement" focus. Contacts are more than just casual encounters but are intentional engagements focused on providing support and resources.

The relatively small number of BHRT engagements is not surprising given the transient nature of the target population. Significant efforts were put into anticipating where clients would be and at what time of day, and planning shifts accordingly. Teams quickly found it was not unusual to spend sizeable portions of the shift visiting high priority locations such as the Crossroads homeless shelter, Kennedy Plaza (transportation depot), or Trinity Square, a location near homeless services where displaced populations are known to congregate.

Two additional project measures tracked emergency department visits/transports, and direct advocacy for BHRT clients with other service providers. Research and practice suggests strong comorbidity between problems associated with physical health, mental health, behavioral health and addiction (Damian & Gallo, 2018). As such, BHRT teams invested significant time facilitating and navigating access to treatment. While one goal of the SPI effort in Providence was to reduce the overreliance on expensive and overburdened services such as emergency departments, the second goal was to better facilitate access to all forms of treatment when actually needed. It is important to consider that a substantial proportion of BHRT clients had serious medical issues that needed routine treatment and aftercare. Data collected indicates approximately 18 emergency department visits were facilitated/co-responded to across the project period, with the largest number of four in September 2019. The shift reports indicate most transports were for serious issues related to intoxication and physical health problems. In addition, BHRT teams documented 59 direct client advocacy events for SPI clients which covered a wide gamut of issues. These direct advocacy events are contacts of significant consequence. For example, BHRT teams successfully advocated for and facilitated access to long care nursing facilities for two clients who were previously experiencing homelessness and had with serious medical histories.

Analysis of Clinical Contact Reports

The BHRT team also documented program activities through the use of a "Client Contact Report." This contact report was used to document all program directed engagements with individual BHRT clients. The form, an example of which is included in the Appendix, identifies the date and time of all contacts, as well as characteristics of client reaction to the contact, and referrals to both The Providence Center and other local service providers.

As described earlier, the BHRT initiative in Providence was designed to identify high rate utilizers of first responder services. More specifically, the goal is to identify individuals with excessive contacts with police and emergency medical services but whose contact with both systems is caused largely by unmet behavioral health problems. The intended population are those chronically experiencing homelessness or otherwise "underhoused" individuals who live a good deal of their existence on the "streets" or on the fringes of communities. These individuals often come into disproportionate contact with the police related to public order offenses connected to their regular presence on the street. Similarly, these populations can disproportionately impact the emergency medical systems including both ambulance services and emergency departments due to disproportionate concerns with public intoxication, poorly managed chronic medical or psychiatry conditions. The elements of successful community-based approaches involve case management models that connect chronically at-risk individuals with intensive support.

Documented Clients

Over the course of the project period, the BHRT team monitored official data for additional clients. These individuals were identified in the course of monitoring police/EMS contact data as well as from direct referrals from other police personnel within the Providence Police Department. It is important to note that one of the early "lessons learned" was that

monitoring police and EMS data was not sufficient to identify high-rate utilizers. As BHRT team members identified potential clients from direct referrals and through their own work on the streets, it became more apparent that many police contacts in particular remain informal and never actually make it into the police record management system. For every documented incident associated with particular individuals, particularly those targeted by the BHRT, there are often numerous contacts that were never recorded. Officers, for example, might have an encounter with someone related to a disturbing the peace, obstructing traffic, or panhandling call. These behaviors, in many cases are either noncriminal behavioral or such low level offenses that officers might otherwise use their discretion not to take legal action. The more well-known an individual is to police the more likely it is that officers may not take legal action due to the regular nature of such occurrences. While monitoring of police public order offenses is a valuable process, it became readily apparent it was not sufficient to identify potential BHRT clients.

The Meaning and Context of "Contacts" as a Measure of Program Fidelity

Like all data, there is a context to the contact data that is important to understand. The term "contact" is generic in nature and does not fully elaborate the complexity or intensity of program treatment rendered. For example, "1" contact might actually be a multi-hour engagement that involves crisis support, medical or medication support, and/or direct advocacy with third parties such as the courts, medical doctors, or housing specialists. It is not uncommon for one crisis associated with one individual to consume the better part of a four-hour BHRT shift. In addition, there would also be an expected positive relationship between the intensity of the clients' needs and consumed program resources. In these program models, client needs are not met merely with the "referral to a service provider" approach; instead, there is a need for

Table 10. Clinician/BHRT Client Contacts (n=609 contacts).

	# of Clients	Contact Counts	Cumulative Contacts
	5	1	5
	3	2	6
	4	3	12
	3	4	12
	1	7	7
	2	9	18
	1	11	11
	1	15	15
	2	16	32
	1	18	18
	1	23	23
	1	24	24
	1	33	33
	1	57	57
	1	75	75
	1	77	77
	1	184	184
Totals	**30 Clients**		**609 Total Contacts**

intensive support and advocacy. Using a medical analogy, equating "1" annual wellness check with "1" organ transplant misses important parts of the story.

Client Engagements

Of the total targeted clients, the BHRT teams were able to document client-level contacts for 30 unique clients for a total of 609 documented clinician/client contacts over the project period. These documented contacts are more than just casual encounters, but intentional outreach contacts related to BHRT shifts. The data provided in Table 10 summarize the distribution of all 609 documented contacts across the 30 unique clients. The table summarizes the total number of clients (column 1) with the total number of contacts (column 2) and the cumulative number of contacts associated with each subgroup (column 3). For example, five individual clients had one contact during the project period for a total of five contacts. Similarly, three individuals had two

contacts for a total of five contacts. Aggregating the contact data in this fashion provides insight into the total number of individuals engaged, but also the intensity of engagements across individuals. The number of contacts ranged from a low of one to a high of 184, or an average of 34 contacts per client. Twelve clients had 10 or more contacts during the project period, and seven had 25 or more.

The data detailed in Table 10 above provide unique insight into how behavioral health initiatives, particularly those intended to serve the needs of chronically at-risk and underserved populations, sometimes unfold. Program models that begin with an intended target population/program size may find it impossible to contact/engage 100% of that target population. The failure to engage 100% of the intended target population is not unexpected due to the transient nature of those presented as potential BHRT clients. From a practical point of view, many of the prioritized BHRT clients do not always live in Providence, but may spend parts of days in the city, or spend time in Providence on particular days of the week only. For example, some unknown percentage of those chronically experiencing homelessness or underhoused individuals take public transportation on a daily basis to Providence from an adjoining community where there is a large homeless shelter. Transient populations commute to Providence for access to services/service providers, availability of daytime support resources, and for social reasons since some of the homeless shelters are closed to clients during daytime hours. From a practical point of view, individual clients can be difficult to track down. Also, their regular movement between adjoining communities makes it difficult for police-oriented social services programs which are often jurisdiction-based. It is important for these type of behavioral health initiatives to find a balance between keeping caseloads sufficiently small to

serve the real needs of clients while at the same time focusing resources on identifying and engaging new clients.

An additional observation in the data presented in Table 8 is recognition that a small number of individuals can result in disproportionate demands on program resources, particularly personnel. The "demand distribution" is not equal across clients. For example, three individuals accounted for 336 or 55% of all BHRT outreach contacts. Similarly, one individual accounted for 187 or 30% of all BHRT outreach contacts. This individual had had a well-known presence on the streets of Providence among police, service providers, and businesses for more than 20 years. This individual was also known to have regular negative contacts with the police, service providers, and businesses over the years due to her regular presence "on the streets," typically seriously inebriated, and having verbal or even physical disputes with people whom she would randomly encounter. Individuals with extensive needs and histories of "falling through the cracks" of the system intended to offer them support usually need extensive support which can result in serious demands on limited behavioral health resources.

Client Responses to Visits and Referrals Made

As previously mentioned, the BHRT program is a non-crisis proactive case management model intended to engage high-risk individuals into services. The program is intended to identify those individuals who, due to behavioral health, mental health, and/or substance use disorder problems, have unnecessary contacts with first-responder systems including police, ambulance, and emergency medical systems. The "non-crisis" aspect of the model is noteworthy because it removes the traditional legal tools police and clinicians can use to immediately intervene in

Table 11. Client Contact Reactions (n=609 contacts).

Client Reaction	Count	Percentage
No Interest	97	16%
Slight Interest	105	17%
Moderate Interest	265	44%
A lot of Interest	137	22%
Missing	5	1%
Total	**609**	100%

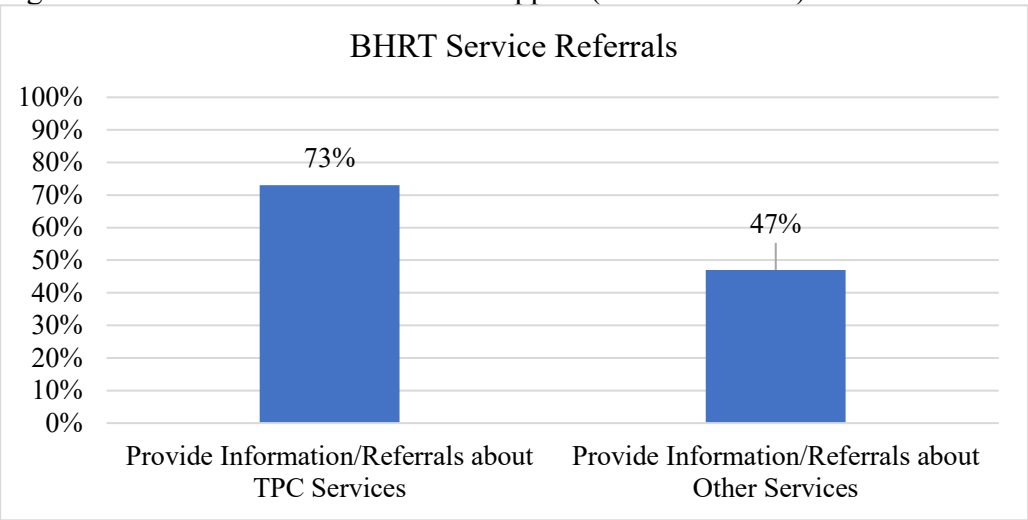
situations. Tools such as arrests, involuntary transports to the hospital or involuntary civil commitments[5] are typically not available pursuant to non-crisis related encounters. It is important for police/clinician teams to approach potential clients in ways that empower individuals to take advantage of the support being offered.

Behavioral health programs often have to strike a balance between assertively offering support and aid to individuals facing serious negative life outcomes while respecting the legal rights individuals have to refuse that help or treatment. The likelihood of having successful relationships with clients and engaging clients in services is based on respecting these rights. The client contact form also records additional details about clients' reactions to outreach visits and support services offered during contact visits. The substance of the BHRT model is built on regular client engagement that meets people "where they are," in a respectful and supportive way.

Staff, for example, were asked to record their perceptions of clients' reactions to BHRT visits. The visits were coded as "no interest in program support," "slight interest in program support," "moderate interest in program support," or "a lot of interest in program support" (see Table 11). Based on staff assessments, clients generally were supportive of the help and

[5] Involuntary civil commitments are referred to as "certifications" in the State of Rhode Island. These legal tools are provided under RI General Law 40.1 For more information, see https://law.justia.com/codes/rhode-island/2017/title-40.1/chapter-40.1-5.3/section-40.1-5.3-4/.

Figure 4. Client Referral to Services/Support (n=609 contacts).



assistance provided by the BHRT. For example, 66% of visits were coded as "moderate" (n=265 or 44%) or "a lot" of interest (n=137 or 22%). Visits were coded as "no interest" in only 16% of 97 visits. While "interest" does not mean clients were necessarily ready to jump directly into services or anticipated a significant life change, these initial impressions were important to track as they provided a foundation for a productive relationship moving forward. Additional information about referrals is provided in Figure 4 by documenting specific referrals to services provided by The Providence Center and other service providers. Contact reports indicated 73% of the BHRT contacts resulted in a referral to The Providence Center and 47% resulted in referrals to other service providers. This is a direct measure of program intensity was the intent of the program is to both enhance connections to support and services.

