Published in final edited form as:

Int J Law Psychiatry. 2014 ; 37(5): 439–447. doi:10.1016/j.ijlp.2014.02.016.

Beyond police crisis intervention: Moving “upstream” to manage cases and places of behavioral health vulnerability

Jennifer Wood^a and Laura Beierschmitt^b

Jennifer Wood: woodj@temple.edu; Laura Beierschmitt: tuc70508@temple.edu

^aDepartment of Criminal Justice and Center for Security and Crime Science, Temple University, 1115 Polett Walk, Gladfelter Hall, Philadelphia, PA 19122, United States of America

^bDepartment of Criminal Justice, Temple University, 1115 Polett Walk, Gladfelter Hall, Philadelphia, PA 19122, United States of America

Abstract

Law enforcement officers continue to serve on the front lines as mental health interventionists, and as such have been subject to a wave of “first generation” reform designed to enhance their crisis response capabilities. Yet, this focus on crisis intervention has not answered recent calls to move “upstream” and bolster early intervention in the name of long-term recovery. This paper reports on findings from an action research project in Philadelphia aimed at exploring opportunities for enhanced upstream engagement. Study methods include spatial analyses of police mental health transportations from an eight year period (2004–2011) and qualitative data from twenty-three “framing conversations” with partners and other stakeholders, seven focus groups with police and outreach workers, five key informant interviews as well as document reviews of the service delivery system in Philadelphia. Recommendations include the need to move beyond a focus on what police can do to a wider conception of city agencies and business stakeholders who can influence vulnerable people and vulnerable spaces of the city. We argue for the need to develop shared principles and rules of engagement that clarify roles and stipulate how best to enlist city resources in a range of circumstances. Since issues of mental health, substance use and disorder are so tightly coupled, we stress the importance of establishing a data-driven approach to crime and disorder reduction in areas of the city we term “hotspots of vulnerability”. In line with a recovery philosophy, such an approach should reduce opportunities for anti-social behavior among the “dually labeled” in ways consistent with “procedural justice”. Furthermore, crime and disorder data flowing from police and security to behavioral health analysts could contribute to a more focused case management of “repeat utilizers” across the two systems. Our central argument is that a twin emphasis on “case management” and “place management” may provide the pillars needed to move upstream and strengthen interventions along a continuum of engagement.

© 2014 Elsevier Ltd. All rights reserved.

Corresponding author: Jennifer Wood, Department of Criminal Justice and Center for Security and Crime Science, Temple University, 1115 Polett Walk, Gladfelter Hall, Philadelphia, PA 19122, United States of America, Te. 1-215-204-8055, woodj@temple.edu.

Publisher's Disclaimer: This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

Keywords

behavioral health; interventions; police; hotspots; place management; Philadelphia

1. Introduction

Law enforcement officers continue to serve on the front lines as mental health interventionists (see Burris et al., 2010; Petrila & Swanson, 2010). They work at the nexus point of two large systems – criminal justice and behavioral health care – in efforts to both support and control “dually labeled” populations (Wolff, 1998). They make use of formal tools including municipal ordinances, criminal law, and civil law governing involuntary commitment, as well as non-legal tools including persuasion, negotiation and referral to services (Wood, Swanson, Burris, & Gilbert, 2011). Overall, the time spent by police engaging people in crisis and non-crisis situations is tremendous, although few attempts have been made to thoroughly quantify the costs involved (Short, MacDonald, Luebbers, Ogloff, & Thomas, 2012).

In efforts to divert people experiencing mental illness into treatment, a set of “first generation interventions” (Wolff et al., 2013) emerged over the last two decades to help re-shape attitudes and practices among police in performing this “incidental” health role (see Burris, et al., 2010). At the heart of this reform is the adoption of crisis intervention models across the United States and globally (for a review see Wood et al., 2011). The Crisis Intervention Team (CIT) model is especially popular for its focus on improving police handling of people in crisis (Oliva & Compton, 2008; Steadman, Deane, Borum, & Morrissey, 2000). CIT officers work to channel people into care with the support of an intake facility that performs psychiatric assessments (Steadman et al., 2001). Relatedly, co-response models such as “mobile crisis teams” provide for physical co-response on the part of an officer and a clinical specialist such as a psychiatric nurse (Hartford, Carey, & Mendonca, 2006; Hails & Borum, 2003).

This first generation effort proves that police awareness and decision-making can be influenced in ways that balance public safety and health care access (Reuland, Schwarzfeld, & Draper, 2009). Positive results have been observed for outcomes including reduced policing costs (Bower & Pettit, 2001), decreased injuries to officers (Dupont & Cochran, 2000) and greater numbers of transports to mental health services (Steadman, et al., 2000). Improvements are also reported in terms of officers’ ability to identify mental illnesses as well as their level of confidence in handling encounters (Borum, Deanne, Steadman, & Morrissey, 1998; Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Watson, Morabito, Draine, & Ottati, 2008).

Despite these results, there are calls to move “upstream” and bolster early intervention and re-intervention in furtherance of long-term stabilization and recovery (Sainsbury Center for Mental Health, 2009; Victoria Police, 2007). “Little attention”, Cordner writes, “has been devoted to developing or implementing a comprehensive and preventive approach to the issue” (2006, p. 2). Tragic events, including the fatal stabbing of two tourists in Atlantic City by a woman experiencing homelessness and schizophrenia (The Associated Press, 2012)

have provoked conversations about prevention. However, this larger agenda is held back, in part, by the structure of behavioral health financing. Philadelphia, for example, spends roughly 3% of its behavioral health budget on prevention and early intervention (Evans, 2013). Indeed, we live in an “age of austerity” (Innes, 2010), but there are nevertheless extensive service deficits for people living in the “grey zone” (Evans, 2013) of needed engagement (those falling outside of voluntary or involuntary commitment). The challenge facing policymakers, and the researchers who support them, is therefore one of focusing and interlocking resources to improve behavioral health while reducing antisocial and criminal behavior.

