Washington Behavioral Health Crisis Response and Suicide Prevention System: Crisis Response Improvement Strategy Steering Committee Progress Report

COMMITTEE PROGRESS REPORT PER RCW 71.24.892

TO
GOVERNOR JAY INSLEE
SENATE WAYS AND MEANS COMMITTEE
SENATE HEALTH AND LONG-TERM CARE COMMITTEE
SENATE HUMAN SERVICES COMMITTEE
HOUSE APPROPRIATIONS COMMITTEE
HOUSE HEALTH CARE AND WELLNESS COMMITTEE

FROM
THE STEERING COMMITTEE
OF THE CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE

DECEMBER 31, 2023

Contents

Legislative Requirements

House Bill (HB) 1477, effective July 25, 2021 following the 2021 regular session of the Washington State legislature, created a Crisis Response Improvement Strategy (CRIS) Committee, a Steering Committee of the CRIS, and Subcommittees to develop recommendations related to the funding and delivery of an integrated behavioral health crisis response and suicide prevention system in Washington.[1] In 2023, HB 1134 enacted several crisis system amendments, including extending the work of the Steering Committee, CRIS and Subcommittees by an additional year.[2]

The Steering Committee—with input from the CRIS Committee and Subcommittees—is charged to deliver to the Governor and Legislature:

- **JANUARY 1, 2022**: a progress report, including results of the comprehensive assessment of the behavioral health crisis response and suicide prevention services systems and preliminary recommendations related to funding of crisis response services.
- **JANUARY 1, 2023**: a second progress report, including a summary of activities completed by the CRIS and Subcommittees during calendar year 2022 and final recommendations related to funding of crisis response services from the 988 Account created by the line tax.
- **JANUARY 1, 2024**: a third progress report regarding activities completed by the CRIS and subcommittees in 2023, and recommendations of the Steering Committee.
- **JANUARY 1, 2025**: a final report by the Steering Committee – informed by the CRIS and Subcommittees – with final recommendations for the funding and delivery of an integrated behavioral health crisis response and suicide prevention system in Washington.

The first and second reports in this series were submitted to the Legislature and Governor in accordance statutory requirements and deadlines. These reports can be found on the Washington State Health Care Authority CRIS Committee webpage.[3, 4] This report serves as the third progress report and fulfills the requirements due January 1, 2024.

[1] House Bill 1477 (2021). Retrieved from https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1477-S2.SL.pdf?q=20231104180909; *See:* Revised Code of Washington 71.24.892.
[2] House Bill 1134 (2023). Retrieved from https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/1134-S2.SL.pdf?q=20231104180729
[3] *Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services in Washington and Preliminary Funding Recommendations* (December 31, 2021). Retrieved from https://www.hca.wa.gov/assets/program/1477-assessment-of%20crisis-delivery-system-20211231.pdf
[4] *Washington Behavioral Health Crisis Response and Suicide Prevention system: HB 1477 Committee Progress Report and Funding Recommendations for the 988 Line Tax* (December 31, 2022). Retrieved from https://www.hca.wa.gov/assets/billers-and-providers/hb-1477-committee-progress-report-202301.pdf

Steering Committee, CRIS Committee, and Subcommittee Structure

The CRIS Committee is made up of 36 members with broad representation outlined in HB 1477, including: [5]

- People with lived experience
- Representatives from state agencies
- Service provider
- First responders
- Medicaid and commercial health plan representatives
- Tribal representatives
- Consumer organizations
- State legislators
- Other partners across the crisis response system.

As a smaller subset of the broader CRIS Committee, the Steering Committee includes six members representing the:

- House of Representatives
- Senate
- Governor's Office
- Health Care Authority
- Department of Health
- People with lived experience.[6]

Eight subcommittees provide professional expertise and community perspectives in the development of crisis system recommendations.[7] The Subcommittees are made up of members of the CRIS, state agency representatives, tribal partners, and other partners offering community perspectives and/or professional expertise in the subcommittee areas of focus.[8]

Figure A: Steering Committee, CRIS Committee, Subcommittee Structure

* Six of the eight subcommittees are established by legislation . The Steering Committee established two additional subcommittees: Lived Experience and Rural & Agricultural Communities
** The Geolocation Subcommittee is expected to be convened in 2024.

[5] A CRIS Committee member list is available on the CRIS webpage at https://www.hca.wa.gov/assets/program/cris-committee-member-list.pdf
[6] In 2023, the Legislature added the sixth voting member of the Steering Committee to represent Lived Experience.
[7] The charge of each subcommittee is described in the *2023 Subcommittee Report* available on the CRIS webpage at: *https://www.hca.wa.gov/assets/program/cris-subcommittee-report-2023.pdf*
[8] A HB 1477 Subcommittee member list is available on the CRIS webpage at: *https://www.hca.wa.gov/assets/program/cris-subcommittee-member-list.pdf*

Executive Summary

Introduction

In 2021, the Washington legislature passed House Bill 1477 to enhance and expand Washington's behavioral health crisis response and suicide prevention system. Goals identified by the bill include:

- ✓ Implementation and expansion of 988, the new three-digit national Lifeline number.
- ✓ Development of 988 Contact Hubs to provide crisis intervention services and streamline access to services.
- ✓ Expansion of crisis services across the service continuum: A Place to Call, Someone to Come, and A Safe Place to Be.
- ✓ Collaboration and coordination across diverse system partners.
- ✓ Workforce training and development.
- ✓ New technology platform to support system coordination.
- ✓ Expanded funding through the 988 Behavioral Health Crisis Response and Suicide Prevention Line Account.

Committee Recommendations

HB 1477 charges the Steering Committee, with input from the CRIS Committee and Subcommittees, to make recommendations to improve Washington's behavioral health crisis response and suicide prevention system. The CRIS and Subcommittees include broad system representation from partners to inform system changes. This representation includes people with lived experience, state agencies, service providers, first responders, Medicaid and commercial health plan representatives, Tribal representatives, consumer organizations, state legislators, and other partners across the crisis response system.[9] The Steering Committee is also engaging in Tribal Consultation to recognize the sovereign authorities of Tribal governments and the existing processes and governing bodies in place to address Tribal behavioral health and crisis system needs and gaps.

The Washington State Health Care Authority (HCA) and Washington State Department of Health (DOH) are the lead authorities for administering Washington's behavioral health crisis response system. As the agencies work to implement 988 and crisis system improvements, Committees are staying closely engaged to inform this work and develop recommendations to strengthen and build upon progress made.

Throughout 2023, the Legislature, state agencies, and the CRIS and Subcommittees continued to make progress to improve Washington's behavioral health crisis response system. Progress by state agencies and the Legislature addressed many recommendations identified by the Committee in 2022. The CRIS and Subcommittees continued to convene to identify recommendations in the eight (8) domains of Committee recommendations summarized below.

I. Vision

In 2022, the Committee engaged in work to develop a vision for Washington's Behavioral Health Crisis Response and Suicide Prevention System. This vision and guiding principles form the foundation of the ongoing work to develop recommendations.

[9] A CRIS Committee member list is available on the CRIS webpage at https://www.hca.wa.gov/assets/program/cris-committee-member-list.pdf

II. Promoting Equity

1. Engage consumer voice in informing system design and changes needed.
2. Develop a Caller Bill of Rights that:
    a. Provides information to communities about what they can expect when they contact 988, and
    b. Holds the system accountable to providing services that help individuals in crisis.
3. Set up a hub where information can be entered and accessed by individuals and families in crisis and all members of their care team.
4. Strengthen support for consumers to navigate the system and simplify access to services.
5. Leverage broad community outreach and public education to address stigma around behavioral health needs and raise awareness around 988.
6. Build upon Tribal Behavioral Health Crisis System improvements and ensure Tribal partners are recognized and connected in the state and local crisis response systems.
7. Conduct research to understand why the crisis response system is not working for some groups.
8. Establish a 988 Diversity, Equity, and Inclusion Director.

III. Services

9. Ensure there are crisis response services available in all regions so people have access to care wherever and whenever needed. Recommendations are outlined for services across the crisis continuum: A Place to Call, Someone to Come, A Safe Place to Be.
10. Strengthen overarching system capacity around behavioral health and suicide prevention services.

IV. System Quality and Oversight

11. Set standards, system performance targets, and metrics and hold the behavioral health system accountable to ensure outcomes that result in meaningful access to services.

V. Cross System Collaboration

12. Support work to ensure that Washington has an appropriate, effective, equitable and safe collaboration between behavioral health crisis response services and first responders (fire, emergency medical services, and law enforcement). This work should support a behavioral health response to individuals in crisis and reduce law enforcement presence when not needed. (See Appendix F for recommendations by the Behavioral Health Crisis Response and First Responder Collaboration Workgroup.)
13. Develop regional collaborations that bring together system partners to create regional plans and protocols for crises.
14. Address youth-focused crisis system coordination as a critical focus area to make sure youth in crisis get care.
15. Develop cross-system coordination protocols between Tribal and state and local systems (including 911, 988, the Native and Strong Lifeline, the Native Resource Hub, local Tribal crisis lines, Indian Health Care Providers, and Tribal Public Safety and Tribal First Responders).

VI. Staffing and Workforce

16. Expand a diverse workforce that shares language, culture, and experience with the people it serves.
17. Engage behavioral health providers and first responder partners in trauma-informed and youth-informed trainings to minimize potential harm and build trust across communities.

VII. Technology

Committee work in 2023 has focused on informing the Request for Information (RFI) and Request for Proposals (RFPs) process led by HCA and DOH to establish Washington's call center and integrated client referral technology platform. In addition, DOH and HCA are engaging input from diverse groups, including the Lived Experience and Tribal Subcommittees, to inform the 988 technology user experience and create a human-centered design for the technology platform.

VIII. Funding

18. Provide additional funding to behavioral health crisis systems across regions, and plan for evaluating adequate distribution of resources:
    a. Pursue consistent funding for mobile crisis response, rather than braided local funding to expand workforce and improve response times.
    b. Provide additional funding to behavioral health crisis response systems in rural communities.
    c. Consider enabling "payer blind" crisis services (i.e., services not just for Medicaid clients or commercially insured clients).
    d. Ensure crisis service funding to the Medicaid Fee-for-Service (FFS) system, as many Tribal members are enrolled in Medicaid FFS rather than managed care.

