

MEETING SUMMARY

CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE MEETING SUMMARY

Wednesday, February 15, 2023; 3:00 pm – 6:00 pm
Zoom

Meeting Agenda, Slides and Recording are available on the CRIS webpage:
<https://www.hca.wa.gov/about-hca/behavioral-health-recovery/crisis-response-improvement-strategy-cris-committees>

ATTENDEES

COMMITTEE MEMBERS

Adam Wasserman, Washington State Emergency Management Division
Amber Leaders, Office of Governor Jay Inslee
Anna Nepomuceno, National Alliance on Mental Illness (NAMI) Washington
Bipasha Mukherjee, Volunteer
Caitlin Safford, Amerigroup
Claudia D'Allegrì, Sea Mar Community Health Centers
Darcy Jaffe, Washington State Hospital Association
Dillon Nishimoto, Asian Counseling and Referral Service
Ellen Carruth, Behavioral Health Counselor and Supervisor, Resonant Relationships
Heather Sanchez, American Lake Veterans Affairs
Jan Tokumoto, Frontier Behavioral Health
Jane Beyer, Washington State Office of the Insurance Commissioner
Jennifer Stuber, UW School of Social Work & Co-Founder Forefront Suicide Prevention
Jessica Shook, Olympic Health and Recovery Services
Joan Miller, Washington Council for Behavioral Health
Kashi Arora, Community Health and Benefit, Seattle Children's
Keri Waterland, Washington State Health Care Authority (HCA)
Kimberly Hendrickson, Poulsbo Fire CARES program
Kimberly Mosolf, Disability Rights Washington
Levi Van Dyke, Volunteers of America Western Washington
Linda Grant, Evergreen Recovery Centers
Marie Fallon, Associated Ministries
Megan Celedonia, Office of Governor Jay Inslee
Michael Reading, Behavioral Health and Recovery Division, King County
Michele Roberts, Washington State Department of Health (DOH)
Puck Kalve Franta, Access & Inclusion Consultant
Robert Small, Premera Blue Cross
Ron Harding, City of Poulsbo
Representative Tina Orwall, Washington State House

COMMITTEE MEMBERS ABSENT

Justin Johnson, Spokane County Regional Behavioral Health Division

HEALTH MANAGEMENT ASSOCIATES



Krystina Felix, The Kalispel Tribe
Michael Robertson, Jaspr Health
Michelle McDaniel, Crisis Connections
Representative Tom Dent, Washington State House
Senator Judy Warnick, Washington State Senate
Senator Manka Dhingra, Washington State Senate
Summer Hammons, Treaty Rights/Government Affairs

AMERICAN SIGN LANGUAGE (ASL) INTERPRETERS

Melissa Shaw
Aaron Medlock

COMMITTEE STAFF

Betsy Jones, Health Management Associates
Jamie Strausz-Clark, Third Sector Intelligence (3Si)
Mark Snowden, Harborview Medical Center
Nicola Pinson, Health Management Associates
Brittany Thompson, Health Management Associates
Chloe Chipman, Health Management Associates (Leavitt Partners)

WELCOME, INTRODUCTIONS, AND TECHNOLOGY REVIEW

Jamie Strausz-Clark, 3Si, convened the meeting and reviewed use of Zoom features to ensure understanding among meeting participants regarding use of Zoom meeting technology and expectations for committee members and public observers. CRIS Committee member Kashi Arora welcomed everyone to the meeting, emphasizing appreciation for everyone's continued commitment improving crisis response system in the state.

In place of a land acknowledgement, Native & Strong Lifeline call center staff, Rosalie Lynd, Heaven Arbuckle, and Robert Coberly, shared reflections of their experiences supporting their native communities through the Native and Strong Lifeline. The three counselors shared ways in which their identity has helped them to better support native people in crisis. The counselors discussed their unique abilities to empathize with and support their communities, their strengthened beliefs in the critical nature of crisis response, and their gratitude toward meeting attendees for improving Washington's system to support people in crisis.

Jamie then introduced the two new CRIS Committee members: Marie Fallon, serving in the CRIS seat representing Lived Experience, and Kim Mosolf, serving in the CRIS seat representing a social justice organization and addressing police accountability and use of deadly force.

