

CCAT

Community Crisis Assistance Team 2023 to 2024



Prepared for Bellevue Police Department & Bellevue Fire Department

Consultant Evaluator

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Introduction

Background and Mission

On May 1, 2021, 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) as a four-month pilot program to field test new policing models to better serve individuals in behavioral/mental health/substance use crisis. Based on data gathered, insights provided by stakeholders, and promising trends, Bellevue fully funded the program. This report presents findings and insights gathered during the first 16 months of the implementation, 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.

Program, Evaluation Design, and Approach

Best practice suggests a logic model be used to guide program implementation and evaluation efforts. A logic model is a theory of change model. It provides a visual overview of the program elements and activities. Its bullet point format provides a summary of the inputs (e.g., community and program resources, client characteristics, etc.), and the activities (e.g., highlights the program approach). The logic model also outlines program outputs. Outputs are a count of the “how many and how much” of what happened (e.g., how many 911 responses, how many clients were served, etc.). The hope is that the actions taken by the program and the resulting outputs will lead to specific and measurable anticipated changes. These changes (outcomes) are the measure of what is different now for clients, and/or for governmental and community systems, because of the program and changes in policies and practices that occurred (e.g., clients are better served and have needs met, police practices are enhanced and result in better outcomes such as increased de-escalation practices, reduced use of force, reduction in unnecessary emergency room utilization and arrests/incarcerations, and strengthened relationships/rapport with individuals).

The CCAT leadership, comprised of BPD and BFD personnel, in partnership with a third-party external evaluator,¹ developed a logic model for CCAT. This team met as needed to oversee

¹ The evaluation study and report were conducted and written by Carol J. Harper of Social Visions, an external researcher. Working closely with the CCAT leadership, Ms. Harper finalized all evaluation tools and facilitated the scheduling of interviews. Ms. Harper conducted all interviews alone, in-person, on Zoom, or over the phone depending on participant’s preference.

program implementation, make program decisions, support evaluation decisions, and review findings. To gain an overview of the CCAT policing design, activities, outputs, and outcomes see Appendix A: CCAT Logic Model.

Evaluation Approach

The major goals for this evaluation were to gather data and insights on the program's impacts and effectiveness and provide recommendations to guide future program efforts. The evaluation design embraced both quantitative and qualitative data gathering.

The quantitative data included BPD administrative data² and information entered in real-time into the CCAT Case Management Database by CCAT units and Bellevue Fire CARES³ staff. Qualitative data was gathered through tailored interviews with 18 individuals (CCAT staff, clients, relatives/friends, and community agency professionals). In addition to those interviewed, another 23 stakeholders completed tailored surveys. Both qualitative approaches provided information about their experiences with and assessments of CCAT. By utilizing qualitative and quantitative data, a more complete snapshot of the program's impact was gathered.

Report Format

Information presented in this report will be presented in sections following the logic model format. The first section of the report highlights program inputs. The second section's focus is on both program activities and outputs. The third section presents information and data on immediate outcomes. The final section provides recommendations for future implementation considerations and a summary and conclusion of findings and insights.

Each section relies heavily on quantitative data presented in charts and tables; both are preceded by a short description of the data presented in the table. The qualitative insights provided by those interviewed and surveyed are inserted within report sections to enhance understanding.

Inputs

Introduction

This report section provides an overview of the CCAT program approach, staffing, and operation, and a description of the demographics of the individuals with whom the CCAT units

² BPD administrative data and analyses were provided by Lynn Boerner, BPD staff member.

³ Bellevue Fire CARES is a program within the Bellevue Fire Department. Since 2012, Masters of Social Work (MSW) student interns, supervised and supported by seasoned MSWs, provide initial and ongoing follow-up supports to clients and relatives engaged by first responders (e.g., through the 911 system). With the implementation of CCAT, individuals who choose to receive case management services are assigned a CARES advocate.

engaged and served.

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

Community Crisis Response Team (CCAT) Model

In 2012 Bellevue Fire launched the Bellevue Fire CARES Program. Staffed by MSW student advocates and a professional MSW supervisor, CARES Advocates follow up on individuals referred by Bellevue Fire and Police following a 911 call response. In 2017, CARES 101, a dispatchable unit staffed by MHPs (Mental Health Professionals), was added, and began to respond on scene at the request of police or fire. CARES101 units are dispatched to provide crisis intervention services and will remain on scene with individuals, if needed, freeing up first responders for other 911 calls. Following a CARES101 response, the CARES MHPs provide support to individuals, who choose to engage in case management services.

CCAT was designed to provide an even more immediate, sustainable, coordinated community response approach, focused on serving individuals experiencing behavioral/mental health crises. CCAT involves the teaming of specially trained BPD patrol officers and MHPs to respond to 911 calls involving individuals in behavioral crisis, as well as those who are unhoused and/or struggle with substance use. CCAT units may also engage individuals they observe or with whom they otherwise engage in the community. If individuals would benefit from ongoing services, CCAT works to connect them with CARES Advocates.

“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 to serve on CCAT units. These officers were selected because of their interest in and compassion for individuals experiencing behavioral/mental health issues. Prior to their CCAT assignment, they served as patrol officers. Some of these CCAT officers also served during the CCAT pilot.

A BFD CARES Licensed Independent Clinical Social Worker (LICSW) supervises the seven MHPs in the Fire Department assigned to CCAT. These MHPs are all experienced MSWs, most of whom have served on the CARES101 dispatch unit prior to this re-assignment.

The Bellevue Community Crisis Response Program Manager is an LICSW in the Fire Department, and has been with the BFD response program since 2013. She oversees all three Bellevue Community Crisis Response Programs on the Bellevue Fire Side: CARES, CARES101, and CCAT. (See Appendix B: Staffing Diagram.)

Operations

CCAT officers and MHPs completed skills trainings, in areas such as crisis intervention techniques, mental illness identification, communication approaches, de-escalation strategies, crisis/hostage negotiation and mental health system processes and procedures. They share office space in one of the city's fire stations. MHPs meet weekly to review client cases and discuss best practice approaches. CCAT units meet quarterly to review cases and exchange insights. These approaches were implemented to enhance case practice, ongoing cross-team education, collaboration, and unit cohesion.

Ideally, a CCAT unit (an officer and an MHP) are the first responders to arrive on scene when individuals are experiencing behavioral/mental health crises. Behavioral/mental health issues may be temporary or long-term. In addition to responding to 911 calls and BPD radio dispatch calls, CCAT units engage in preventative activities and building ongoing relationships with individuals known to have experienced behavioral/mental health crises. They visit people living in homeless encampments, providing bottled water and snacks. They check-in with individuals experiencing homelessness in the streets, on public lands, and those living in their cars. CCAT staff share their direct contact information with these individuals.

CCAT units also seek out relationship building, educational, and outreach opportunities with community agencies, businesses, and the public. The goal is to increase program awareness, build working relationships, and foster trust in advance of a response event.

CCAT hours of operation were adjusted at the beginning of 2025. A heat map analysis of when most behavioral/mental health incidents occurred was used to set work hours. Currently, CCAT coverage is Monday - Thursday: 6 a.m. to 12 midnight, and Friday - Sunday: 6 a.m. to 10 p.m.

CCAT 2023 to 2024 Activities

Bellevue Case Management System

The Bellevue Case Management Database System was initially developed in 2015. In August 2023, efforts began to adjust this database to also house a CCAT Case Management System. On September 1, 2023, CCAT units began entering incident and client data in the CCAT Case Management System. During the initial four months of implementation, adjustments to the database were suggested by staff. (For this reason, analysis that follows is limited to individuals engaged between January 1 and December 31, 2024, for whom there is consistent data.)

The CCAT database supports real-time access to case information. It captures detailed information about the reason for the response, what occurred on scene, and ongoing client actions. CCAT staff complete a CCAT Intake Form for each individual following an initial incident. This step enrolls individuals into CCAT. Once enrolled, all future interactions with an individual are entered in the CCAT Contact Log, also within the database. If the individual elects to accept ongoing case management services through CARES, the CARES staff enters their client interactions into the CCAT Contact Log. This provides CCAT and CARES staff online 24/7 access

to all prior and current client activities. Thus, whenever a CCAT unit or CARES team visits or is dispatched to a client, they can review - enroute or on scene - what has been happening in the client's life. Those details are used to inform their engagement approach and decision making.

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). Between January 1, 2025, and November 15, 2025, an additional 698 individuals were engaged, for a total of 2,218 individuals thus far.

Client demographics and program activity data presented in this report is for the period between on January 1, 2024, and ending on December 31, 2024. Similar data for those engaged and served in 2025 will be made available in 2026.

Demographic data of individuals engaged

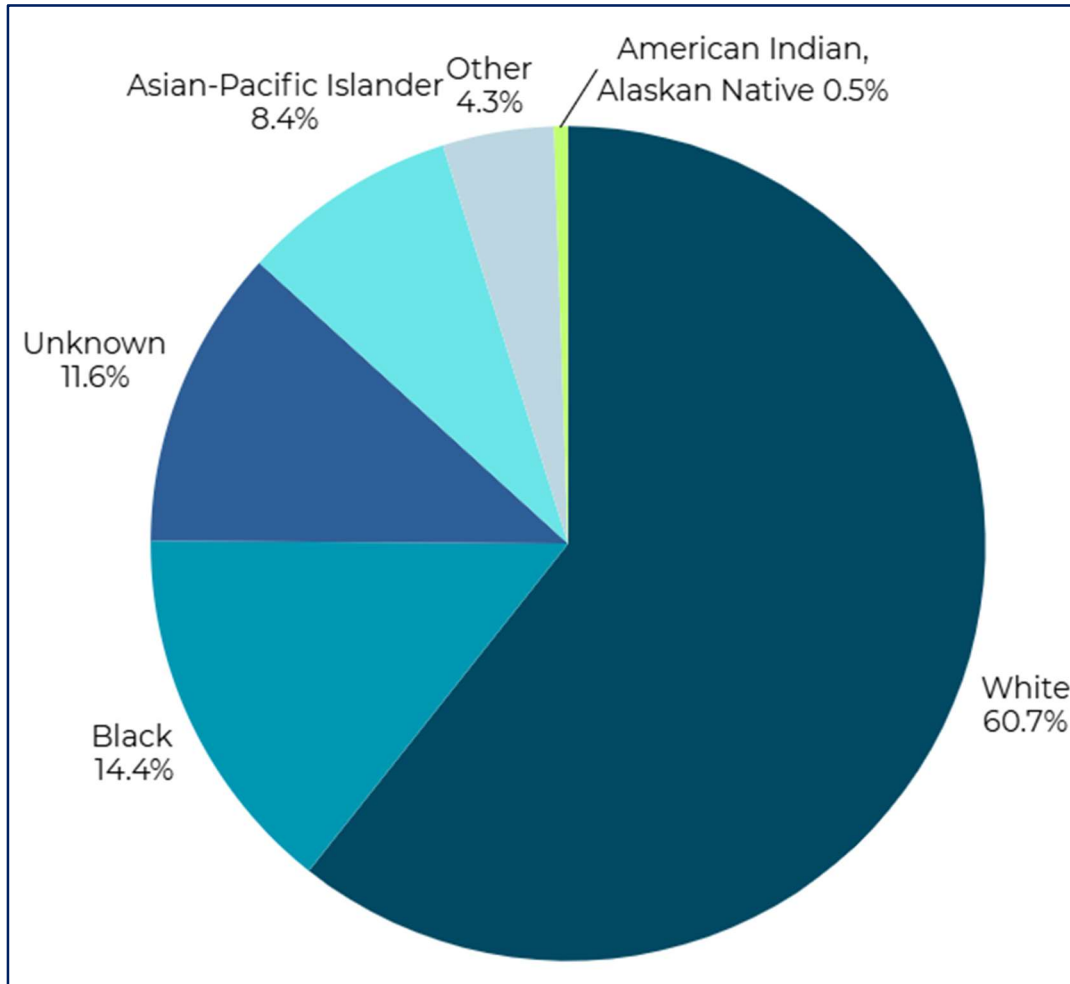
Males represented most individuals engaged (552 or 56.2%). Of the remaining individuals, 412 (42%) were females, 10 (1%) identified as transgender, and 8 (.8%) identified as other. Gender was unknown for 135 (12.1%) individuals.



Age was available for 909 individuals. The average age among those engaged was 42.3 years, with a range of 1 to 96 years of age. The average age was 34.3 years for males, 45.1 years for females, 21.1 years for transgender, and 21 years for those who identified as other.

Documentation of race at initial CCAT engagement does not consistently occur. Unit members reported that because individuals are in crisis and CCAT units are focused on serving clients and building relationships, it is not the ideal time for them to confirm race and ethnicity. For this reason, it is better to use the demographic data captured in BPD LERMS (Law Enforcement Records Management System). Among the 928 individuals entered in this system, most individuals 563 (60.7%) engaged by CCAT units were White. Among those with known ethnicity, Non-Hispanic White was more common. Chart 1 & Table 1 (in Appendix B) provides details on race and ethnicity of individuals engaged.

Chart 1



The primary language spoken by individuals is documented in the CCAT Intake Form. Among the 1,104 individuals whose primary language was documented, 98% percent spoke English. Thirty-one individuals reported having other primary languages; Spanish (7), Russian (6), Chinese/Mandarin (6), and one for each of the following languages: American Sign Language, Amharic, Arabic, Bulgarian, Farsi, Punjabi, Japanese, and Vietnamese. Fourteen of these 31 individuals required a translator.

Presenting issues of individuals at initial engagement

As explained earlier, CCAT units document in the CCAT database details concerning what occurred on scene, as well as what was learned and observed about the individual’s situation (e.g., medical needs, mental health condition, housing). This information shapes initial and ongoing client interactions, decision makings, and case management.

Count of presenting issues:

Among the 1,117 individuals for whom CCAT staff completed an Intake Form, starting in January 2024, 51 (4.6%) had no presenting issue documented. Among the other 1,066 individuals, there were a total of 2,460 issues, thus individual may have more than one presenting issue. In fact, the average number of



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



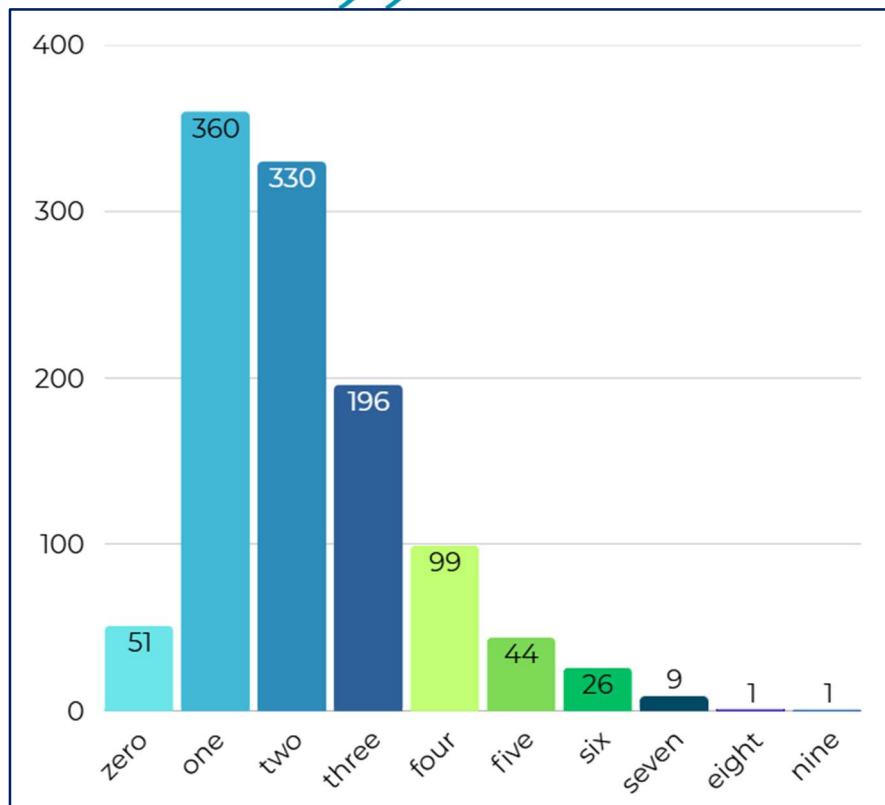
My brother would not take his medication for mental health issues. He wouldn't care for himself and has created [an] extremely hazardous, unhealthy home environment, and has additional behaviors that result in (sic) fire hazards. He almost set my house on fire. I worry about my children's safety.

