

CCAT

Community Crisis Assistance Team 2023 to 2024

EXECUTIVE SUMMARY



Prepared for Bellevue Police Department & Bellevue Fire Department

Consultant Evaluator

Background and Mission

In September 2023, the Bellevue Police Department (BPD), in partnership with Bellevue Fire Department (BFD), in the City of Bellevue, State of Washington, launched the Community Crisis Assistance Team (CCAT). This policing model teamed a BPD officer with a mental health professional (MHP). The aim was to enhance services to individuals experiencing behavioral and mental health crises as well as those who are unhoused and/or struggling with substance use. This summary presents findings and insights gathered during the first 16-months following implementation, from September 1, 2023, through December 31, 2024.

CCAT MISSION

Provide a sustainable coordinated community response for aiding individuals in behavioral crisis with known or suspected mental illness or substance use. As a result, improving the quality of life for individuals by diverting them from the criminal justice system and providing an alternative pathway to addressing their mental health and behavioral crisis.

Bellevue Community Crisis Response Team: Model, Staffing, and Operations

Community Crisis Response Team (CCAT) Model and Historical Background

In 2012 BFD launched the Bellevue Fire CARES Program. Staffed by Masters of Social Work (MSW) student advocates and professional MSW supervisors, CARES Advocates reach out to individuals referred by BFD and BPD following 911 call responses. In 2017, CARES101, a dispatchable unit staffed by MHPs was added to respond on scene at the request of police or fire first responders. CARES101 teams provide crisis intervention services and remain on scene with individuals, if needed, freeing up first responders for other 911 calls. Following a CARES101 response, CARES Advocates provide case management services to individuals who would benefit from voluntarily accepting ongoing support.

CCAT was designed to provide an immediate, sustainable, coordinated community response approach to 911 calls for police, focused on serving individuals in behavioral and mental health crises as well as those who are unhoused and/or struggle with substance use. CCAT units receive specially training in crisis intervention techniques, mental illness identification, communication approaches, de-escalation strategies, crisis/hostage negotiation, and mental health system procedures.

Besides responding to 911 calls, CCAT units engage in preventative activities. If individuals would benefit from ongoing support, CCAT refers them to CARES. CCAT units also work to build relationships and provide educational and outreach opportunities with community agencies, businesses, and the public. The goal is to increase program awareness and foster trust with community stakeholders in advance of a 911 response.



The magic of the CCAT program is that we have the ability to serve people from start to finish. CCAT units responded in the moment of crisis; providing acute triage support and CARES is able to take over to ensure resources and services are in place.

CCAT BPD SUPERVISOR



Staffing

A BPD Captain oversees the CCAT program on the Bellevue Police side. A CCAT Sergeant supervises the five BPD officers who volunteered and were selected because of their interest in and compassion for individuals experiencing behavioral/mental health issues.

A BFD CARES Licensed Independent Clinical Social Worker (LICSW) supervises the seven MHPs in the Fire Department assigned to the CCAT team. All the MHPs are MSWs with experience working in crisis social work and have served on the CARES101 dispatch unit prior to joining the CCAT team. They were selected because of their exhibited skills and passion for working with individuals in behavioral and mental health crisis.

The Bellevue Community Crisis Response Program Manager is an LICSW in the Fire Department who has been with the BFD response program since 2013. The manager spearheaded the development of and oversees all three Bellevue Community Crisis Response Programs on the Bellevue Fire Side: CARES, CARES101, and CCAT.

Operations

CCAT hours of operation are Monday - Thursday: 6 a.m. to 12 midnight, and Friday - Sunday: 6 a.m. to 10 p.m.

CCAT 2023 to 2024 Activities

Evaluation Design and Approach

A logic model was developed to guide program implementation and evaluation efforts. It provides an overview of the program elements and activities and outlines program outputs as well as desired effects/outcomes. CCAT outcomes include individuals having their needs met, strengthened relationships between individuals and BPD, and police practices that result in increased de-escalations, reduced use of force, reduction in unnecessary emergency room visits and arrests/incarcerations. (See Logic Model in the full report.)