This paper reports on findings from an action research project in Philadelphia aimed at exploring opportunities for enhanced upstream engagement. Recommendations include the need to move beyond a focus on what police can do to a wider conception of city agencies and business stakeholders who can influence vulnerable people *and* vulnerable spaces of the city. We argue for the need to develop shared principles and rules of engagement that clarify roles and stipulate how best to enlist city resources in a range of circumstances. Since issues of mental health, substance use and disorder are so tightly coupled, we stress the importance of establishing a data-driven approach to crime and disorder reduction in areas of the city we term “hotspots of vulnerability”. In line with a recovery philosophy, such an approach would aim to reduce opportunities for anti-social behavior among the dually labeled in ways consistent with “procedural justice” (Tyler, 2003). A significant body of empirical evidence already supports the notion that police will have greater legitimacy if they treat people with dignity, transparency and respect, and give them a “voice” during encounters (Sunshine & Tyler, 2003; Tyler, 2004; Tyler, 2006). The present findings point to a need to take procedural justice seriously during behavioral health-related encounters, and to explore opportunities for embedding its principles in the work of all interventionists, including and beyond the police. Furthermore, data linkage across city agencies and organizations could contribute to enhanced case management practices for our most vulnerable populations. In general, a twin focus on “case management” and “place management” (Eck, 1995) may provide the pillars needed to enhance interventions along a continuum of engagement by police and their city partners.

2. Research design

2.1. Participatory action research

This inquiry was designed within a “participatory action research” (PAR) model centered on university researchers working with practitioners as “co-researchers” (Reason & Bradbury, 2008, p. 2) in framing a problem, collecting data, reflecting on findings and enlisting wider networks in furtherance of change (Schensul, 1999; Stringer, 2007). The iterative process of refining a project concept results in a shared language for both understanding the problem and identifying the practical challenges ahead (Mangold et al., 2012; Marks, Wood, Ally, Walsh, & Witbooi, 2010). The means of refining a project concept is akin to a “slow burn” (Marks, et al., 2010, p. 6), where different project partners meet over time in pairs or in larger groups to have conversations about the purpose and focus of the project and to plan next steps. During this time, there is a constant re-articulation of a vision. Such meetings, we

suggest, can be understood as “framing conversations”. Co-researchers include representatives of the Philadelphia Police Department, the Department of Behavioral Health and Intellectual disAbilities, Center City District (a Business Improvement District), and the City of Philadelphia PhillyRising Collaborative. This research partnership was initiated by one of the authors from Temple University, with the simple premise of jointly exploring ideas for a “next wave” of police interventions with people affected by mental illness. The research collaborative has been, and continues to grow, as participants identify “webs of influence” (Braithwaite & Drahos, 2000, p. 12) in the city and the people who can bring to bear distinct knowledge and experience.

2.1.1. Site location and methods—Philadelphia is a city of experimentation. Its criminal justice system demonstrates a longstanding commitment to the diversion of people affected by mental illness and substance use. It began its CIT program in 2009, and as of 2011 had approximately 1000 trained officers (Evans, 2011). In 2012 it also initiated Mental Health First Aid, a twelve-hour training program for community members on how to identify and manage behavioral health situations (Department of Behavioural, 2013b). Additionally the city is home to a Mental Health Court (The First Judicial District of Pennsylvania, 2013). Overall, Philadelphia has numerous criminal justice “intercepts” (Munetz & Griffin, 2006) – formal points of treatment referral along the continuum of justice involvement from police intervention to reentry. With this backdrop, the research collaborative here set out to focus their inquiry on a part of Philadelphia known to have heightened behavioral health vulnerabilities – Center City. A density map of police mental health transportations for 2010 produced by a police crime analyst confirmed participants’ concerns about behavioral health issues in this area. A larger set of transportation data was subsequently analyzed by the academic partner (see below).

Through a prolonged series of conversations it became clear that our analysis would not only encompass mental illness, but behavioral health more generally (including substance use) as well as homelessness. As police engaged in conversations, they emphasized the need to address connections between these co-occurring issues to problems of crime and disorder, including panhandling. All partners stressed the importance of focusing on the problem of “repeat utilization” of emergency resources, which prompted a spatial analysis of repeat police transportation pick-up locations (see below).

After confirming the site location and conceptual focus of the inquiry, participants in the collaborative decided on a focus group method for capturing the perspectives and experiences of outreach workers and police officers on engagement challenges in Center City. The academic partner facilitated seven focus groups in total, all geared toward understanding existing street-level roles and frustrations as well as opportunities for inter-agency linkages. Co-researchers assisted with sampling and recruitment. Twenty-two different outreach workers participated in four focus groups¹ (each lasting approximately one hour). Across the outreach focus groups, workers held a range of specific roles. One group consisted of workers at the supervisory level while representatives from the other three groups provide direct engagement services on the front-line level. Each participant was

¹One worker participated in two different groups.

asked to briefly list their role on a piece of paper. These roles center on engaging and providing assistance to people experiencing homelessness and/or mental health and/or substance use issues. Some workers assist more broadly in case management by helping consumers navigate the system of services including benefits, medical appointments and housing. Participants' years of experience in their current or related role range from six months to twenty-seven years. In two of the groups, a representative (two different individuals respectively) from DBHIDS sat in on the focus groups, mainly to clarify any questions about the purpose of the groups and to help convey the spirit of the research partnership.

A total of twenty-two different police officers working in the Center City area participated in three focus groups (each lasting approximately an hour). Almost all of the officers serve as foot or bicycle patrol officers, which affords them the opportunity to develop an extensive local knowledge of Center City (see Wood, Sorg, Groff, Ratcliffe & Taylor, 2013, on the significance of local knowledge). Ten officers were CIT trained, while seven officers had Mental Health First Aid training (although five of these already had CIT training). Years of experience among the officers ranged from nine to twenty-six years (including different assignments or parts of the city). In all three of these groups, one to two co-researchers from the City of Philadelphia sat in on the focus groups due to their familiarity with the area and its stakeholders. Occasionally they participated in the groups by asking questions or reflecting on a response by an officer. In addition to the focus groups, five individual research interviews (lasting approximately one hour each) were conducted with key informants from the Philadelphia Police Department, the Southeastern Pennsylvania Transportation Authority Police Department, the Mental Health Association of Southeastern Pennsylvania, and Center City District. These were conducted to supplement our focus groups as well as our documentary review of service delivery arrangements in Philadelphia. These respondents were also asked to comment on needed areas of reform.

