GEORGE MASON UNIVERSITY
Center for Evidence-Based Crime Policy
Department of Criminology, Law & Society

RADAR: Response Awareness, De-Escalation, and Referral

Final Evaluation Report

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Summary of Findings

Response Awareness, De-Escalation, and Referral (RADAR) was developed by the Shoreline Police Department, in collaboration with the Center for Evidence-Based Crime Policy at George Mason University and the National Police Foundation, under a FY 2015 Strategies for Policing Innovation (SPI) grant from the Bureau of Justice Assistance. RADAR was first implemented in January 2017 after a one-year planning period. It aimed to institutionalize department-wide and regional information sharing about community members with behavioral health issues or developmental disabilities (BH/DD) who may be at increased risk of violence or use of force; and offer opportunities for outreach and connection to services and resources through a mental health "navigator." A total of 27 response plans for information sharing were created during the RADAR implementation period, and 200 people were contacted by RADAR deputies and the mental health navigator.

Our process and outcome evaluation finds that RADAR was successfully implemented and was well-received by deputies. By 2019 all Shoreline deputies who responded to our survey had heard of RADAR. A majority checked for response plans before responding to calls, viewed RADAR favorably, and believed the program contributed to their job satisfaction and effectiveness. RADAR deputies surveyed after RADAR implementation were also significantly more likely than those surveyed during the planning phase to feel empathy for people with BH/DD and significantly less likely to have used force against them.

Our evaluation did not find significant effects on rates of mental health-related calls for service or incidents. Consistent with the survey, we found that use of force was lower after RADAR was implemented, but this was not statistically significant. However, due to the small number of calls and incidents, especially those involving force, it is likely that we would not have been able to detect significant effects in this study even if they exist. Nonetheless, RADAR has clearly had a positive influence on Shoreline Police Department's culture in terms of changing attitudes and responses to people with BH/DD. It is likely that the translation of this cultural shift into robust effects on calls and incidents could take many years, but the trend points in the right direction.

We conclude our report with a number of recommendations for sustaining and expanding RADAR, particularly the navigator portion, in order to realize any potential long-term benefits of the program. These include:

- continuing to expand the existing regional collaboration, particularly in terms of streamlining technology and information-sharing systems;
- institutionalizing the navigator position as a formal social work career path through intentional, structured hiring, onboarding, and training; and
- identifying additional resources and sources of support in the community to continue implementing the program at relatively low cost.

1. The Research Basis for RADAR

As first responders to a broad variety of criminal and non-criminal incidents, the police encounter community members in numerous and complex ways. Police interactions with people with behavioral health and/or developmental disorders (BH/DD)[1] starkly illustrate this challenge. Over the last fifty years, the deinstitutionalization of people with BH/DD; limited funding of and access to community-based behavioral health services; and "tough on crime" policies have positioned the police as the first, and sometimes only, option when people with BH/DD and their families need help (Manderscheid et al., 2009). For example, family members, friends, or people with BH/DD themselves may call the police to assist in a crisis; or an individual may be acting abnormally in public, attracting the attention of police or concerned citizens, or engaging in unlawful activity. Furthermore, the shift in contemporary policing toward proactive, community-based approaches rather than reactive strategies has normalized encounters with people with BH/DD who may not have committed a crime (Godfredson et al., 2011). As a result, a substantial proportion of people with BH/DD are likely to have contact with the police, which in turn leads to overrepresentation in jails and prisons (Steadman et al., 2009; Sullivan & Spritzer, 1997). According to a frequently-cited statistic, 7 percent of police-citizen interactions in large U.S. cities involved someone whom the police believed to have a mental illness (Deane et al., 1999; see also Gill et al., 2018), but given the age of this study and the lack of systematic data collection on mental and behavioral health in many agencies (Crocker et al., 2015) this is likely an underestimate. There is debate about whether or not police are more likely to use force against people with BH/DD and whether interactions with these individuals are inherently more dangerous for police (e.g. Alpert, 2015; Johnson, 2011; Morabito & Socia, 2015; Rossler & Terrill, 2017; Ruiz & Miller, 2004), but there is some risk that these encounters can escalate, particularly when people with BH/DD are resistant to police (Engel & Silver, 2001; Johnson, 2011; Morabito et al., 2012; Novak & Engel, 2005), and they can become deadly. A 2015 investigation by the Washington Post found that 25 percent of fatal police shootings in the United States that year involved a person experiencing a mental health or emotional crisis (Kindy & Elliott, 2015; see also Cordner, 2006), and the FBI estimates that around 5 percent of identified individuals who feloniously killed law enforcement officers between 2009 and 2018 were known to the officer's agency as having a prior mental disorder.[2] Even less serious calls for service involving people with BH/DD take up a substantial amount of police time and resources compared to other call types (Akins et al., 2016; Borum et al., 1998; Cordner, 2006; Gill et al., 2018; Kisely et al., 2010; Teller et al., 2006; Yang et al., 2018).

The myriad ways in which people with BH/DD interact with law enforcement and the increased amount of time police spend responding to calls may increase the likelihood of escalation, which in turn increases the risk to people with BH/DD and officers alike, simply through increased exposure (e.g. Watson et al., 2008). However, there are a number of other ways in which encounters with people with BH/DD can escalate unpredictably. Fear and misunderstanding on the part of both officers and people with BH/DD can lead to resistant or noncompliant behavior even when the police are simply trying to help rather than coerce. Police officers may be unsure about whether the person is showing symptoms of a BH/DD or if they are simply resistant, and people with BH/DD may misunderstand officers' intentions (Cordner, 2006; Livingston et al., 2014; Morabito & Socia, 2015; Rossler & Terrill, 2017; Ruiz & Miller, 2004; Schulenberg, 2016; Teplin, 2000; Van Maanen, 1978). Studies have shown that people with BH/DD feel particularly threatened by weapons and are specifically afraid of being handcuffed (Boscarato et al., 2014; Butler,

[1] We use this term broadly to describe people with a diagnosed disorder, people exhibiting a symptom of a disorder, or people experiencing a mental health crisis.

[2] Federal Bureau of Investigation, Law Enforcement Officers Killed and Assaulted 2018, Table 45. https://ucr.fbi.gov/leoka/2018/tables/table-45.xls, accessed September 19, 2019.

2014; Krameddine & Silverstone, 2015). Beyond fear, some people with developmental disabilities or who are in extreme distress may simply be unable to process or respond to commands, which an officer may perceive as resistance. Verbal commands and orders from officers could intimidate or aggravate people with BH/DD, causing resistant behavior to escalate (Boscarato et al., 2014; Meade et al., 2017). Officers may also misconstrue unexpected reactions to touch or other stimuli as examples of resistance. For example, some people on the autism spectrum or who have schizophrenia experience touch and pain differently, and their behavior may escalate in response to restraint or even a comforting touch (Blakemore et al., 2006; Dunn, 2001; Riquelme et al., 2016). Furthermore, in the case of people with BH/DD, resistant or erratic behavior may be so severe that officers may not have an opportunity to de-escalate. If someone is posing an active danger to themselves or others, such as threatening suicide by holding a gun to their head or a knife to their wrist, or trying to walk into traffic, the officer's first priority is to ensure the safety of the scene by any means necessary. Finally, the substantial proportion of people with BH/DD who also experience co-occurring substance use disorders are perceived by police as more aggressive, resistant, and disrespectful and are more likely to have force used against them (Morabito et al., 2017; Novak & Engel, 2005; Watson et al., 2010). Thus, the combination of some or all of these factors and the unpredictability with which they can occur potentially endangers people with BH/DD, police officers, and other community members.

Police departments are increasingly adopting approaches to better prepare officers for interactions with people with BH/DD and help facilitate alternatives to the criminal justice system. Crisis Intervention Team training (CIT), which was first developed by the Memphis Police Department and the Memphis chapter of the National Alliance on Mental Illness (NAMI) in 1988 (Deane et al., 1999), is the most well-known and studied of these approaches. CIT involves specially trained officers who create collaborative relationships with mental health professionals in their departments and community, and receive training on behavioral health issues and de-escalation skills. CIT has been found to enhance officers' attitudes about mental illness, and improve their knowledge of de-escalation skills and behavioral health treatment options (Compton et al., 2008; Compton et al., 2014a; Reuland et al., 2012; Reuland et al., 2009; Teller et al., 2006). However, CIT has no effect on use of force (Compton et al., 2014b; Taheri, 2016), although Morabito et al. (2012) found that CIT-trained officers were less likely than those who had not attended training to use force as subject resistance escalated. CIT is primarily an organizational-level approach rather than officer-centric, and some officers find it too theoretical and insufficiently focused on practical tactics and specific information about local options (Gill et al., 2018). Further, CIT programs do not necessarily emphasize formal person-specific information sharing, whereby officers who know how to successfully de-escalate specific people with BH/DD in their communities can easily and *systematically* share this information with colleagues who may need to respond to that person in an emergency, or a direct referral mechanism to ensure people with BH/DD can access needed services. These challenges could explain the mixed findings of CIT evaluations: despite increased awareness and understanding of BH/DD in general, officers may still be wary or even fearful in their encounters with people with BH/DD given the risk of unpredictability and actual or perceived resistant behavior. In addition to this, officers' limited access to specific details about the person's condition or behavior during a crisis response could ultimately influence use of force decisions (Engel & Silver, 2001; Reuland, 2010; Ruiz & Miller, 2004).

This report describes the RADAR—Response Awareness, De-Escalation, and Referral—program, developed by the Shoreline (WA) Police Department, a contract agency of the King County Sheriff's Office (KCSO), under a 2015 Strategies for Policing Innovation (SPI) grant in collaboration with research partners from the Center for Evidence-Based Crime Policy at George Mason University and the National Police Foundation. RADAR, which began implementation in January 2017, aims to address limitations in current practices by emphasizing department-wide and regional information sharing between officers, their

supervisors, and mental health professionals about specific individuals in the community, and targeted outreach to people with BH/DD by an officer and a mental health "navigator" working in partnership. RADAR aims to reduce fear, misunderstanding, and the risk of force through several mechanisms. Research shows that systematic and subject-specific information sharing is supported by both police and people with BH/DD (Butler, 2014; Herrington, 2012; Livingston et al., 2014), and a formalized system supports officer needs by being immediately accessible when needed, decreasing some of the traditional obstacles to information sharing (Borum et al., 1998; Crocker et al., 2015). RADAR's outreach and referral component is a collaborative approach intended to increase trust and break down stigma between police and people with BH/DD through mutual problem solving and improved access to resources. The process seeks to treat people with BH/DD with dignity and respect, emphasize police trustworthiness, and give community members a voice and access to more options—the pillars of procedural justice. People with BH/DD especially value and prioritize elements of procedural justice, particularly voice and dignity (Boscarato et al., 2014; Butler, 2014; Livingston et al., 2014), and negative perceptions of procedural justice among this population are associated with increased resistance in police encounters (Boscarato et al., 2014; Butler, 2014; Watson & Angell, 2013).

2. Study Design and Methodology

The Shoreline Police Department partnered with the Center for Evidence-Based Crime Policy (CEBCP), a research center in the Department of Criminology, Law and Society at George Mason University, and the National Police Foundation to undertake a process and outcome evaluation of RADAR. The mission of CEBCP is to make scientific research a key component in decision-making about crime and justice policies. CEBCP is committed to collaborations and knowledge exchange with the policy and practice communities. The National Police Foundation's mission is to advance policing through innovation and science. It is the oldest nationally-known, non-profit, non-partisan, and non-membership driven organization dedicated to improving policing, and has been on the cutting edge of police innovation for almost fifty years.

The two research partner organizations were involved at all stages of the project. During the planning phase (2016) we produced a comprehensive problem analysis and action plan in collaboration with Shoreline PD. As part of this process we obtained and analyzed calls for service and incident reports; conducted ride-alongs and focus groups with deputies, command staff, and mental health professionals; and surveyed deputies about their attitudes toward mental health and their experiences of dealing with people in crisis. During the implementation period we continued our data analysis, including conducting a thorough search of incident report narratives from 2015 through 2018 to identify behavioral health components in cases not classified as mental complaints or suicide attempts; participated in regular planning and update calls with the police department; and reported on relevant trends from police and navigator data.

2.1. Study location

Shoreline, WA is a city of over 55,000 residents[3] located immediately north of Seattle. Almost 70 percent of its residents are White, and the city is relatively affluent, with just 9% of the population below

[3] Demographic data cited here are from the American Community Survey 2017 5-year population estimate: https://factfinder.census.gov/, accessed October 24, 2019.

the poverty level. Nonetheless, in the initial development of the SPI grant we found that Shoreline disproportionately contributes to mental health-related calls for service within the KCSO service area. The city has a relatively high number of group homes and subsidized housing units, and one of the county's five methadone clinics, which may contribute to mental health-related issues. There is also easy access to the larger city of Seattle via public transit (a major thoroughfare, Aurora Avenue/Highway 99, runs north from Seattle through the center of the city, with multiple bus lines and a transit center along the route), and people who are transient often ride the bus routes from end to end. Shoreline residents comprise approximately 10 percent of the population of the KCSO service area but account for around 15 percent of mental health-related calls. This figure is likely an underestimate because of the number of non-residents moving in and out of Shoreline, and also because KCSO does not routinely flag calls or incidents that include a mental or behavioral health component, so these numbers are based only on calls specifically classified as "mental complaints" or "suicide attempts."[4] Table A1 shows the total number of BH/DD calls for service and incidents in Shoreline during the study period.[5] On average, 3.5% of calls for service in Shoreline in the pre-RADAR period (2015-16) were classified as mental health complaints or suicide attempts. Around 6.5% of incident reports during the same period were classified as mental health complaints/suicide attempts or involved other indicators of BH/DD, which aligns with the estimates from prior research that we described above.

Shoreline Police Department (PD) has 50 sworn staff at all ranks. It is one of 16 cities, tribes, and transit authorities that contract with KCSO for police services. Under this model, contract jurisdictions share communication systems, records, and command staff, and it is common for officers (deputies) to laterally transfer or be promoted to other KCSO divisions or contract agencies, leading to relatively high staff turnover. During the planning phase we conducted informal, exploratory focus groups with deputies and command staff in Shoreline (separate from the post-project focus groups described below) to understand their perceptions and experiences of responding to BH/DD calls.[6] This turnover was mentioned frequently in those focus groups: participants told us it contributed substantially to the challenges of dealing with people with BH/DD, because deputies build up knowledge about the characteristics and needs of specific people in the community that can help them de-escalate crisis situations, but this knowledge is not always shared with new arrivals and can be lost when deputies move on.

2.2. Data, research design, and analytic strategy

In this report we describe the findings from our process and outcome evaluation. We hypothesized that RADAR would help to reduce mental health-related calls for service and incidents, repeat calls for service for RADAR-involved individuals, and use of force incidents. We also hypothesized that RADAR would improve Shoreline deputies' understanding of mental health-related crisis incidents, attitudes toward people with BH/DD, and knowledge of available options. We assessed these outcomes using official KCSO calls for service and incident data for Shoreline and a comparison jurisdiction, case management notes provided by the mental health navigator, and surveys of Shoreline deputies conducted before implementation began and again at the end of the grant period. We provide specific details on these data sources and our analytic strategy for each outcome below.

In addition to these outcomes, we also conducted semi-structured interviews and focus groups at the end

[4] Under KCSO's reporting system these call/incident types are coded as 371 and 232 respectively.
[5] The comparison city shown in Table A1 is described in Section 2.2.1.
[6] Full details are available in our 2016 action plan.

of the grant period to provide qualitative insights into the history and implementation of RADAR and the experiences of those involved in delivering the program. We also used our second wave of surveys to assess the implementation process through questions about deputies' attitudes toward RADAR and how it had impacted their work. We conducted face-to-face interviews or focus groups with the following stakeholders in Shoreline:

- Police chief
- Captain
- RADAR consultant (this person joined the RADAR team in March 2019 and is a researcher with expertise in social work and workplace violence who also served as a mental health navigator with another police agency)
- Project coordinator (a doctoral candidate in social work who has been working with RADAR since 2018 to help develop the navigator portion of the initiative)
- RADAR sergeant, who oversees RADAR implementation and referrals
- Three RADAR deputies
- Two patrol deputies who are not assigned to RADAR but have experienced its use through their patrol work
- Mental health navigator
- The retired captain who originally developed the RADAR concept (phone interview)

The focus groups and interviews were conducted in August 2019. We asked participants about their role in RADAR and how they would describe the program; the effectiveness of the program and how it compared to other options available to assist people in crisis; their expectations at the beginning versus how RADAR had worked in practice; examples of success stories and challenges; and their recommendations for other police departments that are considering implementing similar programs. The semi-structured nature of the conversations also allowed participants to elaborate on specific issues relative to their expertise or experience. For example, the former captain provided a rich history of the development of the program and the RADAR consultant described her previous role as a mental health navigator in a law enforcement setting and how RADAR compared to her experiences. We organized our detailed interview and focus group notes around these key themes and use the data in this report to describe RADAR's history and current process in detail, assist in interpreting our quantitative findings, and shape our conclusions and recommendations.

As we discussed in our implementation plan, we decided not to conduct a randomized controlled trial of RADAR at the outset due to both practical and ethical concerns. We intended to develop a quasi-experimental design based on propensity score matching (PSM) methods in which RADAR response plan recipients would be matched with similarly-situated people in a comparison jurisdiction to compare outcomes. However, RADAR evolved during the course of implementation and the eligibility criteria developed for the response plans were intentionally restrictive, so only a small number of individuals received a plan (there were 27 response plans as of September 2019). There are too few response plans to conduct a rigorous statistical analysis of outcomes. Nonetheless, the addition of the navigator component of

RADAR, which was not part of the original implementation plan, offered a broader (albeit lower-risk) pool of people who received outreach and were connected with services. As we explain below, we were not able to conduct a quantitative analysis of outcomes for these individuals by the final report deadline, but we are able to draw some broad descriptive conclusions using the Navigator's case management data.

2.2.1. Comparison jurisdiction

In addition to the Shoreline data, we received data from KCSO for another contract city to use as a comparison for our analysis of calls for service, incident reports, physical contact and resistance (see below), and repeat calls. The comparison city also borders Seattle, as well as other cities in the wider Seattle metropolitan area, but is not adjacent to Shoreline. The population is just under 51,000[7] and 62 percent of residents are White. The poverty rate is somewhat higher, with 15 percent of residents living below the poverty level. Numbers of police calls and incidents, both overall and mental health-related, were significantly different from those in Shoreline during the baseline period (see Table A1). Nonetheless, while there are some key differences with Shoreline, adding the comparison city allows us to assess the data from Shoreline in relation to a similar jurisdiction that did not make any specific efforts to change its response to people with BH/DD during the intervention period.

2.2.2. Calls for service and incidents at the department level

As previously noted, we received data on calls for police service and incident reports recorded by Shoreline PD and the comparison jurisdiction between January 2014 and December 2018.[8] The reports were provided to us in Microsoft Excel spreadsheets by KCSO crime analysts. The datasets included unique case numbers that allow us to match calls with their subsequent incident reports if one was taken. The calls for service data included the date, time, type, and location (street address) of the call, and the disposition (i.e. incident report written, no action taken, unfounded etc.). The incident report data also included basic demographic information (age, sex, race) about the people involved in the incident and the responding deputy's summary narrative report of the circumstances.

Calls for service and incidents were classified according to KCSO's FCR (final classification reporting) code system. There were two codes directly relevant to BH/DD: "mental complaints" (FCR 371) and suicide attempts (FCR 232). However, as we noted above, we believed that many other incident types could involve a BH/DD. For example, if someone heard noises next door and called 911, the dispatcher might classify this as a disturbance or "suspicious circumstances." However, when the police arrive, they might find that the disturbance is due to a person with a BH/DD acting violently due to a medication issue. Due to the high comorbidity between substance use and BH/DD, a call for service relating to someone who is drunk in public or using drugs might reveal a BH/DD issue as the incident unfolds. KCSO does not have a way to track these more nuanced cases, such as a behavioral health flag in the database.[9] This means that calls involving a BH/DD that were not originally classified as such by the dispatcher cannot be easily

[7] Demographic data cited here are from the American Community Survey 2017 5-year population estimate: https://factfinder.census.gov/, accessed October 24, 2019.

[8] We use data from January 2015 to December 2018 in our analyses unless stated otherwise to ensure an equal number of months pre- and during-intervention (RADAR went into operation in January 2017).

[9] Shoreline deputies completed a mental health incident report form to document cases involving people with BH/DD, but these were only available on paper at the time of the study and we did not have the resources to analyze them.

identified.

To overcome this issue in the incident data, we used the deputy's narrative summary to qualitatively code for BH/DD in the incident reports (narratives for the call data were not available). In consultation with the RADAR team we developed a list of key words and phrases denoting potential BH/DD and related concepts, and used Excel's search function to identify narratives that included these terms. The search terms included: "mental," "overdose," "nudity," names of local hospitals, "diagnosis/diagnosed," names of specific diagnoses such as autism or schizophrenia, the name of the paper mental health incident form, "ITA" or "invol" (terms that refer to circumstances where the deputy can call an ambulance and require an involuntary transfer to hospital), "group home,"[10] "agitation," "excited delirium," "suicide," "danger to self/others," the term "medication" or names of specific medications, and the name of the local ambulance provider. Due to the research we cited above showing the high co-occurrence of BH/DD and substance use disorders, we also included drug and alcohol-related cases (e.g. public intoxication) if they had escalated to the point where people were unable to care for themselves, which we determined to be the case if the report stated that the deputy ordered them to detox or involuntary transfer to hospital.

In this report we present descriptive analyses of the number and type of calls for service and incident reports involving BH/DD. We use basic statistical tests to compare trends in calls (including the time spent on BH-related calls) before and during RADAR implementation, and a difference-in-differences modeling approach using Poisson regression with robust standard errors to estimate whether RADAR is associated with any differences in monthly calls for service and incident reports between Shoreline and the comparison city. The models include the monthly outcome (i) in Shoreline and the comparison area (t), treatment group assignment ($A_i t$), time period (pre/during; $P_i t$), the difference-in-differences interaction term ($P_i t \times A_i t$), which is interpreted to assess the effect, and controls for seasonality and secular trends. We report the incidence rate ratio (IRR) for each model, which represents the ratio of the number of incidents or calls in Shoreline to the number in the comparison city.

2.2.3. Physical contact and subject resistance

We originally intended to examine police use of force against people with BH/DD as one of our outcomes. We received basic data on reportable use of force incidents from KCSO's internal affairs database, which could be linked back to incident reports via the case number. KCSO's use of force policy requires deputies to formally report any incident involving physical or deadly force. Physical force is defined as hitting; kicking; use of a conducted electrical weapon (CEW), firearm, or chemical agent such as pepper spray or tear gas; any force applied to the subject's neck, and any other actions that result in actual or alleged injury to the subject.[11] However, we found that reportable use of force incidents in Shoreline were very rare (in one year there were just four reports), and the internal affairs database did not provide information about the nature of the encounter or any resistance from the subject without referring back to the original incident report. Given the interplay between use of force and resistance, particularly in cases involving BH/DD, as discussed in the Background section above, we decided to take a broader approach to defining force and resistance and qualitatively coded instances of each based on the deputies' summary narratives in the incident report dataset (see also Gill et al., 2018). We coded force and resistance for all incidents

[10] There are a large number of group homes for people with BH/DD in Shoreline. However, they are not well-regulated and we were unable to obtain a comprehensive list of addresses that would have allowed us to track calls and incidents occurring at specific homes.

[11] This policy is documented in the KCSO General Orders Manual, available at https://www.kingcounty.gov/depts/sheriff/about-us/manual.aspx (accessed October 25, 2019).

classified as mental complaints and suicide attempts, and all additional BH-related incidents identified through the coding process described above.

We expanded the definition of "force" to include any physical contact between the deputy and subject, including routine handcuffing and physical escorting. While this includes many cases that would not need to be formally reported per the use of force policy, we justified this definition based on the research cited above that shows people with BH/DD may be particularly affected by any form of physical contact and are particularly afraid of being handcuffed. Thus, we refer to "physical contact" in this report to describe incidents in which police had a physical encounter with an individual with BH/DD (as defined below), but we note that this is a much broader and less conservative assessment of force than the majority of the existing police use of force literature, and most of these incidents would not be considered "force" in practice.

Although verbal force (e.g. shouted commands) has been included in prior research on the use of force continuum (e.g. Garner et al., 1995; Hickman et al., 2008; Klinger, 1995; Skolnick & Fyfe, 1993; Terrill & Reisig, 2003), we did not include it here because we did not expect deputies to consistently record their specific words and commands in the narrative reports (whereas we believed that physical actions would be more likely to be documented, particularly as the level of force increased). We classified instances of physical contact as follows: physical escort, forced to ground, restrained, hobbled, hit/kicked/pushed, handcuffed, use of spit hood or mask, placed on gurney, less-lethal force (includes chemical agent, pepper spray, and CEW), and use of a firearm.

To code resistance by the individual with BH/DD, we relied on Terrill's (2003) resistance scale, which classifies resistant behaviors as verbal, passive, defensive, or active. However, based on the research cited above showing that misunderstandings and misinterpretations are common in interactions between police and people with BH/DD, we added two additional categories to try to capture some of these specific circumstances. In a number of the BH-related incident reports we found that deputies had to use physical contact to move or restrain people who were unable to care for themselves or were actively placing themselves in danger. We believed it was important to distinguish these cases from instances where a person was being deliberately obstructive or intending to harm the deputy. We developed the following expanded resistance scale, adding "self-care" and "harm" to Terrill's scale:

- **Passive:** Unresponsive to police commands; inactivity (e.g. ignoring a command, going limp).
- **Self-care:** Unable to care for self; acting inappropriately (e.g. nudity, inability to communicate or move).
- **Verbal:** Verbally rejects police directives; refuses to cooperate.
- **Defensive:** Tries to evade police control (e.g. runs away, hides, pulls away from deputy's grip).
- **Harm:** Poses an active danger to self (e.g. attempting suicide, running into traffic, and/or deliberate overdose in response to police efforts to control).
- **Active:** Attacks or attempts to attack deputy with hands, feet, object, or weapon; aggressively approaches deputy.

In addition to coding instances of physical contact and resistance in the narratives, we also tracked the order in which they occurred. Our progression started with resistance by the person with BH/DD, based

on our decision not to code verbal force by the police (deputies appeared to document verbal resistance more consistently than their own verbal commands) and our observation that the person might be resistant before the police initiated any physical contact. We then coded the deputy's response, which was either "no force" or one of the physical contact categories above, followed by the person's response to that action, and so on. This gave us four physical contact-resistance pairs (resistance1-contact1 up to resistance4-contact4).

We use descriptive statistics and Poisson regression to compare monthly counts of physical contact and resistance in Shoreline before and during the program, and difference-in-differences Poisson regression to compare physical contact and resistance in Shoreline and the comparison jurisdiction. We decided not to look at physical contact and resistance outcomes for specific individuals who had contact with the RADAR program because of the very small number of cases overall that resulted in physical contact or resistance, even under our expanded definition.

2.2.4. Survey of Shoreline deputies

We conducted a two-wave online, department-wide survey of Shoreline deputies to learn about their experiences and perceptions of dealing with people with BH/DD. The survey included questions about the frequency and types of situations in which deputies encounter these individuals; the options available to them to handle BH/DD-related calls; their experiences of using force with people with BH/DD; and their attitudes toward CIT training and encounters with people with BH/DD. We included three questions from a validated psychometric scale, the Toronto Empathy Questionnaire (Spreng et al., 2009), to assess deputies' feelings of sympathy and protectiveness toward people with BH/DD. In the second wave of the survey, as noted above, we also asked specific questions about deputies' experiences with and attitudes toward RADAR. The first wave of the survey was conducted between June and July 2016. We received 28 responses out of a possible 47 (a 60% response rate). The second wave was sent out in July 2019 and remained open until September. We received 26 responses out of a possible 50 (52% response rate).

Because of the small total number of sworn staff in Shoreline and the even smaller sample size, we primarily use descriptive statistics to analyze the survey. We intended to track within-deputy changes in outcomes between the two waves of the survey, but staff turnover in Shoreline is high (as it is in other KCSO contract cities, as noted above) and the number of responses overall was small, so it was not possible to do this reliably. We simply present overall pre-post comparisons across the entire sample. By mid-September 2019 we had received a very low number of responses; following encouragement from the Chief we were able to increase that number by the grant end date.

2.2.5. Individual-level outcomes

We had planned to analyze outcomes for specific individuals who had contact with RADAR using propensity score matching to identify a comparison group of similar individuals in the comparison city to improve the rigor of our estimates. However, because there was no flag for RADAR involvement or Navigator outreach in the calls for service or incident data we had to rely on incident or CAD numbers collected by the RADAR sergeant, addresses to which response plans were attached, and the names listed in the Navigator's case management records to manually match relevant calls for service and incidents.

In addition to the challenges with coding the comparison city data, we were not confident that the individual-level data were reliable. For example, there were sometimes multiple incident numbers for a single RADAR referral, and it was difficult to tell which person named in the incident data was the subject of the referral (there was not always a match with the case management notes). We lacked sufficient information to account for changes in address, incidents occurring at different locations, or alias names. Finally, about one-third of people referred to RADAR for outreach had no associated call for police service. Their referrals came from other sources, such as school outreach or word-of-mouth in the community. Others only appeared to have the single call that got them referred to the program, and did not have any other contact with the police before or during RADAR. Thus, even with the larger pool of individuals who had contact with the program but no response plan, we have not been able to perform a rigorous statistical analysis due to a lack of data. We plan to continue exploring ways to examine individual outcomes and we will share this analysis with Shoreline PD, BJA, and CNA if we are able to complete it.

3. RADAR in Practice

RADAR stands for "Response Awareness, De-escalation, And Referral." In our original SPI proposal, the first R represented "Risk" rather than "Response"—the program was originally envisaged as a way to improve safety for both deputies and people with BH/DD by sharing information about factors that increased the risk of harm to both parties during an encounter. However, we made the change during the planning phase to better reflect the broader mental health issues in Shoreline. Our initial focus groups revealed that high 911 utilization by some people with BH/DD and a lack of effective options for police to de-escalate situations and refer people to useful treatment and service options were crucial issues. The original objectives and activities for each program element were as follows:

1. **Response awareness:** Deputies would work with people with BH/DD and their family members, caregivers etc. to develop subject-specific response plans that detailed the person's "hooks" (de-escalation factors that enable the deputy to make a connection and calm the person) and "triggers" (escalation factors that may heighten the person's fear or stress); key officer safety information such as presence of weapons in the home and outcomes of previous calls; and contact information for family and service providers. The goal of this portion of the program was to prepare both the person with BH/DD and deputies for encounters and equip them with tools to achieve positive outcomes.

2. **De-escalation:** This portion of the program involved developing a core group of "RADAR designated" deputies, a sergeant, and a captain. This group would oversee response planning, training (which was intended as a complement to existing CIT training), and policy development. The ultimate goal of the RADAR team was to help reduce use of force and improve safety for both deputies and people with BH/DD through improved knowledge and understanding of the program.

3. **Referral:** The final piece of RADAR involved the RADAR team collaborating with a mental health professional called a "Navigator" to help refer people with response plans, as well as other people with BH/DD deputies might encounter in the community, to treatment and services. While the Navigator position was not part of the original grant proposal, we realized during the planning phase that this element of the program was going to be too difficult for the police department alone to implement. It was too labor-intensive and not always within deputies' skill sets to be responsible for recognizing BH/DD, collecting information, identifying resources, and following up

on services. We were able to leverage the SPI grant to receive an additional $100,000 from the King County Mental Illness and Drug Dependency (MIDD) Behavioral Health Sales Tax Fund, a local tax levy that generates funding for programs and services for people with BH/DD, in July 2016. We also planned to collaborate with Shoreline Fire Department's Community Medicine Team and the King County Regional Mental Health Court for referral to services, but these partnerships did not materialize and, as we describe below, the Navigator role became much more important than we originally anticipated.