The evaluation examined BPD administrative data¹ and quantitative data entered in the CCAT Case Management Database by CCAT units and CARES staff. Qualitative data was gathered through interviews with 18 individuals (clients, relatives/friends, CCAT staff, and community agency professionals) who also completed surveys. Another 23 BPD personnel completed online surveys. By utilizing qualitative and quantitative data, a more complete snapshot of the program's impact was possible.

Bellevue Case Management System

The Bellevue Case Management Database System was developed in 2015. In August 2023, adjustments were made to also house a CCAT Case Management System. On September 1, 2023, CCAT units began entering incident and client data. During the initial four months of implementation, adjustments to the database were suggested by staff. The findings that follow are limited to individuals engaged between January 1 and December 31, 2024, the period under review (PUR), for which there is consistent data.

Number of individuals engaged to date

Between September 1, 2023, and December 31, 2024, a total of 1,520 individuals were engaged by CCAT (403 in 2023, and 1,117 in 2024).

¹ BPD administrative data and analyses were provided by Lynn Boerner, BPD staff member.

Demographic data of individuals engaged

Males were the most likely individuals engaged (552, or 56%). Of the remaining individuals, 412 (42%) were females, 10 (1%) identified as transgender, and 8 (.8%) identified as other. Gender was unknown for 135 (12.1%) individuals.

The average age for those engaged was 42.3 years, with a range of 1 to 96 years of age. On average males were 41.4 years while females were 45 years, and transgender/other were 21 years of age.

Most individuals 563 (60.7%) were White, followed by Black (134, or 14.4%), and Asian-Pacific Islander (78, or 8.4%). (Race identification was missing for 17% of individuals.) Among those with known ethnicity, Non-Hispanic White was most common. Ninety-eight percent spoke English; 31 individuals spoke another language.

Presenting issues at initial engagement

CCAT units document in the CCAT Database what occurred on scene, and what they learned and observed about an individual's situation (e.g., medical needs, mental health condition, etc.). The presenting issue (reason) for CCAT engagement shapes initial and ongoing client interactions, decision making, and case management.

Count and type of presenting issues

Among the 1,117 individuals engaged by CCAT in 2024, 1,066 had documented presenting issues (51, or 4.6% people did not have a documented issue). There were a total of 2,460 issues or an average 2.3 issues per individual. The range in number of issues was from one to nine. For example, 360 of the 1,117 (32.2%) individuals engaged had one issue, while 706 (63.2%) had two or more issues.

Nearly sixty percent of the individuals (633, or 59.4%) engaged had behavioral/mental health issues. Specifically, 206 (32.5%) struggled with suicidal ideations or attempted suicide. In addition, 299 (28.0%) were unhoused and 206 (19.3%) had a substance use issue. Individuals may have had one or more of these issues as well as other presenting issues.



My child has (sic) autism and ADHD with a history of psychosis. He was hearing voices, telling him to harm himself. It was very difficult. He was on medication, but the medication wasn't working.

A MOTHER OF A PRE-TEEN



My brother would not take his medication for mental health issues. He wouldn't care for himself and has created [an] extremely hazardous, unhealthy home environment, and has additional behaviors that result in (sic) fire hazards. He almost set my house on fire. I worry about my children's safety.

A SISTER CARING FOR AN ADULT BROTHER



Complexity of cases

Analyses determined 241 (22.6%) individuals faced two or more of these co-occurring issues: mental health, being unhoused, and substance use (some had additional issues as well). For

example, 34 individuals experienced all three complex issues: mental health issues, substance use, and were unhoused. While 85 individuals struggled with both mental health and being unhoused. These findings highlight the complexity of the challenges individuals face, the level of staff efforts, and potential length of time devoted to address these conditions. This does not mean to imply that other issues are easy to address or are less serious or emotionally difficult.



My child is 47 years old. He is schizophrenic, bipolar and has had schizoaffective disorder with bipolar tendencies since 14. He left home and lived with friends, electing to leave home might have been related to drug or alcohol use. We got him into a 30-day treatment program. He did not do well there. My child has been in and out of jail and hospitals ever since and living on the streets. He's a whole different person when medicated and sober. He's kind, loving and generous. When not on meds, he's like a demon almost. I mean, he's just terrible. He has both auditory and visual hallucinations.