Focus of Work to Undertake in 2024

In 2024, the Steering Committee, CRIS, and Subcommittees will build on committee work completed, with a focus on the following areas to develop recommendations to guide improvements to Washington's behavioral health crisis response and suicide prevention system:

1) ***System Quality and Oversight:*** In 2022 and 2023, CRIS and Subcommittees underscored system oversight and performance measurement as foundational work needed for holding the system accountable for achieving goals, ensuring system transparency, and building trust with communities. Committee work in 2024 will build on these initial recommendations and focus on a deeper discussion of system performance measures, oversight, and accountability.
2) ***System Infrastructure:*** To support implementation of Washington's goals, critical system infrastructure – technology, workforce, and cross-system collaboration – is needed. The committees will build on recommendations identified in 2023 and finalize any recommendations related to necessary infrastructure.
3) ***Crisis System Services and Funding:*** The Committees will continue to inform DOH's and HCA's continued work to implement expanded crisis services throughout Washington, and development of sustainable funding models to support these services.

Section I. Background

The Challenge

In 2021, the Washington legislature passed House Bill 1477 to enhance and expand Washington's behavioral health crisis response and suicide prevention system. Goals identified by the bill include:

- ✓ Implementation and expansion of 988, the new three-digit national Lifeline number.
- ✓ Development of 988 Contact Hubs to provide crisis intervention services and streamline access to services.
- ✓ Expansion of crisis services across the service continuum: A Place to Call, Someone to Come, and A Safe Place to Be.
- ✓ Collaboration and coordination across diverse system partners.
- ✓ Workforce training and development.
- ✓ New technology platform to support system coordination.
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Steering Committee Charge

HB 1477 charges the Steering Committee, with input from the CRIS Committee and Subcommittees, to make recommendations to improve Washington's behavioral health crisis response and suicide prevention system. The CRIS and Subcommittees include broad system representation from partners to inform system changes. This representation includes people with lived experience, members of state agencies, service providers, first responders, Medicaid and commercial health plan representatives, Tribal representatives, consumer organizations, state legislators, and other partners across the crisis response system.[10]

Recommendations to be addressed by the Committees fall within the following eight domains:

1. Vision for Washington's crisis response and suicide prevention system
2. Equity
3. Services
4. Quality and Oversight
5. Cross System Collaboration
6. Staffing & Workforce
7. Technology
8. Funding & Cost Estimates

In 2021 and 2022, the Committees engaged in an assessment of the current system and identified recommendations to address identified gaps. The Steering Committee also reviewed and submitted recommendations for the 988 Behavioral Health Crisis Response and Suicide Prevention Line Account. This report builds on the progress by state agencies and the Legislature during 2023 to address system

[10] A CRIS Committee member list is available on the CRIS webpage at: https://www.hca.wa.gov/assets/program/cris-committee-member-list.pdf

gaps, and continues to identify recommendations to strengthen and transform Washington's crisis response system.

Committee Work in 2023

During 2023, the CRIS Committee convened monthly to consider system gaps, progress updates by state agencies and the legislature, and develop recommendations. All CRIS meeting agendas, materials, and recordings are available on the HCA Crisis Response Improvement Strategy Committee webpage.[11] In addition to the CRIS, subcommittees convened to share perspectives and expertise as needed: the Lived Experience and Tribal 988 Subcommittees met monthly; and the Rural & Agricultural Communities Subcommittee convened approximately three times; the Technology Subcommittee met twice to advise on state agency work on the technology platform. All subcommittee meeting summaries are available on the CRIS webpage.[12] The Steering Committee convened twice in 2023 to consider overall progress and provide direction to the Committees, as well as make needed decisions and approvals.

In addition to the Subcommittees, two short-term workgroups were formed in 2023:

1) *Behavioral Health Crisis Response and First Responder Collaboration Workgroup*: This workgroup was formed to further the CRIS committee discussion regarding collaboration between behavioral health and first responders (fire, emergency medical services, and law enforcement) in Washington's crisis response system. The workgroup developed recommendations to support an appropriate, effective, equitable and safe collaboration between behavioral health crisis response and fire, police, and emergency medical services. The CRIS 2023 recommendations throughout this report reflect the workgroup recommendations, which are also summarized in Appendix F.
2) *Crisis Response Dispatch Protocols Workgroup.* This workgroup provided input into draft crisis response dispatch protocols developed by HCA, DOH and system partners to standardize 988 and regional crisis line guidelines for when and how to dispatch crisis response resources. These protocols will support further work by HCA and DOH in 2024 to support implementation of standardized crisis response dispatch protocols in each region.

Members participating in each workgroup included a subset of CRIS members as well as additional members representing lived experience and system subject matter experts.[13]

Work with State Agency Partners

The Steering Committee and CRIS Committee recognize the Washington State Health Care Authority (HCA) and Washington State Department of Health (DOH) as the lead authorities for administering Washington's behavioral health crisis response system. As the agencies work to implement 988 and

[11] Washington State Health Care Authority, Crisis Response Improvement Strategy Committees webpage: https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees

[12] HB 1477 2023 Subcommittee Report available on the CRIS webpage at: https://www.hca.wa.gov/assets/program/cris-subcommittee-report-2023.pdf

[13] A 2023 CRIS Workgroups member list is available in Appendix G.

system improvements, Committees are staying closely engaged to inform this work and develop recommendations to strengthen and build upon progress made.

Agencies can share their extensive experience with Washington's behavioral health crisis response system and programs. DOH leads contracts and oversight of the 988 Lifeline crisis centers, as well as development of the future designated 988 contact hubs, which will help streamline access to care for people seeking help from the 988 Lifeline. HCA oversees regional crisis services throughout the state, including regional crisis lines, mobile rapid response crisis team outreach (MRRCT), and crisis stabilization and follow-up care. The agencies closely coordinate and administer crisis services across the crisis service continuum (see **Figure A**).

Figure A: *Overview of HCA and DOH Roles in the Crisis Response Continuum*

Tribal Consultation

Washington is home to 29 federally-recognized Tribes, which exercise sovereignty over Tribal lands. In carrying out the work of HB 1477, the Steering Committee engages with Tribes in a way that recognizes the sovereign authorities of Tribal governments and respects the existing processes and governing bodies in place to address Tribal behavioral health and crisis system needs and gaps. Upon request of the Tribes, the Steering Committee began a Tribal Consultation process in 2022 to ensure that CRIS Steering Committee recommendations for an integrated behavioral health crisis response and suicide prevention system in Washington includes Tribal perspectives. This process recognizes the government-to-government relationship between Tribal and state government leaders. This relationship is distinct from the state's relationship with other system partners. For this *January 1, 2024 Committee Progress Report*, the consultation process included a Tribal Roundtable held on November 29, 2023, and a formal Tribal Consultation on December 13, 2023. A summary of tribal feedback through the Tribal Roundtable and Consultation is provided in Appendix D. All Tribal feedback received has been addressed and integrated into this report.

In addition to the Tribal Consultation process, the Tribal 988 Subcommittee has played an important advisory role to CRIS and Steering Committee work through work with the Tribal Centric Behavioral Health Advisory Board. This work focuses on Tribal perspectives and existing Tribal efforts to improve the behavioral health crisis response system for Tribal members. Throughout 2023, the Tribal 988 Subcommittee advised on the development of HB 1477 committee recommendations to reflect Tribal priorities.

The CRIS Steering Committee recognizes the extensive work led by Tribes and Urban Indian Health Organizations (UIHOs) in Washington for over a decade to address the significant inequities in health and access to behavioral health crisis services experienced by American Indians and Alaska Natives (AI/AN) in the state. It is important that the Steering Committee aligns its recommendations in a way that strengthens and builds upon the important ongoing work led by Tribes to address behavioral health crisis needs in Tribal communities. See Appendix C for a brief summary of the history of Tribal work to address the barriers in access to behavioral health crisis services for Tribal members.

Section II: 2023 Committee Recommendations

Throughout 2023, the Legislature, state agencies, and the CRIS and Subcommittees continued to make progress to improve Washington's behavioral health crisis response system. Progress by state agencies and the Legislature addressed many recommendations identified by the Committee in 2022. The CRIS and Subcommittees continued to convene to identify recommendations that can further strengthen and build upon the progress made.

This section includes a summary of state agency and legislative progress in 2023, and the **18 committee recommendations** identified to build on this work. This progress and recommendations are organized by the eight (8) domains of Committee recommendations set forth by HB 1477:

1. Vision
2. Promoting Equity
3. Services
4. System Quality and Oversight
5. Cross-System Collaboration
6. Staffing and Workforce
7. Technology
8. Funding

In addition to this narrative summary, a companion excel tool *CRIS Committee Synthesized Recommendations and Priorities* provides:

- Further detail regarding each recommendation
- Priority areas identified by CRIS members
- Alignment between recommendations and the following actions:
    - Current state agency implementation
    - 2024 legislative priorities
    - 2024 CRIS work planned
    - Actions to be determined

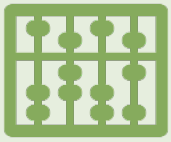
1. Vision

In 2022, the Committee engaged in work to develop a vision for Washington's Behavioral Health Crisis Response and Suicide Prevention System. This vision and guiding principles establish the foundation of the Steering Committee, CRIS Committee, and Subcommittees work to develop recommendations. The vision and guiding principles have not been further updated by Committee recommendations this year and are provided for reference below.

Vision: 988, Washington's Crisis Response: building understanding, hope, and a path forward for those in need, where and when they need it.

Guiding Principles

People in Crisis Experience:	*The Crisis System is Intentionally:*
1. Timely access to high-quality, coordinated care without barriers	**5. Grounded in equity and anti-racism**
2. A welcoming response that is healing, trauma-informed, provides hope, and ensures people are safe	**6. Centered in and informed by lived experience**
3. Person and family centered care	**7. Coordinated and collaborative across system and community partners**
4. Care that is responsive to age, culture, gender, sexual orientation, people with disabilities, geographic location, language, and other needs	**8. Operated in a manner that honors Tribal government-to-government processes**
	9. Empowered by technology that is accessible by all
	10. Financed sustainably and equitably



2. Promoting Equity

State Agency & Legislative Progress in 2023

State agencies and the Legislature made continued progress in 2023 to embed equity and center lived experience in improvements to Washington's behavioral health crisis response system. Several areas of progress related to CRIS recommendations in this section include:

- ✓ DOH began planning for the **988 Communications Campaign** authorized by HB 1134 (2023) to promote awareness among diverse communities. Continued work is planned for developing and implementing the campaign in 2024.
- ✓ **Native and Strong Lifeline and Native Resource Hub communications materials** were developed, and DOH is partnering with Tribes to implement the campaign in 2024.
- ✓ DOH distributed increased funding for 988 centers to **support 988 diversity, equity, and inclusion work.**
- ✓ HCA continues to ensure equity in access through **the Substance Abuse and Mental Health Services Administration (SAMHSA) and National Association of State Mental health Program Directors (NASMHPD) best practices across the lifespan.**
- ✓ **Lived Experience representative was added as voting member** of the Steering Committee (HB 1134, 2023).
- ✓ **Additional progress to promote equity is highlighted throughout this report.**

Committee Recommendations

CRIS and Subcommittee recommendations continue to build on progress made in 2023 to promote equity in Washington's behavioral health crisis response system. As an underlying theme, committees emphasized the need to create a crisis response system that is consumer-driven, responsive to diverse cultural and community needs, and designed by people who are using or have used the system directly. The perspective of lived experience has also offered a grounding and powerful lens for understanding where the system works and doesn't work and informing changes necessary to meet the needs of Washington's communities. Key recommendations that emerged from 2023 committee work to promote equity are summarized below.