3.1. The history of RADAR in Shoreline[12]

Retired Shoreline Captain Scott Strathy, who worked as a consultant on the RADAR grant, first had the idea for RADAR in the early 2000s when he was a sergeant. He observed that there had been a number of dangerous—and in some cases fatal—encounters between officers and people with BH/DD, in which he believed officers had walked into situations without enough information to react safely. For example, in 2000 Deputy Wally Davis was shot in Clallam County, WA while responding to someone who was "going crazy." Deputy Davis knew the man and had handled him before, so he responded to the call alone and was killed.[13] In 2008 Deputy Anne Jackson was killed in Skagit County, WA by a "well-known criminal with mental problems."[14] In both cases, the departments were familiar with the people involved, and Strathy became curious as to why there was no system in place to better prepare deputies to respond to them. Shortly after Strathy transferred to Shoreline, police were called to a domestic situation involving a person with BH/DD in the city during which the suspect was killed after aiming a rifle at deputies. Strathy recalled his colleague testifying at the inquest, in response to the judge asking what he knew going into the call: "On these types of calls you put it together in your brain as you're driving to the scene," before telling the jury "we need more information."

As a result, Strathy also became interested in the research around "front-loading" information and police interactions with people with BH/DD, which he discovered through contacts with local CIT trainers. He realized that most aggression by people with BH/DD is driven by fear, and that police adapt their response depending on whether they think someone is a "creep" or "troublemaker" or may be in crisis and not in control of their actions (e.g. Johnson, 2011; Van Maanen, 1978). He viewed this research as aligning well with his experience in the field. As he came to understand more about the fear experienced by people with BH/DD, the concept of RADAR as a collaborative information-sharing tool began to emerge. If these individuals were afraid of the police, and this fear posed a risk to their own and officers' safety, perhaps the risk could be reduced ahead of time through proactive outreach so that people would not be afraid when the police are called. It also became clear to Strathy that this collaborative approach was more attractive to policymakers and potential funders. He had previously explored grant funding for an officer safety-focused program, but this was not a priority at the time.

After we received the SPI grant for RADAR, Strathy noted that local interest and funding opportunities began to open up. In addition to the MIDD funding for the Navigator, project partners met with KCSO's

[12] Information in this section is primarily drawn from an interview with retired Captain Scott Strathy conducted on August 29, 2019.

[13] https://www.odmp.org/officer/15432-deputy-sheriff-wallace-edward-davis (accessed November 1, 2019); http://community.seattletimes.nwsource.com/archive/?date=20000806&slug=4035466 (accessed November 1, 2019).

[14] https://www.odmp.org/officer/19538-deputy-sheriff-anne-marie-jackson (accessed November 1, 2019); https://www.seattletimes.com/seattle-news/skagit-county-shooting-spree-leaves-6-dead-including-sheriffs-deputy-2-injured/ (accessed November 1, 2019).

Office of Risk Management Services early in the process. They saw the benefit from a liability perspective and provided $50,000 in seed money, which Shoreline PD used in part to visit other agencies that were using innovative approaches to address encounters with people with BH/DD, including Portland, OR and Houston, TX. According to Strathy, a key finding from these information-gathering visits was that a small agency like Shoreline would not be able to sustain the type of "robustly funded" co-response or 24-hour CIT unit model used by these agencies. This inspired the expansion of RADAR into a regional collaboration across five agencies (including other KCSO contract cities and independent departments). The expansion was partly a sustainability effort and also reflected the observation that people with BH/DD in Shoreline tended to cross jurisdictional boundaries regularly. Note that in this report we limit our analysis and discussion to RADAR as it operates in Shoreline; we did not evaluate the regional collaboration.

3.2. BH-related needs and challenges in the Shoreline Police Department

The original idea for RADAR was driven by the potential for serious or fatal violence in encounters between police and people with BH/DD. However, the consensus among Shoreline PD command staff and deputies we interviewed was that Shoreline experiences daily challenges with people with BH/DD that do not necessarily run the risk of escalating into a 'worst-case scenario' but nonetheless stretch their resources. The RADAR sergeant felt Shoreline had more mental health issues compared to other areas in King County and larger cities, and several other Shoreline PD stakeholders shared this belief. While we do not have full county data to corroborate it, we did report in our implementation plan that Shoreline residents comprised 10 percent of the population of KCSO's service area and accounted for 15 percent of its mental complaint and suicide attempt calls in 2012-15. There are a number of high-volume repeat 911 callers with BH/DD, and deputies told us that repeated proactive contacts with these callers are a drain on first responders that can lead to complacency in how they respond.

Our interviewees emphasized the unique building codes in the city, which allow for a large number of group homes for people with mental, behavioral, and developmental disabilities. Furthermore, Seattle has recently started to crack down on homeless encampments, which has (anecdotally) pushed people with BH/DD into neighboring jurisdictions like Shoreline. However, the RADAR sergeant felt that the group homes did not explain the high level of BH-related calls in Shoreline. While a lot of calls come from group homes, they are less of a concern from a patrol perspective because they are generally well-managed and usually have to call 911 per policy rather than because of a situation that is out of control. On the other hand, the bigger challenges for police tend to arise from people who live alone and lack a support system.

Common lower-level but intractable issues relating to BH/DD that deputies experience include questionable disputes (such as the caller believing that their neighbors are spying on or poisoning them); young teenagers with autism or other behavioral issues who are engaging in increasingly violent behavior at home, leaving their parents with limited options beyond the police; and school shooting threats. In the latter case, the RADAR sergeant noted that there seems to be a difference between young people who would likely act on the threats, and those with a BH/DD who are unlikely to follow through. Prior to RADAR, according to Chief Shawn Ledford, deputies' only options in these cases were the mobile crisis team (which, as we learned during our planning stage, serves the entire KCSO area and can take several hours to arrive); jail; or (in)voluntary commitment to hospital. None of these options addresses the underlying issues that leads people to call the police regularly, and can result in criminalizing people who need help. For example, the RADAR sergeant pointed out that in the case of young people with autism who are acting violently at home, the police only really have criminal justice system-based options such

as making an arrest for domestic violence. Deputies find such BH issues particularly challenging during the "graveyard" (night) shifts when access to resources is even more limited and they do not have a lot of time to help people with their issues. As the RADAR sergeant said about one frequent caller in the community: "What can you do about alcoholism and bipolar at 2am?"

3.3. The evolution of RADAR

3.3.1. Response planning

As we described above, RADAR originally focused on developing individualized response plans and de-escalation strategies for identified people with BH/DD in the community. While this remained a key goal of the program, Shoreline PD set restrictive eligibility criteria for the response plan in line with the officer safety priorities of the program. According to the RADAR Standard Operating Procedures (SOP), response plans are initiated when "the person's behaviors in the community suggest the presence of a BH/DD" *and* they meet one or more additional criteria, including involvement in a documented use of force incident or exhibiting behaviors that increase the chance of a use of force incident; making a documented threat of violence against first responders or being subject to an officer safety flag; being under supervision for a violent incident; or having three or more 911 calls within a 7-day period.

The SOP also states that response plans must be requested by a Shoreline deputy or member of the RADAR team, based on personal observations, case reports, or information from an outside party; thus, the development of the response plan was less collaborative than originally envisaged. Nonetheless, the addition of the Navigator to the RADAR program allowed for outreach to the person for whom the response plan was developed, as well as their family members, caregivers, and (where appropriate) treatment providers. The SOP states that "A RADAR deputy and the Navigator are not required to meet with the individual and others, but will determine on a case-by-case basis whether such contact is safe, productive and appropriate."

If deputies encounter someone they think is appropriate for a response plan, the SOP instructs them to email their patrol sergeant with the person's name and the case number of the incident. The sergeant then forwards this to the RADAR deputy team and the case is reviewed by a member of that team in consultation with the RADAR sergeant. Once the response plan has been completed, the RADAR team sends an internal email to all precinct personnel with the name and address of the individual and forwards the information to the CAD system administrator. Technology was a significant challenge in the RADAR process—we originally envisaged that the response plans themselves would be available in CAD for all deputies to consult while responding to calls, but KCSO's CAD system did not permit this. As a compromise, the CAD system administrator creates a "premise warning" for the address, which is a type of flag that alerts the deputy to additional information when responding to that location. The SOP also states that dispatchers will alert deputies when they are responding to a call for service at an address that has a response pan flag. Deputies can then pull up a PDF document from the records management system (RMS) with the response plan information.

The response plans are considered by the department to be advisory in nature. The SOP states that it should not contain private medical information or any other information that is highly personal or potentially embarrassing to the subject. While Shoreline PD is not a treatment provider and therefore not subject to the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), the

absence of specific information of this nature was also intended to mitigate legal concerns about information sharing. The type of information contained in a RADAR response plan includes descriptions of behaviors, individualized strategies to help deputies de-escalate behavior, and information relevant to officer safety such as the presence of weapons at the address. The response plan also lists recent contacts with the police, and the RADAR team reviews the plan after each subsequent contact to determine whether it needs to be updated.

3.3.2. Navigator referral

The additional funding from the MIDD allowed Shoreline PD to substantially enhance the "Referral" portion of the RADAR model compared to the original vision. While the response plans were intentionally restricted to people who were at high risk of violence or a use of force incident, the addition of the Navigator allowed the department to connect with a broader section of the community. As noted previously, the Navigator became a point of contact for people who did not meet response plan criteria or were not approved for a plan after referral to the RADAR team, as well as a resource for response planning. The RADAR SOP explicitly states that deputies may refer people with or without a response plan to the Navigator to connect them with services, with subsequent outreach occurring at the Navigator's discretion. The Navigator identified to work in Shoreline (and the partner jurisdictions in the regional RADAR collaboration) is Susie Kroll, a licensed Mental Health Professional (MHP) who originally served on RADAR's local advisory group. Before coming to Shoreline she had previously worked with other KCSO jurisdictions and the Seattle Police Department on behavioral health calls, crisis planning, and hostage negotiation. She initially assisted with the program on a temporary basis, but eventually began working in the Navigator role full-time with five different departments including Shoreline.

The Navigator role varies by jurisdiction—although Ms. Kroll has been the only person in the position, her activities and access in terms of collaborating with the police was shaped by the unique cultures and norms of the different departments. For example, she has full access to the police station in Redmond, WA but cannot access the Shoreline PD building independently. She does not have access to a laptop in Shoreline (using a personal laptop is problematic due to the sensitive nature of client data); in Kirkland, WA she was given a laptop but is only allowed to use it in the precinct building. In some departments she acts as more of a "co-responder," riding with officers to "live" (in-progress) calls to de-escalate and support people with BH/DD at the scene. In Shoreline, deputies were not receptive to riding with an MHP so the model has been more focused on outreach after the calls.

The Navigator works a 4-hour shift on Friday evenings (4-8pm) in Shoreline. During this time, she reviews response plans and BH/DD calls and conducts home visits with a RADAR deputy to follow up with people who have been referred to RADAR. Occasionally, but not often, she will work additional shifts during the week to conduct further follow-up. She noted that she has occasionally done live calls in Shoreline, but it requires approval from the sergeant. However, she stated that Shoreline's RADAR structure works well because the RADAR sergeant has clear responsibility for follow-up and communication. She is also responsible for case management: keeping track of initial and subsequent contacts with people who are referred to the program and maintaining case notes.

The Navigator viewed her role in Shoreline (and other jurisdictions) as very closely aligned with broader community policing and relationship-building initiatives. As she noted, "the cop is there whether something is bad or not," and she views her role in part as helping to normalize the police as a resource for support and assistance rather than simply responding to "trouble." She is intentional about her appear-

ance and behavior during follow-up calls to ensure she is well-received by community members. She does not wear a uniform or carry a weapon, but does wear body armor for her protection (which she purchased herself in order to transition between the different departments). She wears a "MHP" badge on her jacket, but said that this is not always well-received by people—in particular, those who do not want to be seen as having a "mental health problem"—so she will cover it if necessary and emphasize the Navigator/police partnership role. However, she noted that other people really want to see a mental health professional so she ensures the badge is visible to them.

3.3.3. Additional changes to the program

In addition to the restriction of eligibility for response plans and the enhancement of the Navigator role, the implementation of RADAR was different from the original proposal in several other ways. First, as we noted above, the proposed collaboration with the Shoreline Fire Department did not materialize. This was partly due to data issues—we had hoped to supplement our analysis of calls for police service with data on ambulance/medical calls, but the data we received from the fire department was highly restricted due to patient confidentiality and was not adequately geocoded. Furthermore, the expansion of the Navigator role largely took the place of the collaboration with the Community Mental Health team. Second, the regional focus and expansion of RADAR to five different departments during the course of implementation (which was done using additional grant money leveraged from local sources) considerably broadened the scope of the intervention, even though the program operated somewhat differently in each location. While we only evaluated RADAR in Shoreline, our conclusions and recommendations below do include references to the regional collaboration, as we learned about comparisons between Shoreline and other jurisdictions and related benefits and challenges for RADAR through our focus groups and interviews.

4. Evaluation Results

4.1. RADAR implementation

As of August 2019, 27 formal RADAR response plans were active in Shoreline.[15] The majority of these response plans were connected to addresses in Shoreline, but three were associated with addresses in Kenmore and four response plan subjects were considered transient. However, 200 people in total were contacted by Shoreline PD and the Navigator in 2017-18, with a total of 383 individual contacts (including follow-up contacts in 2019). One individual, who also had a formal response plan, had 34 separate contacts with the Navigator. The next most frequent RADAR user had nine contacts, followed by two individuals who had eight contacts each. Two-thirds (67%) of initial contacts were connected to a Shoreline PD incident report, while other people were identified through reviews of 911 calls by the RADAR sergeant, outreach to the community, and word of mouth. Over three-quarters (76%) of people contacted by the Navigator agreed to accept assistance. Based on our review of the Navigator's case management notes, the issues leading to referral were as follows:[16]

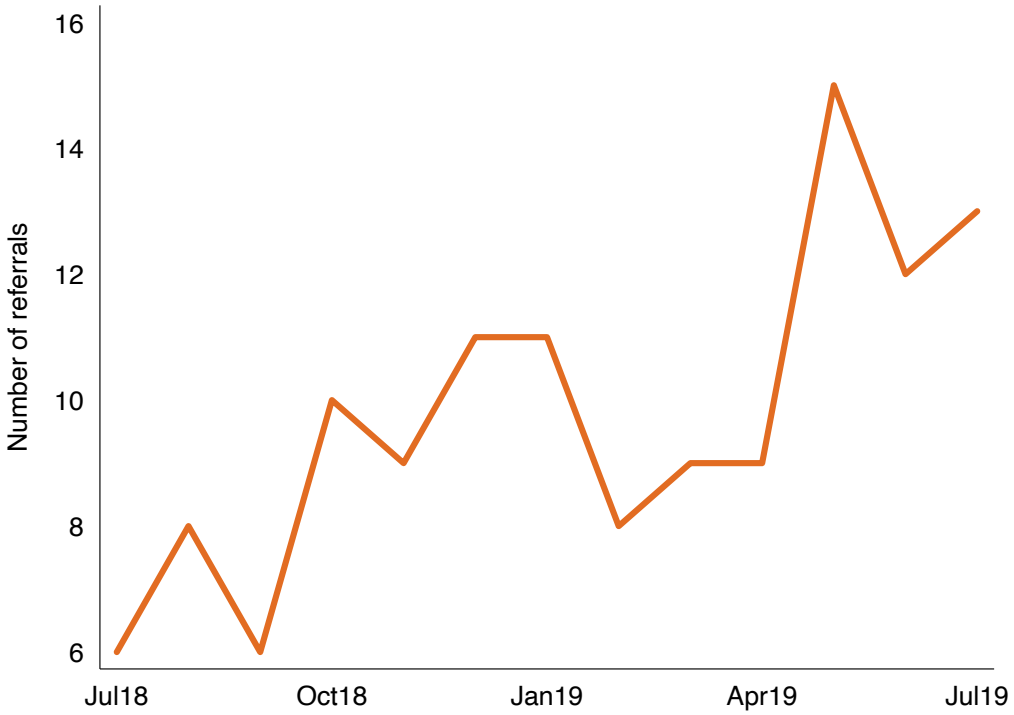
[15] We do not have the dates on which the response plans were approved, so some may have been created in 2019 after our analysis period ended.

[16] More than one issue may have been present for a given person.

- Behavioral health and medical issues (e.g. paranoia, delusions, schizophrenia, dementia, traumatic brain injury): 44%
- Mental health issues (e.g. depression, suicidal behaviors): 38%
- Intoxication/substance use issues: 19% (13% of contacts involved a person with co-occurring substance use and BH/DD issues)
- School issues: 15% (4% threats of school violence and 11% other school stress issues)
- Other crimes (as suspect or victim): 11%
- Life stress: 7%

We also received data from the RADAR sergeant showing the number of referrals from patrol deputies. This information has only been recorded since the current RADAR sergeant took on the role, so it covers July 2018 to July 2019 instead of our 2017-18 analysis period. Nonetheless, Figure 1 shows a steady increase in the number of monthly referrals to the program from non-RADAR-affiliated patrol deputies, with a slight drop during the less busy winter months. This suggests increased awareness and uptake of the program, as supported by the findings from our focus groups that we report below.

Figure 1: Monthly referrals to RADAR from patrol deputies, July 2018-July 2019

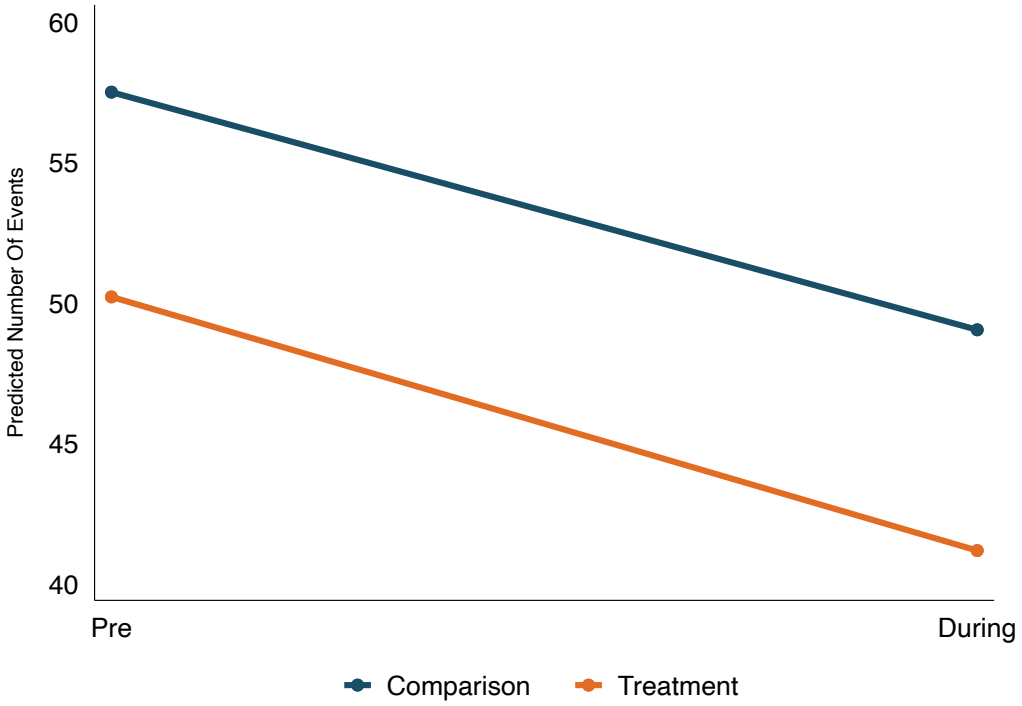


4.2. Mental health-related calls for service

Table A1 (in the Statistical Tables appendix) shows the total number of BH/DD calls for service and incidents in Shoreline and the comparison city during the study period. The average monthly count of all calls for service in the pre-RADAR period (2015-16) was 1,284 in Shoreline and 1,736 in the comparison jurisdiction, which was significantly different ($t = 10.58$, $p < .0001$). On average, 3.5% of calls for service in Shoreline in the pre-RADAR period (2015-16) were classified as mental health complaints or suicide attempts, compared to 3% of calls in the comparison city. Again, the monthly counts of mental health calls were significantly different in the two locations in the pre-RADAR period, with 45 mental health calls per month in Shoreline and 51 in the comparison city ($t = 2.07$, $p= .045$).

During RADAR implementation (2017-18), there was a significant increase in *overall* calls for service in Shoreline (an additional 277 calls per month on average; $t = -5.28$, $p < .0001$). However, the number of mental health calls per month remained steady at 45, so the proportion of calls classified as mental health-related decreased to 3% during RADAR implementation. There were no similar changes in the comparison city. As we would expect given this steady rate, our difference-in-differences model did not show that RADAR had any effect on mental health-related calls for service, controlling for seasonality and trend (see Table A2). Figure 2 shows the predicted number of mental health-related calls for service before and during RADAR in both areas from the model. Although there was a slight decrease in Shoreline, there was a comparable decrease in the comparison city as well, so we cannot conclude that the change was caused by RADAR.

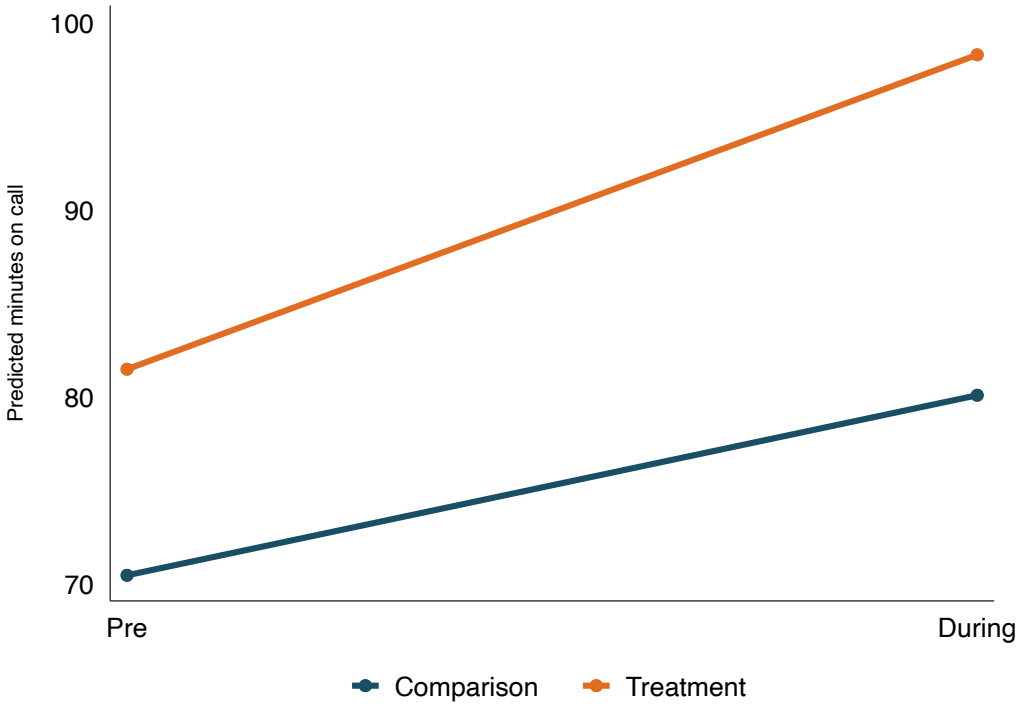
Figure 2: Change in mental health-related calls for service in Shoreline and comparison city, 2015-16 (pre) vs. 2017-18 (during)



We also looked at the amount of time deputies spent responding to mental health-related calls for service

(mental complaints and suicide attempts), based on the research showing that mental health calls can take up more police resources than other call types. Again, Shoreline and the comparison city differed significantly in the pre-RADAR period in the amount of time spent on calls. Across all call types, the average amount of time between deputies' arrival and call closure was 63.4 minutes, compared to 58.8 in the comparison city (t = -5.67, p < .0001), and for mental health-related calls the time increased to 81 minutes, compared to 70.5 (t = 2.40, p = .016). In both Shoreline and the comparison city deputies spent a significantly longer time on mental health calls compared to non-mental health calls. In Shoreline the amount of time spent on mental health calls significantly increased during the RADAR implementation period compared to the pre-RADAR period (98 minutes vs. 81 minutes; t = -3.30, p = .001). However, time spent on mental health calls also increased in the comparison city, and our difference-in-differences analysis showed that while the increase was greater in Shoreline (controlling for seasonality and trend), it was not significantly different from the comparison jurisdiction (Table A3; Figure 3). Again, this means that we cannot attribute the changes in the time spent on mental health calls to the RADAR program.

Figure 3: Change in time spent on mental health-related calls for service in Shoreline and comparison city, 2015-16 (pre) vs. 2017-18 (during)



4.3. Mental health-related incident reports

As with calls for service, Shoreline and the comparison city differed significantly in both total incidents and mental health-related incidents (mental complaints and suicide attempts) in the pre-RADAR period (see Table A1). The average monthly count of incident reports was much higher in the comparison city (865 in 2015-16 versus 528 in Shoreline; t = 15.92, p < .0001). The average monthly count of mental health incidents was also higher in the comparison city (27 vs. 21; t = 3.21, p = .002), but the proportion

of incidents classified as mental complaints or suicide attempts was higher in Shoreline (4.0% vs. 3.1% in the comparison city), consistent with deputies' perceptions that Shoreline has a higher concentration of mental health issues relative to its neighbors.

As we described in the Methodology section, we also identified additional incident reports that were not classified as mental complaints or suicide attempts, but also involved a BH/DD component in the narrative. Table A1 shows the numbers of these "other BH/DD" incidents in Shoreline and the comparison city, as well as "total BH/DD," which also includes the mental complaint and suicide attempt reports. Across the entire study period (2015-18), the most common non-mental complaint or suicide attempt reports that involved a BH/DD component were:

- Drunkenness (33.6% of all non-mental complaint or suicide attempt incidents involving a BH/DD component)
- Trespass (9.2%)
- Welfare status check (7.6%)
- Simple assault (7.2%)
- Person lost, found, or missing (4.8%)

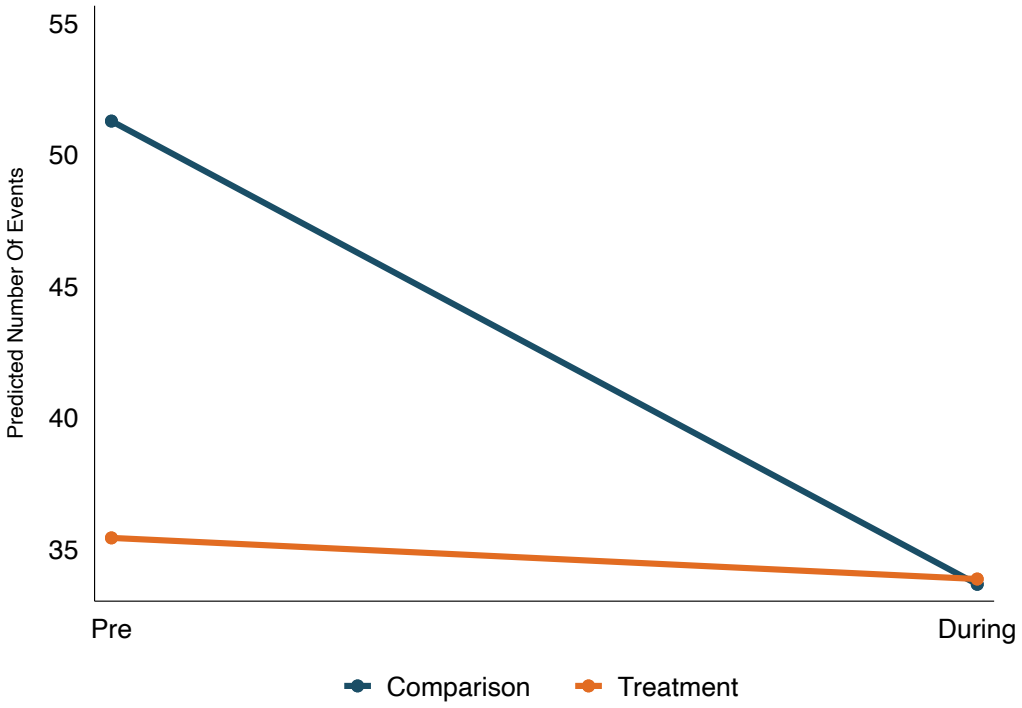
As with mental complaint and suicide attempt incidents, the average monthly count of total BH/DD reports was significantly higher in the comparison city during the pre-RADAR period (49 vs. 34 in Shoreline; $t = 5.79$, $p < .0001$), but the proportion of incidents involving a mental complaint, suicide attempt, or other BH/DD component was higher in Shoreline (6.5% vs. 5.7%).

During the RADAR implementation period (2017-18), there was very little change in the average monthly counts of all types of incident reports in Shoreline. At the same time, there was a larger decrease in overall incident reports in the comparison city, and a slight decrease in total BH/DD reports. Thus, our difference-in-differences model does not show any significant difference between Shoreline and the comparison city in terms of changes in total BH/DD calls between 2015-16 and 2017-18 (see Table A4; Figure 4).

4.4. Physical contact and resistance

As described above, we coded BH/DD incident reports for physical contact (our broad proxy for use of force) and resistance (verbal or physical) to police contact. Table A5 shows the number and types of physical contact and resistance in Shoreline before and during RADAR implementation. The number of instances of both physical contact and resistance occurring during BH/DD incidents was significantly lower during RADAR implementation compared to the pre-RADAR period (physical contact: $\chi^2 = 5.49$, $p = .019$; resistance: $\chi^2 = 13.82$, $p < .0001$). While the numbers are very small, which limits the value of the statistical analysis, Table A5 shows that among different types of physical contact, the reduction in the number of times a deputy physically escorted an individual was statistically significant ($\chi^2 = 7.48$, $p = .006$). Verbal, self-care, and defensive resistance were all significantly lower during the implementation period (verbal: $\chi^2 = 16.07$, $p < .0001$; self-care: $\chi^2 = 4.80$, $p = .028$; defensive: $\chi^2 = 7.45$, $p = .006$). However, the reductions in physical contact and resistance were not statistically significant when we controlled for seasonality and trend (Tables A6 and A7; Figures 5 and 6). We also ran difference-in-differences models

Figure 4: Change in total BH/DD incident reports in Shoreline and comparison city, 2015-16 (pre) vs. 2017-18 (during)



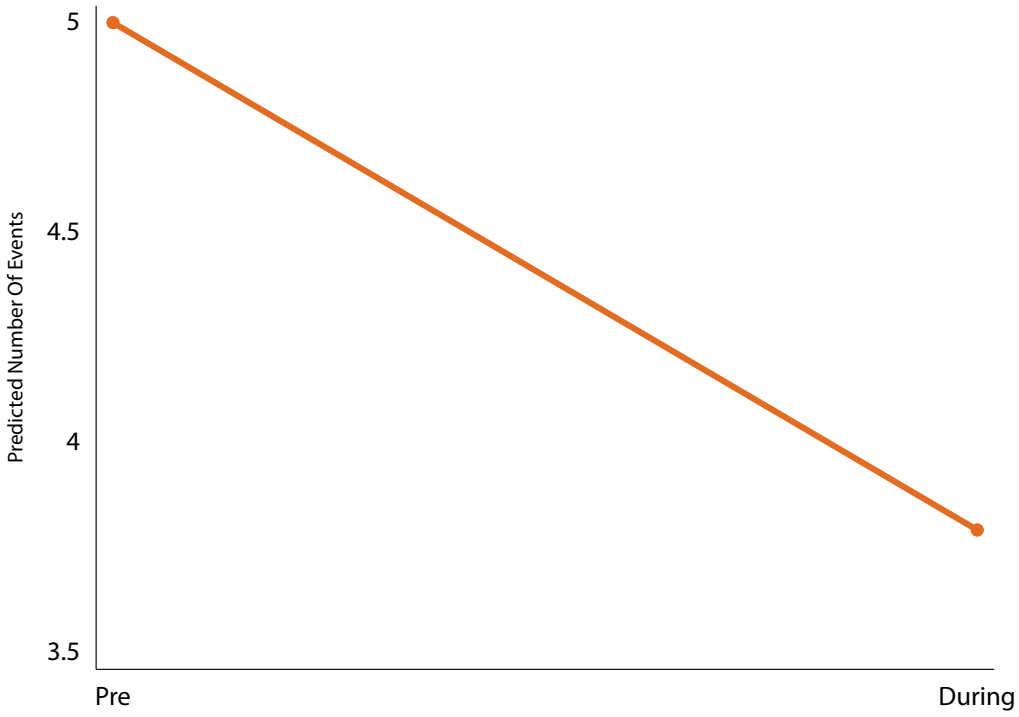
comparing physical contact and resistance in Shoreline with the comparison jurisdiction, but there were no statistically significant differences between the two areas (Tables A8 and A9).

