CCAT

Community Crisis Assistance Team

Prepared for Bellevue Police Department & Bellevue Fire Department

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Introduction

CCAT Pilot Overview and Mission

On May 1, 2021, the Bellevue Police Department (BPD), in partnership with Bellevue Fire Department (BFD), launched the Community Crisis Assistance Team (CCAT). This four-month pilot program served the citizens of the City of Bellevue, State of Washington.

CCAT's Mission Statement:

Provide a sustainable coordinated community response for aiding individuals in behavioral crisis from known or suspected mental illness or substance abuse. 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.

Implementation Approach

Best practice suggests a logic model be developed and used to guide program implementation as well as evaluation efforts. A logic model is best described as a theory of change model. Reviewing the logic model provides a visual overview of the program elements. Using a bullet point format, the model also provides a visual narrative of the inputs (e.g., community and program resources, client characteristics, etc.), and the activities (e.g., program approach and actions). It then lists program outputs. Outputs are a count of the "how many and how much" happened (e.g., how many responses to 911 calls occurred, how many clients were served, etc.). The hope is that inputs and actions taken by the program will result in specific and measurable, anticipated changes. These changes (outcomes) are a measure of what is different now for clients and/or for governmental and community systems due to the implementation of programs or changes in policies or practice. The CCAT Workgroup, in partnership with a third-party external evaluator, [1] developed a CCAT Logic model. (See Appendix A: CCAT Logic Model.)

Evaluation Design and Approach

Although the CCAT pilot was short in duration, a program evaluation was designed and conducted. A major goal for this pilot was to gather valuable insights on promising trends, a sense of the program's potential impact and effectiveness, and recommendations to guide future program efforts. Due to the short pilot duration, there was an understanding that implementation would most likely not result in long-term outcomes; but a hope that it would yield some immediate outcomes. The evaluation design embraced equally quantitative and qualitative data gathering approaches.

[1] The evaluation study and report were conducted/written by Carol J. Harper of Social Visions, an external third-party researcher. Ms. Harper worked closely with the CCAT workgroup (a seven-member team). The workgroup reviewed all evaluation documents and tools and facilitated the scheduling of stakeholder interviews. Ms. Harper conducted all interviews alone, in-person, on Zoom, or over the phone depending on participant's preference.

The quantitative data for this evaluation included BPD administration data[2] and information entered in real-time by CCAT and Bellevue Fire CARES staff into the CCAT Case Management Database. Meanwhile, the qualitative data was gathered through interviews and surveys of CCAT staff, clients, and various community agency professionals. These participants engaged in 35-90-minute structured interviews and completed a tailored written survey. Their insights and assessments provided important information on the program's impact. By utilizing qualitative and quantitative data evaluation approaches, one gains a more complete snapshot of the program's implementation and impact, as well as a sense of whether there are promising patterns and trends.

Report Format

Information presented in this report will follow the logic model format. The first section of the report will highlight program inputs in a narrative format followed by a second section that describes key program activities. The third section's focus is on program outputs. The output section relies heavily on quantitative tables; each table is preceded by a short narrative. The fourth section presents immediate outcome data supported by both quantitative and qualitative findings. Within each section of the report, qualitative insights provided by those interviewed were inserted to enhance readers' understanding of the quantitative findings. The final report section ends with a conclusion and additional qualitative feedback from those with firsthand experience and their suggestions for future implementation considerations.

Inputs: Program Resources and Implementation Approach

Bellevue has an existing response model comprised of a unit staffed by mental health professionals (MHP) that responds with police to calls for those in behavioral health crisis. At the request of police already on scene, the CARES101 unit can be dispatched to the scene to provide crisis intervention. Following the CARES101 unit's response, the Bellevue Fire CARES program provides ongoing support to individuals who agree to case management.

While Bellevue had the existing CARES101 response model, CCAT was designed to provide an even more immediate, sustainable, coordinated community response approach for those in the community experiencing behavioral crisis. CCAT involved the teaming of specially trained BPD patrol officers and mental health professionals (MHP) from the CARES101 team to respond to calls involving a behavioral health crisis.

Seven BPD staff volunteered for this assignment (one supervisor and six officers). These reassigned staff were selected because of their interest in and compassion for working with those who experience mental health and substance use issues, their years of law enforcement experience, and because they had already completed specialized trainings prior to this assignment. Prior to their assignment to the CCAT team, the six officers were serving as patrol officers.

[2] BPD administrative data and analyses were provided by Lynn Boerner and Shawna Gibson, BPD staff members.

MHPs assigned to CCAT were experienced Master of Social Work (MSW) staff from BFD's Mobile Integrated Health Program, Bellevue Fire CARES. Two CARES MHPs, usually assigned to the CARES101 dispatch unit, divided their time each week between CCAT and CARES during the pilot.[3]

Officers and MHPs together participated in additional trainings during the first month of the pilot. Trainings included crisis intervention techniques, mental illness identification, communication approaches, and mental health system processes and procedures. They shared office space in one of the city's fire stations. Since the two departments had shared clients, they jointly participated in weekly client staffing meetings hosted by the CARES Program. These approaches were implemented to support and enhance ongoing cross-team education, collaboration, and bonding.

CCAT units were to serve as first responders for 911 calls which involved individuals experiencing current behavioral crises. They were also allowed to proactively contact individuals experiencing a behavioral crisis. A behavioral crisis event could involve a struggle with mental illness, homelessness, or substance misuse. These individuals' underlying issues were either temporary or long-term.

While the Bellevue Fire CARES101 response model remained in place, two CCAT models were piloted. One model consisted of a single specialized officer teamed with a single MHP. The second model was a team of two specialized officers with radio and phone access to the MHP. (The Bellevue Fire CARES 101 response team was available by phone and for dispatch to the scene when requested by the two officer CCAT teams or the district specific patrol officers.) In Bellevue, BPD patrol officers generally ride alone. Pairing two officers supported the opportunity to work as a team to address and effectively meet the needs of citizens in crisis, while also reducing potential anxiety and stress for individuals uncomfortable with police, by eliminating the number of uniformed personnel on scene. A two-officer team provided an immediate second officer to ensure safety for the response team and the individual. In addition, CCAT Officers wore blue shirts and khaki pants to immediately increase de-escalation factors.

The officer and MHP unit was designated as 8B71. The alternative two-officer units were designated as 8B72 and 8B73. On occasion officers were reassigned to another CCAT unit, but generally they remained on the same unit. Two to three units were deployed daily to respond to dispatches throughout the city; not being limited to specific districts as are patrol officers. These units operated from 8:00 a.m. to 6:00 p.m., Monday through Friday from May 1 to August 31, 2021.

In addition to responding to NORCOM and BPD radio dispatched calls, CCAT units focused on preventative activities and building ongoing relationships with individuals who were in crisis, were known to have experienced crises in the past, and with these individuals' families and friends. For example, they would visit people living in homeless camps and provide bottled water and snacks.

[3] The Bellevue Fire CARES Program has been in operation since 2012. Its mission is to support First Responders, and to engage and assist individuals who are subjects of 911 calls. Should ongoing services be appropriate, and clients agree, they are enrolled into the CARES Program. Once enrolled either a CARES101 MSW or a CARES advocate, (an MSW intern supervised by a Case Supervisor), provides ongoing case management services.

They also checked-in with individuals "wandering" the streets and those living in their cars. CCAT units also sought-out relationship building, educational, and outreach opportunities with community agencies, businesses, and the general public. The goal for engaging in these activities was to increase program awareness, build working relationships, and foster trust in advance of a response event. CCAT staff shared their direct contact information with clients and stakeholder groups. Three stakeholder groups and five clients/relatives talked at length during the interview about how valuable it was to be able contact CCAT units directly. One interviewee specifically shared how helpful it was to request that CCAT units contact missing homeless clients to check on the clients' well-being and to pass along details about upcoming appointments.

Activities: CCAT Actions

Between May 18, and August 31, 2021, CCAT units began entering incident and client data in the CCAT Case Management Database. (The first two weeks of implementation were regarded as a pre-pilot phase.) The CCAT Case Management Database was developed to capture detailed information about what occurred on scene and ongoing client related actions. CCAT staff completed the CCAT Referral Form following each incident. This step enrolled individuals into CCAT. Once enrolled, all future interactions with the individual/client were entered in the Database. This included Bellevue Fire CARES engagement if the client elected to accept ongoing case management services through CARES. By using this Database, CCAT units and CARES staff members could access current client information which was accessible online 24/7. Thus, when a CCAT unit was dispatched, en route or on scene, they could review what had been happening in the individual's life and use that information to inform their engagement approach, dialog with the individual, and decision making.

Engagement of individuals

CCAT units engaged 239 individuals between May 18, and August 31, 2021. The engagement of 203 of these individuals were the result of a NORCOM/BPD dispatch (e.g., 911 calls). CCAT units on their own reached out to 36 individuals.

CCAT unit 8B71 (one Officer and one MHP) completed the referral forms for 55% (126) of the 239 individuals. Based on interview feedback, this was most likely because 8B71 were only responding to P3, P4, and P5 calls which involved a behavioral health concern. Meanwhile, the two officer units were at times requested to respond to other types of calls/dispatches as well as behavioral health calls. Also, should more than one CCAT unit respond to the same dispatch 8B71 generally completed the referral form, in part because the MHPs had prior experience completing the referral form from years of completing a similar form for CARES.

Table 1: CCAT unit responding at the initial engagement

CCAT Unit	Number of engagements	Percent of all engagements
8B71 (one Officer and one MPH)	126	55%
8B72 (two Officers)	63	28%
8B73 (two Officers)	50	22%
Total	**239**	**100%**

Description of what occurred on scene at initial engagement

To gather information on what occurred at initial incidents/engagements, CCAT units answered 13 questions specifically related to that incident in the online Referral Form. Questions included documenting who was on scene, and if there were requested follow ups or any community referrals made. For example, in 72% of these engagements, the CCAT unit was first on the scene. However, there were additional uniformed police officers on scene 46% of the time. From interviews we know that early in the pilot, patrol officers, out of habit, would arrive on scene to serve as a backup. Over time, patrol officers learned not to respond or to respond but remain out of sight. A few of the questions were added between mid-May and mid-June, accounting for some of the missing data documented in Table 2 below. In addition, some questions did not require a "yes" or "no" response; for those questions, if there was not a "yes" or "no" response, the data was listed as missing. Data on what occurred at each of the incidents is presented in rank order in Table 2.

Table 2: What occurred at the initial engagement

Question	Yes	No	Missing	Total
CCAT was first on scene	169	65	5	239
911 call led to initial engagement	157	51	31	239
Uniformed police officers were on scene	110	129	0	239
Consulted a COB MHP (CARES101 or CCAT MHP)	85	154	0	239
CARES follow up needed	77	90	72	239
CCAT Outreach (led to engagement)	36	172	31	239
Both Fire and PD were on scene	29	210	0	239
Police required for CARES to meet with client	24	213	2	239
CCAT and CARES101 both on scene	18	221	0	239
APS referral was made	4	235	0	239
DCR referral was made	4	235	0	239
CPS referral was made	2	237	0	239
Residential Care Services referral was made	0	239	0	239

Client Insights: The five individuals interviewed (four clients and one family member) were asked to share, if they were comfortable, about their initial engagement with CCAT. Presented below is some of what they shared.

- "When he rolled up on me, I thought I was going to be in real trouble! He asked how I was doing. If I needed water or anything. [After we talked ….] he explained where it's OK to park for the night." *Client who lives in his car*

"It was really bad. My breakdown was so bad. I was out of it, laying on the floor crying. When I started to come out of it, I was surrounded by four to five cops in uniforms with big guns. But one guy was in a different uniform started to talk in a calm gentle voice. He asked about my tattoos, the music group I liked (posters of the group were on the walls). He connected with me. [Name of CCAT Officer] related to me. I think he saved my life. I'm a big guy. I think if it wasn't for him, it all would have gone south really fast [client said he thinks he might have got up flighting]." - **Client with mental health issues**

- "When I first came to Bellevue, they stopped me. They saw that I was new, and they just wanted to say 'hello.' And I wasn't in any trouble. So, on my first day in Bellevue, the CCAT Officer got me lunch and water. When you're covered in dirt and dirty, they don't make you feel like a grimy scumbag, you know what I mean? They make you feel like a human being and treat you with respect and kindness. And that has never ever happened with the police." *Unhoused client*

- "[He] talked to you, actually talked to you, and was not [just] fishing for information." *Client lives unhoused and sometimes in Tent City*

- "The first time I talked with [CCAT Officer's name] was when they found my sister after she had been wandering the streets all night because she locked herself out of her house. He reached me by going through her old case files. We [she and her husband with the key] met them at her apartment and we let them in. They were so calm. When they talked, it seemed like they already knew her. We talked about her going to the hospital. I have tried to get her to go many times. She would say yes but would never go. They let her shower and change clothes, and then she did go to the hospital with them." *Family member of a client with mental health issues*

CCAT Staff Insights: During individual interviews with the evaluator, CCAT Officers and MHPs were asked to share their reasons for volunteering for reassignment to CCAT. Below are some of their reasons for volunteering.