A SISTER CARING FOR AN ADULT BROTHER



issues per individual was 2.3. The range in number of issues among these 1,066 individuals was one to nine issues. For example, 360 of the 1,117 (32.2%) individuals engaged by CCAT had one issue while most individuals, 706 (63.2%) had two or more issues. Chart 2 and Table 2 (in Appendix B) provide a count of the individuals, along with the number of issues, and the percentage of individuals having that quantity of issues.

Chart 2



Presenting issues

The analysis above focused on the number of documented issues per individual. This analysis examines the “presenting” issue(s) among these individuals. Analysis revealed the most likely presenting issue (reason) for CCAT engagement was one or more behavioral/mental health issues. In fact, nearly sixty percent (59.4% or 633) had a behavioral/mental health issue.

The second most likely reason for engagement was a welfare check, the belief that a person needed assistance or care, including behavioral/mental health concerns. In fact, 515 (48.3%) individuals were reported in need of assistance/care. The third most likely reason for engagement was that individuals were unhoused, accounting for 299 (28.0%) of the individuals engaged.



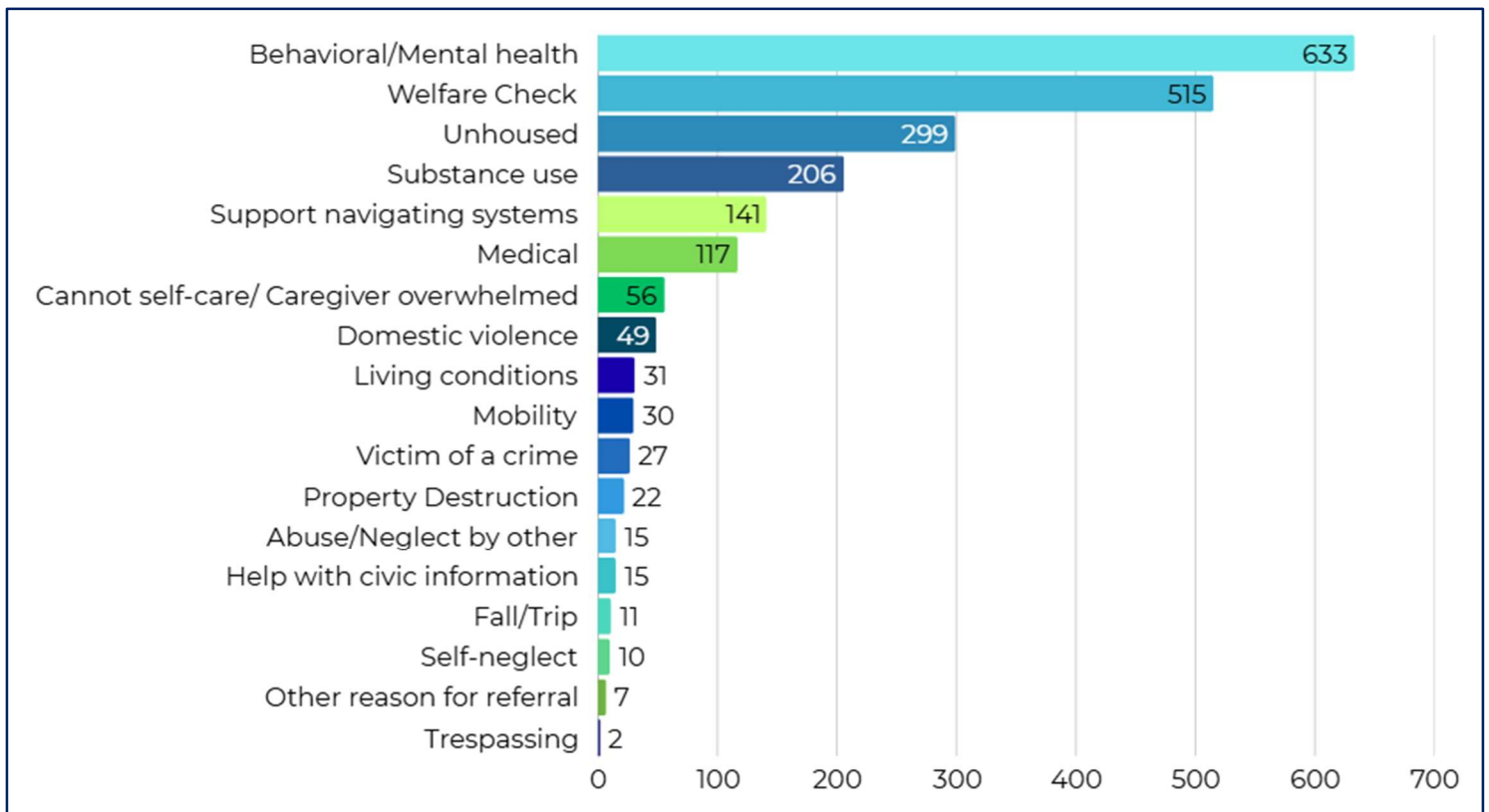
Mental health stuff, it's tricky.
Postpartum, it's tricky.

A CLIENT WHO ATTEMPTED SUICIDE



Chart 3 and Table 3 (in Appendix B) provides a list of presenting issues and a count and percentage of individuals identified with each specific issue. As mentioned above, individuals may have more than one issue. Presenting issues are displayed in rank order from most likely to least likely.

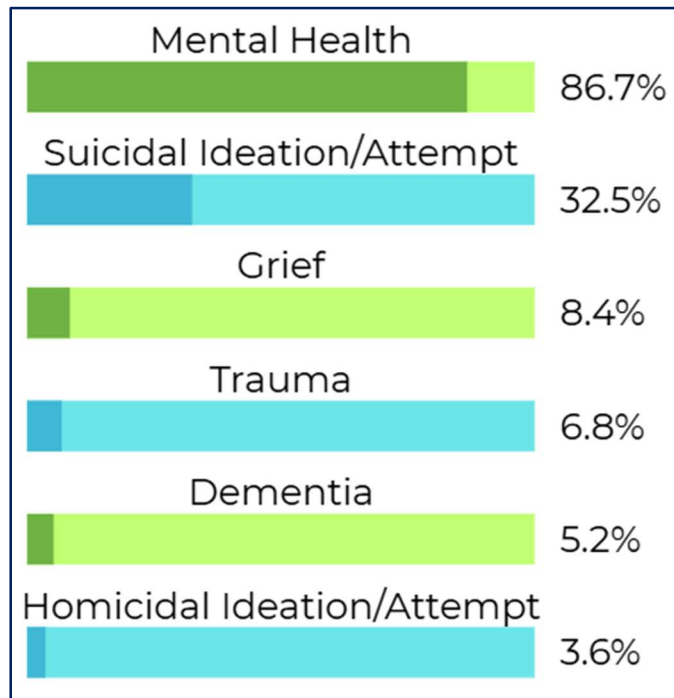
Chart 3



Additional mental health observations

To better understand an individual’s situation, CCAT units listen to what individuals say and observe them to identify potential behavioral/mental health issues. For example, an individual may share their mental health diagnosis, which would be recorded as a “behavioral/mental health” issue in the CCAT database.⁴ However, if during the conversation, the individual also talked about suicide, the CCAT unit would document both “behavioral/mental health” and “suicidal ideation/attempt.” This helps the next engaging unit/team better address the situation. Chart 4 and Table 4 (in Appendix B) provide details on the various types of behavioral/mental health concerns shared or identified among the 633 individuals with behavioral/mental health issues documented at initial engagement.

Chart 4



Complexity of Cases

Additional analyses were conducted to determine the number of individuals who are viewed as having the most challenging combinations of co-occurring presenting issues: mental health, being unhoused, and substance use. This does not mean to imply that other issues are easy to address or are less serious or emotionally difficult.

⁴ In some situations, an individual may not or is unable to share a formal diagnosis due to their current condition, or may not have a diagnosis. MHPs will use their professional knowledge to observe and assess individuals based on their actions and behaviors, and document them but will not make a diagnosis.

A client's father described over 30 years of seeking help for his now adult child.

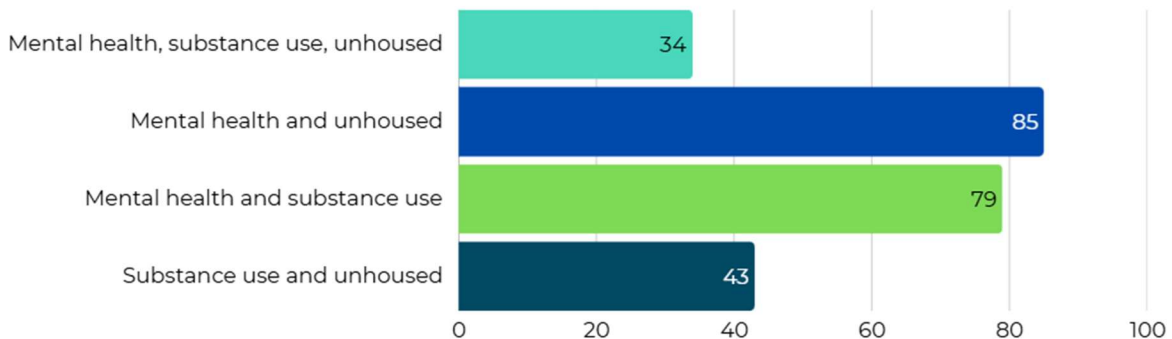


My child is 47 years old. He is schizophrenic, bipolar and has had schizoaffective disorder with bipolar tendencies since 14. He left home and lived with friends, electing to leave home might have been related to drug or alcohol use. We got him into a 30-day treatment program. He did not do well there. 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.



Among the 1,066 individuals seen by CCAT with documented issues, a total of 241 (22.6%) presented with at least two or more of these complex co-occurring issues. 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. Meanwhile, 79 individuals presented with both mental health and substance use. These findings highlight the complexity of issues which individuals faced, level of staff efforts and potential length of time required to address these conditions. Chart 5 and Table 5 (in Appendix B) provide a breakdown by combination of issues and the percentage they represent out of 1,066 initially engaged individuals.

Chart 5



Activities and Outputs: What Occurred? Counts of How Many

This report section provides a snapshot of program activities, and what occurred on scene and after the initial engagement. For example, the call types (reasons) to which CCAT responded, whether other officers were present in addition to CCAT units, and where in the city responses

occurred. The section also highlights outputs. It provides counts of the “how many,” for example, to how many calls CCAT units were dispatched, counts of the various call types to which CCAT units responded, and counts regarding level/extent of engagements (case disposition). Basically, it documents the actions taken by CCAT and provides counts of these actions along with program decisions made by individuals.

It is common for an output section to include information/findings on the amount of time staff spent with individuals, and counts of the various services and resources provided to individuals. However, since the central goal of the CCAT program is to enhance policing approaches, their engagement with individuals with behavioral/mental health issues, these findings will be shared in the outcome section of the report.

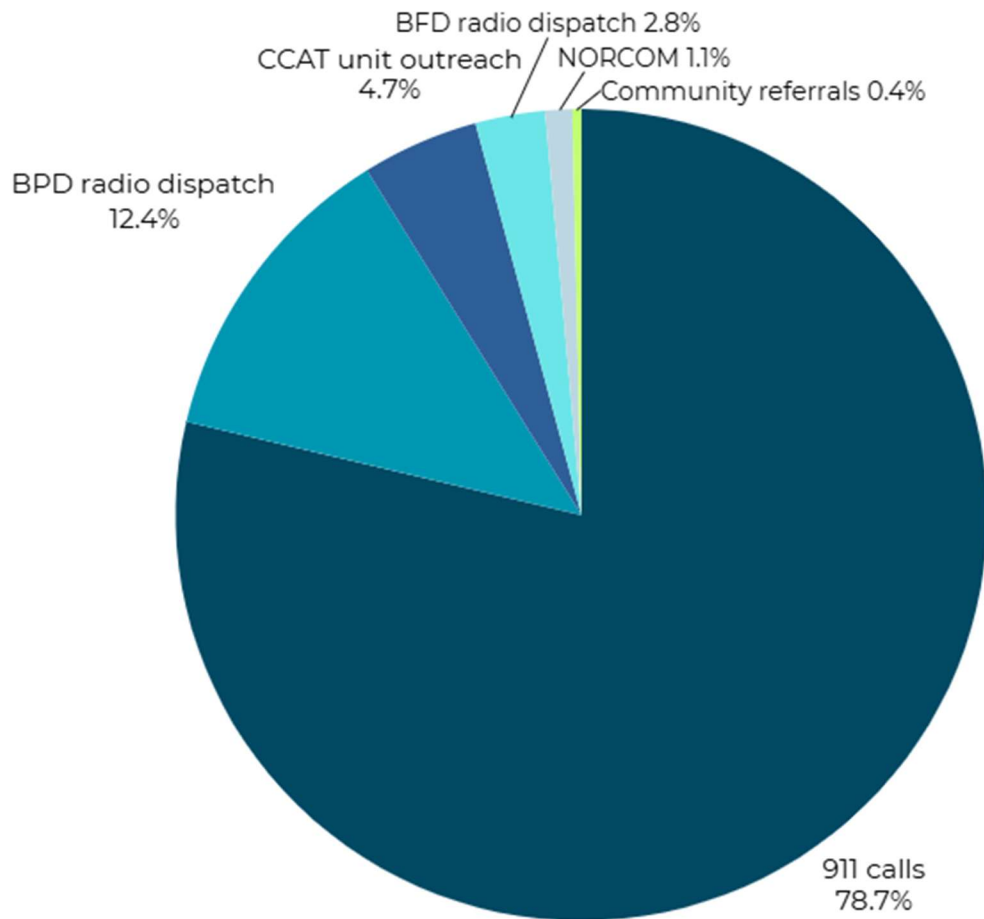
Engagement with Individuals

Call response

On the way to each call, CCAT officers check the BPD database to learn about potential law enforcement engagement by the individual - if they know their name. Meanwhile, CCAT MHPs check the CCAT/CARES databases to determine if the individual was previously engaged. If the individual has been engaged, units are able to access details regarding the person’s past CCAT/CARES interactions. These insights support on scene engagement strategies.

Once the on scene response is completed, CCAT units enter notes on their interaction with the individual into either an Intake Form or the Contact Log. If the individual has been seen previously, the information is entered into the person’s unique record in the Contact Log. If this is the individual’s first CCAT engagement, the information is entered into the Intake Form, which automatically becomes the first entry in their Contact Log. The goal is to ensure that if there is a reason for a future CCAT response, future units are up to date, and if there is a CARES team follow-up, they too are informed.

Chart 6



Call source

During the period under review (PUR), as documented in the CCAT database, CCAT units were dispatched, self-dispatched, and reached out to 1,117 new individuals in 2024. Their primary call source was 911. In fact, 879 (78.7%) of the individuals CCAT units engaged were the result of 911 calls. The next most likely call source was BPD radio dispatch/direct request for another 139 (12.4%) individuals. CCAT units proactively engaged an additional 52 (4.7%) individuals while driving within the community and visiting unhoused camps. Chart 6 and Table 6 (in Appendix B) provides a count and percentage breakdown of initial engagements, in rank order, as documented in the CCAT database system.

While the CCAT Case Management System documented incidents and actions, and served as the case management system for everyone served by CCAT, the BPD Records Management System (RMS) was utilized to track the activities for each CCAT officer and served as BPD’s internal incident report system. A difference between the two systems is that BPD does not separate whether call source responses were initial or follow-up. In 2024, BPD RMS data documented CCAT officers responding to a total of 3,602 incidents for an average of 300

incidents a month. In 2,105 of these responses, CCAT units were the primary unit (first) on the call and the assisting unit for 1,497 responses. BPD RMS data analysis also showed that most calls (2,997) that the CCAT officers responded to were generated by a 911 call (83%), followed by 605 (17%) incidents being either radio or officer-initiated call sources.

