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Child Development–Community Policing: Partnership in a Climate of Violence

Steven Marans, M.S.W., Ph.D.
Miriam Berkman, J.D., M.S.W.

The New Haven Department of Police Services and the Child Study Center at the Yale University School of Medicine have developed a unique collaborative program to address the psychological impact of the chronic exposure to community violence on children and families. The Child Development–Community Policing (CD–CP) program brings police officers and mental health professionals together to provide each other with training, consultation, and support, and to provide direct interdisciplinary intervention to children who are victims, witnesses, or perpetrators of violent crime. The New Haven program serves as a national model for police-mental health partnerships across the country.

Children's Exposure to Violence

The experience of victimization by violence is far too common among children in America, as evidenced below:

- In 1994, almost 2.6 million youth ages 12 to 17 were victims of crime—simple and aggravated assaults, rape, and robbery (Bureau of Justice Statistics, "National Crime Victimization Survey." Unpublished table.).
- In 1994, an estimated 3.1 million children were reported to public welfare agencies for abuse or neglect. More than 1 million of those children were substantiated as victims (Wiese and Dara, 1995).
- Homicide is the leading cause of death among African American males ages 15 to 24 (Hawkins, Crosby, and Hammett, 1994).
- A survey of inner-city high school students revealed that 45 percent had been threatened with a gun, or shot at, and one in three had been beaten up on their way to school (Sheley and Wright, 1993).

In addition, an alarming number of children who are not the direct victims of physical assault become potential psychological casualties as they witness violence both at home and in the broader community. For example:

- In a study conducted at Boston City Hospital, 1 out of every 10 children seen in their primary care clinic had witnessed a shooting or a stabbing before the age of 6—50 percent in the home and 50 percent in the streets. The average age of these children was 2.7 years (Taylor et al., 1992).
- In a study of New Haven 6th, 8th, and 10th grade students, 40 percent reported witnessing at least one violent crime in the previous year (New Haven Public Schools, 1992).
- In a survey of fifth and sixth grade students in Washington, D.C., 31 percent reported having witnessed a shooting;

From the Administrator

Too many of our Nation's children are falling victim to pervasive violence. Even young people who do not bear the physical scars of domestic and societal violence are often emotional casualties.

The tragic consequences to children of chronic exposure to violence are considerable. They include depression, anxiety, stress, and anger. Alcohol abuse, academic failure, and the increased likelihood of acting out in a violent manner are part of the costly legacy left by a climate of violence.

With the support of the Office of Juvenile Justice and Delinquency Prevention, the New Haven Department of Police Services and the Yale University Child Study Center have established a program that addresses the adverse impact of continuing exposure to violence on children and their families, and attempts to interrupt the cycle of violence impacting so many of our children.

Reflecting New Haven's commendable commitment to community policing, the Child Development–Community Policing Program brings law enforcement and mental health professionals together to help children who are victims, witnesses, and even perpetrators of violent acts.

I am pleased to present this promising model of professional partnership for your consideration.

Shay Bilchik
Administrator

17 percent had witnessed a murder; and 23 percent had seen a dead body (Richters and Martinez, 1993).

- Among males in some high schools as many as 21 percent reported seeing a person sexually assaulted; 82 percent had witnessed a beating or mugging in school; 46 percent had seen a person attacked or stabbed with a knife; and 62 percent had witnessed a shooting (Singer et al., 1995).

Children's exposure to violence and maltreatment is significantly associated with increased depression, anxiety, posttraumatic stress, anger, greater alcohol use, and lower school attainment (Garbarino et al., 1992; Martinez and Richters, 1993; Singer et al., 1995; Cicchetti and Carlson, 1989).

Richters and Martinez (1993) produced substantial evidence that parents tend to significantly underestimate their children's exposure to community violence as well as associated stress symptoms. Recognition of and verbal dialog regarding children's experience with violent events were seen as the most likely ways to mitigate the formation of stress symptoms.

Youth who are repeatedly exposed to multiple risk factors—for example, socially isolated, impoverished, violence-ridden neighborhoods—require the most "intensive integrated, sustained, coordinated, and comprehensive intervention" according to the recommendations of a consensus of professionals in the field (Carnegie Council on Adolescent Development, 1992a; Citizens Committee for Children, 1993; Greene, 1996; Palmer, 1983; Schorr, 1989).