- "[A family member] struggled with mental health but our family did not talk about it, we tried to keep it hidden. I understand the hardship and negative impact of dealing with mental health. I want to help others to know life can be different and better." *CCAT Officer*

- "[Where I worked before] I experienced a lot of mental emotional issues going on so it was just something I felt comfortable with and that I like dealing with. [Also…] my family, like other families, had someone with drug use and mental health issues … I had to get used to it and kind of learned how to work with it and around it. My parents talked about how you talk to [relatives] because they're going through this or that… I've always wanted to do something to help. I wanted to do my part…I enjoy doing [CCAT]. *CCAT Officer*

"I see [CCAT] as more of an opportunity. I've dealt in patrol with those who have mental issues, and, you know there's got to be a better way. This was a perfect opportunity to kind of get first-hand knowledge of that better way." - **CCAT Officer**

- "[CCAT] appeals to me. Each of us have our strengths. Outreach like this interested me, it furthered my knowledge as does work with these types of people." *CCAT Officer*
- "It's best practice…a group of people dedicated to talking and contacting [those in behavioral crisis] by responding to calls and doing proactive outreach. I think in the long run it benefits [clients] because they're building rapport and trust with those officers and social workers. [Clients] aren't reinventing the wheel every time they're being contacted. They're not having to repeat the same story, which lends to the trust building, and that helps over time. The theory is that we'll get enough information and hopefully build enough rapport and trust with them, to get them directed towards some other outcome that might not involve 911 every time they need something or have immediate behavior that then results in 911 call." *CCAT Officer*
- "I was glad I was assigned to CCAT. Before the program started, I was worried that I might get into situations where ethically, as a social worker, my hands would be tied. It turned out to be an amazing experience. Honestly, it was even a better experience than I thought it would be. One of the biggest things was the building of partnerships between the officers and CARES. Having the time to talk with each other about our thoughts and perspectives about mental illness and all the other things one sees in the field. Second big thing was the willingness of the officers to let go of some of their control and let the social workers step in. I felt that all the decision making was 50-50. I never felt the officers ignored our opinions." *CCAT MHP*
- "[It was] great to be on the scene from the beginning. It is very insightful to see how the tone is set (compared to when CARES responds after the initial police contact occurred). You get to see the person in their state of crisis. All CCAT Officers have a calming presence. They are not coming in with their minds made up. They have an open mind." *CCAT MHP*

Outputs: An Overview of the "How Many" and "How Much"

Outputs are about "how many" and "how much". For example, in this study, outputs included counts of how many calls NORCOM dispatched to CCAT units and the number of outreach efforts the CCAT unit made to those they observed on the street or in homeless camps. Other types of counts included a total of which services and supports were provided to the individuals. Also highlighted in this section is basic demographic information about the individuals CCAT units engaged and the types of issues they presented. Although demographic and presenting issue data is not regarded as outputs, they are presented in this section to highlight the emotionally difficult and complex struggles those engaged individuals face and the nature of the challenges CCAT staff experienced during engagement and as they looked for solutions.

Call source and number of incidents to which CCAT units responded

During the four-month pilot the BPD administrative data system showed that among the three CCAT units there were a total of 1,163 dispatches/interactions. Dispatches/interactions is how BPD document the activities of their officers. This translated to an average of 13.4 calls per day/shift among the three CCAT units. The primary call source was 9ll calls (Total= 776) followed by radio dispatches/requests (Total= 249). Also, 74 of the dispatches were officer-initiated. Table 3 lists the call sources in rank order. It is important to note that some of the calls that units 8B72 and 8B73 responded to were not specifically CCAT related but are included in this data. Regardless, this data provides a snapshot and is representative of the call sources and counts among the units.

Table 3: Call source

Call sources	Number of calls	Percent of calls
911 calls	776	67%
Radio dispatch/requests	249	21%
Officer-initiated	74	6%
10-digit emergency	58	5%
Text to 911	6	1%
Total	1163	100%

Call types

The BPD administrative system also tracks call types for each dispatch and the unit that was deployed to the scene. BPD provided the list and count of the top ten call types that the CCAT units responded. To enhance understanding, the percent that each call type was among CCAT top ten calls was calculated by dividing the count for each call type by the total number of top ten call types. For example, officer-initiated "contact of a person" was the most likely call type among CCAT units accounting for 179 calls or 18% of the top ten call types. The second most likely of the top ten call types to which CCAT units responded was "welfare check" (164 or 16%), which was not surprising because of CCAT's commitment to outreach and checking in on how individuals were doing. "Assist" was the third most common call type (157 or 16%) and makes logical sense based on CCAT's practice of assisting community agencies engaged in homeless outreach, shelter care, CARES, and

other organizations working closely with individuals in behavioral crisis where safety might be an issue. "Mental/Emotional" call type (128 or 13%) for CCAT also makes sense since this includes individuals who are struggling with behavioral issues. These four categories of the top ten call types and represent 63% of the top call types to which CCAT units were dispatched.[4] During interviews, CCAT Officers reported that there were situations when they engaged individuals briefly and did not document that interaction in the BPD system, which represent undocumented call types in the data table. Table 4 presents in rank order of the top ten call types among CCAT units, and the total number and the percent for each call type.

Table 4: Top ten call types

Call sources	Number of calls (N=996)	Percent of top 10 calls
Contact of a person: officer-initiated contact of a subject	179	18%
Welfare check: check on a subject that is believed to be in need of assistance or care	164	16%
Assist: two main reasons: 1. an outside agency needs assistance; 2. an individual has some type of question for or need from law enforcement	157	16%
Mental/Emotional: individual has some form of behavioral crisis/issue	128	13%
Follow up: request related to an already reported incident	86	9%
Questionable Activity: suspicious activities not fitting into another category; one of the most dangerous calls due to large unknowns	66	7%
Fire Assist: fire or medical response that warrants police response for combative patient, traffic control, cardiac arrest	59	6%
Disturbance: physical or verbal fight reported to police	56	6%
Area check: drive through responses based on suspicious circumstance	56	6%
Trespass: a person is present on property where they have previously been formally asked to leave and told not to return	45	5%

Two NORCOM staff participated in stakeholder interviews. Below are some of the insights they provided regarding the impact of having a CCAT unit available for dispatch.

> "By week 2-3 of CCAT's implementation, hospitals, campus security, residents at shelters, and citizens were asking for CCAT units and sometimes [officers] by name. That's when we knew it was working!" - **NORCOM**

[4] As noted earlier, 8B72 and 8B73 responded to some non-CCAT related calls. It is important to note that most of these non-CCAT calls were P3, P4, and P5 call types; P1 and P2 call types are priority emergency calls, requiring uniformed officers and are normally limited to 1-2 calls per day across the city. Thus, this data does provide a snapshot and is representative of the call types CCAT handles.

- "When there are mental/emotional calls it is very straining on resources. To have two or three patrol officers tied up on these crisis calls for a couple of hours is very straining on the system. Having 2-3 of these CCAT units available is very valuable. And they are very proactive. They monitor the calls and if it looked like it was their specialty area, they would take those calls and handle it." *NORCOM*

Average length of time spent on calls

In addition to determining the average length of time CCAT units spent on calls, this evaluation was equally interested in determining if, on average, the length of time CCAT units spent on calls changed compared to the length of time patrol officers spent on calls. The interest was to determine if CCAT units spend more time with individuals.

Using BPD administrative data, the analysis involved calculating and comparing the length of time that the patrol officers reassigned to CCAT use to spent on calls, determining whether their time on each call type increased, decreased, or remained the same four months prior to their CCAT assignment to the length of time they spent on these same call types during their CCAT assignment. For this evaluation, analysis was conducted on the amount of time spent on the top ten call types.

The analysis revealed that CCAT Officers spent an increased amount of time on each of the top call types. On average, across all ten call types, CCAT Officers spent an additional 16 minutes and 47 seconds longer on a call than they had as patrol officers. Using a change score calculation this represents an 82% increase in length of time spent on calls.

A deeper examination of the data revealed that the average increases in length of time varied greatly depending on call type. For example, prior to CCAT assignment, an officer would spend 21 minutes on trespass calls while during the pilot that same officer now spent just over 1 hour and 13 minutes on trespass calls. Meaning, CCAT units on average spent 49 minutes and 28 seconds more on trespass calls than they did before the pilot. In addition to this major increase in length of time, in eight of the other top ten call types, the average increase in length of time spent on the call increased by nearly a third (e.g., mental/emotional calls from 27 minutes to 40 minutes, follow-up calls from 21 minutes to 32 minutes). Meanwhile, the length of time spent on some call types doubled or nearly doubled (i.e., welfare check, assist, fire assist, area check and contact of a person).[5] Table 5 presents average increases in time on calls by call types in rank order. The narrative following this table provides insights from CCAT staff and stakeholder interviews about what CCAT units did differently on scene with the extra time.

[5] During interviews stakeholders noted, as did patrol officers, that CCAT Officers had a reputation of "going the extra mile "with those they engaged. Thus, a comparison of average time on calls among other patrol officers, in addition to change of time among CCAT Officers, may reveal even greater increases in length of time spent on calls.

Table 5: Average length of time by call type, by officers prior to CCAT and during CCAT
(Time presented h:mm:ss)

Call source	Average time on call during CCAT	Average time on call pre- pilot	Difference in average time on call during CCAT vs pre-pilot
Trespass: person on property; formally asked to leave/not return	1:13:05	20:47	49:28
Assist: outside agency needs assist; individual has question/need	44:38	24:40	19:58
Fire assist: fire or medical response that warrants police	31:56	14:03	17:53
Contact of a person: officer-initiated contact	26:18	8:50	17:28
Area check: based on suspicious circumstance	32:46	16:27	16:19
Welfare check: person believed in need of assistance or care	38:20	25:09	13:11
Mental/Emotional: caller in behavioral crisis	40:05	27:19	12:46
Follow up: request related to an already reported incident	32:32	21:35	10:57
Questionable Activity : suspicious activities not fitting into another category	26:51	18:42	8:09
Disturbance: Physical or verbal fight reported to police	29:11	27:27	1:44
Average time on call	**37:34**	**20:47**	**16:47**

CCAT Staff and Stakeholder Insights: The major theme among all those interviewed was how important and how impressed they were by the amount of time CCAT units were at each call. They spoke of CCAT units spending more time listening to the individual, asking about their specific situation and asking about their needs and wishes. It was felt that these practices were important to the development of solutions clients were willing to follow/agree to. If the person was "trespassing" because they were experiencing homeless, the CCAT unit took the time to listen as well as explain various options for the individual. CCAT teams would ask about potential friends or relatives who might be available or explain the types of shelters or places they could more appropriately park a car. It was reported that CCAT units would even help the individual pack up belongings and support them to get to where they needed to go. Those interviewed compared these actions to witnessing

patrol officers just telling the person to "move on," and leaving, only to have to come back again and again to engage the same individual.

Clients, stakeholders, CCAT staff, and BPD personnel all addressed the value of CCAT units being able to take their time with each call. Based on the feedback provided by these various groups, it appears that having the ability to "take the time needed" permitted CCAT teams the opportunity to use their skills to engage, identify solutions, de-escalate situations, and build rapport. Below are some of the statements shared by persons interviewed.

- "CCAT is different. One of the biggest differences is having more time to talk with the person. As a patrol officer one is looking for a crime or determining that there is not a crime, so a police officer is not needed. However, the person may still be going through something very traumatic even if there is not a crime. As CCAT we can be there a bit longer, to think about and get them to services or just to listen so that the person feels a bit better." *CCAT Officer*

"It's different from patrol where you're jumping from call to call to call or chasing the radio. With CCAT you contact someone and we're able to take the time to work with that person and see what they need or how we can help them. You know, it's really nice to have the time to slow down and hear the details rather than jumping around from here to there. Time is on our side with CCAT." – **CCAT Officer**

- "We related to each other. It felt like [name of CCAT Officer] was there because he wanted to help me, like he had my back. Like he was my friend and wanted me to get better. Not like it was just his job or just following regulations. They were going to call an ambulance. I did not want them to call because of the cost. So [name of CCAT Officer] said he could drive me. [Client would not have gone otherwise.] And afterwards he followed-up with me." *Client in mental health crisis*

- "CCAT was willing to build a relationship [with client and family member] and get her help [and she accepted] because of the relationship. CCAT even called me when my sister would not return their calls. They followed my suggestion to keep trying. In time, my sister did reach out to CCAT. They were responsive. It is wonderful to have someone specific to call [CCAT team] who knows the situation when I was concerned and worried, and not have to call 911 again and again, and explain the whole story again. CCAT knows my sister. Only because CCAT had a relationship with my sister, she got needed help and I got help too." *Family member of a client with mental health issues*

- "I cannot count on my toes and fingers how many times one of those CCAT Officers brought me food or water or checked on me, [they] specifically came and checked on me. And we're off in the trees or at campsites. And they go out of their way. We're covered in mud and dirty, and they just come to look at you in your face, shake your hand and say, "How are you?" *An unhoused client*

Count of individuals engaged and their demographic information

BPD captured demographic information on those involved in each BPD dispatch. Using the list of names of individuals engaged by CCAT units, through LERMS (Law Enforcement Records Management System), they were able to provide basic demographic information on the 261 individuals engaged starting on May 1, 2021. Most individuals engaged by CCAT units were white males of non-Hispanic ethnicity. The second most likely group engaged were white females of non-Hispanic ethnicity. The average age for all individuals engaged were 42 years old.