CCAT responded to 5% of all calls to BPD in 2024 (69,543). CCAT's seemingly 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. 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

The BPD RMS tracked call types (reasons for service requests). BPD Data Analysts generated a list and count of the top 10 call types responded to by CCAT. The BPD analyst also pulled data on the total number of calls to BPD for each of these call types during the hours CCAT operated. This allowed for an analysis of what percentage of each call type were responded to by CCAT units. Analysis revealed that CCAT units were dispatched and handled situations in alignment with their specialized skills. CCAT units respond to 93 (71%) of all suicide calls, 641 (38%) of all behavioral health calls, and 578 (59%) of all welfare check calls in the city that occur during the hours they were in service.

In addition to handling the call types described above, CCAT units responded to many "assist" calls. Assist calls occur for three main reasons: 1. A business or individual needs assistance with an individual on their property, 2. an outside agency needs assistance, 3. an individual needs information or help from law enforcement. CCAT units responded to a total of 869 (14%) assist calls (making this the most likely call type they respond to). CCAT responding to assist calls is appropriate; community agencies interviewed talked about the need for police support and how beneficial it is to have CCAT units respond. Below are select quotes from three agencies interviewed followed by Chart 7 and Table 7 (in Appendix B) which provides a list of the ten most likely call types CCAT units response.



It's critical in that [individuals] feel seen, heard, and valued. The CCAT officers and the social workers do a really good job of that.

HOUSING PROVIDER

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

When CCAT showed up to observe an individual yelling at me right in my face, they didn't like jump in and like rescue me or anything, but they observed. They took a moment and saw what was going on and then invited the tenant - who they were familiar with - to go talk to them outside. They were (sic) able to debrief with me afterwards about her concerns, how she's presenting, and how she's planning to spend the rest of her day. A kind of safety plan with us on site.

HOUSING PROVIDER



Based on current staffing and availability, CCAT units were able to respond to a total of 11.2% of the top 10 call types that occur annually in Bellevue. CCAT's inability to respond to more of these calls was affected both by the limited number of staff available and limited hours of operation (i.e., not operating 24/7 or having more units). Table 7 (in Appendix B) presents in rank order the number of these call types CCAT units handled during their hours of operation. Written text and numbers in bold font are the three highest percentage of call types to which CCAT responded.

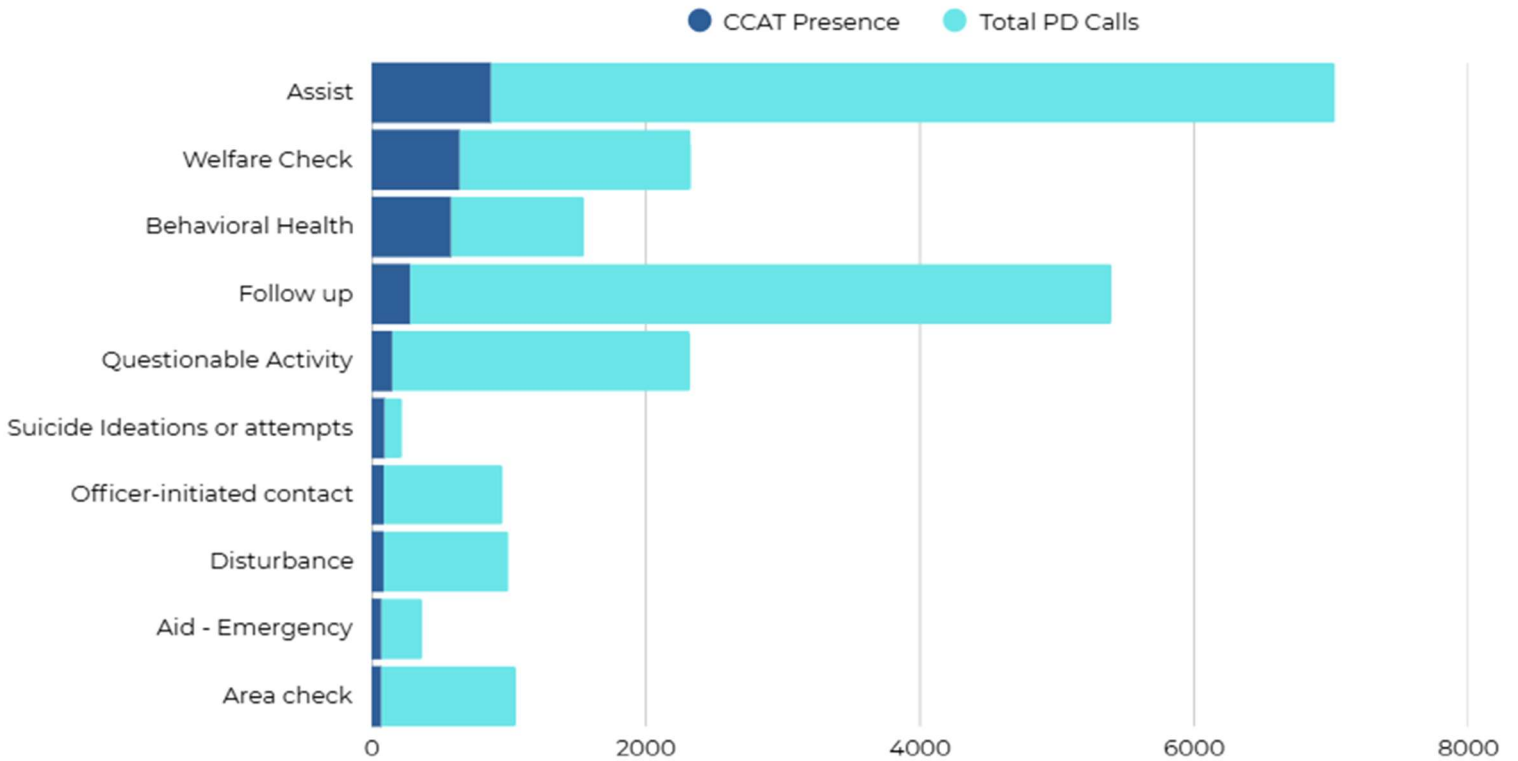


...at the point [we call 911], we have really exhausted ... our verbal de-escalation skills, our physical restraint techniques ... It's not our goal to use external resources often. ... When we [call, we need] a [response in a] timely manner. We have had times where it's been 40 minutes before police [let alone CCAT] can respond, and obviously larger things are going on in the community. But during that time, we have something even more unsafe taking place.

SPECIALIZED SCHOOL PROFESSIONAL



Chart 7



Areas served

CCAT units served the entire City of Bellevue. Most of their responses were concentrated in the northwest area of Bellevue. This area consists of downtown business and the transit center. For example, there were 783 incidents in 11 locations within the city. Locations included a homeless encampment, a school, a shopping mall, two specific apartment complexes, two residences, and two homeless shelters. These locations are within the red highlighted areas in the map below (Figure 1).

Another question on the Intake Form was whether a patrol officer was on scene. They were on scene 487 (43.6%) times, either as the initial first responder, or as backup. Table 8 presents additional details about what occurred at initial engagements.



I remember (MHP's name) showing up in his red, very distinctive uniform and thinking, so they've got one of these, got an observer coming along to help de-escalate the situation, and a subject matter expert for the police. ... You know [sometimes] things go too far with mentally ill individuals; bad things happen to them. I was thinking this is cool. Bellevue is doing something. This is progressive. This is great. This is helpful for people.

**MOTHER WHO ATTEMPTED
SUICIDE DUE TO
POSTPARTUM DEPRESSION**



Table 8: What occurred at the initial engagement

Question	Yes	No	Percent Yes
CCAT was first on scene	741	376	66.3%
Uniformed police officers were on scene	487	630	43.6%
Adult Protective Service (APS) referral made	14	1,103	1.3%
Designated Crisis Responders (DCR) referral	6	1,111	0.5%
Child Protective Service (CPS) referral made	4	1,113	0.4%
Residential Care Services referral made	1	1,116	0.1%
Police required for CARES follow-up visit	62	1,055	5.6%

Number of individuals served

In addition to the 1,117 individuals CCAT units initially engaged in 2024, there were an additional 202 individuals whose initial engagement occurred in 2023, and who continued to be served. Thus, during the PUR, CCAT units along with CARES worked with a total of 1,319 individuals.

After Initial Engagement

What happens following initial engagement?

CCAT and CARES are both voluntary services. Individuals have the right to opt out of services on scene as well as at any point during their contacts with CCAT and CARES. 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, do not provide contact information, or if they live outside of the service area. Eligible individuals who elected not to engage with CCAT or CARES were encouraged to reconsider enrollment if engagement was assessed to be of value. Regardless of their decision, all individuals were provided on scene services to address current crises and supported to access community services. Individuals who elected not to engage were also provided information on how to reconnect with CCAT if they should change their minds. (Information on the services, supports, and resources provided on scene and provided for those who elected to engage are presented in the outcome section of this report.)

Case disposition

Best practice requires an ongoing review of cases to determine service needs and when services may no longer be needed, including when it is time to end engagement based on the desires of the individuals. 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). CCAT learned during their 16-month implementation that implementing a "final" closed case decision was inappropriate for most individuals for the population they served. Behavioral, mental health, and substance use issues, by their nature, have many challenging ups and downs. Dealing with and overcoming these conditions is not a linear journey, but also not an impossible one. Some individuals improve and live fully functional lives, while others may function well for some time before needing services again. A few, unfortunately, may spend the rest of their lives struggling and in need of ongoing support. For these reasons, CCAT learned to be flexible with its case disposition terms, understanding that individuals might flow from one case disposition status to another in a short timeframe, and back again.

CCAT had very few cases that warranted formally closed status. Instead, they created an inactive status category. This makes it easier and quicker for CCAT/CARES staff to access individuals' case files should another crisis occur or should individuals reach out to the program to reactivate services. It is possible to access the case files of those whose cases were closed, but it takes additional computer steps. In 2024, 25 inactive cases were re-opened for service. Outlined below are the definitions for Inactive Cases and Closed Cases. (Description and details of served/closed cases and count of cases remaining opened for services are presented later in this section.)

- **Inactive Case** designation was assigned to cases when individuals were assessed to still need case management services, resources, or treatments. However, these individuals elected to end their engagement - or not follow through with recommendations made by the program or by community providers - reporting they no longer needed services. CARES either did not agree and/or did not know the person's whereabouts. The concern remained high for, but was not limited to, individuals with the following: uncontrolled behavioral/mental health, substance use, and medical conditions, living in unsafe situations, unable to care for and protect themselves, and lack of needed

resources/services. These individuals were believed to be at risk for another crisis and were still living in the service area.

- **Closed Case** designation was reserved for individuals whose program reengagements were unlikely to occur. These include individuals known to have moved out of the service area, who had passed away, or who had followed through with services and were able to safely self-care or were being cared for by community based/private agency, and/or family member. Thus, future crises were unlikely.

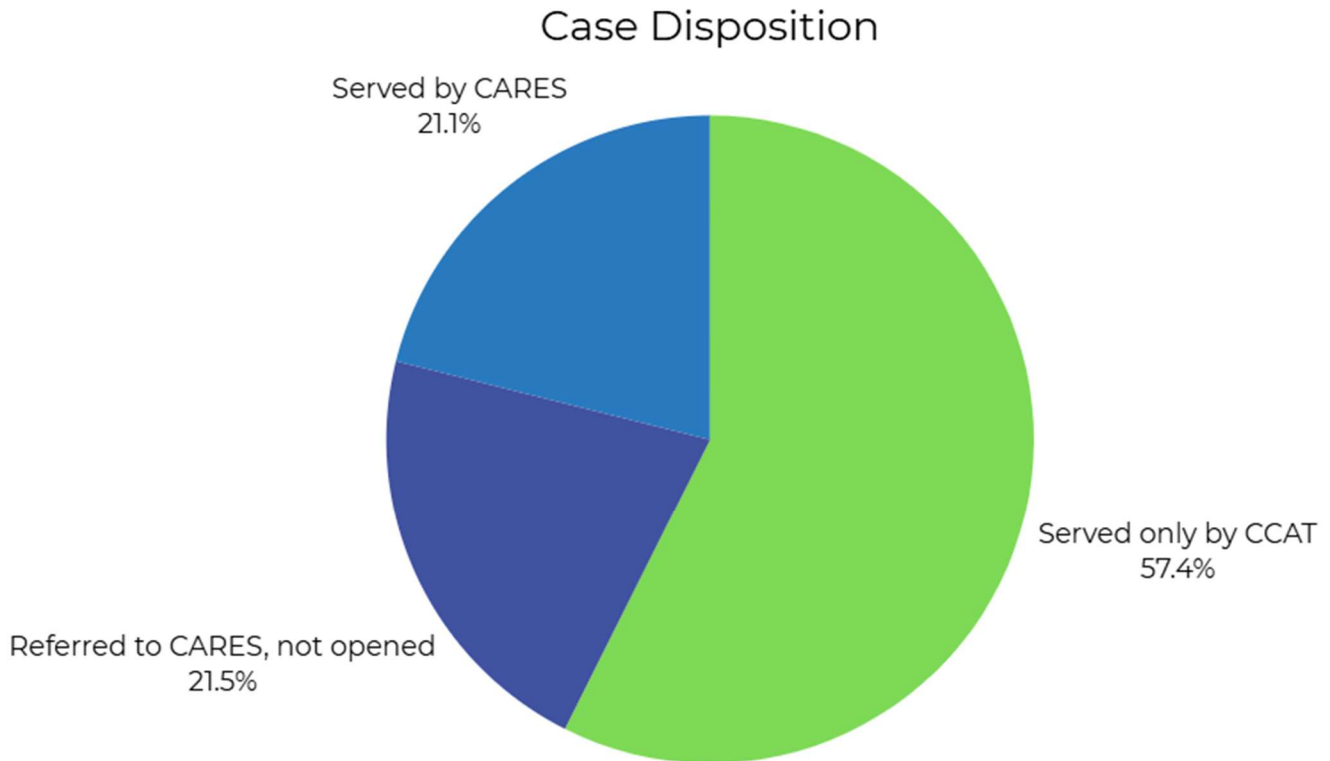
Factors influencing closed/inactive case decisions

This sub-section examines and presents counts of the various case disposition categories and factors associated with cases no longer being actively served by CCAT/CARES. Closed/inactive case disposition begins with the completion of a Case Closure Form. In 2024, case closure/inactive dispositions were completed for 1,184 individuals/cases (those who were initially engaged in 2023 and 2024). The three engagement categories are listed below.

- On scene, only served by CCAT (i.e., individual not referred to CARES for ongoing services)
- Referred to CARES, but not opened (e.g., declined upon contact or unable to contact)
- Served by CARES (i.e., some individuals completed the program, others dropped out)

The most likely closed/inactive category was “on scene, only served by CCAT.” A total of 680 (57.4%) individuals only engaged with CCAT on scene. However, 166 of these individuals were ineligible for additional services/referral to CARES because they lived outside of the service area. Excluding these individuals from analysis reduced the number of individuals in this category to 515 (51.1%), or just over half of those engaged by CCAT. Of the remaining individuals, 242 were referred to CARES, but were not opened for services, and 249 individuals were opened for services. Following Chart 9 and Table 9 (in Appendix B) are detailed descriptions and explanations of the factors that led to each of these case dispositions.

Chart 9



On scene, served only by CCAT

A total of 515 (51.1%) individuals opted out on scene, while 166 (6.6%) were ineligible for referral to ongoing service. There were various factors that influenced this disposition. As noted above, the most likely factor was because individuals (166) were ineligible for enrollment (e.g., they lived outside the service area). They represent 14% of all those engaged on scene. Even though they were ineligible for ongoing services, they and all individuals engaged on scene by CCAT were provided services and information.

