Seattle
City Budget Office

DATE: April 27, 2018

TO: Lorena González, Chair,
Gender Equity, Safe Communities, New Americans, and Education Committee

Kirstan Arestad, Director
Seattle City Council Central Staff

FROM: Seattle Police Department
Seattle Fire Department

RE: Statement of Legislative Intent 195-1-A-1 (First responder partnerships with service providers)

Introduction

This report is provided jointly by the Seattle Police Department and Seattle Fire Department in response to SLI 195-1-A-1. The report is organized in two parts: the first part is centered around programs and partnerships available for callers reporting domestic violence or sexual assault, and the second part focuses on programs and partnerships available for those experiencing mental or behavioral health issues. Each section outlines (1) programs and initiatives available to first responders in Seattle, (2) partnerships and opportunities for partnerships with local non-profits and community-based services, and (3) a sampling of approaches used in other jurisdictions to serve these key populations.

The missions of Seattle's Police and Fire Departments are grounded in fairness and equity. One of SFD's core values is diversity, defined as respect for the different identities, experiences, and perspectives of the communities the department serves. SPD codifies its commitment to equity in its code of ethics, with the first priority being to strive for justice, working toward racial and social justice for all.

Race and social justice are important considerations in the provision of services to those experiencing domestic violence and sexual assault and behavioral and mental health crises. As a result of structural and institutional racism, communities of color are disproportionately impacted by these issues. SPD and SFD consider race and social justice in the training they provide to First Responders and support staff, their internal policy reviews, and the community partnerships they develop in support of victims of these issues.

SPD provides annual RSJI training to the uniformed staff who respond to domestic violence/sexual assault calls and to those seeking aid for someone in behavioral or psychiatric crisis. SPD policies (5.140) state as a departmental objective the provision of equitable police services based upon the needs of community members. SPD recognizes that bias can occur at both an institutional and an individual level and provides mandatory annual bias-free policing training targeted to identified needs and regular updates from leadership to develop the skills of its officers and staff. At SFD, the Equal Opportunity Officer provides training to new recruits and refreshes it with input of department leadership.

Both departments have active Change Teams that include uniformed and civilian staff. At SPD, the Change Team offers guidance for the department's Racial Equity Toolkit work and helps to develop the RSJ program for the department. The SFD Change Team conducts reviews of the department's RSJ approach, develops RETs with input from subject matter experts, and conducts annual presentations to the Gender Equity, Safe Communities, New Americans & Education Committee of the City Council on the RETs it has developed.

Both SPD and SFD choose and develop community partnerships based on an implicit assessment of the unique needs of the communities served. SPD's Code of Ethics and Mission Statement emphasize the importance of community partnerships to crime prevention. Please refer to the specific sections below for more details on how RSJ is incorporated specifically for departmental responses to DV and sexual assault and behavioral and mental health issues.

Connecting 9-1-1 callers reporting domestic violence or sexual assault with social and health services.

Seattle Programs and Initiatives for Victims of Domestic Violence and Sexual Assault

The Seattle Police Department (SPD) has primary responsibility for responding to calls of reported domestic violence or sexual assault. The text below provides a high-level overview of the different programs and initiatives housed within SPD that support victim stabilization and recovery following domestic violence or sexual assault.

A Seattle Fire Department (SFD) dispatcher who has reason to believe that an incident may have a domestic violence and/or sexual assault component will add SPD to the dispatch, and if SFD encounters such circumstances while on a response, the protocol is to request SPD. SFD will remain at the scene until the arrival of SPD to meet any immediate medical or care needs and to ensure access of police responders to the scene. SFD has developed a training module for its first responders in how to recognize a potential domestic-violence incident and how to document the situation and preserve evidence in order to support subsequent investigation by SPD.

Victim Advocates

Post-call, and as the investigative process continues, SPD Victim Advocates play a critical role in the City's provision of social and health services. SPD Victim Advocates ensure that victims, survivors of victims, and witnesses of crimes are heard throughout the criminal justice process, that their rights are protected, and that they are safe and are aware of appropriate resources. Victim Advocates work closely with SPD detectives, King County prosecutors and community agencies to stabilize victims and identify resources to assist them.

Most often, advocates will be notified of a case when a report is assigned to a SPD detective. However, in cases of sexual assault, community agencies may work as intermediaries, connecting victims with Victim Advocates to facilitate filing a report or getting information about the process after reporting. Victim Advocates work with local organizations including Harborview Center for Sexual Assault and Traumatic Stress, King County Sexual Assault Resource Center, Consejo, Salvation Army, NW Justice Project and the Sexual Violence Law Center to assist domestic violence victims.

Victim Advocates are staffed in SPD's Sexual Assault Unit (2.0 FTE), Domestic Violence (2.0 FTE), Elder Abuse Advocate (1.0 FTE), VICE High Risk Victims Unit (1.0 FTE) and Homicide Unit (2.0 FTE). The eight staff (8.0 FTEs) are funded from SPD's existing budget (General Fund).

Victim Support Team

SPD also houses the Victim Support Team (VST), a weekend volunteer-based program that provides a victim-centered, trauma-informed, collaborative response to meet the needs of victims, following traumatic events. VST volunteer teams are called to crime scenes at officers' requests and provide assistance and follow-up after a call response.

The presence of VST volunteers helps victims to feel supported by their community. VST will respond to instances of alleged domestic violence, stalking, sexual assault, child/elder abuse, and adolescent/family violence. Volunteers perform victim-centric tasks including, but not limited to: helping identify safe housing, providing transportation to medical exams, connecting victims with community resources, developing safety plans, and providing companionship for minors as they wait for Child Protective Services (CPS). VST works with over 80 community volunteers and offers resource referrals to 165 community services.

In 2017, VST received a total of 1098 reports and VST volunteers spent 236 weekend hours providing intervention services to victims either in person or over the phone. The VST Follow-up Advocate spent 168 hours talking with 356 victims. VST put 9 families into hotels for a total of 15 nights. Twenty-eight families received gift cards for groceries and other emergency items. Forty-seven families received clothing, food and baby items. One family received a round trip train ticket to/from their hometown, so they could testify against their attacker. Nineteen families received taxi vouchers, so they could be transported to a safe location out of the Seattle city limits. VST paid for 1 family's storage unit, while relocating to safety. One family received services from a moving company to help her relocate.