1. ***Engage consumer voice in informing system design and changes needed.*** Committees continued to emphasize the importance of engaging people from diverse communities the system aims to serve in discussions around system design and improvements. Several opportunities identified for forming workgroups and other mechanisms to engage consumer voice include advising on:
    a. How to build trust in the crisis response system and make it possible for people most at risk of suicide—particularly people of color; lesbian, gay, bisexual, transgender, queer or

questioning, intersex, asexual, and two-spirit people (LGBTQIA2S+); people living in small and rural communities; and youth—to feel safe calling for help in a crisis.

b. How to assess the level of safety risk in behavioral health crises to determine the best response.
c. How to assure communities that services are confidential, particularly in small and rural communities.
d. How to best communicate information and address stigma and other barriers to access in diverse and often oppressed or excluded communities.
e. How to develop of a diverse crisis system workforce, including establishing workforce pipeline programs and training curriculum.
f. 988 community outreach and education campaign.
g. Regional collaborations to address equity and systemic failures.

2. ***Develop a Caller Bill of Rights that provides information to communities about what they can expect when they contact 988 and holds the system accountable to providing services that help people in crisis.*** This recommendation emerged from discussions regarding the fear people experience in reaching out for help. For some people, a call for help resulted in further harm or trauma during the crisis. Members also emphasized the importance of informed consent while also considering circumstances in which consent may not be possible, such as individuals who lack insight into their condition.

3. ***Set up a hub where information can be entered and accessed by someone in crisis, their families, and all members of their care team***. Members recommended that individuals and families have access to an information hub to help share information about the person in crisis with the care team. This would give people and families the ability to share knowledge and preferences they have for responding to their crisis needs, while also reducing the burden of having to repeat information multiple times with different providers to access care. Committee members with lived experience shared the desire to guide a response to their behavioral health crisis needs, before being in a crisis situation that doesn't allow them to give clear direction, such as through a Mental Health Advanced Directive. This hub could also include further investment in 211 or other centralized information about available services and supports, including for example a list of behavioral health providers, prevention, and social support services.

4. ***Strengthen support for consumers to navigate the system and simplify access to services.*** Committee members highlighted the complexity of the crisis response system, noting that it's even difficult for people who work in the system as professionals. System improvements should simplify access to services for people and families in crisis and provide support for navigating the system.

5. ***Leverage broad community outreach and public education to address stigma around behavioral health needs and raising awareness around 988.*** This education could help normalize discussions around stress and behavioral health needs and support wider understanding of behavioral health crises. CRIS and Subcommittees emphasized the critical importance that the 988 awareness campaign engage people of color, Tribes, LGBTQIA2S+

people, rural and agricultural communities, youth, and other groups at high risk of suicide in advising on how best to communicate information and address stigma or other barriers to access in their communities. Committees also underscored the essential importance of the 988 awareness campaign to address the relationship between 988 and 911, along with concerns of people who avoid accessing the system due to fear of engagement with law enforcement. Tribes are working with state agencies to develop the Native and Strong Lifeline and Native Resource Hub communication campaign and emphasized the need for investments to support this outreach. This input can inform DOH's current work to plan and develop the 988 awareness campaign, as established under HB 1134.

6. ***Build upon Tribal Behavioral Health Crisis System improvements and ensure Tribal partners are recognized and connected in the state and local crisis response systems.*** In 2024, Tribes are introducing legislation that continues to build on previous legislative efforts and focuses on keeping Tribes connected with their Tribal members who are in the state crisis system; ensuring Tribes have access to critical information when their members are in the state crisis system; and including Tribal Courts, Indian Health Care Providers, Tribal law enforcement, and Tribal Jails in the state crisis system. (Note: Tribal 2024 proposed behavioral health crisis system legislation is highlighted in this section; additional Tribal priorities for improving Washington's behavioral health crisis response are integrated in committee recommendations throughout.)
7. ***Conduct research to understand why the crisis response system is not working for some populations.*** Committee members emphasized the importance of attention to key groups in need of behavioral health crisis support but aren't currently accessing the system. Further understanding the extent to which these groups currently aren't accessing the system or services, and the reasons behind this, can make it easier to address barriers. These barriers might include stigma, fear of law enforcement involvement, concerns around confidentiality, among others.
8. ***Establish a 988 Diversity, Equity, and Inclusion Director.*** DOH currently funds diversity, equity, and inclusion (DEI) activities within each 988 Lifeline crisis center. A 988 DEI Director could build upon this work and bring a statewide perspective, as well as include appropriate Tribal government-to-government relations and work with Tribal liaisons across the state.

3. Services

State Agency & Legislative Progress in 2023

In 2023, state agencies and the Legislature continued to address service gaps across the crisis service continuum. Key areas of progress made include:

Someone to Call

- ✓ DOH and 988 Lifeline crisis centers **expanded 988 capacity** to respond to increasing call, text, and chat volume.
- ✓ **Native and Strong Lifeline and Native Resource Hub increased capacity** to respond to increasing call volume for AI/AN population.[14] In 2023, calls to the Native and Strong Lifeline have increased steadily as awareness of this resource grows; for example, calls grew from 232 calls per month in December 2022 to 520 calls per month in October 2023 (an increase of 124%). Callers have emphasized the importance of connecting with counselors who are Tribal members and who understand Native cultures and support needed.
- ✓ DOH engaged **988 contact hub rulemaking workshops** to gather input on draft rule development. Rulemaking will continue in 2024, with final rules to be adopted by January 1, 2025.
- ✓ HCA and DOH developed the **Best Practice Guide for 988 and RCLs** to support common standards and best practices across crisis contact centers.

Someone to Come

- ✓ HCA **expanded youth and adult mobile response teams** throughout the state, and created **map of youth and adult teams and projected needs to identify system gaps**. Continued expansion is planned with funding authorized by the Legislature.
- ✓ HCA supported implementation of **Mobile Response and Stabilization Services (MRSS) best practices for youth crisis response.**
- ✓ HCA was awarded a SAMHSA System of Care (SOC) grant **supporting MRSS rollout.**
- ✓ HCA initiated work to develop **Endorsement Standards for mobile rapid response teams and community-based crisis teams**[15] to respond within specific timeframes to people in crisis, as directed by HB 1134. Endorsement Standards are due by April 1, 2024.
- ✓ HCA worked with **Tribal Nations on best practices for MRRCT**, and development of endorsement standards specific to Tribal teams.

[14] For further information, please see Native and Strong Lifeline (nativelifeline.org) and the Native Resource Hub (nativehub.org).

[15] HB 1134 (2023) established community-based crisis teams as a new model with mobile response teams based in first responder or community agencies other than law enforcement.

- ✓ HCA received **SAMHSA grant for supporting community response teams**, a model based on trusted leadership within communities. (Note: this model is distinct from the community-based crisis team model established by HB 1134.)
- ✓ HCA developed the **Best Practice Guide for Mobile Crisis Response** to support common standards and adoption of SAMHSA best practices.

A Safe Place to Be & Follow Up Care

- ✓ DOH engaged process to develop **23-hour Crisis Relief Center licensure rules** by January 1, 2024, as required by SB 5120 (2023). This creates a new model for providing short-term stabilization services for adults in crisis.
- ✓ HCA obtained federal approval for a Medicaid State Plan Amendment, effective January 1, 2024, that allows **up to 8 weeks of in-home stabilization for youth** through the MRSS model.
- ✓ HCA engaged **cost modeling for in-home stabilization** across the lifespan.
- ✓ HCA added **peers to crisis services** to report encounters.
- ✓ HCA worked with OIC to develop the **Next-Day Appointment (NDA) referral directory** and **improved process to connect people to NDAs.**

Committee Recommendations

Throughout 2023, the CRIS and Subcommittees discussed service gaps, progress made to address these gaps, and continued work needed. Below is a summary of recommendations identified by Committees across the crisis service continuum. These recommendations underscore the need to expand existing crisis response services that are working as well as opportunities to build new models for supporting people in crisis.

9. Ensure there are crisis response services available in all regions so that people have access to care wherever and whenever needed.

Someone to Call:

a. Importance of quick response to calls: Committees underscored both the importance of speed for a person in crisis to connect with a 988 Lifeline counselor and concern with the time delay created by the 988 dial-pad options. This issue was raised as a particular area of concern for rural and agricultural communities. (Note: this issue would require federal action to address.)

b. Youth callers: Committee members raised concern regarding the lack of current practice among 988 Lifeline crisis centers to systematically identify youth callers. Members emphasized the need for this information to connect youth callers with youth-specific mobile response and other resources, as discussed further in the recommendations relating to Cross-System Collaboration below.

c. Tribal Partners: Tribal partners highlighted the need for a 988 text and chat option for the Native and Strong Lifeline.

d. Additional committee input into agency rulemaking: DOH engaged and received input from committee members and Tribal partners into **988 contact hub draft rule development**. This process will continue in 2024 with final 988 contact hub rules due by January 1, 2025.

Someone to Come:

e. **Continued expansion of both adult and youth mobile crisis response services** to address current gaps in the system and ensure a timely response to people in crisis. HCA reported on work in 2023 to expand Mobile Rapid Response Crisis Teams (MRRCT) across the state, including expansion of the MRSS model for youth. With HB 1134, HCA is also working to develop endorsement standards for current mobile rapid response teams and the new community-based mobile response teams.
f. **Ensure system capacity to respond to people showing symptoms of mental health and/or substance use disorders**, recognizing this is a significant population in need of crisis support.
g. **Tribal Partners** support continued work to develop Tribal mobile rapid response crisis teams as well as Tribal Designated Crisis Responders. As HCA works to establish mobile team endorsement standards outlined in HB 1134, Tribes are working with the agency to establish endorsement standards and ensure capacity funding specific to Tribal teams.