The second most common reason individuals only received on scene services was that they declined services beyond what they may have received on scene. Of all those eligible for ongoing engagement, a total of 142 individuals (11.1%) declined. Even though they declined ongoing services, they were encouraged to accept said services if the underlying issues might result in future crisis. Keep in mind that there were several reasons that individuals did not select ongoing services. The incident may have been a momentary need, and once the crisis was addressed, there was no longer a need for resources. While for some individuals, additional services to address underlying issues were viewed by CCAT as needed, the individuals were either not ready to address their current situations or felt services were not necessary.

The third most likely reason for not selecting ongoing services was because an individual “already had services in place” and felt additional services were unnecessary. However, of

these 111 individuals, 44 (40%) did elect on scene services from CCAT. Table 10 provides, in rank order, all the reasons individuals only received CCAT services on scene.

Table 10: Reasons individuals only received services on scene

Reason for only on scene services*	Count of individuals	Percent of all closed/inactive cases (1,184)
Individual lived outside of service area	166	14.0%
Declined CCAT services	142	11.1%
Already had services in place at time of CCAT engagement	111	9.4%
CCAT unable to obtain contact information for follow up	101	8.5%
Already enrolled in CARES (6) or CCAT (2)	8	0.7%
Unable to locate	5	0.4%
Individual did not require even initial support	3	0.3%
Total count of factors	536	N/A

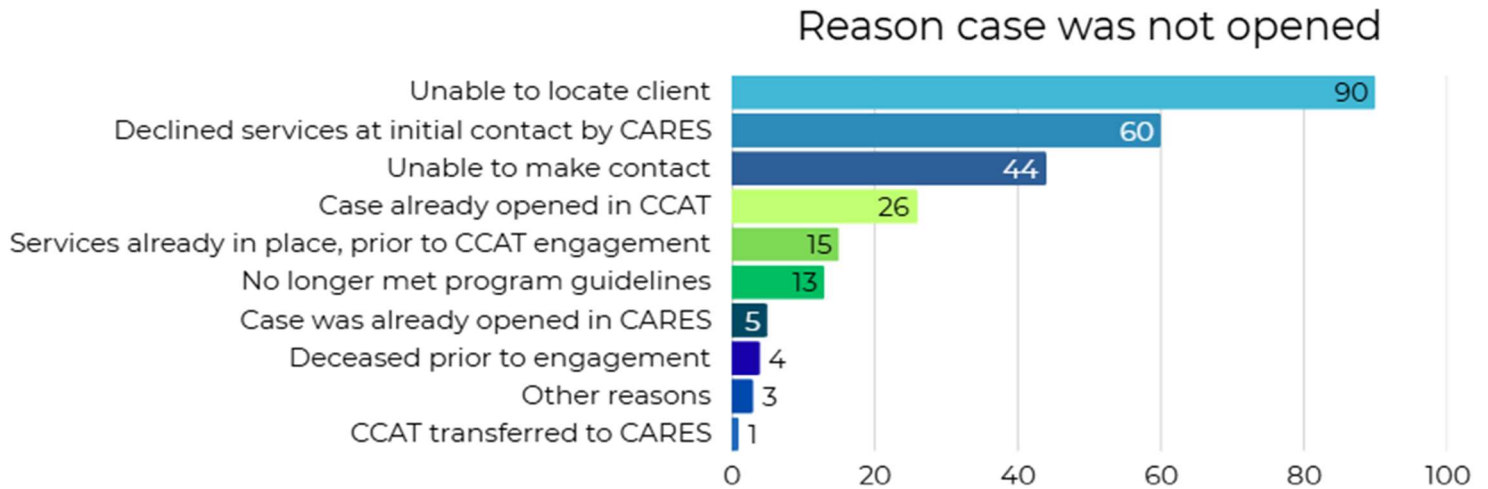
*Individuals may have more than one reason for only receiving services on scene.

Referred to CARES but not opened

Among the 255 (242 ultimately) individuals referred to CARES, whose cases were never opened for case management/services, the primary reason was because CARES team members were unable to locate the individuals. Staff and community providers shared during their interviews that these individuals are a very mobile group, thus they are difficult to locate. Among the 90 individuals CARES was unable to locate, three presenting issues rose to the top (some individuals had more than one of these issues): welfare check, behavioral/mental health issues, and being unhoused.

The second most common reason individuals' cases were not opened for service was because they (60) declined CARES services at initial contact. It was not always known why individuals declined services. Based on professional experiences, reasons can include: with the crisis now behind individuals, they felt hopeful things would be better so ongoing support was not necessary; they did not want to address the underlying issues for now; or they found a solution on their own that they believed would prevent another incident. Although these individuals did not receive ongoing services, many received services from CCAT on scene. Chart 11 and Table 11 (in Appendix B) presents reasons cases were not opened with CARES, the count of individuals and the average percentage of all individuals (1,184) with a completed Case Closure Form.

Chart 11



Referred to and served by CARES

A total of 249 individuals were referred to CARES for case management services, and their cases were served. Among these individuals 105 completed the program and CCAT/CARES closed/inactivated their cases.⁵ However, there were 144 who started but did not fully complete recommended services and treatments. The reasons vary and individuals might have more than one reason for not following through. For example, the most likely reason (68 or 5.7%) was that individuals did not respond after an initial contact and resources were provided by CARES. Other reasons may include, but were not limited to, the fact that the crisis was over, so they felt ongoing support was unnecessary, or they did not want to address the underlying issues.

Moving out of the service area after contact was the secondary factor (37 or 3.1%) followed by clients whose whereabouts were no longer known (16 or 1.7%). It is known that some of them moved to be closer to family, accessed services in other service areas, could no longer afford where they lived, could no longer live with friends/family, and some could not be contacted due to their nomadic lifestyle. Table 12 presents reasons for 144 individuals not completing services following an opened/served CARES status.

⁵ For the 105 who were served and completed recommended programs, their reasons for closure are based on the receipt of services/resources. Details on services/resources and contacts are presented in the outcome section of this report.

Table 12: Reasons CCAT clients with opened/served cases did not complete services

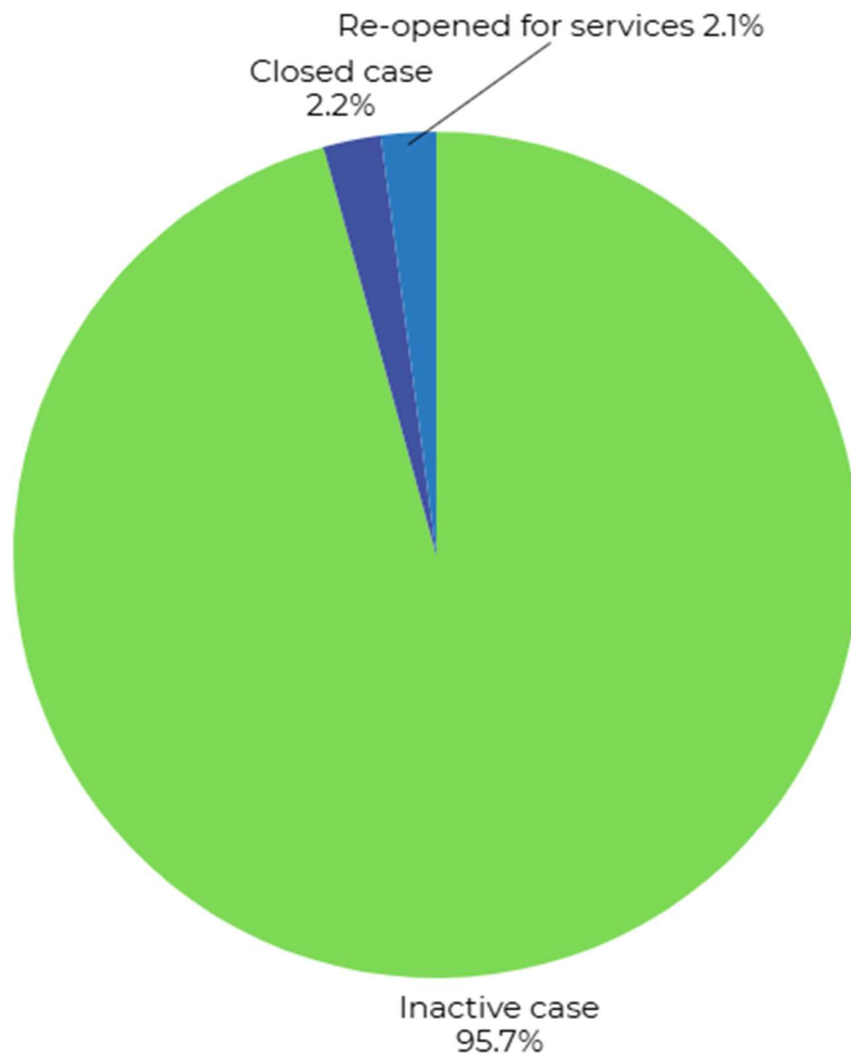
Reason for not completing	Count of reasons*	Percent of all CCAT individuals
Client not responding after initial contact and resource provision	68	5.7%
Client moved out of the service area	37	3.1%
Client whereabouts are no longer known	16	1.4%
Client reported service no longer required, CARES disagrees	15	1.3%
Deceased after engagement	9	0.8%
Client not following through with recommendations	7	0.6%
Other reasons (e.g., connected with other service providers, elected another approach to services)	7	0.6%
Client reported service no longer required, CCAT disagrees	2	0.2%
Referred to community services, however, client did not follow through	2	0.2%
Total of not completing reasons	163	N/A

*Individuals may have more than one reason documented.

Case disposition status for all cases closed/inactivated in 2024

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

Chart 13



Cases remaining open for services

At the end of the calendar year 2024, 53 of the 1,117 individuals engaged in 2024 continued to be served by either CCAT or CARES, or 4.7% of all individuals initially engaged in 2024. In addition, another 32 individuals who were initially enrolled in 2023 remained opened. Thus, at the end of 2024, a total of 85 cases remained opened and were still being served.

Outcomes: What was Achieved? What is Different Now?

Up to this point, the evaluation reported on inputs, activities, and outputs. These areas described what the program did, described the individuals CCAT units engaged, and program completion rates. Knowledge of these elements is important because it provides insight as to

the environment in which the program operates, insights on the implementation approach, and facilitates an understanding of the individuals engaged.

This report section presents immediate outcomes. Of specific interest are the benefits of CCAT as a policing approach and the extent to which CCAT offered and facilitated a different policing experience from what individuals' previous encounters with law enforcement. Of interest is whether these changes lead to greater access to community resources and resulted in improved quality of life outcomes by diverting individuals with behavioral/mental health issues (and others in crisis) from the criminal justice system, where possible. Also of particular interest was the degree to which each of the following police outcomes occurred: de-escalations, reductions in use of force by police, decreases in number of arrests/jailed, and reductions in unnecessary ED/hospital visits and 911 calls.

As noted earlier, quantitative and qualitative data sources are used to determine the extent to which desired outcomes occurred. Quantitative information was pulled from BPD's RMS and the CCAT Case Management Database. Qualitative data was gathered from tailored interviews and written surveys. Interviews with 18 individuals [client (1), family members/friends (4), community providers (4), and CCAT staff (9)], were conducted on Zoom or in-person, lasting between 35 and 60 minutes. Additionally, 42 surveys were completed by clients,⁶ family members/friends, community providers, BPD staff,⁷ and CCAT staff. It was essential to hear from these groups how CCAT units might have engaged individuals differently from traditional policing approaches, and their assessments on the extent to which CCAT units led to desired policing outcomes.

Services Provided to Individuals

Providing and connecting individuals to services is a central CCAT policing approach. The resources (i.e., services/supports/treatments) offered to individuals were provided directly by CCAT and CARES staff, and were brokered by them when they connected individuals to community, governmental and private providers. Documentation of these resource provisions are found in the CCAT Case Management Data System on three separate forms: Intake Form, Contact Log, and Case Closure Form.

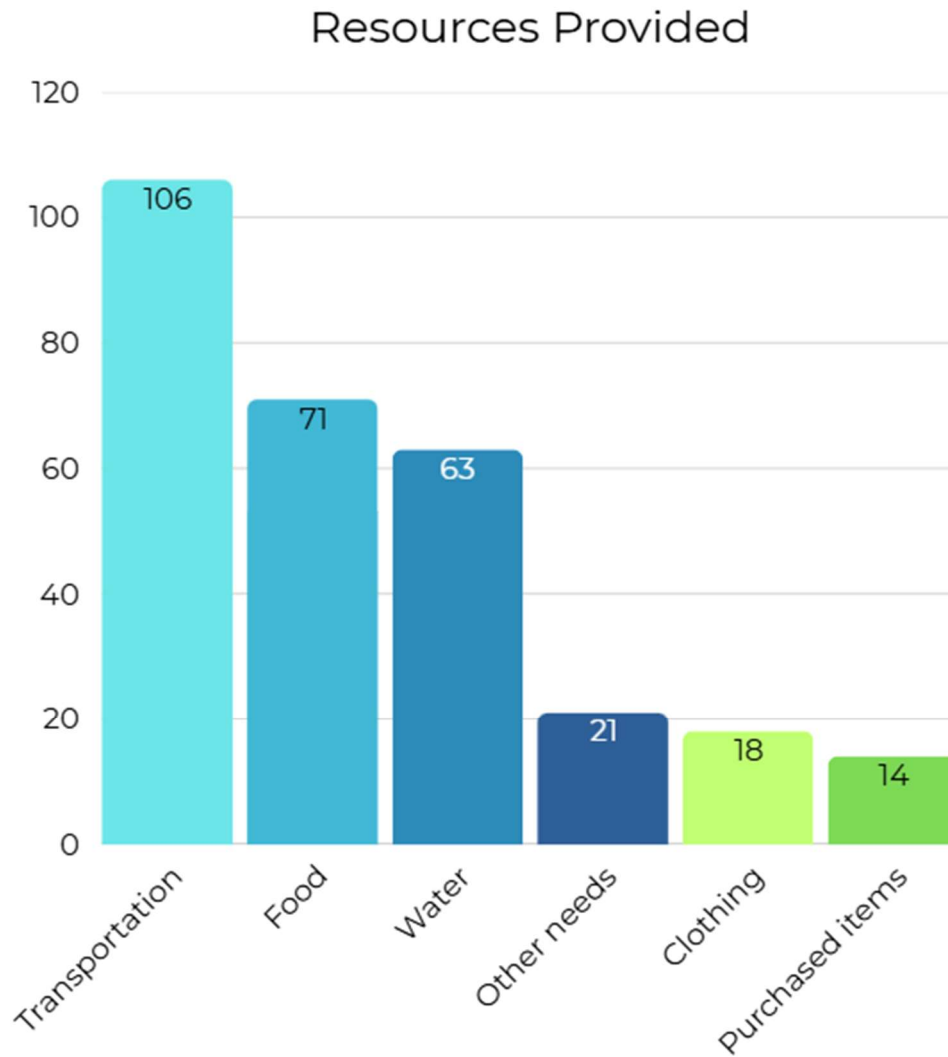
At intake: resources and services provided

When CCAT units complete the Intake Form at initial engagement, they also document any tangible resources they provided. The most provided resource was transporting individuals to treatment/crisis centers, hospitals, and shelters. Below is a chart that presents the tangible resources provided to individuals during their initial on scene engagement with CCAT. Recall that CCAT units also engaged individuals during 'check-ins' and 'drive-bys' and provided many of these same resources, which are not reflected in the count below.

⁶ A Zoom interview occurred with one client who completed the survey verbally. Due to the other three clients' situations, their caregiver/parents reported feeling comfortable responding verbally to the survey questions on behalf of the clients.

⁷ BPD personnel, primary patrol officers, were invited to complete online surveys; 22 did so.

Chart 14



In addition to these on scene tangible resources, most of the individuals engaged received other services and resources on scene. Among the 680 individuals not referred to CARES, 399 or 58.7% were documented as receiving “necessary services provided by CCAT,” as well as 11 or 1.6% being supported by BFD medical evaluations. Another 0.4% were referred to community, governmental, or private resources. Receiving services on scene may be all some individuals required. (It is important to note that CCAT provided these types of services to individuals referred to CARES. However, their receipt of services is not included in Table 15 but appear in Chart 16 and Table 16 (in Appendix B).