SPD employees three civilian staff (3.0 FTE) for the VST program: one program manager, one volunteer supervisor, and one victim advocate. SPD's existing budget supports the three civilian positions and the use of a shared vehicle. The Seattle Police Foundation acts as a fiscal sponsor for the Victim Support Team and helps raise the approximately $20,000 needed annually to cover operating and victim service delivery costs. SFD supports the VST program as well, by providing necessary training on biohazards and injury prevention to volunteers. Other partners for the program include the Seattle/King County Emergency Feeding Program, Westside Baby, and New Beginnings.

Washington Anti-Trafficking Response Network

SPD's Human Trafficking Detail responds to and investigates complaints of human trafficking, whether sex or forced labor. The unit collaborates with the International Rescue Committee (IRC), whose coalition of victim service providers is referred to as the Washington Anti-Trafficking Response Network (WARN). Coalition member organizations in WARN provide direct assistance to victims of trafficking, using a trauma-informed, victim-centered, "do no harm" approach. WARN coalition members focus on victim stabilization and recovery, providing assistance in areas including intensive case management, safe housing, immigration advocacy and legal assistance, and mental and physical health treatment. Local community partners in WARN include the International Rescue Committee in Seattle, API Chaya, Refugee Women's Alliance, YouthCare, and YWCA.

SPD has three staff positions that support this effort; one (1.0 FTE) Victim Advocate, one (.5 FTE) Program Coordinator, and one (1.0 FTE) Investigator. Funding for the Program Coordinator and

Investigator positions come from a U.S. Department of Justice Bureau of Justice Assistance grant (through 9/30/18), while the other position is funded by SPD's existing budget (General Fund).

SFD plans to provide training to all uniformed personnel on sex trafficking later in 2018, with the goal of better resourcing first responders to recognize signs of trafficking and to escalate these concerns to SPD.

Mandatory Reporting

SFD and SPD first responders are mandated reporters of suspected abuse or neglect under state law. If a SFD first responder suspects abuse or neglect of a child or vulnerable adult and SPD is not involved in the response, he or she will submit a report either through the Department of State Health Services (DSHS) hotline (1-866-END-HARM) or the DSHS web form.

Domestic Violence Resource Guide

SPD officers responding to incidents of domestic violence carry a Domestic Violence Resource Guide that they can distribute to victims at the scene. This guide contains information about victims' rights, what to expect, community and legal resources, and the criminal justice system. The guide is printed by King County and funded through a US Department of Justice Office on Violence Against Women grant. SPD coordinates with the King County Prosecutors Office, the Violence Against Women Act (VAWA) Stop Grant Program, and the Seattle Human Services Department – Mayor's Office on Domestic Violence and Sexual Assault (MODVSA) to produce and distribute the guide.

While domestic violence occurs among all race/ethnicities and socioeconomic classes, there are barriers and concerns that are unique to communities of color. Survivors of color often face a lack of culturally appropriate services as well as prevention and supportive resources in diverse languages. SPD recognizes these barriers and prints and distributes this guide in English and six other commonly spoken languages in Seattle. The community partners included in the Resource Guide have a range of cultural competencies and language fluencies, designed to better serve individuals with specific needs and backgrounds. Community partners' areas of focus include targeted services for Hispanic/Latina, Jewish, API, Christian, and LGBTQ victims.

Partnerships with non-profit and community-based counseling and crisis services for domestic violence/sexual assault call response

SPD leverages partner organizations' strengths to improve the service provided to victims of domestic violence and sexual assault. SPD's partner organizations are selected based on their ability to provide key services, culturally competent resources, and long-term support to help address the multi-faceted nature of victims' recovery.

The department maintains relationships with multiple local government programs, community-based organizations, and non-profits in the Greater Seattle area, a sample of which are outlined below.

Improving Reporting and Trauma-Informed Best Practices

SPD partners with King County Sexual Assault Resource Center, Harborview Center for Traumatic Stress, and King County Public Health to improve reporting processes for sexual assault survivors and receive officer training on trauma-informed best practices.

Advocacy and Services

SPD collaborates with programs including New Beginnings, Salvation Army, and the King County Protection Order Advocacy Program to advocate for and provide services to sexual assault and domestic violence victims.

Addressing Threat of Homelessness

SPD works with the King County Homeless Housing Program (HHP) and the King County 211 Community Resource Referral to assist domestic violence and sexual assault victims who are facing the threat of homelessness. These partners serve as a comprehensive resource for housing referrals.

Addressing Barriers Facing Immigrants and Refugees

SPD recognizes that immigrant and refugee communities face barriers to advocacy. The department partners with Consejo, API Chaya, REWA, and the Northwest Immigrant Rights Project, working together to break down barriers and promote access to advocacy for immigrant and refugee communities.

Survey of Victim-Centered Approaches for Domestic Violence and/or Sexual Assault Calls

SPD and SFD researched victim-centered approaches in use by other jurisdictions and present a sample of these approaches below. Evaluating whether these programs are objectively successful is more complicated, since in many cases, outcomes are difficult to measure and/or data is not available. Any recommendations specific to the City of Seattle should be based not only on rigorous objective assessment, but also on an understanding of how such programs could be integrated with and complementary to existing Seattle victim-centered programming.

SPD and SFD will continue to work with the Mayor and other City stakeholders to research best practices and explore possible recommendations in the context of City priorities. In the meantime, the list below represents some strategies employed by other jurisdictions.

Soft Interview Rooms

Soft Interview Rooms are rooms in a police precinct that are designed to make victims feel comfortable. Instead of the clinical feel of a traditional interview room, these living room-like spaces have soft lighting, comfortable seating, and amenities designed to make people feel comfortable. Soft interview rooms are intended to reduce barriers for victims reporting a crime and help put victims at ease.

Victims, who come to the precinct to file a report, can do so in a safe, welcoming space, reducing trauma and stress. Advocates can reassure victims of the safe space at the precinct and mobile advocates could accompany clients as they go to file a report. For survivors without advocacy, or in need of additional information, soft interview rooms might include brochures and other culturally competent resources. Soft interview rooms are in use at the Springfield (MO), Casper (WY), Morgantown (WV), and Orange County (CA) Police Departments.