Program Activities and What Occurred at Initial Engagement and Beyond

Call source

Based on the CCAT Case Management System, the primary call source was CCAT self-dispatching to 911 calls (879, or 78.7%). The next most likely call source (139, or 12.4%) was BPD patrols requesting CCAT units after being dispatched to a 911 call - BPD radio dispatch. The third most likely call source (52, or 4.7%) was CCAT units self-initiating engagements while driving within the community and visiting unhoused camps.

Meanwhile, BPD Records Management System (RMS) tracked activities for each CCAT officer, which only include 911 and BPD dispatched calls. CCAT officers responded to a total of 3,602 incidents for an average of 300 incidents a month, or 5% of all calls to BPD in 2024 (69,543). CCAT's low call response was impacted by their limited hours of operation and limited number of units in the field compared to patrol officers. The ratio of patrol officers to CCAT units in the field, on average, is 6:1 when CCAT is staffed. A BPD data analyst reported, "Even though the CCAT calls only amount for 5% of the overall call volume, the call types that CCAT responds to can be some of the most time-consuming."



[CCAT units] build rapport with chronic callers. Having social workers as teammates gives officers better insight to the behavioral health challenges some of the individuals are facing and help tailor contacts off that information. It frees up patrol officers to take high priority calls while also giving individuals the service/time it takes to get them out of crisis.

BPD PATROL OFFICER



Call type

BPD RMS also tracked call types (reasons for service requests). BPD IT generated the list and count of the top 10 call types responded to by CCAT and pulled data on the number of calls for each call type during the hours CCAT operated. This allowed for an analysis of what percentage of each call type CCAT units responded to. CCAT units responded to 11.2% of these annual top 10 call types. CCAT units handled situations in alignment with their



It's helpful for an officer to be able to step back when appropriate and let the embedded social worker take the floor of the conversation and lead the conversation [with what is] best practice in terms of engaging one-on-one with the individual.

HOMELESS OUTREACH PROFESSIONAL



specialized skills, responding to 93 (71%) of all suicide calls, 641 (38%) of all behavioral health calls, and 578 (59%) of all welfare check calls that occurred during the hours CCAT units were in service.

What happens following initial engagement

In addition to the 1,117 referrals/individuals CCAT units responded to in 2024, there were 201 individuals whose initial engagement occurred in 2023, and who continued to engage in the voluntary service in 2024, for a total of 1,318 individuals. CARES teams follow up with all individuals after an on-scene CCAT response unless individuals clearly state that they do not want follow-up services, or if they live outside of the service area. Eligible individuals who elected not to engage with CCAT or CARES were encouraged to reconsider, if engagement was assessed to be needed. Regardless of their decision, all individuals are provided with on-scene services to address emergent crises and support to access community services.

Case disposition

The term *case disposition* is used to describe/document decisions regarding the status of an individual's relationship with a program (e.g., remain open for services, closed/inactive, etc.). CCAT learned during their 16-month of service that a "final" closed case decision was inappropriate for this population. Behavioral, mental health, and substance use issues, by their nature, have challenging ups and downs. While overcoming these conditions is not impossible, it is not a linear journey. Some individuals improve and live fully functional lives, while others do well for a time before needing services again. Unfortunately, a few spend the rest of their lives struggling. Below are the definitions for Inactive Cases and Closed Cases developed by CCAT.

- **Inactive Case** designations were assigned to individuals assessed to still need case management services, resources, or treatments but elected not to engage in services or to end their engagement - reporting they no longer needed services but appear to continue to have unmanaged behavioral/mental health, substance use, medical conditions, are living in unsafe situations, or are unable to care for and protect themselves or are likely to re-engage with the 911 system in the future

Closed Case designations were assigned to individuals whose program reengagements were unlikely because they moved out of the service area or had passed away. There were individuals who already had a case opened in CARES or CCAT.

In 2024, case closure/inactive dispositions were determined for 1,184 individuals (who were either engaged in 2023 or 2024). In addition to the closure/inactive disposition, one of three engagement categories were assigned to each case closed/inactivated.