Table 15: Services CCAT provided to individuals not referred to CARES

Types of services*	Count of service types	Average percent for all individuals
Necessary services provided by CCAT	399	58.7%
Requested fire department for medical evaluation	11	1.6%
Referred to DCR	3	0.4%
Connect to community/private services/supports	3	0.4%
Referral to APS	2	0.3%
Total Contacts	418	N/A

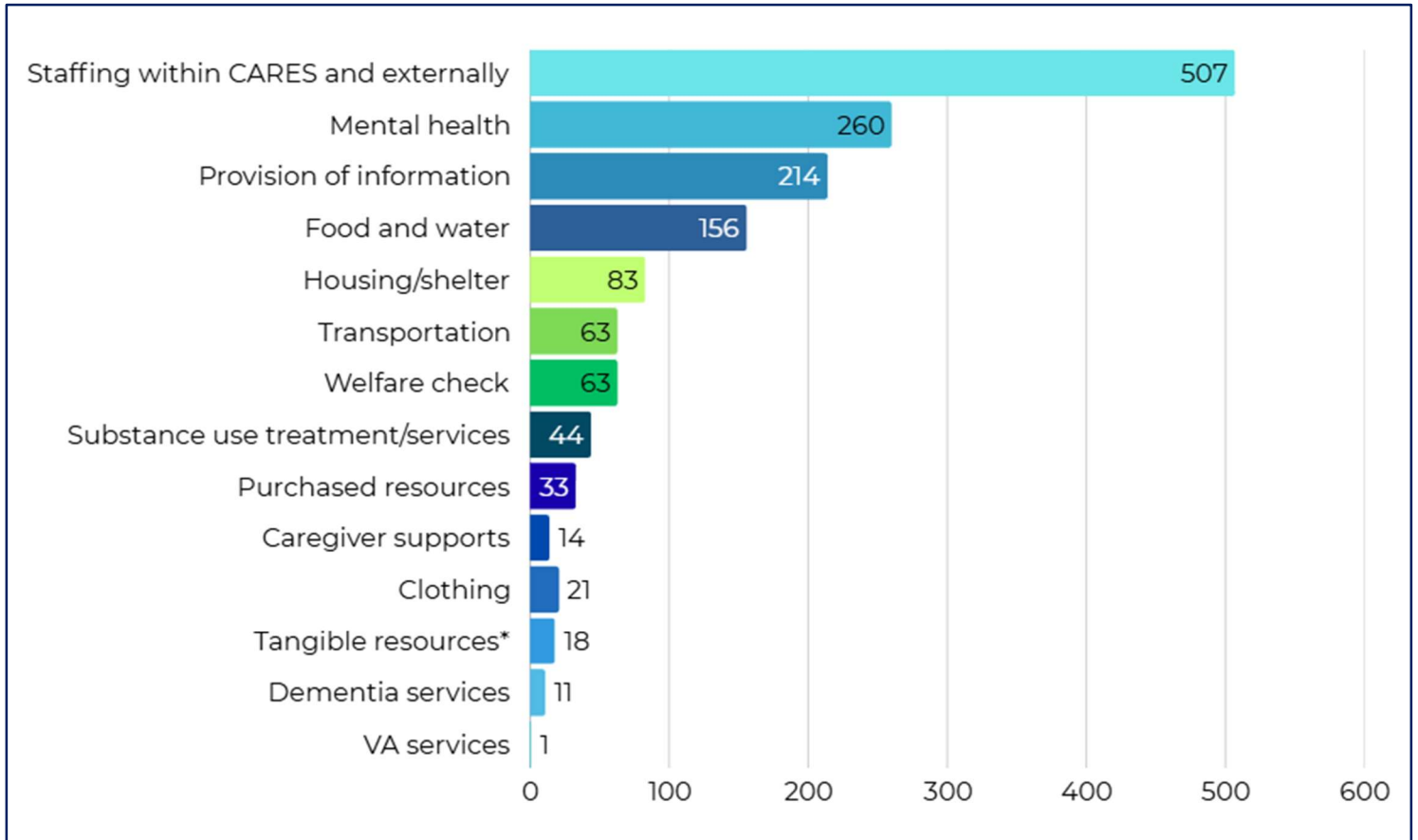
*Individuals may have received more than one of these types of services.

Individuals referred to CARES: resources and services provided

Once individuals were referred by CCAT to CARES for ongoing case management services, CARES teams and CCAT units documented on the Contact Log the type of resources and services provided/brokered for individuals. It is important to note that a count of services individuals received from external agencies are not documented on the Contact Log.

A total of 562 CCAT individuals were referred to CARES to receive case management services and other services through CCAT and CARES (includes individuals engaged in 2023 whose case remained opened). Not all individuals elected to remain involved until they completed all recommended services/treatments. In addition to case management support, and excluding all resources provided at initial engagement, each client was provided/brokered on average, an additional 2.6 resources/services. The most common resources were staffings with providers, mental health treatment, and provision of information. Chart 16 presents in rank order, the types of resources by count.

Chart 16



At case closure: services provided to those who completed all recommendations

When cases were closed/inactivated, staff selected reasons for the change of case disposition. Staff also documented the major services/resources provided and brokered by CCAT and CARES that led to the decision to close/inactivate the case. Among the 105 individuals who were CARES enrolled and had received case management supports until conclusion; a total of 150 resources were named as factors supporting the availability for the case to be closed/inactivated. The three most common reasons which led to the ability to close/inactivate cases were as follows: needs met by CARES; referrals to community, governmental, and private organizations which were now serving the individual; and had needs met by CCAT. Having needs met by CARES was documented as a factor for 44.7% of the individuals. Meanwhile, referrals to other organizations were beneficial to 30% of all the cases, and another 22.7% had needs met by CCAT. Table 17 presents all reasons for case closure.

Table 17: Type and count of services for individuals completing all recommendations

Types of services*	Count of services	Percent of individuals (N=105)
Needs met by CARES	67	44.7%
Referral to community services, client connected e.g., mental health service, treatment centers	45	30.0%
Needs met by CCAT (excluding the provision of fall prevention equipment and referrals to fall provision programs)	34	22.7%
APS referral process completed	2	1.3%
CPS referral made	1	0.7%
Referral to fall prevention program	1	0.7%
Total Contacts	150	N/A

*Some individuals received more than one services.

Stakeholder Survey Ratings: Resources and Service Provision

Stakeholder groups (i.e., clients, family/friend, community providers, BPD personnel, and CCAT staff) were asked to rate how impactful it was for individuals to be connected to resources and services. The survey asked whether the provided resources and services provided supported clients outcomes. All surveys used a 5-point rating scale. A 5 meant “strongly agree,” 4: “agree,” 3: “neither agree or disagree,” 2: “disagree,” and 1: “strongly disagree.” Survey participants also had the option to select “don’t know” or “doesn’t apply” if they felt they could not provide a rating. Rating averages were between 4.0 and 4.5, meaning they “agree” that resources/services did improve individuals’ situations.

Table 18: Stakeholder survey ratings on benefits of services

To what extent do you think each of following	Community providers (N=4)	BPD staff (n=20)	CCAT units (N=10)
CCAT approach supports client success?	Rating average	Rating average	Rating average
Connecting individuals to services and treatment, which supported client success	--	4.5	4.0
Individuals’ situations are generally better because of the help provided by CCAT and through other providers due to CCAT’s action to connect them	4.5	--	--

Using the same 5-point rating scale, three questions were asked of clients and family members/friends. (Hence-forth, family members and friends will be documented as caregivers.) The rating averages among these stakeholders for each of the three questions, were “strongly agree.” They felt the services received were what was needed. The help they received from CCAT and CARES meant their situations were better now as a result.

Table 19: Client and caregiver survey ratings on benefit of services received

Extent to which they think CCAT does each of the following	Client (N=4)	Caregiver (N=4)
	Rating average	Rating average
CCAT got me the services and help I needed	5.0	5.0
My situation is better because of the help provided by or through the CCAT unit	5.0	5.0
My situation is better because of the help provided by or through the CARES program	5.0	5.0

CCAT/CARES Contacts with and on Behalf of Clients

Provision of resources was one intentional component of the CCAT program. Yet, to achieve CCAT’s mission of serving and diverting individuals in behavioral/mental health crisis from the criminal justice system to services/treatments required two additional best practice approaches, according to CCAT staff. First, create trusting, positive relationships with individuals. Doing so also helps to maintain CCAT’s connections with individuals, and CCAT’s ability to encourage individuals to trust and accept ongoing support from CARES and other providers. Second, CCAT maintaining ongoing relationships with individuals supports future successes: effective communications in the event of future incidents, access/ability to assess individuals’ situations when formal and informal contacts happen in the community, and the ability to reinforce individuals’ ongoing commitment to CARES and its case management services.

To measure the extent that CCAT and CARES staff engaged with individuals, and the types of contact staff had with clients, caregivers - and others on behalf of clients - is documented into the CCAT Case Management System. However as noted earlier, there were documentation exceptions for less formal contact, e.g., driving by, checking in to ask how things were going, offering bottled water or a snack. Such actions were ways for units to keep connected and strengthen relationships, assess for potential concerns, and continue building good will and trust.

Even excluding these informal contacts and the referrals and other communications occurring during initial on-scene engagement, CCAT units and CARES recorded 8,114 contacts and

attempted contacts - with or on behalf of clients. This translates into an average of 6.2 contacts or attempted contacts per individual. Nearly all individuals (99.3%) had at least one face-to-face contact during ongoing engagement efforts. In addition, clients received more than one follow-up phone call (120%) along with at least one text, voice message or fax (103.5%) from CCAT/CARES. Of the 8,114 communications, over two-thirds (67.6%) were contacts with the individuals; the remaining communications were with caregivers, providers, and others on behalf of the clients.

Among caregivers (note not all clients had caregivers), 18.2% had a face-to-face meeting with a CCAT/CARES staff member. Meanwhile, 46.5% of caregivers spoke with a CCAT/CARES staff at least once, and 24.8% received a text, voice message or fax. Table 20 presents a count and percentage of individuals for each contact/attempted contact type, and other types of communications that occurred specifically on behalf of the individual.

Table 20: Type and count of contacts/attempts with and on behalf of individuals

Type of contact	Count	Percent of individuals
Face-to-face with clients	1,307	99.3%
Attempted face-to-face with clients	467	35.4%
Phone call with clients	1,581	120.0%
Attempted phone call with clients	770	58.4%
Client text, voice message, fax	1,364	103.5%
Face-to-face with relatives/caregivers	240	18.2%
Attempted face-to-face with relatives/caregivers	23	1.7%
Phone call with relatives/caregiver	613	46.5%
Attempted phone call with relatives/caregiver	180	13.7%
Caregiver text, voice message, fax	327	24.8%
Agency contacts regarding services/supports	445	33.8%
Outreach to another CCAT/CARES advocate	27	2.0%
CCAT/CARES staffing and case contacts/actions	770	58.4%
Total Contacts	8,114	N/A

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 individuals they engaged. In addition, because of their specialized trainings and educational background, the quality of the time spent should be enhanced. Persons struggling with behavioral/mental health issues generally require additional time to calm down, enabling them to verbalize what's happening, 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 individuals. What's being asked of and offered to individuals could take a bit more time and patience. CCAT staff and stakeholder groups talked about the importance of units being able to slow things down, not being rushed, and being able to employ different engagement and communication skills.

CCAT units, unlike patrol officers, were not designated sole responsibility for a set catchment area of the city. Patrol officers feel continuous pressure to resolve one issue, so that they can move on to the next call. Instead, CCAT units have shared responsibility for the city as a whole; their primary focus is to individuals they are engaged with at that moment. Ideally, the extra time supports CCAT units' ability to fully assess situations, the needs of individuals and caregivers, and results in the identification of and connection to appropriate services and treatments for individuals. Having more time, if needed, and the ability to slow things down were reported as a de-escalation strategy. De-escalation, thorough assessments, addressing needs, and developing a plan of action will hopefully also result in the reduction of repeat 911 calls, unnecessary ED visits, the use of force, and arrests.

For these reasons, an examination of time spent on calls was conducted by the BPD administrative data analyst. (BPD data does not include calls on the phone or other means to respond to incidents.) She looked closely at the average time spent by CCAT units during their initial response to the program's three most frequent response call type: behavioral health, suicides, and welfare checks. The overall average length of time spent on these responses was 49 mins and 58 seconds by CCAT as the primary (first) responders. This does not include the time CCAT units, as second on scene, might remain on scene after patrol leaves as they talk with individuals, locate and provided services, and transport or connect individuals to resources. Meanwhile, patrol officers, as the primary responders spend on average 42 mins and 57 seconds on these same three call types for a difference of 7 minutes and 1 second less than CCAT.



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



Follow-up interviews were conducted with CCAT supervisors to determine an explanation for the shorter times documented for suicide calls by CCAT compared to patrol, and why, overall, the time on calls by CCAT were not greater than patrol officers. They shared a few reasons 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) as well as why behavioral health time on scene by CCAT was just over a minute longer than patrol (i.e., on average 1 minute and 7 seconds). Interviewees shared that it is not uncommon for patrol to hesitate when they first arrive on scene for these two service call types; they need to take extra time to assess how best to respond, including working out their approach.

Meanwhile, because of CCAT units' training and experience, they can more quickly engage with individuals. Another factor is that because of prior work with some individuals, CCAT may already have working relationships and rapport with them, thus can engage quickly. Another consideration is that after patrol's initial response to suicides and behavioral health situations, they may call CCAT units and/or their supervisors for assistance. Thus, a portion of their time is spent waiting for backup to arrive. Supervisors also shared that a third call type - welfare checks - involve a wide variety of situations, including underlying mental health issues. Thus, while patrol may address the reason for the call, CCAT units will assess potential underlying issues and identify needed resources. CCAT units spend nearly 15 minutes more on welfare check responses compared to patrol officers.

A major point supervisors made was that time on scene is one measure. But it's also important to be mindful of the quality of the time spent with individuals, and the likelihood that individuals are being connected to needed services. This is a reminder that the roles of patrol and CCAT are different.

Table 21: Average time spent on service calls

Call type	CCAT h:mm:ss	Patrol h:mm:ss
Suicide	1:25:20	1:43:10
Behavioral health	1:06:02	1:04:50
Welfare check	0:40:08	0:25:49
Average time on scene	0:49:58	0:42:57

When stakeholders were asked to assess the value of permitting CCAT units more time on calls, all twenty BPD professionals responding to this question, and the ten CCAT staff, felt permitting more time with individuals supported client success. CCAT officers and BPD personnel rated this statement a "5" or "strongly agree." Among the seven CCAT MHPs, the rating was a bit lower, but near the "strongly agree" mark at 4.7.

Table 22: BPD and CCAT staff survey rating on the value of more time with clients

To what extent do you think permitting more time	BPD (n=20)	CCAT officer (N=3)	CCAT MHP (N=7)
supports client success?	Rating average	Rating average	Rating average
Permitted to take more time with individuals	5.0	5.0	4.7

Community stakeholders, clients, and caregivers were asked two differently worded questions on the survey, but both questions were to some extent related to time CCAT units spent on scene. One survey question asked them to rate the extent to which CCAT units listened to what individuals (clients and caregivers) had to say. The second question rated the extent to which the CCAT units were patient and didn't rush individuals. Participants used the same 5-point scale, a "5" meant "strongly agree." All 12 participants rated both statements as "strongly agree."

Table 23: Client, caregiver, community provider survey ratings on CCAT engagement

Extent to which they think CCAT units	Client (N=4)	Caregiver (N=4)	Community provider (N=4)
does each of the following	Rating average	Rating average	Rating average
Patience and didn't rush individuals (you)	5.0	5.0	5.0
Listen to individuals (you)	5.0	5.0	5.0

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

BPD IT provided some additional information from its data system to help determine how CCAT as a policing approach differs from a traditional police approach. Analysis below presents additional insights gained through interviews with stakeholder groups and survey responses.