"You Have Options" Sexual Assault Reporting Program

'The "You have Options" Program (YHOP) has two goals: (1) to increase the number of victims who report to law enforcement, and (2) to thoroughly investigate identified offenders for serial perpetration.

The program focused on addressing three main barriers to victims reporting: confidentiality, fear of disbelief, and delayed initial reporting. The program includes 20 elements designed to give sexual

assault survivors more control of their experience reporting crimes. These victim-centered elements reduce barriers to reporting and include the following:

- A victim of sexual assault is offered three options for reporting: Information Only, Partial Investigation and Complete Investigation.
- A victim or other reporting party may remain anonymous and still have the information they provide documented by a law enforcement agency.
- When making a report there is no requirement to meet in person with a law enforcement officer. For example, a victim or other reporting party may report using an online form or a victim may choose to have a sexual assault advocate report on their behalf.
- Reasonable efforts will be made to allow the victim or other reporting party control over the location, time and date where their initial report is made to law enforcement.
- A victim may be accompanied by a sexual assault advocate or other appropriate support person during all phases of the reporting process and criminal investigation.

The program also gives law enforcement more tools and information to hold offenders accountable and focuses on identifying serial sexual perpetration. Data shows that a small percentage of the population commits a disproportionately large number of sexual assault offenses. Investigators move beyond traditional sexual assault investigative practices, utilizing the Inquiry into Serial Sexual Assault (ISSA) to provide a clearer picture of the reported incident and the offender.

Utilizing the victim-centered and offender-focused strategies of YHOP allows law enforcement to work collaboratively and gather the information necessary to identify and successfully investigate serial sexual predators. Some jurisdictions that have adopted this program report seeing increased reporting by victims and increased collaboration between community-based advocates and law enforcement, though these results are preliminary.

Sexual Assault Resource Guide

Some cities' first responders distribute a Sexual Assault Resource Guide to sexual assault victims and their families. Distribution of the guide gives sexual assault survivors immediate information about local resources they might need. It may include information about how to access a sexual assault kit, a victim advocate, counseling, a Sexual Assault Protection Order, and other community resources. Sexual Assault Resource Guides are currently being used by Beaverton and Denver Police Departments and the Michigan Department of Health and Human Services.

On-scene Crisis Services Response

Some police agencies provide 24/7 on-scene crisis services through their Victim Assistance Unit. By providing 24/7 on-scene services, advocates can build rapport with the victim, connect them to resources, and start advocacy immediately. The Denver, Kansas City, and Palm Bay Police Departments currently provide 24/7 on-scene crisis services.

Sexual Assault Protection Order (SAPO) Advocates

The King County Protection Order Advocacy Program currently provides assistance to domestic violence victims only. Expanding the program to include SAPO advocates would be another resource that respond to the unique needs of sexual assault victims. SAPO advocates would be experts in the protection order filing process and the court hearing process. They could be immediately accessible to

walk-in traffic to the King County courthouse and serve sexual assault victims as they seek a sexual assault protection order.

The Blueprint for Safety

The Blueprint for Safety is a comprehensive response plan for domestic violence crimes. The Blueprint is designed to improve interagency information sharing and collaboration, risk assessment, victim engagement, and mitigation of unintended negative impacts on survivors and their communities.

One significant change in this design is the increase in detailed information collected by patrol officers in their reports through use of risk assessment questions. A second change is the reprioritization of cases where the suspect was gone on arrival. These cases are found to have a high likelihood of reoccurrence within 30 days, so prioritizing them increases positive outcomes. The Blueprint for Safety was developed by the City of Saint Paul and has been adopted by cities including Duluth (MN), New Orleans (LA), and Shelby County (TN).

Online Portal of Resources and Case Information for Victims

An online portal can help victim navigate their criminal case and provide information that can help them make important decisions about their safety. It can provide links to information about what happens after the crime has been reported/when a Detective is assigned, what rights they have automatically and which ones they will need to ask for, important upcoming court dates, offender status, charges filed, the role of the victim, etc.

Case Companion, developed for and currently used in Multnomah County, OR, is an example of such a portal. It provides a way for victims to look up the offender's status (post-conviction) as they move through the criminal justice system and identifies resources for the victim if they want more support. The use of an online platform helps protect the victim's privacy is protected and give him or her control about what information he or she wants to receive going forward.

School Liaison Program

Dedicated school liaison programs, like those of the Naperville and Meridian Police Departments, have officer liaisons who work with schools and/or in conjunction with community agencies to assist with the reporting sexual assault and child abuse. The liaison can provide sexual assault/internet safety education to youth, parents, and educators. The program can be a positive means of community engagement, building relationships and sharing information between police, children, parents, and teachers.

Connecting 9-1-1 callers experiencing mental or behavioral health issues with social and health services or other resources.

Current Programs and Initiatives for Assisting Persons in Mental/Behavioral Crisis

SPD and SFD employ a holistic approach to assisting persons who are in behavioral crisis. Behavioral emergency responses are by nature dynamic situations. Each unfolds uniquely, with many factors contributing to the final disposition. SPD and SFD have a number of departmental programs and structures in place to support those in behavioral or mental health crisis. In addition, the two departments leverage each other's unique abilities when appropriate to achieve the best resolution possible for the call. For instance, in cases where the patient has a clear medical need or a level of psychosis that warrants hospitalization, SFD and SPD will work jointly to transport the patient to an

emergency department in a safe and appropriate manner (typically with an SPD patrol car, AMR ambulance, or SFD paramedic unit).

SPD Crisis Intervention Program

SPD houses one of the only Crisis Intervention Units in the country that provides *both* direct field response as well as post-incident continuum of care follow-up to people experiencing mental or behavioral crisis. The goal of the Unit is to identify needs or barriers at the point of first contact, then divert, to reduce the myriad of issues that can develop downstream (justice system, ER, etc.). The Crisis Intervention Unit consists of the CIT Commander (Operations Lieutenant), the CIT Coordinator (Sergeant), and the Crisis Response Team (CRT). The Crisis Intervention Unit is funded within SPD's existing budget. The CIT Coordinator is responsible for overseeing the day-to-day operations of the crisis intervention program, assisting with development of the department's crisis intervention training, and coordinating with the Crisis Intervention Committee (CIC).