BHRT Key Stakeholder Interviews

To further illustrate the impact of the SPI project, the research partner conducted interviews with the members of the BHRT to understand their insights into the program. Interviews were conducted in-person by the graduate research assistant and at least one faculty researcher from Roger Williams University. The survey, which is located in the Appendix, asked

BHRT members to identify the specialized training and personality type needed by police officers and clinicians to participate in this program as well as what they liked most and least about their work related to the SPI project. Additional questions focused on barriers that existed in completing their work, how they measured success of the program, and the top recommendations they would make to a police department or community attempting to implement a similar program.

Those interviewed included one captain, one sergeant, and three patrol officers from the Providence Police Department (PPD) and two clinicians and one caseworker from The Providence Center (TPC). The educational level for the PPD staff range from an associate's degree to a master's degree and they range from 17 to 31 years in law enforcement. All PPD members of the BHRT are male. Two of the staff members from TPC have master's degrees and they range in experience from two to five years. All TPC members are female.

Characteristics of Effective Police Officers and Clinicians Selected for BHRT Initiatives

For police officers and clinicians alike, co-responder models represent significant changes to standard operating procedures in many ways (Marans, 1995 – The Police-Mental Health Partnership book). From the police point of view, these partnerships often involve co-locating a civilian directly into police operations. Practical issues regarding danger, liability, and just the potential for "getting in the way" can present real and tangible barriers. Civilians can also create threats related to breaches of confidentiality regarding police operations or other "intelligence" that the traditional culture of policing has long sought to protect. Policing is a profession designed to anticipate and respond to worst-case scenarios, and the presence of civilians in the routine operations of police work creates the potential for liability. Beyond these logistics issues, the presence of civilians creates the potential for disrupting the culture of police

work. Police officers have a tendency toward cynicism of non-police in general (Paoline, 2003), and there is a likelihood this latent cynicism would be exacerbated in the presence of civilians who are presented as "experts" in dealing segments of the public long envisioned as being the domain of policing.

These partnerships also create significant challenges to clinical professionals, some of which are similar to their law enforcement counterparts and others which are unique to clinical work (see Marans, 1995). Issues pertaining to confidentiality, not surprisingly, presents some of the most significant barriers/challenges. Clinical professionals, for example, "are usually aware of major regulations governing confidentiality and privacy which stem from codes of professional practice, state statutes, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)" (Pinals & Anacker, 2020, p. 182). The mere presence of uniformed officers equipped with firearms, conducted energy devices, and even increasingly body-worn cameras can be seen as incompatible with clinical priorities and culture. Finally, the real and perceived dangers associated with police work, including its shift-based nature, and the overall lack of familiarity with unique aspects of police culture makes engagement in the day-in, day-out of these partnerships unappealing for some.

These observations are important because it makes clear that decisions about staffing are critical to the overall success of co-responder models. From both the police *and* clinical point of view, engagement in co-responder programs is not just an "assignment." Instead, serious attention and deliberation should be given to staffing decisions. With this observation in mind, we sought the input from both police officers and clinicians involved in the BHRT initiative.

Interviews with both police personnel and clinicians aligned with the BHRT initiative revealed five distinct characteristics that should be central to the selection of *police officers*.

- Interest: When asked about what characteristics are most important when selecting police officers, the most universal answered identified was a sense of basic *interest* in working on these projects. Police officers in particular stressed the recognition that this type of work cannot be "about the overtime," but instead police personnel must be genuinely interested in doing this type of work. The perceived rewards can often be small and the potential for dangers big so it is critical officers are "in it" for the right reason. As one officer stated, *"If you put the wrong officer in a position like this, things can go real wrong."* Ultimately, officers have to want this assignment and do this type of work.
- Approach work with sense of Empathy and Optimism: Both officers and clinicians stressed that the BHRT initiative represents a difficult type of police work. It is important that officers bring with them a basic sense of empathy to the job. It is too easy to judge someone, the decisions they have made, and the perceived sense of blame they might share for their life circumstances. But at the same time, it is critical for officers to do their best to understand the life circumstances individuals find themselves in and to withhold judgement. Respondents also stressed officers have to be fundamentally optimistic. In reality, BHRT initiatives often bring few daily "success stories," and a sense of regular failure can be defeating. As one officer noted, "*It is really hard not to become jaded – we are out there trying to help, and some people just don't want help*." But this officer and others noted this is the nature of the work they are doing. Community members necessarily happy or excited to see program staff, and may even be resistant. This working environment, however, largely comes with the territory and officers have to be able to still hold true to the

purpose of program efforts while experiencing few "wins" on a daily basis. Related to these issues, one clinician identified a willingness of officers to take a step back and empower individual clients. *"Police have to be willing to share authority with clients. Dysfunction is rooted in some self-interest; if you remove it then it will cause trauma. If you ask someone to stop drinking but that is their only form of socialization, it can result in isolation."* Officers have to be willing to understand and appreciate the nuanced nature of behavioral health work. In behavioral health work, change is better conceptualized as negotiated and renegotiated and not demanded. This concept represents an important conceptual shift in the culture of policing.

- Patient, Calm Demeanor: Respondents also stressed a need for police officers to bring a sense of patience to the job, and to have an otherwise calm demeanor. The value of "patience" was a theme that not only emerged in several interviews, but at different times throughout the initiative itself. Individuals with serious behavioral health, mental health, and substance use histories have a tendency to be uncooperative or even combative. They might also have histories of antagonistic relationships with police and behavioral health specialists. These characteristics, however, often come with the territory. It is critical staff understand this, are willing to expand their thresholds for behaviors, and demonstrate an overall commitment to downplaying coercive tactics wherever possible.
- Familiarity with People and Areas to be Policed: Two respondents, both police officers, also raised the importance of being generally familiar with and comfortable in the areas where this type of police work is done, and with the population that will be served. Not surprisingly, individuals with some of the most chronic behavioral

health problems tend to disproportionately congregate in a relatively small number of locations. In the city of Providence, for example, some of the largest "hotspots" include the Trinity Square area, Kennedy Plaza (transit area), and Crossroads (service provider that provides services/housing support for people experiencing homelessness). Officers have to feel comfortable navigating these areas, sometimes on foot. Basic familiarity and comfort levels goes a long way. The same familiarity and comfort levels hold true for clients themselves. Typical BHRT clients disproportionately have serious challenges associated with personal hygiene, sobriety, and cognitive capacity and officers have to be able to deal with these. As one officer noted, *"if officers approach the work with a 'this place is a shithole' or 'these people' attitude then they are bound to have problems on the job or not be effective."*

- Understand Roles: The final theme to emerge related to important characteristics of police personnel is the ability to fully understand and internalize their role in BHRT initiatives. Co-responder models are, by definition, collaborative work processes that often involve role negotiation. Police officers, professionals who are typically charged with assuming primary and exclusive authority in the context of police work, may have to take a secondary role to civilians in particular contexts in order to better engage and serve clients. All else being equal, it is important for officers to "take a backseat" to their clinical partners. The willingness of sworn officers to step back and turn over a situation to clinicians is often enhanced with experience and trust, but it is important for officers to have a general willingness to acquiesce authority where appropriate.

Respondents were further asked about what characteristics they thought were necessary among clinicians. Responses identified three key themes, issues that were in many ways distinct from those related to the selection of police officers. Themes for clinicians include a willingness to learn the police perspective, the ability to work in isolated and independent ways (they are outside of their professional workplace/environment"; and not be anti-police.

- Willingness to Understand and Appreciate Police Perspective: Both police officers and clinicians stressed the importance that clinicians have to be familiar with and accepting of "police culture." Police work and police culture are different from behavioral health work. While many of the problems and people are similar, the police role, authority, legal responsibilities and even culture result in different orientations. Policing has often been described as a "subculture" (Manning, 1997; Paoline, 2003) that is distinct from other professional cultures. Clinicians must be able to understand and adapt to that, while at the same time holding true to their own professional demands and expectations. One police respondent suggested police have a tendency to *"be controlling."* Sometimes this approach is due to situational dangers associated with the job, or maybe even a lack of familiarity with individual clinicians. If clinicians are offended by this approach then police/partnership programs are probably not right for them. Another officer mentioned while it would be beneficial if clinicians were seen as *"supportive of police"* minimally, it is important they are not viewed as *"anti-police."* Having a civilian as part of a co-responder program can be seen as risky and officers have to know they can trust them. To "trust" largely meant they could be relied upon to try to understand the police point of view, were not perceived as prone to dangerous behavior, and were

equipped to quickly grasp that something was clearly a "police matter" that requires them to take a back seat to policing priorities.

- Ability to Work Independently and in a "Socially Isolated" Fashion: This theme was mentioned by only one clinician but seemed important to identify. This individual observed that clinicians operating in co-responder programs are isolated from their own professional colleagues. This isolation can result in a sense of "being on an island" and lacking the regular sense of collegiality and professional support that oftentimes is associated with working with liked minded colleagues on a daily basis. Clinical professionals in these models may feel as if they do not quite fit in with their police partners, but also with their clinical colleagues who might either have no understanding of what they do or may even be antagonistic to the work.

Recommended Specialized Training

When project stakeholders were asked to identify the types of specialized training they would recommend for both police officers and clinicians prior to engaging in a BHRT-type programs, there was overwhelming support for Crisis Intervention Training for both police officers and clinicians. When clinicians were asked to respond to this question regarding police officers, they believed that police officers should also have de-escalation training, knowledge of the resources available to clients (i.e. home/medical assistance), and training on how trauma impacts the individual and the community. One clinician stated that *"Police have to change their approach; they are used to policing problems but they can't always get compliance from the client. Officers have to realize that a person's dysfunction is rooted in some self-interest and that if it is removed it can cause trauma. If a person stops drinking but does not have another way to socialize, they will isolate themselves and it might cause another problem. They need to*

be able to provide clients with a sober environment and support. The client needs to see the interaction as a fair trade." When asked to respond to this question regarding police officers, the police officers responded that any officer who engages in this type of work needs to have good communication skills, know how to handle and recognize mental illness, and understand how clinicians work.

Clinicians believe that prior to engaging in a program like BHRT, clinicians should have experience working in high stress environments and with people experiencing mental illness, and understand the resources that are available to clients. Police officers stated that clinicians need to understand the role of law enforcement in this process and that there are certain times when a police officer will have to take certain actions regardless of their (clinicians) views for safety reasons or because a crime has occurred. One officer recommended that clinicians could attend a citizen police academy to gain this perspective.

The necessary personality characteristics for police officers engaged in this work include: patience, because people will not be fixed on the first go around; empathy; an interest in mental health and alcohol/drug abuse; and be willing to look for solutions other than arrest. A high-ranking police officer commented that officers who see everything as black and white and go by the letter of the law would not be the right fit for this type of engagement.

Barriers to Completing BHRT Work

There were similarities in the responses by the police officers and clinicians with regards to the question that asked them to identify any barriers that existed to completing their work. A main barrier cited by the officers was the lack of communication between the various hospitals and the organizations that provide the relevant resources for program clients. The current system does not allow for sustainable solutions, i.e. solving the root causes of the behaviors, and often

the client is simply evaluated and released back to the street, creating a revolving door in the system. PPD officers believe that behavioral health teams should become a permanent unit in the department to handle these clients and not be done on an overtime-only team members. Other barriers include difficulty getting clients to appointments if they were not on-duty to drive them and difficulty finding spots in programs for clients. One officer suggested that having laws that enable them to force people into treatment would be useful.

There were three main barriers identified by the clinicians. First, is the difficulty accessing resources during the hours of 3:00 pm and 7:00 pm. The inability to access resources leads to an over-reliance on emergency rooms, which as noted above by the police officers, leads to the client simply being evaluated and released with no treatment plan. Second, are the limitations imposed by privacy laws. For example, when the BHRT initially engages with a client, the police officer has to remain in the background, physically distanced, until the client agrees to enter into the program and signs a waiver, thereby giving permission for the officers to hear their medical and behavioral health histories. The final programmatic barrier is the financial sustainability of the current program. The BHRT is seeing success with clients but once the funding runs out, there is no plan to fund the partnership, leaving the clients behind.