MEETING OBJECTIVES AND AGENDA

Jamie reviewed the meeting agenda and objectives for each agenda item. This meeting of the Washington Crisis Response Improvement Strategy Committee had six objectives:

1. Understand where we've been, where we are now, and where we are going in the CRIS process.

2. Answer questions from CRIS committee members about updates in the monthly CRIS e-newsletter. Jamie noted the e-newsletter will be shared in advance of calls and on the Washington State Health Care Authority CRIS Committee webpage moving forward.
3. Review, discuss, and gain clarity on how mobile crisis teams and co-responder services are distributed regionally and by population.
4. Gather CRIS member input to inform how we approach future discussions about expanding mobile crisis team services.
5. Confirm action items and next steps.
6. Hear public comment. Jamie noted there were no public comment requests for the call at that point. Public comments are welcome in written form at any point throughout the process and may be submitted to HCAprogram1477@hca.wa.gov.)

Jamie shared the CRIS Committee areas for work in 2023 and the decision process map. The meeting today will be focused on setting the table for some of our future discussions about expanding mobile crisis teams as well as the role of co-response teams in Washington's crisis response system. The intent is to devote the March 22nd CRIS Committee meeting to discussing the role of co-responders in Washington's crisis response system.

Jamie shared the CRIS and Steering Committee 2023 Calendar dates. CRIS members received calendar invitations for all meeting dates. The dates are also posted publicly to the CRIS webpage. Jamie also noted Representative Orwall has put forth a bill (HB 1134) that includes an extension to the timeline and would provide additional time for these discussions.

PERSONAL STORY

CRIS and Steering Committee member, Bipasha Mukherjee, provided an introduction for Jerri Clark to share her personal story and experience with Washington's crisis response system. Jerri Clark has lived in Washington State since 1995, moving here shortly before her son Calvin was born. In 2019, she lost Calvin to suicide. Jerri shared slides and walked through the ways in which Washington's current crisis response system imposed barriers to care and resulted in a failed response for their family. Jerri highlighted assisted outpatient treatment (AOT) as the most evidence-based treatment for people with anosognosia and encouraged the CRIS Committee to include AOT as part of the toolkit for the 988-rollout. Jerri has established a grassroots movement, called Mothers of the Mentally Ill (MOMI). A PDF version of Jerri's speech, including relevant links, is attached to the bottom of this document. Jerri's slides and a recording of Jerri's story are part of the meeting materials on the CRIS webpage. Jerri can be reached through an email link on her website, MOMI-WA.org, or directly at jerri.clark@momi-wa.org.

AGENCY Q&A

Jamie facilitated a Q&A session for CRIS members to ask any questions about the updates included in the monthly CRIS e-newsletter (emailed to the CRIS as part of the meeting materials for this meeting).

- Does expanded coverage apply to self-insured plans, and how many lives are within self-insured plans in Washington?

- Jane Beyer (Office of Insurance Commissioner) explained that self-funded group health plans are required to cover behavioral health crisis services that are provided in facilities, including crisis triage facilities, crisis, stabilization, evaluation, and treatment. However, because of a limitation of the use of the term “facility” in federal law, requirements for coverage do not extend to mobile crisis response teams. Jane added about four million people get their coverage through an employer sponsored health plan in Washington State. About 60% of these individuals are enrolled in self-funded health plans.

DISCUSSION: REVIEW AND GAIN CLARITY ON SYSTEM GAPS

Jamie introduced the objective of this agenda topic to support CRIS member understanding of current crisis response service system gaps. Matt Gower and Sherry Wylie with Washington State Health Care Authority (HCA) will share information regarding current system resources and gaps for Mobile Crisis Response teams for adults and youth supported by HCA. Jennifer Stuber with the University of Washington then shared information about current Co-Response team models gathered through a recent survey. In the coming months, HCA is developing a workplan to expand MCR teams in each region, including specialized teams to respond to the unique needs of youth, American Indian and Alaska Native (AI/AN), LGBTQ youth, and geriatric populations. The information shared at today’s meeting will help to inform future discussions of current gaps and priorities to expanding services. Jamie also noted that the data are imperfect, and we will aim to present the best available data as we get it. Betsy Jones, Health Management Associates (HMA), provided an overview of the limitations of the current data as identified in the HB1477 Committee Progress Report submitted January 1, 2023.

Matthew Gower and Sherry Wylie (HCA) provided an overview of HCA’s work to analyze the distribution of Mobile Crisis Response (MCR) teams regionally and estimate resource needs. Matt highlighted the number of teams and distribution in each region, with emphasis that each region currently defines a team differently. He explained types of teams in each region, as well as the approach to use full time employee (FTE) as a common unit of measurement of resources across regions. Matthew also explained the use of the Crisis Now Calculator as a starting point to estimate resource needs in each region and by county. Sherry highlighted the need for a deeper dive into youth data and adaptation of resource estimates needed based on the Mobile Response and Stabilization Services (MRSS) model.