2.1.2. Qualitative analysis—Written notes from twenty-three conversations (lasting approximately one hour each) with different partners and stakeholders were uploaded into *Atlas.ti*, a qualitative software analysis program. The number of people involved in these different conversations varied, ranging from one person to several people from one or more organizations. These conversations were treated as a separate data unit (or “framing data”) containing language and concepts that helped with the coding and analysis of the focus groups and interviews. The focus groups and interviews were audio recorded with the signed permission of participants and transcribed by a member of the academic research team. These data were also entered into *Altas.ti* as a separate data unit.

The senior academic researcher coded all data through an inductive open coding procedure. Beginning with the framing data, an extensive list of codes was gradually merged into larger code categories. Codes that emerged from this process informed, but did not limit the development of preliminary codes for the focus group and individual interview data, which were expanded and altered as the analysis progressed. Conceptual relationships were drawn and modified using the “network” view/diagram function within *Altas.ti*. This diagram provided a preliminary conceptual map of the paper which was further modified during the writing process. As a means of ensuring the credibility, neutrality, and “pragmatic validity”

(Hesse-Biber, 2010, p. 91; Lincoln & Guba, 1985) of the findings, the academic research team presented the key findings and implications to core members of the collaborative. Some research partners (seven individuals) also reviewed a draft of this paper.

2.1.3 Spatial analysis—The academic partner conducted a geographic analysis of police mental health transportations provided by the Philadelphia Police Department (PPD) to validate initial findings regarding behavioral health “hotspots” across the city. We examined the density of call locations and identified patterns in repeat call locations. The data set captures the location of the incident/response: the point from which a person is picked up and transported for a mental health evaluation. Cases where officers transport a person to a medical facility to be evaluated for involuntary civil commitment are assigned the Philadelphia UCR Code 3008. The police role in transportations is governed by Chapter 5100 of the Pennsylvania Code (Pa. Code § ch. 5100), the provisions of which derive from the *Mental Health Procedures Act* (50 P. S. § 7107—7116) and the *Mental Health and Mental Retardation Act* of 1996 (50 P. S. § 4101—4704). A police officer has the authority to petition for an emergency assessment (a “302”) or they may be called by another petitioner to assist with transport. Upon evaluation, if a person is admitted for involuntary psychiatric inpatient treatment, they may not be committed for a period longer than 120 hours, unless the hospital files for an extended period of emergency involuntary treatment (a “303”) or the patient consents to a voluntary stay (Pa. Code § 5100.88–5100.89) (Department of Behavioural, 2013a).

The data set includes all transportations between the years 2004 and 2011. Over the eight years there were a total of 50,570 mental health transportations city-wide. The cases were mapped to the addresses of the calls as reported by the police. There were 358 cases which we could not match to “real” addresses; that is, cases where street names are unrecognizable or addresses are incomplete. There are twenty-one police districts across the city plus a Center City Police District that straddles Districts Nine and Six.² Overall, our matching process resulted in a hit rate of 99.3% (or 50,212 cases). Due to the sensitive nature of the information, our data does not include the names of people transported. The locations of transportation pick-up points are either specific street addresses or intersections. Although a description of location is not included in the data set, more detailed information is contained in the address field for some cases, allowing us to discern a variety of location types, including residences, hospitals, police precincts, transportation hubs, businesses, and parks.

2.2. Analysis

We deployed spatial analytic techniques available in *ArcGIS* software to create a kernel density map of the city for the year 2011. Based on case distribution we created a legend with scales ranging from low to high density. We used the data from the entire eight-year period to identify addresses that have been the site of repeat transportation pick-ups to discern repeat patterns within and across years.

²For our analysis we have drawn the boundaries provided to us by Center City District (CCD). There are subtle differences between this Business Improvement District area and the Center City Police District boundaries which are not relevant to our analysis here.

To begin the repeat analysis, the clean addresses derived from the matching process were aggregated so there is a count of how many calls were made to each address. The resulting table was then used to determine the number of addresses that had repeat calls. The results were categorized according to addresses that had one call, two to three calls, four or five calls, and six or more. The number of calls per category was then converted into percentages. To compare trends in Center City District (CCD) against city-wide patterns, we conducted the same analysis, using an “intersection function” to delimit cases to the CCD boundaries.

3. Results

3.1. Hotspots of vulnerability

Figure 1 illustrates the distribution of mental health transportation cases citywide for the year 2011. As the map confirms, there are specific areas of the city with moderate to high case density. As suggested by our partners, Center City has an especially high concentration.

For the entire eight-year time span, 25,527 unique addresses accounted for the total of 50,212 cases. Some of these addresses were sites of cases that spanned over more than one year. We explored whether repeat location patterns varied across the years or remained generally constant. These results can be seen in Table 1 below. Over the eight-year span there were 613 addresses in Center City that received at least one transport (2.4% of the total city addresses). Notably, for every year the percentage of repeat calls in each category in CCD is higher than the citywide totals. In the year 2011, for example, 32% of CCD addresses had two or more transports, compared to 18% of city-wide addresses with two or more.

In seeking to understand what helps make Center City a hotspot for behavioral health vulnerability, and to identify opportunities for enhanced engagement and intervention, we turn to our qualitative data.

3.2. Qualitative findings: Engagement challenges and opportunities

This section ties together themes that emerged through both the police and outreach focus groups. We connect these data to individual interview data where space allows. Our analysis reveals five core themes: (1) police knowledge about “micro-places” of vulnerability is nuanced, and untapped; (2) the cycle of crisis response is perpetual; (3) there are few “sticks” and fewer “carrots” to influence behavior; (4) procedural justice is critical to engagement and recovery; (5) system-wide information sharing is essential. Each theme is described in turn, followed by a discussion of implications for policy and practice.

3.2.1. Theme 1: police knowledge about “micro-places” of vulnerability is nuanced, and untapped—Officers’ accounts of their engagement challenges reveal considerable, untapped knowledge of the individuals they routinely encounter. Officers witness a tight coupling of co-occurring health issues and anti-social behavior. As one officer said, “[i]f they [Center City] didn’t have the homeless and the panhandlers, and the methadone, and the alcoholics it would be a pleasure to walk around” (PFG-L, Off #4). Comments like these were relayed with geographic precision. Officers made reference to

specific intersections, parks, transportation hubs and buildings that are the subject of their attention on a daily basis. They often said that the vulnerable people they come to know (and sometimes over periods of many years) live their days in and through spaces where they feel comfortable; what environmental criminologists would describe as “activity nodes” (Brantingham, Brantingham, Vajihollahi, & Wuschke, 2009). *“It is the same people, same time, same place...”* one officer commented, noting *“alcohol consuming, panhandling, mentally ill people who are at the same place every day”* (PFG-L, Off#9).