4.5. Survey of deputy perceptions

Table A10 shows descriptive statistics for participants in our survey of Shoreline deputies.[17] As described above, Wave 1 was conducted in the summer of 2016 during the grant planning phase and prior to RADAR implementation. Wave 2 was conducted in the summer and early fall of 2019. Although there was considerable staff turnover between the two waves, which prevented us from being able to measure within-officer changes in outcomes over time, the two samples did not significantly differ in rank ($\chi^2 = 2.930$, $p = .403$), assignment ($\chi^2 = .793$, $p = .851$) or tenure at Shoreline PD ($\chi^2 = .469$, $p = .926$). However, there was a significant difference in the number of survey respondents who had received CIT training between Wave 1 and Wave 2 ($\chi^2 = 9.397$, $p = .024$). In Wave 1, the majority of respondents had received at least the short 8-hour training, but seven had not received any training and nobody had received the advanced training. By Wave 2, all respondents reported that they had received at least some training, and almost half (46.2%) had attended either the full 40-hour or advanced (> 40-hour) course. This change reflects Shoreline PD's increased focus on responding to people with BH/DD during this time period—recall that RADAR was intended as a complement to CIT in the department and that the "de-escalation" part of the program

[17] We did not collect demographic information such as gender or race because of the risk of identifying specific deputies among the small number of participants.

Figure 5: Change in instances of physical contact during MH/DD incidents in Shoreline, 2015-16 (pre) vs. 2017-18 (during)



involved a commitment to better preparing all members of the department to respond to BH/DD issues.

4.5.1. Deputies' experiences with BH/DD and RADAR

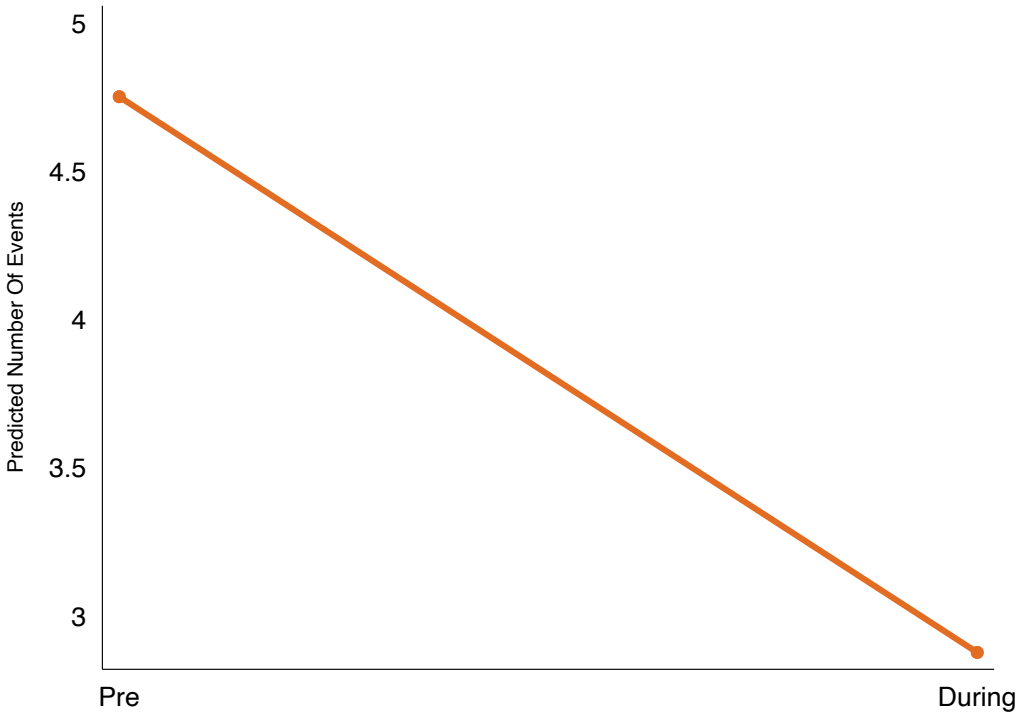
In both Wave 1 and Wave 2, the majority of survey respondents stated that they encountered people with BH/DD every day. This proportion increased from 53.6% in Wave 1 to 69.2% in Wave 2, although the difference was not statistically significant ($\chi^2 = 1.391$, $p = .238$).[18] There were no differences between waves in the types of situations in which deputies encountered people with BH/DD, such as "on-views" (when deputies come across an incident in the course of their patrol), requests for assistance, crisis situations, or as a victim or suspect in a crime.

In Wave 2 we asked deputies whether they had heard of RADAR and how they have encountered it in their work. All 26 respondents to the Wave 2 survey said they had heard of RADAR. This shows that the program has clearly been implemented and publicized in Shoreline, given that in Wave 1 only 57.1% of respondents (16 people) said that they had heard of RADAR during the planning phase. Survey respondents also appeared to be using RADAR.[19] Almost 81% of respondents said that they checked at least sometimes

[18] The original survey question had seven response options ranging from "Never" to "Every Day." These statistics were obtained by comparing the proportion of respondents who answered "Every Day" to respondents who selected any other response.

[19] Note that 9 respondents to the survey stated that they were current or former RADAR deputies and 7 stated they were current or former RADAR supervisors. There is some overlap here as respondents could select more than one response to this question, but these numbers seem too high so some respondents may have misunderstood the question.

Figure 6: Change in instances of resistance during MH/DD incidents in Shoreline, 2015-16 (pre) vs. 2017-18 (during)



to see if there was a response plan before responding to a call involving someone with BH/DD; 31% said they checked often. Sixteen respondents (61.5%) said they had made a referral to RADAR, 13 (50.0%) had consulted a response plan, and 3 had ridden with the navigator (2 of these 3 also identified themselves as current or former RADAR deputies so may have been involved in conducting targeted outreach with the navigator).

In both waves we asked deputies to rank a list of common ways they resolved calls involving people with BH/DD, and in the Wave 2 survey we added "refer to RADAR deputy" and "refer to RADAR navigator" to the list of options. While RADAR did not replace other methods of resolving calls involving people with BH/DD, the survey did show that some deputies had begun using it by the second wave. Involuntary transfer to hospital was ranked as the most common disposition by most respondents in both waves; only two respondents said they would refer to the RADAR deputy (N=1) or navigator (N=1) as their first option. However, four respondents chose "referral to RADAR deputy" as the second most likely disposition in Wave 2 (the most frequently selected second option, arrest, was chosen by 5 respondents and 4 others listed voluntary transfer to hospital as their second option).[20]

We also asked respondents whether they typically shared their experiences with their colleagues after experiencing a person with a BH/DD, and to rank the most common ways in which they did so. We looked at these questions across both waves to assess whether the addition of RADAR referrals and response plans as information-sharing options changed the nature of responses. In both waves, all respondents

[20] We acknowledge that a number of respondents noted they did not like this ranking question because the disposition depends heavily on the circumstances of the particular call. Thus, these results should be viewed with some caution.

said they shared information at least sometimes, but surprisingly the proportion who answered "often" fell from 60.7% in Wave 1 to 42. 3% in Wave 2 (this change was not statistically significant: $\chi^2 = 1.830$, $p = .176$). Again, the method of information sharing ranked by respondents as most common was informal sharing (for example, over coffee or car-to-car) in both waves. Almost three-quarters of respondents in both waves said this was the most common way in which they shared information with each other (Wave 1: 73.1%; Wave 2: 73.9%). However, among the options ranked as second most common, RADAR referrals or response plans were selected by 6 respondents in Wave 2 (an equal number selected group email in Wave 2, and 7 respondents selected roll call). It is possible that some respondents in Wave 2 may also have been thinking about RADAR when they selected "group email," as RADAR response plans and referrals are initiated by sending an email to the RADAR team.

In Wave 2 we also asked respondents whether they shared information about people with BH/DD with non-police entities, such as prosecutors, mental health professionals, hospitals, or community service providers. These types of sharing were reasonably common, with the exception of community service providers. Almost 62% of respondents in Wave 2 said they shared information with prosecutors at least sometimes; 88.5% with mental health professionals (we did not specify the RADAR navigator here, but some respondents may have been referring to her); and 68% with hospitals. Forty percent of respondents said they shared information with community service providers sometimes, but nobody said often.

In Wave 2 only we asked respondents about their attitudes toward RADAR and whether they thought it affected their job satisfaction and effectiveness.[21] Figure 7 shows respondents' attitudes toward RADAR, which are overall very positive. Almost all respondents agreed or strongly agreed that RADAR gave them a tool to proactively assist people with BH/DD and connect them to services (92% of respondents for both questions). A substantial majority (73%) also agreed that RADAR addresses the "revolving door" of mental health calls. However, 42% agreed that RADAR does *not* address the underlying problems that cause people with BH/DD to call the police. This is not a surprising finding given that, for many people, addressing these problems may well require longer-term services and treatment for which deputies are unlikely to see immediate effects.

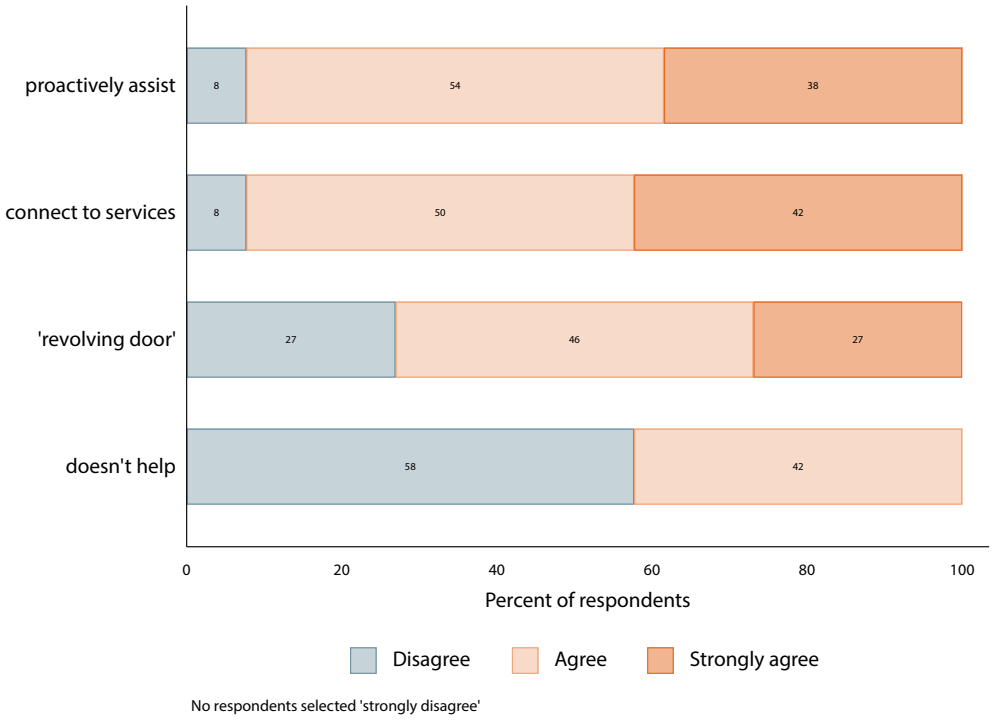
The results for the job satisfaction questions are a little more equivocal, but still very positive overall (Figure 8). Over three-quarters (77%) agreed or strongly agreed that RADAR helped them be more effective at their job, and 70% agreed or strongly agreed that it helped them feel more satisfied with their job. Sixty-five percent of respondents agreed or strongly agreed that RADAR helps them feel they are making a positive difference in people's lives.

Finally, we asked several open-ended questions to learn what respondents viewed as the most and least successful aspects of RADAR and their suggestions for improving the program. The most successful aspects highlighted by respondents were the ability to refer people directly to a MHP for outreach and services (including providing support to their family members); reducing frequent callers; and the response plans. One respondent noted that while the response plans were rarely used, they did provide information about high-risk people. Several other respondents highlighted the officer safety and de-escalation information in the response plans as important—as one respondent wrote, "the more info the better."

Responses to the question about least successful aspects were more varied. Several respondents mentioned that there wasn't enough follow-up in the community and that the program was not expanded

[21] We broke out this analysis by respondents who identified as current or former RADAR deputies/supervisors and those who did not, but there were no significant differences in any of the questions. Given the issue noted in Footnote 19 and the lack of significant differences, we did not include this analysis in the report.

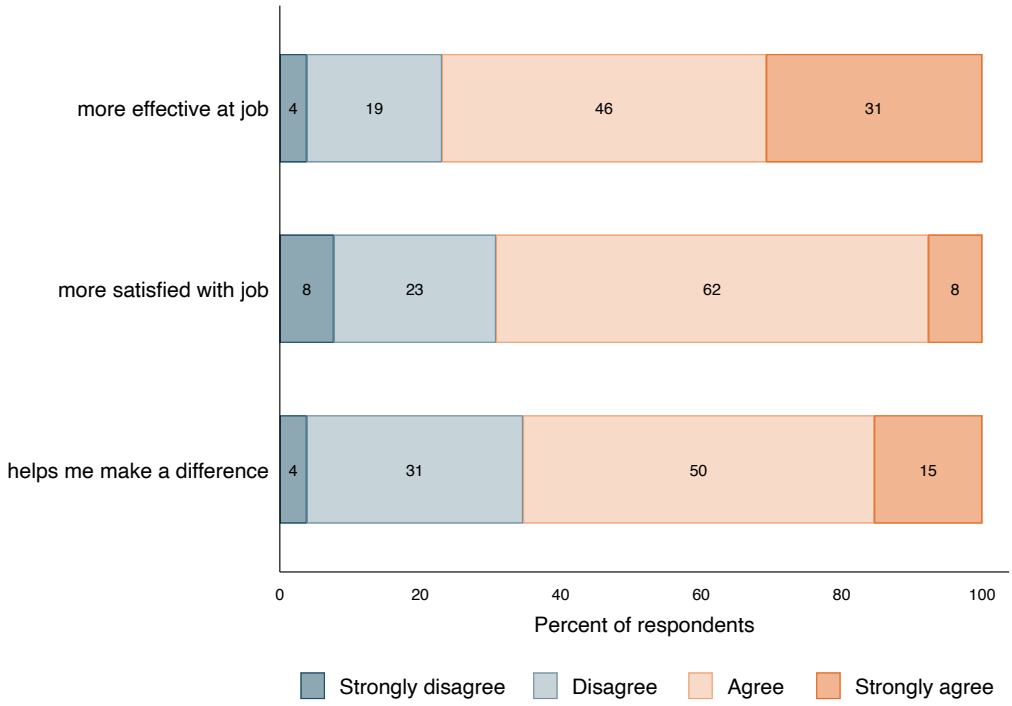
Figure 7: Survey respondents' attitudes toward RADAR, Wave 2 survey



enough; one felt that there was not enough help from the navigator (based on this person's other responses, we interpret this as insufficient navigator positions or resources rather than a criticism of the navigator's work). However, several others felt that community outreach to people who do not qualify for a response plan was not successful, or that RADAR does nothing for the immediate situation. One respondent noted, in line with the questions discussed above, that RADAR provides useful information but does not address the recurring issues that lead people to call 911 regularly. Another highlighted the technology piece as a challenge; particularly keeping things consistent between agencies and tracking information consistently.

When asked how RADAR could be improved, almost all of the people who answered the question said that more navigators and funding for both navigators and officer overtime were needed to expand and sustain the program. However, one person (who also felt there was too much community outreach to lower-risk people) recommended sticking to the original plan of focusing on officer safety and frequent callers rather than broader BH/DD issues. Several respondents mentioned making RADAR a more regular program (i.e. more than weekly outreach) or having a 24-hour crisis line or involving dispatchers to increase the program's availability. Related to this, another respondent did not recommend expanding the program, but cautioned that it should not be sold as something that makes a difference on a daily or call-to-call basis in its current form. The person who highlighted technology and consistency across agencies also recommended developing RADAR as a model policy with support from the Washington Association of Sheriffs and Police Chiefs (WASPC) to ensure the fundamentals of the program are consistent across agencies. This person noted that this would lead to "a better chance to incorporate best practices and work with key service providers."

Figure 8: Survey respondents' job satisfaction related to RADAR, Wave 2 survey



4.5.2. Changes in deputies' perceptions and experiences with BH/DD and RADAR

We asked several questions in both waves of the survey about issues that we hypothesized could be affected by RADAR: deputies' perceptions of fear in encounters with people with BH/DD (both their own fear and fear on the part of the individual with BH/DD); use of force encounters; whether they received sufficient information prior to encounters with people with BH/DD; satisfaction with current options to resolve calls; and perceptions of people with BH/DD. It is important to note again here that we had hoped to be able to measure these changes "within-officer," i.e. explore whether specific deputies who responded to both surveys experienced changes as a result of RADAR, but due to the low response rate and high staff turnover in Shoreline we were unable to do so. The results below therefore reflect overall department changes, which could be driven by factors other than RADAR (e.g. new staff members coming in who have had different experiences). We had also intended to look at whether there were differences in the Wave 2 outcomes depending on whether or not the respondent had made a RADAR referral or checked a response plan, but the numbers are too small to draw meaningful conclusions from such an analysis.

Nonetheless, there are some interesting changes between Waves 1 and 2. Respondents in Wave 2 were less likely than those in Wave 1 to say that in encounters with people with BH/DD they had feared for their own or their partner's safety, perceived that the person was afraid of them, or used force (Table A11). Almost 90% of Wave 1 respondents said they had feared for their safety, compared to 73.1% in Wave 2 (this change was not statistically significant: $\chi^2 = 2.35$, $p = .125$). The differences in perceptions of fear on the part of the person with a BH/DD and use of force were statistically significant. Again, 89.3% of Wave 1 respondents believed the person was afraid of them, compared to 65.4% in Wave 2 ($\chi^2 = 4.46$, $p = .035$). The change in use of force with people with BH/DD is striking: while 89.3% said they had used force

in Wave 1, only 42.3% had done so in Wave 2 ($\chi^2 = 13.39$, $p < .0001$). While our finding of a reduction in physical contact in BH/DD incidents was not statistically significant, it lends some support to these survey fundings.

We asked respondents who had used force several questions about their experiences: was their de-escalation technique effective; did they think they would have been more effective if they had had subject-specific information or more general information about BH/DD; and did they think the situation escalated because of the individual's fear or confusion about police.[22] These results are shown in Table A12. Respondents in Wave 2 were *less* likely than those in Wave 1 to agree that the de-escalation technique they used was effective, that subject-specific or general information would have made their response more effective, or that the situation escalated because of the individual's fear or confusion. In the latter case, only 18.2% of Wave 2 respondents agreed with this statement compared with 41.7% at Wave 1, but none of these differences was statistically significant. We caution against reading too much into these numbers because so few people in Wave 2 said they had used force. It is possible that those who did found themselves in much more challenging situations where many other factors affected the outcome.

There was no difference between waves in whether respondents felt they received enough information about an individual's mental state or cognitive disabilities before responding to a call. In both waves, a majority of respondents said they did not (Wave 1: 75.0%, Wave 2: 76.9%; $\chi^2 = .03$, $p = .869$). Among the different types of subject-specific information deputies might receive before a call (information on the person's mental health condition; family member or caregiver contact information; prior contact with law enforcement; medications; drug/alcohol history; things that tend to calm or excite the person; and information relevant to officer safety), the only statistically significant difference[23] between waves was the frequency with which respondents said they received information about things that calm or excite—the "hooks and triggers" described in response plans. In Wave 1 only 18.5% of respondents said they received this information sometimes or often, whereas 48.0% said they did in Wave 2 ($z = -2.27$, $p = .023$). More respondents in Wave 2 also said they received information pertinent to officer safety, which is also included in response plans, sometimes or often (84.6% vs. 53.9% in Wave 1), but this fell just short of the conventional threshold for statistical significance ($z = -1.91$, $p = .056$). Overall, in both waves the majority of respondents were *not* satisfied with the options available to them to resolve calls involving people with BH/DD, but there was a non-statistically significant increase in those saying they *were* satisfied in Wave 2 (42.3% compared to 25.0% in Wave 1; $\chi^2 = 1.82$, $p = .178$).

Finally, we assessed whether there were any changes in deputies' perceptions of people with BH/DD during RADAR implementation. We asked whether respondents agreed that treatment can help people with BH/DD live normal lives; that family members of people with BH/DD lack sufficient information about resources; and that first responders have a duty to help people with BH/DD access information and resources (Figure 9). Respondents in Wave 2 were significantly more likely than those in Wave 1 to agree that treatment helps ($\chi^2 = 5.32$, $p = .021$).[24] There was also an increase in the number of people agreeing that family members lack information, but this was not statistically significant ($\chi^2 = 3.20$, $p = .074$). Interestingly, the proportion of respondents who agreed that first responders had a duty to help was lower in Wave 2 than Wave 1 (61.5% vs. 78.6% agreed or strongly agreed), although this was not statistically significant ($\chi^2 = 1.88$, $p = .171$). We speculate that greater exposure to the navigator, and the overall positive disposition of deputies toward the navigator's role, may have influenced respondents to

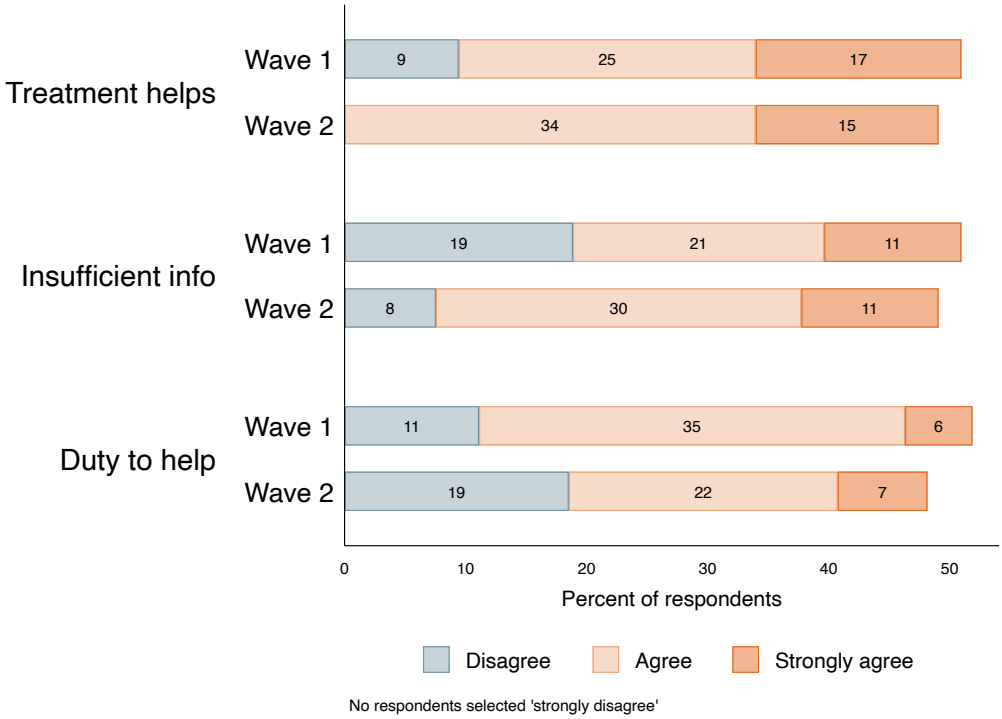
[22] Respondents could answer these questions on a 4-point scale, from "strongly disagree" to "strongly agree." Because of the small number of responses we recoded these questions to "agree/disagree."

[23] Based on two-sample Wilcoxon rank-sum (Mann-Whitney) tests.

[24] Due to low numbers of responses we recoded the 4-point agreement scale to "agree/disagree" for the statistical analysis.

believe that a MHP is better placed than them to provide support and resources to people with BH/DD.

Figure 9: Survey respondents' attitudes toward people with BH/DD, Wave 1 (2016) vs. Wave 2 (2019)

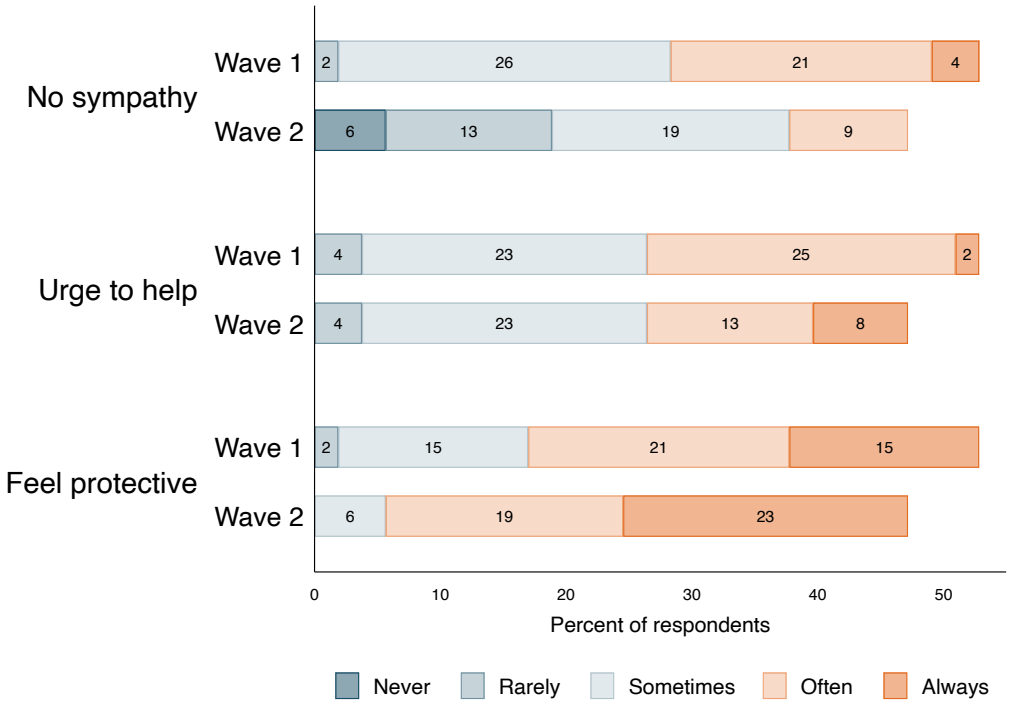


Finally, we examined changes in responses to the three questions from the Toronto Empathy Questionnaire, which measured respondents' empathy toward people in need (see Figure 10). We asked how often (on a scale of Never to Always) respondents did *not* feel sympathy toward those who cause their own serious illness; how often they got a strong urge to help when they see someone who is upset; and how often they feel protective of someone they see being taken advantage of. There was a significant difference between responses to the first question between Waves 1 and 2. More respondents in Wave 2 said they never or rarely lacked sympathy for people (z = 3.12, p = .002). There was little difference in respondents' urge to help (z = -.3, p = .977). Respondents were more likely in Wave 2 to say they felt protective often or always, but this did not meet the threshold for statistical significance (z = -1.87, p = .062).

4.6. Focus groups with key stakeholders

As we described in the Methodology section, we conducted focus groups in August 2019 to understand how various stakeholders had experienced RADAR. We spoke to deputies and their supervisors, command staff, mental health professionals, and others who have been involved with the development of RADAR specifically in Shoreline. Topics of discussion included perceptions of RADAR, including the utility of the response plans and partnerships with the navigator; job satisfaction; and success stories and challenges. We also asked stakeholders what advice they would give to police chiefs or command staff at other departments who were interested in implementing a similar program in their jurisdiction. Responses to this last question are summarized in the Recommendations section.

Figure 10: Survey respondents' empathy toward people with BH/DD, Wave 1 (2016) vs. Wave 2 (2019)



4.6.1. Benefits of RADAR

The overall attitude of focus group participants to RADAR can best be described as "guarded optimism." Stakeholders highlighted a number of benefits to the department, but also noted some of the ways in which the program had not delivered as expected or been challenging to implement.

An important positive theme was the increase in buy-in over time from deputies in the department, which especially grew when the current (as of August 2019) RADAR sergeant assumed his position. RADAR was initially seen as just another "flavor of the month," and deputies did not recognize anything concrete that was useful to them. Our survey findings show this attitude still persists among a handful of deputies, but on the whole most see benefits from the program. The Chief noted that hearing RADAR mentioned across the radio regularly maintains a level of exposure for deputies that reminds them to check response plans. He believed that the terminology of the program is becoming more familiar and has a connotation of importance for deputies when they hear it. The patrol deputies we spoke to agreed that they were skeptical at first because of the limited time they typically have available to spend on calls, but they now see that the program can help them start to address challenging long-term issues in the community. They view RADAR as "one extra tool in the toolbox," especially when a response plan is available. Adding the navigator has been particularly useful because a big reason for lack of buy-in originally was deputies' resistance to doing outreach and referrals themselves.

Related to this, the Chief noted that he has seen a culture change around dealing with people with BH/DD since RADAR began. He sees deputies doing a good job of de-escalating situations and exercising patience and understanding compared to when they started the program, which aligns with our survey

finding that fewer deputies have had to use force against a person with BH/DD since RADAR began. The Chief noted that RADAR is a culture shift from typical CIT training because it goes beyond simply raising awareness of different behavioral health issues. He reported hearing more compliments about deputies' professionalism and calm responses, and hearing compliments more than complaints. In summary, the community has an "expectation of professionalism" and RADAR contributes to increased awareness of this among the deputies.

Both RADAR and regular patrol deputies said that the ability to refer cases to the navigator helps them. Deputies do not have the time or resources to solve problems like those described by the RADAR sergeant as "neighbor disputes" with a BH/DD element (for example, people who call the police believing their neighbors are spying on them or trying to poison them), which can spiral into disruptive behavior. Now, instead of responding to the same people over and over again with limited recourse, they can make a referral to the navigator that opens up the range of resources available to address the issue. They recognize that the problem may not be immediately solved, but in the short-term and from a policing perspective the number of repeat 911 calls noticeably decreases. These success stories are also important for getting buy-in from deputies. We heard several anecdotes about deputies who had been openly skeptical or critical of RADAR but changed their minds and started sending in referrals after seeing examples of it working in practice.

Deputies reported that they particularly liked collaborating with the navigator because she has professional knowledge of available resources and can provide a lot of information that deputies don't know about. This goes beyond information provided to the community—Shoreline's RADAR consultant stressed that a MHP can also help to increase awareness of how the behavioral health system works among deputies themselves. For example, a particular source of frustration we have heard frequently from deputies is the "revolving door:" when they send someone to hospital on an involuntary transfer, the person is often released hours later and comes straight back to the police's attention. The MHP can help explain why hospitals work this way—deputies may not know that the involuntary transfer paperwork they fill out is essentially just a suggestion. As the RADAR consultant noted: "The navigator helps *officers* navigate the system as well as the community." While the revolving door still creates frustration for deputies, the partnership with the navigator addresses some of the dissatisfaction they often feel about only being able to do "triage" rather than solving the problem. The expertise of the navigator allows them to "divide and conquer," focusing on the skills each party is most adept at. For example, deputies can focus on documenting law enforcement-relevant information that can increase the risk of escalation while the navigator provides advice and connections to services in the community.

Command staff in particular found the RADAR response plans useful, even though there were very few of them. The plans help to acclimate new personnel to people in the community who are well-known to other deputies because of repeated personal interactions over time. They can also help supervisors better plan for and control potentially dangerous situations. We were told an anecdote about a sergeant who used a response plan to help formulate a "game plan" with deputies who were tasked with serving an arrest warrant on a person with a violent history who had already been identified by the RADAR program.