Client and caregiver comparison of CCAT to traditional policing experience

Clients and caregivers were asked to provide examples to illustrate how their experiences with CCAT units differed from past experiences with law enforcement approaches, if they had occurred. Each of the clients and caregivers interviewed had at least one prior traditional 911 call police response experience, either in Bellevue or elsewhere. All spoke about how their experience with CCAT was more positive. Below are brief descriptions of their experiences and comparisons.



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

When only a police officer comes, they asked if [name of adult sibling with behavioral/mental health issues] wanted to go to the hospital. If [he] doesn't, then they just leave ... because they can't do anything about it. The difference this time, [name of the CCAT MHP] started really talking and giving his undivided attention and listened to him. [The MHP] was able to talk him into going to the hospital which was what was needed.

SISTER CARING FOR AN ADULT SIBLING

When I called the crisis center in the past, it's been a three to four day wait. By then, the acute crisis was over. Some time, when they arrived [they just] talked to him for a few minutes. However, I could have been killed during the time of crisis. Another time, when I called 911, they just did not listen to me. They said the hospital would not keep my child but would only release him, so there was no reason to go. However, this time CCAT [suggested a specific] hospital that would provide the type of evaluation my child needed. They even offered to drive us to the hospital. A huge offer for a low-income parent. I never had an officer ever do that.

MOTHER OF A PRE-TEEN WHO WAS DELUSIONAL AND HEARS VOICES

Many years ago, I had another mental health incident. [The police] were not mean, but they were impatient. I remember thinking it was like they would like to have been doing other things, if not for me. Not mean, not mean, but not even slightly empathetic. Saying, we've got to take you [to the hospital]. This time [the CCAT unit] was kind, ... and not only cared about me, but my friend who called for help.

NEW MOTHER WHO ATTEMPTED SUICIDE



Community providers' comparison of CCAT to traditional policing

Community providers – four professionals employed by three different agencies - provided a few examples of their experiences with officers, and with CCAT units. Providers reported CCAT units' responses do vary in positive ways from their experiences with sole patrol officers when engaging individuals in behavioral/mental health crises. Providers were keenly aware that patrol officers operate under a different set of guidelines and expectations, and that CCAT as a specialized policing approach, was developed specifically to tailor their efforts to meet the needs of those in behavioral/mental health crises. So, with caution and concern, providers made comparisons, but not wanting to imply that one set of officers were "better than the other set of officers."

Staff from two agencies - the two agencies most likely to request 911 support - reported they value that CCAT units check in with them when responding on scene. CCAT seeks information and insights about what happened to trigger the call prior to engaging with individuals. This was one reason they specifically requested CCAT units when they called 911 for assistance. Another reason was because they felt CCAT officers were better at assessing whether behaviors were mental health related, then intervening more appropriately. These actions were reported to be less likely to traumatize individuals, lead to more appropriate engagements, and result in better outcomes.



I think it's been a much more collaborative approach when we've been able to work with CCAT, so I know that for us, we usually do prefer to be able to have CCAT representatives respond.

**SPECIALIZED SCHOOL
PROFESSIONAL**



One of these providers shared two detailed examples of what occurred during two separate traditional police responses to 911 calls made by individuals served by their program, where many individuals have known mental health issues. The provider believes had officers checked in with staff prior to engaging with individuals, the patrol officers would not have needed to request a specialized police response unit, and an arrest would not have occurred. Both 911 calls were due to mental health issues and not criminal. The provider believes CCAT would have handled both situations differently based on past experiences with CCAT units.

Another provider, from a specialized school, shared why they request CCAT units. "When CCAT is responding to a situation, I have pretty good trust in that the issue is going to be handled in a much more similar fashion [fitting] the mission and values of our school, and [using a] holistic approach. I do think that predictability and consistency is there when CCAT [responds], where it's sometimes a little bit more unpredictable with responses from solely police officers."

Survey ratings of CCAT

Additional insights regarding CCAT units' engagement practices was gathered through five survey questions. Using the same 5-point scale, with 5 meaning "strongly agree," all clients,

caregivers, and community providers rated that CCAT units treated them with respect, and showed concern for individuals at the “strongly agree” level. Meanwhile, rating averages by stakeholders differed a bit. Community providers rated CCAT units’ understanding individual’s situation, and CCAT units’ knowledge at the “agree” level. Meanwhile clients and caregivers rated these questions at the “strongly agree” levels. In addition, clients and caregivers rated that “CCAT units explained their actions and procedures” at the “strongly agree” level. Providers were not asked this question.

Table 24: Client, caregiver, and community provider survey ratings on CCAT approach

Extent to which they think CCAT teams do each of the following?	Client (N=4)	Caregiver (N=4)	Community provider (N=4)
	Rating average	Rating average	Rating average
CCAT teams treated individuals (me) with respect	5.0	5.0	5.0
CCAT teams showed concern for individuals (my situation)	5.0	5.0	5.0
CCAT teams understood individuals’ (my situation)	5.0	5.0	4.3
CCAT teams were knowledge professionals	5.0	5.0	4.0
CCAT teams explained their actions and procedures	5.0	5.0	--

BPD personnel and CCAT staff rated three different policing approach questions also using the 5-point scale. BPD and CCAT rated to what extent they thought each of the following CCAT approaches supported client success: tailoring the response to the individuals encountered, being permitted to work using a broader set of guidelines, and explaining actions and procedures to individuals/getting their approval in advance. Each of these items were rated at the “agree” level. CCAT officers and MHP rating averages are a bit higher, closer to the “strongly agree” levels than those provided by BPD personnel. Table 25 presents rating averages, in rank order, based on BPD’s averages.

To what extent do you think each of these CCAT approach supported client success?	BPD (n=20)	CCAT officer (N=3)	CCAT MHP (N=7)
	Rating average	Rating average	Rating average
Permitted to work with individuals using a broader set of guidelines	4.5	4.5	4.7

Tailoring responses to the individuals encountered	4.4	4.7	4.9
Explaining actions and procedures to individuals and getting their approval in advance	4.0	4.7	4.7

Table 25: BPD and CCAT staff survey rating on CCAT engagement approaches
Policing Outcomes: De-escalation, Reduced Unnecessary Emergency Room/Hospital 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 begin 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. De-escalation on scene was also reported to facilitate caregivers' trust and comfort with the actions of CCAT units.

“ I went out on a call where someone was potentially going to be arrested. I believe it was a trespass violation, or they stole a sandwich. Patrol had them and they called CCAT. Do you have any other options for this person; we don't want them to go to jail. ”

CCAT MHP

and community members focused on enhancing their understanding of, and support for, individuals struggling with behavioral/mental issues. Hopefully, should an individual have a behavioral crisis near them, they would be more receptive to the CCAT unit asking, should it be appropriate, not to press charges for trespassing or theft.

Community providers and CCAT staff reported CCAT units were referred to as “gray pants” (based on what officers' wear instead of the

“ Most of the time when [CCAT officers] approach somebody that they don't know or they haven't met before, they will introduce themselves. And they'll say, 'You're not in trouble. We're a specialized unit. We're here to help. Do you want some water? Do you want some snacks?' I think it [all] makes a big difference. ”

CCAT MHP

CCAT units also work to build positive relationships with business owners and citizens. CCAT units' efforts with businesses

“ I want to shout out [officer's name] who builds rapport with just about everybody. He/she knows them, knows their names, knows what they like, what they don't like, and knows where they hang out. He/she knows who they are and treats them like people. Having an officer to have that level of rapport with somebody whose thinking isn't sometimes aligned with reality, when they're in crisis, when they don't feel safe; having somebody they trust show up, this de-escalates the situation. [If officer's name] is not present, individuals are able to transfer trust and work with another CCAT unit. ”

HOUSING PROVIDER

blue pants of patrol officers), and the “red coats” referring to what MHPs wear. Their assessment was that as more individuals observe CCAT units responding to disturbances around town, in time, potential fight or flight reactions will be even more lessened. This will further set the stage for better engagements; CCAT units’ uniforms themselves help to de-escalate the situation.

“

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

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CCAT units shared that their engagement approaches were central to their ability to de-escalate situations and supports other policing outcomes. CCAT officers and MHPs reported the steps they take to de-escalate, in conjunction with their behavioral/mental health knowledge and specialized training, supported their ability to reduce unnecessary emergency room (ED) visits, use of force, and arrests and incarcerations.

One CCAT officer shared how CCAT builds relationships and de-escalates situations, “[We have and take] time to build rapport, and we ask questions and find out more about the situation they're in and help them navigate; whereas patrols’ [responses] would just be, you move it along.”

“

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

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Reduction in unnecessary emergency department visits

CCAT staff shared there are times when individuals need to go to the emergency department (ED) to be assessed and treated. However, it was reported that historically, police officers took individuals in behavioral crisis to the hospital because they were unsure of how to help the individual, and uncomfortable leaving them there or asking them to move along. They were

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And there's a lot of officers that have a hard time knowing that sometimes people have suicidal thoughts, but they're not, they don't meet imminent risk. [The MHP is able to assess.]

CCAT OFFICER

”

aware that taking individuals to the ED might not resolve the underlying issues, but would hopefully be helpful, if only in the moment.

CCAT units reported having many more options than patrol officers - largely because of the teaming of officers and MHPs. Their combined professional knowledge base, skill sets, and the educational and field experiences of

MHPs - as well as participating in shared trainings, and being permitted more time on scene to slow things down - allow for enhanced engagements. Below are two examples provided by CCAT staff of how they operate.

“

We had a woman who was suicidal, making statements she was gonna throw herself off the balcony of their building. She had been sitting there with cops for a little while ... We were on another call, so we hadn't been able to pick it up. Officers called us to join them as soon as we could.

... One of the things [I saw] when we rolled up was all these officers standing up around this sitting woman. I [suggested] guys you get on her level, sit down or squat down. Talk to her on her level. ... We [the unit] went down; we were chatting with her. She was resistant to going to the hospital. [I said], something like this is where you live. This is where we want you to be able to feel safe. ... I know you were resistant to getting in the back of a cop car. We have an unmarked car. You can come with us. No one's gonna know that you're in a police car.

I think getting down on her level to have a very frank conversation about what was happening, and also about what needed to happen, and about this is not something that we're just gonna drop ... made a difference. We wanna support you through this. I think she felt a lot better and was able to get in our car and go with us to the hospital.”

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 is described as indispensable. MHPs offer insights on how to best engage with individuals on scene and help de-escalate situations. They also help inform decisions of whether going to the ED/hospital is necessary, whether another type of placement or referral was more appropriate, if individuals were in imminent danger or if remaining home was an option and less traumatizing.

Survey ratings reveal that community providers, BPD personnel, and CCAT staff all believe CCAT's policing approach was able to

“

[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

”

divert individuals from unnecessary ED visits. Community providers rating average was “strongly agree.” CCAT rating average was at 4.7, so close to the “strongly agree” level. Although, BPD personnels’ rating average was at the lower end of the “agree” level, no narratives were provided with insights on CCAT’s ability to divert individuals from unnecessary ED visits. However, following Table 26 which provides ratings from these three stakeholder groups, are select quotes from community providers and CCAT staff regarding diversions from unnecessary ED visits.

Table 26: Stakeholder survey rating on diversions from unnecessary ED/hospital visits

To what extent do you think CCAT as	Community provider (N=3)	BPD (n=21)	CCAT officer (N=3)	CCAT MHP (N=7)
a policing approach does the following?	Rating average	Rating average	Rating average	Rating average
Divert individuals from unnecessary ED visits	5.0	4	4.7	4.7

Select quotes from stakeholders.



[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

I think the biggest benefit of working with an officer is being able to go on acute calls and assess whether somebody needs to go to the hospital right now.

CCAT MHP

We know the community, people who call in or might have chronic suicidality ... [while] a normal patrol officer responding might feel like that person meets their involuntary detainment criteria, not knowing that it's actually their baseline. ... We're able to avoid an unnecessary involuntary detainment because we know this person. We know they have a meeting with their therapist in the morning and we know things that are going to safeguard them.

CCAT MHP

We don't need to retraumatize the community/individual, just getting them to the hospital, when they don't need to be there. We're able to rely more on outpatient services, because we just know them better.

CCAT MHP



We'll say, we don't necessarily wanna harass you. ... If you're open to it, we can get you to a shelter or a day center where you can kind of relax, ride this out, whatever you need to do. I think these are the types of things we do. I think that it's our kind of standard emergency department diversion.

CCAT MHP

I've had arguments with paramedics and medics [saying] this person should be involved for danger to themselves. I'm like, well, they don't meet imminent risks. They're not imminent anymore. I don't feel comfortable taking them to the hospital against their will, because they don't meet the imminent [definition], it's a high bar, and it should be a high bar.

CCAT OFFICER

We have people asking just to go to the ED; some people who are very high utilizers (i.e., call 911 often). [Nationally], we've done a really good job of saying, if you need something call 911. ... They don't know that there are [other] options out there.

CCAT MHP



Reduction in the number of repeat 911 calls

It's a hardship - physically, emotionally, and mentally - on BFD and BPD staff to be called out repeatedly, especially to the same individual daily, to assist someone struggling with behavioral/mental health issues. It's not that they don't want to respond, they want to ensure that - when they do respond - individuals' needs are effectively addressed and it is safe to leave them. By nature, first responders are committed to resolving issues and ensuring that individuals and the community are safe. Thus, being unable to address someone's situation is challenging for 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 for someone whom they could potentially help more effectively. For these reasons it's beneficial to individuals, their families, the community, and first responders for CCAT units to reduce the number of repeat 911 calls by individuals with behavioral/mental health issues.

Central to CCAT's efforts to reduce the number of repeat 911 calls is to address the service and treatment needs of the individual and their family by connecting them to the appropriate existing community services. CCAT units also focus on proactively connecting individuals with appropriate services when they observe those individuals in the community who might be currently struggling with behavioral/mental health issues. CCAT checks in with individuals they

have served before to determine whether individuals are well and if they need anything. Their goal is to both address and prevent an event that might trigger a future 911 call.

Stakeholders’ surveys asked participants to rate the extent to which CCAT helps reduce the number of repeat 911 calls among individuals with behavioral/mental health issues. The rating averages among the 33 participants were between 3.4 and 4.5 (on the 5-point scale with 5 meaning “strongly agree”). Community providers, CCAT officers, and CCAT MHPs’ ratings were “agree” while BPD personnel’s rating average was “neither agree nor disagree.” BPD’s 3.4 rating was the lowest rated question among all questions on all four of the stakeholder surveys. An explanation provided by a CCAT supervisor for this lower rating by BPD is that several chronic 911 abusers have not stopped called 911 despite intervention by CCAT, so the perception of BPD officers is that these individuals will continue to call 911 regardless of intervention. Below the survey rating in Table 27 are a few quotes from other stakeholder groups which may provide additional insights regarding BPD’s lower rating average.

Table 27: Stakeholders survey rating on reduction in repeat 911 calls

To what extent do you think CCAT as a	Community provider (n=3)	BPD (n=20)	CCAT officer (N=3)	CCAT MHP (N=7)
policing approach does the following?	Rating average	Rating average	Rating average	Rating average
Reduce the number of repeat 911 calls among those with behavioral/mental health issues.	4.5	3.4	4.2	4.2

A review of interview responses points toward two primary reasons that may help explain the ratings in Table 27. First, by nature resolving behavioral/mental health conditions are difficult. As outlined earlier, behavioral/mental health issues are chronic conditions for some, requiring ongoing management. It’s not uncommon for individuals to go off their medications or to experience ups and downs when dealing with their illnesses. Combining the difficult nature of these diseases along with being unhoused and/or struggling with substance use only complicates disease management. The second reason is having a guaranteed response to 911 calls. Some individuals are alone or isolated with no one else to call for help, so calling 911 is their only way to reach someone who they know will respond. These and other reasons were shared as reasons that make it impossible to have a 100% reduction in the number of repeat 911 calls. However, based on survey ratings from participants, there is a shared belief based on their experiences that CCAT does reduce the number of 911 calls.