In addition, as indicated by the following figures, children who experience violence either as victims or as witnesses are at increased risk of becoming violent themselves:

- In an OJJDP-funded study of children in Rochester, New York, children who had been victims of violence within their families were 24 percent more likely to report violent behavior as adolescents than those who had not been maltreated in childhood. Adolescents who were not themselves victimized but who had grown up in families where partner violence occurred were 21 percent more likely to report violent delinquency than those not so exposed. Overall, children exposed to multiple forms of family violence reported twice the rate of youth violence as those from nonviolent families (Thornberry, 1994).
- In a survey of 30 incarcerated delinquent adolescents in Connecticut, 83 percent reported previously witnessing a shooting, 67 percent reported witnessing a stabbing, and 53 percent reported witnessing a killing. Sixty-three percent of the respondents reported having been shot at and 50 percent reported having been stabbed (Vitulano et al., 1996).
- In a survey of New York City's juvenile detention facility, 79 percent had seen a person stabbed or shot; 58 percent had a family member who had been shot or stabbed; and 38 percent had been shot or stabbed themselves (City of New York, 1993).

These children are of particular concern to law enforcement as they perpetuate the cycle of violence into the next generation.

Police officers, as the first responders on scenes of violence and tragedy, have frequent contact with the children and families most at risk as a result of their exposure to violence. However, officers ordinarily do not have the training, the practical support, or the time to deal effectively with the psychological aftermath of children's experiences with violence. While mental health professionals may be equipped to intervene to ameliorate the psychological consequences of children's exposure to violence, traditional, clinic-based therapists often have no opportunity to treat these children until months or years later, when they are presented with entrenched symptoms such as school failure or dangerous, disruptive, and violent behavior. The CD–CP program, developed in New Haven, Connecticut, brings police and mental health professionals together to develop new, collaborative approaches to problems that are beyond the reach of either profession when working in isolation. This opportunity is especially clear in the context of the New Haven model of community policing, which places officers on permanent assignment in neighborhoods, expands their role in building relationships with community residents, and encourages their regular contact with children and families in a range of nonconfrontational settings.

Community Police Responses

At best, police can provide children and families with a sense of security and safety through rapid, authoritative, and effective responses at times of danger. Often, however, children's contacts with police officers arouse more negative feelings. For example, the arrival of officers after a violent event can reinforce a child's sense of being unprotected and the feeling that those in charge provide too little, too late. For many children, particularly those in impoverished inner cities, the police are seen as representatives of a dominant, insensitive culture and quickly become targets of children's anger toward a hostile and uncaring society.

Community policing provides officers with opportunities to minimize these negative experiences and instead offer children positive models for identification. Police officers who take on a consistent, authoritative presence in their neighborhoods are potential heroes for young people for whom there are all too few prosocial adult models. As community policing places individual officers on long-term assignments in specific neighborhoods and encourages them to work with community residents to analyze and solve problems before they erupt in lethal violence, children and families come in contact with officers in a wide variety of helping roles well beyond the context of such traditional police functions as making arrests or executing search warrants. As community policing integrates officers within their communities they become known as individuals, rather than by role, and they come to know the people they serve as individuals. These strategies allow officers to develop relationships and assume roles in children's lives that would not be possible in a more impersonal, incident-driven policing system.

For example, following a child's exposure to a serious incident of violence, regular contact with a familiar beat officer can serve to increase the child's sense of security, provide a prosocial adult model for identification, and support the child's family to obtain needed mental health or other social services. Similarly, regular, nonconfrontational contact with a neighborhood officer may help some young delinquents to control their impulses to engage in criminal activity and to abide by court-imposed restrictions. As figures of authority, police officers are also in a position to broker services for families

and to coordinate the responses of other institutions. The assumption of such expanded roles in the lives of children also imposes new burdens on police officers and requires new modes of training and operational support.

The CD–CP program reflects and contributes to a more general change in the approach to policing in New Haven. In this model of community policing, the establishment and maintenance of relationships between community-based officers and community residents is of central importance. As New Haven officers have become part of the social landscape of the neighborhoods they serve, they no longer represent an anonymous target for the pent-up frustration and rage felt by underserved and disadvantaged community residents. Consequently, both the physical risk to officers and officers' feelings of apprehension in the community have diminished.