A Safe Place to Be & Follow Up Care

h. **Prioritize crisis stabilization in the home** to support a sense of belonging and connection with family systems. Committees supported the youth MRSS model focus on in-home stabilization and recommended further exploration of this approach for adults.
i. **Expand peer respite services** as a key strategy for expanding access.
j. **Develop partnerships and engage local communities to support expansion of crisis stabilization facilities** across the state. This work should focus on increasing public understanding of the importance of crisis stabilization services and supporting community groups with starting their own crisis stabilization program or facility.
k. **Review capacity of crisis stabilization facilities to serve people who need support for**:
    a. Co-occurring mental health and substance use disorders
    b. Intellectual and developmental disabilities
    c. Activities of daily living
    d. Consideration is also needed for ways to minimize the use of gendered spaces that create further anxiety for non-binary and transgender people.
l. **For youth populations**:
    a. Expand Crisis Relief Centers established under SB 5120 (2023) to serve youth.
    b. Expand juvenile justice programs that provide wrap-around services to youth with behavioral health diagnoses and other needs.
    c. Pursue policy changes that address forensic diversion for youth (i.e., behavioral health-focused care for youth with behavioral health issues who have had involvement with law enforcement).
m. **Review current requirements for discharge planning** and identify gaps to prevent people from being discharged from inpatient psychiatric or hospital settings into circumstances that create a repeated cycle of crisis.
n. **Develop system capacity to follow up** with people who have experienced crisis.
o. **Establish a centralized hub of available services and providers.**

p. **Tribal partners:** Ensure that the range of state and local crisis stabilization services (e.g., peer respite, crisis receiving centers, in-patient care) are culturally tailored for Tribal members. In addition, Tribal partners identified opportunities to support expansion of Tribal in-patient facilities through strategies including additional state funding, transfer of public lands to Tribes to build a facility, and removal of licensing and certification barriers.
q. **Additional committee input into agency rulemaking:** DOH received input from committee members, Tribal partners, and the public on **licensure requirements for the new Crisis Relief Centers for adults** established by SB 5120. Final rules must be adopted by January 1, 2024.

10. ***Strengthen overarching system capacity around behavioral health and suicide prevention services.*** In addition to the expansion of services for people in crisis, committees emphasized the need to focus on system investments needed to prevent behavioral health crisis from happening in the first place. Recommendations identified included:
    - **Emphasis on the importance of prevention services**, including investments in basic social services and ensuring equity in behavioral health crisis and suicide prevention services across the state.
    - **Increase use of telehealth services** to enable access to behavioral health services, particularly in rural areas of the state. This work should include investment in infrastructure to ensure internet access across the state.

4. Quality and Oversight

State Agency & Legislative Progress in 2023

HCA and DOH engaged work in 2023 to develop an inventory of crisis system metrics currently in use in Washington and identify potential additional measures and targets for consideration. This inventory will establish a baseline understanding of current and best practice measures that will inform committee discussions of system quality oversight and accountability planned for 2024.

Committee Recommendations

In 2023, CRIS and Subcommittees underscored system oversight and performance measurement as foundational work needed for holding the system accountable for achieving goals, ensuring system transparency, and building trust with communities. With the extension of the CRIS timeline by one year, Committee work in 2024 will focus on a deeper discussion of system performance measures, oversight, and accountability. Key recommendations relating to system quality and oversight highlighted in 2023 are summarized below.

11. ***Set standards, system performance targets, and metrics and hold the behavioral health crisis system accountable to ensure outcomes result in meaningful access to services.***
    - Leverage existing oversight boards for tracking performance and holding the system accountable.
    - Advise state agencies on key metrics for the crisis system to ensure it is successful at addressing gaps (e.g., set targets for language accessibility and determine gaps; use 2018 or earlier for baseline for youth emergency visits to emergency departments for behavioral health crisis).
    - Work with Tribes to identify system performance metrics and outcomes. In addition, ensure system recognition of Tribal data sovereignty.
    - Include standards and performance metrics for endorsement of mobile rapid response teams and community-based crisis teams.
    - Implement process to capture qualitative data to document outcomes (patient satisfaction, barriers, unmet needs, etc.).
    - Leverage a census model to go into the communities to collect data, including but not limited to data from people experiencing homelessness and incarcerated populations. Make system improvements based on system user experiences and feedback.
    - Create dashboard to display system performance metrics, such as mobile crisis data, and track service outcomes.
    - Implement continuous process improvement on data gathering methods and course correct as needed.
    - Implement quality control initiative and training to ensure consistent level of services across crisis centers.

5. Cross System Collaboration

State Agency & Legislative Progress in 2023

State agencies and the Legislature made continued progress in 2023 to support cross system collaboration.

- ✓ HCA and DOH developed **Crisis Response Dispatch Protocols** to provide standardized guidance for 988 contact centers and regional crisis lines to dispatch crisis response services based on a person's level of crisis.
- ✓ DOH and HCA released a policy statement on the roles of 988 and the regional crisis lines.[16] In addition, the agencies formed a **988/Regional Crisis Line Workgroup** with Behavioral Health Administrative Service Organizations (BH-ASOs) and 988 contact centers to address the current and future roles of regional crisis lines in Washington's behavioral health crisis response system.
- ✓ DOH is engaging a **Mental Health Crisis Call Diversion Initiative**, in which each 988 contact center is partnering with a 911 public safety answering point (PSAP) in their region to embed a 988 call taker in the PSAP.
- ✓ HCA worked with Tribal partners to update the template for **Tribal Crisis Coordination Plans.** These are agreements established between individual Tribes and BH-ASOs to set forth plans for coordination between Tribal partners, state, county and local partners for voluntary and involuntary crisis services for Tribal members.
- ✓ HB 1134 created **community-based crisis teams** as a new model of mobile crisis response teams that are part of an emergency medical services agency, fire service agency, public health agency, or other city or county government entity (other than a law enforcement agency).
- ✓ HB 1134 directs HCA and BH-ASOs to work with a broad range of system partners to develop recommendations for regional crisis workforce and resilience training collaboratives that would support **regional collaboration among behavioral health providers and first responders**.
- ✓ HB 1134 established requirements for BH-ASOs to convene an **annual crisis continuum of care forum with a broad range of regional partners** to identify and develop collaborative regional-based solutions which may include capital infrastructure requests, local capacity building, community investments, and other opportunities.

[16] Washington State Health Care Authority and Washington State Department of Health. (May 2023). Policy statement on the roles of 988 and the regional crisis lines. Retrieved from DOH HCA RCL policy statement May 25, 2023 (wa.gov)

Committee Recommendations

In 2023, CRIS and Subcommittee recommendations focused on a deeper review of work needed to support collaboration across crisis response system partners. Committee recommendations overall emphasized the need to create a unified crisis system response that offers people in crisis a true "No Wrong Door" access to care. This work involves multiple areas of coordination and collaboration across many system partners—988, 911, regional crisis lines, the Native and Strong Lifeline, the Native Resource Hub, Indian Health Care Providers, Tribal partners, mobile response teams, designated crisis responders, and first responders (fire, emergency medical services, and law enforcement), and other partners. These recommendations will inform further work in 2024 focused on ensuring this collaboration serves as critical infrastructure needed to build a well-functioning crisis response system in Washington.

12. ***Support work to ensure that Washington has an appropriate, effective, equitable, and safe collaboration between behavioral health crisis response and first responders (fire, emergency medical services, and law enforcement).*** The CRIS Behavioral Health Crisis Response & First Responder Workgroup identified recommendations to support collaboration between behavioral health crisis response and first responders that ensures a behavioral health response to individuals in crisis and reduces law enforcement presence when not needed. The CRIS 2023 recommendations throughout this report reflect the workgroup recommendations, which are also summarized in Appendix F. The recommendations provide a foundation for continued work in this area, including the work established by HB 1134 to foster regional workforce and resilience training collaboratives to support regional collaboration among behavioral health providers and first responders working within the crisis response system.

    In addition, the CRIS Crisis Response Dispatch Protocols Workgroup provided input into crisis response dispatch protocols developed by HCA and DOH. These protocols support a standardized response across 988 crisis centers and RCLs for callers with varied levels of crisis needs. The protocols address situations in which call-takers can assess the level of risk, safety considerations, and protective factors to determine when behavioral health mobile crisis response is possible, or if there is a need to transfer calls to 911 due to high-risk situations involving harm to the person in crisis or others. The protocols will inform further work in 2024 to support implementation of standardized crisis response dispatch protocols in each region.

13. ***Develop regional collaborations that convene system partners to create regional plans and protocols for crises.*** Committee members emphasized the need to develop regional plans and protocols for crisis response that include statewide standards that can be tailored to the unique needs and partners in each region. This work should focus on ensuring "No Wrong Door" access to care. These recommendations, along with the recommendations noted above by the Behavioral Health Crisis Response and First Responder Collaboration Workgroup, may inform work in 2024 by HCA and Behavioral Health Administrative Service Organizations (BH-ASOs) to develop recommendations for regional workforce and resilience training collaboratives to foster

regional collaboration. This work also aligns with efforts by DOH and HCA to work with BH-ASOs and 988 contact centers regarding the current and future roles of regional crisis lines in Washington's behavioral health crisis response system.

14. ***Address youth-focused crisis system coordination as a critical focus area.*** Committee members emphasized concern that 988 Lifeline crisis centers currently have no way to systematically identify youth callers and connect them with youth-specific mobile response, such as MRSS, and other resources. Potential strategies identified by the Committee include development of a dial-pad "opt-in" prompt to allow youth callers to connect with youth-specific mobile response or other youth-appropriate resources, which would require federal action. Another option may involve integrating the 988 Lifeline with the existing teen suicide hotline so that youth can talk with peers. Additional areas for building youth-specific cross-system connections include data-sharing agreements across school systems and crisis systems (with appropriate confidentiality safeguards) to provide students with better follow-up care.

15. ***Develop cross-system coordination protocols between Tribal and state and local systems (including but not limited to, 911, 988, the Native and Strong Lifeline, the Native Resource Hub, local Tribal crisis lines, Hospitals, Indian Health Care Providers, and Tribal Public Safety and Tribal First Responders).*** Tribal partners highlighted opportunities to develop and implement HCA-Tribal Crisis Coordination Plans. These are agreements established between individual Tribes and BH-ASOs to set forth plans for coordination between Tribal partners, state, county and local partners for voluntary and involuntary crisis services for Tribal members. The Tribal Crisis Coordination Plan template was recently updated by Tribal partners and HCA and is available for individual Tribes to tailor and adopt as desired. Future work will include incorporation of the 988 crisis centers into these plans, as well as exploration of coordination with 911 and the emergency response system. Tribal partners highlighted the importance of collaborating with hospitals in cross system efforts to ensure Tribal members in crisis are connected with IHCPs and Tribal resources. Further cross-system collaboration work is also needed to develop protocols for RCLs and 988 crisis centers to develop best practices for early identification of people with Tribal affiliation, warm transfers to the Native and Strong Lifeline and Native Resource Hub, Tribal Mobile Crisis Response dispatch protocols, and ensuring making connections with Indian Health Care Providers.