Table 6: Demographic Data

Race	Hispanic	Non-Hispanic	TOTAL	Male	Female	Unknown
White	6	109	115	67	48	--
Black	--	35	35	20	15	--
Asian-Pacific Islander	--	19	19	6	13	--
American Indian-Alaskan Native	--	2	2	1	1	--
Unknown	1	82	83	44	29	10
Other	1	6	7	4	3	--
Grand Total	8	253	261	142	109	10

Types and count of presenting issues among CCAT engaged individuals

As reported earlier in this report, CCAT staff documented in the CCAT Database the details of what occurred on scene. They also documented in the database what was learned and observed about the individual's presenting issues (e.g., their situation, needs, condition, such as mental health or homelessness). This and other intake information about the person were documented in the Referral Form; this information shapes initial and ongoing client assessments, client interactions, decision making, and case management.

Among the 239 individuals for whom CCAT staff completed a Referral Form, five individuals had no issue/concern documented. Among the 234 individuals with documented issues, there were a total of 492 issues/concerns. This finding demonstrates that most of the individuals (65% or 151) had multiple issues/concerns. The range in number of concerns among the 234 individuals was between one to seven issues. The average number of issues/concerns per individual was 2.1 issues/concerns.

Table 7 provides a count of the number of individuals, along with the number of issues/concerns, and the percentage of all individuals having that quantity of issues/concerns. For example, 83 individuals (35% of those CCAT engaged) had one issue/concern while 84 individuals (36%) had two presenting issues/concerns.

Table 7: Count of individuals by number of presenting issues/concerns

Count of issues/concerns among individuals	Number of issues/concerns	Total count of issues/concerns	Percent of individuals with this number of presenting issues/concerns
83	one	83	35%
84	two	168	36%
42	three	126	18%
15	four	60	6%
6	five	30	3%
3	six	18	1%
1	seven	7	0%
234	N/A	492	100%

Analysis of the types of presenting issues/concerns among the 234 individuals was also performed. As reported above, 65% of the individuals had more than one presenting issue. For over two-thirds of the individuals (68% or 160) mental health was the most likely reason for CCAT engagement. Additionally, 113 of the 160 individuals with mental health concerns also presented with at least one other issue/concern; leaving 47 individuals presenting with only mental health as their issue. The second most likely presenting issue was being unhoused. In fact, 44% of all individuals (102) reported being unhoused as an issue. Among these 102 unhoused individuals, 70 also presented with at least one other presenting issue/concern; leaving 21 individuals with being unhoused as their only issue.

Table 8 provides a count of the number of individuals with each presenting issue/concern as well as the percent of individuals identified with that specific issue/concern. The types of presenting issues/concerns are displayed in rank order. Among the 234 individuals with documented issues, The three most common presenting issues were mental health, being unhoused, and substance abuse.

Table 8: Identified presenting issues/concerns among individuals

Issue/Concern	Count of individuals with this issue/concerns*	Percent of individuals identified with this issue/concern
Mental health	160	68%
Unhoused/homelessness	102	44%
Substance abuse	61	26%
Welfare check	38	16%
Medical	28	12%
Criminal activity	19	8%
Mobility	14	6%
Patient cannot self-care/Caregiver overwhelmed	12	5%
Living conditions	11	5%
Fall/Trip	5	2%
Patient cannot self-advocate	5	2%
Self-neglect	3	1%
Victim of a crime	2	1%
Fire	1	0%
Domestic violence	1	0%
Other reason for referral	30	13%
Total number of issues/concerns among clients	492	N/A

*Individuals may have more than one issue/concern

Complexity of CCAT Cases

Additional analyses were conducted to determine the number of individuals with the most challenging co-occurring combinations of presenting issues: mental health, being unhoused, and substance abuse. In addition, some of these individuals also presented with other issues/concerns. Among the 234 individuals seen by CCAT 37% (87) of them presented with at least two or more of these complexed issues.

Table 9 provides the count of cases where two or three of these complex co-occurring issues were identified among individuals. For example, 30 individuals presented with both mental health and substance abuse. Meanwhile, 28 individuals had all three of these serious co-occurring issues/concerns i.e., mental health, substance abuse, and were unhoused. This data highlights the complexity of engaging with these individuals, the service needed, and intervention time required to address these issues.

*Table 9: Count of CCAT individuals with major co-occurring issues/concerns**

Issues/concerns	Count of individuals (n=87)	Percent of all individuals
Mental health, substance abuse, unhoused	28	12%
Mental health and unhoused	30	13%
Mental health and substance abuse	15	6%
Substance abuse and unhoused	14	6%

*Individuals may have more than one issue/concern.

Analysis of Criminal Activities Combined with Other Presenting Issues

Nineteen of 234 individuals presented with criminal activity as a presenting issue; representing 8% of all those engaged. None of these 19 individuals had criminal activities as their only issue/concern. The data reveals that 16 of the 19 clients had mental health as one of their co-occurring issues. Being unhoused along with struggling with substance abuse were the second most likely combination.

During interviews CCAT staff shared that if a truly criminal activity occurred, they followed the law. Since CCAT's goal was to divert individuals from the criminal justice system, if it was appropriate, staff were able to resolve some situations through de-escalation and finding alternative solutions.

The reason for the low number of clients with criminal activity as their presenting issues and having none with only criminal activities as an issue, lead to one of two conclusions based on interview insights. The first conclusion is that most of the individuals with behavioral issues were not "truly criminal" in nature but were due to the individuals' situations/conditions that had them make poor decisions. The second conclusion is that because of CCAT units' efforts to facilitate solutions, criminal charges were not necessary. Below is one example of a de-escalated diversion shared by a CCAT Officer, followed by insights provided by a stakeholder on why criminal activities were not always the issue.

> An above average size adult male with developmental delays walked into a local store. He opened a bag of chips and started to eat without paying for it. The shop owner called 911. CCAT heard the description of the man on the radio and asked to respond to the call since they recognized the man's description. Upon arrival they approached the man, engaged him, and explained to the man he had to pay before eating. Knowing the man would have money in his pocket, they asked him to put money on the counter. The store owner having witnessed what happened, hearing the officer's explanation of the man's developmental situation, and learning about CCAT and its goal to help individuals, elected not to press charges when the officers explained it was his right to do so. As several interview participants reported, owners like this and other community members say that they would rather individuals receive help than be arrested. It was shared that, because of their lack of knowledge, this situation could have turned out very differently had other officers responded.

- "Understand that people are not criminals but people in distress. Understand these are people struggling. Focus is on the mental health issues. [CCAT] led with that and not the criminal aspect at that moment. That helps to the calm the situation. It helps to decrease the individual['s] anxiety and find a solution to the current crisis. One can address the criminal concerns later and call/engage more officers if needed." *Shelter staff*

Table 10 presents data on the combination of issue(s)/concern(s) individuals presented with in addition to criminal activities.

Table 10: Clients with criminal activities along with other issues/concerns

Criminal Activities along with other issues/concerns	Number of individuals (n=19)
Mental Health	5
Mental Health, substance abuse, unhoused	4
Mental health and substance abuse	2
Mental Health, substance abuse, medical, unhoused	1
Mental health, substance abuse, medical, unhoused,	1
Mental health, substance abuse, unhoused, welfare check	1
Mental health, substance abuse, unhoused, living conditions	1
Mental health and unhoused	1
Unhoused	1
Victim of a crime	1
Welfare and others	1

Below are additional stakeholder interview insights regarding the relationship between poor decision making and behavioral crises, and the value of the CCAT approach.

"In Bellevue we were arresting people with mental health issues who were not "really" criminals [for their actions]. The number of suicides is high in Bellevue. There is a need for a mental health unit. These people [with mental health] need someone to listen to them, check on them, get them resources, basically help them get through life. Everyone agrees that this type of unit is the right thing to do." – **Bellevue Patrol Officer**

- "Those persons who are substance abusing and homeless are part of the population who sometimes have mental health issues, that can be the underlining problem…They are stealing because of their substance use and homelessness. The citizens I talked with liked the idea of CCAT because they do not want persons with these issues to just get arrested. They wanted them to get help." *Bellevue Patrol Officer*

Count of client contacts and contacts on behalf of the clients

As noted earlier, CCAT's mission is to aid individuals in behavioral crisis by improving their quality of life by diverting them from the criminal justice system and providing an alternative pathway to address their mental health and behavioral crisis. Central to achieving this mission was creating trusting, positive, relationships with individuals. As a result, in time, individuals would learn to trust those in positions of power and systems, such as CCAT, and would be more open to engaging and listening as well as accept and engage in services when it is suggested and offered.

CCAT staff were to document in the CCAT Database every contact they had with clients as well as the type of services and supports they had offered. From interviews, it is likely that CCAT units did not always document each contact or service provided. It was common for them to stop when driving just to check in with a client to say hello, ask how things were going, if they needed something or give them bottled water or a snack. Also, at the initial encounter, staff documented client engagement and contacts on the referral form. In the interest of not having staff duplicate documentation, staff did not enter these actions into the client contact log. Thus, hundreds of contacts (and services) were undocumented.

Even without the exact number of undocumented brief contacts made during or after the initial engagement, a total of 1,785 contacts entries were entered in the CCAT Database. This demonstrates that on average 7.5 contacts or attempted contacts were made with each client or with others on behalf of the client. These contacts were made by either CCAT units or CARES staff following the initial engagement. An analysis of documentation revealed that 39% of these ongoing contacts were directly with the client of which 17% were face-to-face, 13% by phone, and 9% via text, voice message or fax. Contacts with relatives/caregivers accounted for 9% of their efforts (7% face-to-face and 2% via text, voice message or fax). Table 11 provides a percentage breakdown of type of contacts and reveals the pattern of staff interactions and actions.

Table 11: Percent of client contacts/attempts and contacts on behalf of the client

Types of contacts and actions	Percent of all contacts
Face-to-face with clients	17%
Phone call with clients	13%
Client text, voice message, fax	9%
Attempted face-to-face with clients	6%
Attempted phone call with clients	7%
Face-to-face with relatives/caregiver	1%
Phone call with relatives/caregiver	4%
Client text, voice message, fax	2%
Attempted face-to-face with relatives/caregiver	0%
Attempted phone call with relatives/caregiver	1%
CCAT/CARES advocates contact	2%
Agency contacts	14%
CCAT/CARES staffing and case contacts/actions	24%

Below are insights provided by clients/relatives regarding the value of the contacts by CCAT.

> "It's different when the police stop by once a day, or every couple days, they just say 'how are you?' I'm no longer afraid of interactions with the police. I no longer dread 'em. Now when I see a police officer, I don't get anxious and antsy." – **An Unhoused Client**

- "CCAT and CARES give me a touch point. A place to call for help without just calling the police each time and explaining everything over again. Having a single resource for services, the only one I found. They are special people who are skilled…my vote is to keep CCAT." *Family member of a client with mental health issues*

- "They make sure your OK. I mean it's something as simple as when they stop by and go 'hey, you know it's been hot out. They brought us ice water in that heat wave we had. And when you know 50,000 people out there who don't like you for being poor and homeless… you truly appreciate how good one of these cops is, let alone the whole team are*." An unhoused client and unhoused traveling friend*

Type and count of services provided or brokered for individuals

Connecting clients to services and supports was another central goal for CCAT. Both CCAT and CARES staff were asked to document in the CCAT Database the type of services and supports they referred or provided to individuals. As noted above, not all service efforts were documented by CCAT staff, and these services/supports provided at initial engagement were also not documented in the contact log section of the database. In addition, the services and supports individuals received through the community agencies that CCAT or CARES had connected them to were not documented in the CCAT Database. In other words, individuals received more services/supports than are presented below.