The central focus on relationships between police and community members has also resulted in other markers of law enforcement success. When officers know the community, they recognize that the majority of citizens are law abiding and represent potential partners for a better neighborhood. This frees officers to focus more effective enforcement efforts on the small number of career and violent offenders. For example, after the 1991 inception of community-based policing in New Haven, four major drug gangs were targeted by a joint Federal/State task force on drug enforcement. Relationships between community patrol officers and residents in neighborhoods most affected by drugs and associated violence led to extensive intelligence that was invaluable to the effective Federal prosecution and long-term incarceration of high-level leaders in all four gangs. Similarly, the New Haven police focus on personal relationships as the core of community policing has resulted in a 95-percent closure rate of all homicide investigations.

Collaborative Responses

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

The CD–CP program has become a foundation for officers to broaden their roles as problem solvers. The process of consultation and collaboration with mental health and allied professionals breaks down barriers to the idea that complex problems require multiple solutions that involve new partners. As the burden and problem-solving tasks are shared, officers experience a greater sense of effectiveness and are increasingly able to sustain their engagement in the lives of children. When problems can be assessed in the context of the CD–CP partnership, intervention can not only take place in a more timely fashion but also without the fragmentation of services that so often leads to a squandering of limited resources.

Program Outline

The CD–CP program model consists of interrelated training and consultative components that aim at sharing knowledge and developing ongoing collegial relationships between police officers and mental health professionals.

1. Child Development Fellowships for Police Supervisors

Child Development Fellowships help provide supervisory officers with the special psychological expertise they need to lead a cohesive team of community-based officers in a wide variety of crime prevention, early intervention, and relationship-building activities involving children, families, and community agencies in their individual neighborhoods. Child Development Fellows spend 3 to 4 hours per week over the course of 3 to 4 months in the Child Study Center. Fellows participate in a range of activities and observations that familiarize them with developmental concepts, patterns of psychological disturbance, methods of clinical intervention, and settings for treatment and care. Police supervisors involved in the fellowship also provide basic knowledge about police practice to their mental health colleagues. A major goal of the fellowship is to establish relationships between the fellows and the child mental health professionals with whom they will be collaborating in the future.

2. Police Fellowships for Clinicians

The Police Fellowship provides clinicians with opportunities to spend time with police colleagues in squad cars, in police stations, and in the streets observing and learning directly from officers about their day-to-day activities. This exposure assists clinicians in understanding the environment to which children and families are exposed, the relationships between members of the community and the police, and the various uses of police authority in daily interactions with community residents. Observing the realities of officers' interactions with children provides a framework for understanding the roles that officers play in the psychological lives of children and families and prepares mental health professionals to intervene collaboratively with police partners in cases referred through the consultation service. Extended contact with police colleagues through the fellowship also provides the basis for trust in the ongoing working relationships on which the program depends.

3. Seminar on Child Development, Human Functioning, and Policing Strategies

The CD–CP seminar on child development, human functioning, and policing strategies is a course for police officers, mental health clinicians, and related professionals (e.g., probation officers) that is co-led by a team of clinical faculty members and a police supervisor experienced in the CD–CP program. The seminar meets each week for 1.5 hours over a period of 10 weeks. Using case scenarios drawn from the experiences of the seminar members and group leaders, the seminar applies principles of child development to the daily work of police officers to provide officers and clinicians with knowledge and a sense of personal empowerment to intervene positively with

children and families. Exposure to developmental principles introduces officers to the importance of thinking about children's development and their own influence on children. Exposure to police perspectives on children, families, violence, and crime expands clinicians' understanding of the children they work with and the role of legal authority in containing children's responses to violence.

4. Consultation Service

As community-based police officers become more active and visible within their neighborhoods, they establish more frequent contact with children and families who are in danger or distress, including victims or witnesses of violence, truants from school, and teens involved with gang activity. These neighborhood officers need a resource to turn to for discussion, guidance, and an immediate clinical response, especially when the child is in great distress, as happens so often following exposure to serious violence. The CD–CP consultation service allows police officers to make referrals and to obtain immediate clinical guidance, especially in the aftermath of children's traumatic experiences. Consultation service clinicians and police supervisors experienced in the program are on call 24 hours a day to discuss difficult situations involving children and adolescents. When a direct clinical response is necessitated by the urgency of a child's distress (e.g., a child who has just witnessed the murder of a relative), a clinician will respond immediately and may see the child and family at the clinic, the police station, or the child's home. Less urgent clinical meetings, referrals to other services, coordination with other agencies, and regular followup by both police and clinicians are also arranged.