In general, deputies reported that RADAR has a positive effect on their job satisfaction. This also aligns with our survey findings showing that a majority of respondents viewed RADAR favorably from this perspective. The RADAR deputies noted that it offers a different pace, approach, and mindset from regular patrol. Because they divided their time between RADAR and regular patrol, this made the job more dynamic and interesting, and allowed them to feel like they were having a positive impact on people's lives. For example, deputies told us about several well-known high-frequency callers in the community who

had reduced their contact with police since receiving outreach from the RADAR deputies and navigator, such as a man who typically calls police several times a day believing his neighbors were shooting lasers at him who had not called in several months. The deputies described RADAR as a "long game:" "You can't look at RADAR as being able to 'fix' someone… but how has it helped us to get them to where they are now?" They see their role in the program as trying to get people to the point where they're willing to seek help. Then, even if they relapse, the process has still been set in motion, so they believe they have still successfully moved the needle.

The Navigator has also seen benefits of RADAR in Shoreline. She reported that she has been largely well-received by people in the community. While some people are understandably embarrassed about being referred, only a few have refused to work with her at all. Reflecting the comments of the RADAR deputies about the "long game," she saw the co-responder model as a way to improve rapport between people with BH/DD and the police, even if the outcome isn't an immediate or obvious "success story." Some people will stop engaging with treatment but still proactively work with the RADAR team, maintaining the "in" that opens up opportunities for more support in the future. She appeared to view herself as playing a supporting role in changing community perceptions of the police—through their collaborative outreach, she and the RADAR deputy can show people that the police are there to help and don't only come when someone is in trouble. Ultimately this could help to reduce fear of the police among people with BH/DD. The "long game" is about using these changed perceptions to create supportive, positive police-community relations where people feel comfortable reaching out to police and service providers about their mental health needs.

To this point, it is important to caution that we did not collect data directly from people with BH/DD who were involved with RADAR and therefore only have the word of the police and the navigator about the benefits to the community. However, this collaborative, community-oriented approach does align with the research discussed above on procedural justice and the police's 'caregiving' role. Although RADAR originally focused primarily on the creation of response plans for people who were considered a danger to police and/or high-frequency callers, the addition of the navigator allowed for a greater variety of outreach and assistance, identifying "hooks and triggers," and creating alternatives to arrest. As the RADAR project coordinator—a doctoral candidate in social work—stated, "this is the way of the future." Questions are often raised about the extent to which police should be expected to carry out 'social work' roles whereas RADAR brings the social workers to the street to an extent. In the project coordinator's words, "social workers can be in any situation—it's like the EMT relationship to the fire department."

Finally, while we did not evaluate the broader regional RADAR collaboration and cannot speak to the program's implementation in the other agencies, several stakeholders noted the benefits of this collaboration. In particular, the fact that people regularly cross jurisdictional boundaries (especially in a suburban metropolitan area like Shoreline that lacks clear delineation between cities—for example, one crosses from Shoreline into Seattle simply by driving from one side of an intersection to the other) underscores the importance of information sharing across agencies, and several response plan subjects have addresses outside of Shoreline city limits. Several stakeholders told us a story about someone who assaulted a police officer in one of the collaborating jurisdictions. When Shoreline heard about the case they created a response plan for the perpetrator. Later on, there was a call involving someone with BH/DD in a third participating jurisdiction that shares a data system with Shoreline, which turned out to be the same person. They were able to pull up Shoreline's response plan and de-escalate the situation (this particular story was also held up as a RADAR selling point for a notably skeptical sergeant).

4.6.2. Challenges of RADAR and areas for improvement

While our focus group participants highlighted a number of RADAR benefits and success stories, they also discussed several challenges and problems. These primarily revolved around the sustainability of the navigator position—similar to our survey findings, there was strong support for the navigator but concerns about how the role works in practice—and failure to deliver on the technology side of the program.

It was clear in our discussions with the deputies that they had developed a great deal of trust and respect for the current navigator. In fact, one of the RADAR deputies stated: "If we didn't have [Ms. Kroll], the program would have died years ago." However, this relationship took time to develop and may not be replicated fully with a different person. There were some personality conflicts at first, especially given that police officers are not used to riding with a non-law enforcement partner. As we noted above, Shoreline quickly moved away from a true co-responder model where deputies and MHPs responded to 'live' calls because deputies did not want to ride with 'outsiders' and were understandably nervous about being responsible for an untrained person in the middle of an unfolding law enforcement situation. Ms. Kroll was able to navigate her role more easily because, although she has not worked in law enforcement, she comes from a law enforcement family and has an understanding of the culture and hierarchy. Future navigators may not have the same experience or mindset. As the RADAR consultant pointed out, co-responder models are a very new area for social work and there is nothing in social work training about working with the police.

Another important challenge with the navigator, which was also borne out in the survey responses, was that there was only one. In Shoreline specifically, deputies wanted the navigator to be more proactive in making contact with people rather than reviewing reports and responding later (for example, the project coordinator suggested that navigators should have radios to be able to check in with dispatch when they arrive on shift to find out what situations may have happened that day). However, with only one navigator (who works across all five collaborating agencies, plus a sixth agency), deputies felt they couldn't always get access to the program when they wanted or needed it. They wanted a dedicated person, at least during high-volume call times.

The RADAR sergeant highlighted this as RADAR's "biggest challenge." He said that Ms. Kroll "shouldn't have to be a counselor or case manager for the whole city—everyone is calling or checking in with her for support." She frequently gets calls and emails at all hours of the day or night, and because she is "known and a friendly face" she may come across to people as "less faceless than using the resources she's connected them with." Thus, RADAR has effectively displaced the problem of repeat calls for service to the navigator rather than addressing the issue. This might not sound like a bad thing, but for the fact that there is only one navigator, who just happens to be particularly dedicated. The navigator herself understands and appreciates that she "can't be everywhere at once" or cover a department full-time by herself.

There is a resource-sharing agreement between the five agencies participating in RADAR, which includes a plan to hire 4 part-time navigators and a full-time program manager. The navigators will go wherever they are needed across the region rather than being assigned to a specific department. However, the current navigator explained that adding more navigators will only be feasible if there is a deliberate structure for interviewing, onboarding, and training in place—it is crucial to continue working on getting buy-in from the police to work with a "stranger." Just because they are used to working with one navigator, it does not mean a new one will automatically be tolerated. The lack of knowledge about police-social work

collaborations in the social work field has also limited their ability to hire a program manager, according to the RADAR consultant.

As the current navigator's experience highlights, an important challenge for the navigator side of RADAR is the blurring of roles between outreach and case management. The RADAR consultant felt it was a good idea for the navigator to do case management, but police departments in the region wanted someone more focused on doing triage and referral; the navigator here has ended up having to do a bit of both. She explained that case management (or performing diagnostic or clinical work in the field) represents a different type of relationship with the client. The navigator is supposed to serve as a "bridge" between the police department and the community; the community members is "not supposed to think the navigator is 'theirs.' " A further challenge here is that this also represents a change in mindset for most MHPs who might become navigators: the consultant noted that MHPs are typically trained to follow people through the system, whereas RADAR requires them not to follow but to refer out.

Returning to deputies' concerns about riding with untrained outsiders, recruitment and training of navigators is also a key challenge for RADAR. Again, this has not been a specific issue with the current navigator, but this is primarily because of her personality and experience (she described her job as "a calling") and is not sustainable. The RADAR deputies even said that the qualities she has "can't be trained"—she understands working with police, knows her role, and "doesn't ask stupid questions," whereas other people might be more like an inexperienced ride-along participant who ends up being more of a liability than an asset. Other stakeholders did feel that training is possible (see the Recommendations section for more details), but highlighted important qualities that should be selected for at the recruitment stage. The patrol deputies stressed that the navigator should be "realistic but positive" about the realities of law enforcement and could not be someone who is hostile toward police. They noted, for example, that some people outside law enforcement have the view that the police should never use force, but a navigator would need to recognize that sometimes it is necessary to use force to secure a scene.

The current navigator reiterated this view, stating that navigators need to be able to see the value in both worlds and translate between them. However, she also highlighted challenges to recruitment and hiring. Some MHPs who work with people who are multiple-system involved view the police as "adversarial, harmful, and have traumatized their client," and she was even hesitant to tell her colleagues what she was doing initially because of the cultural and ideological differences between the two fields. Another challenge with hiring navigators is that a non-trivial number of MHPs would not be able to pass a background check. She believed that some people go into mental health work because they are "in recovery from something" themselves. Furthermore, while marijuana is legal in Washington, it can still create problems for law enforcement background checks and it is likely that people would fail on that basis.

Finally, the technology piece of RADAR has been the source of numerous challenges. The difficulties are twofold: at the local level, the integration of response plans into the CAD system was not effectively realized; and at the regional level stakeholders reported difficulties sharing information across different agencies and systems. While some commanders felt that the workaround of attaching response plans as PDFs in the records management system (RMS) had been useful, deputies on the ground found them difficult to access and "not quick to look at"—they had to navigate through multiple screens to find them. On the other hand, the deputies found that the summary emails sent by the current RADAR sergeant contained all the information they needed about "hooks and triggers" and were easy to understand. Thus, as it currently stands, the information sharing piece of RADAR has not really addressed the "front-loading" goal—the front-loading is being done manually by the sergeant, which is not sustainable. The

RADAR sergeant moved to another agency in October 2019 and it is possible that his successor may use a different approach. While the patrol deputies felt the response plans were useful for people who were new or not working in Shoreline full-time, the specific deputies we spoke to preferred to continue relying on their own knowledge of people in the community.

A further issue with the response plans is that the RMS workaround only allowed a plan to be connected to its subject by address. This is at odds with the reality of people in the community with BH/DD, some of whom are homeless or transient, or simply move frequently. The Chief noted that it would be helpful to be able to connect the response plans to other data points, like the person's name or driver's license number. However, for privacy reasons this would require legislative action. The technology may be years away from being fully realized, and is not a priority for KCSO. One important challenge is that a new King County Sheriff was elected during the RADAR implementation period and Shoreline and the other collaborating agencies under KCSO's purview are still working on developing buy-in from leadership. The program may be viewed as "the previous Sheriff's program" and therefore not a key priority for the new administration. Thus, the broader operational context for implementation is not as favorable and the elements of RADAR that rely on external support have been more limited.

One member of the command staff we spoke with noted that in terms of the regional collaboration, technology and systems were "so compartmentalized it's hard to integrate" RADAR—especially given that the collaboration involves some agencies that are KCSO contract cities and others that are completely independent. RADAR has evolved differently in each area, which may create challenges for sustainability and broader recognition and political support. He stated that it needs to be thought of as one would think about scaling up a business—identifying the right staff for different roles and gauging political will and funding availability. The collaboration across different jurisdictions also creates territorial issues, even when they have agreed to cooperate. Chiefs still have to focus on what is best for their own city, because ultimately they are responsible for their own city. This may explain why RADAR looks so different in the various agencies. Ultimately, the success of the regional collaboration may hinge on visionary chiefs who are willing to take risks. This has largely been the case so far, which has helped the collaboration develop, but not all chiefs may follow the same approach and the program could ultimately rise or fall depending on who is in the role.

5. Conclusions and Recommendations

In this report we described a process and outcome evaluation of RADAR—Response Awareness, De-Escalation, and Referral. This program was developed by the Shoreline Police Department under a FY 2015 Strategies for Policing Innovation (SPI) grant from the Bureau of Justice Assistance and evaluated by the Center for Evidence-Based Crime Policy at George Mason University and the National Police Foundation. RADAR was first implemented in January 2017 after a one-year planning period. It aimed to institutionalize department-wide and regional information sharing about community members with behavioral health issues or developmental disabilities (BH/DD) who may be at increased risk of violence or use of force; and offer opportunities for outreach and connection to services and resources through a mental health "navigator."

RADAR evolved during the course of implementation to become more focused on the outreach and referral portion of the program than originally expected. Subject-specific response plans, used to highlight information about community members' "hooks and triggers"—factors that could calm or excite them—

and potential risks posed to the police were created, but limited to those at highest risk of violence, use of force, or repeat calls. Only 27 response plans were created during the two-year implementation period we studied, but 200 people in total were contacted through response plans and/or navigator outreach during the same period. However, there were no significant changes in mental health-related calls for service or BH/DD-related incident reports during the implementation period compared to a similar jurisdiction in the King County Sheriff's Office service area. There were fewer instances of physical contact in Shoreline during RADAR implementation—a broad definition of "use of force" that also includes routine actions like handcuffing and physically escorting people, which can also increase fear among people with BH/DD. While this finding is promising, it is not statistically significant.

Although our outcome evaluation did not show strong positive results, there are some promising findings from our survey of Shoreline deputies and our focus groups with deputies and other stakeholders. While there were some implementation challenges, particularly around the technology issues that limited the ways in which response plans were shared and sustainability and resources to support the navigator's role, RADAR was generally well-received by deputies. Most deputies checked for response plans at least sometimes when responding to calls and viewed the navigator very favorably. They viewed RADAR as a useful additional tool in their toolbox for dealing with situations involving people with BH/DD and another way to help address the "revolving door" of mental health calls, especially through the support provided by the navigator. A majority of deputies we surveyed post-RADAR implementation felt it improved their job satisfaction. Our survey results indicated significant culture changes in Shoreline Police Department following RADAR implementation. All respondents to our follow-up survey had received CIT training. Deputies were much less likely to have used force in encounters with people with BH/DD, and felt that people with BH/DD were less afraid of them. They felt they received more information about people's "hooks and triggers" before responding to a call. Finally, there were improvements in deputies' attitudes and empathy toward people with BH/DD—they were significantly more likely to feel sympathy toward people with BH/DD and believe that treatment can help them.

There are several limitations to our study. Most importantly, we lack any data on the perceptions and experiences of people with BH/DD who received response plans or navigator outreach. We found that most people who received outreach were willing to accept help, which is promising, but we lack insight into why or whether the support helped them in the longer term. This points to a larger issue with the available data that may explain why we did not find statistically significant differences in incidents, calls for service, and physical contact. Even though Shoreline has a higher volume of mental health-related calls relative to other agencies, the actual numbers of calls and incidents are small and the number of people who received response plans and even navigator outreach is unlikely to make a significant dent in department-wide call rates. Furthermore, as we discussed above, the response rates for our deputy surveys were low and the total population surveyed was also small. There was considerable turnover in the department between Wave 1 and Wave 2. Thus, our survey findings should not be taken as conclusive evidence of change. Finally, as we have noted throughout, the changing nature of the RADAR program over time, its multiple components, and challenges with data availability, make it very challenging to produce a rigorous evaluation.

RADAR is also unlikely to affect outcomes at the point of the call because in Shoreline the navigator outreach was reactive and limited in time. We had hoped to be able to analyze outcomes for specific people who received RADAR contact, but as we documented earlier it was extremely difficult to identify them in the official data. Furthermore, many people contacted for outreach were low-risk and only had one contact with police—the call that initially got them referred to RADAR. A substantial minority of people were referred through other channels and had no calls for police service at all. For example, several young

people who were contacted were identified because their schools were concerned about their behavior and referred them to the school resource officer. In this case there was no call for service or specific incident that led to the outreach. This does not provide us with enough data to reliably assess individual effects. Overall, it is likely that our study is underpowered to detect any effects of RADAR on calls and incidents, even if they do exist.

In addition, as several of the deputies and other stakeholders in Shoreline told us, RADAR is a "long game." Even if RADAR is effective and we could measure it, it is possible that the full benefits have not been realized yet, especially in terms of contributing to reductions in BH/DD calls and incidents involving physical contact and resistance. As evidenced by the survey findings, a majority of deputies recognized that one or two outreach contacts with a person with BH/DD may not be enough to address all the underlying issues, but they at least felt like they were helping the person to take a step in the right direction and open up the possibility of getting further help in the future. Overall, RADAR's initial implementation focused on changing the culture of the police department in terms of how deputies responded to and interacted with people with BH/DD. The promising results from our survey, showing that deputies are less likely to use force and that they like the program and are using it, do provide some evidence that this culture change is happening, although we could not rigorously assess this. Ultimately that culture change may set the scene for longer-term effects that cannot be measured yet.

5.1. Recommendations

We conclude this report with recommendations for the further development and sustainability of RADAR, many of which are based on our focus group conversations with RADAR stakeholders. These recommendations are important for sustaining the culture change that may allow for more positive effects in the future.

5.1.1. Recommendation 1: Improve RADAR data tracking

A crucial element of program evaluation is being able to successfully track data to measure outcomes. As our challenges with this evaluation demonstrate, we cannot measure outcomes for specific individuals unless we know who participated in the program. Matching people by names or addresses is not sufficient, as people often change addresses or give different names to the police (whether aliases or differences in spelling etc.). **RADAR needs a standardized way of tracking referrals from patrol** that still needs to be user-friendly for deputies and the RADAR sergeant—the use of emails to refer cases has worked well in practice, but it presents challenges from an evaluation perspective. The RADAR sergeant who was in the role when we conducted our focus groups had developed an excellent Excel-based tracking system, but this was entirely based on his own skill set and attention to detail and still did not provide a standardized way for an evaluator to connect the referral with data from the CAD and RMS systems.

We recommend **including a RADAR flag in both the CAD and RMS systems**. In CAD, dispatchers could add the RADAR flag whenever a call comes in that is related to someone with a RADAR response plan—this is more proactive than looking up the premise warning, which may not attach to every call. To get around the challenge of response plans being linked only to addresses, deputies could also radio dispatch to add a flag during the call if it becomes clear that the person has or needs to be referred for a response plan. In the RMS, deputies could check a box indicating that the incident was related to RADAR when they

write up their incident report. Finally, while this does add some work for deputies, we recommend that RADAR deputies write reports when they conduct outreach with the navigator. This would document the nature of the outreach in a way that is accessible to deputies who might respond to that person in the future and would also ensure that the police department has a record of the contact—which means it can be measured. For our evaluation we could only rely on the navigator's case management notes to understand the outreach, but these are not written from a police operational perspective. Ideally, it may be worthwhile to add a CAD call type for RADAR outreach that deputies can log when they go to an address (just as they would log that they are going on directed patrol or checking out for a break), which could then be connected to a related incident report documenting the details of the outreach.

5.1.2. Recommendation 2: Continue regional collaboration efforts

As we have seen, the **regional collaboration** Shoreline has been developing around RADAR will be crucial to working out the program's technology challenges. Regional collaboration and funding is especially important for small and midsize agencies that serve populations of 50,000 or less (i.e. the vast majority of police departments in the United States)—although the Shoreline area is relatively affluent compared to many of these agencies, the small population can still limit access to sufficient resources so it becomes very important to pool efforts across multiple departments wherever possible. We recommend that the departments **continue their partnership and efforts to strengthen awareness of RADAR within KCSO** overall. This will require special focus on overcoming the challenges of information sharing across different data and dispatch systems. Efforts are already under way to do this; however, the RADAR deputies suggested to us that lessons could be drawn from programs like the Amber Alert system, which could be leveraged into a regional notification that goes out when someone has a response plan.

5.1.3. Recommendation 3: Focus on sustainability of the navigator position

One of the biggest issues identified in our surveys and focus groups was the **sustainability of the navigator position**, especially given that there is currently only one navigator who is shared across multiple agencies. In general, deputies saw opportunities to expand the number of issues that could be referred to and handled by the navigator, but recognized that there were insufficient resources to have the navigator available whenever needed. The collaborative outreach also has implications for officer time, especially in a smaller agency with a more limited pool of deputies. Rather than incurring large overtime costs for deputy outreach, increasing the capacity of the navigator portion of the program could eventually allow them to conduct follow-ups alone, as long as they were comfortable with the environment and there were no safety issues.

In order to expand and sustain the navigator program, the role needs to be further developed with a **deliberate structure for navigator interviewing, on-boarding, and training**. The current navigator suggested that a "mini-FTO" (supervised field training) program should be developed for navigators, mirroring police field training. This could be followed by a probationary period during which new navigators would ride with deputies and learn more about police culture and the nature of BH/DD incidents. Although in Shoreline deputies were generally resistant to riding with MHPs, the deputies we spoke to agreed that it was important for navigators to ride with officers to get a feel for the job. As the RADAR sergeant put it: "The more exposure in the cop car, the better." However, he cautioned that you can't just

put a deputy and a navigator together in a car and expect them to immediately work as a team because they are not natural partners. There needs to be a period where they sit down and talk over coffee and share different resources in order to develop trust.

As we heard in our focus groups, **selecting the right person for the navigator role** is vital to develop this trust and overcome the challenge of not being a "natural partner" for the police. Based on our conversations with both the deputies and MHPs, the ideal candidate for a navigator needs to be humble; able to take direction and defer to officers while also being able to take the lead in some situations; understand the criminal justice system and police perspectives; possess strong CIT or de-escalation skills and good clinical skills if the role moves more toward case management; and work independently. Crucially, they need to understand police culture but also understand that they are "not a cop" and cannot misrepresent their role. It is important that the navigator is not too "extreme" in either direction: they cannot be "scared of guns" and must be willing to accept the risk that they could get hurt. It is very different to the normal MHP experience of sitting in a clinic, which is a closed, controlled environment. The project coordinator noted that the navigator must feel comfortable "tromping through the woods," going to homeless encampments and encountering used needles and feces. On the other hand, too strong a personality may also be a disadvantage. The navigator must be able to respect the police hierarchy and not come in thinking they can change policing (for example, they must accept that it is sometimes necessary to use force).

Clearly, then, the navigator role is not for everyone. While some of the deputies we spoke to felt that the success of the current navigator was down to elements of her personality that could not be trained, the RADAR consultant has developed a certification program that is being offered at Shoreline Community College, with the goal of making the navigator role a new and specific career path within social work. The program is a 60-hour course that includes the continuing education credits MHPs need for accreditation. The course focuses specifically on familiarizing MHPs with police culture and procedures, including how to document activities via witness statements and affidavits if they witness use of force issues or other challenges. The consultant believes this program will be crucial to improving the acceptance of the navigator among deputies, because it focuses on empowering MHPs to handle themselves in the field—deputies do not want to feel responsible for the safety of a non-law enforcement partner on top of everything else they have to deal with. There are a number of successful police-MHP partnerships around the United States that could serve as models for the development of the training (e.g. Reuland et al., 2012; Reuland et al., 2009).

The MHP stakeholders we spoke to also stressed the importance of creating a structured navigator team, including a supervisor. This is important not only for sustainability, but also for the integrity of the program. The RADAR consultant noted that it is not appropriate for the navigator to be supervised by a law enforcement officer, just as it would not be appropriate for the navigator to tell the deputies how to do their job. The supervisor should have clinical social work experience, especially if the role moves more toward case management. Ideally the supervisor would also be well-equipped to go out into the field, while also being able to manage people who are in the field. Stakeholders likened the role to the navigator program's equivalent of a community outreach officer—the supervisor should be public facing and able to talk to the media if issues arise, for example. They cautioned that this work is emotionally heavy, especially for a supervisor, so a focus on self-care in training and day-to-day work is a must.

Ultimately, for full integration of the navigator into the department, there could be centralized RADAR check-ins, weekly team meetings, and/or briefings to ensure navigators and deputies were on the same page. Integration of the navigator is crucial for sustainability—the navigator is the key point of contact

or "bridge" between the police department and the community and needs full access to information to be able to do their job (for example, access to the police department building and systems). The current navigator suggested that the navigators should be able to write and update response plans so that behavioral health information can be accurately reported and updates can be documented quickly after conducting outreach or attending briefings. She noted that response plans are often not updated because they are created in-house and she does not always have an opportunity to conduct outreach specifically with people who have response plans.

5.1.4. Recommendation 4: Select the right deputies for RADAR

The RADAR sergeant and deputies we spoke to also provided insights into the ideal law enforcement candidates for a program like RADAR. The RADAR sergeant needs to be someone who is well-known and respected in the department, otherwise deputies will not feel comfortable making referrals. RADAR deputies need to be open-minded and willing to come off the patrol shift and start a different job with a slower pace and a completely different approach to dealing with people. The RADAR deputies we spoke to cautioned that this job is not "proactive policing or running warrants"—it is hands-off and focused on identifying resources. They warned: "Don't use RADAR as sticks to offer people carrots"—in other words, RADAR should not be used to arrest their way out of a problem and then attempt to gain trust and offer assistance. Overall, the program needs to be developed from the bottom up, not the top down, in order to succeed. The RADAR sergeant and deputies need to be allowed the autonomy to fine-tune the program in the field, as the current RADAR sergeant has done with the referral and tracking process, to avoid the program being viewed as just another "flavor of the month."

5.1.5. Recommendation 5: Develop a supportive organizational context

Asked what advice they would give to chiefs in other departments who might want to implement a program like RADAR, stakeholders stressed the importance of not reinventing the wheel. It is important to collaborate with other agencies and find out what they are doing, understand the resources that exist in the jurisdiction, and then take the elements that work for the specific context and improve on them as needed. It is important to start slowly and make sure there is a strong foundation and training for the program so that it gets off the ground smoothly. Ideally, stakeholders recommended hiring a project manager who knows the worlds of both policing and social work to help build the program. This person should have practical knowledge of law enforcement procedures and social work licensing requirements, as well as a good understanding of cultural differences and challenges. To increase buy-in for the program, deputies and command staff recommended selling RADAR as an officer safety, police-focused program with assistance from a mental health professional, rather than a MHP-run program. Commanders should be able to point to the ways in which it specifically responds to officers' needs. However, this also needs to be balanced with the potential benefits of the program for the community, including the identification of effective resources for referral.

Finally, stakeholders highlighted the importance of using existing resources and maximizing efficiency, especially in a smaller agency. They believed that RADAR could be a relatively low-cost program if attention was paid to these issues. Commanders felt that being able to demonstrate how existing resources are being used and shared across jurisdictions is crucial to obtain buy-in from local and regional funders because it demonstrates fiscal responsibility. They acknowledged that other police departments may

not have the luxury, like Shoreline did, of being able to tap into taxpayer bond-funded resources like the MIDD funding, which provided support to develop the navigator program. However, agencies should take the time to carefully research what other options might be available instead. Overall, while we did not find that RADAR had demonstrable benefits for rates of calls for service, incidents, or physical contact and resistance, it has clearly changed police culture around people with BH/DD in the short term, providing a strong foundation for longer-term improvements. A focus on sustainability and creative approaches to resource allocation and sharing will go a long way toward ensuring these potential effects can be realized.

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GEORGE MASON UNIVERSITY
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Department of Criminology, Law & Society

RADAR: Response Awareness, De-Escalation, and Referral

Final Evaluation Report

Appendices

A. Statistical Tables

Table A1: Calls for service and incidents in Shoreline and the comparison city, 2015-18

	Shoreline		Comparison	
	Pre (2015-16) N	During (2017-18) N	Pre (2015-16) N	During (2017-18) N
Calls for service				
Total	30,820	37,455	41,659	42,540
MH-related[a]	1,088	1,084	1,246	1,291
Incidents				
Total	12,670	12,797	20,750	19,137
MH-related[a]	509	554	653	670
All BH/DD[b]	819	841	1,186	836

[a] Mental complaints and suicide attempts
[b] Mental complaints, suicide attempts, and other incidents coded as having a BH/DD component

Table A2: Difference-in-differences Poisson regression on mental health-related calls for service

	MH calls for service	
	IRR	Robust SE
During	.853	.079
Treatment	.873**	.045
During × Treatment	.962	.070
Month (ref: Jan)		
Feb	.861	.115
Mar	1.049	.094
Apr	1.160	.112
May	1.225*	.121
Jun	.994	.104
Jul	1.224*	.124
Aug	1.030	.105
Sep	.909	.098
Oct	1.001	.097
Nov	.920	.112
Dec	.967	.092
Trend	1.008**	.003
Constant	41.343***	4.038
Log pseudolikelihood	-351.101	
Pseudo R^2	.119	
Wald χ^2	82.598***	
N	96	

Exponentiated coefficients (incidence rate ratio, IRR)
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table A3: Difference-in-differences linear regression on time spent on mental health-related calls for service

	Average time arrival to close (mins)	
	b	Robust SE
During	9.618*	4.357
Treatment	11.007	7.327
During × Treatment	7.178	6.713
Month (ref: Jan)		
Feb	-1.300	8.624
Mar	-9.495	7.754
Apr	-2.597	8.091
May	14.814	8.629
Jun	-1.325	8.122
Jul	5.314	8.924
Aug	-3.491	7.742
Sep	6.652	8.956
Oct	1.460	8.017
Nov	1.855	8.338
Dec	3.116	8.082
Trend	-.000	.000
Constant	69.500***	7.259
F	3.12***	
R^2	.010	
RMSE	112.344	
N	4571	

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table A4: Difference-in-differences Poisson regression on BH/DD incident reports

	BH/DD incidents	
	IRR	Robust SE
During	.656***	.070
Treatment	.691***	.032
During × Treatment	1.457***	.121
Month (ref: Jan)		
Feb	.870	.117
Mar	.963	.102
Apr	1.086	.109
May	1.233*	.123
Jun	1.138	.136
Jul	1.114	.136
Aug	1.063	.136
Sep	.997	.126
Oct	1.084	.120
Nov	.917	.120
Dec	.981	.111
Trend	1.003	.003
Constant	44.273***	5.398
Log pseudolikelihood	-338.999	
Pseudo R^2	.161	
Wald χ^2	132.615***	
N	96	

Exponentiated coefficients (incidence rate ratio, IRR)
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table A5: Physical contact and subject resistance in Shoreline, 2015-18

	Pre (2015-16) N (%)	During (2017-18) N (%)
All BH/DD incidents	819	841
Physical contact		
Incidents with physical contact	120 (14.7%)	91 (10.8%)
Escorted	12	2
Forced to ground	4	7
Restrained	17	21
Hobbled	1	1
Handcuffed	87	68
Spit hood/mask	4	2
Gurney	15	21
Less-lethal force (e.g. CEW)	5	3
Firearm	0	1
Hit/kick/push	0	1
Subject resistance		
Incidents with subject resistance	114 (13.9%)	69 (8.2%)
Passive	13	11
Verbal	29	6
Self-care	26	13
Defensive	44	23
Active	29	17
Harm	21	15

Table A6: Poisson regression on incidences of physical contact in Shoreline (pre/during RADAR)

	Physical contact	
	IRR	Robust SE
During	1.602	.566
Month (ref: Jan)		
Feb	.802	.274
Mar	1.123	.480
Apr	1.342	.484
May	1.573	.611
Jun	1.428	.464
Jul	.670	.311
Aug	1.106	.452
Sep	.713	.376
Oct	1.765	.664
Nov	.835	.337
Dec	1.565	.643
Trend	.969*	.014
Constant	9.094***	2.836
Log pseudolikelihood	-109.207	
Pseudo R^2	.121	
Wald χ^2	26.310*	
N	48	

Exponentiated coefficients (incidence rate ratio, IRR)
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table A7: Poisson regression on incidences of subject resistance in Shoreline (pre/during RADAR)

	Subject resistance	
	IRR	Robust SE
During	1.255	.423
Month (ref: Jan)		
Feb	.663	.209
Mar	1.442	.576
Apr	1.487	.632
May	1.694	.538
Jun	1.663	.505
Jul	.943	.446
Aug	1.060	.369
Sep	.547	.244
Oct	2.253*	.794
Nov	.774	.285
Dec	1.996	.755
Trend	.970*	.013
Constant	7.640***	2.284
Log pseudolikelihood	-95.471	
Pseudo R^2	.189	
Wald χ^2	58.411***	
N	48	

Exponentiated coefficients (incidence rate ratio, IRR)
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table A8: Difference-in-differences Poisson regression on incidences of physical contact

	Physical contact	
	IRR	Robust SE
During	1.537	.524
Treatment	.976	.148
During × Treatment	.992	.245
Month (ref: Jan)		
Feb	.858	.180
Mar	1.148	.296
Apr	1.182	.266
May	1.467	.349
Jun	1.606	.474
Jul	1.125	.368
Aug	1.090	.282
Sep	.806	.315
Oct	1.444	.414
Nov	.669	.211
Dec	1.530	.434
Trend	.971**	.010
Constant	8.858***	2.198
Log pseudolikelihood	-227.607	
Pseudo R^2	.096	
Wald χ^2	39.048***	
N	96	

Exponentiated coefficients (incidence rate ratio, IRR)
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table A9: Difference-in-differences Poisson regression on incidences of subject resistance

	Subject resistance	
	IRR	Robust SE
During	1.159	.433
Treatment	.760	.133
During × Treatment	1.009	.263
Month (ref: Jan)		
Feb	.899	.235
Mar	1.354	.337
Apr	1.323	.360
May	1.709*	.425
Jun	1.398	.465
Jul	1.842	.693
Aug	1.098	.282
Sep	.856	.280
Oct	1.480	.471
Nov	.740	.206
Dec	1.648	.538
Trend	.973*	.011
Constant	9.427***	2.669
Log pseudolikelihood	-227.153	
Pseudo R^2	.145	
Wald χ^2	54.838***	
N	96	

Exponentiated coefficients (incidence rate ratio, IRR)
* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table A10: Characteristics of survey respondents

	Wave 1 (2016) N	Wave 2 (2019) N
Total respondents	28	26
Rank		
Deputy	21	14
Sergeant	4	6
Deputy MPO	1	3
Command	2	3
Assignment		
Uniformed patrol	19	17
Special emphasis team	2	2
Criminal investigations	3	2
Other	3	5
Unknown	1	0
Tenure in Shoreline		
Less than 1 year	2	3
1-5 years	14	11
6-10 years	5	5
More than 10 years	7	6
CIT training		
None	7	0
Short (8 hours)	11	14
Full (40 hours)	9	10
Advanced (>40 hours)	0	2
Unknown	1	0

Table A11: Survey respondents' experiences in encounters with people with BH/DD

	Wave 1 N (%)	Wave 2 N (%)
Ever feared for safety?		
Yes	25 (89.3)	19 (73.1)
No	3 (10.7)	7 (26.9)
Person with BH/DD afraid of you?		
Yes	25 (89.3)	17 (65.4)
No	3 (10.7)	9 (34.6)
Ever used force?		
Yes	25 (89.3)	11 (42.3)
No	3 (10.7)	15 (57.7)

Table A12: Experiences of survey respondents who used force with people with BH/DD

	Wave 1 N (%)	Wave 2 N (%)
De-escalation technique was effective		
Yes	15 (62.5)	6 (54.5)
No	9 (37.5)	5 (45.5)
Would have been more effective with subject-specific information		
Yes	18 (75.0)	7 (63.6)
No	6 (25.0)	4 (36.4)
Would have been more effective with general information about BH/DD		
Yes	19 (79.2)	7 (63.6)
No	5 (20.8)	4 (36.4)
Situation escalated because of person's fear/confusion		
Yes	10 (41.7)	2 (18.2)
No	14 (58.3)	9 (81.8)

B. RADAR Standard Operating Procedures

RADAR
Response Awareness De-escalation And Referral

STANDARD OPERATING PROCEDURES

INTRODUCTION:

RADAR is an effort by the Shoreline Police Department to address the rights and needs of individuals with behavioral health issues and/or developmental disabilities (BH/DD). Its purpose is to decrease use-of-force incidents between police and individuals with BH/DD and to reduce the repeated and inappropriate use of emergency services. It uses community-policing strategies to achieve these objectives. RADAR encourages the building of relationships between police and the populations they serve and the sharing of information amongst first responders to allow a more effective and safe response during a times of crisis. Through communication and collaborative planning, RADAR seeks to reduce use of force incidents engendered by fear or misunderstanding. It is a pilot program funded by the United States Department of Justice through the Bureau of Justice Assistance Smart Policing Initiative. The program will go into effect January 1, 2017 and will be evaluated by researchers at George Mason University and the Police Foundation in 2018.