Measures of Success

Research studies often measure success with a significant reduction or absence of a specific phenomenon; however, given the small project sample size at hand the BHRT and researchers were interested in others ways to measure success often based on individual anecdotes. One success story mentioned by a senior officer was assisting an alcohol addicted client who was experiencing homelessness to stop drinking and obtain a place to live. The officer He also said “this may not be my idea of a good life but it is right for them.” Another measure of

success identified by the police officers was the positive feedback they received from other organizations and the clients, as well as officers outside of the program who make referrals to the team to get people assistance.

According to the clinicians, one measure of success is the individual client's subjective opinion of whether or not they believe the assistance they have been given is successful. There was also consensus that another measure of program success was the degree to which a client adopts the view that the police are there to help and not just enforce the laws; that is you can interact with the police without a crime having been committed. The clinicians also mentioned that clients who have refused help for years are now engaging in treatment and being compliant with a plan.

Recommendations to Agencies that want to Implement a Similar Program

One of the last questions asked of BHRT members was "What would be the top three recommendations you would make to a police department or community attempting to implement a project similar to PPD's SPI program?"

From the police officer perspective, the main recommendation is for an agency to identify and select officers who are willing to do this type of work, full-time and not as an overtime only program. This recommendation is critical because as one officer commented, "This work will absolutely wear on you. There are some weeks I can't even do this work; it is too negative at times and I need a break. If you don't have the right mindset this will not work." **Respondents also mentioned that selecting officers with more time on the job could be useful because they may have prior knowledge of the selected clients.** Also related to this recommendation is ensuring the right dynamic between the officer and clinician because of the need to rely on one another. Agencies should seek out the right combination of partners. **Other**

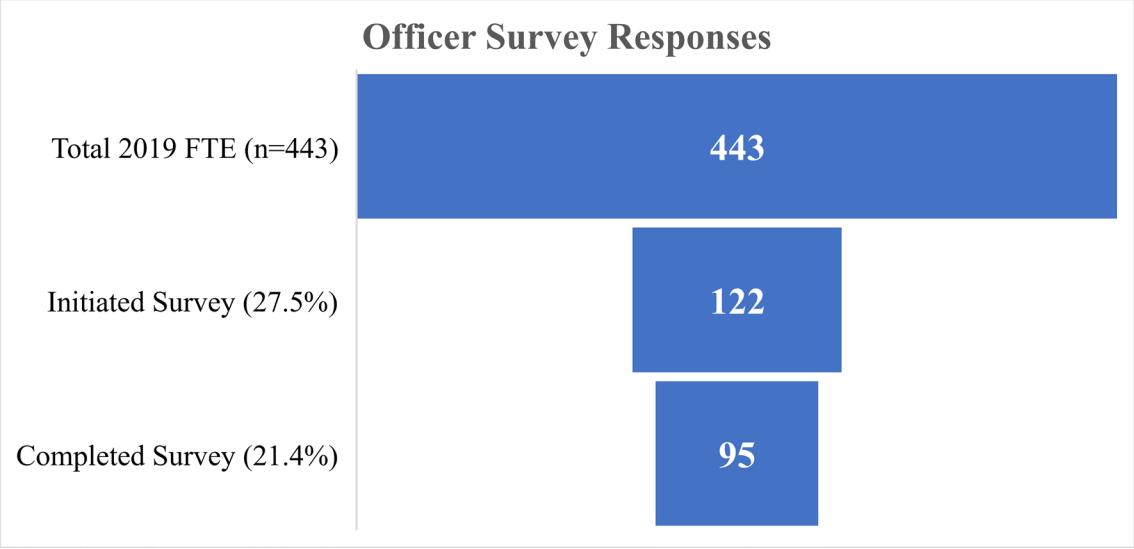
recommendations include the need for good leadership who can make things happen, and having a dedicated transport vehicle for the Teams. Being patient is a final recommendation from the police officers. "Be patient – they are high risk people who need patience. Their issues do not change overnight. If there is no patience, there is no change. This type of program shouldn't be number driven but more focused on qualitative work."

The clinicians also strongly recommended the careful selection of officers to ensure those who are chosen to engage with clients are caring and want to see change. They also believe that permanent, full-time officers should be devoted to this type of program and not be done on an overtime basis only. Other suggestions include being okay with small wins, being proactive, familiarize oneself with other agencies involved in community outreach because working with them can be beneficial to the program, setting aside funds to assist clients with basic needs like food, clothing, and shelter (e.g. 'barrier buster' funds), and consider morning/afternoon outreach to maximize meaningful outcomes.

Police Officer Survey

As an additional point of assessment, the research team developed and administered a survey to all police officers employed by the Providence Police Department. The survey was intended to inform five distinct research questions: (1) To what extent do behavioral health and related calls for service impact police officer workload? (2) How well known was the BHRT initiative across police officers? (3) What is the frequency police officers report engaging the BHRT team/capacity via direct referrals? (4) To what extent do police personnel across the Providence Police Department support efforts such as the BHRT initiative? (5) If given the opportunity, what is the level of interest in getting involved in organizational strategies such as the BHRT initiative? The answers to these questions provide important insight into how the

Figure 5. Overview of Police Survey Response Rate.



BHRT initiative has penetrated the Providence Police Department, both practically and culturally.

The survey was developed by the research team from Roger Williams University and delivered electronically via the Qualtrics online survey platform. The research team developed

an introductory email that explained the purpose of the survey, and included an overview of the anonymity of the data and how the data would be used. The email and the requests for participation were sent on two separate occasions in October-November 2020, and May 2021. Respondents were not provided any incentives to participate, and shift commanders were instructed to stress the importance of the survey and to encourage their officers to complete the survey on a timely basis. By the end of May 2021, 122 officers initiated the survey and 95 officers provided surveys that were substantially complete (e.g., at least 75% of responses provided). The 95 completed survey represents a 21.4% response rate (see Figure 5). While the low response rate raises concerns about the generalizability of the survey results they do provide a general framework for assessing the impact of the BHRT initiative.

Behavioral Health/Related Calls and Police Work

The first set of survey questions asked officers about how behavioral health and related calls impact policework generally. Respondents were asked "What percentage of work-related encounters involve individuals with significance substance use, mental health, or behavioral health problems?"

Table 12. What Percentage of work-related encounters involve individual with significant substance use, mental health, or behavioral health problems?

Response	Percent
None	1%
A few	11%
Some	45%
Most	35%
Nearly All	5%
Missing	3%
Total (Count)	95

Many of the survey questions were generalized to reference "substance use, mental health, or behavioral health" problems due to their comorbid nature. Respondents were also asked to report how well prepared they are to handle these type of calls/incident types.

Approximately 40% of the respondents indicated "most" or "nearly all" of their policing calls involve individuals with significant substance use, mental health, or behavioral health problems with an additional 45% reporting "some" (see Table 12). A relatively small percentage of respondents indicated "none" (1%) or "a few" (11%). Not surprising, these data support the conclusion that behavioral health and related incident types dominate the realities of police work in important ways.

Respondents were also asked to indicate their level of agreement with the following statement: "I personally am prepared to handle most calls that involve individuals with mental and/or behavioral health problems."

Table 13. I personally am prepared to handle most calls involving individuals with mental and/or behavioral health problems.

Response	Percent
Strongly Disagree	5%
Disagree	16%
Agree	55%
Strongly Agree	16%
Neither Agree/ Disagree	5%
Missing	3%
Total (Count)	95

This indicator is important because it assesses officers' self-confidence in handling incident/call types that dominate policework. Nearly 71% of the respondents either agreed or strongly agreed with the statement, indicating an overall high degree of confidence in their capacity to handle these call types. This confidence is important to emphasize, in part due to the long-term attention the Providence Police Department has given to better preparing officers to effectively handle these call types. The partnerships between the Providence Police Department and both The Providence Center and Family Services of Rhode Island are longstanding and part of a longer organizational commitment to policing these problems in ways that are not just more fair and more equitable, but also produce better outcomes.

Table 14. Comparison of Means: Years of Experience and Ability to Handle Behavioral Health Incidents/Calls (n=95).

		Disagree/ Strongly Disagree	Agree/ Strongly Agree*	Total
1-10 Years	Count	7	25	32
	Percent	21.9%	78.1%	100.0%
11+ Years	Count	18	41	59
	Percent	30.5%	69.5%	100.0%
Total	Count	25	66	91
	Percent	27.5%	72.5%	100.0%

It is also important to recognize approximately 21% of respondents also reported disagreement with this statement. This recognition is important because problems associated with behavioral health, substance use, and mental health are so prevalent in police work. It would be useful in later research to explore this dynamic as a way of better understanding the factors that are associated with officers' confidence in policing these complex problems. One key factor that might help to explain officer confidence about policing behavioral health problems could be related to officer levels of experience. To test this potential relationship, the variable "years on the job" was transformed from an ordinal level variable with five categories to two categories that include "1-10 years" (n=32) and "11+" years (n=59). The agreement scale was also transformed to a binary scale where 1=agree/strongly agree and 0=disagree/strongly disagree.

Table 14 revealed an unexpected finding where officers with less experience (1-10 years) reported higher levels of agreement (78.1% agreed or strongly agreed) compared to those with 11 or more years of experience (69.5%). While the numeric difference did not reach the level of statistical significance, it is an interesting point worthy of exploration in the future. There are many factors that might explain this difference. For example, it is possible younger officers have received different types of training and/or assignments that expose them to more effective

contemporary approaches. There is also a possiblity that experience better positions officers to

Table 15. Comparison of Means: Years of Experience by ability to handle behavioral health incidents/calls (n=95).

		Disagree/ Strongly Disagree	Agree/ Strongly Agree*	Total
1-10 Years	Count	7	25	32
	Percent	21.9%	78.1%	100.0%
11+ Years	Count	18	41	59
	Percent	30.5%	69.5%	100.0%
Total	Count	25	66	91
	Percent	27.5%	72.5%	100.0%

Table 16. Awareness of BHRT Initiative (n=95).

Please Check the statement that best reflects your opinion of BHRT	Percent
I am very supportive of efforts such as the BHRT initiative	76%
I am somewhat supportive of efforts such as the BHRT initiative	7%
I am opposed to efforts such as the BHRT initiative	1%
I am indifferent to efforts such as the BHRT initiative	2%
Missing	14%
Total	95

understand the complexity of the problems they face when responding to behavioral health and related calls and the shortcomings of existing strategies and/or infrastructure. While these observations amount to little more than specultation, future exploration of this dynamic is worth considering.

Officer Support of BHRT Initiative and Referrals

From an evaluation point of view, the research partners were interested in surveying all Providence Police officers about their level of support for the BHRT Initiative. Respondents were asked not only to specifically rate their overall level of support, but also the extent to which they had made a referral to the BHRT or specifically sought their assistance for a community

member at least once in the prior six months. These two measures together are important because they reflect not just awareness of the BHRT resource, but a willingness and capacity to engage the team in support of specific individuals.

Respondents reported an overwhelming level of support for the BHRT program. When asked to select the response that best reflects their opinion about the BHRT, 76% of the respondents indicated they were "very supportive" of efforts such as the BHRT initiative, and an additional 7% reported being "somewhat supportive" (see Table 16). An additional 1% of respondents indicated they were opposed to the initiative, and 2% reported being "indifferent." When asked about their engagement with the BHRT, 72% of the respondents indicated they had made a referral to the BHRT initiative or otherwise sought their assistance specific for a community member within the past six months and 28% indicated they had not. This last indicator is particularly important as it indicates not just an awareness, but a willingness to engage on behalf of community members.

Figure 6. Percentage of respondents having made referral to BHRT within prior 6 months (n=95).