5. Program Conference

Police officers and clinicians who staff the CD–CP program meet weekly to discuss difficult and perplexing cases that arise from officers' direct experiences in their neighborhoods and from the consultation service. The case discussions provide a forum for police, clinicians, and allied professionals to examine cases from a variety of perspectives in order to understand better the experience of children and families exposed to violence, to explore the limits of current intervention strategies, and to develop improved methods of collaboration and response. The conference also provides a regular forum for planning and evaluation of program activities and for examining systemic, institutional, and administrative issues. Police supervisors representing all sectors of the city participate in the program conference and bring to the discussion the various concerns of community residents in their districts.

Juvenile Justice Response

Many of the children and adolescents about whom police officers and clinicians are most concerned are those who have experienced chronic exposure to violence and who are now becoming involved in delinquent activities. To respond to these children and adolescents, the CD–CP collaboration has expanded to include representatives of the juvenile justice system. In addition, the team's approaches to intervention with this group of children have expanded the use of legal authority to provide external structure where internal and family structures are lacking.

As a result of the placement of juvenile probation officers in several New Haven neighborhoods, with offices in the local community substations, police officers, clinicians, and juvenile probation officers have more closely coordinated their work with young delinquents. In this context, the CD–CP training and weekly conference has provided a central forum for examining comprehensive approaches to programmatic innovation as well as case planning for individual juveniles. As a result of this planning process, neighborhood police officers and juvenile probation officers collaborate in the supervision of young offenders by regularly sharing information about children and adolescents on probation and assigning police officers to supervise some community service projects. In addition, CD–CP clinicians provide regular consultation to juvenile probation officers and the local juvenile detention center regarding the mental health needs of children and adolescents involved in the juvenile justice system.

Results of the CD–CP Program's First 5 Years

The expected outcomes of the CD–CP program can be generally stated as broadening the frames of references that govern the work of the police, mental health professionals, and additional collaborators and that contribute to an increasing array of coordinated responses to the witnesses of community violence and to youth involved in the perpetration of violence and other gateway criminal activities that may involve or lead to violent crimes. These outcomes may be indicated by:

1. Organizational changes in the provision of police and mental health services.
2. Development of protocols and procedures for responding to youth exposed to or involved in violent and other at-risk, criminal activities.
3. An increase in the number of cases in which consultation and coordinated interventions occur.
4. An increase in the number of collaborations with schools, child welfare, probation, etc., for primary prevention and intervention.
5. Police officers' greater knowledge of the experience of children and greater appreciation for the potential benefits of collaborative intervention.
6. Clinicians' increased knowledge of policing strategies and practices and greater appreciation of the potential therapeutic value of police authority.
7. Implementation of a protocol for regular tracking and monitoring of children referred to the consultation service across a variety of domains, including exposure to additional violent incidents, involvement in delinquent activities, and experience of post-traumatic symptoms.

Training

Since the CD–CP program began formal operation in January 1992, the entire department has received orientation and training regarding program goals and utilization of on-call and referral services; a range of inservice training related to CD–CP principles and practice has been presented; approximately 250 officers have completed the 10-week CD–CP seminar; the assistant chief of police and 39 supervisory sergeants and lieutenants have completed the Child Development Fellowship and continue to attend the weekly Program Conference; 8 Child Study Center faculty members have completed the Police Fellowship; and an elective for mental health professionals in training has been developed.

Referrals and Consultations

The Consultation Service has received approximately 350 referrals regarding

more than 600 children. Calls to the Consultation Service have concerned children of all ages who have been involved in a variety of violent incidents as victims, witnesses, or perpetrators, both in their families and in the larger community. Children who have been referred have been seen both individually and in groups in their homes, police stations, hospitals, schools, and the Child Study Center. In addition, formal protocols have been developed regarding such practices as notification of the Consultation Service in critical incidents involving children as victims, witnesses, or perpetrators; distribution of informational pamphlets describing the psychological impact on children of their exposure to violence and the availability of assistance through the CD–CP program; and routine followup by neighborhood officers to ensure the security and stability of families exposed to violence.