At a minimum, on average, each client was referred to three services/supports. **The most common services included substance abuse treatment, mental health services, and housing/shelter.** A list and count of services/support entered in the CCAT Database is presented in Table 12.

Table 12: Type and count of services/supports provided and brokered for individuals

Types of services	Number of services
Substance Abuse treatment/services	236
Mental health	223
Housing/shelter	110
Caregiver supports	37
Welfare check	33
Other resources	30
Food	17
Dementia services	11
VA services	9
Total	706

Based on interviews with clients and relatives, clients also regarded all forms of check-ins by CCAT and the CARES Program staff as a service. For them contacts by text, in-person, and phone were invaluable. They specifically talked about the impact of having CCAT staff care enough to check on them, listen to them, and give them items such as snacks, food, water, gas cards, and bus passes. Especially to the unhoused, they reported that these actions were essential to their physical, emotional, and mental well-being. Some even regarded being given CCAT Officers' phone numbers as a service. It served as a "lifeline" for clients and relatives and reduced their stress and anxiety levels; led an internal calming effect and provided them with a sense of much needed hope.

Below are some of the services and supports clients shared that they valued.

"You really do not understand the level of compassion and respect that these police officers associated with the CCAT program provide. I mean, they're going in there and like, doing almost triage compassion, like when they clean one girl's infected arm, wiping it down. They helped her before the ambulance came. Like, I really cannot stress how important these specific officers are." – **An Unhoused Client**

- "CCAT Officers ask if you have eaten today." *An unhoused client*
- "CCAT helped me to get me gas coupons (so he can work), personnel care items, food stamps, and housing set up (for him and his brother who is expecting his first child)." *Client living in his car*
- "Connected me to Sound Counseling. [CCAT Officer] emails me. He listened to me. And understanding my situation, knowing I am not able to work now, he brings me some food." *Client with mental health issues*

"When someone stole my dog, they actually wanted to get my dog for me. He [the dog] is still missing and they ask me all the time, if he is found." – **An Unhoused Client Who Sometimes Resides in Tent City**

- "The Salvation Army, Outreach, Reach, and like eight different places. Got food stamps set up." *An unhoused client*

- "He [CCAT Officer] helped me with my son's no contact order. I didn't wanna go all the way to Everett to go pick up his court papers. [CCAT Officer] just said 'sit tight,' and talked to someone on his computer and printed it out. Saved me a trip." *An unhoused client who sometimes lives in Tent City*

"It's different when the police stop by once a day, or every couple days, they just say 'how are you?' I'm no longer afraid of interactions with the police. I no longer dread 'em. Now when I see a police officer, I don't get anxious and antsy." – **An Unhoused Client**

- "If we ever needed a bus ticket, we can ask. Any type of medical care. Bellevue Police is your friend." (For those on the street, it is important for their emotional and mental well-being to know they have someone they can reach out to for help.) *An unhoused client*

Outcomes: What is Different

Up to this point in the report, the evaluation information focused on inputs, activities, and outputs. Highlighting what CCAT units did and providing counts of how often, how many, and how much. Knowledge of these elements is important because it provided insights regarding the implementation, the environment in which the program operated, and facilitates understanding of the individuals engaged and services provided.

The remainder of this report presents immediate outcome findings. Data sources include written surveys ratings from 66 participants, and interview insights from 38 participants. Participants provided information on their experiences with and assessments of CCAT's program approach including its impact on service access and policing practices and outcomes. BPD administrative data was pulled to provide measurable data related to changes in policing outcomes (i.e., reductions in use of force, arrest, and incarcerations).

Stakeholder, BPD Personnel, Clients, and CCAT Officers Survey Results

Clients, CCAT Officers, BPD personnel, and community stakeholders (which included CARES staff and the MHPs assigned to CCAT) were provided an opportunity to provide feedback through a one-page survey. Most individuals completed their surveys prior to participation in the in-person, on the phone, or Zoom interview. The exception was the 32 BPD personnel who only completed the on-line version of the survey. Four survey types were developed. Overlapping questions were designed across survey types to support response comparison. Some language adjustments were made to tailor statements for appropriateness, depending on participant group. Also, some of the system focused statements did not appear on the client version of the survey.

All participants were asked to rate the extent to which they agree with each survey statement. Instructions were the same and the same rating scale was used by all participant groups to rate statements. A rating of "5" meant the participant "strongly agreed" with the statement, "4" meant "agree," "3" meant "neither agree nor disagree", 2 meant "disagree," and "1 meant "strongly disagree" with the statement. Participants also had the option to select "don't know" or that a statement "doesn't apply" to them. The counts of those participants are not provided in the table. However, that number can be calculated by looking at the "n=x" following each statement and subtracting that number from the total number of participants completing the survey that appears in the title of the table. Percentages represent only those who rated the statement.

Summary of overall survey findings

A total of 67 participants completed a written survey. Six were clients/relatives (one of which did not participate in interviews), seven were CCAT Officers, 16 were stakeholders, and 38 BPD personnel. Ratings across the four participant groups were very positive. In fact, across three surveys (clients, CCAT Officers, and stakeholders), only one stakeholder participant rated one statement "disagree." The statement was "CCAT teams facilitate individuals' connections to services and treatments." Based on the interview with that individual, his/her rating appeared to be related more to lack of service availability, and that CARES staff generally takes on the role of identifying community services and not CCAT.

Among BPD, ratings were generally positive. However, there were three participants whose ratings across nearly all statements were negative. Details on the potential reasons are provided in that subsection of this report. This section presents aggregate survey ratings by participant group.

Stakeholder Survey Results

A total of 17 questions were on the stakeholder survey. Sixteen participants completed the survey. Respondents include community professionals and staff members from a hospital, homeless shelter, tent city, homeless outreach, Bellevue Parks, NORCOM, and CARES program staff including MHPs assigned part-time to CCAT. Participants were asked to document the types of services their agency provided to clients. A count of the types of services provided by these stakeholders' agencies included: homelessness (11), mental health services (8), substance abuse services (6), resources (e.g., food, clothing, financial, personal care) (5), law enforcement (3), fire services (3), medical services (2), and other services (2). Twelve of these professionals shared that they have worked in

their field for an average of 7 years, with length of service ranging from 1 to 20 years. Nearly all have spent these numbers of years working in Bellevue.

The most likely rating response was “strongly agree” followed by an “agree” rating. The only statement with a “disagree” rating was about CCAT connecting clients to services. As reported above, this rating appears to be because CARES generally takes the lead on facilitating service connections. There were four statements that had a few “neither agree nor disagree” ratings. Two statements, based on interview data, are areas CCAT had less control over. For example, CCAT diverts clients from arrest or jail had one “neither agree nor disagree” rating because there are situations when officers must follow the law and make an arrest (e.g., domestic violence). Similarly, the statement regarding CCAT’s ability to divert clients from the ED or hospital also had two “neither agree nor disagree” ratings because officers must take those who request the ED or hospital there.

Table 13 lists all the statements on the survey. Statements appear in this table in rank order with those receiving the most “strongly agree” responses appearing first to support comparison of the findings, instead of the order statements appeared on the survey itself. Again, the original survey had columns for a respondent to select “don’t know” or “does not apply” as a response option for each statement. These counts were not included in the calculations presented. Read the “n” count following each statement if there is an interest in learning the number of respondents for each question.

Table 13: Stakeholder survey results

Question	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
CCAT is a positive policing approach to address those in mental health and behavioral crisis (n=16)	--	--	--	12% (2)	88% (14)
CCAT fills a needed service in our city (n=16)	--	--	--	12% (2)	88% (14)
CCAT teams show concern for individuals (n=16)	--	--	--	19% (3)	81% (13)
CCAT teams treat individuals with respect (n=16)	--	--	--	19% (3)	81% (13)
CCAT teams' approaches help to de-escalate situations (n=16)	--	--	--	19% (3)	81% (13)
CCAT teams' approaches appear to reduce the need for use of force by police (n=16)	--	--	--	19% (3)	81% (13)
CCAT teams listen to individuals (n=15)	--	--	--	20% (3)	80% (12)
CCAT teams understand individuals' situations (n=16)	--	--	--	25% (4)	75% (12)
CCAT teams facilitate individuals' connections to services and treatments (n=16)	--	6% (1)	6% (1)	13% (2)	75% (12)
CCAT teams explain their actions and procedures to individuals (n=14)	--	--	--	29% (4)	71% (10)
CCAT teams are patient/didn't rush individuals(n=16)	--	--	--	31% (5)	69% (11)
Individuals' situations are generally better because of the help provided by CCAT or through other providers due to CCAT teams' actions (n=16)	--	--	--	31% (5)	69% (11)
CCAT teams' approaches appear to divert individuals from unnecessary emergency department/ hospitalization (n=15)	--	--	13% (2)	20% (3)	67% (10)
CCAT responses are tailored to the needs of individuals they encounter (n=14)	--	--	7% (1)	29% (4)	64% (9)
CCAT teams enhance police interactions with hospital staff when emergency department/ hospitalization is required (n=12)	--	--	17% (2)	25% (3)	58% (7)
CCAT teams' approaches appear to divert individuals from being arrested or jailed (n=14)	--	--	7% (1)	36% (5)	57% (8)
CCAT teams are knowledgeable (n=16)	--	--	--	50% (8)	50% (8)

Quotes from interviews are presented below to strengthen understanding.

- "CCAT Officers were patient, knowledgeable, and personally invested. CCAT Officers knew the type of information important for an MHP to effectively engage and understand the situation and did not leave out important information details. They also knew about clients from prior experience*." CARES Staff who provide ongoing case management*

- '[CCAT] gave my folks the benefit of the doubt. They always give them respect. They do not give up on the person. They are patient, compassionate and respectful always and that is what is required to do this job. Understanding that it might take 30 to 50 contacts before the person will be reached or respond." *Homeless Outreach*

- "I have utter faith in our police officers but when we have officers trained to deal with these situations (mental health) it's a match made in heaven in these times when one sees police (poorly handling situations) in the media. I just can't think of a better place to put our funding. I know that every city is strapped. But I can't offer a better place to put it [funding]." *NORCOM Staff*

BPD members (excluding CCAT Officers) Survey Results

A total of 38 BPD personnel completed either an on-line (32) or paper version (6) of a survey to provide input regarding their experience with CCAT. Their position with BPD ranged from detective, patrol officers, and those who only identified themselves as police. Number of years in law enforcement ranged from 3 to 34 with an average of 16 years. Number of years on BPD ranged from 1 to 24 with an average of 11 years.

Close examination of the rates reveals that to six of the 13 statements, between 90% or 97% of BPD respondents either "strongly agree" or "agree." For example, CCAT units are permitted to take more time with each individual they engage (97%); CCAT facilitate individuals' connections to service and treatments (91%); CCAT is a positive policing approach to address those in mental health and behavioral crisis (91%); and individuals' situations are generally better because of the help provided by CCAT or through other providers due to CCAT teams' actions (91%)

Combining the "strongly agree" or "agree" ratings for each of the seven remaining 13 statements revealed four statements received these positive ratings from another 85% to 83% of the participants, while two other statements received these positive ratings from 79% and 73% of the participants. The last statement received a 67% participant approve rating. This statement was "CCAT teams' approaches appear to divert individuals from being arrested or jailed." This statement was lower because it received the largest number participants (8) who select "neither agree nor disagree." For all other statements, the range of percent with "neither agree nor disagree" 1-3 participants selected that rating.

An examination of individual ratings revealed that two people only answered "I don't know" to all 13 statements. Another person answered "I don't know" to all but four statements. Two of these

people were patrol officers working graveyard shifts who reported they have no first-hand experience with CCAT. The other person was a detective who also reported limited CCAT experience.

The examination of individual ratings also revealed that three BPD personnel accounted for nearly all “strongly disagree” or “disagree” ratings. In fact, one participant rated all 13 statements as “strongly disagree.” In the narrative, this patrol officer suggested to “eliminate the CCAT unit.” They shared that “Patrol is a better use of limited resources.” Another person rated two of the 13 statements as “strongly disagree”, five as “disagree”, and four statements as “neither agree nor disagree.” The only “agree” rating from this person was that ‘CCAT teams did have more time to spend with individuals.’ The final person rated seven of the 13 statements as “disagree” along with rating five statements as “neither agree nor disagree.” Neither of these persons provided any narrative comment regarding their thoughts or program recommendations.

In Table 14, statements appear in rank order with those statements having more participants ratings the statements as “strongly agree” listed first.