Not only did they imply a geographic pattern to the behaviors they witnessed, they noted temporal patterns as well. Chronic inebriation, for example, was described as manifesting in particular ways throughout the course of a given day. Officers made reference to a significant subgroup of panhandlers who allegedly collect money for the sole purpose of feeding their addiction. Panhandling therefore also has a predictable rhythm. *“They [people who panhandle] look at it as a job for them”*, one officer claimed. *“They come out here, they get started at 7[am], they get their money by 9, they’re drunk by 9:30, and they are totally incapacitated by 10”* (PFG-L, Off #6).

Officers implied that the social and physical environment of Center City enables and perpetuates this behavioral cycle. One source of frustration traces back to kind-spirited citizens who dole out money. *“Well, what about the people giving them the money that think they are doing good? It starts the vicious circle”* (PFG-L, Off #7). *“They think they are giving them money to buy food”*, another officer claimed, *“but they are not. They are buying alcohol”* (PFG-L, Off #2). With this knowledge, officers expressed little hope in their ability to have a lasting influence on both disorder and its underlying behavioral health dynamics. *“There is nowhere else to go”*, an officer explained,

You can get money down here.. [s]o they are all going to be here....[W]e are dealing with the same problems time and time again and there is no, there is no finality to it....I wish we had a solution, I wish there was some way we could help them because obviously... they need help. (PFG-D, #6)

3.2.2. Theme 2: the cycle of crisis response is perpetual—Due to the protections of mental health law, and the principles of autonomy and self-determination that underpin them, the capacity of police to link people to behavioral health services is largely constrained to crisis situations. In such cases, police can trust that people are receiving the help they need, but they expressed seeing no reduction in their crisis response workload, a problem which was confirmed in the repeat case analysis discussed above. For mental health crises, filing 302 petitions is a useful and necessary tool, yet officers revealed doubt about the long-term effectiveness of involuntary commitments.

They voiced similar frustrations about the cycle of chronic inebriation; frustrations they assumed were shared by ambulance personnel. In one focus group, officers claimed that medics *“know a lot of the regulars”* (PFG-D, Off#2), and are routinely called in to transport alcoholics in medical distress. With this in mind, officers speculated that a lack of sustained follow-up care is perpetuating a cycle of repeat hospitalization. *“[W]ith the mentally handicapped”*, one officer explained,

Sometimes they [medics] will take them away and then get them back on their meds and everything and... it is like talking to a completely different person. Then you see the slow deterioration when they start... it seems like they start thinking they don't need the meds or whatever, they stop having the access to them or whatever and you can see where they start falling off... (PFG-D, Off #1)

A fellow officer added,

[W]ell that is the homeless... We will 302 them, they leave after three days, they clean them up, and they send them out with prescriptions. They have no clue how to keep taking it day in and day out. They just either sell them so they can get the alcohol, or different drugs and then you see them start coming to slide down and they don't care. There is nobody to watch them. (PFG-D, Off #4)

3.2.3. Theme 3: there are few “sticks” and fewer “carrots” to influence behavior—

In addition to repeat users of crisis services, there are other “regulars” known by police to have chronic behavioral health issues, especially addiction, but whose behavior cannot be influenced by officers due to a dearth of legal and non-legal tools and resources. In this vein, some officers lamented the loss of the Community Court (closed in 2011 for complex economic and political reasons) which was a structure for dealing with non-violent misdemeanors in ways that addressed underlying health issues. It provided a good mix of “carrots” and “sticks,” as was suggested once in a conversation with a police manager. Officers would bring arrestees straight to a court appearance, avoiding the problem of “failure to appear.” Judges would then mete out dispositions including community service as well as treatment for addiction or mental health services (Babcock, 2012). “[T]he Community Court”, explained a CIT-trained officer in an interview, “would send them to prison, the prison would have a hospital facility that they could stay in for ninety days. That is where you would get a lot of the people who would recover...” The officer added,

A lot of them that would come out would thank [officers] for locking them up because of the fact that they got the necessary help. And it is not because they like the prison food; once in the system they realize that they needed the rehab.

The lack of a criminal justice “pipeline” into treatment is exacerbated, according to some officers, by the absence of a physical location where they could bring someone for voluntary engagement. An example of a new alternative is the “Hub of Hope,” a program that began in 2012 and operates in an underground transportation concourse in Center City for select hours on a seasonal basis (January to April). It was designed to connect chronically homeless people, who may be experiencing mental and/or physical health issues, to needed services. The program, supported through a multi-agency collaboration, provides connections to social services and attempts to link individuals with housing as well as basic medical and psychiatric care (Project HOME, 2012). In an interview, a SEPTA officer spoke with praise about the Hub, contending that with,

The mental health side of things, those individuals were... more or less cooperative to seeking treatment. When the law enforcement side comes into it, it is like the heavy hand, it is the authority side, where the hub of hope is more the civilian side, the nurturing side.

As a kind of “carrot”, to draw from the previous analogy, an officer in a focus group recommended the idea of a mobile unit, providing services not unlike the Hub that could park during select periods of time in hotspots of vulnerability. The following scenario illustrates the idea:

Maybe these guys that are kind of coming off their medication, maybe you can get them back up on it before they fall off to the point where we would normally deal with them. So you can get it in the hotspots...instead of having one designated location.” (PFG-D, Off #1)

3.2.4. Theme 4: procedural justice is critical to engagement and recovery—

While police yearn for more “sticks” and “carrots”, outreach workers stressed concerns about the *process* of engagement. In particular, the quality and integrity of engagement relationships with clients/consumers was highlighted as an essential aspect of achieving long-term recovery. Their descriptions of effective engagement resonate with the concept of “procedural justice”, which Tyler and others use to characterize positive interactions with legal and non-legal authorities (Tyler, 2003; 2004). According to this view, people who feel respected, are given a “voice”, and are treated with fairness and dignity during their encounters with authorities are much more likely to see authorities as legitimate, and are thereby more likely to voluntarily comply with behavioral guidelines (Ibid). Tyler and Mentovich have recently urged health researchers and practitioners to take procedural justice seriously (2013), and so too have others studying police mental health interventions (Watson & Angell, 2007) (Herrington, 2012).