The results of the CD–CP program can also be seen in the following representative examples of cases referred by police to the Consultation Service:

- A mother and two children, ages 2 and 10, were present when a relative was shot to death through the door of their apartment. The district supervisor, a CD–CP fellow, offered a referral for mental health services and also provided the mother with his beeper number. The supervisory sergeant accepted daily calls from the mother, during which he provided her with information regarding the family's protection from reprisal and reminded her that clinical support was available. With the ongoing support of the sergeant, the mother was able to accept the mental health referral for herself and her children. After intensive treatment, both children are functioning well in school and the mother was able to relocate her family to a safer neighborhood.
- A woman was stabbed to death by her estranged boyfriend in the presence of her eight children. CD–CP clinicians responded to the scene, provided acute clinical assessments of the children, and consulted with relatives and police as to how to tell the children their mother was dead. Police conducted followup visits to the family, providing practical recommendations for the security of the home and information regarding the status of the prosecution. The efforts of police, mental health, child welfare, and home-based support professionals, coordinated by the CD–CP team, allowed the children to remain together rather than be dispersed to multiple foster homes. CD–CP clinicians evaluated each of the children and engaged several members of the family in long-term psychotherapy. All of the children are currently attending school. Symptoms of anxiety, depression, and aggressive behavior have diminished.
- A 15-year-old boy was robbed at gunpoint by two men. In the immediate aftermath of the robbery, he was too shaken to say anything to police about what had happened. Officers referred him for an urgent clinical evaluation, which took place at the local hospital. During the course of the clinical interview, the boy reported wanting to get a gun and take revenge. By the end of the interview, however, he had recovered sufficient memory of the events to become an effective aid to investigating detectives, who were then able to arrest the robbers. Local community-based officers established regular contact with the boy, supporting him in the maintenance of his good school record and deterring an early-stage involvement with neighborhood drug dealers.
- A 14-year-old boy was involved in leading a group of other teens in a series of beatings and criminal mischief that terrorized his neighborhood. Although police officers were aware of his activities, they were unable to obtain sufficient evidence to arrest him. CD–CP officers and clinicians convened a series of meetings regarding community safety, which were attended by local officers, school officials, juvenile probation, clinical consultants, and community leaders. As a result of the meetings, police obtained more effective cooperation from the community and eventually arrested the boy. The CD–CP program conference provided a forum for case planning, and the collaborative group recommended close probation supervision to the court. Under strict supervision, the boy's criminal activities were curtailed, and he returned to school. Throughout his probation, police and probation officers maintained close contact to monitor his behavior.
- A 12-year-old boy was arrested 8 times for auto theft. He had been truant from school more days than not over a 2-year period. When the boy's cases were finally adjudicated, he was referred to a pilot project, developed and coordinated by the CD–CP program, in which strict probation supervision is supplemented by community service, home-based case management, recreational activities, and group therapy. The boy returned to school and has not been rearrested in 4 months. Friends from his neighborhood ask to come with him to group activities.
- Following the shooting death of a 17-year-old gang member, there was good reason for concern about retaliation and further bloodshed. In the days that followed the death, grieving gang members congregated on the corner where the shooting had taken place. Efforts at increased presence and containment took the form of police, neighborhood-based probation officers, and clinicians spending time on the corner listening to gang members' express their grief. As one senior police officer put it, "We could show our concern for their trauma by being with them, lending an adult ear to their misery. Alternatively, we could put more officers on the street, show them who's boss, and with a show of force, sweep them off the corner as often as necessary. . . .We could then offer them an additional enemy and wait for them to explode." At this crucial moment, the police did not assume the role of enemy. They did not serve as a target for displaced rage or, in confrontation, offer an easy antidote to sadness and helplessness. Rather than exacting "payback" in blood, the typical gang response, the gang discreetly assisted the police in making a swift arrest in the shooting. As one gang member, the brother of the victim, put it to a neighborhood cop, "You were there for us; that helped. . . ."

Juvenile Justice Responses

Because of their powerful and positive experience with the addition of juvenile probation to the CD–CP program, the group has also developed a pilot intervention project that applies the program's collaborative principles to community-based work with adolescents who are beginning to engage in delinquent activities. This Gateway Offenders Program brings together community-based police officers, community-based probation officers, CD–CP clinicians, school officials, and case managers to provide coordinated, comprehensive, and structured

assessment and intervention for a small group of juvenile offenders who are at high risk of escalating criminal involvement and removal from the community. Probation and police officers provide the external authority necessary to contain program participants through intensive supervision, frequent monitoring, and the imposition of variable sanctions for violations. In close collaboration with these figures of authority, clinicians, educators, and case managers provide a range of educational, therapeutic, and recreational interventions, including life skills and conflict resolution training, community service projects, afterschool activities, wilderness experiences, group psychotherapy, and coordination with participants' parents. In this context, clinical evaluations and treatment are not seen as an alternative to judicial action but as part of a coordinated response. In the first 4 months of the project, only 1 of 15 participants has been rearrested for new criminal behavior (Juvenile Services Unit, New Haven Department of Police Services).