- **On scene, only served by CCAT (i.e., individual not referred to CARES):** A total of 680 (57.4%) individuals were engaged only by CCAT on scene. Of these individuals, 166 were ineligible for CARES referral because they lived outside of the service area, reducing the number of individuals eligible for referral to 515 (51.1%). The next most common reason individuals only received on-scene services was that they declined services beyond what they may have received on scene (142, or 11.1%). The third most likely reason for not being referred to CARES was because individuals “already had services in place,” and felt other services were unnecessary (111, or 9.4%).
- **Referred to CARES, but case not opened:** A total 242 (24.1%) individuals were referred to CARES, but their cases were not opened for services. The most common reason was that CARES was unable to locate them (90, or 7.6%). Staff and community providers noted that this targeted population is highly mobile. The second most common reason was individuals (60, or 5.1%) declined CARES services when contacted. It was not always known why they declined services, but reasons included: with the crisis now behind, they felt hopeful things would be better; they did not want to address the underlying issues; or they found a solution on their own that they believed would prevent another incident. Cases were also not opened for individuals who did not respond after three or more contact attempts by CARES (44, or 3.7%).
- **Served by CARES (i.e., some individuals completed the program, but some dropped out):** A total of 249 (24.8%) individuals were opened for services. While 144 did not complete recommended services and treatments, 105 completed the program. The reasons individuals might not have followed through included: individuals not responding after initial resources were provided by CARES (68, or 5.7%); moving out of the service area after contact (37, or 3.1%); and clients whose whereabouts were no longer known (16, or 1.7%).

Case disposition status for all cases closed/inactivated in 2024

The completion of the Case Closure Form required staff to decide whether to close a case or make it inactive. The most common case disposition decision (1,133) was to inactivate cases, with 25 of those cases re-opened for services. Meanwhile, 26 of the 1,184 cases were closed.

Cases remaining open for services

At the end of the calendar year 2024, 85 individual cases remained open for services: 53 (4.7%) of the 1,117 individuals initially engaged in 2024 and 32 individuals initially enrolled in 2023.

Outcomes: What was Achieved? What is Different Now?

Are individuals better off because of increased access to community resources, and being diverted from the criminal justice system? What policing benefits has CCAT facilitated? Of particular interest is if police outcomes such as de-escalations, reductions in use of force by police, decreases in the number of arrests with confinement, or reductions in unnecessary emergency department visits and 911 calls occurred.

Resources Provided to Individuals

Providing and connecting individuals to resources is central to CCAT’s policing approach. Resources (i.e., services/supports/treatments) were provided directly by CCAT and CARES staff, and were brokered by the

programs (e.g., connecting individuals to community, governmental and private providers). Clients, their families/friends (hence-forth caregivers), community providers, BPD personal, and CCAT units, all viewed received services from CCAT as central to client success and/or improved individuals' situations. Using a 5-point scale, with 5 meaning "strongly agree", ratings ranged from 5 to 4 (agree). Clients and caregivers' ratings were all 5s.

Resources were provided at initial engagement. A total of 293 resources, primarily transportation to treatment/crisis centers, emergency departments (ED), and shelters (106), food (71), and water (63) were provided. Of the 680 individuals not referred to CARES (399, or 58.7%) were documented as having received "necessary services provided by CCAT," and 11 (1.6%) received BFD medical evaluations. Another 3 (0.4%) of the individuals were referred to community, governmental, or private resources. Receiving services on scene may have been all the support some individuals required.

The 562 individuals referred to CARES for case management services, in addition to whatever resources they received at initial engagement, received an additional 1,488 services/supports or, on average an additional 2.6 to each client. The most common resources were staffing discussions with providers/within CARES (507), mental health treatment (260), and provision of information (214). (This does not include the count of the services provided by community providers to whom CCAT/CARES referred individuals.)