Table 14: BPD member survey results

Question	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Combined Strongly Agree nor Agree
CCAT units are permitted to take more time with each individual they engage (n=38)	3% (1)	--	--	28% (10)	69% (25)	97% (35)
CCAT teams facilitate individuals' connections to service and treatments (n=32)	3% (1)	--	6% (2)	13% (4)	78% (25)	91% (29)
CCAT is a positive policing approach to address those in mental health and behavioral crisis (n=33)	3% (1)	3% (1)	3% (1)	18% (6)	73% (24)	91% (30)
Individuals' situations are generally better because of the help provided by CCAT or through other providers due to CCAT teams' actions (n=31)	3% (1)	6% (2)	--	26% (8)	65% (20)	91% (28)
CCAT responses are tailored to the needs of individuals they encounter (n=30)	3% (1)	--	7% (2)	27% (8)	63% (19)	90% (27)
CCAT teams' approaches help to de-escalate situations (n=30)	3% (1)	7% (2)	--	30% (9)	60% (18)	90% (27)
CCAT fills a needed service in our city (n=33)	3% (1)	6% (2)	6% (2)	12% (4)	73% (24)	85% (28)
CCAT fills a needed service in our city (n=34)	3% (1)	6% (2)	6% (2)	12% (5)	73% (24)	85% (27)
CCAT units are permitted to work with individuals using broaden guidelines (n=25)	4% (1)	--	12% (3)	36% (9)	48% (12)	84% (21)
CCAT teams explain their actions and procedures to individuals (n=29)	7% (2)	7% (2)	3% (1)	28% (8)	55% (16)	83% (22)
CCAT teams' approaches appear to divert individuals from unnecessary emergency department/ hospitalization (n=28)	7% (2)	4% (1)	11% (3)	25% (7)	54% (15)	79% (22)
CCAT teams' approaches appear to reduce the need for use of force by police (n=30)	7% (2)	10% (3)	10% (3)	20% (6)	53% (16)	73% (22)
CCAT teams' approaches appear to divert individuals from being arrested or jailed (n=30)	3% (1)	3% (1)	27.7% (8)	20% (6)	47% (14)	67% (20)

BPD personnel were able to provide addition narrative feedback. Below are some of their thoughts about CCAT.

- "Out of all the specialist units created to assist patrol, CCAT has proven to be the most efficient and helpful."

- "I am thankful for their work, both with CCAT calls and assisting patrol calls when in the area."

- "[CCAT] is necessary...hands down."

> "CCAT was an incredible resource during the pilot program. I found myself wishing we had them available on days they weren't working (weekends or when the pilot was over). With the increase in mental health and drug induced calls, there needs to be a unit like CCAT that can assist patrol officers by taking some of that load off their plate. I saw first-hand that they did that during the pilot program."

- "It was extremely valuable having them available for the many calls that take more time but are difficult for patrol officers to resolve by traditional means."

- "I have specifically heard two people who we have contacted on numerous occasions while on patrol state CCAT has gotten them on the right track."

- "I have been on calls with them where I watched them take the time to call and make referrals to shelters to get people immediate housing. As a patrol Officer I cannot do that. Some of the places have specific rules and guidelines and they know who to work with that will take someone with substance abuse issues or mental health."

- "I have witnessed the CCAT team take the time needed to find shelter and resources for transients and those experiencing mental health crisis. They have the time to tackle these issues and free up patrol officers to handle other emergency calls. I have seen them offer rides to shelters, hospitals, and other locations, so the individuals don't have to take public transportation or arrange their own rides."

- "CCAT Officers were able to develop relationships with many of the "frequent flyers", so there was continuity in their response to calls and the help they could offer."

Client Survey Results

Five clients and one family member, who participated on behalf of a client who was unable to participate, completed the written survey containing 11 statements. All 11 survey statement ratings

were either "strongly agree" or "agree."[6] Eight statements only had "strongly agree" ratings while the remaining three statement had a few "agree" ratings. Note there was not any statement with a rating less than "agree" from this survey group.

Ratings revealed that all participants felt their interactions with CCAT units were extremely positive when also taking into consideration what they shared during interviews (one participant did not participate in an interview). Their ratings revealed how positive they felt about their interactions with CCAT. They specifically valued not being rushed in their interactions. They reported being heard, respected, and having actions and procedures explained to them. As one unhoused client reported, ***"They [CCAT] see us. They treat us like we're human beings."***

All participants reported being 'satisfied' with their interactions with CCAT at the "strongly agree" level, as well as rated that "…because of CCAT their situation is better." Following Table 15 are some of the narrative feedbacks received from clients/family member during their interviews to further understanding regarding these ratings.

Table 15: Client survey results

Question	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
CCAT teams listen to what you have to say (n=6)	--	--	--	--	100% (6)
CCAT teams show concern for your situation (n=6)	--	--	--	--	100% (6)
CCAT teams treat you with respect (n=6)	--	--	--	--	100% (6)
CCAT teams are patient/didn't rush me (n=6)	--	--	--	--	100% (6)
CCAT teams explain their actions and procedures (n=6)	--	--	--	--	100% (6)
My situation is better because of the help provided by or through the **CCAT** teams (n=6)	--	--	--	--	100% (6)
I am satisfied with my interactions with CCAT (n=6)	--	--	--	--	100% (6)
My situation is better because of the help provided by or through the CARES **p**rogram (n=5)	--	--	--	--	100% (5)
Help provided by or through CCAT teams improved my situation (n=6)	--	--	--	17% (1)	87% (5)
CCAT teams are knowledgeable (n=6)	--	--	--	17% (1)	87% (5)
CCAT teams understand your situation (n=6)	--	--	--	33% (2)	67% (4)

Client Interview Insights

- "For people like me who are going through the worst time of their lives and really struggling, it was nice to have someone there who was not divisive, aggressive. A friendly face and who is there to connect with you and make you feel safe." *Client in mental health crisis*

[6] The family member did rate one statement as "don't know."

- *"*Yeah, it feels weird. I've never once in my life had this kind of relationship, a cordial relationship, with police. They make you almost [feel you're at] their level… If I had to, I would put it [CCAT] at the top of the list the people who cared out here." *An unhoused client*

- CCAT reaching out and talking with him has allowed him to build a relationship with police. He gains a sense of peace he has never experience. Not being judged and pushed. He has the CCAT Officer's number and can text almost every day. He has problem with authority and this officer's approach works well. *Summary from a client living in his car*

CCAT Officer Survey Results

All seven CCAT staff rated each of the 12 survey statements. They rated each statement either "strongly agree" or "agree" except for one statement. One officer rated the statement "CCAT units' approaches appear to divert individuals from unnecessary emergency department/ hospitalization" as "neither agree nor disagree." The reason for this rating, shared during the interview, was if someone asks to go to the hospital officers must follow this request regardless of the situation.

Meanwhile, all seven respondents rated "strongly agree" to four of the 12 statements. These statements included: CCAT approaches help to de-escalate situations, CCAT is permitted to take more time with everyone engaged, CCAT is a positive policing approach to address those in mental health and behavioral crisis, and CCAT fills a service needed in the city. Combining participants' "strongly agree" and "agree" for each statement resulted in 12 out of 13 statements having 100% of positive ratings. The final statement "CCAT units' approaches appear to divert individuals from unnecessary emergency department/ hospitalization" has an 86% positive rating because of the one "neither agree nor disagree". Table 16 provides a full account of the ratings, presented in rank order by statements with the highest percent of "strongly agree" ratings listed first.

Table 16: CCAT Officers survey results

To what extend do you think each are the benefits of having CCAT units in service?	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
CCAT units' approaches help to de-escalate situations (n=7)	--	--	--	--	100% (7)
CCAT units are permitted to take more time with each individual they engage (n=7)	--	--	--	--	100% (7)
CCAT is a positive policing approach to address those in mental health and behavioral crisis (n=7)	--	--	--	--	100% (7)
CCAT fills a service need in our city (n=7)	--	--	--	--	100% (7)
CCAT responses are tailored to the needs of individuals they encounter (n=7)	--	--	--	29% (2)	71% (5)
CCAT units facilitate individuals' connections to services and treatments (n=7)	--	--	--	29% (2)	71% (5)
CCAT units' approaches appear to divert individuals from unnecessary emergency department/ hospitalization (n=7)	--	--	14% (1)	14% (1)	71% (5)
CCAT units are expected to spend more time explaining actions and procedures to individuals (n=7)	--	--	--	43% (3)	57% (4)
Individuals' situations are generally better because of the types of help provided by CCAT or through other providers due to CCAT's actions (n=7)	--	--	--	43% (3)	57% (4)
CCAT units' approaches appear to reduce the need for use of force by police (n=7)	--	--	--	43% (3)	57% (4)
CCAT units are permitted to work with individuals using broad guidelines (n=7)	--	--	--	43% (3)	57% (4)
CCAT units' approaches appear to divert individuals from being arrested or jailed (n=7)	--	--	--	57% (4)	43% (3)

Reduced Interactions with Outcome of Use of Force

Use of force is defined as the "amount of effort required by police to compel compliance by an unwilling subject". Officers' goal is to only use the amount 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, less-lethal force, and lethal force. In CCAT, officers tried to use de-escalation tactics such as verbal commands to limit the need to use force.

During interviews, stakeholders and CCAT Officers were asked about CCAT units' efforts to de-escalate those they engaged. The shared theme among participants about what made the difference was the ability of CCAT staff to take their time on each call, the specialized training in de-escalation, their knowledge of how to engage with people in crisis, and the genuine compassion of the staff. Based on insights shared, this is how it played out in the field. Because CCAT units were able to take their time on calls, it allowed clients the time they needed to tell their stories and feel heard. Officers and others reported that some clients need to "rant," "yell," and "get in the officer's face." A few stakeholders reported that CCAT staff "accepted these behaviors beyond what patrol would allow." CCAT units also understood the importance of allowing greater physical space between themselves and clients when initially approaching the individual. Being too close initially was "threatening" to some individuals.

Clients and community shareholders reported that because CCAT units wore blue shirts and khaki pants instead of traditional uniforms they did not trigger historical fears among some clients. The presence of an MHP was another benefit. In addition to the MHPs' skill set, not being an officer and being women, made a difference for some individuals. They also reported that not having as many police officers in the area, especially not surrounding a client, played a big factor in the client being more relaxed. By having these program elements and taking these actions use force was unnecessary in most interactions. Based on CCAT Officers' survey rating, all reported either at the "strongly agree" (57%) or "agree" (43%) level that they too felt that their approaches reduced the use of force.

Whenever an officer does use force on the job, they are required to document the level of force required (e.g., physical restraint, handcuffed standing, takedown). To determine if there was a reduction in use of force, BPD pulled the use of force documentation for **all officers** between May and August 2020 (the year prior to the pilot) and compared this count to documentation for all officers between May and August 2021 (during the pilot). Using a change score calculation found a 24% reduction in the use of force (38 incidents prior to pilot to 29 incidents during the pilot). During the pilot, CCAT Officers accounted for five of the 29 incidents. It is interesting to note that with each month the number of times a use of force involved CCAT Officers declined. Of the five CCAT uses of force during the pilot, three occurred in June, two July, and none in August.

During interviews various participants shared their thoughts regarding the reasons they felt CCAT did not use force as often.

> "CCAT allows us the time needed to hopefully de-escalate situations. Patrol officers are pressured to be quick with each call so they can get on to the next call. They feel they are always on the clock, need to be available for the something 'big' that can come up, so you need to always to be available." - **CCAT Officer**

- One client reported the calming voice of the CCAT Officer in a non-traditional uniform as he was coming out of a mental health breakdown made the difference for him. *A client with mental health issues*

- "Used less force because of our approach, and our non-uniform. Clients are more calm and able to connect." *CCAT Officer*

- "I think the other aspect that they really assisted with is the new laws where there's an emphasis on the de-escalation. [CCAT] tend to bring a stronger approach to that than my patrol officers, not that they're not capable." *BPD Sgt*

- "CCAT Officers see what patrol officers see, but if you look around the room and did not see current threat to others then CCAT moved back to de-escalate so force is not needed because the person becomes more complainant. Take time…time is your friend. Take it slow." *CCAT Officer*

- "CCAT's response is to give options. The de-escalation they provide is good for clients. CCAT is good for the community too because they can respond before the situation becomes a bigger problem and before I can get there." *Homeless Outreach*

Reduced Interactions with Outcomes of Arrest and Incarceration

Two approaches were used to examine if, and to what extent, CCAT had on reducing arrest or incarceration. The first approach was for BPD analysts, using administrative data, to determine if there were changes in arrest rates by each CCAT Officer. The second approach involved CCAT Officers reflecting on incident and decisions they made in the field with regards to both arrest and incarceration. Both approaches revealed reductions in arrest and incarcerations as presented in the following narratives.