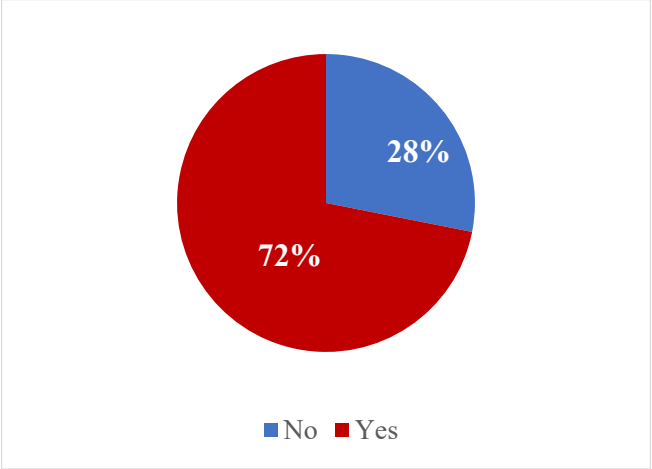


Table 17. Belief in value of police involvement in behavioral health initiatives (n=95).

Question	Strong Disagree	Disagree	Agree	Strongly Agree	Neither	Missing	Percent A/SA
Partnerships between police and behavioral health specialists are important.	0%	3%	28%	65%	0%	3%	94%
Police officers should be directly involved in these types of initiatives (e.g., BHRT).	4%	4%	33%	48%	6%	4%	81%

Belief in Value of Police Involvement in Behavioral Health Initiatives

Survey questions also measured respondents' support of behavioral health initiatives, including their belief that police should be directly engaged in such efforts (see Table 17). Police who articulate support for these types of efforts are, by extension, more likely to engage available resources (Becker, 2021). When asked about their agreement with the statement "Partnerships between police and behavioral health specialists are important," 94% of the respondents either "agreed" or "strongly agreed." Importantly, 65% of the respondents responded "strongly agreed." This level of support for police/behavioral health partnerships is overwhelming and a statement to the importance to policework. Considering the importance of these partnerships, respondents were subsequently asked their support for the direct engagement of police in said partnerships.

It is important to point out police/behavioral health partnerships can "look and feel" different depending not just on the location, but the nature of the calls handled. That is, the local context is important. For example, some communities dispatch civilian specialists to handle behavioral calls absent direct police involvement (Collins, 2021). Other communities such as

Table 18. Respondent interesting in BHRT Training and Program Involvement (n=95).

Question	Strong Disagree	Disagree	Agree	Strongly Agree	Neither	Missing	Percent A/SA
I am interested in getting BHRT Training.	5%	18%	38%	28%	7%	3%	66%
I would be interested in working on the BHRT team.	8%	25%	26%	27%	7%	5%	54%

Memphis, Tennessee train sworn police officers as "crisis intervention specialists" who largely respond to behavioral health related calls without regular civilian involvement in policing efforts (Vickers, 2000). Still other communities create partnerships between sworn police officers and civilian partners to respond to behavioral health, mental health, and substance use problems (Moynihan, Kelley, & Varano, 2021; The Providence Center, 2017). The finding that 81% of respondents "agreed" or "strongly agreed" with approaches where police officers are directly engaged/partnered with clinical behavioral health specialists is a statement about the importance of the program model to the overall policing efforts in Providence.

Respondent Interested in Training and BHRT Involvement

The final survey questions assess respondents' interests in getting BHRT training and interest in working on the BHRT team. The findings indicate approximately 66% of the respondents either "agreed" or "strongly agreed" that they had interest in getting BHRT training, and an additional 54% expressed agreement with the statement "I would be interested in working on the BHRT team." Both measures provide strong evidence about the perceived value and

support for the larger organizational efforts to partner police/clinical partners, and for the BHRT initiative in particular. It is no surprise to anyone connected to police work that the culture is often characterized by cynicism and skepticism. The finding that such a large percentage of respondents not only support such efforts, but have interest in direct involvement is important. It is also worth considering the context of both sets of findings presented in Tables 16 and 18. Although 40%-50% of respondents reported they were not necessarily interested in direct involvement in the BHRT initiative or participating in related training, most still supported these efforts (see Table 16). It is important that successful behavioral health, mental health, and substance use program models are staffed by the right individuals who are at the right point in their careers to be involved in this type of work. Behavioral health program models are not necessarily right for every police officer, and it is likely that police officers themselves intrinsically understand this. While some may feel they are not the right "fit" for such an assignment, they still support the organizational strategies themselves.

Analysis of Arrest/Contact Data

Background

The use of official statistics produced by police agencies, emergency medical services (EMS) and other official data sources to tell the story of the "impacts" of behavioral health programs on populations with unstable living situations, chronic undertreated mental health and substance use issues is tricky. Police, EMS, homeless shelter employees, and other "front line" staff often know these individuals very well and in some cases client histories go back years or even decades. These "frequent fliers" are sometimes colorful individuals with complicated pasts and complex problems that are not captured by official statistics.

This discussion connects to "official data" as a measure of program outcomes in important ways. Policing is an occupation long associated with discretionary decision-making.

Scholars have noted that official statistics like arrests, recorded crimes, and even field contacts are best viewed as social artifacts that are products of officer-level determinants, situational determinants, changing community standards, and organizational priorities (Black, 1971, 1980, 1991; Black & Reiss, 1970; Goldstein, 1960; Mastrofski, Ritti, & Hoffmaster, 1987). Individuals who are known to the police and other first responders as having long-standing mental health/behavioral health problems are likely, at times, treated differently than others. It is likely that in many scenarios police, for example, might be inclined to downplay official responses such as arrests, tickets, and possibly even transports to the hospital due to a perception such responses are a "waste of time" because of perceived ambivalence or indifference on the part of downstream officials (Skogan, 1977). It is also likely that police might respond to encounters with known "problem populations" in more punitive ways, either because they are perceived as more dangerous to the collective community good or due to intolerance, frustration, or both. While the official data discussed below is important to consider, the meaning attached to the results should be understood through this lens.

Methodology

Data related to both police contacts and EMS transports were coded by research staff and a representative from the Providence Police Department. The study period included January 1, 2015 through December 31, 2020. Using October 2018 as the official start of the BHRT outreach, the analysis covers approximately 46 months before the initiation of the program model and 26 months after. Coding was a multi-phase process whereby staff first queried records using a combination of names, dates of birth, and master identification number fields associated with program participants (i.e. unique identifier assigned by law enforcement). While the master identification number is typically considered the individual-level unique identifier, there are

times where one individual could be associated with multiple unique identifiers. The strategy of using multiple combinations of identifier data ensured the analysis was as inclusive as possible. As it relates to the police records in particular, records were identified where program clients could have been in the role of complainant, victim, or suspect/offender. The most typical "role" identified for BHRT clients was that of suspect/offender, or stated more precisely, the subject of the emergency call or proactive police engagement.

Once these records were identified as involving BHRT clients, staff then initiated a coding process to identify elements of the incidents. Data elements coded include temporal data and time of contact, district (post-car area), how the call was initiated (e.g., 911 call or officer initiated), and clients' role in each incident (e.g., complainant/victim or suspect/target of call). Staff also coded if an arrest was made, charges associated with arrests, if force was used, if clients were transported for services, injuries incurred during encounters, and event disposition.

Results, Police Contacts

The impact of the BHRT program is now explored through an analysis of police contact/arrest data. Police contacts represent uniquely important points of consideration as individuals with unmet behavioral health needs who spend considerable amounts of time "on the streets" often experience elevated levels of victimization and negative encounters as well as with police and long-term problems with police. Repeated negative interactions between police and "street populations" can result in perceptions on the part of these individuals, true or otherwise, that police are not concerned with their needs and perceive them to be a danger (Krameddine & Silverstone, 2016).

The 26 BHRT clients with formal program "intakes" accounted for 395 total police encounters during the study period. The total number of documented police encounters ranged

Table 19. BHRT/SPI Client Pre-Post Program Involvement Police Contact Summary (n=395).

Source	Complainant, Non-victim	Complainant, Victim	Suspect/ Target of Call	Total
911/Call	9 (90%) (3%)	62 (77%) (23%)	200 (66%) (74%)	271 (69%) (100%)
Self-Initiated	1 (1%) (14%)	5 (6%) (71%)	2 (<1%) (29%)	7 (2%) (100%)
Officer Initiated	0 (0%) (0%)	14 (17%) (12%)	102 (34%) (89%)	114 (29%) (100%)
Total	10 (100%) (3%)	81 (100%) (21%)	304 (100%) (77%)	395 (100%) (100%)

from a low of one to a high of 49, and an average of 15. Among the 26 clients, 10 had 10 or fewer contacts over the study period and six had 25 or more contacts. The wide distribution or range in the number of recorded contacts is of initial importance. All of the individuals who were proactively engaged as part of the BHRT initiative were targeted due to their identification as a "frequent flyer" of the criminal justice system, local emergency healthcare system and/or other public facing frontline support systems. While many of these individuals were well-known to the project staff and often have reputations as being known "problems" on the street, several were directly referred to the program from patrol officers or other community partners. All of these individuals were vetted and identified as individuals with chronic and unmet behavioral health concerns who were disproportionately impacting the frontline systems. Interestingly, at least as it relates to police contact data, a notable number had few recorded contacts with police. This finding indicates that, although official measures such as contacts and transports often drive the discourse on high-rate utilizers, there are also similarly situated individuals in the same space and of similar concern but for whom the official data do not necessary identify to. It is presumed

in these cases the police or other community partners referred these at-risk individuals to the program.

Sources of Calls/Incidents

Table 19 provides baseline information for all 395 documented police contacts associated with the BHRT clients with program intakes (n=26). Not surprisingly, the vast majority of clients came to the contact of police through the 911 system (n=271). In 62 (23%) of those cases, program clients were the complainant, most typically as the identified victim. In the remaining 200 (74%) incidents, the 911 system indicated that program clients were identified as the suspect or target of the call. Of the remaining police contacts, 114 (29%) were officer initiated and seven calls (2%) were self-initiated by participants.

Program clients were identified as the suspect or target of the police inquiry in 77% (n=304) of all incidents with which they were associated with. In the remaining 81 cases program clients were either identified as the victim/complainant (n=81) or nonvictim/complainant (n=10). While the data clearly indicated program clients were disproportionately identified as suspects/targets in the vast majority of incidents, these data also made it clear that there was a fair degree of victimization associated with this population. The recognition that individuals with chronic behavioral health and related problems living in unstable housing situations experience elevated levels of victimization is important and holds implications for how agencies should consider developing programming. It is worth noting that 16% of these incidents involved warrants, something that should be an issue of special consideration not just for this program, but for other similar programs. Individuals with chronic behavioral health challenges, many of whom are more likely to spend considerable time on the streets, can often be deterred by seeking help due to concerns

Table 20. Analysis of Call/Crime Categorizations.

Charge Type	Total	Percent of Total
Felony Assault	3	1%
Assault Domestic	3	1%
Assault Simple	16	4%
Assault on Police	2	1%
Property Damage	3	1%
Larceny	4	1%
Indecent Exposure	1	<1%
Shoplifting	5	1%
Trespassing	20	5%
Bomb Threat	1	0%
Drugs	12	3%
Weapon	1	0%
Public Drinking	12	3%
Failure To Move	4	1%
Suspicious Person	1	<1%
Panhandling	1	<1%
Disorderly	45	11%
Person Annoyed	2	1%
Warrant/Capias	63	16%
Other Public Order	196	50%
Total	395	100%

about warrants or similar pending legal matters (Varano, Kelley, & Makhlouta, 2019). Unmet behavioral health challenges in combination with transient life circumstances place people who have contact with the criminal justice system at greater likelihood of having warrants due to unmet criminal justice obligations. The presence of warrants, many of which are likely for relatively minor behaviors, such as failure to appear in court or pay fines, may further marginalize these individuals by pushing them increasingly underground to avoid the consequences of warrants. This issue has the potential to create complicated interactions that can only make individuals complicated life situations even more complicated.

Analysis of Contact Types

The 395 police contacts resulted in criminal charges being filed in 191 cases (see Table 20). The largest category of all charges was for non-specific public order offenses (50%) followed by warrants/capias public (16%) order type offenses such as disorderly conduct (11%) and trespassing (5%). More serious violent and property crime was relatively rare among this population, but when it did occur, simply assault (4%) was among the most common. Approximately 3% of the total charge types involved violations of narcotic laws, with simple possession the most common crime.