6. Staffing and Workforce

State Agency & Legislative Progress in 2023

In 2023, Washington's Legislature and state agencies made continued progress to support expansion of the behavioral health crisis workforce and address workforce training needs. These efforts build on the workforce and training recommendations identified by the CRIS and Subcommittees in 2022. Specific highlights of progress made this year include:

- HB 1134 established requirements to engage a broad set of partners in an **assessment of Washington's crisis system training needs and develop recommendations for crisis workforce and resilience training collaboratives**. These collaboratives would offer foundational and advanced skills in crisis response plus foster regional collaboration.
- ✓ SB 5555 established **Certified Peer Specialists and Certified Peer Specialist Trainees** as new health professions that may engage in the practice of peer support services.
- ✓ **Several legislative bills passed to support expansion of the crisis system workforce** (HB 1069 Mental Health Counselor compact for out of state counselors; SB 5189 certification for behavioral health support specialists; HB 1724 helps get qualified behavioral health providers into the field as quickly and safely as possible.)

Committee Recommendations

In 2023, the CRIS and Subcommittees continued to underscore the need for an adequately trained, supported, and diverse workforce that can provide culturally responsive and linguistically appropriate crisis response services across the full continuum of care. Below are key areas of recommendations emphasized by the committees this year:

16. ***Expand a diverse workforce that shares language, culture, and experience with the populations being served.*** Committee members emphasized the need for a diverse behavioral health workforce that represents the populations being served as a cornerstone to improving Washington's crisis response system. Without an adequate workforce to provide care, attention to expanding and improving the system carries little value. Below are several specific recommendations identified:

    a. ***Continued emphasis on the need to integrate peer providers across the continuum of crisis response services and ensure an adequate wage for these workers.*** SB 5555, passed during the 2023 legislative session, was an important step to recognize peer providers as a new health profession and require insurance coverage for these services. Committees highlighted several issues to continue to address:
        - Engage proactive outreach to help organizations understand ways to integrate peers and maximize the important role they can play in client care.

- Support opportunities for culturally appropriate training to increase the Tribal peer workforce, and ensure Tribes are engaged in the Peer Support Specialist rule development.
- Understand and address limitations that Criminal Justice Information Services (CJIS) laws place on the ability of peers to work with law enforcement.

b. Establish requirements for translation and interpretation for crisis response services.

c. Establish a workgroup and engage consumer voice to develop recommendations to build and sustain a behavioral health workforce, including workforce pipeline programs that help to diversify the workforce. There is opportunity to learn from other states about strategies for funding and expansion of the workforce to help meet this need. Communities should also consider opportunities to partner with local community colleges to support crisis provider staffing needs.

d. Ensure parity in payment for behavioral health crisis providers, including but not limited to residential substance use disorder withdrawal management programs, and provide liability protection to crisis responders to reduce barriers to providing services. Committees emphasized the need to make sure behavioral health crisis care providers receive a living wage. As part of agency proposals for the upcoming 2024 legislative session, HCA included a request to provide liability protections to remove barriers for crisis responders to provide care without risk of liability.

e. Advise state agencies on diverse approaches to supporting caregivers. Committees recognized families and caregivers as a critical source of support for people in crisis. There is need to provide respite as well as develop systems to support families of a person in crisis, including resources to help with loss of income and skills to support a loved one in crisis.

17. Engage behavioral health providers and first responder partners in trauma-informed and youth-informed trainings to minimize potential harms and build trust across communities.
Committee members underscore the value of cross-system training to build a unified system response in Washington. This training should include the development of standardized training curriculum that may be tailored locally as needed, as well as evaluation components to measure training outcomes and results. This work should also engage people with lived experience and diverse consumer voices to advise on training curricula needed. Key training topic areas identified include:

- Overview of roles, authority, requirements, training, and approaches for responding to behavioral health crisis for both behavioral health care workers and first responders.
- Ensure 988 Lifeline crisis centers' training is responsive to diverse groups of youth at wide range of developmental levels and can support parents and caregivers in crisis to keep youth safe.
- Understanding and interacting with rural/agricultural communities.

- Understanding of the prevalence and effects of substance use disorders in behavioral health crisis, and responding in manner that is culturally appropriate and centered in equity.
- How to respond to and support people with intellectual and/or developmental disabilities.
- Implicit bias and recognizing and addressing power and privilege.
- Best practices for engaging with people who appear erratic or are exhibiting unmanageable behavior and understanding the difference between crisis situations where safety is a concern requiring involvement of law enforcement versus crisis situations that can be handled solely by a behavioral health team.
- Coordinate training as requested by the Tribal Mobile Crisis Response Workgroup and Tribal Partners.
- Expand mental health first aid training and education for laypeople. Consider mandating appropriate school-aged audiences take mental health first aid training.

7. Technology

State Agency & Legislative Progress in 2023

In 2023, DOH and HCA made continued progress to implement the Technical and Operational Plan completed in 2022 to support the development of integrated crisis system technology platform. Specific accomplishments in 2023 include:

- ✓ HCA and DOH **completed the Request for Information (RFI)** process to gather information from technology vendors to inform the development of Washington's call center and integrated client referral technology platform.
- ✓ HCA and DOH are currently working to **develop the Request for Proposal (RFP)** for the call center platform and behavioral health integrated client referral system, informed by information gathered through RFI.
- ✓ HB 1134 created a **988 Geolocation Subcommittee** to examine privacy issues to route 988 calls and texts based on a person's location, rather than area code.

Committee Recommendations

In 2023, Committee work has focused on informing the RFI and RFPs process led by HCA and DOH. The agencies asked the Technology Subcommittee for input throughout the RFI process. Currently, the agencies are working with system partners, as well as Technology Subcommittee volunteers, to refine the technical specifications in the RFP based on 988 crisis center needs, legislative requirements, and learnings from the RFI. Committee recommendations specific to the technology platform are otherwise not identified outside of this committee engagement to inform current agency work.

In addition, DOH and HCA are asking for input from diverse groups, including the Lived Experience and Tribal Subcommittees, to inform the 988 technology user experience and work to ensure a human-centered design for the technology platform.

In 2023, HB 1134 also established a new Geolocation Subcommittee to examine privacy issues related to federal planning efforts to route 988 calls and texts based on a person's location, rather than area code. Further work is anticipated for 2024 to engage this Subcommittee to inform understanding of these issues and state decisions where relevant.

8. Funding

State Agency & Legislative Progress in 2023

State agencies and the Legislature made continued progress in 2023 to support equitable funding of crisis services throughout Washington. Specific areas of progress include:

- ✓ HCA initiated **actuarial analysis for endorsed mobile response teams and development of performance payment options.** Preliminary actuarial report for payments to endorse mobile response teams will be delivered in January 2024, and final report will be submitted in Spring 2024.
- ✓ HCA is convening a workgroup with system providers per a 2023 budget proviso to **assess gaps in the current funding model for crisis services, including facility-based stabilization, and to recommend options** to address these gaps. A preliminary report with analysis of crisis system funding gaps will be submitted in January 2024 with a final report in spring 2024.
- ✓ HCA and the Washington Office of the Insurance Commissioner (OIC) are implementing **recommendations to support processes to bill commercial insurers** for behavioral health emergency response services, as guided by HB 1688 Workgroup.

Committee Recommendations

CRIS and Subcommittee recommendations continued to emphasize the need for adequate funding to support equitable distribution of crisis response services across Washington. To support this goal, Committees highlighted specific areas of focus below.

18. ***Provide additional funding to behavioral health crisis systems across regions, and plan for evaluating adequate distribution of resources:***
    a. ***Pursue consistent funding for mobile crisis response, rather than braided local funding to expand workforce and improve response times.***
    b. ***Provide additional funding to behavioral health crisis response systems in rural communities.***
    c. ***Consider enabling "payer blind" crisis services (i.e., services not just for Medicaid clients or commercially insured clients).*** Tribal Partners emphasized, for example, the need for the system to ensure seamless access to services for Tribal members covered by Medicaid FFS who may seek coverage through Medicaid managed care to access services from providers who do not otherwise accept Medicaid FFS.
    d. ***Ensure crisis service funding to the Medicaid FFS system, recognizing that many Tribal members are enrolled in Medicaid FFS rather than managed care.***

Section III. What We Need to Explore in 2024

In 2024, the Steering Committee, CRIS, and Subcommittees will build on committee work completed, with a focus on the following areas to develop recommendations to guide improvements to Washington's behavioral health crisis response and suicide prevention system:

1) ***System Quality and Oversight:*** In 2022 and 2023, CRIS and Subcommittees underscored system oversight and performance measurement as foundational work needed for holding the system accountable for achieving goals, ensuring system transparency, and building trust with communities. Committee work in 2024 will build on these initial recommendations and focus on a deeper discussion of system performance measures, oversight, and accountability.
2) ***System Infrastructure:*** To support implementation of Washington's goals, critical system infrastructure – technology, workforce, and cross-system collaboration – is needed. The committees will build on recommendations identified in 2023 and finalize any recommendations related to necessary infrastructure.
3) ***Crisis System Services and Funding:*** The Committees will continue to inform DOH's and HCA's continued work to implement expanded crisis services throughout Washington, and development of sustainable funding models to support these services.

Appendices

Appendix A: List of Acronyms Used in this Report

Acronym	Meaning	Acronym	Meaning
AI/AN	American Indian or Alaskan Native	MRRCT	Mobile Rapid Response Crisis Team
AIHC	American Indian Health Commission	MRSS	Mobile Response and Stabilization Service
BH	Behavioral Health	MRRCT	Mobile Rapid Response Crisis Team
BH-ASO	Behavioral Health Administrative Services Organization	NDA	Next Day Appointment
CJIS	Criminal Justice Information Services	NASMHPD	National Association of State Mental Health Program Directors
CRC	Crisis Relief Center	NPAIHB	Northwest Portland Area Indian Health Board
CRIS	Crisis Response Improvement Strategy Committee	NSLL	Native and Strong Lifeline
CSU	Crisis Stabilization Unit	NSPL	National Suicide Prevention Lifeline
DCR	Designated Crisis Responder	OCIO	Office of the Chief Information Officer
DEI	Diversity, Equity, and Inclusion	OIC	Washington State Office of the Insurance Commissioner
DOH	Department of Health	PSAP	Public Safety Answering Point (911 Call Center)
E&T	Evaluation and Treatment	RCL	Regional crisis line
ED	Emergency Department	RCW	Revised Code of Washington
EMS	Emergency Medical Service	RFI	Request for information
FFS	Fee-for-Service	RFP	Request for proposal
HB	House Bill	RT	Round table
HCA	Health Care Authority	SAMHSA	Substance Abuse and Mental Health Services Administration
ITA	Involuntary Treatment Act	SB	Senate Bill
HMA	Health Management Associates	SME	Subject Matter Expert
IHCP	Indian Health Care Provider	SUD	Substance Use Disorder
LE	Lived Experience	TCBHAB	Tribal Centric Behavioral Health Advisory Board
LGBTQIA2S+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, Two-Spirit	UIHO	Urban Indian Health Organization
MH	Mental Health	UIHP	Urban Indian Health Program

Appendix B: Definitions for Terms Related to Crisis Delivery

23-hour Crisis Relief Center: means a community-based facility or portion of a facility serving adults, which is licensed or certified by the department of health and open 24 hours a day, seven days a week, offering access to mental health and substance use care for no more than 23 hours and 59 minutes at a time per patient, and which accepts all behavioral health crisis walk-ins drop-offs from first responders, and individuals referred through the 988 system regardless of behavioral health acuity, and meets the requirements under RCW 71.24.916.