One outreach worker’s depiction of their role resonated with procedural justice principles when they claimed “[w]e build rapport, we build relationships. It is very simple... and to be able to deal with these people, whatever is going on around them, with dignity and respect.” (OFG-R, #3). Freedom from domination and coercion is the key to achieving behavioral change, as is a longer “temporal horizon” (Morabito, 2007) of engagement that values the need to meet people “where they are at” (OFG-Y, W#3) in their process of recovery. In this vein, the outside pressure felt by outreach workers to help “move people along” or “take them away” is a source of considerable stress. As one worker put it,

We can’t come and physically remove anyone, because our services are of free will. So I think that a lot of times, and that is not just with the police, that is with business merchants as well, it’s like “come and get the person”.... [b]ut this is a human being that we are talking about.... (OFG-R, W#6)

Treating people like “human beings” is at the heart of the outreach role, despite being called to address anti-social behavior. *[T]hey still have rights*”, a worker explained,

and all we can do is offer them services and it is up to them, unless we see something else - they are going to hurt themselves, or they are threatening to others - but it is up to them to take that. (OFG-C, OW #3)

The need to cherish and protect the process of engagement has implications for how outreach workers relate to police officers in different situations. If disorderly or criminal behavior (such as drug dealing) is an issue, officers’ imperatives to exercise coercion or

invoke the criminal law can trump outreach concerns about long-term recovery. Despite some extremely positive remarks about the behavior of some police, it was implied that a certain degree of street-level “parallelism” (Wolff, 1998) in service delivery is unavoidable. As one worker put it,

They [population of homeless] have a whole society within itself, and you really have to be allowed in.... and that is where we have to draw the line with the partnership [with police] because a lot of us have been allowed in. And we don't want to be thrown out; it will mess up all the work you did to get in. (OFG-Y, W #3)

Outreach workers also pointed out that the quality of the engagement process extends well beyond encounters with police to include private security and others involved in the regulation of disorder and/or behavioral health. As an illustration, an outreach worker explained,

I was 302ing somebody... and they [private security] tried to put him out[side] while I'm 302ing him. He just had on jeans, a blanket, and a pink boa, no upper clothing. And I explained the situation; "I'm 302ing him"; it was a Code Blue [cold weather alert], and they said, "well he is going to have to wait outside."... What happens if you send him outside and he walks away and we find out later he froze to death that night? No, he is going to sit right here... I think they need to also be informed on how to approach our people.... just don't say, "oh you can't stand here, get out". Or, I have seen them [security] push them or kick their things out the door. It's the wrong approach. (OFG-C, W #5)

Notwithstanding such concerns with the engagement practices of others, outreach workers did hold out the hope for enhanced collaboration behind the scenes.

3.2.5. Theme 5: system-wide information sharing is essential—In discussing opportunities for better linkages with police, some outreach workers said they'd benefit from knowing more about the nature and outcomes of police encounters, because this knowledge can help them better understand and manage consumers' risk factors. As one worker explained,

I think that if [there] was more opportunity for communication with the police in terms of not calling outreach as a "come and get this individual", but let's talk about who this might be, give us a descriptive, let us go out to assess the situation and then make a determination. Then, if this individual is spotted again then you know to contact outreach, because nine times out of ten somebody from outreach has some kind of contact with them...[I]f they go to jail they're like off the radar.... (OFG-R, W #6)

“Going off the radar” was also a concern in relation to unknown involuntary commitments. Outreach may not be aware of involuntary commitment petitions initiated by police, or vice versa. “*I guess from a systems perspective there is not shared information*”, a worker said (OFG-Y, #9). One worker suggested the possibility of “*a basic information sharing session*,

whether it is a quarterly meeting, of sharing information on target people that are out there” (OFG-Y, #3), while another participant held out hope for a larger agenda.

There are systems, there are whole cities who have figured out how to negotiate those issues [sharing information] and it is really not targeting individuals but preventing homelessness. They prevent, using less resources... We are really focused on how we save money, but the by-product of that is actually saving people’s lives. (OFG-Y, #8)

4. Discussion

Our objective was to explore conditions of possibility for moving upstream to enhance the wider system of behavioral health intervention in the city. Our findings suggest that enhancing case management across sectors is essential to this, but “place management” (Eck, 1995) is arguably just as important. Although improved case management has long been a priority for behavioral health agents, in broadening our focus to other street-level interventionists (police, private security, health, outreach), the challenge is all the more complex. Different interventionists can be seen as “nodes” (Wood & Shearing, 2007) that do not necessarily shape behavioral health risk factors using the same principles and logics. Views from outreach, however, give us an important clue that shared principles of engagement devoted to long-term individual recovery may be the key to this coordinated nodal effort. Workers emphasized principles that are central to the “procedural justice” movement that is now highly influential in debates about police legitimacy and citizen compliance (Tyler & Huo, 2002; Murphy, 2009; Skogan, 2005). CIT officers (and many generalist police officers as well) are skilled, procedurally, in handling crisis encounters, but the engagement challenge is broader than de-escalation, or even avoiding arrest. A central concern for both police and outreach is *voluntary* engagement and long-term recovery. This has both practical and normative dimensions. For police especially, voluntary engagement (and ultimately compliance) is critical during a range of encounters where legal tools aren’t plentiful, or are otherwise ineffective. For outreach, voluntary engagement, based on relationships of trust and legitimacy, is pivotal to recovery and self-determination. A procedural justice framework may therefore work to tie these two dimensions together.

A multi-sector or multi-nodal protocol is one possible means of providing basic guidance on how to engage our most vulnerable within a procedural justice framework. The protocol could also specify which agencies to enlist in a range of situations across the continuum from non-crisis to crisis situations. Inspiration for this can be found in the state of Victoria, Australia, where the Department of Health and Victoria Police established a protocol that addresses how, and in what urgent and non-urgent situations, the police should request the help of mental health clinicians (and vice versa) (Victorian Department of Health, 2010).