In addition to the charges, researchers coded additional aspects of police encounters with specific attention to determining if the individual was arrested or transported to the hospital, and if the police incident report narrative indicated evidence of intoxication, mental health crisis or the presence of a weapon. These incident characteristics help inform not just the characteristics of events, but how police typically resolve situations involving program clients. The data provided in Table 21 indicate police contacts involving BHRT clients are "resource intensive" in that they often involve collateral impacts beyond the police such as EMS/Fire and hospital systems. For example,

Table 21. Characteristics of Police Contacts (n=395).

Incident Characteristics	Total	Percent of Total
Arrested	191	48%
Evidence of Intoxication	121	31%
Mental Health Crisis	34	9%
EMS/Fire Mobilized	91	23%
Hospital Transport	122	31%
Weapon	6	2%

arrests were made in 48% (n=191) of all encounters with BHRT clients. Moreover, EMS/Fire was also mobilized in 23% (n=91) of all encounters and individuals were transported to hospitals in 31% (n=122) of the incidents. Incidents involving presence of police officers, EMS/Fire

personnel, and transports to the hospital are not just labor intensive but result in significant financial impacts. While this information is not surprising, it did inform the development of the program model at the outset. Analysis of incident characteristics further illustrates this point.

The data also indicated that individuals were intoxicated in 121 (31%) of the incidents. Experience from program staff suggests that when intoxication exists it is often severe and likely factors into a need for EMS/Fire and even hospital transports. The prevalence of instances of serious intoxication was so consequential that it eventually shifted the BHRT outreach model. When the program first started, police/clinical teams often scheduled overtime shifts in the afternoon into the early evening. Shifts were scheduled at times when staff anticipated they would be most successful in locating clients on the streets of Providence. The outreach teams were routinely faced with clients with such severe levels of intoxication that no meaningful engagement was possible. In many cases, clients were too intoxicated to seriously entertain conversations about program enrollment and were not practically capable of agreeing or consenting to much, particularly programmatic goals such as signing waivers and agreeing to enroll in treatment. This challenge was so significant that by the summer of 2019 the entire approach was changed to direct outreach shifts to morning or early afternoon before clients were able to get too intoxicated.

Table 22 depicts changes in official pre-program (January 1, 2015 to September 31, 2018) and post-program (October 1, 2018 to December 1, 2020) police contacts/arrests for each BHRT clients. The 26 BHRT clients had 262 documented police contacts in the pre-program time period, with a range from one to 31 contacts. Clients had an additional 133 documented police contacts during the post-program period, with a range from zero to 18, with an average of 5.1 police contacts per client. At the aggregate level, BHRT clients experienced almost a 50%

reduction in police contacts during the program period and a similar decrease in the per person average contacts.

Table 22. Change in Pre-Post BHRT Police Contacts (n=26 clients).

Program Measures	Total
Total Pre-Program Police Contacts/Arrests for BHRT Clients	262
Average Pre-Program Police Contacts/Arrests	10.0
Total Post-Program Police Contacts/Arrests	133
Average Post-Program Police Contacts/Arrests	5.1
Outcomes	
Clients with No Change/Increase in Police Contacts	8
Range of Increase in Contacts	1-15
Clients with Decrease in Police Contacts	18
Range of Decrease in Contacts	2-21
Net Change in Police Contacts (All)	129
Net Change in Police Contacts (Clients with Decrease Only)	161
Avg Change in Police Contacts (All)	-4.7
Avg Change in Police Contacts (Clients with Decrease Only)	-8.9

A closer examination of the police contact/arrest data revealed eight of the 26 clients experienced an overall increase in the number of police contacts after the initiation of the BHRT model and the remaining 18 experienced decreases. For the eight with increases in police contacts, the total increase ranged from one to 15 police contacts. For the 18 individuals who experienced decreases in police contacts, the decreases ranged from two to 21. The post-program period was associated with an overall decrease of 129 police contacts and a decrease of 161 among the 18 clients who experienced an overall decline in police contacts. On average, individual clients experienced an overall 4.7 reduction in police contacts. Those with actual decreases in police contacts experienced, on average, a reduction of 8.9 police contacts after the initiation of the BHRT program.

While the data provide evidence of reductions in police contacts associated with the implementation of the BHRT initiative, there is also evidence of tragic outcomes. Three clients passed away during the project period due to health complications. Two of those clients died from apparent overdoses and the third from a hit and run accident, presumably from sleeping on a public road and ultimately being hit by a car.

Notable Client Outcomes

Background

These program impacts are not easily told with highly quantitative data. Therefore, we chose to document notable clients qualitatively. Clinical staff were asked, where appropriate, to document these impacts using the form referenced in the Appendix (see Notable Client Outcomes form). The first three clients (MW, DL, JJ) are presented as "success" stories whereas the next two clients (AC, DP) are presented to demonstrate the difficulty and barriers to helping those with chronic alcoholism and complicated medical histories. The last two clients (SS, TR) passed away during the project period.

MW08241960 (MW)

Since working with the BHRT, MW's quality of life has greatly improved in many different aspects including his compliance with treatment, substance use, and overall insight into his own medical needs. When the BHRT began working with MW, he had just been evicted from his housing provided by The Providence Center and was living on the sidewalk in Olneyville Square. Olneyville Square is a major traffic intersection located in the Olneyville neighborhood in Providence which has been identified as one of the most dangerous neighborhoods within the City (www.areavibes.com). MW was heavily using alcohol, and possibly other substances, on a daily basis. MW was also medically compromised and this fact led to him being taken

advantage of by other people in the area. MW needed a walker or cane to be mobile and these objects had been stolen from him on several occasions. During many of the BHRT's encounters with MW, they found him covered in his own urine and feces. MW was constantly in and out of the emergency departments for intoxication, his medical needs, and suicidal ideations.

During one of his many visits to the emergency department, medical workers determined that he needed hip surgery. After receiving this information, the BHRT coordinated with treatment providers and his primary care physician to have MW placed in a nursing and rehabilitation facility. MW refused to stay in the facility for more than a week and left against medical advice. In the weeks after, the BHRT encouraged MW to return to treatment. During these interactions, MW was tearful and stated his regret for leaving the facility but he was unable to stay compliant with treatment.

Later that year the BHRT encountered MW in Olneyville Square and he was extremely intoxicated and making suicidal statements. The BHRT facilitated MW going to Roger Williams Medical Center where they provided collateral information directly to the clinician and pleaded with the clinician to provide a detox bed and encouraged MW to stay, which he agreed to do. It was during this hospitalization that MW decided to comply with treatment and was transferred from Roger Williams Medical Center to the Kingston Center, a nursing and rehabilitation center in South Kingston, Rhode Island, where he continues to comply with treatment. He will stay and continue to receive care until his hip can be operated on.

The BHRT credits MW's compliance with his treatment plan to his improved understanding of his own medical needs and limitations. When the BHRT began working with him, MW struggled to admit the level of care he needed. Even in the early days at the Kingston Center, MW was constantly telling the BHRT that he wanted to leave, live independently and get

an apartment before his hip surgery. The BHRT provided MW with a lot of verbal encouragement during the early days, encouraging him to remain in treatment and telling him that he was unable to care for himself at that time. The BHRT considers the fact that MW, without any encouragement or prompting, now states that he thinks the best course of action is to remain at the Kingston Center until his hip is operated on and remain there for rehabilitation post-surgery, as a major success. MW constantly talks about his preference to stay at the Kingston Center than return to "the streets."

MW's improved insight also applies to his opinions on housing. When the BHRT first began working with him, MW wanted The Providence Center to assist him with finding housing in Providence. During the BHRT's last outreach with him, MW expressed a desire to have housing as far as possible from the city because he believed there would be less triggers and negative influences. MW stated that he would stay at the Kingston Center as long as it took for TPC to place him; he would rather remain in treatment than experience homelessness again.

Once MW became compliant with treatment he no longer used substances. MW reported that he no longer craved alcohol and was attempting to stop smoking cigarettes which is a requirement to have the hip surgery. During the BHRT's last visit, MW reported only smoking eight cigarettes a day, down from 1.5 packs a day.

In total, MW had 34 contacts with the BHRT during the project period. Prior to the project's start, MW had six official police contacts. In the period after the project began, MW had only one official police contact, outside of the BHRT contacts.

DL04241960 (DL)

Since working with the BHRT, DL's quality of life has significantly improved. Notable areas of improvement include her housing situation, medication compliance, medical treatment,

and her overall relationship with treatment providers. When the BHRT first began working with DL it was difficult to locate her on a consistent basis. Despite having her own apartment at Crossroads Rhode Island, DL spent most of her time outside in the downtown area. Crossroads Rhode Island provides housing and services to the state's residents who are experiencing homelessness. They also provide a range of services which include referrals, education, and employment services (providencechamber.com). DL was well known in the community and with Providence Police Department for loitering and being a nuisance in the downtown area. DL has a history of aggressive behavior and being assaultive towards passers-by. In early 2020, the BHRT was able to locate DL on a consistent basis in either the community or at Crossroads Rhode Island. Having almost daily contact with DL improved the BHRT's ability to monitor her behavioral health, physical health, and medications. Providence Police Department officers not working on the project also noticed a change in DL's behavior and have verbally expressed to the BHRT the improvements they have seen in her behavior along with a decrease in contacts with her.

One of the greatest improvements to DL's quality of life is her housing situation. As previously mentioned, when the BHRT began working with DL she did have an apartment at Crossroads Rhode Island; however, she very rarely, if ever, spent time in it. The BHRT has worked over the past few months to help her feel more comfortable in her apartment. During outreach the BHRT made every effort to try and get DL into her apartment, even offering to spend time with her in the apartment to help her become comfortable. Towards the end of this project, DL was spending a great deal of time in her apartment. DL states that she mostly sleeps in her apartment nowadays but still spends some time in Crossroads Rhode Island lobby. She came to appreciate spending time in her apartment on her own throughout the day. The BHRT

has observed this during several of their outreach visits with DL. DL has been seen in her apartment listening to music or watching television. DL has also reached a point where she actively asks staff members to go into her apartment and becomes upset when it takes the staff "too long" to let her in. On occasion, the BHRT have utilized DL's new-found comfort in her apartment to de-escalate episodes where she has become agitated with Crossroads Rhode Island staff and residents. DL is easily redirected into her apartment and calms down.

Although her specific medical issues cannot be divulged, DL is now in compliance with her monthly injections and allows the nurse from The Providence Center into her apartment in lieu of having it done on the streets. This change is a huge success because when the BHRT began working with her, DL was minimally compliant with her injections. On scheduled injection days, DL would tell staff that she did not want the injection thereby causing the medication's effectiveness to wear off. In these instances, either BHRT or TPC staff would need to persuade her to get the injection. DL will now actively ask when her injection is due and will inform a BHRT member if she feels that she needs her injection earlier than her scheduled time. DL's ability to advocate for herself led to the determination of her TPC treatment team that she needs her injection every three weeks instead of every four weeks. Further evidence of DL's improved attitude towards her injection can be seen in her statements, "it calms me," "I need it," and "Keep it coming." DL relayed to the BHRT that in March she remembered she was scheduled for an injection and left the downtown area and returned to Crossroads Rhode Island because "she had an appointment."

DL has also become more complaint with her mental health treatment. She recently found a new primary care physician and has attended all of her medical appointments and has agreed to

and completed medical lab work. As a result of her seeing a primary care doctor DL has been prescribed additional medication and is compliant with taking it.

Since the BHRT has been working with DL, her overall attitude toward treatment and treatment providers has improved. Towards the end of the project, the BHRT encountered DL on an almost daily basis and she was constantly excited and happy to see the team. DL often thanked the BHRT for "taking care of her." DL is now in more treatment to address her mental and physical health. She is able to use the resources around her to get herself help if she needs it, as evidenced by her self-hospitalization during which she was diagnosed with pneumonia. Crossroads Rhode Island staff and non-BHRT police officers have verbalized an improvement in her overall attitude and behavior as well.

Throughout the course of the project, DL had 193 contacts with the BHRT, the most of any client. Prior to the start of the project, DL had five official police contacts. After the project began, her number of official police contacts increased to eight.