911: The universal emergency number across the US that typically dispatches to local police, fire, or sheriff departments.

988 Lifeline: The universal telephone number within the United States designated for the purpose of the national suicide prevention and mental health crisis hotline system operating through the national suicide prevention lifeline (RCW 71.24.025).

988 Contact Hubs: A state-designated contact center that streamlines clinical interventions and access to resources for people experiencing a behavioral health crisis and participates in the national suicide prevention lifeline network to respond to statewide or regional 988 contacts that meets the requirements of RCW 71.24.890.

Behavioral Health Aide: means a counselor, health educator, and advocate who helps address individual and community-based behavioral health needs, including those related to alcohol, drug, and tobacco abuse as well as mental health problems such as grief, depression, suicide, and related issues and is certified by a community health aide program of the Indian health service or one or more tribes or tribal organizations consistent with the provisions of 125 U.S.C. Sec. 1616l and RCW 43.71B.010 (7) and (8).

Community-based Crisis Team: A team that is part of an emergency medical services agency, a fire service agency, a public health agency, a medical facility, a nonprofit crisis response provider, or a city or county government entity, other than a law enforcement agency, that provides the on-site community-based interventions of a mobile rapid response crisis team for individuals who are experiencing a behavioral health crisis (RCW 71.24.025).

Crisis Stabilization Facility: A short-term facility or portion of a facility that has been designed to assess, diagnose and treat persons experiencing an acute crisis without the use of long-term hospitalization. Also referred to as Crisis Stabilization Units (CSU). (RCW 71.05.020)

Crisis Stabilization Services: Means services such as 23-hour crisis relief centers, crisis stabilization units, short-term respite facilities, peer-run respite services, and same-day walk-in behavioral health services, including within the overall crisis system components that operate like hospital emergency departments that access all walk-ins, and ambulance, fire, and policy drop-offs, or determine the need for involuntary hospitalization of an individual (RCW 71.24.025).

Evaluation and Treatment Facility: means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the Department of Health. The Health Care Authority may certify single beds as temporary evaluation and treatment beds under RCW 71.05.745. A physically separate and

separately operated portion of a state hospital may be designated as an evaluation and treatment facility.

Indian Health Care Provider: means a health care program operated by the Indian health service or by a tribe, tribal organization, or urban Indian organization as those terms are defined in the Indian health care improvement act (25 U.S.C. Sec. 1603).

Intensive Behavioral Health Facilities: A specialized residential treatment facility for people with behavioral health conditions, including people discharging or being diverted from state and local hospitals, whose impairment or behaviors do not meet, or no longer meet, criteria for involuntary inpatient commitment, but whose care needs cannot be met in other community placement settings.[17]

Peer Respite: A peer-run facility to serve people in need of voluntary, short-term, non-crisis services that focus on recovery and wellness. (RCW 71.24.025).

Psychiatric Hospital Beds: Inpatient mental health facilities where people may go voluntarily or involuntarily.

Designated Crisis Responder (DCR): a mental health professional appointed by the county, by an entity appointed by the county, or by the authority in consultation with a federally recognized Indian tribe or after meeting and conferring with an Indian health care provider, to perform specified duties. RCW 71.05.020

Emergency Medical Services (EMS): Also considered first responder services, EMS are typically ambulance or paramedic services, and operate within a system of coordinated response and emergency medical care that is integrated with other services and systems with the goal to maintain and enhance the community's health and safety.[18]

Evaluation and Treatment Facilities (E&Ts): E&Ts are free-standing or hospital-based facilities that are certified by the Department of Health to provide acute psychiatric inpatient care to people detained under the Involuntary Treatment Act (RCW 71.05 and 71.34). This level of care provides evaluation, diagnosis, treatment, and stabilization of acute symptoms.[19]

Historical Trauma: The Washington Community Behavioral Health Services Act defines "historical trauma" as situations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were perpetuated by outsiders with a destructive or genocidal intent.

[17] See Crisis Triage/ Crisis Stabilization Facilities Fact Sheet. (May 2022). Retrieved from file:///C:/Users/npinson/Downloads/BHF%20HCA-external-fact-sheet-Crisis%20Triage%20and%20Stabilization%20Facilities%20Adult%20Youth%20FInal%20(2).pdf

[18] Office of EMS, *What is EMS?*, Available at https://www.ems.gov/whatisems.html

[19] Washington State Health Care Authority, *Health Care Supports and Services* (2021) available at https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/acute-mental-health-care-inpatient

Hospital Emergency Departments (ED): The department of a hospital responsible for the providing medical and surgical care to patients arriving at the hospital in need of immediate care. The emergency department is also called the emergency room or ER.[20]

Involuntary Treatment Act Investigation: The DCR conducts an evaluation and investigation pursuant to chapters 71.05 and 71.34 RCW. This investigation is conducted to determine if a person presents a harm to self, others, property; needs assisted outpatient behavioral health treatment; is gravely disabled and at imminent risk; or has a nonemergent risk due to a substance use disorder or other behavioral health condition.[21]

Mobile Rapid Response Crisis Team: means a team that provides professional on-site community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for individuals who are experiencing a behavioral health crisis, that shall include certified peer counselors as a best practice to the extent practicable based on workforce availability, and that meets standards for response times established by the Health Care Authority.

Mobile Response and Stabilization Services: A MRRCT that provides developmentally appropriate crisis outreach when youth and families ask for help. MRSS is screened in, not out, and breaks down barriers to care by allowing the caller to define the crisis. This promotes upstream interventions designed to interrupt the pathways leading to more restrictive, facility-based care and emergency department use for behavioral health needs. Teams can follow up for 8 weeks to stabilize the family and keep youth safe at home.

Outpatient Treatment Facilities: Facilities that provide behavioral health services to people who live in the community. These facilities do not provide inpatient beds.[22]

Residential Treatment Facilities: Residential treatment facilities (RTFs) are licensed, community-based facilities that provide 24-hour inpatient care for people with mental health and/or substance use disorders in a residential treatment setting.[23] This license is often combined with endorsements to provide services in the RTF that include E&Ts, CSUs, and withdrawal management.

Secure Withdrawal Management and Stabilization: A facility that provides care to voluntary individuals and individuals involuntarily detained and committed for whom there is a likelihood of serious harm or who are gravely disabled due to the presence of a substance use disorder.[24]

Substance Abuse Treatment Facilities: All other substance abuse treatment facilities that provide treatment to people living with substance use disorders.[25]

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[20] MedicineNet, *Medical Definition Of Emergency Department* (2021) available at https://www.medicinenet.com/emergency_department/definition.htm
[21] Washington State Health Care Authority, *Designated Crisis Responders* (2021) available at https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/designated-crisis-responders-dcr
[22] Washington Behavioral Health Facilities Program Report (2020).
[23] Washington State Department of Health, *Residential Treatment Facilities* (2021) available at https://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/ResidentialTreatmentFacilities#:~:text=Residential%20treatment%20facilities%20(RTF)%20are,in%20a%20residential%20treatment%20setting.
[24] Washington Behavioral Health Facilities Program Report (2020).
[25] Washington Behavioral Health Facilities Report (2020)

Appendix C. History of Tribal Centric Behavioral Health Crisis System Efforts

Tribes have a longstanding history with barriers in accessing needed crisis services for their Tribal members. Washington State's movement towards managed care and crisis services supported through a county and regional system did not provide resources to Tribal governments to fund services to members within their communities. Issues relate to access to timely services, honoring of Tribal court orders and clinical assessments, and funding to support Tribal crisis resources. The Tribes have worked with the state to advocate and develop plans to:

- Improve crisis services for Tribal members and urban Native people across the state
- Address longstanding barriers to access to care and the significant crisis and mental health outcomes for AI/AN people

AI/AN people and families navigating behavioral health crises experience extensive wait times for ITA evaluations and mobile crisis response. At times, the tribe may not agree with the DCR's ITA evaluation of a Tribal member.

Tribes have led efforts to pass legislation in Washington to address inequities experienced by Tribal members in the crisis response system through the Indian Health Improvement Act (RCW 43.71B)[26] and the Indian Behavioral Health Act (SB 6259).[27]

In 2013, the Tribes, Indian Policy Advisory Committee, and the Department of Social and Health Services developed a report to the legislature that outlined the following crisis improvement recommendations to improve the Tribal Centric Crisis System:

- Timely and equitable access to crisis services for AI/AN people
- Improved ability to have designated crisis responders (formally DMHPs)
- Notification and coordination by evaluation and treatment facilities when discharging AI/AN people from care
- Legislation to allow Tribal courts to issue ITA commitments for Tribal citizens
- Training for non-Tribal DCRs for evaluations of AI/AN people
- Conduct feasibility study for one or more E&T facilities to serve AI/AN people in need of inpatient psychiatric care

Between the years of 2016 – 2023, the State has supported work to establish and maintain planning efforts to support the feasibility study for one or more E&T facilities per the recommendation of the 2013 report. The Tribes met to establish a workgroup in 2017 and have continued working on this plan since its development in 2019. The robust plan outlined goals and activities to address crisis services for AI/AN people and create a successful culturally appropriate behavioral health crisis facility. Activities put into action by the workgroup include:

[26] Washington State Senate Bill 5415, 2019. Accessed at: https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Senate%20Passed%20Legislature/5415.PL.pdf
[27] Washington State Senate Bill 6259, 2020. Accessed at https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/6259-S.SL.pdf?q=20211115124634

- Continued planning on the development of a culturally appropriate Tribal inpatient behavioral health facility managed by the TCBHAB.
- Development of Tribal DCRs (T-DCR), appointed by the tribe and appointed by HCA for state jurisdiction processes, that can evaluate anywhere and with anyone in the state.
- Funding support for T-DCR services.
- Legislation to enhance tribes' ability to provide crisis services to their Tribal and community members, including notification to tribes for ITA investigations of Tribal members and AI/AN people with an Indian Health Care Provider (IHCP) as a medical home.[28]
    - Training and technical assistance to tribes and IHCPs on enhancing crisis services, including development of T-DCR Tribal Codes, DCR processes and procedures/T-DCR protocols, operationalization of T-DCR, tabletop exercise for tribes.
    - Training and technical assistance to non-Tribal crisis providers and DCRs on working with AI/AN people and Tribal communities, including reviewing and providing feedback on the DCR protocols.
    - Improvements to the Tribal Crisis Coordination Protocols template and processes.
    - The Native and Strong Lifeline and Native Resource Hub.
- Establishment of a formal Tribal Centric Behavioral Health Advisory Board (TCBHAB) to oversee these activities

In addition to the statewide Tribal/state crisis improvement projects, the 29 tribes are at different stages of implementation of crisis services. Under the self-determination act, Tribes have moved toward implementation of crisis services for their Tribal and community members. Several Tribes have crisis lines available either on a workday basis or 24/7 basis. Several tribes are working on establishing Tribal designated crisis responders who will conduct ITA evaluation and investigations through the state system as well as through their Tribal court systems. Tribes are also exploring mobile crisis response teams and crisis facilities.