Committee Discussion:

- How is the need calculated?
 - It is the total number of FTE needed to respond within 1 hour.
- Is the FTE need broken down by youth versus adult teams or just FTE needed overall?
 - The projected needs are based on the total population living in the region and are not broken down by target age group. As noted previously, there is a need for deeper review and understanding of youth system data and resource needs.

- Noted that the numbers listed for Kitsap County appear to be a combination of designated crisis responders and non-designated crisis responders. This sounds like it conflicts with the definition of mobile crisis team; it would be great to exclude designated crisis responders.
 - These numbers are based on a survey and have not been peer reviewed by our regions to validate accuracy. Regardless, we agree that designated crisis responders would not be part of the MCR model and should not be counted in these numbers.
- Is there one mental health professional supervisor for each clinician and peer provider dyad (i.e., pair)? How many teams are the mental health professional supervisors supporting?
 - HCA hasn't yet finalized a definition. Our working definition has been about five dyads per one supervisor just to try to limit the amount of burnout on the supervisor. Different teams have different standards; what's defined as a team in some regions may include multiple supervisors to cover day shifts, night shifts, etc. This is the rough ratio that we have been using for a mental health professional.
- Did the calculation factor for a number of teams needed for 24/7 coverage?
 - Yes.
- I heard that the models are voluntary. Is there a best practice outlined in the Substance Abuse and Mental Health Services Administration (SAMHSA) model about when there's a hand off, or a connection, or an invocation of involuntary service?
 - HCA is approaching the system so that mobile crisis would be the first offering, and then, if they are unable to help, they would bring in the designated crisis responders. This is one of the reasons we didn't want to include designated crisis responders as part of the MCR teams – so that there is an ability to respond when needed. The mobile crisis team would be able to stay with the individual until that happened or help transport them to a more secure place depending on the situation.
 - HCA is working on developing Crisis Response Best Practice Guidelines to support a consistent approach and standards for response in the context of Washington's regional system that allows for some flexibility based on local needs. These guidelines will be published in July and will be coming to the CRIS for input in advance.
- How decisions are made to direct someone from voluntary care to involuntary care would be an important issue to consider as part of these guidelines. If this is not defined, there is significant room for bias and can be a dangerous position for providers who do not have the resources to make the connections needed to get someone to the appropriate care.
- Will this information and data be shared with ASOs to validate and comment?
 - Yes, if this report moves along and is processed.
- How many teams total, how many FTEs total, and what percentage of the need is currently being met as per the definition?
 - We currently have about 40% of total FTE needed in the state based on the 1-hour response time standard. The need is probably most concentrated in our two largest counties.

- The slide that we shared regarding the lack of common performance metrics across the state was concerning. Would like to support effort to develop common metrics and standards so that we have better sense of what's happening.
- Is the 1-hour response in person, onsite? Or looking at telehealth?
 - In person. Obvious limitation is geography, where it may be impossible to get from one place to another in an hour in certain parts of the state.

Jennifer Stuber, CRIS member, Associate Professor at the University of Washington School of Social Work and Co-Founder Forefront Suicide Prevention, shared the results of a recent survey to learn more about co-response programs in Washington state. Co-response programs are partnerships between first responders (including law enforcement, fire/EMS, or EMS agencies) and human services professionals (such as behavioral health professionals, social workers, community health workers, or peer support workers). In response to SB 5644, UW surveyed co-response programs across the state to carry out a landscape analysis of current programs. Jenn shared a link to an [interactive map](#) and survey results:

- 95% of surveyed programs reported offering crisis prevention services
- 90% reported offering crisis intervention services
- 55% reported offering crisis follow-up services
- Co-response offers a flexible model that can be responsive to any crisis
- Programs are disproportionately located in the I-5 corridor, the Puget Sound Basin region; large swaths of the state do not have co-response programs
- 435 total FTEs working in co-response across surveyed programs
- Average of 8 FTE people per program
- Programs are disproportionately staffed by human services professionals

Committee Discussion:

- Did you ask respondents what percent of behavioral health related 911 calls are able to be referred to a co-responder team?
 - No, but we hope to send a follow-up survey and could consider asking this question.
- How are programs screening and making the decision to use a co-response team versus a police response?
 - Ron Harding, City of Poulsbo: Information is often collected through dispatch; the need is not always apparent. It depends on what the call taker is hearing and the information they are given. We send out our team, and the outcome is often determined by what they find when they get there.
 - Adam Wasserman, Washington State Emergency Management Division: Dispatchers are the first ones to touch the events, and their decision-making is key to what gets sent out. We wish we had more co-response teams because so many of the 911 centers lack the option. Important to bring 911 in when that discussion happens.
- Do we have any information on how co-responder programs are funded?

