Behavioral Health Crisis & First Responders Collaboration Workgroup Update for the CRIS Committee (July 17, 2023)

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 Recommendations (DRAFT) *Note – 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. 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. 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. 4. Invite behavioral health professionals to serve on the Criminal Justice Training Commission.
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. 2. Fund more prevention services to avoid need for crisis
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. 2. Advocate for policy changes related to public information requests and body cam footage for when there are patient confidentiality concerns 3. Include requirements for translation services for crisis response services and invest in culturally specific service providers 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 5. Advocate for lessening CJIS (laws that prevent Peers to have access to working within law enforcement)
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. 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. 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. 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.

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	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 6. Look at the Stepping Up initiative with a goal of it being in all counties in Washington 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. 8. Prioritize SIM and Crisis Intervention Training (CIT), not just the 40 hour training but true collaboration across all systems
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: - 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-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 3. Develop and launch a community outreach and education campaign on 911 and 988 system and co response 4. Create behavioral health lexicon/glossary and share across systems and for community education campaigns 5. Build out training on "client-centered services, systems, and approaches" to start a paradigm shift for workforce 6. Develop a 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 7. include more information on medical clearance process, rules, and practices in all training 8. Include messaging on immigration status and process/policies in community education and training 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. 10. Standard Dementia crisis intervention and transport for all first responders
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 2. Conduct an audit to ensure alignment with current CIT training standards for co-response programs in Washington 3. Spread 988 dispatch protocols and monitor for implementation