Since the implementation of the CD–CP program, there have been significant changes in police approaches to juvenile delinquency and corresponding changes in results. Based on community officers' familiarity with New Haven neighborhoods and the coordination of their efforts with community-based juvenile probation officers, there are no outstanding warrants for the arrest of juveniles in New Haven (Juvenile Probation Division, New Haven County). In addition, while New Haven currently refers twice the number of juvenile offenders to the juvenile justice system, it sends only half the number of juveniles to correctional facilities as Hartford, and three times fewer than Bridgeport. This suggests that, in the community in which the collaboration was developed, alternatives to incarceration have increased significantly.

Truancy Intervention

The CD–CP program has also had an impact on rates of truancy in New Haven. As an outgrowth of the police-mental health collaboration, police have increased their involvement with the New Haven public schools. Teams of community-based officers and dropout prevention workers canvass New Haven neighborhoods during school hours, approaching suspected truants, identifying them, taking them to school, and contacting school personnel and parents about their attendance and other school-related problems (e.g., fighting, drug or gang involvement, etc.). Responding to reports from the daytime team, evening shift officers follow up with visits to the children's homes, discussing truancy issues with both the student and his or her parents. For many parents, these visits mark the first time that they become fully aware of the extent of a child's truancy. The first visit is followed by others if the student continues to miss school and contingencies are developed with parents, school officials, mental health professionals, probation officers, and social service workers who are already involved or may need to be involved with the youngster and his or her family. With a mixture of authority, psychological sophistication, and persistence, officers involved in the truancy reduction efforts have been enormously successful. In the first 6 months of operation, the truancy initiative accounted for a reduction of 20,000 unexcused absences. In one urban middle school, daily unexcused absences have decreased from more than 120 to fewer than 70 (New Haven Schools). It is anticipated that the decrease in truancy will, in turn, result in a reduction in criminal activity in New Haven, where police have estimated that juveniles were responsible for 60 percent of auto thefts (Juvenile Services Unit, New Haven Department of Police Services).

Program Evaluation Research

The nature of the collaboration, and the clinical, consultative, and specialized police work that occurs within the collaboration, is a challenge to document reliably and consistently. CD–CP research staff have developed a comprehensive electronic case and activity recording system that is the centerpiece of data collection. This system allows program personnel to enter detailed information describing the nature of each case and the response to that case, information regarding the event and the roles of children with regard to that event (e.g., witness, victim, perpetrator, etc.), characteristics of the home and school of children served, diagnostic and evaluation data, intervention data, functional outcome measurement, and other clinical and police activities. An interview protocol has been developed for a retrospective study of children seen in the first 4 years of the consultation service, which will investigate children's general developmental status, posttraumatic responses, exposure to additional episodes of violence, and subjective experience of the CD–CP intervention. In addition, surveys have been developed to measure changes in the attitudes and practices of police officers and mental health professionals as a result of their involvement in the collaborative program.

Program Replication

The CD–CP program is a national model that is now being replicated under an OJJDP grant in four cities: Buffalo, New York; Charlotte, North Carolina; Nashville, Tennessee; and Portland, Oregon. Additional, privately funded program replication efforts are under way in Baltimore, Maryland; Framingham, Massachusetts; and Newark, New Jersey. A CD–CP program manual, *The Police Mental Health Partnership: A Community-Based Response to Urban Violence* (Marans et al., 1995), has also been developed with OJJDP support.

The Program Replication Process

While each police-mental health partnership will develop its own unique attributes based on the specific needs and resources of the community in which it operates, the CD–CP program model assumes that each new collaborative program will adopt the basic program elements described in this bulletin. CD–CP program staff have been intensively involved in providing training, consultation, and technical assistance to developing programs. The following points highlight the requirements for effective implementation of the program model, based on the experience of the program's developers.