Currently, SFD first responders do not request SPD CIT officers directly. Instead, SFD requests SPD assistance and on-scene SPD officers evaluate and may initiate a CIT response, as needed. As part of the broader protocol review described below, the department recognized the need to better operationalize its coordination with SPD for behavioral-emergency requests and committed to making process changes. SFD is currently distributing to all operations staff new resource guides on crisis response that were developed with the assistance of the SPD CIT coordinator. These guides are intended to better inform SFD first responders about when a CIT response is appropriate and instruct them in how to request this response from the Fire Alarm Center (FAC). Within the next month, SFD will provide training to FAC call-takers and dispatchers on best practices for making such requests.

Crisis Intervention Training

SPD is nationally recognized for its crisis intervention training. The objective of SPD crisis intervention training is to minimize conflict with persons in mental or behavioral crisis and refer those persons to needed services, when appropriate. In 2016, the Department began a more comprehensive approach to integrated training by incorporating CIT skills into tactical de-escalation training and scenario-based trainings to create a seamless and more practical approach to responding to individuals exhibiting escalating behavior. In 2017, the department expanded this approach, designing specific drills and scenarios across all tactical training and emphasize the application of crisis intervention/de-escalation concepts.

All officers and sergeants participate in hands-on exercises over three training days that emphasize de-escalation for persons in crisis. Training focuses on differentiating between circumstances where exigent officer or public safety concerns exist that require immediate action and circumstances in which time and the opportunity to make tactical decisions that allow for distance and shielding permit officers to slow down the course of events, potentially mitigating the need to use force. By integrating crisis intervention training as a core skill across multiple disciplines, officers evaluate each incident for symptomatic behaviors of a behavioral crisis as well as the need for and feasibility of de-escalation. This process, in turn, reinforces CIT/de-escalation concepts in all training scenarios.

In-person training for all personnel is supported by a series of e-Learning modules that address developing topics, reinforce trained skills and expand on existing approaches to persons in crisis. Topic-specific e-learnings include "Crisis Intervention and De-escalation for Subjects with Alzheimer's or Dementia" and "Emergent Detentions, Investigations and Updates."

Crisis Response Unit (CRU)

The Crisis Response Unit serves as a city-wide resource to provide continuity of care. In addition to coordinating training and outreach, the CRU reviews all reports of contacts with persons in crisis and selectively develops tailored response plans for individuals. The CRU is composed of a Sergeant, five specially trained CIT-certified officers, and a civilian mental health professional. The CRU has two components: the Crisis Response Team (CRT), which responds to incidents in the field that involve subjects in extreme states of behavioral crisis, and the Crisis Follow-Up Team (CFT), which follows up on cases involving serious behavioral crisis through intervention. This follow up can include coordination with the court systems, service providers, and/or case managers to establish response plans tailored to their unique needs.

In 2017, the CRU handled nearly 10,000 crisis reports, representing over 6,000 different subjects. Over 200 cases were assigned for specific follow-up (including over 50 individuals expressing suicidal ideations and in possession of firearms) and another 100+ individuals were specifically designated for "outreach." The CRU published 62 unique Response Plans for individuals and petitioned for 10 Extreme Risk Protection Orders (ERPOs). Data has shown a 76% reduction in calls for service after the implementation of a Response Plan. Crisis Response Units responded to over 1,000 in-progress calls, assisted with over 400 instances of field assessments and mental health court support, and met directly with service providers on over 600 occasions. CRT officers continue to report a significant increase in activity on the front-end of crisis incidents, including patrol support and field outreach, working with service providers, and responding to shelters and day services.

In January 2018, the CRU was realigned to have each member default to a "precinct of responsibility," managing both internal and external assignments. This realignment aims to balance limited personnel resources with a growing demand for both patrol response and follow-up assignments. Early feedback indicates that this realignment enables the CRT to have more regular contact with patrol and be able to respond to dynamic crisis incidents on a timelier basis. Additionally, officers assigned to post-incident follow up can complete their investigations more efficiently which allows for completion of new reporting requirements (RCW 71.05.457, Reports of Threatened or Attempted Suicide), completion of Extreme Risk Protection Orders (live in June 2017), and publication of crisis response bulletins for those incidents involving escalating crisis-based behavior.

Crisis Intervention Committee (CIC)

SPD's Crisis Intervention Program is advised by the CIC, a voluntary interagency advisory committee that includes the region's leading mental and behavioral health experts, social service providers, clinicians, community advocates, academics, other law enforcement agencies, the judiciary and representatives of SPD. The purpose of the CIC is to make recommendations on how to build and sustain an effective regional crisis incident response based on best practices, innovation and experience. SPD works in tandem with the CIC to make sure that its crisis intervention training and policies are consistent with legal standards, best practices and community expectations.

The committee:

- Evaluates SPD's Crisis Intervention Program, studies national models, and makes recommendations on the structure and design of the program;
- Reviews and weighs-in on the Department's CIT training;

- Develops policy and procedures regarding dispositions and options available to officers when responding to individuals in behavioral health crisis. Those options include jails, receiving facilities, hospitals and local mental health and/or social services agencies. They also provide guidance to clearly describe the roles of those entities when utilized as a disposition option and the roles and responsibilities of the SPD CIT-Certified officers in the process;
- Enhances community connections with advocates and social service professionals, as well as attempts to provide a seamless system of care for persons experiencing crisis;
- Communicates bilaterally to problem solve; and
- Reviews and actively solicits feedback from SPD patrol operations personnel regarding concerns and makes recommendations.

SPD First Responder On-Scene and Post-Scene Resources

SPD and SFD First Responders use a number of the same on-scene and post-call resources to better serve people in mental or behavioral crisis. SPD values its relationships and collaboration with community, non-profit, and governmental organizations that work to serve this vulnerable population. SPD First Responders utilize a variety of resources including, but not limited to: the Mobile Crisis Team, Vulnerable Adult Referral, and the Navigation team. SPD First Responders assess the needs of the person(s) at the scene and contact the appropriate resource based on that assessment.

New Behavioral Crisis Protocol Development

SFD is leading the development of a new suite of emergency medical dispatch protocols, in partnership with SPD, to respond to calls from those experiencing mental or behavioral health crises. These protocols may direct more psychiatric calls to SPD, leveraging SPD responders' higher degree of specialized training and resources to better respond to those needs.