- Co-response has a wide diversity of funding sources across the state. Funding can come from fire and police departments, counties, city governments, Washington Association of Sheriffs & Police Chiefs (WASPEC), and behavioral health administrative service organizations.
- The True Blood case funded about 5 different co-responder models between 2018 until just recently. When we funded those, each program was hugely different and developed differently, staffed differently. Are you able to look at the variation, and how these teams are set up? Relatedly, are there best practices or most efficient models that are being developed? We struggled with those programs to measure outcomes.
 - Every region is varied because the funding isn't standardized. There are huge disparities—everyone is standing up what they need the most. We do have information capturing different categories. We could work toward the long-term idea of standardizing how programs are measuring impact, how teams are measuring impact. We have some limited information about that from the survey.
 - It is difficult that so much operates under the heading of co-response without any shared best practices in place. It's our hope that by partnering with UW we can come up with best practices to mimic SAMHSA's mobile crisis resources.
- Are all the surveyed programs self-identified as co-response programs? Are there perhaps other co-responder models out there that aren't calling themselves co-response?
 - We sent the definition with the survey and asked people to indicate whether they consider themselves co-response. Due to the lack of a standard definition, a lot of the teams refer to themselves as something different, such as "mobile integrated health teams".
- Are there takeaways in terms of people who have utilized or received response? I don't know if there's any way to compare the care you receive when you get a mobile crisis response versus a co-response model. Who gets what response seems to be rife with bias to me—who gets 911, who gets co-response, who gets mobile crisis response. I appreciate your point that both of these models are necessary; we needed an array of options. I think that's a question I've been struggling with.
 - These are the topics we will tackle further in March.

Representative Tina Orwall shared a high-level overview of HB 1134 and proposed changes.

- HB 1134 is considering creation of clinical, rapid response team for the small number of 988 calls that require in-person response, which includes those that are part of the Native & Strong Lifeline as well as the three crisis centers.
- The bill proposes an opt-in model to create a rapid response team to be dispatched by 988. The teams include behavioral health and mental health professionals, certified peers (people with lived experience), and relationships with an agency van and/or Emergency Medical Services (EMS) to carry out transport. While this represents a non-police response, there would be a close working relationship with law enforcement.
- 30% of the bill funding would be for Tribes to have their own rapid response teams dedicated to the Native and Strong Lifeline.
- Proposed timeline for implementation and response time standards in the bill:

- July 2023 – December 2024: Rapid Response Crisis Team Formation
- January 2025 – December 2026: 80% of the time – arrival in 30 minutes in urban areas, arrival in 40 minutes in suburban areas, on route in 15 minutes in rural areas
- January 2027 – forward: 80% of the time – arrival in 20 minutes in urban areas, arrival in 30 minutes in suburban areas, on route in 10 minutes in rural areas

DISCUSSION: HOW TO APPROACH FUTURE DISCUSSIONS

Jamie facilitated the large group discussion and provided the following discussion questions for committee members to consider:

- What are your observations about the information presented?
- What additional information do you as a CRIS member need to inform HCA’s workplan to expand MCR services? (e.g., team composition definition; underreported needs among populations that don’t seek services; demographic data)
- Recognizing that we may never have perfect data, how do we continue to move this crisis response improvement strategy forward, even when we don’t always have full information?