JJ10161965 (JJ)

When the BHRT began working with JJ10161965 he responded very enthusiastically to team intervention. JJ is experiencing homelessness and has a heavy dependence on several substances primarily including, but not necessarily limited to, alcohol and cocaine. JJ has, and continues, to struggle with honesty about his sobriety to the team.

BHRT was able to connect JJ with a TPC team where is currently still an active client. In the beginning of his treatment with the TPC team, JJ attended his scheduled appointments but has recently struggled being consistent with appointments and is at risk of being closed to treatment at TPC.

During his time working with the team JJ did spent a few months in the Adult Correctional Institutions, the state prison system, for possession of narcotics. After his release JJ has continued to fall in and out of sobriety. The team is unable to verify his sobriety when he is out in the community and can only be assured of his sobriety when he is in a treatment facility.

During his time engaged with the BHRT JJ has been in and out of treatment facilities and hospitals for various reasons and durations. JJ recently stayed at the Kingston Center Nursing and Rehabilitation Center for over 30 days. JJ was sent to this facility in an attempt to meet medical requirements for knee replacement surgery. He was able to maintain his sobriety and stop the use of cigarettes during his stay there. JJ also displayed an increased awareness of his success in getting sober while being away from the community in Providence. JJ eventually left the nursing home because, according to him, he was informed by his doctors that he needed to lose additional weight before his surgery. JJ stated that he would rather attempted to lose the weight "at home." His "home" is his significant other's home who also uses substances and often does not allow JJ to stay there. Since leaving the Kingston Center, JJ has returned to using substances and has had multiple hospitalizations due to substance related medical concerns including, but not limited to, concerns with his heart and stomach.

BHRT has connected with JJ several times since he has left the Kingston Center and has encouraged him to return to either the Kingston Center or another facility with a similar level of care. JJ has shown that he understands that he can be successful in a Kingston Center environment but continues to make excuses as to not wanting to return. The BHRT has also been working to reengage JJ with TPC team, which due to personal choices, multiple hospitalizations, and not making scheduled appointments he was not doing. JJ has stated on multiple occasions that he would like to return and reengage with his TPC team.

In total, JJ had 73 contacts with the BHRT during the project period. Prior to the project's start, MW had 12 official police contacts outside of the BHRT contacts. In the period after the project began, MW had only one official police contact, outside of the BHRT contacts.

AC11061967 (AC)

When the BHRT began outreach to AC11061967, he was verbally receptive to outreach but struggled with committing to a plan for treatment. On multiple occasions the BHRT would encounter AC and offer services to help him achieve sobriety. AC often denied services at that time and would ask the BHRT to outreach him later that week or the next week.

During an outreach in January 2020, the BHRT encountered AC, who was intoxicated, and encouraged him to seek medical attention. While at the hospital it became apparent that AC had a serious infection on his foot that needed immediate medical attention. Due to the severity of the infection, AC required half of his foot to be amputated. During his hospitalization after surgery, AC remained compliant with medical treatment. AC was transferred to a long-term rehabilitation facility and remained there for over two months. During this time AC remained sober and worked actively on his needs which included making inquiries into obtaining new dentures and medical cards. AC also showed interest in housing and stated that he would remain in the rehabilitation facility until housing could be arranged. AC left the rehabilitation facility on his own in March, 2020 partially due to the COVID-19 outbreak. AC stated to the BHRT that he felt trapped in the facility and was also concerned about his health if he remained in the facility. After leaving the facility, AC continued to stay in touch with treatment providers, as well as the BHRT and is still looking for permanent housing.

In total, AC had 77 contacts with the BHRT during the project period. Prior to the project's start, AC had one official police contact outside of the BHRT contacts. In the period after the project began, AC had 16 official police contact, outside of the BHRT contacts.

DP06181988 (DP)

From the beginning of the program, DP06181988 was very hesitant to engage with the BHRT, was difficult to locate at times and had been in and out of the Adult Correctional Institutions. DP has declined services almost every time the BHRT has offered him services; however, he continued to speak with and engage with the Team. The Team had an encounter with DP a few months back where he agreed to be transported by the police to TPC to have an intake done. Unfortunately, DP did not go to his follow-up appointments and was not assigned to a TPC team. DP continues to frequent emergency departments and treatment facilities, including TPC's crisis stabilization unit. DP struggles with substance use which continues to be a major barrier to treatment.

In total, DP had 24 contacts with the BHRT during the project period. Prior to the project's start, DP had 18 official police contacts outside of the BHRT contacts. In the period after the project began, MW had only eight official police contacts, outside of the BHRT contacts.

SS01231958 (SS)

When the BHRT first began working with SS01231958, he was very hesitant to engage in treatment. After several outreach attempts, he agreed to work with the BHRT. SS heavily consumed alcohol on a daily basis and his substance use was his greatest barrier to treatment. SS had a room at Crossroads but according to staff, he only used the room to sleep for a few hours each day. The BHRT saw him consistently a few times a week and continued to offer him

services related to mental health, health care, housing, and substance abuse. SS was agreeable to the BHRT "checking- in" with him but never accepted any other services. SS was also very guarded in providing information to the BHRT, often deflecting their inquiries by singing a song to them. Unfortunately, SS fell asleep under a car one evening and was killed when the driver ran over him. It is unclear if SS was under the influence of any substances at that time. Prior to his death, SS had 15 contacts with the BHRT during the project period.

TR12051976 (TR)

When the BHRT began working with TR, she had prior involvement with a TPC team. Through coordination with TR's TPC team members, the BHRT was able to connect with her and she was agreeable to extra support through the BHRT. TR had housing and was, for the most part, compliant with treatment. TR struggled with substance use and had prior involvement with the court system. The BHRT supported TR with her court involvement, which included attending one of her court hearings, however the team could not locate her that morning. Unfortunately, TR died in a substance use related death a few months before the end of the project. TL only had five contacts with the BHRT before his death.

Conclusion

These seven clients were selected as highlights because official data, in and of itself, does not portray their individual needs and complicated histories. These clients illustrate the amount of time it can take to earn a client's trust, get them into the appropriate program/treatment, and work to ensure they remain compliant. Some may be quick to point out that the expense associated with the number of program contacts is much higher than any savings realized by the shown reduction in official police contacts but we caution that this comparison may be misguided as prevention is difficult to measure. First, it is impossible to assign a cost to an

increased trust in police and clinical personal and getting them the needed mental health and substance abuse treatment. Second, we cannot predict just how many future calls to police are avoided because a client agreed to get services and address their issues. Finally, it is difficult to measure the reduced burden on other partners such as emergency departments and other emergency agencies.

Conclusions and Recommendations

Policing in the United States has hit a crossroads in recent years. Different voices from different communities representing different constituencies across different corners of the country have demanded reforms. Although the reform demands currently underway are not new to American policing (see Varano & Schafer, 2021), the intensity of the rhetoric and diversity in voices making these demands is something likely not seen since the 1960s. These recommendations have covered the gamut from outright elimination of policing in some cases to less drastic, but still significant efforts, involving differential call strategies that redirect certain "non-emergency" 911 calls to other community partners [CITE]. Other approaches typically referred to as "co-responder" models that partner police with behavioral health specialists, have also been put forward as more effective ways of delivering better services to some of the most vulnerable populations living in our communities. The development and implementation of a behavioral health response team (BHRT) by the Providence Police Department and their behavioral health partner, The Providence Center, was timely. Co-responding partnerships between police and civilian support specialists are difficult to implement and even more difficult to sustain. Problems related to long term funding, perceived incapability in business processes, and even differences in professional culture can sabotage such efforts before they even get off the ground (see International Association of Chiefs of Police, 2021).

The BHRT project, first proposed in 2017, was an expansion of an on-going policing model, first piloted in the Providence Police Department in 2004, that assigned behavioral health specialists to ride with patrol officers handling routine 911 calls. While on patrol, these co-responding units respond to routine calls and can also be deployed to support other patrol units anywhere across the city if incidents/calls require behavioral/mental health support. Co-responding units are flexible assets that can support a variety of frontline policing needs across Providence. As of September 2021, the Providence Police Department is typically able to ensure that there is at least one co-responding unit on all shifts, seven days a week.

The implementation of this partnership has been routinely recognized as a major organizational accomplishment for the Providence Police Department. Former Chief of Police Dean Esserman, for example, touted this model in his comments to the U.S. Congress' Judiciary Committee in March of 2010. Chief Esserman characterized these and similar partnerships as part of Providence's "innovative and cost effective crime reduction" efforts (U.S. Senate Committee on the Judiciary, 2010, p. 11). Regarding the partnership with The Providence Center, current Chief of Police, Hugh Clements, has stated "The partnership has been positive for all. The Providence Center clinicians are able to connect people who need it most to treatment, and the officers gain a greater understanding about how to deal with people in a mental health or substance use crisis and avoid unnecessary arrests" (The Providence Center, 2021).

The BHRT program was seen as a natural extension of the existing police/clinical partnerships. The Providence Police Department developed this SPI initiative to take the partnership to the next level. The behavioral health response team was designed to create capacity to provide more comprehensive support to individuals who disproportionately impact

first responder systems such as police, EMS, and emergency departments. The program model was also designed to be a quasi-case management approach to support the transition of high-risk clients into comprehensive behavioral health support programs.

The project was designed to achieve four primary goals/objectives. Key among them were:

1. Develop a process for using police data to identify high-rate utilizers of police/first responder services;
2. Reduce arrest of high-rate utilizers with chronic behavioral health problems;
3. Increase access to behavioral health services for high-rate utilizers with behavioral health needs;
4. Increase PPD's capacity to effectively respond to individuals with chronic substance use/mental health problems.

The information detailed below are somewhat mixed as it relates to the extent to which these goals were achieved.

Goal 1: Develop process for identifying high-rate utilizers of police/EMS services

The Providence Police Department was largely successful in developing an organizational strategy for identifying potential clients for the BHRT project. The Team routinely monitored police arrest and contact data, as well as ambulance run/EMS data to identify potential clients for outreach. This process, however, ultimately involved more manual work than initially conceptualized. When the initial concept was developed, the project team envisioned a process were EMS and police contact data would be routinely monitored and summarized in ways that allowed for potential clients to be identified, yet unanticipated practical barriers made this type of automation more complicated than initially anticipated. Chief among

these complications were: (1) disparate systems with different data structures; (2) inconsistent individual identifiers across systems; and (3) disparate event-level coding schemes that do not support unified analysis and interpretation.

Notwithstanding the technical difficulties identified above, the on-going analysis also required project staff to conduct more substantive analysis of event-level records than initially anticipated. Generic police incident codes were not sufficient to identify the type of incidents of interest to program staff. Police codes such as "disorderly conduct," "trespassing," and "resisting officer" are vague and can encompass a wide range of incidents and behaviors. The record management system used by the Providence Police Department does not include standardized codes for behavioral health, mental health, or even substance abuse problems associated with an individual's police encounter. Staff routinely found themselves faced with reading police incident report narratives to get a sense of whether or not incidents were consistent with the program model. As one can imagine, this effort was both labor intensive and not as clearly defined as initially anticipated.

However, an unanticipated outcome of the BHRT initiative is that the team received numerous referrals from other staff within the Providence Police Department. Evidence from the police officer survey and focus groups with program staff indicated they were seen as a referral resource. Police officers routinely encounter people in the course of their shifts that they know need help and are likely good candidates for diversion-like responses. Police officers, however, may be faced with the question, "divert to what?" When communities lack sufficient alternatives to arrest or transport a person to the hospital, police will more often than not respond with the few tools they have as "doing nothing" is typically not an option. When presented with viable alternatives, the data presented here suggest Providence police officers are willing and interested

in making referrals to community programs better able to meet the needs of individuals with complex behavioral health problems. Police officers demonstrated high levels of awareness of the program, reported they made referrals to the BHRT, and believe these types of intervention models are viable approaches to dealing with high-risk individuals. This finding supports the conclusion that police officers themselves support the need for similar program models.