A concomitant emphasis on places requires a shift to smaller geographic units of analysis to understand the spaces where behavioral health problems cluster and receive the bulk of police attention. Supplementing such formal data is the extensive local knowledge of police, especially those on bike and foot patrol who develop, like outreach workers, a “situated” (Thacher, 2008) understanding of co-occurring social problems (see Draine, Salzer,

Culhane, & Hadley, 2002). Our analysis of police mental health transportations reveals hotspots of vulnerability across the city. Our multi-year repeat analysis suggests that the overall resource burden on police has not diminished, despite clear improvements in police training and know-how. Both police and outreach yearn to break out of the cycle of repeat crisis intervention to see long-term reductions in crime and disorder as well as progress in community-level behavioral health.

Breaking out of the cycle of repeat crisis intervention does not entail an abandonment of the police role as mental health interventionists. This role has long been noted, at least as far back as the work of Bittner (1967), and if anything, should be more explicitly recognized (Crofts, James, Herrington, & Thomson, 2012). What we now know though, from criminology, is that police knowledge and resources can be used more effectively when they are focused. Part of this focus involves thinking strategically about “place” and the factors that may work together to heighten risks at certain locations (Weisburd, Groff & Yang, 2012). In short, reactive and generic responses to calls are less effective than focused interventions tailored to high risk groups and environments (Weisburd & Eck, 2004).

In thinking about place, it’s essential that such a protocol mentioned above acknowledge the concerns of Center City stakeholders with respect to behaviors that are criminal and disorderly, even if some of the people involved are vulnerable. Behaviors including drug dealing and panhandling, for example, can be intimidating, and can diminish the economic vitality of the area. Our respondents acknowledge that not all drug dealers or panhandlers are homeless or in need of a therapeutic intervention. Although police can often spot the difference, this does not change the task before them, nor does it comfort the business sector that must respond to antisocial behavior in a given time-space moment. A cross-sector protocol could encourage a more strategic, “Problem-Oriented Policing” (Goldstein, 1990) approach to shared crime and disorder issues in known locations. This approach centers on the analysis of data to establish patterns and trends, followed by the development of interventions that encourage use of “softer” crime prevention tactics (see Innes, 2005). As one example, police, along with other city agencies and the business sector, could “inject” pro-social activities in panhandling hotspots, or could ratchet-up the regulation of businesses known to sell alcohol to chronic alcoholics. Public education campaigns could also be developed to encourage people to donate food vouchers to panhandlers instead of money (Scott, 2002). In all such efforts, a commitment to procedural justice can be maintained.

Moving our focus from “places” to “cases”, there is indeed fragmentation in police, ambulance and behavioral health data systems. This is due in part to laws governing health information privacy. Notwithstanding, the police, as well as security providers could contribute to behavioral health “surveillance”, defined as “the ongoing, systematic collection, analysis, interpretation, and dissemination of data on health-related events for use in public health action to reduce morbidity and mortality and to improve health” (Horan & Mallonee, 2003, p. 24). There’s little opportunity to share health data with police, with some exceptions related to crisis situations and missing persons (Petrila & Fader-Towe, 2010), but police data (as well as ambulance data) could help fill out the behavioral health picture on repeat utilization among the dually labeled. For instance, some “low level” recidivists for the police might also be caught up in a cycle of civil commitment, without underlying substance

use issues being addressed. Systemic data such as this could inform targeted case management efforts that provide intensive follow-up care, including the monitoring of medication adherence (see again related efforts in Victoria, Australia, Victorian Department of Health, 2010).

If a mobile unit, what one might term a Mobile Assessment and Resource Center (MARC) could be established in different hotspots, it would provide for another data point in a better coordinated system. A MARC could serve as an upstream triage mechanism centered on screening and assessing for multiple needs, and channeling people into treatment and support, with appropriate follow-up mechanisms. Similar to the Hub of Hope, a MARC could be staffed by those with expertise in physical and behavioral health as well as housing support. This staff could link (either physically or virtually) to a criminal justice representative who could help remove unnecessary legal blockages – such as bench warrants for minor criminal behavior – that might otherwise get in the way of a successful recovery. A MARC could thus fill a void in the continuum of intervention consistent with a recovery philosophy. It could provide an attractive means of persuading people to access help, while promoting procedural justice and autonomy. MARCs could function as a form of what Thaler and Sustein (2008) describe as “choice architecture” – a physical (but mobile) location offering behavioral health interventions that “preserve freedom of choice while also nudging people in directions that will improve their lives” (Ibid., p. 252). Currently, informal efforts on the part of the police, security and others to help vulnerable people are not formally recorded because they don’t constitute “official” activity. Referrals to a MARC however, could easily be captured because they would be voluntary in nature, and there would be a “handoff” to a behavioral health intake person. Within a MARC, a clinician or other agent with authority to access personal health information could access the larger case history of an individual’s recovery process and refer them accordingly, with medium to long-term follow-up provided by trusted people like peer specialists.

Overall, our recommendations for moving beyond crisis intervention to enhanced intervention along a continuum of engagement rest on the twin pillars of targeted case management and targeted place management. Context matters. In thinking about what cities can do to improve population mental health, it’s critical that knowledge systems be linked. This includes the street-level knowledge of our workers doing direct engagement as well as the corporate knowledge contained in organizational data systems. The next generation of reform should perhaps focus less on “model replication” (Reuland, 2010) and more on an integrated analysis of vulnerability, and the policing of vulnerability (Bartkowiak-Théron & Asquith, 2012) across time and space.

Acknowledgments

We are very grateful to our research partners who kindly reviewed a draft of this paper. This study was supported by the National Institute of Mental Health (MH079920-05).