1. Institutional Investment

Because the CD–CP program seeks to achieve fundamental change in the operations and the climate of the police department and a collaborating mental health agency, the leadership of both institutions must commit themselves to a process of questioning and modifying traditional practices and be prepared to support their respective staffs in the implementation of collaborative approaches to intervention with children and families exposed to and involved in violence in their community. Issues of time, money, staffing, program expectations, and evaluation should be identified and addressed at the outset. In many of the communities currently involved in the replication project, a single sector of the city has been selected to begin a program pilot.

2. Participating Police Department

The CD–CP program model builds on the philosophy of community policing and therefore requires that the participating police department have implemented community policing strategies or be engaged in the process of their implementing, particularly with regard to children, adolescents, and families. The program also requires that the policing agency be committed to (a) allowing sufficient time for supervisors and rank and file officers to participate in CD–CP training (approximately 15–20 hours for each seminar and 40 hours for CD–CP Fellowship training); (b) allowing time for supervisors centrally involved in the program to act as seminar leaders and to maintain participation in a weekly program conference; and (c) providing observation and training experiences for mental health professionals involved in the program (e.g., ride alongs, short courses in policing practice).

3. Participating Mental Health Agency

The CD–CP program requires a mental health collaborator with staff who are (a) experienced in the evaluation and treatment of children, adolescents, and families, including individuals exposed to criminal violence and other traumatic events; and (b) experienced in teaching and training other professionals in child development principles. The program requires the mental health agency to provide opportunities for police officers to observe children in different clinical settings. The mental health institution also must provide partial salary support for participating staff (three or four clinicians to start) to spend sufficient time observing and meeting with police colleagues, responding to emergency calls from the police for consultation, and co-leading the CD–CP seminar. Funding is not required for ongoing mental health treatment; public benefits, private insurance and/or out-of-pocket payment should be available.

4. Other Participating Institutions

Developing collaborative programs may wish to include other institutions that are centrally involved in addressing the needs of children and families exposed to violence such as juvenile probation, schools, or child welfare agencies. In considering expansion of the CD–CP model, program developers should take into account both the benefits to be derived from a broader coordination and the difficulties associated with developing and maintaining a more complex set of institutional and personal relationships.

5. Training, Consultation, and Technical Assistance for Developing Programs

Staff of the New Haven CD–CP program are available to provide a program of training and technical assistance to developing programs. Consultation begins with the heads of the participating agencies developing clear goals for the collaborative program. Agency leaders then identify a small working group of community policing supervisors and mental health clinicians who will be responsible for implementing the police-mental health collaboration in their community and who will work closely with the CD–CP consultants. Members of the working group attend a series of intensive meetings and observations, co-led by New Haven police supervisors and Child Study Center clinicians. These meetings provide a comprehensive introduction to the CD–CP program and a forum for considering the steps needed to adapt and implement the program in each replication site. Following the New Haven-based training and consultation meetings, CD–CP consultants provide ongoing on- and off-site technical assistance to guide and support the developing new programs. In addition, CD–CP consultants teach and implement procedures for standardized data collection that serve the program evaluation research. A national network of CD–CP programs facilitates sharing information about the process and results of the interdisciplinary collaboration through conferences, newsletters, and other means.

6. Program Evaluation Research

To facilitate consistent data collection across the replication sites and to permit comparisons among the sites, CD–CP consultants will provide personnel in each developing program with copies of the data collection software and survey instruments designed to evaluate the collaborative program (described above). CD–CP staff will provide technical assistance in implementing the data collection and will analyze and report survey results.

One of the fundamental goals of the CD–CP program is to broaden and shift the perspective of officers and clinicians participating in the collaboration. It is believed that officers develop greater knowledge of child development, insight into psychological contributions to human behavior and the implications for policing, a capacity to reflect on and consider a broader range of options, an awareness of the experience of children, an understanding of and favorable attitude toward mental health personnel, and the merits of interventions that emphasize structure, authority, and/or clinical service. Similarly, it is believed that clinicians acquire knowledge of policing and a greater appreciation for the role of police officers in development and therapeutic intervention, the therapeutic value of structure, and the value of mental health consultation to law enforcement. It is changes of this sort that make collaboration possible and presumably result in benefits to children and families in the community. In order to evaluate these changes, CD–CP staff have developed two surveys that provide a comprehensive assessment of officer and clinician knowledge, attitudes, and assumptions as noted above as well as overall satisfaction with the program. Administration of the surveys in the replication sites will allow the program evaluators to follow the development of officers and clinicians over time within each site and also to compare across replication sites. Additional measures of program replication outcome in the various sites will include changes in policing and mental health protocols, numbers of referrals, attendance at collaborative meetings, participation in collaborative training seminars, and outcome measurements related to the children served.