The new protocols may direct FAC dispatchers to refer calls that include suicidality with intent and plan, violent psychosis, or non-medical behavioral calls to SPD. The protocols may also offer SFD call-takers the option of transferring callers directly to the King County Crisis Line, for free and confidential crisis professionals. If a call reaches the FAC solely for social service needs, such as utility or insurance assistance, call-takers may transfer the caller to King County 2-1-1.

SFD and SPD recognize the unique needs of callers experiencing behavioral and mental health crises, and these protocols are one example of how the departments are working to leverage each other's skills to better serve those in need. *These protocols are still being developed and will be finalized and deployed later in the year.*

Until they are deployed, protocol for callers who report a psychiatric emergency to the SFD with no medical component is to transfer the call to an SPD call-taker for dispatch of a police-only response. In cases where there is an identified medical component, the patient is in a position that indicates a potential medical problem, or there is an imminent threat of violence, the FAC will send the appropriate SFD response alongside the police. This may comprise a single-unit aid response up to a multi-unit paramedic response for severe conditions such as excited delirium. For low-level behavioral complaints, such as a stable patient who verbalizes that he or she is under psychiatric treatment, the call-taker may transfer the caller directly to AMR, which is SFD's current provider of Basic Life Support (BLS) ambulance transportation.

SFD First Responder On-Scene Resources

SFD first responders can offer both on-scene and post-call resources to callers with non-medical mental or behavioral health needs. The following on-scene resources are used singly or in combination on a case-by-case basis:

King County Emergency Services Patrol (ESP): This patrol, more commonly known as the Sobering Van, is administered by King County, but it receives a portion of its budget (40% in 2018) from the Seattle Human Services Department. The ESP is dispatched centrally through the SPD Communications Center, following a SFD first responder request for service (ESP vans have police radios only). The van serves ambulatory and medically stable individuals who are currently under the influence of drugs or alcohol. It typically facilitates transport to the Dutch Shisler Sobering Center in South Lake Union, though it will on occasion return patients to locations such as homeless shelters or supported housing, particularly the Wintonia and 1811 Eastlake Project.

Mobile Crisis Team (MCT): This team, staffed by the Downtown Emergency Service Center (DESC) and funded by the King County Mental Illness and Drug Dependency (MIDD) program, takes referrals from SFD first responders of individuals in behavioral or substance abuse crisis. Mobile Crisis Teams are each staffed with a chemical dependency professional and a mental health professional and they have a wide array of tools at their disposal, including on-scene counseling; the ability to provide transportation to the Crisis Solutions Center, shelters, or the sobering center; and the ability to assist with provision of ID or warm clothing, navigation of hospital services, and reunion with family members.

To make a referral to the MCT, SFD first responders call a dedicated phone number and give a short report. If the MCT screens the patient in, the SFD unit may wait for the MCT or return to service, in part depending on the estimated response time of the MCT. In 2017, SFD made over 270 MCT referrals, with more than 85% of patients receiving a service other than hospital transport. SFD began to train responders in MCT referral protocol in 2016, and it is the department's goal to train all first responders by the end of 2018.

Children's Crisis Outreach Response System (CCORS): SFD first responders also receive training on how and when to request the Children's Crisis Outreach Response System. For children and young adults aged 3 to 18 this mobile unit provides on-scene outreach and intervention in behavioral crises. CCORS is a King County program, administered by their Behavioral Health and Recovery Division (BHRD) and staffed and run by the YMCA.

Taxi Voucher Transport: Using current resources, SFD is currently piloting a program that provides taxi vouchers for medically stable callers who request transportation, as an alternative to using SFD first responders and vehicles for this purpose. Firefighters in the Rainier Valley/Columbia City area (the pilot site) have access to pre-paid taxi vouchers through Puget Sound Dispatch, and they can use the vouchers to arrange transportation for these patients to locations such as urgent care, primary care, behavioral healthcare, homeless shelters, and pharmacies. For patients whose medical needs are non-acute or who require only social service resources, transportation vouchers may facilitate more appropriate outcomes than delivery of the patient to a hospital emergency department. *SFD expects to be able to report on this pilot program in late 2018 or early 2019.*

SFD First Responder Post-Call Resources

SFD first responders also have several post-call options for reporting or referring patients for social service needs, behavioral health needs, or non-acute medical concerns. Post-call options are those that are implemented following the return to service of the SFD unit that responded to the initial call.

Low Acuity Alarm Program Referral: Following an incident, firefighters may report a patient to SFD's Low Acuity Alarm Program using the SFD electronic healthcare record software, a dedicated SharePoint site, or via phone or email. Low Acuity referrals are intended to be for individuals who are frequent users of the 9-1-1 service, but there are no absolute criteria for eligibility to be a Low Acuity referral and first responders may make such referrals on a discretionary basis. Screen-out criteria for direct engagement are minimal and include violence or other safety concerns, severe psychosis, or inability to effectively engage with others. Note that the Low Acuity Alarm Program staff also provide indirect care coordination for patients screened out of direct intervention eligibility based on one or more of these factors.

Referrals are routed to the Low Acuity Alarm Program case manager. The nature and timing of subsequent outreach by the case manager is context dependent. It may include direct contact; contact by health care providers or other case managers; referrals to homeless outreach programs, Adult Protective Services, long-term care, or a chemical dependency program; direct contact with the patient; and/or discussion of the patient's needs with one or more local High Utilizer Groups (see below).

SFD conducted a Racial Equity Toolkit (RET) analysis of the Low Acuity Program. Data from this analysis shows that this program serves clients and patients from underrepresented groups commensurate with their representation in the population. SFD does not anticipate changing the focus or the client base of the Low Acuity Program, so it hopes to continue meeting the identified community need.

Vulnerable Adult Referral: Seattle firefighters have access to a post-call referral form for cases of identified or suspected abuse or neglect in vulnerable adults (individuals above sixty years of age, individuals found incapacitated under RCW 11.88, or individuals determined to be developmentally disabled as defined in RCW 71A.10.020).