CRIS Committee members shared their input and feedback on how to approach future discussions about MCR services:

- Observations about the information presented
 - The information presented was helpful. It’s exciting to see the initial work that’s being done.
 - There is a lot of room for standardization and guidelines, with an understanding of local and population variation.
 - In response to the co-response presentation:
 - CRIS committee members have expressed verbally and in the chat that they are wrestling with conflicting feelings about the presence of co-responders at a crisis. This will be the focus of our discussion at the March CRIS meeting.
 - Opportunities in co-response for pairing nurses and social workers, paramedics, fire, EMS, etc.
 - In response to Rep. Orwall’s bill:
 - We have a great opportunity to think about how to achieve those timeframes for response and work within our communities (e.g., universities, school-aged populations) and talk about the value of human service.
- Additional information needed
 - More granular information about how different crisis teams respond, and what exactly they are doing. We will want to break those down and understand the functions of the different teams.
 - Request for clarity on terms and models (i.e., crisis response, mobile response, co-response, rapid response)
 - Co-responders:
 - When and why co-responder teams are being used instead of mobile crisis response (e.g., timeframe and flexibility).

- What are the operational response differences between co-responder teams based in fire departments versus those based in police departments—are there differences? How do those play out?
 - Best practices about the ratio of co-response to mobile crisis response.
 - What consistency is there in training law enforcement members of co-response teams in trauma-informed care and anti-racism?
 - Need to learn from others:
 - Hear from crisis workers (e.g., co-responders, mobile crisis teams, paramedics, nurses) about their experience in the field, gaps in response, how they would like to work together with other parts of the system.
 - Hear from states that have already thought through how co-response and mobile crisis can and should work together, and how their systems are working (e.g., Arizona, Texas).
- Considerations for how to move the strategy forward
 - How to best support the workforce and capacity needed for additional services and expanded teams.
 - Determine where true emergencies—those needing immediate response—fit into this response (e.g., trip to the emergency room).
 - How co-response can work together in concert for community response when there is a crisis moment. There needs to be oversight over co-response to develop a unified response.
 - Determine to what extent we are trying to proactively move law enforcement out of crisis response.
 - Determine new terminology when designing the team.
 - Co-location and training that can help the system work together (e.g., allowing a small number of 988 responders to co-locate with larger 911 centers)
 - How to provide centralized information/education to people on where to place a call (i.e., 911 vs. 988).
 - Funding concerns need to be discussed.
 - At some point, we will need to move forward planning the system without all the data—will need to determine what that point is.
 - Involving folks from CRIS Committee member organizations where relevant.

As a homework request, CRIS Committee members were asked to consider additional questions, with particular focus placed on the first question:

- What additional information do you as a CRIS member need to make recommendations about the **role of co-responder teams**?
- What additional information do you as a CRIS member need to make recommendations around the **youth crisis response services needed**? (Optional – a future meeting will be dedicated to providing an overview of current data about the youth system resources and needs. This will allow CRIS member to further consider additional information needed.)

ACTION ITEMS AND NEXT STEPS

Next steps and action items for the meeting:

- HMA will follow up by email with the homework and request for CRIS Committee member responses.

PUBLIC COMMENT PERIOD

There were no public comment requests for the call. Jamie highlighted the opportunity to submit public comment via email to: HCAprogram1477@hca.wa.gov.

MEETING ADJOURNED

View Jerri Clark's CRIS Committee speech here:

CRIS Committee speech 2.15.23

Jerri Clark, family advocate with lived experience

It was in key moments on the phone with crisis responders that I knew my son would not survive. They told me he had to:

1. Hurt himself.
2. Become medically incapacitated.
3. Commit a crime.
4. Hurt me.

I'll cover these four topics today.

Overall, I want to make clear that a crisis call never changed my family's trajectory toward the better and instead consistently made things worse. I want to make sure that sharing my story leads to action and isn't treated as a sound bite. I appreciate your attention.

For his type of illness and level of acuity, those were the requirements for response. We were trapped by our son's illness, with doors marked tragedy as the only exits. Each time I called crisis, I got a person trying to convince me that I was mistaken and ours wasn't a crisis at all.

1. Hurt himself.

At the moment he stepped off a hotel roof and plunged to his death, my son met that elusive criteria. His final act was to prove himself suicidal. The crisis system isn't built to prevent harm but instead requires harm. My son was too smart to fail at suicide, so that's how four years of crises ended. He killed himself March 18, 2019.

2. Become medically incapacitated.

I remember one crisis call with acute detail. In deep psychosis with severe paranoia, my son was afraid to drink or eat for a couple days because he believed we were trying to poison him. A crisis counselor arrogantly explained how only a medical doctor could determine grave disability, possible only if my son voluntarily went to an emergency department and requested an examination. If he were in early stage death, she explained, he could be found gravely disabled and hospitalized.