When cases were closed/inactivated, CCAT/CARES staff selected reasons for the change of case disposition and documented the major resources provided/brokered. Additional analysis of resources provided was conducted for the 105 individuals who were CARES-enrolled and who completed/mostly completed the program. On the Closure/Inactive Form staff provide an overall summary of the types of resources provided which led to the decision to change the case disposition to a closed/inactivate status. There were a total of 150 resources provided among the 105 individuals. The three most common resources provided to individuals were having their needs met by CARES (44.7% of the individuals), referrals to other organizations (for 30% of the individuals), and having their needs met by CCAT (for 22.7% of the individuals). Some individuals received more than one of these or other resources. In a survey, all clients and caregivers reported at "a strongly agree" level that "CCAT got me the services and help I needed" as well as "My situation is better because of the help provided by or through the CARES program."

CCAT/CARES Contacts with and on Behalf of Clients

CCAT and CARES staff documented all contacts with and on behalf of clients (e.g., communications with clients, their family, and community providers for services/treatments). CCAT units and CARES recorded 8,671 contacts and attempted contacts. This translates to an average of 6.6 contacts or attempted contacts per individual. On average, nearly all individuals (99.3%) had at least one face-to-face contact during ongoing engagement efforts. On average, clients also received more than one follow-up phone call along with at least one text, voice message or fax (103.5%). Of the 8,671 communications, over two-thirds (64.0%) were direct attempts/contacts with the individual client and the remaining communications were with caregivers, community providers, and others on behalf of the client. These contact counts are in addition to contacts made during initial on-scene engagements which are documented in narrative format on the Intake Form and those informal check-ins that occur with individuals that are not documented in the Contact Log.

For clients with caregivers, 18.2% of the caregivers had a face-to-face meeting with a CCAT/CARES staff member, in addition to potential initial engagement on scene. In addition, 46.5% of caregivers spoke on the phone with a CCAT/CARES staff, and 24.8% received a text, voice message or fax; again, in addition to what may have occurred during initial on-scene engagement.

Average Length of Time Spent on Service Calls

The CCAT program was designed to allow officers and MHPs to spend as much time as necessary with the individuals they engaged. On average, when CCAT units were the primary responders to their three most frequent response call type (behavioral health, suicides, and welfare checks), they spent seven more minutes on scene when compared to patrol. Length of time was noted as only one measure and should be assessed with the quality of the time, experience, and their increased ability to access additional needed services in mind. CCAT staff and stakeholder groups talked about the importance of units being able to “slow time down,” and employ different engagement and communication skills; important because persons struggling with behavioral/mental health issues generally require additional time to calm down, enabling them to verbalize what’s happening, express how they are feeling, and describe what’s troubling and/or scaring them at that moment. Cognitive and comprehension impairments might also be factors for some individuals. What’s being asked of and offered to individuals could take a bit more time and patience.

Stakeholders shared a few reasons to explain why CCAT units’ time on scene for suicides was less than patrol (i.e., patrol spent on average of 17 minutes and 50 seconds more time than CCAT) and why behavioral health time on scene by CCAT was just over a minute longer than patrol. Interviewees shared that in addition to CCAT units’ skills in quickly building rapport, it is not uncommon for patrol to hesitate when they first arrive on scene for these service call types, saying they need extra time to assess how best to respond, including working out their approach, and may have called CCAT and were waiting for CCAT to arrive.

CCAT as a Policing Approach and How It Differs from Traditional Policing

Clients and caregivers provided examples of how their experiences with CCAT units differed from other experiences with law enforcement. All reported that during their CCAT experience they felt police officers and MHPs were interested in understanding of what was happening, listened to what both clients and caregivers had to say, and offered supports that made their situation better. For two clients their prior experiences occurred outside of Bellevue.



Folks were very concerned about this man's safety. [Patrol] very quickly went hands-on. I think for us, that's not something that we would have done. I think that he really wanted to talk about this specific thing, but patrol officers got really stuck on, this is why [BPD] were called. For [CCAT] officers and for us when we're on scene we have this lens of we have more time, we can take a step back, we can look at the whole picture that has been so beneficial for us.