MISSION:

During police incidents involving people with behavioral health issues and/or developmental disabilities (BH/DD), RADAR will improve the safety of individuals, the safety of the public, and the safety of Shoreline Deputies and other first responders. In order to reduce the occurrence of police incidents, RADAR also seeks to connect people with behavioral health needs to appropriate treatment and services.

GOALS:

- Develop individualized de-escalation strategies to reduce police use-of-force incidents during encounters with people with BH/DD.
- Collaborate with a mental health professional to connect individuals with BH/DD to existing services and treatment.
- Reduce repeat encounters with first responders and increase the effectiveness of police responses.
- Create cost effective community-policing strategies and promote increased collaboration between deputies, persons with BH/DD, caregivers, and families.

RADAR is intended to support the King County Sheriff's Office GOM 5.08.10 "Persons in Behavioral Crisis" and existing Crisis Intervention Team (CIT) training.

DEFINITIONS:

"Behavioral Health Issues and/or Developmental Disabilities" (BH/DD) refers to people who have or appear to have sensory, mental, or physical impairment as a result of mental illness, developmental disability, other cognitive disabilities, or co-occuring substance use.

"Behavioral Health Crisis" means a significantly disruptive episode of mental and or emotional distress in a person due to a BH/DD. People experiencing behavioral health crisis may self-identify or be exhibiting signs of mental illness, developmental disability, other cognitive disabilities including intellectual disability or traumatic brain injury, or co-occurring substance use.

"Precinct RADAR Team" consists of one RADAR Sergeant, three RADAR Deputies, one RADAR Training Coordinator, one RADAR Navigator, and the Program Coordinator. The Community Service Officer will work with the Precinct RADAR Team on an as-needed basis.

"RADAR" is an abbreviation for Response Awareness, De-escalation, And Referral.

"Response Plan" is a document that contains information to promote safe, collaborative and effective interactions with individuals with BH/DD, including individualized de-escalation strategies.

"Response Plan Flag" is an indication within the KCSO Computer Aided Dispatch (CAD) System that a Response Plan for a specific individual is available.

PROGRAM POSITIONS:

The Shoreline Chief will be briefed on RADAR activity by the Project Coordinator on a regular basis. Each member of the Precinct RADAR team will be responsible for the following duties.

RADAR Deputies

- Work with individuals with BH/DD and their caregivers on an as needed basis to develop and modify Response Plans.

- Work with the RADAR Sergeant, Program Coordinator and the Navigator to create, modify, and update individual Response Plans.
- Serve as a subject matter resource in RADAR procedures.
- Work with the RADAR Navigator to connect frequent utilizers of police services who have BH/DD to services and treatment.

Deputies interested in becoming a RADAR deputy should submit an Officer's' Report to the Precinct Commander via the chain of command. Selections are made by the Precinct Commander or their designee.

RADAR Navigator

- Assists RADAR Deputies and the Project Coordinator in creating Response Plans.
- Works with people identified by police and fire personnel as at risk of crisis to divert away from jail and emergency services.
- Works to connect at risk individuals to resources and treatment.
- Assists Deputies with information pertaining to community resources.

RADAR Project Coordinator

- Serves as the point of contact for the community on RADAR-related issues.
- Organizes internal and external meetings related to the RADAR program.
- Works with community partners.
- Maintains the RADAR website.
- Supervises the RADAR Navigator.
- Coordinates the activities of the RADAR Sergeant, RADAR Navigator and RADAR Deputies to create, update, and purge Response Plans.

RADAR Sergeant

- Manages the workload and resources associated with the RADAR Deputies, Training Coordinator, and Community Service Officer.
- Pre -approves overtime associated with the Department of Justice Smart Policing grant.

RADAR Training Coordinator

- Develops training protocol and curriculum based on policy and procedure.

- Manage and schedule training activities associated with the Department of Justice Smart Policing grant.

Community Services Officer

- Provide support to the RADAR program on an as needed basis.

RESPONSE PLAN FORMATION, PROCEDURES, AND RETENTION:

Referral Sources: Response Plans can be requested in three ways:

1. A Shoreline Deputy may request a plan based on personal observation, experience, or information from an outside party.
2. A member of the Precinct RADAR team may request a plan based on information in case reports or information from an outside party.
3. A community member may request a plan by contacting the RADAR Program Coordinator.

A referral for a possible Response Plan should occur whenever Deputies encounter a person who has attempted suicide with a weapon or exhibited signs of acute crisis that impact the safety of others. A RADAR referral should be made even if other actions have been taken such as arrest, hospital transport, use of Crisis Response Team, etc. Referrals should be made to the RADAR Sergeant via email.

Identification of Possible Response Plans: Upon receiving a referral, the RADAR Sergeant will direct the Project Coordinator to assemble a packet documenting police contacts and other relevant information. After reviewing this information, the RADAR Sergeant will determine if a Response Plan is appropriate and assign a RADAR Deputy to prepare a Response Plan.

Content of Response Plan. The RADAR Deputy, in collaboration with the RADAR Navigator and RADAR Project Coordinator, shall prepare a draft Response Plan using RADAR Response Plan form #100. A RADAR Response plan may include some or all of the following information:

- Photograph and other identifying information;
- Officer safety and public safety considerations;
- Special response protocol (example: two Deputy response);
- Known weapons;
- Possible behavioral triggers and inhibitors;

- Suggested de-escalation plan, including positive behavioral interventions, specific de-escalation strategies and other useful information;
- Recent contacts with summarized description of event and closure;
- Suggested behavioral agreements with person to decrease risk of use-of-force incidents;
- Contact information for relevant family, friends, and/or caregivers;
- Follow-up services/treatment; and/or
- Release conditions/conditions of supervision.
- Other information that may assist Deputies in deescalating crisis situations

A RADAR Deputy will, when appropriate, partner with the Navigator to meet with an individual who appears to meet Plan criteria. This initial outreach is for the purpose of establishing a positive relationship and obtaining input for the Response Plan, especially on collaborative de-escalation strategies. Where appropriate, the RADAR Deputy and Navigator will solicit input from a person's treatment provider, caregiver, and circle of support. A RADAR Deputy and the Navigator are not required to meet with the individual and others, but will determine on case-by-case basis whether such contact is safe, productive and appropriate.

Draft Response Plans. A Draft Response Plan created by the RADAR Deputy will be reviewed by the RADAR Project Coordinator and the Sergeant for consistency with program policy. Response Plans will be written to minimize private information or potentially embarrassing content. Where possible, Response Plans will not include highly personal information or private medical information like specific diagnoses or prescribed medications. The focus of the plan is to describe behaviors and identify practical, individualized strategies to help responding Deputies de-escalate crisis situations.

RADAR Response Plans are advisory in nature and used only as an informational tool for Deputies responding to a crises situation. A RADAR Response Plan is created solely for police community caretaking activities. It does not create a special relationship with a person or imply a specific duty to any individual beyond the need to treat all citizens with care, respect, and professionalism. The Shoreline Police Department is not a treatment provider and the Response Plan is not a HIPAA protected record.

Final Response Plan Approval and Implementation. The RADAR Sergeant is responsible for approving all Response Plans. The Response Plan shall be effective upon approval. A Response Plan may be authorized and implemented when the RADAR Sergeant determines that the following criteria are satisfied:

1. The person's behaviors in the community suggest the presence of a BH/DD, AND

2. The person meets one or more of the following criteria:

   (a) has a prior charge or conviction for a violent offense within the last three years;[1]
   (b) has a prior use-of-force incident with police or other first responders within the last three years;
   (c) has made a documented threat of violence against police or other first responders within the last three years;
   (d) is the subject of an officer safety flag, active law enforcement alert, or officer safety bulletin;
   (d) is under supervision for a violent incident;
   (e) exhibits behaviors that significantly increase the chance of a use-of-force incident due the nature of those behaviors;
   (f) has frequently used emergency response systems in a manner that suggests overutilization of public resources; OR

3. A RADAR Response Plan has been authorized by Command Staff for documented reasons consistent with the goals of the RADAR Program.

A Response Plan for a person who meets criteria 2 (a)-(e) will be color-coded red. All other Response Plans will be color coded blue.

Provisional Response Plans. Based on the above criteria, the RADAR Sergeant, a RADAR Deputy or Command staff may authorize a provisional RADAR Response Plan, which will take effect immediately and remain in effect for up to five days. At the conclusion of the five-day period, where appropriate, a provisional Response Plan may be replaced by a regular Response Plan that has been fully approved under this section.

Communications Center. Once a Response Plan is approved, the Communications Center will connect a Response Plan Flag to the individual's address within the CAD system to indicate to Dispatchers and Deputies that a Response Plan is available. Communications Center Dispatchers shall notify Deputies when a Flag corresponds with a dispatched call for service.

Updates to Response Plans. Once a Plan is created, RADAR Deputies and the Navigator may make follow-up outreach efforts to build relationships with the person, continue to refine de-escalation strategies, and connect the person to resources and services. The efficacy and nature of further follow-up visits with the person or the

[1] Any three year period listed in this section does not include any periods of incarceration or confinement.

person's circle of support is a matter within the discretion of the Precinct RADAR Team. The RADAR Deputies, in conjunction with the Navigator, will determine whether further outreach efforts are likely to yield positive results, or be counterproductive.

When a police event occurs involving a person with a Response Plan, the responding Deputy shall notify their supervisor and the RADAR Project Coordinator via email. The notification shall include a brief summary of the event and the associated incident number. The Project Coordinator will consult with the Precinct RADAR Team to determine whether to include the new information in the Response Plan. When appropriate, the most recent event shall be added to the "Recent Contacts" portion of the RADAR Response Plan. A RADAR Sergeant will approve any proposed changes to the de-escalation plan based on new information.

Referrals to RADAR Navigator. Deputies may refer an individual with or without a Response Plan to the RADAR Navigator in order to connect them to beneficial services. All referrals to the Navigator should be made through email and include the case number (if available) and a brief description of why a Navigator is requested. Using professional discretion, the Navigator will determine if outreach is warranted and shall document all actions and the reasons for those actions.

Retention of Response Plans. Response Plans will remain active for a period of up to three years. After three years, a Response Plan will be removed from the RADAR system unless it is re-approved using the criteria above. The Project Coordinator will ensure that deactivated Response Plans are sent to the King County Sheriff Office's Records Unit to be destroyed in accord with state record retention laws.

INCIDENT REPORTING:

Deputies will follow standard report writing procedures. Whenever responding to a call involving an individual who appears to have BH/DD, the deputy should write "BHI" in the IRIS Quick Summary box.

The Program Coordinator and RADAR Navigator will review all reports marked BHI on a weekly basis.

PUBLIC RECORDS REQUESTS:

Public records requests for RADAR information shall be directed to the King County Sheriff's Office records unit.

INTERAGENCY INFORMATION SHARING:

Information contained in a Response Plan may be shared with other agencies and/or mental health professionals when it is consistent with RADAR goals.

RADAR TRAINING:

The Department of Justice Smart Policing grant provides all members of the Shoreline Police Department a 4-hour core block of training directly related to the RADAR pilot program. This training will compliment existing CIT training.

COMMUNITY OUTREACH:

When a person does not meet the criteria for a Response Plan, Shoreline Deputies should inform community members of resources like Smart 911 and other crisis planning tools. In situations where it would be beneficial and where resources allow, Shoreline deputies should contact the RADAR Navigator who may be able to assist individuals who do not qualify for a Response plan with obtaining access to treatment and other resources.

C. Original SPI Shoreline Action Plan (July 2016)

SPI Action Plan

Shoreline, WA

Introduction

This project is for the development, implementation, and evaluation of an innovative subject-specific police information sharing, de-escalation and response strategy for persons with behavioral health issues (PBHI), including mental illness, cognitive and developmental disabilities, and substance use called **RADAR: Response Awareness, De-Escalation, And Referral**. The goals of our project are to:

1. enhance community and first responder safety by reducing police use of physical force with PBHI;
2. strengthen community/police partnerships; and
3. increase the connection of persons at risk with effective behavioral health services and treatments.

RADAR involves direct engagement, information sharing, and collaboration between police, high-risk individuals, and individuals' circles of support (such as their families and mental health professionals). In addition, RADAR provides a welcoming outlet where PBHIs who pose *no* risk to first responders or the community can voluntarily enter into cooperative alliances with police in order to prevent misunderstandings. This report describes our initial analyses of the challenges facing police and individuals with behavioral health issues in Shoreline to date, and the planned intervention and evaluation strategies to address them.

The Targeted Problem

Nature and Extent of the Problem

Shoreline, WA is a city of approximately 53,000 residents located immediately north of Seattle. It is one of 16 cities, tribes, and transit authorities that contract with King County Sheriff's Office (KCSO) for police services. Under this model, partners share communication systems, records, and command staff. The initial analysis that we conducted for our grant proposal indicated that Shoreline disproportionately contributed to mental health related complaints and suicide attempt calls in King County, perhaps because of its relatively high number of group homes, subsidized housing units, and the presence of one of the county's five methadone clinics. Shoreline residents comprise 10.2 percent of the population within the KCSO service area but account for 15 percent of mental health/suicide related calls. This number may be an under-representation, since behavioral health issues also factor in calls that are not immediately identified as mental health related (i.e. where a crime has been committed, or there is another type of complaint such as suspicious circumstances or a

This project was supported by Grant No. 2015-WY-BX-0005 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

disorderly person). KCSO does not systematically flag these other calls with a behavioral health component. We are in the process of examining the narrative reports of incidents that are not classified as mental health complaints to assess the extent to which this is the case.

Mental health related calls for service in Shoreline

We examined mental health related calls for service and incident reports recorded in Shoreline in 2014 and 2015. The term "mental health related" in this analysis refers to calls and incidents classified as either "371" (called "mental complaints" in KCSO data) or "232" (suicide attempts). In 2014, these call types combined accounted for 3.3 percent of Shoreline's calls for service (N=497). In 2015 they accounted for 3.5 percent of all calls (N=514). Mental complaint calls were much more prevalent than calls classified as suicide attempts (951 in total compared to 60).

Table 1. Mental Health Related Calls for Service in Shoreline, 2014-2015

	Number of Calls		
	2014	2015	Combined
Total calls for service	14,873	14,872	29,745
Mental complaint calls ("371")	464	487	951
Suicide attempt calls ("232")	33	27	60
Total mental health related calls	497	514	1,011

We examined the distribution of mental health related calls by time of day, day of week, and month of year to assess whether these calls were more likely to occur at certain times, days, or times of year than others. The most common day and time for mental health related calls was Friday at 3pm (Figure 1), although we caution that the numbers are small. In general there were few distinctive patterns—calls were slightly more common during the day and evening compared to the early hours of the morning, with the exception of Saturdays when they appeared to be somewhat more spread out throughout the day. In 2014 calls were slightly more likely during the summer months (July, August, and September), but in 2015 March and April saw more calls than other months (Figure 2). This indicates that Shoreline police can expect to receive mental health related calls at almost any point during their shift, on any given day of the week, and in any season.

While the number of mental health related calls in Shoreline is small, we found that calls are highly concentrated at a very small number of addresses. According to King County there are 17,263 residential and commercial buildings with Shoreline addresses. About 69 percent of these addresses had no calls for service of any kind during 2014. 208 addresses (1.2%) had 10 or more calls, accounting for 40 percent of all calls citywide. 277 addresses in

Figure 1. Mental health related calls for service by time of day and day of week, 2014-2015

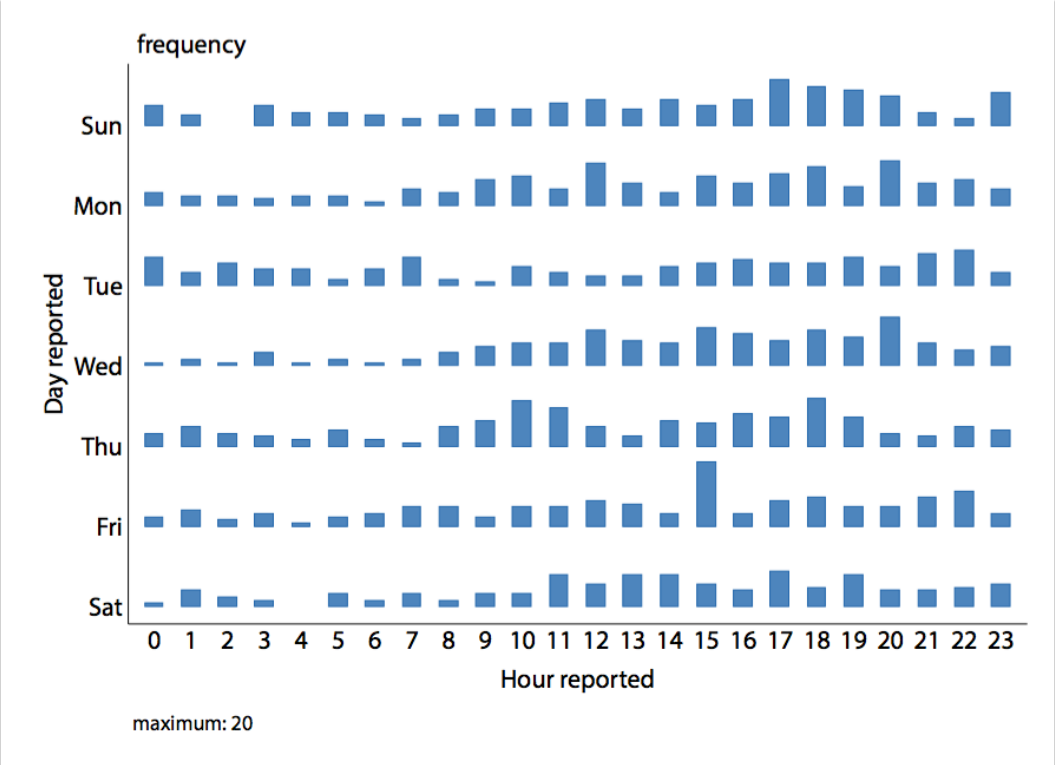
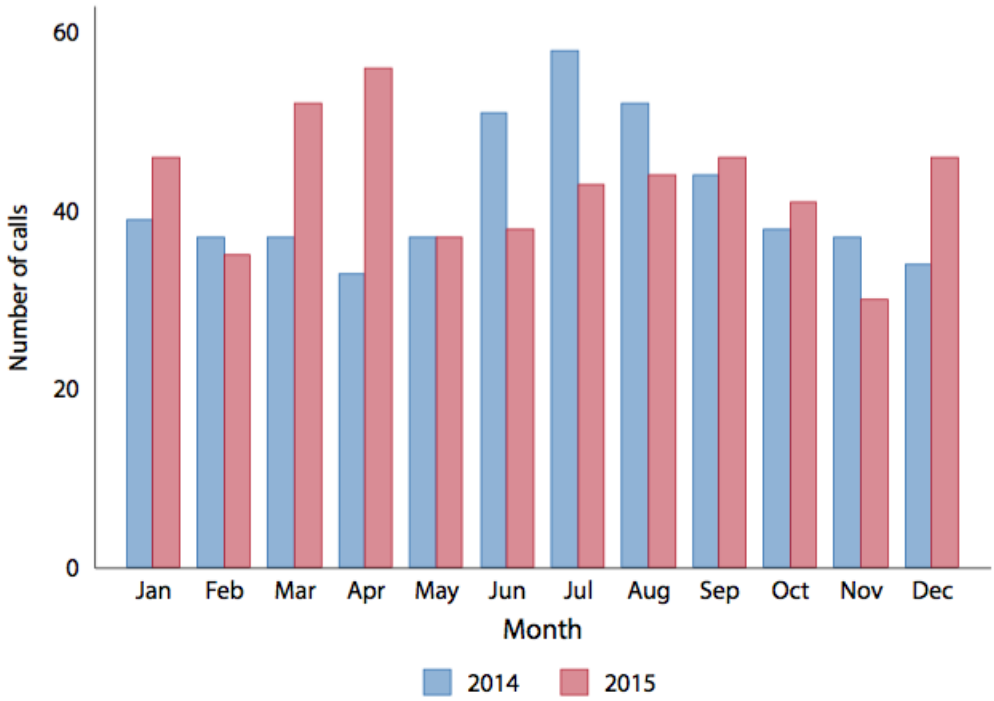


Figure 2. Mental health related calls for service by month, 2014-2015



Shoreline (1.6%) had one or more mental health related call for service in 2014. Of these, 93 were repeat call addresses that accounted for 54.5 percent of all mental health related calls for service in Shoreline in 2014. The top three addresses that year were an apartment complex with 68 mental health related calls, another apartment complex with 18 calls, and a bus station/commercial area with 9 calls. The remaining addresses in the top 10 were almost all single-family homes, except for one other apartment complex. At least one of the single-family homes in the top 10 is a group home for people with mental health issues or cognitive disabilities.[1] There was also a small but statistically significant correlation between mental health and substance use related calls for service at the address level (r = 0.27, $p < .001$), indicating that addresses that produce mental health related calls for service are also likely to have substance use related calls for service, but no correlation between mental health calls and calls for violent crime or disorderly persons (although, as we have noted, we do not know the extent to which these other call types also involve behavioral health issues).

The concentration of calls for service in 2015 was similar to our observations for 2014. Seventy-nine percent of addresses had no calls for service in 2015 and 217 (1.2%) of addresses had 10 or more calls of any kind, accounting for 42 percent of calls in the city. Slightly more addresses had a mental health related call in 2015 (310 compared to 277 in 2014), but the same number (93) had repeat calls. The top ranked address for mental health related calls in 2015 was the same apartment complex that ranked highest in 2014. There were 54 calls for this location in 2015. An address in a commercial area ranked second with 9 calls (this location was not in the 2014 top 10), and in third place was an apartment complex with 8 calls that ranked 9th in 2014. The addresses with the second and third highest number of calls in 2014 did not appear in the top 10 in 2015. Overall, 46 percent of the 93 repeat call locations from 2014 remained repeat mental health related call locations in 2015 (N=43).

We also found that mental health related calls take up significantly (25 percent) more police time than calls in general (Table 2). From the time of police arrival to calls being closed, non-mental health related calls took 60 minutes on average, while mental health related calls took 75 minutes. Cumulatively, this means that an additional 125 more officer hours per year were spent clearing mental health related calls.

Finally, it is likely that the number of mental health related calls for service recorded by KCSO underestimates the number of incidents to which police could potentially be called. Data from Shoreline Fire indicate that the fire department responded to 516 calls with a behavioral or psychological component (according to the firefighter's report) in 2015. We have not been able to assess the extent to which these overlap or which agency tends to respond first, although we know from our informal discussions with Shoreline deputies and firefighters that the two agencies collaborate fairly regularly on calls.

[1] During a visit to Shoreline in March 2016 the research partners rode with Shoreline Police and attended a mental health related call at a group home. The address of that home appears on the top 10 list in both 2014 and 2015.

Table 2. Time from Police Arrival to Call Closed, 2014-2015

	Average Time in Minutes (SD)		
	2014	2015	Combined
Mental health related calls	73.2 (93.1)	79.2 (100.7)	76.2 (97.0)
Other call types	59.9 (102.9)	61.6 (111.1)	60.8 (107.1)
Mean difference	13.3** (SE=4.7)	17.6*** (SE=5.0)	15.5*** (SE=3.5)

* $p \leq .05$ ** $p \leq .01$ *** $p < .001$

Mental health related incidents in Shoreline

According to the disposition (call resolution) information provided in the KCSO calls for service dataset, a police incident report was written for almost one-half (N=473, 46.8%) of mental health related calls for service (Table 3). Almost all of the other calls were resolved on scene or by telephone without a need for further documentation. We note that while the number of calls resolved by taking an individual home, to a family member, or to a medical facility is very small, this category only includes situations in which the police took this action without writing an incident report. It does not capture incidents where an ambulance was called and a report was written. Shoreline's local ambulance provider, AMR, provided data showing that police in Shoreline requested their services 111 times in 2015 (note that AMR does not consistently code whether the request resulted from a mental health related call).

We also analyzed a separate dataset from KCSO containing incident report data from the Total Enforcement (TE) records management system. This allowed us to examine in further detail how the final classification of the call compared to its initial classification (i.e., whether calls for service classified as mental complaints or suicide attempts are classified in the same way in written reports, or whether calls that come in under a different code are reclassified as mental health related. The TE data also provides basic demographic information (age, sex, and race) on individuals involved in mental health related incidents.

Table 4 shows the number of incident reports completed for mental health related calls for service in 2014 and 2015. Mental health related incidents comprise a slightly higher proportion of all incident reports taken, compared to the proportion of calls for service (4% of incidents compared to 3.2 percent of calls). Note that the number of incident reports is higher than the number of calls for service noted in Table 3. The information comes from two separate systems so there may be reporting inconsistencies. It is also likely that some calls for service were not initially classified as mental health related, and therefore are not captured in Table 3, but were later classified as such when the report was written (for example, someone may have called the police reporting a disturbance or suspicious circumstances after hearing screaming next door; on police arrival it is found to be a suicide attempt). We examine this further in Table 5.

Table 3. How Mental Health Calls for Service were Resolved, 2014-2015

	Number (Percent[a])
Incident report on scene[b]	473 (46.8)
Assistance rendered[c]	448 (44.3)
Referred to agency other than KCSO	29 (2.9)
No police action possible/necessary	22 (2.2)
Unable to locate incident/individual	14 (1.4)
Other[d]	10 (1.0)
Follow-up on scene (no arrest)	8 (0.8)
Taken to home/family/medical facility	7 (0.7)
Total	1,011 (100)

Notes:

[a] May not add up to 100 due to rounding.

[b] In all but one of these cases, no arrest, booking, or citation was made.

[c] Assistance was rendered on scene in 442 cases and over telephone in 6 cases.

[d] Includes warning given (N=6), field investigative report made (N=3), and canceled by radio (N=1)

Table 4. Mental Health Related Incident Reports in Shoreline, 2014-2015

	Number of Incident Reports		
	2014	2015	Combined
Total incident reports	6,598	6,014	12,612
Mental complaint reports ("371")	216	223	439
Suicide attempt reports ("232")	35	29	64
Total mental health related reports	251	252	503

Table 5 shows that only a small number of cases were reclassified between the initial call for service and incident report (in terms of being changed to/from mental health related). There were ten cases in which the initial call was not mental health related but the incident report was classified as such. The initial classifications of these cases were welfare check (N=4), area check (N=2), suspicious circumstances, forest fires, call for medical assistance, and request for assistance from another agency (N=1 each). For the seven cases in which the initial classification was mental health related and the incident report differed, the final classifications were obstructing an officer, threats, larceny, stolen property, trespass, vandalism, and welfare check (N=1 each). Note that this does not suggest that we have necessarily captured most of the mental health related calls in Shoreline through calls and incidents classified as 371 or 232. If a call came in as an assault and there was

sufficient reason to classify the incident report as an assault, there could still be a behavioral health component that would only be noted in the report narrative.

Table 5. Initial and Final Classification of Mental Health Related Calls, 2014-2015

	Final Classification (Incident Report)	
	Mental Health Related	Not Mental Health Related
Initial Classification (Call for Service)		
Mental Health Related	469	7
Not Mental Health Related	10	6,879

Note: This table is based only on cases for which there was a match by CAD (call for service) ID number between the calls for service and incident report databases (N=7,365).

A total of 961 people are recorded in the TE data as being involved in a mental health related incident in 2014 and 2015. Note that this includes witnesses and people who report incidents as well as victims, suspects etc. In the majority of cases, it appears that the person who is having the mental health issue is listed as the victim. The demographic information in Table 6 is based on individuals whose role in the incident is listed as arrested, subject, suspect, or victim (N=487). Table 6 shows that the majority (91%) of these individuals were listed as victims rather than subjects, suspects, or arrestees. Just over half of individuals involved in mental health related incidents were female (52%), and almost 90 percent were White. The average age of these individuals at the time of the incident was 37 years old. We note that King County records only capture limited information about race and ethnicity (Hispanic/non-Hispanic) is not recorded. Hispanic individuals may therefore be categorized as either White or Black.

Table 6. Role and Demographic Characteristics of Individuals Involved in Mental Health Related Incidents, 2014-2015

	Number (Percent[a])
Role	
Victim	442 (90.8)
Subject/Suspect/Arrested	45 (9.2)
Sex	
Female	253 (52.2)
Male	232 (47.8)
Race	
White	419 (87.7)
Black	42 (8.8)
Asian	16 (3.4)
Native American	1 (0.2)

Mean age = 37.3 (SD = 16.1). No significant differences by sex or race

Notes:

[a] May not add up to 100 due to rounding.

Officer Survey and Needs Assessment

In addition to our analysis of mental health related calls for service and incident reports, we conducted a baseline survey of Shoreline deputies to learn about their experiences in dealing with mental health related issues and what factors would improve their responses to these situations. The survey was conducted online via the Qualtrics platform and was sent to all current sworn employees of Shoreline Police Department (N=47) in June 2016. Email addresses of respondents were collected (separately from their survey responses) to facilitate a follow-up survey after program implementation. As of July 5, 2016, 28 responses had been collected, a response rate of 60 percent. Table 7 shows the basic characteristics of the sample (we did not collect demographic characteristics such as sex and race for confidentiality reasons; due to the small number of officers we believed this risked identifying specific individuals).