BPD administrative data analysis

The approach BPD used was to pull a count of all arrests the patrol officers assigned to CCAT made four months prior to the pilot (January to April 2021). Next, BPD pulled a count of arrests made by these same officers during the pilot (May to August 2021). Two points regarding this data and analysis: First, this data presents arrests regardless of priority call level for pre-pilot (P1 through P5). For CCAT units during the pilot, 8B71 only responded to P3 through P5 calls while 8B72 and 8B73

responded to P1 through P5 calls. (However, there are very few P1 and P2 calls on any given day in Bellevue). Second, arrest rates are generally higher in the summer months (during the pilot) than in winter months (during the pre-pilot).

Prior to the pilot (January to April 2021) there were a total of 46 arrests among the seven officers prior to their CCAT assignment. During the pilot (May to August 2021), these same officers made 9 arrests (4 of which were outside of their CCAT assignment.) The comparison revealed a decrease of 37 arrests during the pilot (in the summer months when arrests are generally higher). This represents an 80.4% decrease (reduction) in number of arrests. Below is one example of why CCAT interactions reduce number of arrests and incarceration.

SCENARIO

"[The client] went into a couple of businesses, took some alcohol, took some food. And of course, security is around surrounding the young lady. Other officers are there and then I showed up. And they're like, she's giving fake names. I call her by name, she immediately calms down, walks right over to me. And is like shaking my hand and hey old friend. And of course, I took the conversation into her favorite thing because of my experience with her. And it goes into kind of like this whimsical, unrealistic reality. Then everybody kind of stops (and realizes) she's kind of special needs. Store owners are kind of like, 'I don't want to prosecute her. I didn't realize that was the case. I tried to treat her as an adult but mentally she's maybe 12. And now I can see that, if you can just get this stuff back'." - **CCAT Officer**

CCAT Officers' reflection and reassessment of arrest and incarceration decisions

CCAT Officers were asked to participate in a facilitated discussion, led by a senior BPD officer with over 20 years of experience. Drawing upon their combined years of professional experiences and judgement, the officers reviewed and reflected on each of the client incident(s). Their goal was to determine if they believed that the actions and decisions they made during incidents resulted in a diversion from arrest and incarceration. They compared the actions they believe they would have taken when they were patrol officers to that of a CCAT Officer. They took into consideration the unpressured time constraints they had as CCAT Officers, their new trainings and skills, and the knowledge/insights gained through working closely with MHPs. They reassessed to determine why an arrest or incarceration did not occur. Below is an example of one such diversion.

> "[King County Transit metro] was gearing up with a bulldozer. She either had to move or would be arrested for trespassing (using a bus stop as a campsite). I went on a mile walk with her and had a conversation about life in general. She shared her past including her mental health diagnosis. My partner was walking behind us was radioing the information she shared back to the MHP. Based on insights gathered, we were putting together a potential plan; they had already made the phone calls to potential resources by the time we got back from the walk. The whole team was at the campsite when they returned. They had figured out where she could move and linked in a social worker she liked, but had lost track of, as part of the plan. I explained to her that because we are now friends, and these are my friends they're now your friends. She agreed they could help her move her stuff. This took two-three hours. She was not arrested, nor experienced

the trauma of having her things bulldozed. One month later she was staying with relatives." – CCAT Officer

Officers reviewed a total of 254 incidents occurring between May 10 and August 31, 2021, related to 241 individuals. Most individuals (219) had only one incident. There were 12 individuals with two incidents, and 1 individual with 3 incidents. Based on group consensus, there were a total of 53 diversions: 43 arrests and 10 incarcerations/jail. This means had it not been for CCAT, 21% of these incidents would have resulted in either arrest or incarceration. Table 17 provides a count and percent for each diversion type.

Table 17: Arrest and incarceration diversion data

Type of diversion	Count	Percent
Arrest	43	17%
Incarceration	10	4%
Total	**53**	**21%**

Below are insights provided by CCAT Officers, CCAT MHP and stakeholders regarding diversion. It is important to know that although incidents still resulted in an arrest and incarceration, through this pilot some CCAT staff became aware of a specialized court for persons with mental health issues, developmental disabilities and abuse, and substance abuse problems. Thus, for a few of the of the individuals, although arrested and incarcerated, they were seen by a specialized court, and by the next day, released and connected to services.

- "I mean, except for incidents of domestic violence, where our hands are tied in those incidents, the state says that's a mandatory, they don't care (we must arrest). Even though we know there's mental illness, even though I know that I can't prove it. The law says very clearly that someone must be arrested. So other than those incidents, or even some of those, those mandatory arrests, but I was able to get those cases pushed into our ITA court." *CCAT Officer*

- "Arrest is both the role of patrol and citizen who do not want to have a thief in the community. With CCAT there also is time to educate and share with citizen what is going on with the person, to humanize the situation. Then, if citizens are OK with (not arresting) knowing the person is going to get the help they need [arrest] doesn't happen." *CCAT Officer*

- "[There are] differences between patrol and CCAT. With patrol you're kind of limited. Your role is to take charge, command presence. Your whole approach is different with CCAT; it's about de-escalation and then how you talk to someone." *CCAT Officer*

- "I would like to believe that if I'm contacting that person over and over, I'm learning how best to interact with them or how they respond, and you know how I need to have my tone of voice, my inflection, what things I can talk about what things I shouldn't talk about, what triggers and topics to avoid that if it's their mom, if it's their dad… If my ability to respond to

them, either through my training or my experience with them, gets them to leave willingly [e.g., trespassing] and I can avoid that arrest, then that's a win. And I believe I've diverted them from jail." *CCAT Officer*

- "People are trespassing because they're just dealing with a mental health issue. They're not necessarily creating a criminal issue. I mean, trespass is a criminal issue if you take it. It's a solution. But that's not addressing the core underlying issue of the mental health individual. They were probably the best piece of [CCAT], because now maybe we can look at actually taking them to a resource rather than jail. [Also] when we do push somebody in front of the ITA court [BPD can make] a much better case for them, because we can speak in their language (having gained insights from training and MHPs on what the court wants to know). *BPD Sgt*

Even if you make that arrest when they go to jail, they're probably going to be out later today or tomorrow. And then we'll be right back there again. So, taking some extra time. Maybe taking a different approach, which can still include an arrest, if you think that's the most appropriate thing, but how you do that and how you educate about it and how you handle it might have more long-lasting impacts." **CCAT Officer**

- "I think [CCAT] plays a strong role in how that process goes …when subjects could be arrested; we can open a second door for them. Rather than only having the one door of jail, we can maybe defer the arrest, maybe let it go to the prosecutor, and then take them to resources instead." *BPD Sgt*

- "Before it was all about safety, and safety come in numbers [of officers]. They would surround the person. This just raises the heat. That practice has a negative impact, especially for someone in a mental health crisis." *Shelter Staff*

Reduced Interactions with an Outcome of Unnecessary Emergency Department Visit/Hospitalization

During a group facilitated process, CCAT Officers were asked to review each of the incidents CCAT responded to and then reflect on potential diversions from unnecessary emergency department visit/hospitalizations that occurred. Like the group facilitated process used to reflect on arrest and incarceration diversions, officers were asked to take into consideration the impact of their training, unpressured time constraints as a CCAT Officer, and knowledge/insights gained through working with MHPs.

CCAT Officers determined that in 32 of 254 incidents in which an ED visit or hospitalization might have been an outcome in the past, they were able to divert the individual from an unnecessary

emergency department visit or hospitalizations. This represents a 13% reduction in the number of unnecessary emergency department visits or hospitalizations.

Table 18: Diversion from unnecessary emergency department visit or hospitalization

Type of diversion	Count	Percent
ED/Hospitalization	32	13%
Total	**32**	**13%**

In addition to officers' reflections, stakeholders and CCAT Officers reported in their surveys that they believed CCAT did divert individuals from unnecessary emergency department visits and hospitalization. In fact, 83% of the stakeholders either "strongly agree" or "agree" that CCAT did divert individuals, while two (17%) "neither agree nor disagree." CCAT Officers felt similarly; 85% of them either "strongly agree" or "agree" that CCAT did divert individuals, while one (14%) "neither agrees nor disagrees."

In their interviews, stakeholders provided additional insights regarding CCAT's approach to increasing diversions from unnecessary ED visits/ hospitalization. Shelter staff shared that because CCAT units allowed individuals in crisis an opportunity to talk and talk, in time their "craziness" and "undesired behaviors" dissipated. Having been heard, these individuals were now in a position to engage in more constructive conversation. This process not only allowed the individual the opportunity to vent, but it also provided CCAT staff the opportunity to learn about the person's worries, why they were upset, and what they want/need. Then, together the client and CCAT could explore options. Below is an example of an ED diversion; followed by additional thoughts about how CCAT was able to divert clients.

- Washington State Patrol and BPD called for CCAT support. A new mother wanted to kill herself by running into traffic. After talking with her and others involved, (her mother, boyfriend, and father of the child), a plan with several safeguards and a backup plan were developed. She was able to go home with a CARES case management follow-up plan organized. It was decided that if the mother was to be taken to the ED it would have been too traumatizing for all involved and most likely she would have been sent home from the hospital based on her current state of mind because of on scene actions. *Summary of a CCAT MHP example*

- "[We know some] are satisfied by going to the hospital. We know that every time we contact them, they act in a behavior that we normally would end up taking them to the hospital. Because I received specialized training, coupled with building rapport, and experience and understanding with them, I now know that maybe my response should be spending 30 minutes talking with them. [This] will satisfy whatever need they would have [received] by going to the hospital. Now they've said okay, 'I've got somebody to pay attention to me or…' I'm just saying they've gotten the attention they needed. That's a win because I've now diverted them from the hospital and whatever resources it would have taken to get them there whether an ambulance and then the hospital staff [time] to evaluate." *CCAT Officer*

- A 13-year-old boy assaulted his mother. The officer, having been called to the home before, went into the boy's room and talked with him as they together cleaned up the room. They talked about football, games, and other things he would enjoy just to calm him down. CARES staff talked with the mom during that time. *Summary of a CARES Staff example*

Increased Quality/Focused Interactions between CCAT and Hospital Staff when an Emergency Department (ED) Visit / Hospitalization Occurs

Assessing the level of impact the CCAT pilot had on increasing the quality of the interactions between BPD and the Emergency Department (ED) was gathered through interviews and via a question in the stakeholder's survey. Among the 12 stakeholders responding to the question of if "CCAT teams enhance police interactions with hospital staff when emergency department/ hospitalization is required," 83% (10) "strongly agree" or "agree". The remaining 14% (2) "nether agree or disagree."

A 20-year hospital administrator/practitioner reported during the interview that the hospital staff felt positive changes in the quality of information they received from BPD during the four-month pilot. CCAT Officers provided increasingly more relevant details and information about clients' situations. In the past it would have taken them hours for hospital staff to hear this information from clients in behavioral crisis. In addition, the practitioner reported they have noticed clients brought to the ED by CCAT units appear to be calmer than those brought by patrol officers. Both of these outcomes allowed ED/hospital staff to more quickly assess what clients needed in terms of short and long-term medical and treatment plans and permitted the ED to provide appropriate services in a more timely manner.

The ED staff member also reported the overall value of having CCAT engaged. CCAT units were able to find clients post-hospital visits and share clients' status. This is because as law enforcement officers, CCAT units were able to go to locations that other professionals were unable to go for safety reasons. The staff member also reported that having an MHP on scene meant receiving another level of assessment which medical staff found very valuable.

One of the CCAT MHPs shared that on one occasion ED staff invited the CCAT team to join the doctor/nursing staff in the examination room. The client had built such a rapport with the team that the client was calmer when the CCAT team was present. Below are additional insights gathered during interviews.

> "I have learned a lot about the health care system. It's nice to learn other professionals' understanding about what can be done, and not just be limited by my view as an officer. This has changed my understanding of what happens to a client with mental health issues … I also learned others' [professionals] hands are tied too. We have learned how to work with them." **CCAT Officer**

- "This is a kind of network communication opportunity, having each other really brought us together and is filling in more of what hospitals want." *CCAT Officer*

- "A couple of charge nurses we've talked to actually turned us on to a computer program, like a central warehouse, where you can call up at any given time, give a name, date of birth, someone's personal info, and they will give you basic, basic information … like has there been a diagnose and signs in the past for that person. This helps us with our interactions." *CCAT Officer*

Enhanced BPD and BFD Professional Understanding, Client Staffing, and Information Sharing

CCAT Officers and MPHs, as well as CCAT workgroup members, comprised of BPD and BFD leadership, spoke of how CCAT has enhanced there professional understanding of each other's mission and work, how CCAT has strengthened working relationships and led to increased information sharing. Although they have worked together in the past, this opportunity has led to a new level of partnership.

At the leadership level, weekly face-to-face meetings of one to two hours, and checking in with one another as needed, has allowed them to understand more completely and with deeper appreciation each of their unique practice approaches, limitations, and strengths. Various leadership members have jointly attended trainings, workshops, and conferences. Although the piloted ended the first of September, the CCAT Workgroup continues to meet to plan for potential next steps.