CCAT MHP





One of the times police was (sic) called to the home, my adult child and I were both taken to jail, and we stayed there three days. I was unwilling to share who was the aggressor. I knew my child needed medication and treatment, and would not receive [it] if taken to jail. Also, in jail he gets physically abused because of his behavioral/mental health condition. ... CCAT's engagement was different. CCAT, CARES, the police officers, and courts listened to me. The jail gave my son enough meds in jail so that when he was released, he could navigate through the airport and fly to where he had been treated previously. It was in part because of the involvement of CCAT and CARES, who offered support and advocated."

A FATHER OF AN ADULT CHILD WHO WAS A FIRST RESPONDER HIMSELF

Community providers also shared examples of their experiences with patrol officers and with CCAT units. Providers were keenly aware that patrol officers operate under a different set of guidelines and expectations, and that CCAT is a specialized policing approach tailored to meet the needs of those in behavioral/mental health crises. Staff from two agencies reported they valued that CCAT units check in with them when responding on scene. CCAT seeks insights about what triggered the call prior to engaging with individuals. Another factor they appreciated was CCAT units being able to better assess mental health related issues and then having the skills and knowledge to intervene more appropriately.

Stakeholders were asked three questions that examined how CCAT might differ from traditional policing. Using a 5-point scale, with 5 meaning "strongly agree," all clients, caregivers, and community providers rated 5 to indicate that CCAT units treated individuals with respect, showed concern, and explained their actions and procedures. Community providers rated CCAT units' understanding of individuals' situations and knowledge both at 4, "agree", levels, while clients and caregivers rated these two questions at the "strongly agree", 5, levels.

Policing Outcomes: De-escalation, Reduced Unnecessary Emergency Department Visits, 911 calls, Use of Force, and Arrest/Incarceration

De-escalation

CCAT units reported their efforts to build positive relationships with those struggling with behavioral/mental health issues prior to and when on scene. Their hope is that this practice aids in their future de-escalation efforts. Individuals will hopefully have stored trust and a better response to CCAT units' efforts to engage with them. CCAT units also work to build positive relationships with business owners and citizens. CCAT units' efforts focused on enhancing understanding of and support for individuals struggling with behavioral/mental issues.

Should there be a behavioral crisis near them, they are more receptive to the CCAT unit and less likely to press charges for trespassing or theft thanks to these efforts.

Reduction in unnecessary emergency department (ED) visits

Historically, police officers took individuals in behavioral crisis to ED because they did not have access to better resources to help the individual and were uncomfortable leaving them or asking them to move along. Additionally, officers taking individuals to the ED were hopeful that this resource would be helpful, if only in the moment, even knowing from experience that it didn't resolve the underlying issues. CCAT units reported having many more options than patrol officers - largely because of the teaming of officers and MHPs and the trainings units have received.



I think patrol officers have few options ... they defer to the ED because they need to do something with this person, leaving them is not an option or not appropriate or not safe ... and arrest is not appropriate."

CCAT MHP



Having MHPs on scene was regarded as an essential practice approach by clients, caregivers, community providers, BPD personnel, and CCAT units. The ability to observe individuals on scene and make assessments of an individual's current condition was described as indispensable. MHPs reported offering insights on how to best engage with individuals and de-escalate situations. They also informed decisions about whether going to the ED was necessary, whether another type of placement was more appropriate, if individuals were in imminent danger or if remaining home was a viable option and less

traumatizing. However, there were times when individuals needed to go to the ED to be further assessed and treated.

Survey ratings revealed that community providers, BPD personnel, and CCAT staff all believe CCAT's policing approach was able to divert individuals from unnecessary ED visits. Community providers rating average was "strongly agree" at 5. CCAT units rating average was at 4.7, close to the "strongly agree" level. Although, BPD personnel's rating average was at the "agree" level, 4, no additional narratives were provided regarding their rating.



A CCAT team brings an incredible amount of experience, knowledge, and resources to a given situation which helps tremendously with conflict resolution, future care options, and client relationships.

PATROL OFFICER



[911] calls for service that include a behavioral health component can be dispatched to a CCAT unit which is able to provide better trained service and direction for resources. The process frees up patrol officers to respond to other calls for services within the community.