Table 7. Characteristics of officer survey respondents

	Number (Percent)
Rank	
Deputy	21 (75.0)
Sergeant	4 (14.3)
Deputy MPO	1 (3.6)
Captain	1 (3.6)
Major	1 (3.6)
Assignment	
Uniformed patrol	19 (70.4)
Special Emphasis Team	2 (7.4)
Criminal Investigations Division	3 (11.1)
Other	3 (11.1)
Length of Service in Shoreline	
Less than 1 year	2 (7.1)
1 year or more but less than 5 years	14 (50.0)
5 years or more but less than 10 years	5 (17.9)
10 years or more	7 (25.0)

Respondents reported that encountering PBHI was a very common part of their job. Most respondents (N=24, 85.7%) stated that they encountered PBHIs every day or several times a week when on duty (Figure 3). There was no clear pattern in the type of situation in which respondents encountered PBHIs (Figure 4). Most respondents stated that they sometimes or often encountered PBHIs during on-views (officer-initiated activity), as offenders, as victims, during or immediately after a crisis, or in response to a request for assistance. Nobody responded that they rarely or never encountered PBHIs in these situations.

Figure 3. When you are on duty, how frequently do you encounter PBHIs?

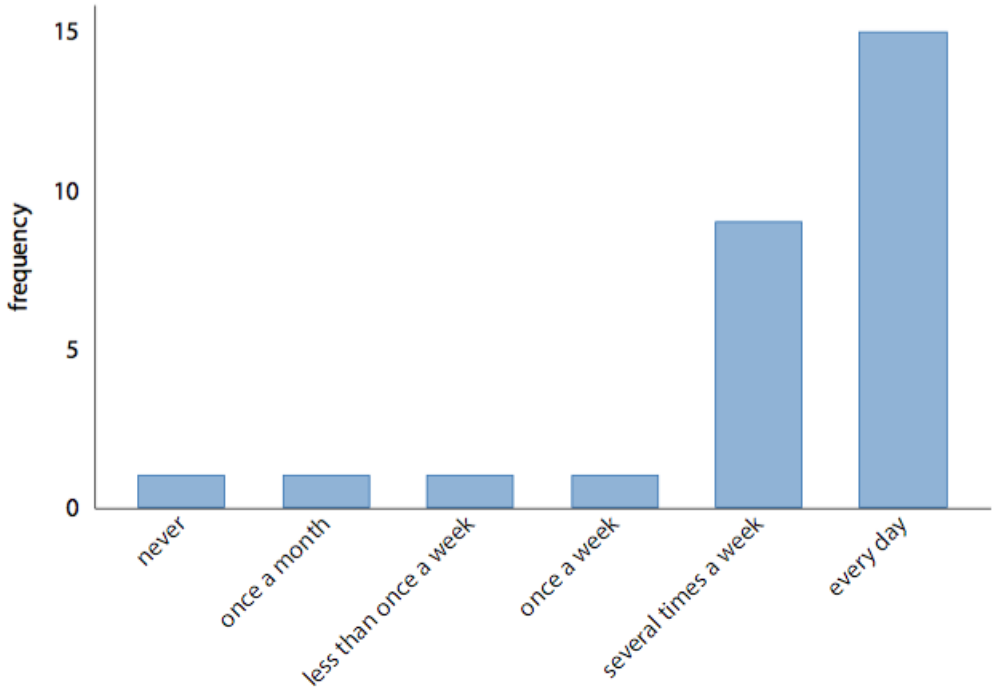
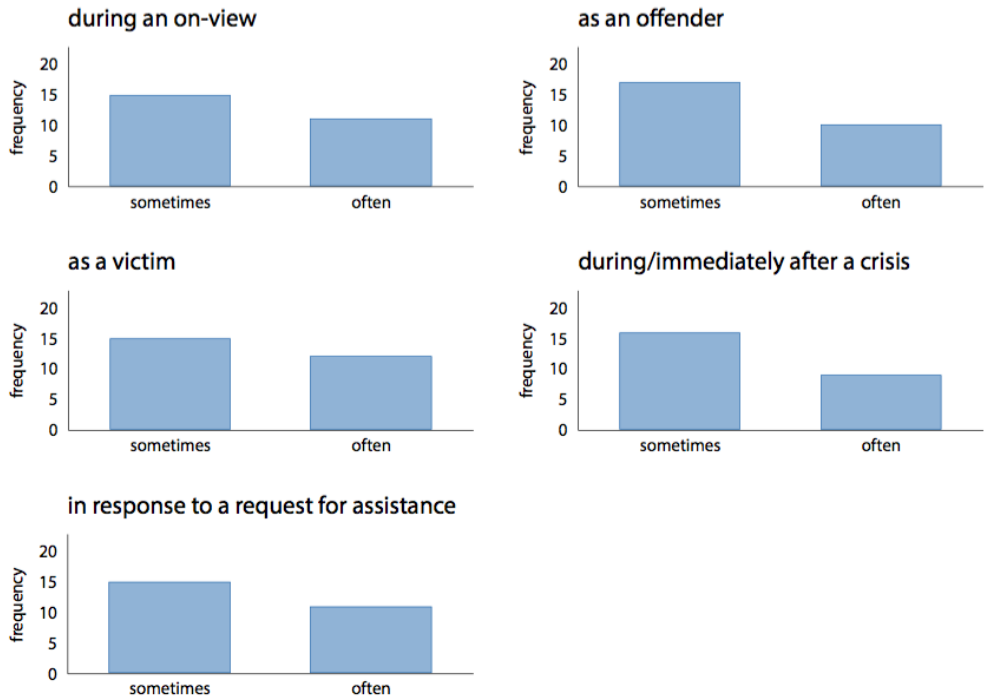


Figure 4. How often do you encounter PBHIs in the following situations?



Respondents were asked to rank the most common way they resolved calls involving PBHIs, with 1 being the most common resolution. Calling AMR (the ambulance provider) for an involuntary transfer to the hospital was most often ranked number 1 (52% of respondents, N=13), followed by no action (24%, N=6), calling AMR for a voluntary transfer or contacting the fire department/EMS (both 8%, N=2), arresting the individual, or asking the dispatcher to place a note in the CAD system (both 4%, N=1). No respondents ranked recommending referral to mental health court, transport to crisis diversion center, contacting the Mobile Crisis Unit, or documenting with an information case report as number 1. This aligns with other information provided to us by other King County agencies showing low usage of these services. For example, data from King County's involuntary commitment coordinator shows that Designated Mental Health Professionals receive only one or two requests per year for psychiatric evaluations from police in Shoreline. The Behavioral Health and Recovery Division reports only five referrals to the crisis center from Shoreline Police Department between 2012 and 2015 (and one from Shoreline Fire during the same period). Usage of the Mobile Crisis Unit is slightly higher and has generally increased over the years, but is still low compared to the total number of mental health related calls (Table 8).

Strikingly, 75 percent of respondents (N=21) stated that they were not satisfied with the current options available to them for resolving calls involving PBHIs. We included an open-ended question inviting respondents who said they were not satisfied to indicate other options they would like to have. The responses are included verbatim below. In general, responses highlighted a need for more knowledge about alternative dispositions, more integration with mental health professionals and service providers, including options to hand over to professionals when situation is no longer a law enforcement issue, and longer-term treatment options to deal with underlying issues and reduce the "revolving door" of individuals whose issues recur over and over again.

- *more, unknown what's available*
- *In-the-field resources, like crisis teams, who can come and work toward solutions with people. We are band-aids. Is the scene safe? Is the person in danger? Are others? If there's no safety concerns, the Police job is typically done*
- *Something meaningful where a person can actually be held and treated*
- *We generally have two options...arrest or ITA/Invol. Having a more direct referral (a 3rd option) to mental health court would streamline case disposition. We often have two stakeholders in a case. Consider a person with mental health issues trespassing at a casino. We have a responsibility to the suspect/subject but we also have a Shoreline business who wants the disruption to their business/customers addressed. Nothing is a bad option but so is arrest as we've just shifted the problem to the courts*
- *any updated information is useful*
- *Warning or Flagged information when mental illness person has to be contacted*
- *Mental health professionals that manage the person when they are in crisis for alcoholism or drug problems*
- *In general, my interactions with people with mental health issues are complicated by their use of drugs and/or alcohol. Under community caretaking, I evaluate them for involuntarily sending them to the hospital. If they do not meet the criteria, I will offer them to speak to the Mobile Crisis Team. Generally, they do not want help. I*

rarely deal with someone who has mental health issues only. Those interactions are generally at group homes where the staff is under-qualified to deal with the issues

- *We really only have a good solution for people in crisis, but not baseline issues that come up. The homeless and self medicating don't meet the criteria for invol* [involuntary commitment] *and there is no services that I can offer that fix or patch the problem on scene. I can tell them to check out xyz resource, but they have to go. We are usually called for the "fix it now" issue and there is no fix*
- *More information about involved subjects*
- *location other than hospital for people to go to that is close by*
- *Immediate field response and hand off to mental health professionals in situations that are not criminal in nature. LE* [law enforcement] *has core functions that do not include being significant mental health practitioners and the movement towards the same is taking limited resources away from crime reduction efforts*
- *Actual results from the mental health arena. All we usually see is a revolving door with nothing being done or changing.*

Table 8. Referrals to Mobile Crisis Team and Crisis Diversion Center, 2012-2015

	2012	2013	2014	2015	Total
Requests for Mobile Crisis Team					
Shoreline Police	3	14	46	25	88
Shoreline Fire	0	9	22	32	63
Referral to Crisis Diversion Center					
Shoreline Police	2	0	2	1	5
Shoreline Fire	0	1	0	0	1

Source: King County Behavioral Health and Recovery Division

All respondents reported that they shared information with other deputies about their experiences with PBHIs after an encounter. Sixty percent reported sharing information often and 40 percent shared their experiences sometimes. Respondents also ranked the most common method for information sharing. Almost 75 percent of respondents (N=19) stated that informal information sharing—for example, over a meal or coffee or car-to-car—was the method they used most frequently, while 23 percent (N=6) said they most frequently documented information in an IRIS case report (Shoreline's system for looking up and recording information about individuals who have had contact with the police).

Email was most commonly ranked as the second most frequently used method (by 26 percent of respondents, N=7).

We asked respondents who typically initiated calls about PBHIs and where they usually happened. Figure 5 shows who initiated the calls. Most respondents selected "often" for the PBHI him- or herself, persons with no significant relationship (such as members of the public, store clerks, etc.), and staff or management of public housing complexes. Almost all respondents stated that calls often occurred at public transit locations (such as bus stops, on buses, etc), and a majority stated that calls often happened at group homes and other (non-transit) public places (Figure 6).

Figure 5. In your experience, how often are calls involving PBHI initiated by the following people?

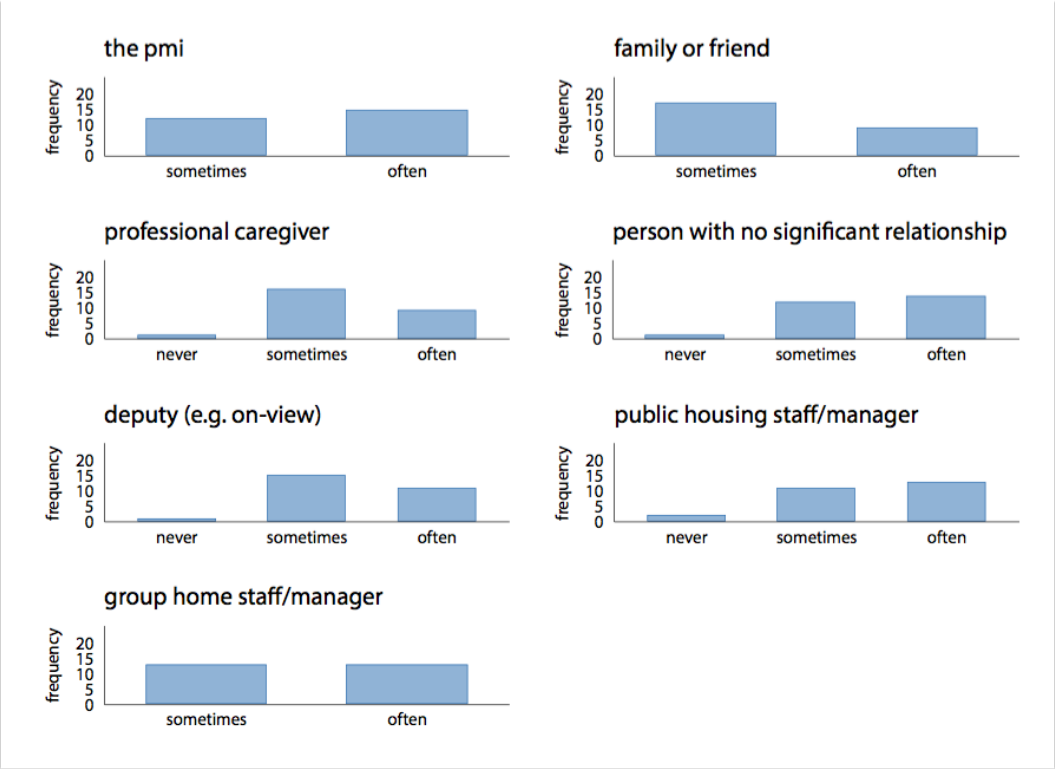
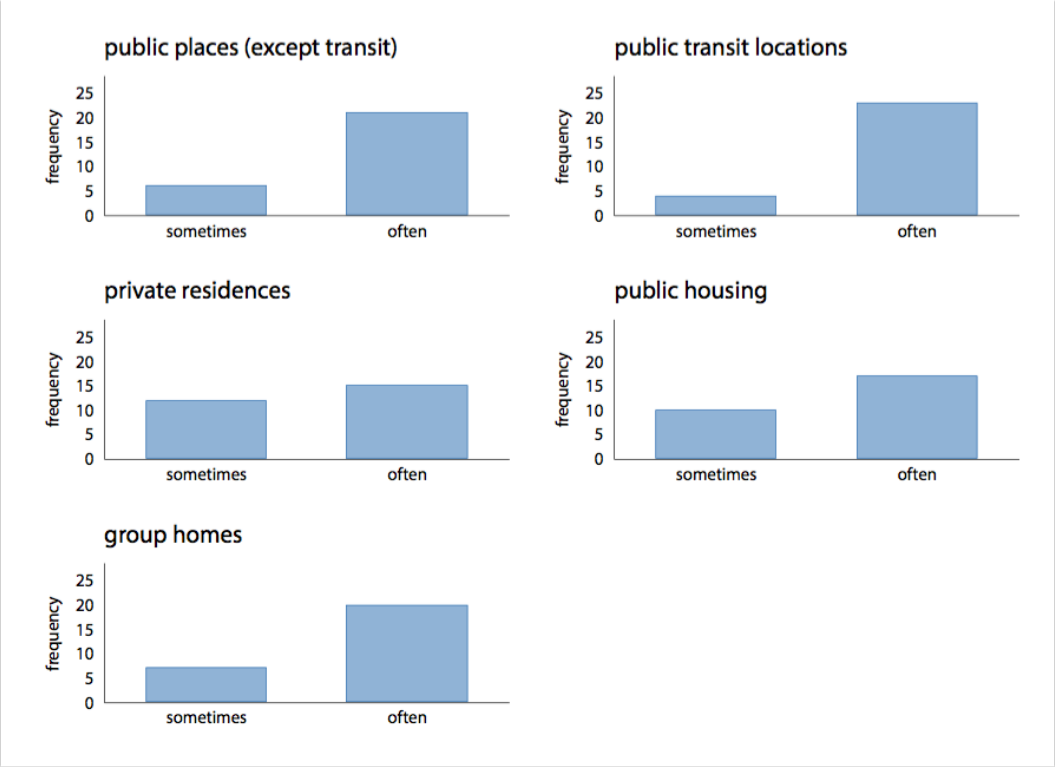


Figure 6. In your experience, how often do calls involving PBHI occur in the following places?



We also asked officers whether they had ever feared for their own or their partner's safety during encounters with PBHI, whether a PBHI had ever appeared to be afraid of them, and whether they had ever used force during an encounter with a PBHI. The responses are striking—90 percent of the respondents (N=25) answered "yes" to each question; however, only one respondent answered "no" to all three questions. Those who responded "yes" to the use of force question were also asked a follow-up question about their experience. All of the respondents to this question (N=24) agreed or strongly agreed with the following statements about their use of force experience:

- The de-escalation technique that I used was effective (16.7% strongly agreed, 83.3% agreed)
- I would have been more effective if I had specific information about the individual's mental health issues/cognitive disabilities before responding to the call (29.2% strongly agreed, 70.8% agreed)
- I would have been more effective if I had more general knowledge about mental health issues/cognitive disabilities (8.3% strongly agreed, 91.7% agreed)
- The situation escalated because of the individual's fear or confusion about police (12.5% strongly agreed, 87.5% agreed)

Respondents were asked how often they learned about particular types of information relating to PBHIs before the call and what information they found most useful when

responding. Figure 7 shows how often respondents received various kinds of information. Most respondents selected "often" for many of the items; however, a larger number of respondents selected "never" for information about the medications a PBHI is taking and factors that can help to calm the individual down or that might excite him or her than for other types of information. Officers found all sources of information somewhat or very useful when responding to calls involving PBHIs, but most rated their own previous experience with the specific PBHI as very useful, followed by direct information about the individual provided by other deputies or Shoreline Fire/EMS (Figure 8). They were less likely to rate indirect information, such as case reports, information from the dispatcher, and summaries of the individual's prior law enforcement contacts as "very useful." However, three-quarters of respondents stated that they did not feel they received enough information about an individual's mental state or cognitive disabilities before responding to a call (N=21).

Figure 7. How often do you learn about the following types of information prior to contact with a PBHI?

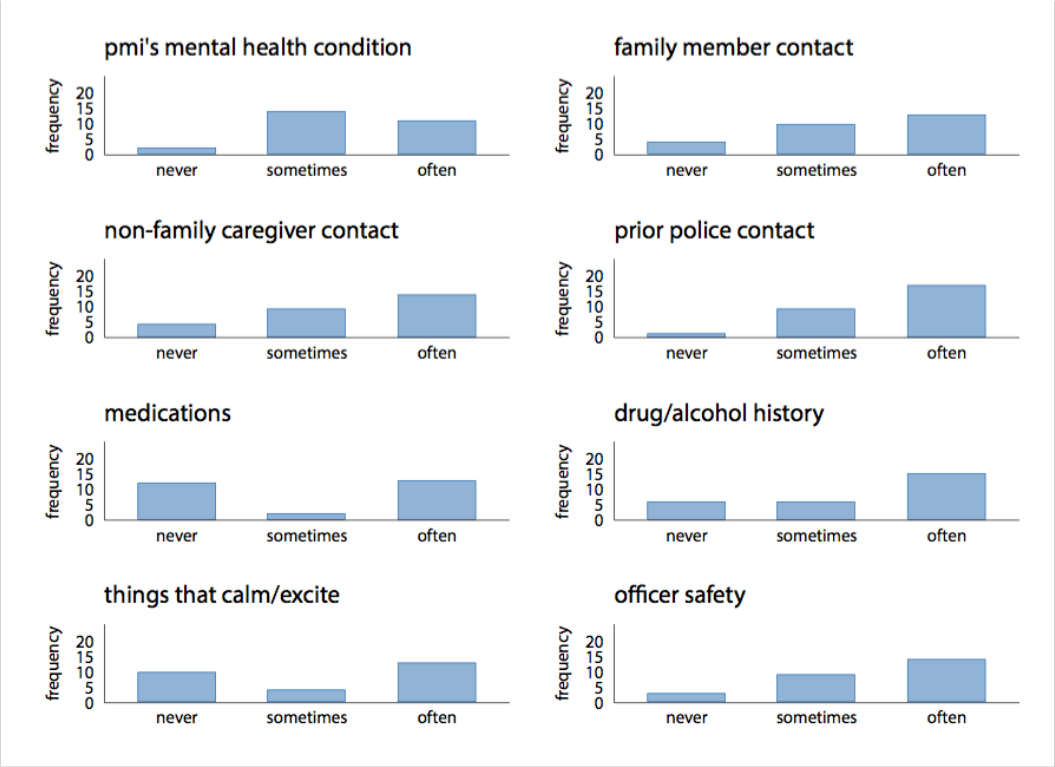
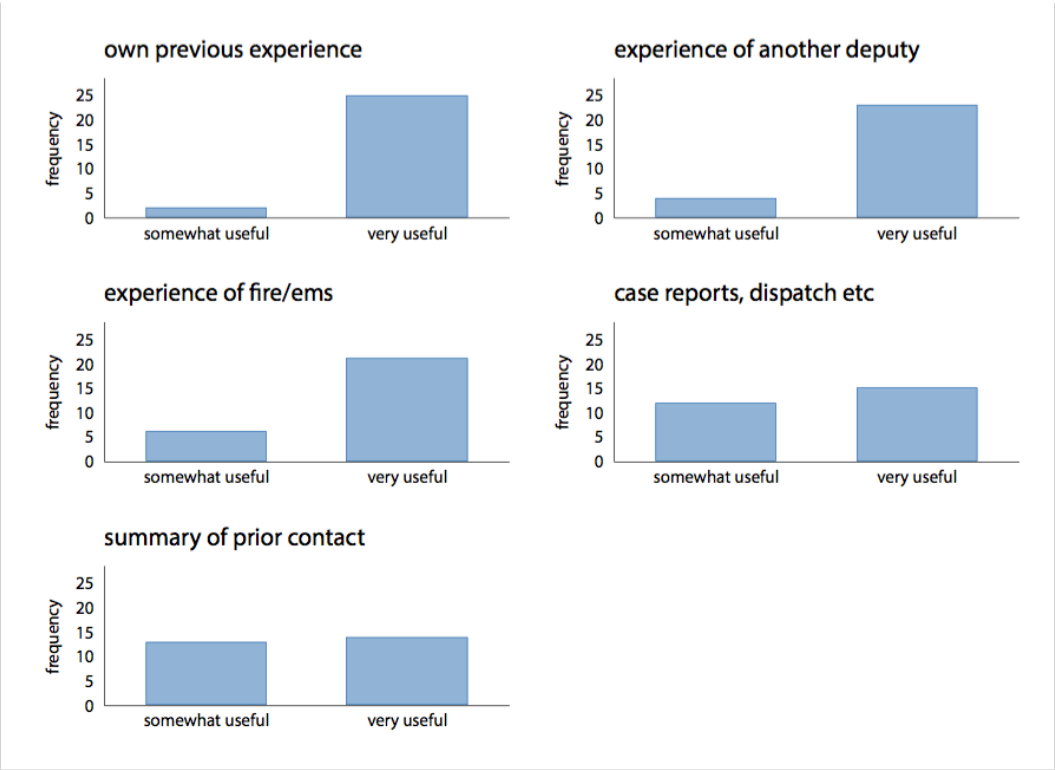


Figure 8. How useful are the following types of information to you when responding to calls involving a PBHI?



King County's Behavioral Health and Recovery Division reports that 20 Shoreline officers received Crisis Intervention Team (CIT) training between October 2010 and December 2015. This aligns with the 20 survey respondents (71%) who stated that they have received the training, although we are unable to verify whether they are the same officers. In our survey, 55 percent of those who said they received the training reported taking the short (8-hour) version and 45 percent had taken the full (40-hour) course. We included an open-ended question asking those who had taken the training what they would add to make it more useful. In summary, those who responded to the question highlighted the need for refresher training, more case studies and specific tactics rather than theory, and more information about the range of options available to them. The responses are included verbatim below:

- *Refresher courses*
- *Training in resources/referrals. We usually only have Band-Aid solutions to the problem of the day/hour... Either invol, arrest, walk away, or see if crisis team will respond. The solutions to the problem at-hand (for police officers with all kinds of things to do during a shift) are rarely solved with a Band-Aid for more than a day, if that. We need to know more about mental health court options, in-the-field resources, and referrals that will be of use*
- *More specific, relevant case studies and less 'theory'*
- *Police relevant training on resources, most of the course seemed geared towards mental health professionals*

- *Nothing. The basic skills are covered. The varied responses of people with mental health issues who are often under the influence of drugs and/or alcohol is too broad to cover every scenario*
- *I found that they spent too much talking about the issues and disabilities and not enough time with effectively dealing with them. The subjects that are about the individuals recovery, while heart warming, don't give the responder information about how to safely and successfully resolve the situation when recovery is not working. The Mock Scenes just ended with "I will call the mobile crisis team" and there was not enough application practice*
- *Nothing. Have it taught by cops. Not by academics that work in a sterile safe environment. Police just need to be reminded that this is a call like any other, a person in crisis, that words and patience works. List of current resources is all that is needed.*

The 20 respondents who had attended CIT training were also asked whether the training helped officers to be more effective in the following scenarios; almost all respondents agreed with each statement:

- CIT trained officers are better able to identify PBHIs (10% strongly agreed, 90% agreed)
- CIT trained officers are more likely to refer PBHIs to services/treatment (5% strongly agreed, 95% agreed)
- CIT trained officers are more effective in de-escalating events involving PBHIs (5% strongly agreed, 85% agreed, 10% did not know)
- CIT trained officers are less likely to arrest PBHIs for minor offenses (15% strongly agreed, 70% agreed, 15% did not know).

We asked several questions to assess officers' attitudes and perceptions about situations involving PBHIs. All respondents agreed or strongly agreed that treatment can help PBHIs lead normal lives, that family members of PBHIs lack sufficient information about to help their loved ones or themselves, and that first responders have a duty to help PBHIs and their loved ones access information and resources (Figure 9). On the recommendation of our medical advisor we also selected three questions from the Toronto Empathy Questionnaire (Spreng et al., 2009), a validated psychometric scale, that we believed were relevant to people working in law enforcement (Figure 10). These results showed more variable responses than other questions in our survey. Most respondents indicated that they sometimes or often did not feel sympathy for people who caused their own serious illnesses. However, most respondents also indicated that they sometimes or often felt a strong urge to help when they see someone who is upset and sometimes, often, or always feel protective of individuals who are being taken advantage of.

Finally, we asked respondents whether they had been told about the RADAR initiative. Just over half (57%) said that they had been told in detail.

Figure 9. Respondents' agreement with statements about PBHIs and first responders

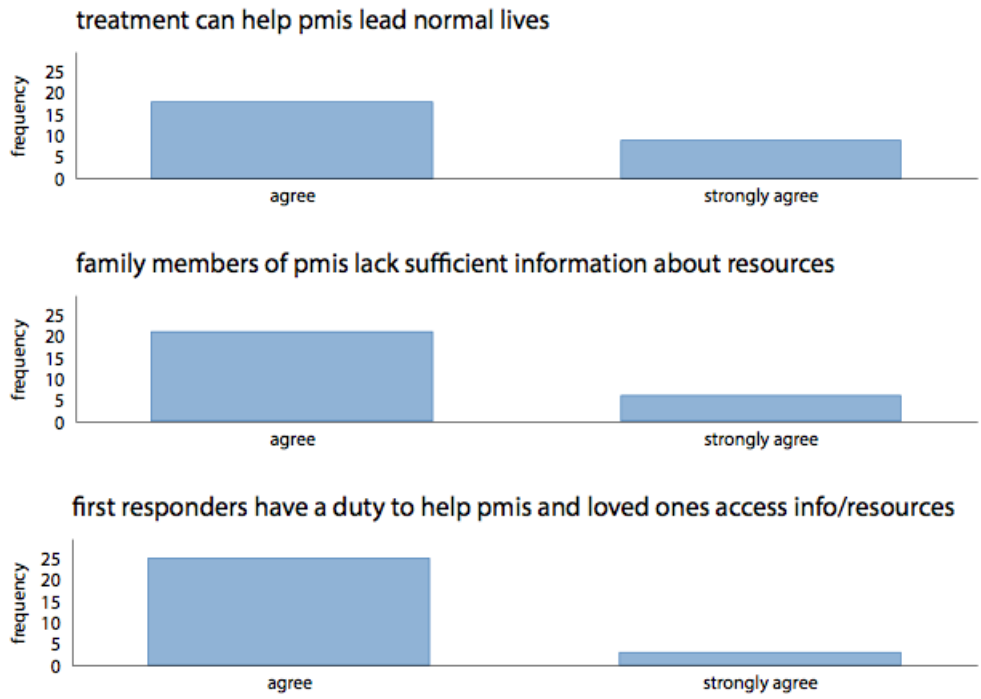
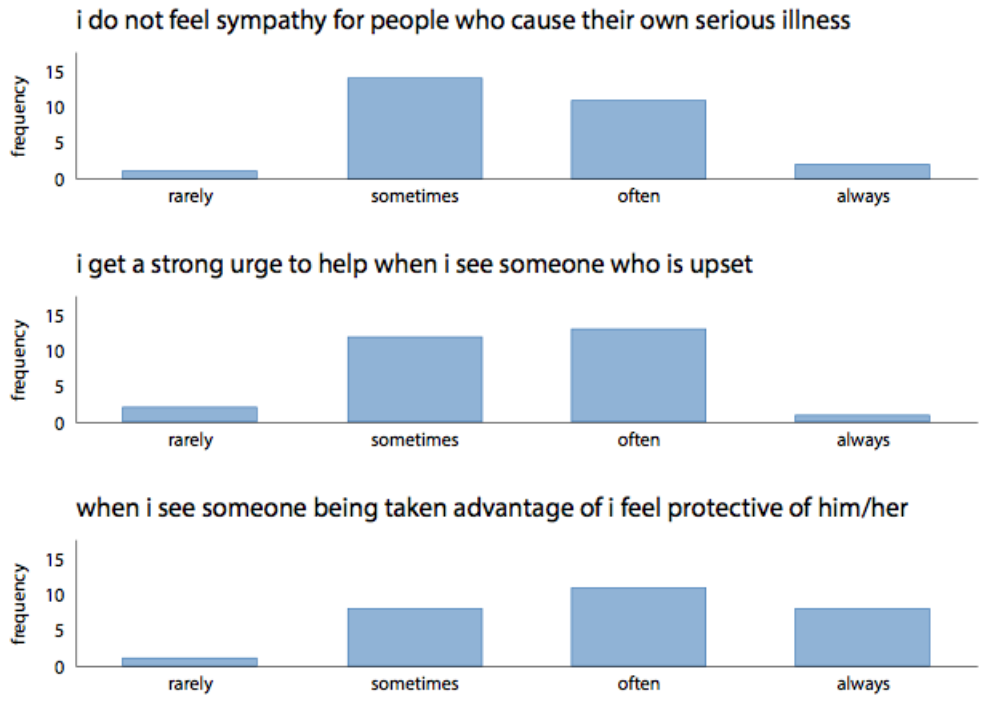


Figure 10. How frequently respondents feel or act in the manner described



Discussion of Findings

Our findings from our analysis of mental health related calls for service and incidents and from the officer survey and needs assessment highlight several key problems that we aim to address through RADAR.

First, while we have not yet been able to analyze data on the prevalence of police use of physical force in Shoreline,[2] our survey reveals that a majority of deputies have used force in cases involving PBHI and that there is a very high level of fear and confusion on both sides. This aligns with the research discussed in our literature review below, which shows that the likelihood of police use of force increases when officers encounter PBHI, and that the probability of a fatal police shooting is much higher in these encounters than with members of the general population. A report compiled by the King County Office of Risk Management (Appendix A) indicates that at least nine liability claims have been filed against the county between 2006 and 2016 involving use of force in this context (specifically, nine closed claims, including two relating to citizens who died, and an undisclosed number of open claims, including more than one death). As the reports included in Appendix A show, police encounters with PBHI are unpredictable, difficult, and at times extremely dangerous for affected individuals, their families, and the officers involved.