During interviews, CCAT Officers, CCAT MHPs, and CARES staff reported that they better understand each other's professional approaches and appreciate the knowledge and skill set each bring to this work. An MHP shared that initially, she was concerned about what might happen when teaming with law enforcement. Would she be expected to set aside social work principles? Her concern was that officers would take the lead. Instead, she quickly experienced officers respecting the knowledge and skill that MHPs brought to the situation. As a unit they learned to work with each other, learned the "dance" of when to let each have the lead based on the situation, and how to bounce ideas off each other. Officers reported that the MHP had a wealth of knowledge about resources in the community and they knew how to engage clients. Officers learned from MHPs and from the CARES staff how to better understand behavioral crises and engage individuals based on specific behavioral cues and mental health conditions.

A total of three CARES program staff were interviewed. They shared that they too felt the CCAT implementation has changed their ongoing understanding and relationship with BPD in general. Shared weekly staffing meetings played an important role in creating understanding, trust, and ongoing information dissemination. Now, when CARES responds to 911 calls, they better understand how to work with officers more effectively. CARES staff also reported less apprehensiveness about going into situations where BPD is present, after experiencing positive interactions and knowing officers and MHPs share the same goal of helping those in behavioral crises. Below are statements from CCAT Officers, CCAT MHPs and BFD CARES staff.

- "Networking and communications are stronger with CARES. The increased communication beyond BPD and CARES is one of the things I liked about CCAT. I value CARES more now and will use them more." *CCAT Officer*

- "Met with CARES team in staffing once a week. Helpful to learn and hear about CARES clients in case we run into them. We get the background story of that person. We do the best we can to be helpful… gaining understanding [from CARES] is helpful." *CCAT Officers*

- "There were times when CARES itself had clients who hadn't been seen in a while because they didn't know where they were. We are able to help connect them to clients living in places they cannot safely go too." *CCAT Officers*

- "CCAT can reach out where CARES cannot, to meet with homeless individuals. We have more homeless clients now and because we often have no physical details on their location, we cannot always find them. [Now] CCAT would tell them to wait for CARES." *CARES Staff*

- "I have gained knowledge about PD. What they can and cannot do." *CCAT MHP*

"CCAT has increased BPD collaboration with CARES and other community providers. Through this work, we have experienced BPD's interest in safety for MHPs' without overstepping. They respect and allow MHPs to do their job but know when to step in and when to let MHP continue." **CARES Staff**

Increased Number of Clients Connected to Services (e.g., shelter, food)

There is no baseline data available regarding the level of client services engagement by BPD. To investigate this outcome the primary information source comes from survey rates and interview feedback. Readers will also recall that in the output section of this report, the narrative noted that at a minimum, on average each client was referred to three services and supports.

Each survey type, CCAT Officers, Stakeholder, BPD personnel, and Client, contained at least one question about services and/or the impact of clients receiving services. The CCAT Officer survey had two separate questions. The first was whether "CCAT units facilitate individuals' connections to services and treatment." All seven officers rated this question as "strongly agree" (71%) or "agree" (29%). The second was whether "Individuals' situations are generally better because of the types of help provided by CCAT or through other providers (e.g., community providers) due to CCAT's actions." Again, all seven rated this question as "strongly agree" (57%) or "agree" (43%). (See Table 11 to review the breakdown of the type and number of services provide to clients.)

Stakeholders also responded to one of the same questions as CCAT Officers, "Individuals' situations are generally better because of the help provided by CCAT or through other providers due to CCAT teams' actions." All 14 participants rated this question as "strongly agree" (75%) or "agree" (13%). In addition, stakeholders shared during interviews that clients were being connected to services.

A similar question was asked of clients. All clients/relatives (6) rated the question "My situation is better because of the help provided by or through the CCAT teams" as "strongly agree." In addition, clients and others were asked during the interviews specifically about the services CCAT provided. Below are statements and insights stakeholders provided.

- "As CCAT, in our non-uniforms, we now can go to homeless camps and conduct outreach. We provide the department phone for anybody to make phone call, call relatives whatever and whoever they would like, like checking if medications are ready. One woman living in the woods for months learned that the Housing Assistance had found her a place. We point people to food, shelters, and where things are. We come back a week later and there are half as many people [living in the camp]." *CCAT Officer*

- "Well, we've had a couple of people, residents in camp, that have mental issues. …when he runs out of pills, he doesn't go to get more. So, we have called CCAT a couple times for him and they have come out, worked really well with him. Saying 'You know, you need to go see your doctor, you need to …, get your pills adjusted.' And it's worked out very well. *Homeless Outreach*

"Yes, clients are more connected to services. Especially with the MHP because of their knowledge of resources. And [they are] connected right away when they are in crisis. [CCAT] can transport the person to the services, a big plus." **Homeless Outreach**

- CCAT let's clients use their phones to get in contact with their case manager (e.g., Sound Health and shelters) and talk if needed. [Their] case managers are too busy to reach out to them sometimes for a long time. *CCAT Officers*

- "CCAT is starting to create trust with clients and enhanced ability to work with them. Thus, clients learn to trust persons in authority (police) which in turns helps the clients to work with professionals from agencies (others in positions of power.)" *CARES Staff*

- "CCAT Officers are engaging and talking with clients. First listen, and then approach topics regarding behaviors and service needs/options. Saying things like 'Hey Man what are you doing? You seem a bit off. Are you taking your meds today?'" *CARES Staff*

- "For people to seek treatment they need to engage with trained individuals to lay the groundwork for the person to take the next step. CCAT set a positive tone for the next steps." *Shelter Staff Stakeholder*

Clients Enrolling in CARES

CCAT units offered to refer any client that felt that they could benefit from its services to the CARES program. A total of 108 individuals elected to enroll in the CARES program and received initial and ongoing case management services.

Improved Clients' Experiences and Relationships with Police

Based on survey ratings and interview feedback, clients were very pleased with their interactions with police and developed trusting relationships. None of the clients interviewed reported interactions with BPD prior to the pilot. Only the relative interviewed had any prior experience with BPD. She reported her interactions through CCAT were better. In fact, she reported that CCAT was a "godsend." She finally feels supported and has someone to reach out to for ongoing help.

Although clients had no interactions with BPD prior to CCAT, except for the relative, all talked about prior interactions with police departments in other jurisdictions. They talked about adolescent and adult interactions, none of which they regarded as positive. They all expressed how their interactions with CCAT were different. For example, on the survey they all felt at a "strongly agree" level that they were listened to and not rushed by the CCAT units. They felt the team was concerned about their situation and treated them with respect. In addition, all clients/relative rated at the 'strongly agree" level that they were "satisfied with their interactions with CCAT." Below are interview quotes for various participants.

"[CCAT Officer's name] is my friend, like family. He really cares about us [unhoused persons]. He gives us water, food, and checks on us. I would never think of stealing from businesses here or even throw trash on the ground. Because this is his area. Why would I do that to someone who is like family." **An Unhoused Client**

- "The Officer gave me his phone number. In the past, I would just call 911 and each time I would get a different officer. I would have to explain what was going on each time. It is so nice to have someone to call. It's like having a touch stone to someone who knows her and the situation, and who cares about her." *Sister of a client with mental health issues*

Summary and Conclusion

The reason pilot programs are implemented is to test an approach for effectiveness. During that process one identifies both the strengths of the approach as well as challenges and barriers. To this extent this pilot was a success in several ways. First, BPD and BFD, as the city's primary first responders, successfully pooled their time and resources to create and implement what appears to be a promising approach to effectively engage and serve, joining with other community providers, underserved individuals challenged with behavioral crises. Through this effort they strengthened their working relationship and enhanced communication and information sharing both at the leadership and staff levels. Although the piloted CCAT program is currently not in operation pending

future funding, based on interview feedback, BPD and BFD CARES continues to benefit from their enhanced communication and information sharing.

The second success occurred during the early planning and two-week pre-pilot phase. Working together BPD and BFD faced some policies, labor union, and practice challenges. The CCAT Workgroup and reassigned staff were able to adjust and successfully find solutions to both major and minor program changes; this highlights the value of implementing a pilot. For example, not moving forward with an MHP only unit approach, identifying space to house the CCAT units that also supported team bonding, engaging BPD patrol officers to adjust traditional practices by not responding to CCAT calls to serve as back up unless radioed, found the means to adjust discretionary fund that BPD personnel use to better serve individuals, team members' clothing negotiation, etc. Together necessary adjustments were made quickly, which allowed the pilot phase to begin as planned.

More importantly, through months of pre-planning and hours of dialog, the pilot approach developed and implemented was well received by clients and the numerous stakeholder groups. As presented in the report, all the clients/relatives contacted were very satisfied with their CCAT experience, and reported their lives were better now because of their CCAT engagement. Among the various community stakeholder groups, a 100% of 16 professionals attached to community organizations reported that CCAT filled a service gap in the community. They reported that the teaming of specially trained law enforcement officers with MHPs provided an outreach effort that others could not match. They reported this approach places BPD, BFD, and the city in the forefront and cutting edge of service delivery to persons with behavioral health issues. As noted earlier in the report, NORCOM staff, by the second and third weeks of the pilot's implementation were receiving calls from individuals, businesses, and agencies specifically requesting CCAT support; a signal to NORCOM staff that this pilot was meeting a need and serving successfully in the city.

The field testing of two teaming approaches was intentional. CCAT was seeking insights on the potential benefits of both the one officer and MHP unit approach and the two-officer unit approach. Through those interviewed it was learned that both approaches have value. CCAT Officers pointed to the value and effectiveness that results of having a second officer when dealing with someone in a behavioral crisis, primarily because the patrol officers are on their own. Having radio/phone access to a dedicated experience MHP was equally valued. However, officers and stakeholders noted that there were some situations when it could be too dangerous to send a single officer and MHP. In these situations, having the specialized two officer units made more sense.

However, especially among the community's professional stakeholders, who work daily with individuals with behavioral and mental health issues, they felt that for most situations involving teams of highly skilled experienced individuals from law enforcement and an MHP would be more appropriate and more effective. They liked that each of these professionals brings their unique, but complementarity set of knowledge and skills to engage and connect individuals to needed resources. The value of having an experienced MHP present at the onset to observe first-hand, help inform engagement options, and identify resources based on how the individual presents was viewed a plus. Also, the ability of the team to tailor who took the lead based on an individual's

historical and current emotional state of mind was another factor that tipped the scale. If a situation is initially unsafe for the MHP or the situation turns and it's no longer safe, the MHP can engage or reengage as needed. Below are a few quotes regarding the value of an officer and MHP unit from those interviewed.

- "I like the [officer and MHP unit] more. More, because I was able to see how they interact, I was able to see their methods of talking to people and opening those lines of communication." *Shelter staff*

- "Having an MHP is necessary in my mind or at least very beneficial because they know about the services options that are out there and what other options are out there, while our work has traditionally been tailored to incarceration or hospitalization." *CCAT Officer*

- "CCAT, from resource management (freeing up patrol officers) is beneficial (effective) in dealing with mental health calls. Public relationship very important in these times…everyone is asking for and screaming for this type of response. They want to see this type of police response. What we have here is something that absolutely works! To have this type of response. A unit with a police officer and someone who can step in with another type of expertise (MHP) is invaluable. People can see the impact. It looks good on paper, in the media and for every person involved." *NORCOM*

- "Think the social worker team is better. It's just softer. There are fewer uniforms present because the social worker is not in uniform. I think there would certainly be situations where that may not be appropriate (MHP/Officer) but to have two officers is not generally needed at parks." *Park Ranger*

"With the increase of mental emotional situations, a program like this is necessary. I think the public would respond well that PD is doing all it can to help those with mental issues. It also allows patrol to get back into service since patrol cannot spend as much time as needed for these types of calls. I would recommend the program be a 7-day a week service to gain maximum use." **BPD Patrol Officer**

- "It's been helpful to team together because some people do not want to talk to a social worker because of past experiences and others do not want to talk with a police officer. Some people hate police, so I step in and some didn't like a woman or a social worker so the officer steps in." *CCAT MHP*

- "It may have made a difference for me, or others, because of past (negative) engagement with police [to have an MHP on scene]. It's good to have an MHP on scene because they are a middle-ground person." *Client with mental health crisis*

In closing, a lot was learned through this pilot. BDP administrative data and CCAT Database information revealed promising trends. The insights shared from clients, stakeholders, CCAT staff and BPD personnel were very supportive for program continuation. At the end of each person's interview, they were asked what program elements they hoped CCAT would maintain, recommendations for program adjustments, and what, if any, were the program benefits for individuals, agencies, BPD, and the community. Based on findings already shared, and the closing insights shared during interviews, support for CCAT is high. All would like the program to continue, and for additional teams deployed. At a minimum, stakeholders and BPD personnel would like for the hours of operations to be expanded (e.g., 7 a.m. to 10 p.m.) as well as expand operation beyond weekday, if funding would permit. For those interested in learning more details, a summary of these and additional insights provided can be found in Appendix B.