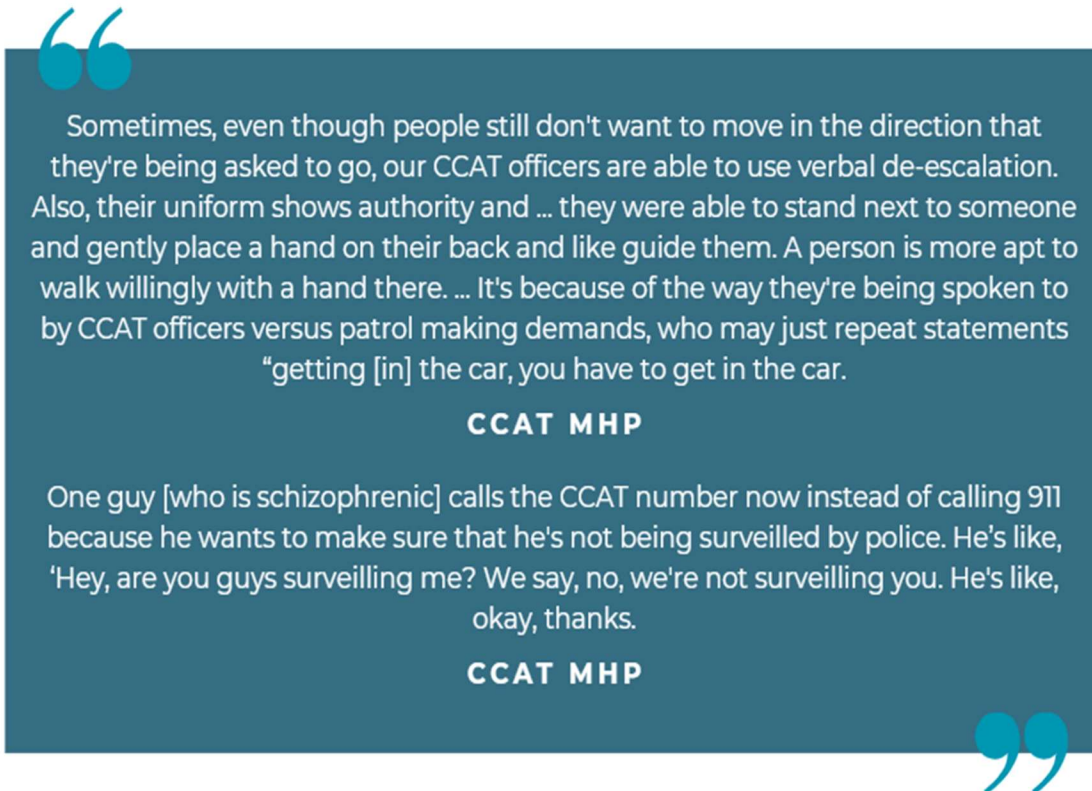
BPD SERGEANT/SUPERVISOR



Reduction in the number of repeat 911 calls

It is understandably a hardship - physically, emotionally, and mentally - on BFD and BPD first responders to be called out repeatedly, particularly to the same individual daily, to assist someone struggling with behavioral/mental health issues. Being unable to address someone's situation is emotionally challenging for them and they want to ensure that when they do respond, an individual's needs are effectively addressed, and it is safe to leave them. They are also concerned, when responding multiple times in a day (or a week) to the same individuals, that it takes them out of service, reducing their availability for someone whom they could potentially help more effectively.

CCAT's efforts to reduce the number of repeat 911 calls occurred by appropriately assessing and addressing the



needs of the individual and their family and connecting them to appropriate existing community services. CCAT also suggested individuals call them directly when they need to talk with someone or want support instead of calling 911. This has been effective with some clients who called 911 frequently.

Two survey questions provided clients and caregivers an opportunity to assess the extent to which they believe CCAT and CARES were meeting needs, which support the reduction in repeat 911 calls. They were asked to rate the extent to which their situation was better because of the help provided by CCAT, and the extent to which services provided through CARES were helpful. Rating averages for both questions were “strongly agree.” None of these individuals made another 911 call.