A second problem related to mental health-related calls in Shoreline concerns high consumption of police and other emergency services (911 dispatch, fire, ambulance, emergency departments). Our analysis of mental health related calls and interviews with deputies indicate that there is a cohort of the Shoreline population that uses the 911 system for non-emergency issues related to their mental health conditions. In addition to the high concentration of calls we found at specific addresses, our preliminary qualitative analysis of the incident report narratives for mental health related calls shows that 18% of reports in 2014 and 13% in 2015 arose from just 4 or 5 group homes in Shoreline, which house individuals with a range of behavioral health concerns of varying severity.[3] In 2014, a

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[2] Use of force is a continuum that can range from verbal commands to use of a deadly weapon. For the purposes of this study, we consider "use of force" to include any action that meets King County Sheriff's Office's definitions as laid out in Section 6.00.010 of the General Orders Manual (http://www.kingcounty.gov/~/media/depts/sheriff/documents/goms-current/public-gom-06-16-16.ashx?la=en). According to this policy, "physical force" is "the intentional application of force through the use of physical contact that does not rise to the level of deadly force," including hitting with or without an object, kicking, use of a chemical agent, or other action that results in injury or complaint of injury. Routine handcuffing and control holds are not included unless one of the other conditions applies. "Deadly force" is "the intentional application of force through the use of firearms or any other means reasonably likely to cause death or serious physical injury." We use the term "use of physical force" in this study to clarify our definition; this term should be taken to include deadly force. KCSO is in the process of extracting data that will allow us to analyze use of force incidents but they were not able to provide it in time for the completion of the action plan.

[3] Group homes in Shoreline are not heavily regulated and we do not currently have access to information about the locations of all of the homes or how many residents live in each one. The research team visited a group home during a ride-along and observed that it was a single-family

single caller accounted for 20 of the 216 incident reports, and there were sometimes multiple reports at that person's address on the same day. In one of the reports, the deputy notes that this caller frequently used 911 to self-refer to a mental health facility for their 'preferred treatment,' and that AMR, Shoreline Police, Shoreline Fire, and the King County Mobile Crisis Team had met to determine a course of action to reduce abuse of the 911 system. Patrol officers we spoke to report spending a disproportionate amount of time responding and re-responding to the same group of troubled individuals without the capacity to address their underlying conditions. These assertions are supported by the survey responses and our finding that mental health related calls consume significantly more police time than non-mental health related calls. Our survey and conversations with officers indicate that officers are frequently sending PBHIs to the emergency department for psychiatric evaluation, but PBHIs are often released a few hours later because they do not meet the criteria for involuntary commitment. The use of police officers, dispatch centers, ambulances, fire personnel and emergency rooms to treat chronic and non-life threatening behavioral health issues is expensive, frustrating, and inefficient.

The third problem related to mental health related calls, associated with the point above, is the inefficiency of the current police response and its effect on officer morale. Our initial conversations with deputies in Shoreline and our officer survey reveal significant frustration among officers around dealing with PBHI, particularly with being stuck in what one deputy calls the "stupid circle." The "stupid circle" refers to PBHIs having repeated contact with police because they are not getting the help they need elsewhere in the system. Officers feel they have limited access to mental or behavioral health services or providers to refer individuals for assistance. Their default response to calls involving mental health issues is arrest or transfer to a local hospital emergency department to begin the process of involuntary commitment. We know from preliminary data that most of these transfers do *not* result in a commitment decision, prompting individuals to be returned to the community and the "stupid circle" to continue. Even when patrol deputies take action that leads to involuntary commitment, they feel disconnected from the process and subsequent actions of the hospital and affiliated mental health professionals. In addition to the frustrations of having limited options to deal with PBHI, some deputies indicated that the lack of information and follow-up made their work and actions seem meaningless. However, data from our survey and from King County behavioral health services reveal that deputies rarely make use of the services that are available, suggesting that raising awareness among deputies about existing options should also be a key part of our response.

Problem Identification

The Center for Evidence-Based Crime Policy (CEBCP), Department of Criminology, Law and Society, George Mason University and the Washington, DC-based Police Foundation (PF) worked in collaboration with the Shoreline Police Department, King County Sheriff's Office, Shoreline Fire Department, and other local agencies to collect and assess data on

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home on a residential street that appeared to have 3 or 4 bedrooms and one resident per room, with a shared living and dining area. We intend to find out more information about these locations as we continue with our project and data analysis.

calls for service and incidents involving PBHIs. The analysis above uses KCSO data on police calls for service and incident reports in Shoreline for 2014 and 2015, and we plan to work with KCSO to obtain data for additional years to strengthen our analysis, and to broaden our coverage of mental health related issues. In particular, the officer survey revealed that officers believe incidents frequently happen in transit locations. KCSO has a separate transit police division and we plan to obtain additional data from this division to assess whether any cases in Shoreline were not included in the initial information about Shoreline. KCSO will also provide data for the comparison jurisdiction(s) in the county (see Impact Evaluation Plan). KCSO maintains a database of use of force incidents in Shoreline, which is being obtained, and we are exploring options for receiving more detailed Fire Department and paramedic data. We have also obtained data from the King County Office of Risk Management on claims involving police use of force with PBHIs and information about involuntary mental health referrals and detentions from the county Designated Mental Health Professionals team (DMHP), which oversees involuntary commitments and court referrals, and about police CIT training and utilization of mental health resources from the King County Behavioral Health and Recovery Division.

We have supplemented the analysis of calls for service and incident reports and the officer survey with qualitative information gathered from conversations, observations, and ride-alongs conducted by the research partners and implementation team. We plan to extend the officer survey to officers in the comparison jurisdiction(s) in the coming months before the intervention phase begins. Finally, we are planning a community survey in the next few months, and the City of Shoreline has added a question to its regular citizen surveys asking residents about their current perceptions of police interactions with PBHIs in Shoreline.

Changes to the Problem

The original proposal and problem statement emphasized the risk of harm to PBHIs and officers during police encounters. RADAR, as originally conceived, was predominantly a safety and risk reduction program. As the project has developed and we have talked to first responders, community members, and mental health professionals in the Shoreline area, we realized that safety issues are important but they are only part of the local problem. The high utilization by some PBHIs of 911/police/fire services and the limited number of effective interventions available to police for behavioral health issues, as described above, are equally important. The decision to change the project's name from "risk awareness" to "response awareness" reflects this broader sense of what problems, in the behavioral health context, require addressing.

The original proposal called for a new data sharing system to record and share information about PBHIs with Shoreline deputies and other first responders. We realized in our first few months of planning that this approach would create a new set of problems: resentment by PBHIs and their caregivers about being profiled in a database; resistance of officers to a new records system; infrastructural barriers to communication between police and fire personnel; and expense (it would be difficult to replicate our program if it requires thousands of dollars to create a new information system). Our new strategy is to use a "low tech" approach to share information, namely PDF "response plans" that connect to existing

records systems. Linking PDF response plans to existing systems reduces the risk of profiling and stigmatization (we are creating carefully defined documents to help vulnerable individuals in crisis situations), is extremely low cost, and gives us the flexibility to attach documents to different systems (police, fire, dispatch). A mockup of the proposed format for the PDF response plan is included as Appendix B.

The Problem-Solving Approach

Problem-Solving Strategies

Through this Smart Policing Initiative we seek to develop and implement an innovative model called RADAR (**R**esponse **A**wareness, **D**e-escalation **A**nd **R**eferral). The goals of RADAR are to enhance community and first responder safety, reduce use of physical force, build police/community partnerships, reduce the use of emergency services for non-emergency behavioral health issues, and connect people, when appropriate, to services and treatment. It encourages police to adopt community caretaking and procedural justice strategies in contacts with people who suffer from behavioral health issues such as mental illness, cognitive and developmental disabilities, or co-occurring drug and alcohol abuse. The three elements of RADAR are **response awareness**—planning with these individuals and their families before police-involved crisis situations occur; **de-escalation** to reduce the necessity of force during crisis situations; and **referrals** made before and after police encounters that connect people with appropriate services. Our measures of success include reduced use of force, a decrease in police calls from "high utilizers" (that is, people who frequently call 911 to request police services), a reduced reliance on emergency room transfers to address non-emergent behavioral health issues, referrals to services, and officer/community satisfaction.

Response awareness

Objectives: *prepare both individuals with behavioral health issues and police officers for police encounters; equip them with tools to achieve positive outcomes.*

In the RADAR program, Shoreline deputies work with individuals and their "circles of support" (COS)—family members, friends, service providers, and other caretakers—to create de-escalation and response plans. Response plans may include strategies for calming individuals, identification of "triggers" that heighten stress and fear, and the names of people who should be contacted in emergent situations. In order to avoid preventable use of force incidents, this subject-specific information will be shared between RADAR deputies, other officers, and fire department personnel. Key information about individualized de-escalation plans and a person's COS is of little use if the knowledge is limited to a single deputy who is unavailable at the time of a crisis. The subject-specific response plan places crucial and immediately accessible information both on the dispatcher's screen and in the patrol car. Working with dispatchers, the officers will have the ability to immediately access pertinent de-escalation strategies and officer safety information on the way to a crisis call.

Through initial discussions between the project team, research partners, and Shoreline deputies we have developed an initial format for the categories that will be included in the PDF response plan. In order of the priorities highlighted by deputies, these are:

1. **Identifying data and photo**

   Basic information about the individual, including name, date of birth, address etc.

2. **Response plan**

   Essential information necessary for officer safety, e.g. has the person been assaultive toward police in the past; are there weapons in the house; is a multiple deputy response necessary.

   Key behavioral triggers and inhibitors (words and actions)

   Inappropriate behaviors (e.g. false allegations of police use of force or sexual assault)

3. **Previous clearances**

   Single sentence, color coded descriptions of clearances from previous calls. Deputies felt this was extremely important to help them understand what they might be going into when they are en route to a call. In that environment, they noted that "the more you see on your computer screen, the less you read," so color coding of past clearances (e.g. green for non-crimes, red for violence) would be "huge."

4. **Immediate contacts**

   Full contact information for people to call to assist or de-escalate a crisis, including COS members, service providers, case management etc. These should be individuals who get along well or have a trusting relationship with the PBHI. When possible, this category will also include someone who will follow up with support and services. Rather than simply driving away, deputies would like access to a contact they can call and relay information to, whether this be a loved one, a health care professional, and/or the Shoreline Fire Department's Community Medicine Team (CMT).

The RADAR information-sharing strategy is still in the developmental stage. We know, at this point, that response plans will be written in PDF files that link to the Shoreline Police Department's records management system. After a response plan has been created, the 911/emergency dispatch center will add a "response plan" flag to the individual's record. This flag will appear when a 911 call comes in involving the individual's name or address, enabling the dispatcher to inform the responding officer that a response plan exists in the system. We are also working with Shoreline Fire to explore strategies for integrating this information into the dispatch and records management systems used by firefighters and paramedics.

The RADAR program encourages outreach and education during constructive periods of calm, rather than the usual situation in which officers may meet a person for the first time during an emergent and dangerous situation. Shoreline deputies will work with individuals, their COS, treatment providers, and other first responders to establish cooperative and trusting relationships, where possible, before crisis events occur. From this foundation of trust and understanding, response plans can be developed that will maximize the

opportunity for successful, non-violent interactions, and facilitate access to appropriate services.

De-escalation

Objectives: *reduce the use of force during police encounters with people with behavioral health issues and promote the physical safety of both individuals with behavioral health issues and police officers.*

A fundamental aspect of RADAR, as noted, is the sharing of de-escalation information among officers and other first responders while dealing with a crisis incident. A complementary part of the program is department-wide training that incorporates existing CIT principles (particularly de-escalation, trust building and communication strategies) and trauma-informed approaches with training in RADAR techniques.

All Shoreline deputies will receive at least 8 hours of CIT training and 4 hours of RADAR training. A core group of 3-4 "RADAR-designated" officers, which will include at least one patrol deputy, one patrol sergeant, and one patrol captain, will receive at least an additional 4 hours of RADAR training to give them the tools to identify a range of mental illnesses and cognitive disabilities, design response plans, and work with community partners. These RADAR-designated deputies will subsequently form an advisory group to provide the project team with officer insight into project and policy development. We also anticipate members of Shoreline Fire Department's Community Medicine Team participating in both basic and advanced RADAR training.

Training protocols and content will be developed later in the Planning Phase. However, as noted, we anticipate that training will build on existing CIT and trauma-informed approaches and will also incorporate the following topics:

- RADAR policy, procedures, and reporting requirements
- How to utilize the RADAR PDF response plan
- Principles for building trust and reducing fear among PBHIs and their COS
- Principles of de-escalation, behavioral triggers and inhibitors
- Weapons and weapon retention
- Addressing HIPAA and other legal/privacy concerns
- Awareness of existing services, including mental health court and Community Medicine Team
- Training blocks from Mental Health Navigators (see "Referral" section below), NAMI, ACLU
- Opportunity for questions and discussion

Referral

Objectives: *direct people with behavioral health issues, as appropriate, to services and treatment—to both reduce the occurrence of crisis situations and promote individuals' wellbeing.*

As noted, Shoreline deputies encounter people with untreated mental health and co-occurring substance use disorders on a regular basis. Specially designated RADAR officers, working in conjunction with a mental health professional ("Navigator"—see below) will have the knowledge and tools to make effective health care referrals and facilitate (re)entry into treatment. Our primary referral partner will be Sound Mental Health (SMH). We will hire mental health "Navigators" through this organization via a $100,000 grant approved specifically for this purpose by King County Council on July 13, 2016 in support of RADAR efforts. The job description for the Navigator position will be determined in a subsequent meeting with SMH, in collaboration with Shoreline Fire. We anticipate that the Navigators will help to develop our training program and support deputies and firefighters with response planning, referral support and other assistance. We will also work closely with Shoreline Fire Department's Community Medicine Team (CMT) to facilitate access to resources and treatment. Finally, deputies will work closely with the Shoreline prosecutor to make referrals to the King County Regional Mental Health Court, which provides a wide range of services to participants with behavioral health issues, and collaborate with the other organizations and service providers listed under Collaboration and Outreach below.

An important ancillary benefit of RADAR is the ability to better serve individuals and families with children who are developmentally disabled or who suffer from autism or other behavioral health conditions, but present no risk to police or others. Parents and caregivers will have the option to work voluntarily with deputies to create response plans to reduce the probability of misunderstandings during police calls. Relationship building in these circumstances would focus on *continuing* a positive and supportive relationship between police, families, and COS. A response plan in these circumstances would primarily focus on ensuring that deputies do not accidentally mistake the symptoms of a mental or behavioral health condition for an aggressive act.

Project Timeline

Task	Key Personnel	Status
Planning Phase (January-December 2016)		
Collection and baseline analysis of data	Research partners, project coordinator, Shoreline PD/KCSO	Ongoing
Complete action plan	Research partners, project	Ongoing

	coordinator, Shoreline PD/KCSO	
Baseline surveys of officers and community	Research partners	Ongoing
Focus groups, interviews, ride-alongs	Research partners, project coordinator	Ongoing
Identification of and data collection in comparison area(s)	Research partners	In development
Develop information sharing process	Project coordinator, Shoreline PD	Ongoing
Develop training program	Project coordinator, Shoreline PD	In development
Training and certification of officers	Shoreline PD	Pending
Identify eligible individuals	Project coordinator, Shoreline PD, research partners	Pending
Intervention Phase (January-December 2017)		
Outreach to eligible individuals and COS	Project coordinator, Shoreline PD	Pending
Develop subject-specific response plans	Shoreline PD	Pending
Establish relationships with service providers, other first responders	Project coordinator, Shoreline PD	Ongoing
Establish community outreach and social media strategies	Project coordinator, Shoreline PD	Pending
Continue to develop and implement information sharing solutions	Project coordinator, Shoreline PD/KCSO	Pending
Collection of process data	Research partners, project coordinator, Shoreline PD/KCSO	Pending
Assessment of knowledge and attitudes about the	Research partners	Pending

program		
Analysis and Assessment Phase (January-December 2018)		
Collect remaining process and outcome data	Research partners, project coordinator, Shoreline PD/KCSO	Pending
Conduct propensity score matching	Research partners	Pending
Outcome analysis of calls for service, use of force, treatment referrals, impact on police response	Research partners	Pending
Follow-up surveys of officers and community	Research partners	Pending
Focus groups, interviews, ride-alongs	Research partners, project coordinator, Shoreline PD/KCSO	Pending
Outcome analysis of individual/COS, community, and officer perceptions of program and impact	Research partners	Pending
Development of program and training manuals	Research partners, project coordinator, Shoreline PD/KCSO	Pending
Develop final report and publications	Research partners, project coordinator, Shoreline PD/KCSO	Pending
Presentations of findings	Research partners, project coordinator, Shoreline PD/KCSO	Pending

Research Basis

Persons with mental illness (PBHIs) or other behavioral health challenges who are in crisis encounter police officers in a variety of ways. Friends or family members may reach out to police and call 911 out of a need for assistance or concern for their loved one's safety. Community members unrelated to the PBHI may alert police to unusual or what they may

deem suspicious behavior. These calls in particular are most likely routed to police rather than other emergency services. Police-citizen contacts involving PBHIs (specifically, individuals with mental illness) have been estimated to comprise 7 percent of all such contacts in large U.S. cities (Deane et al., 1999), although this is likely an underestimate given a lack of systematic data collection in many agencies. The shift in contemporary policing toward proactive community-based approaches rather than reactive strategies such as focusing on arresting offenders has normalized encounters with PBHIs who may not have committed a crime (Godfredson et al., 2011), but there remains a lack of training and information sharing about risk and de-escalation strategies as well as a lack of research on police-PBHI encounters and evidence-based practices for responding effectively to PBHIs (Crocker et al., 2015). Enhancing knowledge and improving police practice in this area is especially vital as a number of U.S. police departments (including nearby Seattle, WA and Portland, OR) are facing close scrutiny by the Department of Justice over their use of force policies.

The President's Task Force on 21st Century Policing recommends that "[l]aw enforcement agencies should engage in multidisciplinary, community team approaches for planning, implementing, and responding to crisis situations with complex causal factors" (2015, p. 44). Calls for police service involving PBHIs are by their nature complex due to the range of factors, including mental health issues, substance use, and cognitive/intellectual deficits, which can trigger them and the variety of different ways that individuals respond to stressors under these conditions. However, knowledge about best practices to deal with specific individuals in the community is often 'siloed' within an individual agency, such as the police or fire department (Wartell, 2014). Even within an agency, some officers hold more knowledge about community members than others due to experience or assignment (for example, community policing officers usually have more time than patrol officers to develop relationships and share information with residents), but are not always available to respond. This issue is particularly pertinent in contract agencies such as Shoreline, where deputies who usually work elsewhere in King County and have little knowledge of the local community may be temporarily assigned.

The lack of easily accessible subject-specific information increases the likelihood that de-escalation attempts will be ineffective, thus increasing the risk that physical force could be used if officers are forced to fall back on traditional law enforcement responses in the "heat of the moment." An officer with limited information may view the PBHI's behavior as disorderly or aggressive, therefore reacting to them as if they were a "dangerous felon" (Ruiz & Miller, 2004). This type of misinterpretation can lead to an escalation of violence in various ways (Teplin, 2000). The nature of the officer's response is crucial to the outcome of these situations, as many PBHIs are concerned about over-reactive police responses that could further aggravate a crisis, such as feeling threatened by a lethal weapon (Boscarato et al., 2014; Watson et al., 2008b). In extreme cases, these situations may be fatal. For example, in February 2013 Seattle police shot dead a 21-year-old mentally ill man whose aggressive behaviors—and effective methods to de-escalate them—were well-known to some local officers but not those called to the scene.

On the other hand, officers do frequently share information informally. The research partners witnessed this on an initial site visit in Shoreline when, en route to a call involving a man with a developmental disability who was acting violently at a group home, one deputy who had responded to the man several times in the past day radioed the other responding officer to inform him that although the man was large in stature, appeared threatening, and could be very aggressive, he did not mean any harm. The deputy shared that the man liked police officers and particularly enjoyed collecting police badge stickers. Before entering the house, the other officer brought additional stickers from his car and approached the situation gently. After the situation was de-escalated, the second officer shared with the researchers that he did not know the man involved and without the information from the first deputy he would have approached the situation very differently given the man's stature and the extent of the damage he had done to the house (he had punched a wall down to the studs). This anecdote supports the finding from the officer survey indicating that deputies most often share information about PBHIs through informal channels, and illustrates the need to formalize the sharing of effective and actionable information so that if the first deputy had no longer been on duty, the experience and knowledge he had obtained would still be available to other officers responding to that address.

In addition to the examples above, research supports the concept of information sharing and developing subject-specific response plans in collaboration with individuals and their supporters (e.g. Butler, 2014; Herrington, 2012; Livingston et al., 2014; Logan, 2010). Such an approach could improve the police response and ability to assist PBHIs, and promote safety for everyone involved in a crisis situation. PBHIs are often trapped in a vicious cycle in which they fear that they may be stereotyped by police as violent, incapable of comprehending the situation, and unable to make decisions regarding themselves due to stigma surrounding their diagnosis (Butler, 2014). As a result, they may be less cooperative with the police (Watson & Angell, 2013), leading to a negative experience that reinforces their fear the next time they encounter law enforcement. Furthermore, due to their life circumstances PBHIs often live in economically deprived areas in which they are more likely to come into contact with the police in non-crisis situations, such as pedestrian stops (Butler, 2014; Crocker et al., 2015; Desmarias et al., 2014; Watson & Angell, 2013). Watson et al. (2008) found in a study of individuals participating in a psychological rehabilitation program that many were poor, had a history of offending, and spent most of their time in public places because of their circumstances. These circumstances led to greater visibility and scrutiny by police. These individuals subsequently experienced many street stops and were the subject of nuisance calls. They perceived these stops as harassment caused by police stereotyping their lifestyle and circumstances.

Thus, increasing collaboration between PBHIs, their COS, and police outside of a crisis situation through mutual problem-solving and response development may serve to break down stigma, increase officers' neutrality and de-escalation skills, and help officers to understand when the PBHI's actions are a symptom of their condition rather than an act of resistance (Livingston et al., 2014; Van Maanen, 1978). To the extent that these collaborations take place within a procedural justice framework—i.e., give citizens a voice, emphasize police neutrality and trustworthiness, and offer citizens dignity and respect—they can also help to improve the outcomes of future interactions between PBHIs and the

police and subsequently increase the safety of all parties. Watson et al. (2013) found that negative perceptions of procedural justice among PBHIs in police encounters are associated with increased resistance, while Butler (2014) finds that PBHIs prioritize elements of procedural justice, including feeling that they have a voice and being treated with dignity and respect, in evaluating their interactions with the police (see also Boscarato et al., 2014). Procedural justice also closely aligns with effective de-escalation strategies such as empathetic listening.

Improving procedural justice may not only enhance officer and PBHI safety in a crisis situation, but also contribute to improved perceptions of the police among PBHIs in particular and the broader community more generally. There is a strong body of research indicating that procedural justice is a mechanism for achieving police legitimacy—public trust and confidence in the police, willingness to defer to police authority, and the belief that police actions are morally justifiable and appropriate given the circumstances of a situation (e.g. Tyler, 1990; Tyler & Huo, 2002; Sunshine & Tyler, 2003, Paternoster et al., 1997). Interactions between the police and public have lasting effects on people's perceptions of the police, and negative interactions have stronger effects than positive ones (Butler, 2014). On the other hand, procedural justice predicts PBHI cooperation with police during crisis situations and increases citizens' satisfaction with police-PBHI encounters.

Of the current tools available to law enforcement to interact with PBHIs, the most well-known and studied is the Crisis Intervention Team (CIT) program. CITs consist of specially trained officers who create collaborative relationships with mental health professionals, both in their departments and in the community. This program shifts from the traditional law enforcement model to a more service-oriented policing approach (Compton et al., 2011; Watson et al, 2008a). However one of the limitations of the CIT program is that it is a systematic approach to empowering the department overall rather than at the individual officer level. Systematic reviews and other studies on the effectiveness of the CIT program have produced either mixed results (Compton et al., 2008; Davidson, 2014) at best or no discernable effect at worst (Taheri, 2016). Furthermore, CIT, at least as traditionally understood, does not include a mechanism for systematizing information sharing between officers to avoid the types of situations described above, where either officers who knew how to deal with an individual successfully were not available to respond, resulting in use of force or, on the other hand, informal exchanges of information took place simply because an officer was in the right place at the right time (although in practice police departments that use CIT, including Shoreline, do engage in these activities informally). Nor does the CIT model necessarily emphasize the direct involvement and collaboration of the PBHI and their COS in developing response strategies and planning for future crises.

The proposed RADAR program seeks to move beyond traditional CIT programs by providing information at the individual level to officers. Communication between law enforcement and PBHIs in the community is vital, and something surveyed PBHIs have indicated positive reception toward (Butler, 2014). A dispatch tool of this nature not only makes officers feel more confident about responding to calls involving PBHIs, but is also accessible at all times and specifically tailored to the individual *officer's* needs (Borum et al.,

1998). This can decrease some of the traditional obstacles associated with information sharing (Crocker et al., 2015).

Furthermore, direct involvement of the PBHI and his or her COS in the development of these response plans is crucial for enhancing procedural justice and effectiveness. Respecting an individual's preferred sources of care is important for ensuring that PBHIs feel that their autonomy is respected, and many PBHIs view family members and friends as their preferred source of assistance during a crisis (Boscarato et al., 2014). Involvement also ensures that information sharing is achieved within an ethical framework with the full knowledge and consent of those whose information is being collected, avoiding situations like the recent news story about an apparently "secretive" database of PBHIs in New York City (Pearson & Peltz, 2016). Butler (2014) finds that PBHIs are generally receptive and supportive of the police having more information about mental illness, as well as certain individualized details. Two-way communication can also help to reduce PBHIs' uncertainty and anxiety about what might happen when police respond to a call.

Collaboration and Outreach

The nature of this intervention requires a high level of collaboration with other agencies, organizations, and community groups, as well as individual community members themselves—particularly PBHIs and their COS. We anticipate that the support and involvement of the following agencies and organizations will be crucial to both the implementation of the intervention and the program evaluation:

- **The National Alliance of Mental Illness (NAMI)-Eastside Chapter:** providing us with continuing feedback about our program from the perspective of caregivers and consumers.
- **Sound Mental Health (SMH):** our primary mental health services partner. SMH professionals ("Navigators") will be assisting Shoreline deputies and the Fire Department with referral services and training.
- **Center for Psychiatric Services (CPS):** CPS mental health professionals will be assisting Shoreline deputies with referral services.
- **King County Behavioral Health and Recovery Division:** providing us with feedback of our program; helping to coordinate our efforts with other first responders in King County. Oversight of two key referral partners on the ground: **King County Mobile Crisis Team** and **King County Crisis Center.**
- **Developmental Disabilities Administration (DDA):** DDA counselors will be assisting Shoreline deputies with referral services.
- **Shoreline Municipal Court and the King County Regional Mental Health Court:** RADAR deputies will be working with prosecutors in both courts, when appropriate, to pursue diversion strategies.
- **Shoreline Fire Department Community Medicine Team (CMT):** CMT will provide follow up services to individuals police encounter who are at risk of behavioral crisis; important link between at risk individuals and service providers

- **King County DMHPs:** designated mental health professionals will assist Shoreline deputies with training and assessment; will provide feedback about officer use of emergency services

Once the RADAR program officially launches in January 2017, we will begin a media and social media campaign to inform the Shoreline community about the program.

Expected Results

Based on the research reviewed above, we expect that the RADAR approach will positively impact outcomes associated with the three problems identified above: use of force (as defined above) during PBHI encounters, high-volume callers, and ineffective police response.

1. Use of physical force

   We anticipate that RADAR will reduce the likelihood that deputies have to use physical force in crisis situations involving PBHIs. RADAR aims to reduce the fear and stigma associated with mental health crisis, enhance information sharing between both the police department and PBHI, and individual deputies, and reduce uncertainty by providing PBHIs in the program with a sense of what to expect from the police if they are involved in a call for service or police encounter. While we are still in the process of gathering specific data about use of physical force with PBHIs in Shoreline, our officer survey suggests that almost all deputies have used force in situations involving PBHIs and most indicated that fear is a factor for both deputies and PBHIs during these encounters. Our research review suggests that use of force may be more likely in circumstances where there is fear and uncertainty. Thus, we hypothesize that by increasing information sharing, managing expectations on both sides, and facilitating collaboration between police, PBHIs, and their COS, incidents of police use of physical force may decrease. We will adjust our hypothesis as necessary based on the data we receive.

2. Frequent callers

   We hypothesize that RADAR will reduce the prevalence of frequent callers in Shoreline, and either reduce the frequency with which the same individual calls the police or increase the duration between calls. The Referrals element of RADAR focuses on identifying options for longer-term service provision and follow-up, rather than the limited and short-term options deputies in Shoreline currently have available. This should help to ensure that individuals are stabilized for a longer period of time and less likely to experience a crisis. Overall, this should translate to an overall reduction in mental health-related calls for service and incident reports, although it is possible that calls for service will increase as community members' (e.g. COS) trust and confidence in police increase and they feel more comfortable calling for assistance. Even if calls for service increase, we would expect to see an

increase in positive resolutions, such as referral to services rather than involuntary temporary detention, from which the individual is likely to be released with little support after a few hours.

3. Ineffective police response

   We expect that RADAR will reduce the amount of time officers spend on calls with PBHIs. If implemented as planned, officers will have easier access to information about de-escalation strategies and service providers who can assist and follow up with the PBHI. RADAR will also reduce repeat dispatches to the same individual or address (see above), offer an increased range of options to responding deputies, and reduce officer and PBHI frustration.

Anticipated longer-term outcomes of the program include increased community trust in the police and improved officer job satisfaction. We hypothesize that any positive impacts of RADAR, publicized through community outreach and social media, will improve citizen perceptions of the police as legitimate and their satisfaction with police policies and approaches. Cases involving police use of force against PBHIs have received extensive coverage in the national media and have divided public opinion about police responses. RADAR should increase community trust in police by indicating that officers are committed to working with individuals and their families to reduce the risk of similar situations occurring in future. In addition, we hypothesize that RADAR will increase police job satisfaction and attitudes toward PBHIs by providing additional knowledge and options around how to approach complex behavioral health cases and arrange for longer-term solutions to the problems that individuals are facing. RADAR should help to eliminate the "stupid circle" and associated frustration that officers face when they believe they have no effective tools to help, especially in the case of repeat callers.

A key goal of RADAR during the grant period is to develop a process for information sharing and collaboration that is effective, sustainable, and replicable in other police departments. The key elements of the program—response plans linked to records management systems, a core group of RADAR-enabled officers who engage in community outreach and facilitate referrals, and police/fire collaboration around behavioral health issues—do not require a significant financial commitment after the initial research and development phase. The program will be sustainable in the City of Shoreline after the grant ends, and with the assistance of the research partners we will carefully document the process in order to assist other small and mid-sized jurisdictions to implement the approach if it is successful.

Impact Evaluation Plan

Role of the Research Partner

Shoreline Police Department has partnered with Dr. Charlotte Gill of the Center for

Evidence-Based Crime Policy (CEBCP), a research center in the Department of Criminology, Law and Society at George Mason University, and Dr. Breanne Cave of the Police Foundation in Washington, DC for the research and evaluation component of this project. The mission of CEBCP is to make scientific research a key component in decision- making about crime and justice policies. CEBCP is particularly committed to collaborations with and knowledge transfer between the policy and practice communities, and its faculty researchers have extensive experience of conducting high-quality experimental and quasi-experimental evaluations of policing strategies, including hot spots policing and community mobilization efforts. The Police Foundation's mission is to advance policing through innovation and science. It is the oldest nationally-known, non-profit, non-partisan, and non-membership-driven organization dedicated to improving policing, and has been on the cutting edge of police innovation since it was established 45 years ago by the Ford Foundation. The Police Foundation conducts a wide range of research studies, including social and behavioral science research and experimental evaluations, with support from federal, state, local, and private funders. While the current project represents the first collaboration between Shoreline Police Department and CEBCP/Police Foundation, the experience of both research organizations with research-practitioner partnerships and their shared vision for the project provide a solid foundation for successful collaboration.

The research partners are involved at all stages of the project, not only the evaluation component. They will assist in identifying the problem and developing the action plan, assessing knowledge of and attitudes toward RADAR throughout the grant period, supporting program development through reviews of scholarly literature and evidence-based practice, and conducting a rigorous process and outcome evaluation.