Appendix A: Logic Model

Community Crisis Assistance Team (CCAT) Mission: Provide a coordinated community response for aiding individuals in behavioral crisis from known or suspected mental illness or substance abuse. 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	Long-term Outcomes
Crisis Identification Sources • Select 911 dispatches • First responder referrals • CCAT Teams	• Responding to NORCOM dispatches • CCAT outreach efforts	• # of NORCOM dispatches • # of BPD dispatches • # of CCAT outreach		
Program Preparation • CCAT Work Group • Partnership agreement & data sharing agreements • Evaluation development • Technology/Database development to support case mgt & evaluation	• CCAT Work Group (as least weekly communications) • Initial and ongoing dialogs with partners (e.g., BFD, NORCOM, community providers, external evaluator)	• CCAT Work Group meetings • Refined evaluation design • Field tested database	• Enhanced BPD and BFD professional understanding, staff teaming and information sharing	• Ongoing BPD and BFD communication and working together

Program Delivery
• Response options
  ○ CCAT 2 officer team
  ○ CCAT/MHP team
• Ongoing case mgt (CCAT and CARES, if client elects)
• Community partners (MH providers, hospitals, and Homeless Outreach Coordinator)
• Provide or broker services with existing community organization
• External third-party evaluator and database development
	• Identify and reassign staff
	• Initial and ongoing staff trainings
	• Respond to dispatches and CCAT engaged outreach
	• Connect with clients and develop plans with client
	• Provide and broker services
	• Client staffing (weekly)
	• Create city, county, interagency partnerships
	• Provide inter-department education
	• Community education and outreach
	• Ongoing evaluation efforts and updates
		• Count of clients engaged
		• Count and summary of client contacts
		• Count and summary of services provided/brokered to clients and their relatives
		• Inter-department partnership, and community engagement/education activities
		• Evaluation findings and report
			• Reduced use of force
			• Reduced interactions with outcomes of arrest, or incarceration
			• Reduced interactions with outcomes of unnecessary ED or hospitalization
			• Increased quality/focused interactions between CCAT and hospital staff when an ED/ hospitalization occurs
			• Increased number of clients connected to services (e.g., shelter, food)
			• Clients enrolling in CARES
			• Improved client experience and relationship with police
				• 8 Full-Time MHPs with 24/7 coverage
				• Sustainable city, county, community partnerships
				• Sustainable pathway for members of the community with MH/ME issues to obtain supports and services

Appendix B: Summary of Program Elements Participants' Valued and Suggested

Introduction

A review of the data and insights provided by participants make CCAT a promising approach to address behavioral crises. Throughout all the interviewers, only one stakeholder, who was still very supportive of ongoing CCAT implementation, shared he wished in only one incident that the CCAT team would have taken an individual to the ED for an assessment, instead of re-locating the individual, because some days later the man attacked someone who then required medical aid. Besides this stakeholder feedback and from three BPD personnel who were not supportive of the program, (one suggesting that the funds would be more wisely used to support underfunded patrol officer efforts; the other two did not provide any insights into their less positive rating), all others interviewed had only positive feedback.

Highlighted below are program elements participants valued and would like to see continue if CCAT was funded, followed then by recommendations and adjustments to enhance the program. The final section highlights insights from participants on what they believe are the benefits of CCAT.

CCAT elements and practices clients, stakeholders and CCAT Officers would want to maintain

The elements and practices listed were shared by numerous participants even though in some cases only one individual is listed.

- Engage in outreach activities, continue to check in and just talk to individuals, and build relationships by not judging and pushing. *Client*

- Provide CCAT staff contact information to clients so they can reach out to officers. Also, have CCAT staff randomly follow up and checking in with clients. *Client*

- Assign officers who truly care, are kind, and compassionate. Who are super patient and willing to not take individuals' responses and rejections personally. A person with the right temperament. *Homeless outreach worker and CCAT Officers*

- The ability to be proactive. Understanding that individuals are more responsive to engagement, services, requests, and options if they're not de-hydrated and hungry. Addressing these types of needs, and making small connections, even just smiling now, will later make the differences. *CCAT Officer and Shelter staff*

- The level of communication between BPD and CARES. The right amount of flexibility currently available. *CCAT Officer*

- Only being focused on a broad set of mental health and substance abuse issues, and a lot of homelessness. Having a partner also focused on serving the same population is very helpful. *CCAT Officer*

- Assign only very experienced and specialized training officers and MHP to CCAT. The knowledge and skills required to do this job effectively are high. They also must want to work with those with mental health, substance misuse, and homeless issues. *Shelter staff*

- CCAT staff need to be committed to trying new approaches because past approaches have not been as effective. *CCAT Officers*

- Just continue what they are doing. Highly impressed by the services and support they provided and the professionalism and skills of these officers. *Family member of sister with mental health issues*

- Wearing different clothing from uniformed but similar among the team so they are identifiable, ideally with a less bulky vest. *Stakeholders*

- Specialized training (even more). *CCAT Officers*

- The commitment of the police department to focus on a more community-focused approach to solving problems. This is especially true, something other than just punishment is what's needed. *BPD Sgt*

- Team bonding time including opportunities to sit down to talk about the program, training, CARES staffing (but maybe not all officers each time). *CCAT MHP*

- Ability to transport people to needed services and supports. *Homeless outreach*

- Clearly defined population groups CCAT is to serve and provide them with targeted trainings. *Stakeholders*

- Revisit and explore what should CCAT staff wear. *CCAT staff and Stakeholders*

- Supportive of early prevention outreach with those not yet in crisis. *Shelter staff*

- Support new discussions about protocols on the engagement of clients. e.g., let MHPs be the first to talk to the clients in some safe situation like a drug store. *CCAT MHP*

- Initiate dialogs with key community agencies and organizations working with the same clients and develop protocols, standards, and expectations. *Homeless outreach and Parks*

- Fund CCAT for three or more years, to formalize working relationships and allow system changes to occur. *Stakeholders*

- Work to adjust delay in response time (CARES) or at least strengthen communication; especially need the end of the workday so agencies know whether or not to still expect support. *Stakeholder*

- Need a crisis center in Bellevue and/or more beds and services for individuals presenting with various issues and levels of needed (e.g., unsober, wanting showers, mental health services/housing, substance abuse treatment*). Stakeholders, CCAT Staff and BPD*

- Continue unrestricted time allowance for each call. Do not limit CCAT teams to districts. *All stakeholders and CCAT staff*

Recommendation and Adjustments

- Expand hours and days of the week CCAT is in operation. Consider when parks, businesses, restaurants up and close for the day. Be aware when homeless are more likely to be anxious about having a place to bed down for the night. Look at starting as early as 7a.m. and ending at 10 p.m. *Stakeholders and CCAT staff*

- Not only does the CCAT team need to exist, but they need to expand, with coverage on weekends if possible. *Patrol Officer*

- Have the CCAT program up and running when the train system is running…because new groups of people will come to Bellevue daily. Aim to get them connected the day of their arrival. *CCAT Officer*

- Fund at least three to four CCAT teams, hopeful the officer and MHP units. Fund for three or more years so staff will stay. *Shelter staff*

- Designate CCAT as a specialty unit. Understand how more stressful and emotionally taxing it is for officers to handle up to eight mental health calls a day. Adjust pay accordingly. *CCAT Officer*

- Give MHPs (and CCAT Units) access to bus, food, snacks, basic personal items as well as emergency supplies (e.g., socks, hats, coat) to give to clients. *CARES staff and CCAT MHPs*

- Provide additional training and education to BPD personnel and NORCOM on when to call CCAT vs. CARES. *CARES staff*

Benefits of CCAT

- "The relationship between the community and police is not good. To have outreach programs like CCAT that gets police into the community in positive ways can change the divisiveness in the media, that's a good thing." *BPD personnel*

- "CCAT provides an opportunity not only for the person but for everyone connected to the situation in the community; an opportunity to move forward in a positive way." *BPD Sgt*

- "I know we're just a couple of bums from Washington, but please, for the love of God, please do not cut the CCAT people on anything. I don't know anything about financial stuff. [CCAT] helps too many people that no one else cares about. If it was not for these officers, there would not be a level of help for homeless people, period." *Client*

- The biggest benefit for the city and its citizens having resources for those coping with mental health and substance abuse in their families and homes. Many people share my home is being destroyed and I am being beaten to a pulp because it is only as a last resort that I will call the police. *CCAT Officer*

- You know, the quote to the public is PD is here "to protect and serve." Citizens are saying they want BPD to help people, all individuals in the community as well as the community at large. Getting help to those in need leads to a safer community for everyone. *BPD personnel*

- The benefit for the individual is they will have persons they can depend on. A person they can trust. A person they know understands them. A person that will help them. *CCAT Officer*

- The benefit to the community is that there will be a team proactively getting the homeless and people in need the services they need instead of just moving them on. *CCAT Officer*

- The benefit for BPD is having experienced, trained officers who are motivated to work with those with homelessness and those in crisis. It will reduce the use of force or other negative outcomes that make the news. Thus, CCAT reduces the level of liability for the department. *Stakeholders and BPD staff*

- BPD will have options that are needed. It will also retain officers that want to do this type of work and truly want new ways to help people. *CCAT Officers*

- CCAT Officers know the 'regulars' and because of the teams' knowledge and skills they can effective explain the situation to community citizens as well as get individuals to comply. *CCAT Officers and Stakeholders*

- For clients, CCAT is a more integrated and holistic approach. Peoples are not just seen as 'a criminal' or a problem but they are seen as a person with complex needs and receive a complex response. For some, their experience is that all systems have failed them. Through CCAT they get a gentler response from MHPs and Officers who understand their situation. *CCAT staff*

- Reduced use of force and arrest for misdemeanors. Have more options to intervene in a problem that is not criminal. Ability to problem solve situations because not all situations they are called for are criminal in nature. *Stakeholder*

- CCAT can more quickly meet needs. Thereby, prevent future crisis in the community. Allow people to safely remain in the community. *BPD personnel*

- Overall, CCAT provides an incredible opportunity for the PD and the city. There are so many more approaches to try (as the program matures). This is just the start of it. *BPD personnel*

- Clients and community feel they are being heard. Current environment is one of damaged relationships and CCAT is a way for citizens to feel they are heard and repairs relationships. *BPD personnel*

- Mental Health/Substance Abuse clients are better served by specialized officers who can get them into needed services. *Stakeholders*

- Citizens seeing officers being calm, helpful, compassionate changes their perception of the police department and repairs relationships and builds trust. *Stakeholders*

- Systems are broken, even if not in jail still not getting the services needed; they just go around and around without getting needed treatment. *Stakeholders*

- CCAT is the best plan/approach to deal with homelessness. CCAT can respond in a timely manner with the skills and knowledge. [Homelessness] is not going to get any better. Citizens want to know how the city can address homelessness and CCAT is what will make this city standout as part of a coordinated team. *Homeless outreach*.

- Ongoing relationships with a resource like CCAT are a benefit for agencies. You feel like you are alone, and they can meet the needs of the client if you can't. You know the focus is not arrest and the person is not re-traumatized. Thus, the client is better off and able to accept services. When we call for assistance, we know that we are not calling in the "big guns" but someone to help us solve the issue. *Shelter staff*

- Being known as a compassionate police department is politically important at this time in our country. Not being heavy handed is important. CCAT will change public perception of BPD. Those who are privileged are concerned about BPD focus and actions; but those without privileged are stressed. *Shelter staff*

Appendix C: Definition of Terms

8B71 – CCAT unit staffed by a police officer and Mental Health Professional

8B72 – CCAT unit staffed by two police officers

8B73 – CCAT unit staffed by two police officers

APS – Adult Protective Services

BFD – Bellevue Fire Department

BPD – Bellevue Police Department

CARES – Bellevue Fire Department Mobile Integrated Health Program

CCAT – Community Crisis Assistance Team

COB – City of Bellevue

CPS – Child Protective Services

DCR – Designated Crisis Responders - mental health professionals who provide evaluation of people with behavioral health disorders for involuntary detention in psychiatric facilities

ED – Emergency Department (hospital)

FD – Fire Department

ITA – Involuntary Treatment Act

LERMS - Law Enforcement Records Management System

MH – Mental Health

MHP – Mental Health Professional

MSW – Master of Social Work

N= - Number equals

NORCOM - consolidated 911 call taking and dispatching communications center serving Bellevue Fire and Police

P1, P2, P3, P4, P5 call – Priority level of 911 call

PD – Police Department