Reduction in use of force

Use of force is defined as the "amount of effort required by police to compel compliance by an unwilling subject." An officer's goal is to use only the amount of force necessary to mitigate an incident, make an arrest, and protect themselves or others from harm. Based on a review of BPD data, per the definition of “reportable

use of force” established by the Washington State Office of the Attorney General and the Washington State Data Exchange for Public Safety (WADEPS), there were no reportable uses of force by CCAT officers during 2024. At the same time, and in keeping with the Police Department’s commitment to transparency, accountability, and high-quality service, BPD continued to document instances in which officers used minimal force or safety specialized safety restraints that didn’t require a report at the State level. Based on this more comprehensive use of force reporting standards utilized by the Bellevue Police Department, there were 3 Use of Force reports taken that occurred during CCAT calls in 2024.

Community providers, CCAT MHPs, CCAT officers, and BPD personnel rated the extent to which they think CCAT as a policing approach reduces the need for use of force. Among community providers and CCAT officers, all ratings were “strongly agree”, at 5, while CCAT MHPs’ and BPD’s personnel rating averages were “agreed” at 4.5 and 4.0, respectively.

Reduction in arrests and incarcerations

Similarly to the reduction in use of force, the ability of CCAT units to de-escalate situations when engaging individuals was noted by all those interviewed as a major positive CCAT outcome and a reason they have been able to reduce arrests and incarcerations. Community providers, BPD personnel, CCAT officers, and CCAT MHPs rated the extent to which they think CCAT diverts individuals from being arrested and jailed. For all these stakeholders, except BPD, rating averages were at the “agree” level between 4.3 and 4.8. BPD personnel rating average was at the higher end of “neither agree nor disagree” at 3.7.



[CCAT] proactively engages folks who need support to get connected to the support that they need to keep them out of hospitals and jails.

HOUSING PROVIDER



Improved Clients Experiences and Relationships with Police

Clients and caregivers were very pleased with their CCAT interactions. All had prior police engagement and reported their CCAT experience to be more helpful. They rated CCAT at the highest possible rating of “strongly agree” (5 on a 5-point scale) on all eleven survey questions. Some noted that they wished they could have rated some questions higher. Below are select quotes from two caregivers highlighting how they felt about their CCAT experience.



When it's just an officer, they can't really do too much...They could only make a brief assessment, ask a couple of questions, say they can't do anything and leave. Police are hired to look for a certain thing in criminal situations. It's better when a social worker is here. The social worker can assess somebody with mental health issues right away, determine what help they need, and they're able to make that decision, something that the police can't make.

SISTER CAREGIVING FOR A SIBLING WITH MENTAL HEALTH ISSUES WHO PRESENTED A HEALTH AND FIRE RISK TO HER AND HER FAMILY

As a parent, you're like something's going on with your child. ... You're frantic and you're worrying, but [with CCAT] you have someone there to calm you down. [They say] 'Let's talk about it.' They understand and are just [there to] be helpful.

MOTHER OF PRE-TEEN WITH MENTAL HEALTH ISSUES, HEARING VOICES CALLING FOR SELF-HARM



Summary and Conclusion

This evaluation examined the initial 16 months of CCAT's implementation; focused on both process and outcome findings. The goal was to determine what occurred, who was served, what services and supports were provided, and to measure immediate client and policing outcomes. Stakeholders also provided program enhancement recommendations, which are available in the full report.

BPD and BFD successfully pooled their time and resources to create and implement a new policing approach. All stakeholders - clients, caregivers, community providers, and BPD personnel including CCAT units – reported CCAT as effective in engaging and serving individuals challenged with behavioral/mental health issues, and that the CCAT program should be expanded both in the number of units per shift and hours of operation. They would like to have more CCAT units available to respond to more behavioral/mental health crisis situations that occur during their current shifts. Currently, units are only able to respond to 71% of suicides and 59% of behavioral health calls with current hours of coverage. Stakeholders requested expansion because they have witnessed the improved quality of life among individuals and caregivers served. They are also supportive of CCAT's ability to de-escalate difficult situations, and reduce unnecessary ED visits, use of force, repeat 911 calls, and arrests and incarcerations. Stakeholders believe CCAT filled an important service gap in the city, strengthened BPD's working relationships with the community, and enhanced communication and information-sharing with community providers.