References

Department of Behavioural Health and Intellectual disAbility Services. Mental Health Court. 2013a. Retrieved March 14, 2013, from <http://dbhids.org/mental-health-court/>

- Department of Behavioural Health and Intellectual disAbility Services. Mental Health First Aid. 2013b. Retrieved March 14, 2013, from <http://dbhids.org/mental-health-first-aid/>
- Babcock W. Philadelphia community court: A model for other Pennsylvania cities. *The Pennsylvania Lawyer*, March/April. 2012:39–41.
- Bartkowiak-Théron, I.; Asquith, NL., editors. *Policing vulnerability*. Annandale, N.S.W.: Federation Press; 2012.
- Bittner E. Police discretion in emergency apprehension of mentally ill persons. *Social Problems*. 1967; 14(3):278–292.
- Borum R, Deanne MW, Steadman HJ, Morrissey J. Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness. *Behavioral Sciences & the Law*. 1998; 16(4): 393–405. [PubMed: 9924765]
- Bower DL, Pettit WG. The Albuquerque Police Department's crisis intervention team: A report card. *FBI Law Enforcement Bulletin*. 2001; 70(2):1–6.
- Braithwaite, J.; Drahos, P. *Global business regulation*. New York, NY: Cambridge University Press; 2000.
- Brantingham, PL.; Brantingham, PJ.; Vajihollahi, M.; Wuschke, K. Crime analysis at multiple scales of aggregation: A topological approach. In: Weisburd, D.; Bernasco, W.; Bruinsma, GN., editors. *Putting crime in its place*. New York, NY: Springer; 2009. p. 87-107.
- Burris S, Wagenaar AC, Swanson J, Ibrahim JK, Wood J, Mello MM. Making the case for laws that improve health: A framework for public health law research. *The Milbank Quarterly*. 2010; 88(2): 169–210. [PubMed: 20579282]
- Compton MT, Esterberg ML, McGee R, Kotwicki RJ, Oliva JR. Brief reports: Crisis intervention team training: Changes in knowledge, attitudes, and stigma related to schizophrenia. *Psychiatric Services*. 2006; 57(8):1199–1202. [PubMed: 16870973]
- Cordner, G. People with mental illness (Problem-Oriented Guides of Police Problem- Specific Guides Series No. 40). 2006. Retrived from <http://www.cops.usdoj.gov/files/ric/CDROMs/tribal/law/PeopleWithMentalIllness.pdf>
- Crofts N, James S, Herrington V, Thomson N. The importance of law enforcement in promoting and protecting the public health. *Australasian Policing: A Journal of Professional Practice and Research*. 2012; 4(1):3–4.
- Draine J, Salzer MS, Culhane DP, Hadley TR. Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services*. 2002; 53(5):565–573. [PubMed: 11986504]
- Dupont R, Cochran S. Police response to mental health emergencies: Barriers to change. *Journal of American Academy of Psychiatry and the Law*. 2000; 28(3):338–344.
- Eck, JE. A general model of the geography of illicit retail marketplaces. In: Eck, JE.; Weisburd, D., editors. *Crime and place*. Monsey, NY: Willow Tree Press; 1995. p. 67-93.
- Evans, AC. Helping Philly Police Officers Deal with Behavioral Health Crises (Transformation Brief Vol. 3). 2011. Retrived from Department of Behavioral Health and Intellectual disAbility Services website: <http://dbhids.org/assets/Forms-- Documents/newsletters/tbCIT.pdf>
- Evans, AC. Mental health's great gray area. *Philadelphia Inquirer*. 2013 Jan 11. Retrieved from http://articles.philly.com/2013-01-11/news/36281940_1_mental-illness-mental-health-health-issues
- Goldstein, H. *Problem-oriented policing*. Philadelphia, Pa: Temple University Press; 1990.
- Hails J, Borum R. Police training and specialized approaches to respond to people with mental illnesses. *Crime & Delinquency*. 2003; 49(1):52–61.
- Hartford K, Carey R, Mendonca J. Pre-arrest diversion of people with mental illness: Literature review and international survey. *Behavioral Sciences & the Law*. 2006; 24(6):845–856. [PubMed: 17171772]
- Herrington V. Inter-agency cooperation and joined-up working in police responses to persons with a mental illness: Lessons from New South Wales. *Policing : A Journal of Policy and Practice*. 2012; 6(4):388.
- Hesse-Biber, SN. *Mixed methods research: merging theory with practice*. New York: Guilford Press; 2010.

- Horan JM, Mallonee S. Injury surveillance. *Epidemiological Reviews*. 2003; 25:24–42.
- Innes M. Why 'soft' policing is hard: On the curious development of reassurance policing, how it became neighbourhood policing and what this signifies about the politics of police reform. *Journal of Community and Applied Social Psychology*. 2005; 15(3):156–169.
- Innes M. A 'mirror' and a 'motor': Researching and reforming policing in an age of austerity. *Policing*. 2010; 4(2):127–134.
- Lincoln, YS.; Guba, EG. *Naturalistic inquiry*. Beverly Hills: Sage; 1985.
- Mangold SV, Cerulli C, Kapcar G, Ward Allen C, Kaukeinen K, He H. Using community based participatory research to study the relationship between sources and types of funding and mental health outcomes for children served by the Child Welfare System in Ohio. *Journal of Law and Policy*. 2012; 21:113–139.
- Marks M, Wood J, Ally F, Walsh T, Witbooi A. Worlds apart? On the possibilities of police/academic collaborations. *Policing*. 2010; 4(2):112–118.
- Morabito MS. Horizons of context: Understanding the police decision to arrest people with mental illness. *Psychiatric Services*. 2007; 58(12):1582–1587. [PubMed: 18048560]
- Munetz MR, Griffin PA. Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*. 2006; 57(4):544–549. [PubMed: 16603751]
- Murphy K. Public satisfaction with police: The importance of procedural justice and police performance in police-citizen encounters. *The Australian and New Zealand Journal of Criminology*. 2009; 42(2):159–178.
- Oliva JR, Compton MT. A statewide crisis intervention team (CIT) initiative: Evolution of the Georgia CIT program. *Journal of American Academy of Psychiatry Law*. 2008; 36(1):38–46.
- Petrila, J.; Fader-Towe, H. *Information sharing in criminal justice-mental health collaborations: Working with HIPAA and other privacy laws*. New York, NY: Council of State Governments Justice Center; 2010.
- Petrila, J.; Swanson, J. *Mental illness law, and a public health law research agenda*. Philadelphia, PA: National Program Office, Robert Wood Johnson program for Public Health Law Research; 2010.
- Project HOME. *The Hub of Hope Project Outcomes Report*. Philadelphia: 2012.
- Reason, P.; Bradbury, H. *Introduction*. The SAGE handbook of action research. London: SAGE Publications Ltd; 2008.
- Reuland M. Tailoring the police response to people with mental illness to community characteristics in the USA. *Police Practice and Research*. 2010; 11(4):315–329.
- Reuland, M.; Schwarzfeld, M.; Draper, L. *Law enforcement responses to people with mental illness: A guide to research-informed policy and practice*. New York: Council of State Governments; 2009.
- Sainsbury Center for Mental Health. *All-stages Diversion: A Model for the Future*. London: 2009.
- Schensul JJ. Organizing community research partnerships in the struggle against AIDS. *Health Education & Behavior*. 1999; 26(2):266–283. [PubMed: 10097969]
- Scott, MS. *Panhandling: Office of Community Oriented Policing Services*. U.S. Department of Justice; 2002.
- Short TBR, MacDonald C, Luebbbers S, Ogloff JRP, Thomas SDM. The nature of police involvement in mental health transfers. *Police Practice and Research*. 2012:1–13.
- Skogan WG. Citizen satisfaction with police encounters. *Police Quarterly*. 2005; 8(3):298–321.
- Steadman HJ, Deane MW, Borum R, Morrissey JP. Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services*. 2000; 51(5):645–649. [PubMed: 10783184]
- Steadman HJ, Stainbrook KA, Griffin P, Draine J, Dupont R, Horey C. A specialized crisis response site as a core element of police-based diversion programs. *Psychiatric Services*. 2001; 52(2):219–222. [PubMed: 11157122]
- Stringer, ET. *Action research*. Los Angeles, CA: Sage Publications; 2007.
- Sunshine J, Tyler TR. The role of procedural justice and legitimacy in shaping public support for policing. *Law & Society Review*. 2003; 37(3):513–548.
- Thacher D. Research for the front lines. *Policing and Society*. 2008; 18(1):46–59.