A report filed by a firefighter is automatically sent to DSHS Adult Protective Services, a dedicated case manager with Seattle Aging and Disability Services, a detective at SPD, the SFD Low Acuity Alarm Program, and a coordinating captain at SFD. If the patient resides in a long-term care facility, the report is also sent to DSHS Residential Care Services.

In 2017, SFD personnel reported 309 individuals as vulnerable adults for conditions such as extreme self-neglect, hoarding disorders, caregiver abuse, and financial exploitation. 60% of these individuals were receiving no formal assistance at the time of the report. Of those, 50% subsequently began receiving services. (For the other 50%, Adult Protective Services declined to act in response to the SFD report or the subject of the report declined offered services.)

Navigation Team Referral: The Low Acuity program is currently piloting a program in which firefighters can make referrals to the Seattle Navigation Team. These referrals are on behalf of individuals experiencing homelessness who express a desire to be connected with services (housing, chemical dependency, employment, healthcare, etc.).

The pilot site for this referral program is Fire Station 10 (Pioneer Square). Firefighters there forward the relevant electronic healthcare record to the Low Acuity Alarm Program team, which reviews it and forwards it to the Navigation Team. *SFD expects to be able to report on this pilot program in late 2018.*

SFD First Responder Post-Call Consultations and Referrals

Primarily through the Low Acuity and Vulnerable Adult programs, SFD has range of post-call community service consultation and referral options. Please see appendix for a complete list and details.

SFD Tracking Responses to Mental and Behavioral Crisis Calls

Over the past year, SFD has been modifying its electronic healthcare records collection to increase the tracking and visibility around people experiencing mental or behavioral health issues.

SFD has been using electronic healthcare records to record and track its medical responses since June 2017. Over a six-month period beginning in July 2017, SFD recorded 6,327 incidents, of a total of 35,621, with a primary impression that included a clear psychiatric etiology (e.g. behavioral/psychiatric episode) or involved substance abuse (e.g. alcohol use or opioid-related disorders). Within this same period, solely behavioral records totaled 2,869. In addition, SFD entered 2,105 records with the primary impression of "no complaints or injury/illness noted." In practice, these incidents comprise a wide variety of situations, but many of them correlate with homelessness, social service requests only, or with other conditions encompassed by this SLI. SFD aggregates these impression types (behavioral, substance abuse, and no complaint) and estimates that mental and/or behavioral health crises comprise of approximately 21% of all medical responses.

SFD's electronic healthcare records includes an optional field that gives SFD first responders the option of providing context for the reported primary impression. Over the same six-month period, first responders noted 728 support-sign instances of "anxiety or worries," 670 of "intoxication," 612 of "fatigue," 298 of "malaise," 181 of "delusional disorders," 162 of "suicidal ideations," and 160 of "emotional stress." Due to user unfamiliarity with a new software system, it is possible that these support signs are being underreported.

As February 8, 2018, SFD added a mandatory question to its electronic healthcare record that asks a responder to specify whether a patient is experiencing homelessness.

Partnerships with non-profit and community-based counseling and crisis services for mental/behavioral health crisis call response

Seattle Police Department

The SPD is dedicated to the mission of 'delivering a seamless system of care for those living with mental illness.' SPD will continue to engage social service providers who are willing to partner with SPD to complete this body of work. SPD holds contracts with Downtown Emergency Service Center (DESC) and Seattle Housing Authority (SHA); partnering with each agency to provide a better product by "both partners sharing the load." The SPD has previously applied for grants with the goal of expanding coverage to service additional community needs. Currently, SPD is in negotiations with the YMCA's CCORS program (Children's Crisis Outreach Response System) on a partnership where the YMCA would provide a qualified Mental Health Professional (MHP) in an "on-loan" part-time basis to SPD (at no cost) to partner in a Co-Responder team.

SPD's vision is to reduce the amount of people with demonstrated mental health needs interacting with the criminal justice system and instead, divert those individuals to appropriate services. SPD will continue to seek out and develop partnerships with organizations interested in collaborating on this area of work. One option SPD is considering is forming a high-level partnership with the King County Behavioral Health and Recovery Division (BHRD) to directly reduce the number of individuals introduced to the criminal justice/emergency psychiatric system. SPD believes that overly investing in post-incident programming and not enough emphasis on pre-booking/alternative disposition programming misses the opportunity to assist these clients at crisis inception.

Seattle Fire Department

SFD believes that any new means of providing behavioral-crisis or social service assistance must dovetail with services currently being provided by other agencies. SFD recognizes the important work being done by many community partners and sees value in complementing, not replacing, them. The primary gap it would seek to address would be in crises where resources are requested via a call to the 9-1-1 system. The two most promising strategies it has identified for closing this gap are nurse triage service based in the 9-1-1 call center and alternative response units such as those described below.

Particularly in conjunction with a transport method, a nurse triage line would help callers connect with non-emergency department health-care resources, a capability SFD currently lacks. To implement an alternative response unit, SFD would work with stakeholders including SPD, King County DCHS and Healthcare for the Homeless Network, the Mobile Crisis Team, federally-qualified healthcare centers, Harborview Medical Center, Neighborcare Health, and community psychiatric resources to build a robust alternate destination palette for crisis callers. Transportation to non-ED locations is presently the single largest obstacle to SFD appropriately managing crisis calls. The combination of identified treatment providers and a means of connecting patients to them would significantly improve call outcomes as measured by patient linkage to the resource best able to address their underlying problem.

With existing resources, SFD has the opportunity to work more closely with the Seattle Navigation Team, Evergreen Treatment Services REACH, Healthcare for the Homeless outreach nurses, the DESC HOST team, and other partners currently providing on-scene outreach. Particularly in the areas of on-scene response and post-call firefighter referral, SFD can and should build more referral pathways for medically stable patients experiencing behavioral crisis, social service needs, opioid-related crises, and the constellation of issues surrounding homelessness. These partnerships should be augmented with enhanced training for Seattle firefighters on mitigating these emergencies and understanding the wider social service system in Seattle beyond 9-1-1.

Survey of Victim-Centered Approaches for Calls Related to Mental and Behavioral Health

SPD and SFD researched other jurisdictions' approaches to responding to mental and behavioral crises calls and have included a sample of approaches and models below. Both departments regularly track and study how other jurisdictions are implementing programs in order to maintain and strengthen their ability to better respond to mental and behavioral crisis calls.