The state is working to ensure that we account for the diversity of Tribal and Urban Indian Health Organization resources and protocols for engaging with Tribes and urban Indian organizations when serving AI/AN people in crisis and in need of behavioral health resources. Some of these efforts include completing the State/Tribe Tribal Crisis Coordination Protocols, ensuring others working in the crisis system are aware of these protocols, and the developing the Native and Strong Lifeline and Native Resource Hub.

[28] Senate Bill 6259 (2020, enrolled). Retrieved from https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/6259-S.SL.pdf?q=20221127130523

Appendix D: Summary of Tribal Consultation Process and Tribal Feedback

For this *January 1, 2024 Committee Progress Report*, the Tribal consultation process included a Tribal Roundtable held on November 29, 2023 and a formal Tribal Consultation on December 13, 2023. A summary of tribal feedback through the Tribal Roundtable and Consultation is provided in this Appendix D. All of the Tribal feedback received has been addressed and integrated into this report.

In addition to the Tribal Consultation process, the HB 1477 Tribal 988 Subcommittee, through the Tribal Centric Behavioral Health Advisory Board, has played an important advisory role to HB 1477 committee work regarding Tribal perspectives and the existing Tribal efforts to improve the behavioral health crisis response system for Tribal members. A summary of Tribal feedback through the Tribal Roundtables and Consultation, as well as through the Tribal 988 Subcommittee, is provided below in Table D.1.

Table D.1. Summary of Tribal Feedback and References Integrated Throughout the HB 1477 Committee Progress Report (January 1, 2024)		**Page #**
Legislative Requirements		
Committee Structure	○ Visual of committee structure includes Tribal representatives on the CRIS committee and the Tribal 988 Subcommittee	Page 2
Executive Summary		
Committee Recommendations	○ Reference to Tribal Consultation Process and recognition of exiting Tribal processes and governing bodies to address Tribal behavioral health and crisis system needs and gaps. ○ Recommendation 6: Build upon Tribal Behavioral Health Crisis System Improvements ○ Recommendation 15: Develop cross-system coordination protocols between Tribal and state and local systems. ○ Technology: engaged input from the Tribal 988 Subcommittee ○ Funding: Ensure crisis service funding to the Medicaid Fee-for-Service System.	Pages 3-5
Section I: Background		
Committee Work in 2023	○ Reference to CRIS tribal representatives and Tribal 988 Subcommittee	Page 7
Tribal Consultation	○ Overview of Tribal Consultation Process	Pages 8-9
Section II. Committee Recommendations		
1. Vision	○ Vision and guiding principles informed by Tribes during 2022 process to develop. ○ Guiding principles include: care that is responsive to cultural needs and system that is operated in a manner that honors	Page 11

Table D.1. Summary of Tribal Feedback and References Integrated Throughout the HB 1477 Committee Progress Report (January 1, 2024)		**Page #**
	Tribal government to government process.	
2. Equity	○ Recommendation 5: Emphasized need for investments to support the Native and Strong Lifeline and Native Resource Hub communication campaign. ○ Recommendation 6: Build upon Tribal Behavioral Health Crisis System Improvements and support 2024 Tribal behavioral health crisis legislative priorities. ○ Recommendation: 8: A 988 DEI Director could build upon this work and bring a statewide perspective, as well as include appropriate Tribal government-to-government relations and work with Tribal liaisons across the state.	Pages 13-14
3. Services	○ *A Place to Call:* ▪ Tribal partners highlighted the need for a 988 text and chat option for the Native and Strong Lifeline. ▪ Highlighted data regarding increasing call volume to the NSLL and added links to the NSLL and Native Resource Hub websites. ▪ Tribal partners provided input into DOH's 988 contact hub draft rule development process. ○ *Someone to Come:* ▪ Tribal Partners support continued work to develop Tribal mobile rapid response crisis teams as well as Tribal Designated Crisis Responders. As HCA works to establish mobile team endorsement standards outlined in HB 1134, Tribes are working with the agency to establish endorsement standards and ensure capacity funding specific to Tribal teams. ○ *A Place to Go:* ▪ Tribal partners: Ensure that the range of state and local crisis stabilization services (e.g., peer respite, crisis receiving centers, in-patient care) are culturally tailored for Tribal members. In addition, Tribal partners identified opportunities to support expansion of Tribal in-patient facilities through strategies including additional state funding, transfer of public lands to Tribes to build a facility, and removal of licensing and certification barriers. ▪ DOH received input from committee members, Tribal partners, and the public on licensure requirements for the new Crisis Relief Centers for adults established by SB 5120.	Pages 16-18
4. Quality and Oversight	[*This will be HB 1477 Committee focus area for 2024*] ○ Work with Tribes to identify system performance metrics and outcomes.	Page 19

Table D.1. Summary of Tribal Feedback and References Integrated Throughout the HB 1477 Committee Progress Report (January 1, 2024)		**Page #**
	○ Recognize Tribal Data Sovereignty.	
5. Cross-System Collaboration	○ Recommendation 15: Develop cross-system coordination protocols between Tribal and state and local systems (including 911, 988, the Native and Strong Lifeline, the Native Resource Hub, local Tribal crisis lines, Hospitals, Indian Health Care Providers, and Tribal Public Safety and Tribal First Responders). Tribal partners highlighted opportunities to develop and implement HCA-Tribal Crisis Coordination Plans.	Page 22
6. Staffing and Workforce	○ Recommendation 16: includes reference to support opportunities for culturally appropriate training to increase the Tribal peer workforce, and ensure Tribes are engaged in the Peer Support Specialist rule development; also highlights recommendation to coordinate training requested by the Tribal Mobile Crisis Response Workgroup.	Pages 24 - 25
7. Technology	○ DOH and HCA are engaging Tribal input into the technology system user-experience work to ensure the system design is human-centered.	Page 26
8. Funding	○ Recommendation 18: highlights need to ensure crisis service funding to the Medicaid FFS system, recognizing that many Tribal members are enrolled in Medicaid FFS rather than managed care. Emphasizes need for the system to ensure seamless access to services for Tribal members covered by Medicaid FFS who may seek coverage through Medicaid managed care to access services from providers who do not otherwise accept Medicaid FFS.	Page 27
Work Ahead in 2024		
What we need to explore in 2024	○ General overview of 2024 focus areas: • System Quality and Oversight • System Infrastructure (technology, workforce, cross-system collaboration) • Crisis System Services and Funding	Page 28
Appendices		
Appendix A: Acronyms	○ AI/AN American Indian or Alaska Native people ○ AIHC American Indian Health Commission ○ IHCP Indian Health Care Provider ○ NPAIHB Northwest Portland Area Indian Health Board ○ NSLL Native and Strong Lifeline ○ TCBHAB Tribal Centric Behavioral Health Advisory Board ○ UIHO Urban Indian Health Organization (also referred to an Urban Indian Health Program or UIHP)	Page 29

Table D.1. Summary of Tribal Feedback and References Integrated Throughout the HB 1477 Committee Progress Report (January 1, 2024)		**Page #**
Appendix B: Definitions	○ Historical Trauma	Page 32
Appendix C: History of Tribal Center Behavioral Health Crisis System Efforts	○ Note: this section is excerpted from the HB 1477 Final Technical and Operational Plan (Appendix E) to ensure a summary of the history of tribal work to address the behavioral health crisis system is recognized within HB 1477 committee recommendations to improve Washington's behavioral health crisis response and suicide prevention system.	Pages 33
Appendix D: Summary of Tribal Consultation Process and Feedback	○ Summarizes Tribal feedback received through the 2023 Tribal Consultation Process, the 988 Tribal Subcommittee, TCBHAB, and the American Indian Health Commission (AIHC).	Pages 35
Appendix E: Subcommittee Report	○ Includes link Tribal 988 Subcommittee meeting information through the TCBHAB.	Page 39
Appendix F: Behavioral Health Crisis Response and First Responder Collaboration Workgroup Recommendations	○ Workgroup included Tribal representatives	Page 40

Appendix E: 2023 Subcommittee Report

The 2023 Subcommittee Report includes a compilation of all HB 1477 subcommittee meeting summaries in 2023, and is available on the CRIS webpage: https://www.hca.wa.gov/assets/program/cris-subcommittee-report-2023.pdf

Appendix F: Behavioral Health Crisis & First Responder Collaboration Recommendations

The CRIS formed a Behavioral Health Crisis & First Responder Collaboration Workgroup in 2023 to further CRIS discussions regarding collaboration between behavioral health and first responders in Washington's behavioral health crisis response system. Workgroup members included a subset of CRIS members as well as additional members representing lived experience and system subject matter experts. The workgroup met approximately five times in May and June 2023, and developed a working vision, guiding principles, current barriers, and set of recommendations summarized below.

The CRIS 2023 recommendations throughout this report reflect the workgroup recommendations. A crosswalk between CRIS and workgroup recommendations is indicated in [brackets] after each workgroup recommendation below.

Working Vision

Washington has an appropriate, effective, equitable and safe collaboration between behavioral health crisis response and fire, police, and emergency medical services (first responders).

Emerging Guiding Principles

1. Shared goal to move towards a more collaborative approach with aligned and complimentary systems.
2. People with lived experience should be included in every aspect of this work.
3. This is not about *if* first responders and mobile crisis response will collaborate, but rather *how* they will collaborate.
4. This is about systems, not individuals. We can critique a system while still acknowledging that good people work within them.
5. Ensure collaboration and partnership with Tribes in a manner that respects their sovereignty.

Barriers to this Vision

What gets in the way of having appropriate, effective, equitable and safe collaboration between behavioral health crisis response and first responders (fire, police, and emergency medical services)?