The selected quotes below are from stakeholder interviews. Some of them do not directly address the call reduction issue. Nor do the quotes specifically address services/treatments individuals receive that help resolve or contribute to the management of their behavioral/mental health issues, which in turn might reduce the number of 911 calls. Instead,

these quotes highlight other approaches implemented by CCAT to reduce the number of repeat 911 calls.



That's a difficult one [for CCAT to reduce the number of repeat 911 calls]. We get those who are 'really out of the loop.' ... I think some [are] more comfortable calling 911, even when they're having low level crisis because they know someone will come. So instead of having to remember our phone number, they call 911 and request us specifically.

CCAT MHP

A lot of times fire will ask if CCAT is available. We watch the 911 board. If we see something that looks like it's ours, ... we'll open it up to see if it's one of our people or if it's an address we're often at, or if they're describing mental health issues. Then we'll self-dispatch. We try to be proactive and get as many of those as we can.

CCAT MHP

A ... CCAT officer is focusing on helping that person and figuring out what it's going to take to get them [needed resources] and eliminating those barriers. It benefits the whole community. It helps us not just to be reactive to that case, but to be proactive in making sure that we're putting everyone in a position where it doesn't have to happen again.

HOMELESSNESS OUTREACH PROFESSIONAL

One guy [who is schizophrenic] calls the CCAT number now instead of calling 911 because he wants to make sure that he's not being surveilled by police. He's like, 'Hey, are you guys surveilling me? We say, no, we're not surveilling you. He's like, okay, thanks.

CCAT MHP

They still call 911 and we're able to pick up those calls, which is great. It takes them off patrol's plate, but it doesn't necessarily stop them from calling 911 all the time.

CCAT MHP

We have maybe four or five guys that call the CCAT line and they just leave a voicemail. They use it like a journal; they rant. That's like what we do for them, and tell them if we're not answering the phone, [that] we will listen to your voicemail. And [if] they say, I need help or I'm hurt or something, they know we will respond.

CCAT MHP



Another set of two survey questions provided clients and caregivers an opportunity to assess the extent to which they think CCAT and CARES were meeting needs. If their needs were being met, that should have helped reduce the number of repeat 911 calls. They were asked to rate the extent to which their situation was better because of the help provided by CCAT, and to rate the extent to which services provided through CARES were helpful. One client did not engage with CARES services, thus did not rate the second question. The rating averages for both questions were “strongly agree.” None of the individuals had made another call to 911.

Table 28: Client and caregiver survey ratings whether their situation is better

To what extent do you think each statement is true	Client (N=4)	Caregiver (N=4)
based on your experience with CCAT?	Rating average	Rating average
My situation is better because of the help provided by or through the CCAT team.	5.0	5.0
My situation is better because of the help provided by or through the CARES program.	5.0	5.0

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." The goal of officers is to use only the amount of force necessary to mitigate an incident, make an arrest, and protect themselves or others from harm. Use of force can be viewed as a continuum from basic verbal commands to physical restraint. Touching someone on the back with one’s hand is a mild use of force or De minimis force, and is not reportable level, because it didn’t cause any pain or injury. CCAT officers report they try to use de-escalation tactics such as verbal commands to limit the need for use of force.

During interviews, CCAT officers and MHPs were asked their thoughts regarding whether CCAT’s policing approach reduced the need for use of force. Both sets of professionals talked at length about their efforts to de-escalate, which were more possible for CCAT officers to achieve when compared to patrol officers due to their policing guidelines. CCAT officers highlighted the many options available to them: taking time on each call to slow everything down on the scene, not to rush, specialized training they received in de-escalation, the ability to draw from the knowledge of MHPs - both to assess individuals, and to better engage with people in crises.

The value of having more time on calls was noted many times. It allowed units to give clients the time they needed to tell their stories and feel heard. Officers and community providers reported that some clients need to “rant,” “yell,” and “get in their face.” A few providers talked about CCAT staff “listening to and accepting individuals” current realities, beyond what patrol may allow. One CCAT officer added, “CCAT officers understood the importance of allowing greater physical space between themselves and clients when initially approaching individuals.

Being too close could be threatening to some individuals; plus, with more distance, everyone including the unit was safer.”

Because CCAT unit officers wear gray pants and MHPs wear red coats (instead of traditional uniforms), on approach, they do not trigger historical fears among some individuals. Not having as many police officers in the area - especially not surrounding an individual - was provided as another method of how the presence of CCAT supports individuals to feel more relaxed. Officers and MHPs also mentioned the importance of CCAT presence in situations where other first responders believe there is a need to take individuals to the hospital, and the individuals don't want to go. Often, these were situations where use of force would have occurred, according to a CCAT MHP. However, due to CCAT units' assessment skills and knowledge of other options, the need to transport to the ED was less. When hospitalization was required, another MHP estimated that “95% of those transports were cooperative because of de-escalation practices.” Though CCAT officers may use a lower level of force, i.e., hands on the back.

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, we continue to document instances in which officers use any level of force, beyond de minimis force, when an individual complains of pain, to overcome resistance or when specialized restraint devices are applied. These internal reports are taken to ensure that officers are acting in accordance with department policy and state law, and to demonstrate to the public that even low-level, State non-reportable uses of force are reviewed to maintain professional standards. During 2024 there were 3 Use of Force reports taken during CCAT calls that are defined as non-use of force per Washington State. Below are three stories provided during interviews; one includes the use of force and two demonstrate how use of force was avoided due to CCAT units' involvement.



Sometimes, even though people still don't want to move in the direction that they're being asked to go, our CCAT officers are able to use verbal de-escalation. Also, their uniform shows authority and ... they were able to stand next to someone and gently place a hand on their back and like guide them. A person is more apt to walk willingly with a hand there. And, if they start to resist, I think it might turn into more of a use of force, but that type of physical contact, in more a gentle way. It's because of the way they're being spoken to by CCAT officers versus patrol making demands, who may just repeat statements "getting [in] the car, you have to get in the car.

CCAT MHP



We are called on a lot to [reduce the use of force]. They're DCR assist calls ... when the designated crisis responders have a warrant for someone's involuntary detainment signed by the judge. They're going out there to get that person to take [them] to the hospital. They call for patrol or any police officer to come help them literally get the person transported to the hospital. So CCAT tries to pick up most of those calls because most of the time we know those people. We're able to talk with them and convince them verbally to get in the ambulance, [explaining that] they'll get their evaluation at the hospital versus DCR showing up with a warrant and patrol and saying, 'No, you have to go', and then patrol ending up in a use of force situation to get that person to [the] help [they need].

CCAT MHP

We had an occasion with a young girl that we thought maybe had knives. We said [between ourselves], if she comes down the stairs with a knife, we're leaving. We're backing away. We're not going to engage a taser or weapons. Our option, our number one primary is to back away. She's home alone. She's not going to hurt any other person. If our concern was that she's going to hurt herself and we go in, now we're putting ourselves at risk, now we could potentially have to use deadly force to protect ourselves. We're not going to use deadly force to protect her from herself.^[9]

CCAT OFFICER



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

Table 29: Stakeholders survey rating on reduction in use of force

To what extent do you think CCAT as a	Community provider (N=4)	BPD (n=21)	CCAT officer (N=3)	CCAT MHP (N=7)
policing approach does the following?	Rating average	Rating average	Rating average	Rating average
Helps reduce the need for use of force	5.0	4.0	5.0	4.5

Below are select quotes from the CCAT units about how they reduce the use of force.



I was anticipating seeing a lot of use of force [before I started working with CCAT], but I could maybe count on like one hand the number of times that I've seen it. And there are like very specific instances where I can recall if we were not there, things would have gone very differently.

CCAT MHP

I think what happens is we really extend the communication. We put a lot of empathy ... and where we may have to use force, we explain the thought of it, and empathize with them that, this isn't something we want [to do].

CCAT OFFICER

Bellevue is pretty unique in that we really put an emphasis on use of hands and safe use of hands training. We have multiple occasions where our first primary option is to back away and leave.

CCAT OFFICER

It's knowing when to slow down, knowing when to not rush in, not to press the situation, keep your distance, talk slowly, and not feeling the need to go into that room or into that building.

CCAT OFFICER

We don't need to overwhelm them. It's more just go slow, talk slow, offer solutions, saying let's talk about it. Let's really slow things down and keep a safe distance because if we maintain a safe distance, we maintain good reaction time.

CCAT OFFICER

We don't have to use force. We don't have to overwhelm them with too many people in the room at the same time or feel the need to have to grab them right away or force them into handcuffs.

CCAT OFFICER

I feel comfortable talking with somebody who's in crisis and not feel the need to have to force them into a pair of handcuffs because that would instigate a fight. A fight is going to ensue [if] I insist that they be in handcuffs before they talk to me.

CCAT OFFICER



Reduction in arrests and incarcerations

Like the reduction in use of force analysis, the ability of CCAT units to de-escalate situations when engaging individuals was noted by all those interviewed as a major positive CCAT

outcome. CCAT units' engagement practices with individuals who were trespassing, then assisting them to move peacefully to approved places such as shelters, housing centers, and treatment centers was provided as an example. Another example was of CCAT units working with business owners not to press charges in situations where known individuals struggling with behavioral/mental health issues have stolen food or other minor items. CCAT units reported explaining to business owners things related to individuals' actions, and the scope of what CCAT was doing or was willing to do to affect change in that individuals' future actions. CCAT shared that business owners want to know individuals are receiving needed help instead of being arrested. It was noted that because of the limitations of patrol, individuals might have otherwise been arrested.

Another way CCAT units prevent arrest and incarceration is by taking individuals who are willing to receive treatment - and who might have only minor level warrants - to treatment centers instead of arresting them. CCAT does so with the understanding that it's in the best interest of individuals, the justice system, and the community to change these individuals' trajectories. As one CCAT MHP shared, incarcerated individuals may not receive needed medication and treatment, are at risk of re-traumatization, and may be released after a few days. The CCAT MHP supervisor shared, "Jails house more mentally ill individuals than treatment centers. Only the extremely ill persons are placed in mental health units. Most are placed in the general population and do not receive medications or needed treatment." Thus, these individuals may present even more of an issue to the community the next time. However, there are times when CCAT units must, by law, arrest individuals; for example, arrests are mandatory in cases of domestic violence.

“

About 1 in 7 state and federal prisoners (14%) and 1 in 4 jail inmates (26%) ... met the threshold for serious psychological distress. Similarly, 37% of prisoners and 44% of jail inmates had been told in the past by an MHP that they had a mental disorder.

**U.S. OFFICE OF JUSTICE PROGRAMS,
BUREAU OF JUSTICE PROGRAM,
JUNE 2017,
[HTTPS://BJS.OJP.GOV/CONTENT/PUB/PDF/IMHPRPJ11112.PDF](https://bjs.ojp.gov/content/pub/pdf/IMHPRPJ11112.pdf)**

”

Community providers, BPD personnel, CCAT officers, and CCAT MHPs were asked on the survey to rate the extent to which they think CCAT as a policing approach diverts individuals from being arrested and jailed. For all stakeholders, except BPD, rating averages were at the “agree” level between 4.3 and 4.8. BPD personnel rating average was at the high end of “neither agree nor disagree” at 3.7. This is the second lowest rating of all survey questions. (The use of force question was rated low by BPD at 3.4, which was the lowest rating on all survey questions.) Of note, BPD personnel were the only stakeholder that had any rating averages at the “neither agree nor disagree” level.

Table 30: Stakeholders survey rating on diversions from arrests and incarceration

To what extent do you think CCAT as a	Community provider (N=4)	BPD (n=21)	CCAT officer (N=3)	CCAT MHP (N=7)
policing approach does the following?	Rating average	Rating average	Rating average	Rating average
Diverting individuals from being arrested and jailed	4.8	3.7	4.3	4.7

Below are select CCAT units’ assessments of their efforts and thoughts about diverting individuals from being arrested and jailed.

“

We [review] 911 calls coming in. I can see that patrol is going out to an individual that we've had a lot of contact [with]. ... If it looks like they have probable cause to arrest this person for a low level crime ... and I know he is currently working and trying to get better, but still struggling a little bit, we can also get out there and work with patrol, work with a victim, and business. [We can say] listen, we've been working with this person. We don't have to tell this person's life story, but we can give some true facts to show this person is trying, working ... then they [often don't] press charges.

CCAT OFFICER

I will say many businesses and individuals respect [diversion over arrest]. They want the person to get better. They know that this isn't a normal thing for people to do. They're very good at just wanting them to get some help.

CCAT OFFICER

The other thing is the prosecutors here in Bellevue, they're good at reading [CCAT] reports. They can also divert charges like to mental health court, which is also very helpful.

CCAT OFFICER

I think it's about the verbal de-escalation. Sometimes it's about helping [individuals] make a decision to move on. I think patrol is quicker to use arrest as an option. Like, you're trespassed; you're in a place you're not supposed to be. Where CCAT has a different approach; like can I take you somewhere? Do you need to get somewhere? Do you need a bus ticket? Why are you hanging out at this place [you know] you are trespassing? ... Trying to problem solve.”

CCAT MHP

”



We are able to do a jail diversion to the crisis solution center when a person agrees to get support; they opened up about their substance use, housing issues, and the goals in life that they would rather work on than just sit in jail.

CCAT MHP

In DV cases there's mandatory arrests. Even though it's a client we've known for years, and we know they lashed out due to not being on their medication, [and] even their families [are] asking for them to go to the hospital instead, the law requires an arrest. The most we can do is once they get to jail, ask that their mental health be assessed, so that they get transferred to a hospital, but in some of these situations we can't do anything.

CCAT MHP



Improved Clients Experiences and Relationships with Police

Based on survey ratings and interview feedback, clients and caregivers were very pleased with their interactions with CCAT, and developed trusting relationships. All had prior police engagement, and reported their CCAT experience to be more helpful. In fact, all of them rated CCAT on all the survey questions at the highest possible rating of “strongly agree” (a 5 on a 5-point scale). Some noted that they wished they could have rated some questions higher. Their survey responses have been presented in various subsections of this report. To honor the thoughts of clients and caregivers, their survey rating averages are presented below in the single table, followed by one select quote from each case to highlight what they felt regarding their CCAT experience.

Table 31: Client and caregiver comprehensive CCAT survey ratings

Statement	Client (N=4)			Caregiver (N=4)		
	Rating average	Don't know	Doesn't apply	Rating average	Don't know	Doesn't apply
CCAT Team listened to what I have to say	5.0	--	--	5.0	--	--
CCAT Team understood my situation (n=3 clients)	5.0	1	--	5.0	--	--
CCAT Team showed concern for my situation	5.0	--	--	5.0	--	--
CCAT Team treated me with respect	5.0	--	--	5.0	--	--
CCAT Team was patient and didn't rush me	5.0	--	--	5.0	--	--
CCAT Team was knowledgeable (n=3 clients)	5.0	1	--	5.0	--	--
CCAT Team explained their actions and procedures	5.0	--	--	5.0	--	--
CCAT Team got me the services and help I needed (n=3 clients and n=3, friend)	5.0	1	--	5.0	--	1
My situation is better because of the help provided by or through the CCAT teams (n=3 clients)	5.0	1	--	5.0	--	--
I am satisfied with my interaction(s) with CCAT	5.0	--	--	5.0	--	--
My situation is better because of the help provided by or through the CARES program (n=3 clients)	5.0	1	--	5.0	--	--

“ The [MHP] and Bellevue police officer were wonderful. [The MHP] was very empathetic, very understanding, did whatever he/she could do to locate my child and help. The MHP kept in contact with me the whole time, and basically would call me every day to let me know what was going on, and what they were trying to do. I remember that they notified other people to look for him too.