There is a wide array of approaches to behavioral and general social service outreach models in operation within the region and nationwide. Broadly speaking, the goals of these outreach models are a reduction in call volume by high-utilizing callers, on-scene treatment that either addresses the caller's complaint or results in transportation to a location other than a hospital emergency department, and improved health care and wellness measures across a population (for instance, more connections made

to primary-care providers). While such models vary considerably in their composition, staffing, and methods, they typically share two important factors.

First, they are multidisciplinary. Rather than being comprised of staff from a single agency, these approaches are reliant on the cooperation, engagement, and support of partner organizations, particularly, but not limited to, around assessing mental health.

Second, the organizational models in use by other jurisdictions invariably offer multiple treatment, transportation, and referral pathways. Rather than a one-size-fits-all approach (such as the historical default system of routing 9-1-1 callers to emergency rooms), these programs are flexible and can offer a range of dispositions that depend on the unique aspects of the patient, his or her complaint, and the attendant situation.

Approaches within Police Departments

While SPD has a nationally recognized crisis intervention program, the department continuously strives for improvement. The department regularly attends regional and national conferences, reviews publications, monitors trends and changes in laws, and attends regional and national training opportunities. SPD continues to seek opportunities to strengthen its programs based on review of the designs and successes of other jurisdictions.

Below is a sample of programs that SPD has reviewed. It is important to note, however, that the needs of each jurisdiction and the makeup of the community within make identifying one specific "model" impossible. A key to the program's success is keeping deployment efforts fluid and adjustable.
Below is a sample of programs that SPD has reviewed:

Portland (OR) Police Bureau has a Behavioral Health Unit (BHU) that oversees four tiers of police response to people in crisis. Like Seattle, all patrol officers receive Crisis Intervention training. The BHU houses the Enhanced Crisis Intervention Team, which is a group of volunteer officers that respond to mental health crisis calls. BHU also includes a proactive Behavioral Health Response Team (BHRT) which pairs a patrol officer with a mental health professional from Cascadia Project Respond to work with those suffering from mental illness who are identified as having multiple or high-risk contacts with the police. Finally, BHU includes a Service Coordination Team which offers treatment to Portland's most frequent drug and property crime offenders to address their drug and alcohol addictions, mental health treatment, and criminality.

Houston (TX) Police Department staffs a Crisis Intervention Response Team (CIRT) and a Homeless Outreach Team (HOT). The CIRT pairs a Houston CIT officer with a mental health professional from The Harris Center for Mental Health and IDD. There are currently twelve CIT units and they respond citywide to CIT calls. They assist officers with CIT calls, conduct proactive and follow-up CIT investigations, assist SWAT as a resource, as needed, conduct jail assessments, and handle the most serious CIT calls. The Homeless Outreach Team is composed of one sergeant, five officers and three case managers. HOT's goals are to help get chronically homeless off the streets and into housing. HOT partners with local service providers to connect individuals experiencing homelessness with needed services.

Boston (MA) Police Department has a Boston Emergency Services Team (BEST) which is part of an overarching "Stepping Up" initiative. The "Stepping Up" initiative is a national effort designed to reduce the number of incarcerated people with mental illness. The initiative provides resources and information to local jurisdictions, helping them assess their own efforts to divert mentally ill into treatment. The BEST team is made up of 2 full-time clinicians who rotate precincts and ride with a pre-selected cadre of

CIT Certified officers. The team provides direct field response, calming people in mental distress. After the initial evaluation by the BEST clinician, they can call a mobile BEST team, as needed, who can be dispatched to continue care.

The program relies on a strong partnership and trust between the Boston Police Department and BEST. It is similar to SPD's Mobile Crisis Team (MCT), who when called upon, arrive at the scene to assist with crisis calls. They do not provide post-incident follow up on police activity.

Approaches within Fire Departments

Many programs housed in Fire Departments for those experiencing mental or behavioral crisis follow a model known as Integrated Mobile Integrated Health (IMIH). The IMIH model seeks to provide not just dispatched firefighter/EMT response but the array of services, support, treatment and transportation necessary for crisis prevention, response, and stabilization.

A major constraint around replicating one of these models in Seattle is statutory: ambulances in Washington State currently cannot bill the Health Care Authority for Medicaid reimbursement for non-transport or alternative transport dispositions. Following the passage of HB 1358 in 2017, the Health Care Authority was tasked with drafting new rules that would reverse this prohibition, but that work is ongoing. Currently, SFD cannot use ambulances to divert patients to locations other than hospital emergency rooms.

In addition to the statutory limitation, other constraints include technological (such as the ability to share patient information among agencies in a real-time basis) and budgetary ones. SFD cannot redirect first-responder staff from front-line response units to a crisis-response unit such as those described above, so additional staffing would be required for response tailored to behavioral and psychiatric crises. In addition, both SFD and SPD would likely need to refine their call-taking and dispatching protocols to accommodate such an alternate response model.

The programs described below highlight the different approaches used in this work:

Colorado Springs Community Response Team, Colorado Springs, CO. Led by the Colorado Springs Fire Department (CSFD), this team includes a team comprised of a CSFD paramedic, a Colorado Springs Police Department officer or officers, and a registered nurse from Aspen Pointe, a behavioral health organization. Team members are trained in de-escalation, patient risk assessment, and on-scene counseling. After providing an initial field medical clearance, they provide services that can include transport to a shelter, crisis support unit, hospital, jail, detox, or other psychiatric facilities. The program's internal data shows that transportation of behavioral emergencies to a hospital emergency department fell from 98% pre-program to 13.1% with the program in place.

Nurse Triage Line, Ft. Worth TX, MedStar Mobile Healthcare. At MedStar's 9-1-1 center, triage nurses are embedded with traditional 9-1-1 call-takers. Based on assessed caller acuity, call-takers may refer callers to the nurses, who utilize the Emergency Communication Nurse System, a set of algorithms designed to safety triage and to redirect lower acuity complaints. MedStar passes approximately 5% of its total inbound 9-1-1 call volume to its. All calls receive post-call quality assurance follow-up. MedStar estimates that its nurse triage program saved $2.62 million over 4.5 years due to avoided ambulance and ED costs.