Goal 2: Reduce arrest/formal police contacts of high-rate utilizers with chronic behavioral health problems

The data presented in this report also indicate the implementation of the BHRT initiative was associated with a substantial reduction in arrests and police contacts for the program-identified clients. "Program-identified clients" are those individuals that agreed to have a program intake and signed a waiver permitting information sharing. Formal police contacts are recorded instances of official police action, typically coercive or enforcement-related actions, pursuant to emergency calls or self-initiated work performed by police officers on shift. Not included in this analysis are program-initiated outreach contacts performed by BHRT staff. Table 19 indicates that of the 395 arrests/police contacts associated with BHRT clients, these clients were identified as a suspect or target of the incident in 76% of the cases and identified as a victim in 22% of the remaining cases.

Of the 24 clients who provided an intake and signed waiver, 18 have decreases in the number of police contacts post-program and six experienced increases. For the six clients with increased police contact, the per client increases ranged from one to eleven. For the 18 individuals with reductions in police contacts, the reductions ranged from two to 31 fewer police contacts or arrests with a total reduction of 141 across these individuals. Among all 24 clients, BHRT clients experienced 109 fewer police contacts. The average number of police contacts per

client was also reduced from 10 to 5.5 with an average *change* in police contacts of -4.5 for all clients and -7.8 among those clients with reduced police contact.

A cautionary note must be added as it relates to changes in the official data discussed above. The coronavirus pandemic swept across the United States beginning in March 2020 and lasted through the end of the project period. The coronavirus has been a significant disruptor to "normal" community institutions and has challenged the capacity of many education, economic, and social systems. Many businesses closed temporarily in the weeks and months that followed in the Spring of 2020, and even more quickly adapted to a virtual workforce. Much of the criminal justice system similarly pivoted in response to the ever-shifting reality on the streets. Many court systems temporarily suspended all but the most serious legal proceedings, some correctional institution worked to reduce incarcerated populations, and even police became more strategic about how and when respond to calls for service and/or take legal action (e.g. initiated traffic stops or make arrests) where discretion existed (Boman & Gallupe, 2020; Jackson et al., 2021). With these adaptations in mind, it is unclear how the coronavirus pandemic and the impact it had on individual and institutional behavior impacted these data points.

Goal 3: Increase access to behavioral health services for high-rate utilizers with behavioral health needs

The BHRT project had difficulty demonstrating their efforts were able to connect clients to behavioral health services to the extent envisioned at the outset of the program. The program evaluators were purposely ambitious but due to a lack of prior research in this area, the hurdles that developed were almost impossible to predict and work-arounds had to be implemented. It was also difficult to document important program measures. One of the primary factors prohibiting this type of data collection is that the plan itself was more ambitious than originally

anticipated. When the evaluation plan was initially created, the program designers envisioned that clients would readily agree to formally enroll in treatment services, and subsequent individual-level treatment data could be tracked. In reality, many BHRT clients typically had long histories with serious and chronic behavioral health, mental health, and substance use problems and were well known to local service providers. Clients were typically most welcoming of short-term stabilization support that met some of their most immediate needs but were almost universally reluctant to voluntarily enroll in long-term treatment programs.

The notable client outcomes section of this report was an attempt to tell the more nuanced stories of important program outcomes that in some cases quite likely saved the lives of targeted individuals. It is hard to fully communicate the complicated life-histories of many of these clients, including the intensity of their challenges. In two particular documented cases, clients had serious health issues that could not be medically addressed due to chronic alcohol abuse issues. Staff worked to stabilize these individuals enough to get the needed medical care, and then ultimately transition them from the streets to long-term care facilities. Although one client ultimately returned to the streets due to his in ability to stay sober, his prior connections with program staff resulted in him voluntarily seeking their support and subsequent enrollment in a detox program. The BHRT often worked with complicated people in "messy" life situations. The complexity of these cases is often one of the primary reasons other service providers might walk away. Unfortunately, these are not always storybook endings with case studies of clear success. As hard as it is to say, the BHRT was more often than not involved in work that could be best described as death prevention. It is often acknowledged in the field of harm reduction that preventing death gives one more opportunity at helping, the complicated work done by staff to stabilize individuals created new opportunities for improvement of quality of life.

One important lesson learned during the implementation of the BHRT initiative was the unanticipated culture conflict related to one's right to refuse treatment. Police officers typically approach their work through the lens of coercive authority. Police responses are, more often than not, mobilized as a response to an incident connected to issues of public safety. Whether it be responding to a 911 call or self-initiated activity, police authority is mobilized when there is present danger to the safety of individuals or communities. Public safety concerns give police a certain level of authority to take action and that action is often at odds with the wishes of individuals. Clinicians, however, bring a much different orientation to these partnerships. Absent clear emergency circumstances, the professional culture and principles of ethics of social work and related fields is that individuals have the right to refuse help (Ruffalo, 2016). Clients with the cognitive capacity to make decisions should, when all else is equal, be given a degree of self-agency to refuse treatment. Forced treatment is often discouraged among clinicians due to evidence that such approaches can often create more problems than they fix (Chau et al., 2021).

The issue of forced treatment versus the right to refuse assistance has the potential to cause problems in co-responder program models. The action orientation in police culture can sometimes be at odds with a clinical culture that leans heavily toward individual choice, even if that choice might result in bad outcomes. These tensions often become even more pronounced in proactive, case-management approaches where the day-to-day encounters are initiated by program staff versus pursuant to emergency calls. The BHRT staff, all of whom have a long history of professional collaboration, were able to rely on their mutual respect and understanding of each parties' professional responsibilities. Clinical staff, all of whom also had histories of riding on patrol and handling 911 calls, had a good sense of policing and situations where they need to take a step back and allow police to do their jobs. With this deep history and mutual

trust as a background, sworn members of the BHRT demonstrated a willingness to defer to clinicians in proactive program encounters. Formal police responses such as arrests and citations were heavily deemphasized as a formal part of the program model, and police demonstrated a willingness to come to terms with the "no response is (or can be) an appropriate response" orientation when determined appropriate by co-responding teams. This orientation is an area for potential conflict if not understood and proactively addressed at the planning stages of similar programs.

Goal 4: Increase PPD's capacity to effectively respond to individuals with chronic substance use/mental health problems.

The data provided in this report provide strong support that the Providence Police Department, in partnership with The Providence Center, has significantly improved their capacity to effectively respond to individuals with chronic substance use/mental health problems. The BHRT program was an outgrowth of the on-going partnership between these organizations. The existing co-responder program, which is still in effective today, has created an ability for police to more effectively address the needs of people in crisis during police encounters. This programmatic infrastructure created a new starting point for the Providence Police Department. The BHRT was intended to compliment this approach by thinking more holistically about the needs of high rate utilizers of first-responder systems. Instead of just dealing with people in acute crises, the BHRT effort was designed to identify those regularly in acute crisis and engaging them in proactive outreach with the intent of stabilizing them and creating long term access to treatment. The evidence provided from the focus groups and the survey of police officers indicates strong levels of support. Seventy-six percent of surveyed officers indicated they were supportive of the BHRT program and 72% reported they made a referral to the BHRT

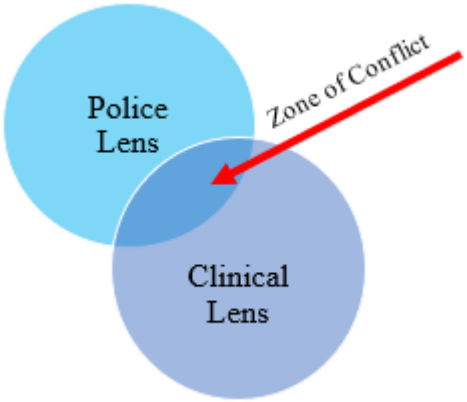
in the six months prior to the survey. In addition, 81% of police officer respondents indicated they were supportive of partnerships between police and behavioral health specialists. The high degree of support among police officers and their use of these resources provides strong support that this model is appropriate and important to policing.

Recommendations for Moving Forward

1. Co-Responder models as viable approach to individuals with behavioral health problems: This project supports the conclusion that co-responder models are viable approaches to delivering more efficacious services to at-risk individuals living in communities with behavioral health problems that bring them into frequent contact with the criminal justice system.
2. Staffing Matters: Communities considering implementing co-responder models similar to the BHRT initiative are encouraged to give serious attention to staffing decisions. From the police perspective, it is important that officers understand this type of work is not just another overtime shift. Working with individuals with significant behavioral health, mental health and/or substance use issues is not for everyone. It is important that police officers approach this work with a sense of "thick skin" and exercise maximum tolerance, where appropriate, for noncompliant or even antagonistic attitudes. Patience, empathy, and understanding must govern police/community member interactions in these type of program models. When working directly with non-police partners, police officers must also be willing to negotiate the parameters of their working relationship. Decisions about if and when to arrest, issue citations, search a person, etc. must be considered through a behavioral health lens. From a clinician point of view, clinical staff must feel comfortable collaborating with police and should understand police culture. Police

culture is often associated with a morbid or dark sense of humor and cynicism. There are also times when police must exert their authority to invoke the law (e.g., make an arrest or use force), even if invoking the law might seem to run counter to clinical goals. The most effective partnerships are those where both parties bring humility, mutual respect,

Figure 7. Behavioral health co-responder models – Zone of Conflict.



and trust to the relationship. Parties must be willing to negotiate and renegotiate the boundaries of these relationships as programs evolve over time. Communities considering co-responder models are strongly encouraged to work these issues out in advance as they are bound to cause conflict if they are not addressed up front. Agencies are encouraged to provide clear Memorandums of Understanding that clearly outline each partners' responsibilities and any issues related to information sharing. Partners should not reply on habit and past practice to ensure work can continue to the future. These agreements must be codified into formal documents.

3. Establishing program ground rules early on – Business Practices: Communities are also encouraged to recognize there may be times when one partner's professional lens/orientation might appear to be in conflict with the other partner's professional lens/orientation. Respecting those boundaries, and creating shared agreement as to what

will happen when these situations arise is critical for success. We believe the illustration in Figure 7 symbolizes the reality that some responses to incidents/people might be clearly criminal justice in nature; other responses clearly clinical in nature, and yet other responses will fall into a gray area. Communities are encouraged to recognize the reality of these likely conflicts and create frameworks that minimize their potential impacts.

4. Need for leadership at federal and state level to guide the legal frameworks: There are important legal and ethical questions that naturally arise in co-responder programs that will likely emerge in any new programs. Clinicians are faced with professional and personal liability if they do not abide by state-level and federal regulations related to privacy and information sharing. HIPAA and other legal frameworks such as 42CFR Part 2 restrict information sharing that can thwart some of the most well-intended collaborations. The U.S. Department of Justice and Department of Health and Human Services have published some guidelines to help inform these partnerships.[i] The general consensus is that exigent circumstances associated with responding to 911 calls or "emergency circumstances" permits data sharing between police and clinical partners. The BHRT program pushes the boundaries of this understanding. The BHRT initiative adopted a proactive, case management approach that is arguably not consistent with "exigent circumstances" classification. The BHRT was able to sidestep some of these issues through the use of signed waivers, and even situations where clinicians knowingly withheld protected information from police personnel. The liability faced on police and clinicians is real and the federal government should take the lead by clarifying the implications of privacy laws, and where needed, creating new laws that facilitate these

types of innovative partnerships. It is not reasonable to ask organizations to "hope for the best" and move forward as the costs are too great, both personally and professionally.

5. Practical issues that should be addressed early on: There are additional programmatic considerations communities are encouraged to plan for that emerged during this project. First, communities are encouraged to develop plans for how to handle warrants toward the beginning stages of their program. The BHRT found that numerous clients had warrants, mostly for relatively minor issues such as unpaid fines or failure to appear in court. Warrants can pose a significant barrier as those with warrants will opt not to access treatment. It could be useful to develop a parallel process for helping individuals to address outstanding warrants without necessarily needing to resort to arrests. Second, communities are encouraged to think long and hard about practical issues such as the timing of co-responding shifts. The BHRT initially scheduled outreach shifts in the late afternoon or early evening based on the thought more people would be "out and about" and more easily contacted. The team eventually learned it was better to schedule shifts in the late morning because clients were often too intoxicated later in the afternoon for meaningful engagement.
6. Right to refuse help: Behavioral health work typically involves a general understanding that people have a right to refuse help. Assuming individuals are not in imminent danger to themselves or others, behavioral health specialists typically discourage forced treatment program models. This practice can sometimes cause conflict with police partners as police are generally action-oriented and inclined to take some action to mitigate a problem or danger. It is important that police and co-responder partners develop clear protocols around this issue.