1. Planning/analysis phase

    - Analyze calls for service, incident reports, and other relevant data to identify high-risk individuals and locations
    - Provide supporting literature for hypotheses and processes (including action plan)
    - Develop process and outcome measures, data collection instruments
    - Collect baseline data on arrests, calls for service, use of force
    - Assess preliminary knowledge and attitudes (including training) among police officers, other first responders, service providers, and community members

2. Intervention phase (process evaluation)

    - Assist with intervention development
        - What do effective police-service provider partnerships look like?

- How does officer training translate into more effective practices?
- What do we know about the effectiveness of information sharing? What information is important?

- Continue to assess knowledge and attitudes among officers, other service providers, and the community through focus groups and surveys
- Collect process data (e.g. content analysis of call/incident reports involving RADAR eligible individuals; RADAR support plans)
- Development of program documentation, training manuals etc.

3. Impact evaluation

- Analyze process and outcome data to assess impact of the project
- Conduct a quasi-experimental outcome analysis using propensity score matching to compare Shoreline to similar jurisdictions
- Conduct a qualitative assessment of RADAR process and outcomes
  - Surveys, focus groups, content analysis
  - Impact on PBHI, COS, wider community, first responders
  - User experiences and attitudes

The research team has already established regular communication efforts. The researchers have visited Shoreline and have met Shoreline team members in Washington, DC to discuss the project in person. The Shoreline project team and research partners participate in a biweekly meeting to discuss project progress and updates (at minimum, these calls involve the Shoreline project coordinator Kim Hendrickson and research partners Charlotte Gill and Breanne Cave), and the full team meets monthly with CNA and the SMEs to discuss challenges and next steps on key project milestones.

Evaluation Plan

CEBCP and the Police Foundation will develop a rigorous quasi-experimental design using propensity score matching and analysis (Maryland Scientific Methods Scale Level 4) to evaluate the impact of the RADAR program. A randomized controlled trial (Level 5) was not practical or ethical in this case because of the subject-specific nature of RADAR, the extent of the effort required to engage high-risk individuals and their COS, and the potential risk of harm to officers and civilians if information is not shared. Propensity score matching (PSM) provides a rigorous quasi-experimental alternative to true randomization

in situations where the latter is not feasible (e.g. Rosenbaum & Rubin, 1983; 1984). PSM is an analytic technique for estimating program effects by balancing the covariates that predict receiving the "treatment" across samples of treated and similarly-situated non-treated individuals. In practical terms, the propensity score represents the probability that a given individual would be "treated" under RADAR. Controlling for the propensity score in an analysis is analogous to controlling for group differences due to any of the variables used to estimate the propensity score (Pasta, 2000). The predicted probabilities are used to match a "treatment" case with one or more comparison case(s). We plan to identify at least one additional KCSO contract city with a similar demographic profile (e.g. Burien, WA) as a comparison area and examine the nature of mental health related calls and incidents and use of force cases in that jurisdiction across the same time period. If possible, we will also match individuals in the comparison jurisdiction(s) with individuals in Shoreline to examine individual-level outcomes such as repeat calls and service provision.

Our outcomes of interest are use of force cases involving PBHIs, mental health related calls for service and arrests/detentions, referrals to treatment or services for individuals, and variables relating to the effectiveness of the police response, including time spent on calls, repeat dispatches to the same individual (prevalence and frequency), and options available to officers for referral to services/treatment and follow-up. We will primarily use data provided by KCSO on police calls for service and incident reports to assess these outcomes, and we are currently conducting a content analysis of the narratives of incident reports, recognizing that not all cases are neatly categorized as involving behavioral health issues. We are also in the process of obtaining data from other sources, such as Shoreline Fire and the Designated Mental Health Professionals (DMHP) program to add to our understanding of mental health incidents and referrals.

We also plan to examine the impact of RADAR on officer attitudes to PBHIs and their job satisfaction (in particular, whether RADAR enables them to escape the "stupid circle" described above and how that impacts the feelings of frustration and helplessness they have reported), perceptions of the RADAR process among participating individuals and their COS, including satisfaction with police service and perceptions of procedural justice, and the impact of the program on community trust and knowledge/understanding about PBHI. We have conducted initial focus groups with Shoreline officers to learn about their current response to PBHIs and the limitations and opportunities they perceive, and we have developed a baseline officer survey that is about to be distributed to officers who have contact with PBHIs. These initial data collection efforts will provide a baseline understanding of police response in Shoreline, and we will conduct follow-ups during the intervention period to assess change in attitudes and perceptions over time. In the next few months we will be developing a community survey and exploring sampling methods for implementing it. We have worked with the City of Shoreline to include one additional question on their regular citizen surveys, which will ask community members about their current impressions of how Shoreline Police handle cases involving PBHIs. Once the intervention is under way, we will conduct baseline and follow-up surveys and interviews or focus groups with participating individuals and their COS to assess satisfaction with police contacts and longer-term attitudes toward police and first responders.

Finally, we will gather process data throughout the project period to understand the use of RADAR in practice, including the information sharing process and the collaborations with individuals and their COS. This information will include observations of the program in practice gathered through ride-alongs and interviews or focus groups; surveys and focus groups to assess first responders' impressions of data quality, ease of access, user interface, connectivity, use of information, and ease of sharing between agencies. We will collect data on the number of individuals with contact information in the system (including COS), the number officers trained and their perceptions of the training, and the number of subjects contacted and designated as RADAR participants. This information will be used to develop program and training manuals to ensure fidelity of implementation of the program in Shoreline and replicability in other jurisdictions if the approach is successful.

Validity

Our evaluation plan is designed to maximize all elements of study validity as far as possible (see Cook & Campbell, 1979; Farrington, 2003; Shadish, Cook, & Campbell, 2002):

1. Internal validity

   We anticipate that the internal validity of this study will be relatively high because treatment units will be statistically matched to comparison units based on a range of different variables that may explain variations in treatment effects.

2. Statistical conclusion validity

   Given the number of mental health related calls for service in Shoreline and the surrounding jurisdictions, we anticipate that our study will have sufficient statistical power to detect moderate differences in outcomes between treatment and comparison units.

3. Construct validity

   We will draw upon previous research to develop survey questions and other measures to ensure we are capturing the same underlying constructs as prior researchers. We plan to use multiple outcome measures related to use of force and calls for service from a number of sources (e.g. police records, fire/paramedic records where possible, local service providers) to capture the effects of the intervention. As noted above, our baseline officer survey draws upon prior studies examining officer job satisfaction and contains elements of the Toronto Empathy Questionnaire (Spreng et al., 2009), a validated psychometric scale, to assess officer attitudes toward PBHIs. Our measures of satisfaction with the police and perceptions of procedural justice will be drawn from the Police Contact Experience Scale (PCES) which has been developed and tested among samples of persons with serious mental illness who have recently encountered the police (Watson et al., 2010).

4. External and descriptive validity

   Farrington (2003) notes that external validity is difficult to investigate in a single study; however, we aim to gather and document sufficient information about the development and implementation of the program to allow other agencies to determine whether and how the intervention could be applied to their populations. This is closely related to the issue of descriptive validity (see also Gill, 2011), which highlights the importance of providing sufficient information in publications about the study to allow other researchers and practitioners to assess the key features and validity of a study. Our intervention builds on existing theory and research, allowing us to anticipate potential moderators and mediators of study effects that could provide clues to differential effects across populations or locations.

Training and Technical Assistance

We welcome the opportunity to engage with BJA, CNA, and our subject matter experts in training and technical assistance. Team members have already participated in required meetings, including the inaugural meeting in Phoenix in June 2016, CNA's workshop on community partnerships, and a site visit with all partners. We plan to take advantage of webinars and other resources throughout the project period. In particular, we hope to have the opportunity to conduct site visits with other SPI projects working on mental health related issues.

Toward the end of the project period we will develop publications and conference presentations as appropriate. While the research partners are experienced with preparing final technical reports, journal articles and conference presentation, we hope to collaborate with BJA and CNA to disseminate our findings to other police agencies and mental health practitioners. A key area for TTA at this time will be sustainability of the intervention beyond the grant period if it appears to be effective.

Logic Model

In this section we describe our logic model for the proposed RADAR program, including our goals, inputs, outputs, outcomes, assumptions, and external factors. The logic model is also represented graphically in Appendix C.

Goal

The goal of the Shoreline, WA Smart Policing Initiative is to enhance community and first responder safety through the development and implementation of an innovative police community caretaking model based on procedural justice strategies for assisting people who

suffer from behavioral health issues. Shoreline deputies need to be better prepared for calls involving mental illness, cognitive disability, and co-occurring substance use disorders.

Inputs

- Shoreline Police Department
  - Leadership & vision (Chief Shawn Ledford, Scott Strathy)
  - Project coordinator (Kim Hendrickson)
  - Patrol officers
  - RADAR-enabled officers
- Center for Evidence-Based Crime Policy, George Mason University
  - Principal investigator (Charlotte Gill)
  - Research assistance (Rachel Jensen, Denise Nazaire)
  - Expertise of senior staff if needed
- Police Foundation
  - Co-Principal investigator (Breanne Cave)
  - Research assistance
  - Expertise of senior staff and national police constituents if needed
- King County
  - Prosecutor's Office (David Hackett and team)
  - Sheriff's Office
  - King County Behavioral Health and Recovery Division
  - King County Office of Risk Management
- Medical adviser (Stuart Lewis, MD, New York University School of Medicine)
- Shoreline Fire
  - Community Medicine Team (Jodi Denney)
- Service providers and representatives
  - NAMI
  - DMHP
  - Sound
  - Center for Psychiatric Services
  - Crisis Diversion Center
  - Crisis Mobile Team
- BJA funding and staff
- CNA organizational resources and staff
- Subject matter experts
  - Julie Wartell
  - Natalie Hipple
- RADAR eligible individuals and COS

- Shoreline community members
- Data and software
    - Calls for service and incident reports
    - Use of force database
    - Demographic information
    - Subject specific data
    - Surveys and qualitative data

Outputs (Activities)

1. Problem identification
2. Develop and implement information sharing process
3. Develop and implement training
4. Identify RADAR eligible individuals and COS and develop subject-specific response plans
5. Outreach and relationship-building with service providers, first responders, community
6. Collect follow-up data
7. Conduct process evaluation
8. Conduct impact evaluation
9. Participate in BJA/CNA National Meetings, webinars, site visits, and consultation calls

Outcomes (Impact)

Short-term

- Number of officers trained
- Number of officers designated RADAR officers
- First responder impressions of information sharing process
- Number of individuals with RADAR response plans
- Number of service providers, first responders etc. contacted
- Officer perceptions of RADAR
- PBHI/COS perceptions of RADAR
- PBHI service referrals

Medium-term

- Officer perceptions of PBHIs

- Officer job satisfaction
- PBHI/COS perceptions of police
- Community knowledge/awareness and attitudes toward mental illness and policing
- Community perceptions of police

Long-term

- Reduction in police use of force in cases involving PBHIs
- Reductions in mental health related calls for service and incidents
- Reduction in prevalence and frequency of repeat calls
- Generation of knowledge to develop long term, sustainable strategy for implementation in Shoreline and elsewhere
- Contribution to scholarly evidence and theory

Assumptions

- Sound theory linking RADAR process to increased trust/procedural justice, reduced use of force
- Sufficient cases will be available in Shoreline to detect an effect
- SPI project remains consistent with Shoreline PD/KCSO priorities
- Patrol officers share vision of RADAR
- Grant resources are sufficient
- Existing CAD/RMS technology can be successfully integrated with the information sharing approach
- PBHIs in Shoreline and their COS are willing to participate
- Service providers are willing to participate
- Other first responders are willing to participate

External Factors

- Sufficient and continued funding
- Political support
- Travel constraints
- Staff turnover
- Experience of research partners
- Experience and availability of SMEs
- Nature and composition of community of PBHIs/supporters in Shoreline
- Availability and capacity of service providers

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Appendix A: Use of Force Claims Report from King County Office of Risk Management

Analysis of Liability Claims Filed against King County Sheriff's Office Related to Mental Illness

Background and introduction

King County Sheriff's Office (KCSO) Deputies face challenging circumstances when call responses are complicated by mental illness. King County has an explicit and dedicated interest in preserving the life and safety of all its constituents. This interest applies especially to vulnerable populations which face historic and systemic challenges related to equity and social justice (ESJ), such as those experiencing mental illness.

KCSO has engaged with the City of Shoreline (which contracts its law enforcement services through KCSO) and the federal Bureau of Justice in a Smart Policing Initiative – Risk Awareness, De-escalation and Referral (RADAR) – to understand and improve the ways in which law enforcement personnel interact with individuals experiencing mental illness. RADAR involves strategies of direct engagement, information sharing, and collaboration between police, high risk individuals, and the individuals' circles of support (such as their families and mental health professionals).

The Office of Risk Management (ORM) has conducted this analysis in support of RADAR in order to identify liability claims and incidents in KCSO's history which may inform the potential benefits of RADAR and illustrate specific examples where outcomes may have been improved if RADAR's practices were implemented.

The costs of these claims is low in comparison to other causes of loss in King County, and the number of claims identified comprises less than one percent of the closed claims against KCSO in the same period. The circumstances of these incidents and the legal protections afforded KCSO Deputies in the course of performing their duties generally provide strong protections for the County in terms of the potential costs of liability.

From an enterprise risk management perspective which considers risks beyond liability, the potentially critical outcomes of these incidents represent significant risks King County. Accordingly, the County should continue its efforts to effectively to control and manage these risks, and RADAR represents one such effort.

Data analysis

Parameters and Analytic Process

We reviewed liability claims filed against KCSO with an incident date after January 1, 2006 as of April 21, 2016. The data was limited to claims involving the following alleged causes and/or circumstances:

- Use of force
- Officer-involved shooting
- Death of a constituent
- Civil rights violation
- Involuntary commitment
- Welfare check on a building occupant

Claim descriptions (as provided by claimants) and claim files were further reviewed to identify:

1. Whether the primary individual involved was likely to be experiencing mental illness, and
2. Whether the circumstances of the incidents were relevant to the strategies of RADAR.

Specifically, claims were included if they involved one or more of the following keywords or phrases in their descriptions and disclosable files:

- Mental illness
- Mental health
- Involuntary commitment
- Self-harm
- Suicide
- Excited delirium
- Altered mental state

Addressing Open Claims

This analytic process identified a number of open claims with circumstances which may be relevant to the objectives and strategies of RADAR. However, several of these open claims involve ongoing or pending litigation and the facts of their circumstances may not be fully established. More than one of these claims involves the death of a constituent. With this sensitivity in mind, open claims have been excluded from this analysis. However, their identification through the analytic process indicates that the issues RADAR seeks to address are relevant to KCSO's current operations.

Analyzing Closed Claims

This process of reviewing claims data led to the identification of nine closed liability claims with specific circumstances relevant to RADAR's objectives. The circumstances which these claims share in common are described below. Note that some claims have aspects which may be included in more than one grouping, so the numbers noted do not sum to the nine claims examined:

- Two incidents – which together account for 95% of the costs incurred – resulted in the death of a person shot by a KCSO Deputy using a firearm. Due to their severity, these are examined in further detail in their own section below. Related documentation of each incident is attached as well.
- Five incidents involve KCSO personnel initiating a forced entry to a home in order to establish the welfare of an occupant, usually after emergency calls from friends, family members, or neighbors indicating the individuals in question had threatened self-harm.
- Two incidents involve claimants alleging they were involuntarily admitted to medical facilities after threatening self-harm.
- Two incidents were initiated through emergency calls related to domestic violence.
- Two incidents involved the use of intoxicants such as drugs or alcohol by the primary person involved, who may have been experiencing mental illness.

The only payment made to a claimant, their family, or their counsel in these claims was one of $5,857 related to property damage sustained in the course of a welfare check. The County spent a total of $116,001 on two other claims, which was associated with expenses such as outside counsel, expert witnesses, and investigations. The other six claims were closed with no incurred costs through the insurance fund or expenses. These figures do not include time and expenses associated with KCSO event responses or operational investigations, ORM investigative time and expenses, or the time and expenses of internal Prosecuting Attorney Office counsel and staff.

The dates of these nine incidents range from June 2006 through October 2013. The time from the date of incident to the date of claim filing ranged from just under four weeks to just over four years. The time from the date of incident to the closure of the claim ranged from 4 ½ months to 6 ⅓ years.

Incidents Involving a Constituent's Death

These incidents are shared here with the goal of describing a critical incident in real terms which may lead to more in-depth understanding and opportunities to ensure future similar interactions end without loss of life, if possible.

Pedro Jo

This incident received local media coverage immediately following it and a subsequent inquest by a jury. Those articles are the sole basis for this narrative description.

In the early morning hours of June 5, 2006, Pedro Jo, 33, was stopped for erratic driving on Interstate 5 in Seattle's south end. According to a woman being transported in the KCSO deputy's vehicle, Mr. Jo initially stopped in the center of the roadway and then pulled over to the shoulder at the deputy's request. While the deputy was occupied with another task, Jo attacked him from behind. A lengthy and violent fight ensued, which ended when Mr. Jo jumped into his vehicle and moved toward the passenger seat, leading the deputy to believe Mr. Jo was retrieving a weapon. The deputy then shot Mr. Jo, striking him 11 times, resulting in his death.

According to the Seattle Times, Mr. Jo's history included an involuntary commitment to a Seattle hospital in 2001 after threatening his parents with a knife. He had undergone psychiatric evaluation several other times. He was twice admitted to a psychiatric hospital in California in 1998 and 1999 with diagnoses of schizophrenia and bipolar disorder. Mr. Jo was sent to Western State Hospital for a mental health and competency evaluation in 2003 after being arrested for attacking and robbing a woman who was using a pay phone. A forensic mental health evaluation of Mr. Jo conducted at the time noted that he had twice been secluded for making threats to staff members and peers, and found him at high risk to commit future criminal acts.

On February 1, 2007, an inquest jury unanimously decided the deputy had reason to believe Mr. Jo was dangerous when he shot him. A Seattle Post-Intelligencer article describes the deputy's testimony as having been attacked without provocation and believing Mr. Jo was trying to kill him. The deputy described Mr. Jo choking him with a radio microphone cord and trying to remove the deputy's gun. The deputy also described Mr. Jo as appearing intoxicated, though that proved incorrect based on the Medical Examiner's report, which found only caffeine in Mr. Jo's system. Evidence of Mr. Jo's history of mental illness was not presented to the inquest jurors.

King County's costs in relation to this incident were legal expenses related to preparations and investigations related to the inquest. There was no liability claim filed in relation to this incident.

The news articles associated with this incident are included as Attachment A.

James Slater, Jr.

The primary sources informing this summary include media coverage of the incident and KCSO reports associated with it.

On the evening of July 4, 2009, KCSO deputies responded to a domestic violence call at the home of Michael Slater, a 59-year-old unemployed construction worker, and his wife, Laura Casablanca.

The first deputy to arrive noticed injuries to Ms. Casablanca, and identified Mr. Slater as the suspect who they believed had caused them. A second deputy arrived and together they approached Mr. Slater, who had sat down on a bench in a neighbor's yard holding a knife, and cut his wrists deeply. Mr. Slater disobeyed the deputies' commands, got up off the bench, and charged at a deputy who then shot him twice in the chest with his rifle, resulting in his death.

Ms. Casablanca later stated that he had expressed suicidal feelings on previous occasions and that she believed Mr. Slater may have wanted the deputies to shoot him. She described previous suicidal threats by Mr. Slater as well as her efforts to remove a shotgun from the house. However, analysis from KCSO indicates there was not enough definitive evidence to determine that Mr. Slater had intended to put the deputies in a position where they would be forced to shoot him.

Prior to the 911 call which dispatched the deputies, Mr. Slater had been drinking and also cut one of his wrists, which Ms. Casablanca had bandaged. He had then fallen asleep briefly, during which time her daughter arrived to help her remove a collection of knives from the home.

King County's costs associated with this incident were legal expenses related to preparations and investigations related to the inquest. Ms. Casablanca did file a liability claim which was resolved through summary judgement in the County's favor.

The KCSO reports associated with this claim are included as Attachment B.

KING5.COM
Coverage You Can Count On

Deputy shoots man in fight on I-5

06:12 AM PDT on Tuesday, June 6, 2006

Associated Press

SEATTLE - A man who was stopped for erratic driving on Interstate 5 in Seattle's south end attacked a King County sheriff's deputy who then shot him to death as they struggled early Tuesday, authorities said.

Neither the deputy nor the man was immediately identified, nor were investigators immediately able to determine whether the man had a weapon, sheriff's Sgt. John W. Urquhart said.

KING

A man who was stopped for erratic driving on Interstate 5 in Seattle s south end attacked a King County sheriff s deputy who then shot him to death as they struggled early Tuesday, authorities said.

Two city police cars heading for the scene collided at a downtown intersection near the freeway and both officers were taken to Harborview Medical Center to be checked for head injuries. The deputy also was taken to Harborview for treatment of minor injuries.

The deputy, assigned to police work in SeaTac, was bringing a woman from the suburb by Seattle-Tacoma International Airport to jail in downtown Seattle about 2:30 a.m. when he noticed a gray 1990s-model Pontiac Bonneville cutting through traffic erratically, Urquhart said.

Upon being signaled to pull over, the Bonneville driver stopped in the center of the northbound lanes, then moved to the side and—according to the woman's account—got out of his car and attacked the

deputy, resulting in "a knock-down, drag-out fight," Urquhart said.

The officer called for help on his radio, but it was not immediately clear whether he did so before or after shooting the man to death.

KING5.COM
Coverage You Can Count On

Man fatally shot on I-5 was felon, UW student video

05:28 PM PDT on Tuesday, June 6, 2006

By KING 5 News Staff and Associated Press Reports

SEATTLE - A man who was stopped for erratic driving on Interstate 5 in Seattle's south end attacked a King County sheriff's deputy who then shot him to death as they struggled early Tuesday, authorities said.

The man killed was 33-year-old Pedro Jo, a convicted felon and University of Washington student.

Video

KING 5's Bernard Choi reports

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A man who was stopped for erratic driving on Interstate 5 in Seattle s south end attacked a King County sheriff s deputy who then shot him to death as they struggled early Tuesday, authorities said.

The incident happened as the deputy was transporting a woman from the suburb of Seatac to the King County Jail in downtown Seattle about 2:30 a.m. He noticed a gray 1990s-model Pontiac Bonneville cutting through traffic erratically, according to King County Sheriff's spokesman Joahn Urquhart.

"This guy was so dangerous on the freeway, apparently he felt he needed to pull him over right then and there, and he did," said Urquhart.

Upon being signaled to pull over, the Bonneville's driver stopped in the center of the northbound lanes, then moved to the side and — according to the woman's account — got out of his car and attacked the deputy, resulting in "a knock-down, drag-out fight," Urquhart said.

"During the fight the microphone from the deputy's portable radio was ripped off by the suspect, so he wasn't able to radio for help," added Urquhart.

Passing drivers called 9-1-1. At one point during the scuffle, the deputy shot the suspect.

The deputy,28, was treated for minor injuries. Authorities were interviewing drivers who saw the fight take place and the woman who was in the back seat of the deputy's car, who is now the case's number one witness.

"She saw pretty much the whole thing, so she'll be a very good witness," said Urquhart.

Several lanes of northbound Interstate 5 were closed during the investigation, reducing traffic to a crawl for four hours.

The five-year deputy was placed on administrative leave during the investigation as standard procedure.

The dead man's brother, Frank Jo, reached in Los Angeles, said his brother should not have been killed.

"I'm really concerned because he was shot more than one time. My brother does get violent, but not to the point he needs to be shot. I don't understand why he was shot in his car. He did not have a gun, did not have a knife."

Two city police cars heading for the scene collided at a downtown intersection near the freeway and both officers were taken to Harborview Medical Center to be checked for head injuries. The deputy also was taken to Harborview for treatment of minor injuries.

The Seattle Times
seattletimes.com

Friday, June 9, 2006 - 12:00 AM

Man shot by officer had troubled past

By Christine Clarridge
Seattle Times staff reporter

The man fatally shot by a King County sheriff's deputy during a roadside brawl on Tuesday morning had been involuntarily committed to a Seattle hospital in 2001 after threatening his parents with a knife, according to court records.

Pedro Jo, 33, who was fatally shot by Deputy Paul Schene, had undergone psychiatric evaluation several other times. King County Superior Court documents show that Jo was twice admitted to a psychiatric hospital in California in 1998 and 1999 with the diagnoses of schizophrenia and bipolar disorder.

Earlier this year, a University of Washington professor was so frightened of Jo that he asked campus police for protection when he passed out grades to his student, according to a source close to the investigation into Jo's shooting.

And two of his former roommates said they moved out of a home they shared with Jo because they were afraid for their safety, the source said.

As the sheriff's department waits to interview Schene about the shooting, it is also learning more about Jo's past.

Jo was sent to Western State Hospital for a mental-health and competency evaluation in 2003 after being arrested for attacking and robbing a woman who was using a pay phone. A forensic mental-health evaluation of Jo conducted at that time noted that he had twice been secluded for making threats to staff members and peers, and found him at high risk to commit future criminal acts.

He pleaded guilty to third-degree assault and was sentenced to three months in jail and ordered to complete mental-health treatment.

Jo transferred to the UW as a junior last year from Highline Community College. UW police Assistant Chief Ray Whittmier confirmed that Jo was known to police and had been the subject of several police reports, but would not elaborate on the incidents.

Additional details about his time at the UW was expected to be included in search-warrant documents expected to be filed today. The documents will include information on what was found during searches of Jo's car and home.

Jo was shot about 2 a.m. after he was pulled over by Schene for driving erratically on northbound Interstate 5 in South Seattle. According to the sheriff's department, Schene was on his way to King County Jail with a woman who was to be booked on drug charges when he saw Jo speeding, cutting through traffic and driving erratically.

The deputy turned on his lights and siren and Jo stopped his car in the middle of the freeway, the sheriff's office said. Schene got out of the car, talked to Jo and persuaded him to pull his car to the shoulder, the sheriff's department said. Once there, Schene again got out of the patrol car and spoke with Jo, then returned to his vehicle, where the woman he was transporting asked him to loosen her handcuffs.

While Schene was attending to the woman, Jo got out of his car and attacked the deputy from behind, according to Sgt John Urquhart, King County sheriff's spokesman.

Urquhart said Jo and Schene had a "knock-down, drag-out" fight in which Jo bit and kicked Schene and managed to rip the cord of the deputy's portable radio.

Schene has not yet made a statement to investigators about the incident, and police said they do not know exactly what happened after the fight. At some point, Jo returned to his car and the deputy fired the weapon. Police also have not said whether Jo was armed.

Deputies involved in a shooting incident are encouraged to seek the counsel of attorneys or guild representatives before making a statement, Urquhart said. If the sheriff's office decides to order the deputy to make a statement, he would have 72 hours in which to comply.

The shooting was the second for the 28-year-old Schene, a five-year veteran of the sheriff's office who is stationed in SeaTac. Schene has been put on paid administrative leave as is standard practice following an officer-involved shooting.

In 2002, Schene wounded a man who had rammed his car into the legs of another deputy, gotten out of the car and was rushing toward Schene, according to police. The shooting was deemed justifiable.

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Appendix B: Mockup of RADAR PDF Response Plan

SUBJECT INFORMATION AND DE-ESCALATION PLAN

The information contained in this report is for the exclusive use of first responders. Subject specific information and recommended de-escalation plans represent a supplemental source of information not intended to replace professional discretion, training, and/or the demands of individualized situations.

Name: SCOTT "CAP" STRATHY
DOB: 10/26/1957 (Age 58)
Eyes: Blue
Hair: Brown
Height: 6'1
Weight: 195 lbs
Distinguishing Marks: "Mommy" tattoo — right forearm
RADAR: Since 11/28/2015.
Assigned: RADAR Dep. Sue Smith.

Criminal Hx: Misd. Trespass (2015); Shoplift x3 (2014); Misd. Vandalism (2013); Indecent exposure/ public urination (2011); Assault 4 x2 (2011); Assault 2 DV (1996). In addition, over 15 misdemeanor charges over past 20 years involving petty theft and minor property crimes.

Mental Hx: Tiered client of SMH. Active LR order prohibiting consumption of drugs/alcohol. Must take psychotropic meds. No known weapons.

Threats: On 11/20/2015, told probation officer, "Fuck the pigs! I just wanna be left alone. They bother me again — I'm gonna bleed 'em!" (Subsequently committed under ITA).

De-escalation Plan: Cap Strathy is highly personable when on his meds and complying with treatment, but becomes quickly agitated and potentially violent when discontinues tx. *Mandatory two officer response.* Subject can be re-directed through discussions of hockey. Likes to talk about career as ferry boat deck hand. SMH therapist Fred Jarrod and RADAR Deputy Smith have excellent relationships him and willing to assist. Daughter available by phone. Subjects to avoid: baseball, especially Mariners and relief pitching.

Prior contacts: 5/16/2016: Cap in good spirits and reports he is following treatment (Deputies Smith & Jones); 3/10/2016: Cap glad to see us and apologetic for incident in February. He slipped away from treatment and was depressed about his brother's death. We went over expectations again and de-escalation planning. Urged him to continue with SMH per his LR; 2/4/2014: 911 caller reported that Cap was opening peanut butter jars at Safeway, scooping out bites in middle of the store with thumb, screaming at customers and threatening staff. Successfully de-escalated. Detained for 72 hour hold. #16-100405 (Sgt. Kanner): 12/1/2015 — following November 2015 commitment under ITA and inclusion in RADAR, approached Cap Strathy who is well known to myself and other officers to discuss RADAR, de-escalation planning and mutual expectations. Subject responded well (Deputies Smith & Anderson).

Circle of Support: Fred Jarrod (SMH Therapist, 425-555-5555 (cell), Suzy Strathy (daughter, 512-555-5555).

Follow-up Services: None. Tiered client of SMH subject to LR.

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Appendix C: RADAR Logic Model

Shoreline, WA SPI Logic Model

GOAL: Enhance community and first responder safety in Shoreline, WA through the development and implementation of an innovative police community caretaking model based on procedural justice strategies for assisting people who suffer from behavioral health issues.

Inputs
• Shoreline Police Department • Center for Evidence-Based Crime Policy • Police Foundation • King County • Medical adviser • Shoreline Fire • Service providers and representatives • BJA funding and staff • CNA organizational resources and staff • Subject matter experts • RADAR eligible individuals and COS • Shoreline community members • Data and software

Outputs
Activities
(1) Problem identification **(2)** Develop and implement information sharing process **(3)** Develop and implement training **(4)** Identify RADAR eligible individuals and COS, develop response plans **(5)** Outreach and relationship building **(6)** Collect follow up data **(7)** Conduct process evaluation **(8)** Conduct impact evaluation **(9)** Participate in BJA/CNA national meetings, webinars, site visits, consultation calls

Outcomes – Impact
Short-term
• Officers trained • Officers designated RADAR-enabled • First responder impressions of information sharing process • Individuals with response plan in system • Service providers/first responders etc. contacted • Officer perceptions of RADAR • PBHI/COS perceptions of RADAR • PBHI service referrals
Medium-term
• Officer perceptions/attitudes about incidents involving PBHIs • Officer job satisfaction • PBHI/COS perceptions of police • Community knowledge/awareness, perceptions, attitudes toward mental illness and policing
Long-term
• Reduction in police use of force involving PBHIs • Reduction in prevalence and frequency of repeat calls • Generation of knowledge to develop long-term, sustainable strategy for implementation in Shoreline and elsewhere • Contribution to scholarly evidence and theory

Assumptions: *Sound theory linking RADAR to increased trust/procedural justice; reduced use of force; sufficient cases to detect an effect; SPI project remains consistent with Shoreline/KCSO priorities; patrol officers share vision; grant resources are sufficient; existing technology can be integrated with information sharing approach; PBHIs/COS in Shoreline/service providers/other first responders are willing to participate.*

External Factors*: Sufficient and continued funding; political support; travel constraints; staff turnover; experience of research partners; commitment of implementation partners; experience and availability of SMEs; nature and composition of community of PBHIs/COS in Shoreline; availability and capacity of service providers.*