Mobile Integrated Healthcare Program, Stanislaus County, CA. This program, administered by AMR, follows the same basic model as Colorado Springs. A program vehicle, which is staffed by community paramedics (paramedics with an additional level of training), is dispatched to psychiatric emergencies. The community paramedics then rule out major illnesses and, after liaising with police and psychiatric experts, can facilitate transport directly to a psychiatric emergency facility. Initial data show that only 12 of 285 of eligible transported patients were subsequently re-transferred to a hospital, indicating that community paramedics can safely and effectively divert these patients.

Fire Department Community Assistance, Referrals and Education Services (FD CARES), Kent, WA. The Puget Sound Regional Fire Authority, which covers Kent, Covington, and SeaTac, runs the FD CARES program. It fields a response vehicle (not an ambulance) staffed with a firefighter/EMT and a registered nurse, who may also consult with a social worker located at Fire Authority headquarters. FD CARES responds to 9-1-1 calls and performs proactive outreach to high 9-1-1 utilizers and individuals with complex care needs. FD CARES can refer to the King County Mobile Crisis Team and can facilitate transport to alternate locations such as detox or urgent care. In 2016, only 27% of FD CARES contacts were transported to an emergency room, with the remainder treated on scene or transported to an alternative destination.

Chronic Utilizer Alternative Response Team (CHART), Everett, WA. This program focuses on high utilizers of EMS, law enforcement, corrections, social services, and hospitals. It is not solely concerned with behavioral/social emergencies, but in practice, it covers many of them. The CHART team is drawn from the Everett Police Department, Everett Fire Department, Snohomish County Department of Human Services, Snohomish County Jail, the Everett City Attorney's Office, Providence Regional Medical Center, and other social service agencies. The CHART initiative focuses on outreach and care planning. It does not have its own vehicles, nor does it provide patient transport. High utilizers of any of those services are identified, and when they sign a release of information, the team devises a system-wide plan for coordinated care and services that may or may not require active participation by the high utilizer. A 2016 program analysis showed significant usage decreases in EMS, criminal justice, and emergency room visits by CHART participants.

Resource Access Program (RAP), San Diego, CA. The RAP program (on temporary hiatus due to funding issues) is a long-standing multidisciplinary outreach program based in the San Diego Fire Department (SDFD). It began as a solely high-utilizer focused initiative, but it has since broadened to high-needs individuals and those experiencing homelessness and/or behavioral emergencies. RAP is staffed by SDFD/AMR community paramedics, who liaise closely with county 2-1-1, the San Diego police, hospital health information exchanges, and a coalition of local social service agencies. RAP has pioneered the use of technology to identify high utilizers, apply vulnerability measures to them, and share data with referral partners throughout the city.

Appendix

Primarily through the Low Acuity and Vulnerable Adult programs, SFD has access to a range of post-call consultation and referral options. SFD generally means "referrals" to imply a team-to-team handoff of a specific patient and a variety of services provided in response to factors like high system utilization, behavioral health, and homelessness. SFD's referral options are as follows:

- *Seattle Navigation Team* – For individual referrals, questions about encampments, and outreach to homeless individuals
- *Downtown High Utilizer Group* – Multidisciplinary group discussing, staffing, and referring individuals presenting to the Harborview, Swedish, and Virginia Mason Emergency Departments on a frequent basis. This group also staffs challenging cases, high utilizers of other social services, and clients with multi-system involvement.
- *North End High Utilizer Group* – Multidisciplinary group covering high utilizers in the north end of Seattle and Shoreline; focus is on challenging cases and high utilizers of EMS/Sheriff/Police as well clients with multi-system involvement
- *Seattle Outreach Committee* – A group of homeless outreach providers who gather to staff active cases. Members include SPD crisis intervention team, the Navigation Team, shelter staff and mental health professionals working with the homeless, primarily in the downtown core.
- *Harborview High Utilizer case management* – Harborview Medical Center has a designated group- of case managers who work with patients who meet Harborview's high-utilization criteria.
- *Downtown Emergency Service Center* – SFD first responders can refer individuals experiencing homelessness to Homeless Outreach Stabilization and Transition (HOST) and mentally ill individuals to Support, Advocacy, Growth, and Employment (SAGE), both of which are run by DESC. They may also contact he Mobile Crisis Team on a post-call basis for advice and other referrals.
- *Evergreen Treatment Services REACH* – This outreach team, which focuses on individuals experiencing homelessness, is embedded with the City Navigation Team and works with the LEAD program.
- *SPD Mental Health Liaison* – The SFD Low Acuity program frequently consults with this embedded social worker, a DESC employee, for details on outreach to this population and clients' interactions with police.
- *Mental health providers* – Including Sound (formerly Sound Mental Health), Navos, Evergreen Treatment Services, Valley Cities, Community Psychiatric Clinic, and others

Consultations are more general engagements that enhance and inform the work done by the Low Acuity and Vulnerable Adult programs. SFD's consultation options are as follows:

- *King County Healthcare for the Homeless Network* – Including scheduled stop times and locations of the Mobile Medical Van and referrals to the Housing Health Outreach Team (HHOT)
- *Providers of service to individuals experiencing homelessness* – These include shelters run by DESC, Catholic Community Services, Plymouth Housing, and others.
- *Supported housing* – Independent housing for former chronically homeless individuals. Clients have access to services such as case management within the buildings. Agencies such

as DESC, Compass Housing Alliance, Plymouth Housing Group, Seattle Housing Authority, and others provide housing in these multi-family units;

- *Information and assistance providers* – Including Sound Generations, 2-1-1/Crisis Line, Jewish Family Services, SeaMar Community Health Centers, and others
- *Long-term care* – Disabled and chronically ill patients on Medicaid may have case management services through DSHS Aging and Long-Term Support Administration (ALTSA). DSHS subcontractors like the City of Seattle Aging and Disability Services provide ongoing Case Management and do the annual State CARE reassessment for services provided by the state (such as in-home care). The Low Acuity Case Manager frequently coordinates care with these providers.
- *Home care agencies* – Including Full Life Care, Kin-on Home Care, Catholic Community Services, and others
- *Health care providers* – Including Neighborcare Health, University of Washington Medicine, Seattle Indian Health Board, Veterans Affairs Hospital, Virginia Mason, and others