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[i] https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf.

APPENDIX

Shift Overtime Report

Providence Police Department
SPI Program
Police Overtime Shift Report

Date: _____ Shift Start/End: _____

PPD Staff Involved in Outreach: _____

Clinical/Case Management Staff Involved: _____

	Count
How many unique SPI clients were targeted for this shift?:	
How many unique SPI clients were contacted during this shift?:	
How many unique non-SPI BHRT clients did the team contact?:	
How many visits to an EMERGENCY DEPARTMENT were made during shift on behalf of SPI clients?	
How many phone/personal communications were made on behalf of SPI clients with medical personnel?	
How many phone/personal communications were made on behalf of SPI clients with other Clinical/Case Management personnel?	
Shift Narrative:	

Client Outreach Form

Providence Police Department
SPI Program
Police-Directed Client Outreach

Date: _____ Time: _____

PPD Staff Involved in Outreach: _____

Outreach Location (Address if Possible): _____

Client ID[1]: _____

How would best describe client's response to this outreach visit?: (Choose One)

☐ 1=Openly hostile/combative	☐ 4=Reluctant but cooperative
☐ 2=Neutral	☐ 5=Fully Cooperative
☐ 3=Disengaged but not hostile	☐ 6=Other: _____ _____

Was client considered an "active" or "enrolled" program participant at the time of outreach visit?

☐ No ☐ Yes

If "No," was client asked to consent to participate in the SPI program?

☐ No ☐ Yes ☐ N/A - Client was already an enrolled participant

If "No," did client consent to participate in the SPI program based on this contact?

☐ No ☐ Yes ☐ N/A - Client was already an enrolled participant

After the outreach visit, how would you best characterize client's program consent?

☐ 1= Consent signed during visit	☐ 3= Consent not yet provided
☐ 2=Consent already on file	

How would you best describe client's willingness to get access support offered from the SPI program? (Choose One)

☐ 1= No interest in additional help/support	☐ 3= Moderate interest in additional help/support
☐ 2= Slight interest in additional help/support	☐ 3= A lot of interest in additional help/support

What interventions did you provide specifically during outreach visit? (Check all that apply)

☐Provided handouts/printed info about services ☐ Provided verbal information about TPC

☐Provided verbal information about other services ☐ Transported directly to services

If transported, please identify where: _____

[1] This form cannot be submitted without a verified client ID. If one is not available, please request one from BHRT clinician.

Providence Police Department

SPI Program

Police-Directed Client Outreach

Form Description:

This program documentation instrument is intended to establish a formalized approach to documenting officer initiated outreach victims. This form will be collected by police officers only, and the data will be collected and maintained in a program specific database. The form links to several program objectives. The following information defines those objectives, with a brief explanation how this form links to these goals:

Goal 1: SPI will establish a protocol for identifying high rate utilizers of police/fire/ems services, and develop a protocol for police directed outreach visits to offer support.

- ✓ This form provides the capacity to track client-level contacts. This provides the capacity to measure total program contacts, frequency of clients, and client-specific contact measures.

Goal 2: SPI will establish a police-clinical partnership which will facilitate access to behavioral/mental health support services.

- ✓ This form permits staff to track two critical issues central to access services: (1) Consent to participate and data share; and (2) Willingness to participate. Consent is tracked as a series of separate measures since it is critical to the overall case management function.

Goal 3: SPI will provide direct support to clients during outreach visits. Support will be in the form of information about services.

- ✓ This form tracks support information/support provided to client by SPI staff.

Notable Client Outcome Form

Providence Police Department
SPI Program
Notable Client Outcomes

[This document is intended to track notable client outcomes for the SPI program. A "Notable Client Outcome" is defined as a key milestone on road to treatment and quality life outcomes.]

Client ID: _____ Report Date: _____

BHRT/SPI Staff Completing Report: _____

Clinical/Case Management Staff Involved: _____

Outcome Domains:

☐ Behavioral Outcome ☐ Substance Use Outcome ☐ Healthcare/Medical Outcome
☐ Housing Outcome ☐ Other: _____

Provide Summary of the Client Outcome and how it relates to SPI Goals

BHRT Staff Interview Protocol

Roger Williams University
School of Justice Studies
One Old Ferry Road, Bristol, Rhode Island 02809-2921
401.254.3021 • 401.254.3431 Fax • 1.800.458.7144 • www.rwu.edu

Strategies for Policing Innovation/Behavioral Health Response Team

Staff Interview Form

1. Identify staff's primary role on the SPI program: [ ] Clinician [ ] Police Officer
2. Approximately how many years have you been working in this role: _____
3. What is the highest degree you have earned? [ ] HS Diploma [ ] BA/BS [ ] Grad.
4. Have you have specialized training that you feel prepares you to work on the SPI program?

   [ ] No [ ] Yes – If Yes, Describe:
   _____

5. How would you best describe a "typical day" working on the SPI program? Can you provide a run down for how the day is structured?

6. How would you best describe your main responsibilities on the SPI program?

7. How did you become involved in the SPI program? The SPI program is different in many ways from how both police and clinicians do their typical job. Why did you get involved in this program?

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8. Based on your experience working on SPI, what type of specialized training would you recommend for police officers to do this type of work effectively?

9. Based on your experience working on SPI, what type of specialized training would you recommend for clinicians/clinical staff to do this type of work effectively?

10. Based on your experience working on SPI, what type of personality characteristics would you recommend for clinicians/clinical staff to do this type of work effectively?

11. Based on your experience working on SPI, what type of personality characteristics would you recommend for clinicians/clinical staff to do this type of work effectively?

12. How would you best describe the role of police staff on the SPI program? Please speak specifically to all aspects of the program, including program management and client engagement.

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13. How would you best describe the role of clinical staff on the SPI program? Please speak specifically to all aspects of the program, including program management and client engagement.

14. What do you like most about your work related to SPI?

15. What do you like least about your work related to SPI?

16. What are the most pressing barriers you experience that reduce your ability to do what you need to do on the SPI program?

17. What do you think is a measure of success for the SPI project?

18. What would be the top 3 recommendations you would make to a police department or community attempting to implementing a project similar to PPD's SPI program?

Providence Police Department Survey Instrument

Default Question Block

Roger Williams University
School of Justice Studies

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INFORMED CONSENT DOCUMENT

STUDY TITLE: Providence Police Department Officer Survey

RESEARCH PROCEDURES This research is being conducted to allow Providence Police Department (PPD) officers an opportunity to comment on the department's Behavioral Health Response Team (BHRT) initiative. If you agree to participate, you will be asked to complete a survey which will take about 15 minutes to complete.

The BHRT is a partnership between the Providence Police Department and The Providence Center. The BHRT creates street-level response teams that partner police officers with clinical staff to respond to the needs of those encountered by the police who are experiencing psychiatric (emotional, behavior) emergencies. The BHRT provides an alternative response capability which deemphasizes the arrest response in favor of behavioral health support.

RISKS There are no risks for participating in this research. The questions asked are general questions about your attitudes toward the BHRT and crisis intervention in general. The survey and each of its questions are voluntary, and you may choose not to answer any questions. Your answers are confidential.

BENEFITS There are no benefits to you as a participant other than the opportunity to share your opinions and to advance research in policing.

CONFIDENTIALITY Your name is not recorded in this survey and only the Roger Williams University (RWU) research team will have access to completed surveys. Cumulative results will be shared only in the aggregate such that responses will not be associated with any individual participant.

PARTICIPATION Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or if you withdraw from the study, there is no penalty. There are no costs to you or any other party for participating in this research.

CONTACT This research is being conducted by Dr. Sean Varano and Dr. Stephanie Manzi at Roger Williams University. Dr. Varano may be reached at 401-254-3738 and Dr. Manzi may be reached at 401-254-3369 for questions or to report a research-related problem.

CONSENT Please indicate if you wish to participate in this survey below:

- ○ I consent to participate in this study
- ○ I do not wish to participate in this study

Background

The Behavioral Health Response Team (BHRT) is an initiative developed between the Providence Police Department and The Providence Center (TPC) in 2017 to provide proactive support for individuals in the City of Providence experiencing chronic mental health and substance use issues that put them in regular contact with the police. *This effort is separate and distinct from the existing partnerships between the Providence Police Department and behavioral health agencies such as TPC and Family Services of RI.*

Please answer the following questions based on the Providence Police Department's **BHRT Initiative:**

	Strongly Agree	Agree	Disagree	Strong Disagree	Neither Agree/ Disagree
Prior to this survey, I was aware about the presence of the BHRT initiative.	○	○	○	○	○
Prior to this survey, I understood the purpose of the department's BHRT initiative.	○	○	○	○	○
Prior to this survey, most of my colleagues were aware of the presence of the BHRT initiative.	○	○	○	○	○

	Strongly Agree	Agree	Disagree	Strong Disagree	Neither Agree/ Disagree
I can think of at least 1 specific community member the BHRT has provided important support.	○	○	○	○	○
Efforts such as the BHRT are important to our department's policing efforts.	○	○	○	○	○

How often do you use the BHRT/other clinicians to serve community members experiencing a mental health crisis?

- ○ Daily
- ○ Weekly
- ○ Monthly
- ○ A few times a year
- ○ Yearly
- ○ Less than One a year
- ○ Never but Aware of Initiative
- ○ Never but NOT Aware of Initiative

In the past 6 months, have you ever made a referral to the BHRT or otherwise sought their input related to a specific individual?

- ○ Yes
- ○ No

If yes, approximately how many times?

Regardless if you were previously aware of the BHRT Initiative, please check the statement that best reflects your opinions:

- ○ I am very supportive of efforts such as the BHRT Initiative
- ○ I am somewhat supportive of efforts such as the BHRT Initiative

- ○ I am somewhat opposed to efforts such as the BHRT Initiative
- ○ I am very opposed to efforts such as the BHRT Initiative
- ○ I am indifferent to efforts such as the BHRT Initiative

Please answer the following questions:

	Strongly Agree	Agree	Disagree	Strong Disagree	Neither Agree/ Disagree
I am interested in getting BHRT Training	○	○	○	○	○
I would be interested in working on BHRT specialized unit/team	○	○	○	○	○
Partnerships between police and behavioral health specialists is important	○	○	○	○	○
Police officers should be directly involved in these types of initiatives (e.g., BHRT)	○	○	○	○	○
Police officers should not be directly involved in these types of initiatives (e.g. BHRT)	○	○	○	○	○
I personally am prepared to handle most calls involving individuals with mental health and/or behavioral health problems	○	○	○	○	○

What overall percentage of your work-related encounters with the public involve an individual with significant substance use, mental health, or behavioral health problems?

- ○ None
- ○ A few
- ○ Some
- ○ Most
- ○ Nearly All

After responding to a call involving a person exhibiting signs of mental illness, how long (approximately) does it typically take until you are able to resume your other law enforcement duties?

- Less than 1 hour
- 1 hour
- 2 hours
- 3+ hours
- Not Applicable

Now Tell Us a Little About You:

What District Are you Currently Assigned To:

Approximately how many years have you been employed by the Providence Police Department?

- Less Than 1 Year
- 1-3 Years
- 4-6 Years
- 7-10 Years
- 11+ Years

What shift do you typically work now?

- Days
- Out First
- Out Last
- Other/Non-Patrol

If "Other/Non-Patrol," what is your assignment?

- Detectives/Youth Services
- Traffic
- Narcotics

Have you received Crisis Intervention Team (CIT) training or other similar training specific to handling an individual experiencing a mental health or emotional crisis?

- Yes
- No

How effective was the CIT training (or similar training) you received in terms of providing you with the tools to respond to an individual experiencing a mental health or emotional crisis?

- Very Effective
- Somewhat effective
- Not Effective
- I have not taken CIT Training