FATHER WITH AN ADULT CHILD WITH SEVERAL MENTAL HEALTH DIAGNOSES LIVING ON THE STREET

”



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



Recommendations

All stakeholder groups reported they valued CCAT as a policing approach, and shared their belief that CCAT provided a needed solution that filled a service gap in the city.⁸ One provider noted, “CCAT is [not just about policing] but like policing plus [and that] is essentially what’s happening.” Additionally, stakeholder groups provided insights about program benefits, what practices were valuable and should continue, as well as recommendations moving forward to enhance the program. Below are their recommendations:

- Continue to fund CCAT as a policing approach. In fact, expand the number of CCAT units/personnel available during peak demand hours, and expand current hours of operation to serve more individuals with behavioral/mental health issues.
- Continue to provide tangible resources to individuals (e.g., food, clothing, transportation, etc.). Explore the possibility of CCAT/CARES covering less traditional provisions, and at times a bit more costly, such as car parts and car repairs.

⁸ The one exception to support for CCAT was voiced by one of the 22 BPD staff members who responded to the online survey. This police officer wrote, “[CCAT was a] waste of resources. They should go back to patrol and fill patrol shifts.”

- Explore and implement work options for CCAT units to meet at the start of each shift; other first responder programs have such approaches.
- Continue bi-weekly, monthly, or quarterly meetings with community providers regarding program adjustments, and to review cases when there are shared clients. Proactively reaching out to providers about what's happening with clients following incidents, and to update them on case management activities. Engage in more community activities.
- Continue to serve as a resource to enhance collaboration - and bridge the gap between community agencies and BPD - regarding services for individuals struggling with behavioral/mental health issues and their family members.
- Continue CCAT's formal support of community providers and fellow BPD staff's development to improve their engagement with individuals who have behavioral/mental health issues, including de-escalation approaches and strategies. Accomplish these objectives by presenting at and attending agencies' meetings, as well as providing and inviting participants to educational and training opportunities hosted by CCAT.
- Continue efforts to enhance citizens' understanding of behaviors they see in the community to increase empathy for individuals with behavioral/mental health issues. Consider having BPD send a follow-up text to those calling 911 to thank them for caring enough to call when observing an individual struggling, since it resulted in "someone receiving life-saving mental health care."
- Continue to provide post-crisis care plans/case management to individuals and families through CARES.
- Provide clarification and information regarding CCAT's role and responsibilities in relationship to CARES and CARES101. Delineate the extent to which CCAT is an emergency response as opposed to a case management program. Information concerning staffing patterns would also be useful, i.e., when MSW students versus seasoned MSWs are assigned to provide case management services.
- Have CCAT continue to speak up regarding the lack of available shelters, housing, and mental health and substance use treatment options in the community for individuals struggling with behavioral/mental health issues.
- Add an attorney to the program to strengthen its work on behalf of those with mental health issues. It was reported, that while public defenders focus on getting arrested individuals released, legal efforts are sometimes needed to get the services and treatments individuals need.

- Explore and support adjustments to current involuntary involvement/restraint laws. Determine what can be done legally to increase the likelihood of those struggling with behavioral/mental health issues receiving needed services in a moment of crisis, even though they are not open to treatment.

Summary and Conclusion

This evaluation examined the initial 16 months of CCAT's implementation, focused on both process and outcome findings. The goals were to determine what occurred, who was served, what services and supports were provided, and to measure some of the immediate client and policing outcomes. BPD and BFD, as the city's primary first responders, successfully pooled their time and resources to create and implement a new policing approach that all stakeholders - clients, caregivers, community providers, and BPD personnel including CCAT units - reported as effective in engaging and serving individuals challenged with behavioral/mental health issues. Through its efforts, stakeholders reported, the CCAT filled a service gap in the city, strengthened BPD working relationships with the community, and enhanced communication and information-sharing with community providers, although a few community providers believe there remains some room for improvement in a few areas.

Clients and their family members/friends highly supported CCAT's implementation. They and all other stakeholders recommended extending both the number of CCAT units and the hours of operation. BPD RMS data revealed CCAT units responded to many of the behavioral/mental health crisis situations, but were unable to cover all calls even during their hours of operation (i.e., responding to 71% of suicides and 59% of behavioral health calls). Stakeholders requested expansion because they witnessed the quality of life improve for individuals and caregivers served. Professional stakeholders also reported reductions in unnecessary ED visits, use of force, repeat 911 calls, and arrests and incarcerations. CCAT's ability to spend needed time with individuals - combined with their professional skills and specialized training - were central to their ability to de-escalate difficult situations, which was reported to be highly effective.

This CCAT implementation also provided the opportunity to further assess the application of specially trained BPD officers working in concert with seasoned social workers/mental health professionals, which was one of two policing options piloted in 2021. During the pilot, an officer and MHP teaming approach was compared to the teaming of two officers. Stakeholders during the pilot recommended the officer and MHP approach. A current CCAT officer who was in the pilot - and engaged in both policing approaches pilot - concurred that the officer and MHP teaming approach was the correct decision. Based on feedback about the effectiveness of this program from community providers, clients, caregivers, and BPD staff, this policing approach has been validated as the correct selection. All communicated the value of having an MHP as a member of the initial response team. Not only did their presence support on scene assessments of the situation, but they also identified appropriate service options.

The teaming of two MHPs, instead of an officer and MHP, was an approach some citizens wanted to explore. During interviews with CCAT units and community providers, concerns about that approach were voiced. A major concern was that the absence of an officer would limit where and when two MHPs could be safely dispatched. Officers can support the safety of the MHP as well as other individuals on scene, if required. Officers also provided the needed legal authority in some situations, and they represent the first responder type some individuals want and expect when they call 911, while MHPs provide important assessments at the time of crisis. The careful selection of CCAT officers and MHPs - as well as the provision of specialized training - helped address concerns about having an effective response to calls involving behavioral/mental health issues. In addition, Bellevue has the benefit of having both the CARES101 “teamed MHPs” dispatch unit and CARES to continue working with individuals and families after the initial response.

The CCAT program made some changes during the 16-month implementation. For example, hours of operation were adjusted, and units expanded the types of calls to which they would respond - including situations where someone had died, and incidents involving weapons. These changes and others occurred as experiences and skill sets developed, and units demonstrated proven abilities. In 2024, the database was also adjusted to be more robust, and it was decided that further CCAT database enhancements were required. Transferring the existing data and case management documentation to another system (Julota) will be finalized the first quarter of 2026. This new system will provide additional case management capabilities, including the ability to enhance communication and information-sharing with community agencies, as community providers recommended. The new system will also link to existing city and King County first responder and medical systems. This access will enhance evaluation capacity, options, information-gathering, and analyses.

In closing, clients, caregivers, community providers, CCAT staff, and BPD personnel were very supportive of CCAT’s continuation based on their experiences. Not only did they report that CCAT filled a needed service gap in the community but spoke about how the program supported individuals struggling with behavioral/mental health issues, substance use, and being unhoused. The consensus is that CCAT represents a positive culture shift within BPD and for the city.

Appendix A

Appendix A: Community Crisis Assistance Team (CCAT) Log Model

CCAT Mission: Provide a coordinated community response for aiding individuals experiencing a behavioral crisis. 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.

Inputs	Activities	Outputs	Immediate Outcomes	
<i>Crisis Identification Source</i> 911 & NORCOM dispatch First responder call CCAT Team outreach CARES Team outreach Community providers	Respond to 911 and NORCOM dispatches On-scene responses to first responder requests CCAT outreach/drive-by Community provider contacts	# of 911/NORCOM dispatches # of first responder calls # of CCAT outreach/drive-bys # of referrals from community providers	Enhanced understanding and working relationships with first responders and community providers	
<i>Preparation/Administration</i> Work Group/staff Partnership agreement & data sharing agreements Evaluation design and case management database	Work Group/staff meetings Ongoing dialogs with partners (e.g., NORCOM, BPD, BFD, community providers, external evaluator) Work with evaluation team	Work Group/staff meetings Information sharing with city and governmental officials, and conferences Refined evaluation approach and database system	Strengthened BPD and BFD communication and information sharing	Enhanced BPD and BFD working relationships
<i>Program Elements</i> Officer & MHP units (5) Ongoing case mgt (CARES, if client elects) Individuals, family members, caregivers Community partners (MH providers, hospitals, and Homeless Outreach Coordinator, etc.) Provide and broker services with existing community organization External third-party evaluator Bellevue Community Crisis Response Program Case Management System for case documentation & to supports program evaluation)	Identify, reassign, hire staff Ongoing staff trainings Connect with client: engage, build trust, provide service / supports, ongoing contact Connect and build relationships with clients' family and friends, as appropriate Provide & broker services Client staffing (weekly) Create regional/interagency community partnerships Provide inter-department education Broad community education & outreach Develop data tools, support data collect, and conduct evaluation analysis, annually and as requested	Number of CCAT responses by call type (reason for engagement) Number of clients engaged Summary of activities, client engagements and contacts Inter-department partnership, and community engagement and education activities Use of evaluation findings for program adjustments and decisions Sharing of findings to funders, and various city, government and stakeholder groups Annual report	Clients connected to services/supports, provided or brokered Type and count of communications with clients, caregivers, others on behalf or client Increased rate of de-escalation with clients Reduced number of repeat 911 calls Reduced use of force Reduced arrest/incarceration Reduced unnecessary ED or hospital visits Clients enrolled in CARES, when appropriate Improved clients & BPD experience/relationship	Creation of regional/interagency community partnerships Fully staffed number of CCAT units required to meet community need Creation of an enhanced sustainable pathway for members of the community with behavioral/emotional health issues to access supports and services

Appendix B

Table 1: Race/Ethnicity

Race (n=928)	Hispanic	Non- Hispanic	Unknown ethnicity	Count of individual by race	Percent of individual by race
White	37	177	349	563	60.7%
Black	0	51	83	134	14.4%
Unknown	2	9	97	108	11.6%
Asian-Pacific Islander	0	45	33	78	8.4%
Other	9	16	15	40	4.3%
American Indian, Alaskan Native	0	2	3	5	0.5%
Total Count and Percent	48	300	580	928	100%
Total Percent	5.2%	32.3%	62.5%	100%	100%

Table 2: Number of individuals and count of presenting issues

Number of individuals	Number of issues	Count of issues	Percent of individuals with this quantity of presenting issues
51	zero	0	4.6%
360	one	360	32.2%
330	two	660	29.5%
196	three	588	17.5%
99	four	396	8.9%
44	five	220	3.9%
26	six	156	2.3%
9	seven	63	0.8%
1	eight	8	0.1%
1	nine	9	0.1%
1,117	N/A	2,460	100%

Table 3: Presenting issues identified at initial engagement

Issue	Number of individuals with this issue*	Percent identified with this issue
Behavioral/Mental health	633	59.4%
Welfare Check	515	48.3%
Unhoused	299	28.0%
Substance use	206	19.3%
Support navigating systems	141	13.2%
Medical	117	11.0%
Person cannot self-care/Caregiver overwhelmed	56	5.3%
Domestic violence	49	4.6%
Living conditions	31	2.9%
Mobility	30	2.8%
Victim of a crime	27	2.5%
Property Destruction	22	2.1%
Abuse/Neglect by other	15	1.4%
Help with civic information	15	1.4%
Fall/Trip	11	1.0%
Self-neglect	10	0.9%
Other reason for referral	7	0.7%
Trespassing	2	0.2%
Total count of all issues	2,186	N/A
Count of additional conditions for the 633 persons with behavioral/mental health issues. See Table 4.	274	N/A
Count of all presenting issues/reasons	2,460	N/A

*Individuals may have more than one of these issues.

Table 4: Behavioral/Mental health issues at initial engagement

Issue	Count of this type of issue*	Percent of 633 individuals with behavioral/mental health issues
Mental health	549	86.7%
Suicidal ideation/attempt	206	32.5%
Grief (e.g., loss of loved one)	53	8.4%
Trauma (i.e., result of being abused, witnessing/experiencing an event)	43	6.8%
Dementia	33	5.2%
Homicidal ideation/attempt	23	3.6%
Total number of behavioral issues	907	N/A

*Individuals may have more than one of these issues/concerns.

Table 5: Count of individuals with co-occurring issues

Co-occurring issues*	Count of individuals	Percent of all individuals
Mental health, substance use, unhoused	34	3.2%
Mental health and unhoused	85	8.0%
Mental health and substance use	79	7.4%
Substance use and unhoused	43	4.0%
Total number of individuals with complex issues	241	22.6%

*Individuals may have additional issues beyond these co-occurring issues.

Table 6: CCAT Initial Call Sources

Call source	Number by call source	Percent of all call source
911 calls	879	78.7%
BPD radio dispatch	139	12.4%
CCAT unit outreach (includes officer-initiated)	52	4.7%
BFD radio dispatch	31	2.8%
NORCOM	12	1.1%
Community referrals	4	0.4%
Total number of individuals	1,117	100%

Table 7: Top 10 call types CCAT responded

Call Type*	Count of CCAT response by call type	Number of calls during CCAT coverage	Percent of call type CCAT responded
Assist: Three main reasons: 1. A business or individual needs assistance with an individual on their property, 2. outside agency needs assistance; 3. individual needs information or help from law enforcement	869	6,160	14%
Welfare check: check on an individual believed to need assistance or care	641	1,688	38%
Behavioral Health (Mental/Emotional): individual has some form of behavioral crisis/issue	578	973	59%
Follow up: request related to an already reported incident	280	5,118	5%
Questionable Activity: suspicious activities not fitting into another category; dangerous calls due to large unknowns	149	2,174	7%
Suicide: ideations or attempts	93	131	71%
Officer-initiated contact of an individual	88	870	10%
Disturbance: physical or verbal fight reported to police	87	912	10%
Aid - Emergency	70	302	23%
Area check: drive through based on suspicious circumstance	69	984	7%
Total	2,924	19,312	N/A

*There were other call types to which CCAT units responded beyond these ten call types.

Table 9: Case disposition

Closed/inactive category	Count of individuals	Percent of closed/inactive category	Count of eligible only individuals	Percent of eligible only engaged category
On scene, served only by CCAT	680	57.4%	515	51.1%
Referred to CARES but not opened	255	21.5%	242*	24.1%
Served by CARES	249	21.1%	249	24.8%

Total	1,184	100%	1,006	100%
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*13 “referred to CARES but not opened” cases became ineligible, they moved outside of the service area.

Table 11: Reasons cases referred to CARES were not opened for services

Reason case was not opened for services*	Count of individuals	Percent of closed/inactive cases
Unable to locate client	90	7.6%
Declined services at initial contact by CARES	60	5.1%
Unable to make contact (no response to repeated attempts)	44	3.7%
Case already opened in CCAT	26	2.2%
Services already in place (other than CARES), prior to CCAT engagement	15	1.3%
No longer met program guidelines (e.g., moved out of service area since referral)	13	1.1%
Case was already opened in CARES	5	0.4%
Deceased prior to engagement	4	0.3%
Other reasons (i.e., 2 persons with warrants for arrest and 1 person for whom service not required)	3	0.3%
CCAT transferred to CARES	1	0.1%
Total Contacts	261	N/A

*Individuals may have more than one of these reasons for case closure.

Table 13: Disposition status of closed/inactivated cases

Case disposition status	Count of individuals	Percent of all cases
Inactive case	1,133	95.7%
Closed case	26	2.2%
Re-opened for services	25	2.1%
Total	1,184	100%

Table 14: Tangible resources provided at initial engagement

Type of resources	Count
Transportation	106
Food	71
Water	63
Other needs	21
Clothing	18
Purchased items	14
Total	293

Table 16: Type and count of resources provided/brokered for individuals

Type of service/support	Count of service/support type
Staffing within CARES and externally	507
Mental health	260
Provision of information	214
Food and water	156
Housing/shelter	83
Transportation	63
Welfare check	63
Substance use treatment/services	44
Purchased resources	33
Caregiver supports	14
Clothing	21
Tangible resources*	18
Dementia services	11
VA services	1
Total	1,488

*For example: cell phone, hygiene supplies, specific foods, bus ticket, hand warmer, heat blanket, prescription medication, Narcan, sleeping bag, fuel, hotel stay.

BELLEVUE COMMUNITY CRISIS RESPONSE PROGRAM