1. Lack of adequate or consistent training, integrated systems, and shared understanding of roles, responsibilities, authority, and approaches between BH and First responders including across 988 and 911.
2. Lack of consistent and clear processes for determining when a behavioral health crisis has an existing safety risk component that requires first responders which can lead to an inappropriate response to the level of need.
3. Lack of parity in funding for crisis system (at systems level) which result in 911/emergency room being the default. Additional challenges with livable wages and workforce retention across all systems.
4. Lack of trust and relationships between systems, between systems and communities, etc. (behavioral health, first responder, hospital/ER systems).
5. The "crisis system" is not consumer or community centered or easy to access. Nor is there consistency or a baseline level of services between all the regions.
6. Lack of a shared vision for Co-Response models in Washington leading to differences in standards, implementation, oversight, and outcomes.

7. Concerns over consumer confidentiality and presence of body cams.
8. Access barriers due to concerns over US Immigration and Customs Enforcement involvement.
9. Complex social and medical needs combined with lack of resources further exacerbating crisis situations.

Summary of Behavioral Health Crisis Response and First Responder Collaboration Workgroup Recommendations *** Some recommendations span multiple pillars.**	
Pillar 1: Leadership	1. Form a workgroup, in partnership with the Co-Response Outreach Network (CROA), to develop the protocols, best practices, training, and other resources to support co-response in Washington in manner that allows first responders and behavioral health professionals to have co-ownership in system. **[*CRIS recommendation 17*]** 2. Create a Washington Behavioral Health and Crisis System workgroup to research and develop recommendations to build and sustain behavioral health workforce including workforce pipeline programs that help to diversify the behavioral health workforce. **[*CRIS recommendation 16*]** 3. Encourage regular cross collaboration and partnership. For example, hold annual conferences, engage quarterly workgroup meetings with representatives across systems as part of the co- response workgroup. **[*CRIS recommendation 12*]** 4. Invite behavioral health professionals to serve on the Criminal Justice Training Commission. **[*CRIS recommendation 17*]**
Pillar 2: Resources	1. Advocate for increased resources for all systems supporting the crisis response system to ensure a living wage, adequate resources, and workforce stability with a focus on behavioral health. **[*CRIS recommendation 16*]** 2. Fund more prevention services to avoid need for crisis. **[*CRIS recommendation 10*]**
Pillar 3: Policies	1. Convene a workgroup with representatives from first responders, behavioral health staff, people of color, and people with lived experience (and intersections of these identities) to make recommendations about how to determine and define how to assess safety risk in behavioral health crisis and appropriate response. This should include establishing shared understanding or definition of "safety" that acknowledges and takes into account how racism and bias show impact this. Any policy decisions should lead to the development of standardized protocols for implementation. It should include identifying what data and indicators to monitor to assess impact. **[*CRIS recommendation 1*]** 2. Advocate for policy changes related to public information requests and body cam footage for when there are patient confidentiality concerns. **[*CRIS recommendation 12*]** 3. Include requirements for translation services for crisis response services and invest in culturally specific service providers. **[*CRIS recommendation 16*]**

Summary of Behavioral Health Crisis Response and First Responder Collaboration Workgroup Recommendations *** Some recommendations span multiple pillars.**	
	4. Advocate for policy changes that bar immigration status to be used in behavioral health crisis response situations (mostly through requirements for first responders to identify individuals)- likely through removal of the requirement for identifying the person in crisis. **[*CRIS recommendation 12*]** 5. Advocate for lessening CJIS (laws that prevent Peers to have access to working within law enforcement). **[*CRIS recommendation 16*]**
Pillar 4: Procedures, Workflows, Protocols	1. Develop protocols for determining who is "lead" in the field based on safety issues and how and when that shifts. Should start with behavioral health as automatic lead unless safety concerns are present. Also needs to address how implicit bias and racism impact staff of color in the field and interactions/dismissal by first responders. **[*CRIS recommendation 12*]** 2. Establish a consensus on the rights of people in crisis and create a "caller bill of rights." Focus on informed consent for community. Develop clear materials for communities on what to expect when they call. Develop monitoring plan to include in system oversight to assess trends. **[*CRIS recommendation 2*]** 3. Ask co-response group to tackle developing core standards for embedded co-response programs that are consistent no matter which system they reside in. **[*CRIS recommendation 12*]** 4. Build upon current 988 dispatch protocols to include 911 but do this through a collaborative workgroup of people from both systems and then train - scale and spread. **[*CRIS recommendation 12*]** 5. Develop and spread best practices for effective handoffs between systems with a goal of being least restrictive response. This should be addressed in the workgroup that is charged with expanding and spreading the 988 dispatch protocols. **[*CRIS recommendation 12*]** 6. Look at the Stepping Up initiative with a goal of it being in all counties in Washington **[*CRIS recommendation 17*]** 7. Develop and pilot a crisis response and first responder collaboration in a region that is receptive to developing more of a "shared system" and capture best practices and spread. **[*CRIS recommendation 13*]** 8. Prioritize SIM and Crisis Intervention Training (CIT), not just the 40 hour training but true collaboration across all systems. **[*CRIS recommendation 17*]**
Pillar 5: Training	1. Partner with people with lived experience to create and require participation in a comprehensive training curriculum for behavioral health and first responders that includes: **[*CRIS recommendation 17*]** - overview of roles, authority, requirements, training, and approaches for responding to behavioral health crisis for both behavioral health and first responders - implicit bias and recognizing and addressing power and privilege - best practices for engaging with people who are appear erratic or non-

Summary of Behavioral Health Crisis Response and First Responder Collaboration Workgroup Recommendations *** Some recommendations span multiple pillars.**	
	compliant - understanding difference between safety issues and behavioral health crisis - person-first and respectful interactions (cultural responsiveness and trauma-informed) 2. Develop and implement cross training and ride alongs across systems. [***CRIS recommendation 17***] 3. Develop and launch a community outreach and education campaign on 911 and 988 system and co response. [***CRIS recommendation 5***] 4. Create behavioral health lexicon/glossary and share across systems and for community education campaigns. [***CRIS recommendation 5***] 5. Build out training on "client-centered services, systems, and approaches" to start a paradigm shift for workforce. [***CRIS recommendation 17***] 6. Develop training for first responders and crisis response on confidentiality laws and use of data and body cam footage so everyone understands dos and don'ts. [***CRIS recommendation 17***] 7. Include more information on medical clearance process, rules, and practices in all training. [***CRIS recommendation 17***] 8. Include messaging on immigration status and process/policies in community education and training. [***CRIS recommendation 17***] 9. Expand on the work happening under Mental Health Advanced Directives that can help advise on community education campaigns, and champion things that make the system more client- centered including behavioral health release of information or mental health advanced directive. Incorporate into integrated platform. [***CRIS recommendation 3***] 10. Standard Dementia crisis intervention and transport for all first responders. [***CRIS recommendation 17***]
Pillar 6: Monitoring and Accountability	1. Do root cause analysis on lack of trust issue between systems and systems and community (behavioral health and first responders and between both systems and communities) - then acknowledge causes and work to develop solutions. [***CRIS recommendation 12***] 2. Conduct an audit to ensure alignment with current CIT training standards for co-response programs in Washington. [***CRIS recommendation 11***] 3. Spread 988 dispatch protocols and monitor for implementation. [***CRIS recommendation 11***]

Appendix G. CRIS Committee 2023 Workgroups

Crisis Response Dispatch Protocols Workgroup	
MEMBER INFORMATION:	
MEMBER NAMES:	1. Adam Wasserman (911) 2. Anna Nepomuceno (NAMI) 3. Jan Tokumoto (988 center) 4. Joe Avalos (Thurston-Mason BH-ASO) 5. Kashi Arora (Children and Youth) 6. Kathryn Akeah (American Indian Health Commission) 7. Kim Mosolf (Police accountability) 8. Kristen Wells (Lived Experience) 9. Levi Van Dyke (988 center) 10. Michelle McDaniel (988 center) 11. Michael McAuley (North Sound BH-ASO) 12. Michael Robertson (Lived Experience) 13. Puck Franta (Lived Experience) 14. Ron Harding (Law enforcement)
AGENCY STAFF LEADS	1. Matt Gower and Sherry Wylie (HCA) 2. Lonnie Peterson (DOH)
MEMBERSHIP CRITERIA:	Subset of CRIS Committee members
MEETING'S:	Two meetings: 1. May 4, 3:00-4:30pm 2. May 17, 1-2:30pm
PURPOSE:	This group will review and provide input into draft crisis response dispatch protocols that have been developed by HCA and partners. The protocols are intended to standardize guidelines for when and how to dispatch crisis response resources. The workgroup will support HCA's review of the documents in advance of bringing to the full CRIS Committee to ensure they are useful and reflect Washington's crisis response system vision and guiding principles. The dispatch protocols will be part of the Crisis Response Best Practice Guidelines due by July 1, 2023. The Guidelines will be continuously updated and incorporate changes as HB 1477 is rolled out.

Behavioral Health Crisis Response & First Responder Collaboration Workgroup	
MEMBER INFORMATION:	
MEMBER NAMES:	1. Adam Wasserman (911) 2. Bethany Phenix-Osgood (Tribal Liaison, Aging & Long Term Care of E. WA) 3. Brittany Miles (Lived Experience) 4. Christal Eshelman (Carelon BH-ASO) 5. Dianne Boyd (Children's Crisis Outreach Response System) 6. Gordon Cable (Greater Columbia BH-ASO) 7. Heather Sanchez (Veterans) 8. Jan Tokumoto (988 center) 9. Jessica Shook (Crisis responders – DCR and MCR) 10. Kashi Arora (Children and Youth) 11. Kelly Waibel, Crisis Intervention Specialist, Tulalip Tribes 12. Kim Mosolf (Police accountability) 13. Levi Van Dyke (988 center) 14. Marie Fallon (Lived Experience) 15. Puck Franta (Lived Experience) 16. Ron Harding (Law enforcement)
AGENCY STAFF LEADS	1. Matt Gower and Sherry Wylie (HCA) 2. Lonnie Peterson (DOH)
MEMBERSHIP CRITERIA:	Subset of CRIS Committee members and identified system subject matter experts
MEETINGS:	Three meetings 1. May 11, 3:00-5:00 pm 2. May 25, 3:00-5:00 pm 3. June 1, 3:00-5:00 pm 4. June 22, 3:00-5:00 pm 5. June 29, 3:00-5:00 pm
PURPOSE:	This group will meet to further the CRIS Committee discussion regarding collaboration between behavioral health and first responders (fire, emergency medical services, and law enforcement) in Washington's crisis response system. Workgroup discussions will inform the CRIS and the Steering Committee as they develop recommendations for Washington's behavioral health crisis response system.