Further information about the CD–CP program can be obtained from:

Colleen Vadala, Administrative Assistant
Child Development–Community Policing Program
Yale Child Study Center
47 College Street, Suite 212
New Haven, CT 06510
203–785–7047

OR

Bob Hubbard, Program Manager
Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Justice
633 Indiana Avenue NW., Room 707
Washington, DC 20531
202–616–3567

References

Bureau of Justice Statistics. "National Crime Victimization Survey." Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice. Unpublished table.

Carnegie Council on Adolescent Development. 1992. *A Matter of Time.* Woodlawn, MD: Wolk Press.

Cicchetti, D., and V. Carlson. 1989. *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect.* New York, NY: Cambridge University Press.

Citizens' Committee for Children. 1993. *Keeping Track of New York's Children.* New York, NY: Citizens' Committee for Children.

City of New York. 1993 (August). Juvenile detention alternatives initiative.

Garbarino, J., N. Dubrow, K. Kostelny, and C. Pardo. 1992. *Children in Danger: Coping With the Consequences of Community Violence.* San Francisco, CA: Jossey-Bass.

Greene, M.B. 1993. Chronic exposure to violence and poverty: Interventions that work for youth. *Crime and Delinquency* 39(1):106–124.

Hawkins, D.F., A.E. Crosby, and M. Hammett. 1994. Homicide, Suicide and Assaultive Violence: The Impact of Intentional Injury on the Health of African Americans. In L.L. Livingston, ed. *Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies and Prospects.* Westport, CT: Greenwood Press.

Marans, S., et al. 1995. *The Police Mental Health Partnership: A Community-Based Response to Urban Violence.* New Haven, CT: Yale University Press.

Marans, S., and D. Cohen. 1993. Children and Inner-City Violence: Strategies for Intervention. In L. Leavitt and N. Fox, eds. *The Psychological Effects of War and Violence on Children.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Marans, S., M. Berkman, and D. Cohen. 1996. Child Development and Adaptation to Catastrophic Circumstances. In *Minefields in Their Hearts: The Mental Health of Children in War and Communal Violence*. R. Apfel and B. Simon, eds. New Haven, CT: Yale University Press.

Martinez, P., and J.E. Richters. 1993. The NIMH community violence project II: Children's distress symptoms associated with violence. *Psychiatry* 56:22–35.

New Haven Public Schools. 1992. Report on the SAHA. *Social Development Project Evaluation, 1991–92: Final Report.* 179–196.

Palmer, T. 1983. The 'effectiveness' issues today: An overview. *Federal Probation* 47:3–10.

Richters, J.E., and P. Martinez. 1993. The NIMH community violence project I: Children as victims of and witnesses of violence. *Psychiatry* 56:7–21.

Schorr, Lisbeth B. 1989. *Within Our Reach.* New York, NY: Doubleday & Co., Inc.

Sheley, J.F., and J.D. Wright. 1993 (December). *Gun Acquisition and Possession in Selected Juvenile Samples.* Washington, DC: National Institute of Justice and Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

Singer, M., T. Anglin, L. Song, and L. Lunghofer. 1995. Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of the American Medical Association* 273(6): 477–482.

Taylor, L., B. Suckerman, V. Harik, and B. McAlister-Groves. 1992. Exposure to violence among inner-city parents and young children. *ADJC* 146:487–494.

Thornberry, T. 1994. Violent Families and Youth Violence. Program of Research on Causes and Correlates of Delinquency. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

Vitulano, L.A., et al. 1996. Children and Violence: Posttraumatic Stress Disorder with Conduct Disorder. (Invited address at the American Psychological Association in Toronto, ON, August 10, 1996.)

Wiese, D., and D. Dara. 1995. *Current Trends in Child Abuse Reporting Fatalities: The Results of the 1994 Annual Fifty State Survey.* Chicago, IL: National Committee to Prevent Child Abuse.

This Bulletin was written by project staff of the Child Study Center, Yale University School of Medicine. Steven Marans, M.S.W., Ph.D., is Harris Assistant Professor of Child Psychoanalysis, and Miriam Berkman, J.D., M.S.W., is an assistant clinical professor in social work.

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