- Thaler, RH.; Sunstein, CR. *Nudge: Improving decisions about health, wealth, and happiness*. New Haven, CT: Yale University Press; 2008.
- The Associated Press. Woman charged in stabbing deaths of 2 Canadian tourists in Atlantic City. NY Daily News. 2012. Retrieved from <http://www.nydailynews.com/news/crime/woman-charged-stabbing-2-canadian-tourists-deaths-atlantic-city-article-1.1082841>
- The First Judicial District of Pennsylvania. Pennsylvania's first re-entry mental health court. 2013. Retrieved 12 March, 2013, from <http://www.courts.phila.gov/common-pleas/trial/criminal/mhc.asp>
- Tyler, TR. Procedural justice, legitimacy, and the effective rule of law. In: Tonry, MH., editor. *Crime and justice: A review of research*. Vol. 30. Chicago, IL: University of Chicago Press; 2003. p. 431-505.
- Tyler TR. Enhancing police legitimacy. *ANNALS of the American Academy of Political and Social Science*. 2004; 593(1):84-99.
- Tyler, TR. *Why people obey the law*. Princeton, NJ: Princeton University Press; 2006.
- Tyler, TR.; Huo, YJ. *Trust in the law: Encouraging public cooperation with the police and courts*. New York, NY: Russell Sage Foundation; 2002.
- Tyler, TR.; Mentovich, A. Mechanisms of legal effect: Theories of procedural justice. In: Wagenaar, AC.; Burris, S., editors. *Public Health Law Research: Theory and Methods*. San Francisco, CA: Jossey-Boss; 2013.
- Victoria Police. *Peace of mind: Providing policing services to people with, or affected by, mental disorders*. Melbourne: 2007.
- Victorian Department of Health. *Department of Health and Victoria police protocol for mental health*. Melbourne: 2010.
- Watson AC, Angell B. Applying procedural justice theory to law enforcement's response to persons with mental illness. *Psychiatric Services*. 2007; 58(6):787-793. [PubMed: 17535938]
- Watson AC, Morabito MS, Draine J, Ottati V. Improving police response to persons with mental illness: a multi-level conceptualization of CIT. *International Journal of Law and Psychiatry*. 2008; 31(4):359-368. [PubMed: 18632154]
- Weisburd D, Eck JE. What can police do to reduce crime, disorder, and fear? *ANNALS of the American Academy of Political and Social Science*. 2004; 593(1):42-65.
- Weisburd, D.; Groff, ER.; Yang, SM. *The Criminology of Place: Street Segments and Our Understanding of the Crime Problem*. Oxford, UK: Oxford University Press; 2012.
- Wolff N. Interactions between mental health and law enforcement systems: problems and prospects for cooperation. *Journal of Health Politics, Policy and Law*. 1998; 23(1):133-174.
- Wolff N, Frueh BC, Huening J, Shi J, Epperson MW, Morgan R, et al. Practice informs the next generation of behavioral health and criminal justice interventions. *International Journal of Law and Psychiatry*. 2013; 36(1):1-10. [PubMed: 23182402]
- Wood, J.; Shearing, C. *Imagining Security*. Collumpton, UK: Willan; 2007.
- Wood J, Sorg ET, Groff ER, Ratcliffe JH, Taylor CJ. Cops as treatment providers: Realities and ironies of police work in a foot patrol experiment. *Policing and Society: An International Journal of Research and Policy*. 2013
- Wood, J.; Swanson, J.; Burris, S.; Gilbert, A. *Police interventions with persons affected by mental illnesses*. New Brunswick, NJ: Center for Behavioral Health Services and Criminal Justice Research, Rutgers University; 2011.

Figure 1.
Police Mental Health Transportations in 2011 in Philadelphia, PA. Provided by the
Philadelphia Police Department.

Table 1

Repeat Address Analysis of Police Mental Health Transportations

Year	Citywide					Center City				
	N (addresses)	1	2 to 3	4 to 5	6 or more	N (addresses)	1	2 to 3	4 to 5	6 or more
2004	4839	82.35%	13.72%	2.15%	1.78%	188	72.87%	18.09%	5.32%	3.72%
2005	4693	82.21%	13.83%	2.05%	1.92%	184	69.02%	21.74%	4.35%	4.89%
2006	4434	83.13%	13.26%	1.85%	1.76%	170	64.71%	28.24%	3.53%	3.52%
2007	4354	82.22%	13.87%	2.25%	1.65%	161	71.43%	22.36%	3.73%	2.48%
2008	4666	81.85%	14.74%	1.78%	1.63%	138	60.87%	29.71%	5.80%	3.62%
2009	4264	83.02%	13.27%	1.97%	1.74%	148	77.03%	16.22%	2.70%	4.05%
2010	4433	82.43%	13.85%	2.12%	1.60%	155	70.32%	19.35%	7.10%	3.23%
2011	4115	82.31%	14.29%	1.75%	1.65%	153	67.97%	22.22%	5.23%	4.58%