I've been told since that the information was inaccurate. Oops. Too late. Regardless, I know our state's grave disability statute is poorly understood and not used well to save lives. Training is badly needed. Getting an evaluation from an elusive Designated Crisis Responder is an enigma. Families like mine in Washington State know that the crisis system is mostly designed to keep us at bay. My perception was always that a DCR's primary job was to find a way to justify describing my son as perfectly fine.

3. Commit a crime.

Every crisis responder I ever spoke to defended my son's right to be ill. They defended his psychosis over protecting health and safety—his and ours. I knew it would destroy him to hurt me in a psychotic rage, but seeing what was obvious got me nowhere. Responders were a stuck record on this point: "It's not illegal to be psychotic." That's how most of my crisis calls ended. That and telling me that tricking my son into committing a crime might help the situation.

My son got sick enough so that jail happened, and that made everything worse.

The obvious ethical thing to do when someone is dangerously disconnected from reality is to treat them, not leave them to suffer or cause harm, but our medical/legal system isn't built to act ethically. Dangerousness is prioritized. When that standard is finally met, there's almost always been a crime. A person's relationships are broken, their employment opportunities are dead on arrival, and their level of brain damage and trauma make it nearly impossible to ever recover.

That's why we have almost 900 people in jail waiting almost a year for a competency restoration bed at one of our state hospitals. The status quo will keep making this worse unless we radically change our crisis response system. Let's get to my fourth point:

4. Hurt me

The crisis system needs an entirely different protocol when a family member calls because a loved one is disconnected from reality due to psychosis and has symptoms of illness that disable their brain from seeing its illness or understanding why treatment is essential.

This is the area of your work that I most want to influence.

Too few people understand severe mental illness and what it's like to live with it in your home. Before he was ill, my son always treated me with love and respect. When he was lost in his disordered mind, Calvin lashed out at me in bizarre and vicious ways. I now know he had a symptom called anosognosia, which meant his brain was unable to see its illness or recognize the need for treatment. No provider or crisis responder ever taught me about this symptom and how difficult it would make my attempts to communicate with my son or help him seek appropriate care.

I talk with families all the time who know that getting hurt themselves might finally get their loved one with anosognosia a ticket into treatment. I know three women who have been nearly killed by their sons with schizophrenia. None of those young men ever threatened to hurt anyone until they experienced untreated psychosis. Their actions were a result of florid, untreated psychosis.

Two weeks ago a teacher in Tacoma was killed by her son in a way that fulfilled my long-time worst fear. The young man stabbed his mom to death. He told police he had to "pop the robot's head off."

A similar incident in 2019 happened in Port Angeles, when a young man bludgeoned to death a long-time family friend in a state of untreated psychosis. He demonstrated for a judge that he was defending himself against "threatening behavior," which looked like the offer of a hug to anyone in their right mind.

We should all be terrified that the status quo is designed for outcomes just like this. Both families tried desperately to get mental health help for their loved ones before these tragedies.

I tried so hard to get my son help in that narrow window of dangerousness that opened before it became super likely he would hurt me. My husband refused to let me be injured, and that part of our story is something too painful for me to discuss anymore. I am glad that I'm still here and able to do this work.

Some people will accuse me of furthering stigma by sharing this true information. From my vantage point, stigma is made worse by people whose unmet needs lead to horrific harm. We need to treat their illnesses to stop the harm, not throw a cloak over the truth.

I added a slide today to honor my friend Eric Smith. Eric is featured in the People Magazine coming out at the end of this week. He talks about his anosognosia and how in a delusional state he threatened to kill his mother. The opening line to the article is this: "Twelve years ago Eric Smith believed he was a secret agent who needed to kill his mother to save the world."

Within the article, there's a picture of Eric and his mom, happily together now. I've told Eric many times that I wish my son's story included the upward spiral of his—but Calvin didn't get AOT. Eric experienced crisis after crisis, with providers telling his parents that he would need to be arrested to get any help. His downward spiral was finally stopped when a particular crisis led him into AOT. Texas had that option.

I'm pretty sure some of you are thinking AOT is outside the scope of your work on this committee. You are wrong. If the 988 rollout doesn't include AOT as part of its toolkit, it will keep failing people like my son and Eric.

I tried so hard to get my son help in that narrow window of dangerousness that opened before it became super likely he would hurt me. My husband refused to let me be injured, and that part of our story is something too painful for me to discuss anymore.

Your job is to fix what happens when a crisis is underway. Your work cannot improve outcomes unless it's part of a system reboot. The most evidence-based treatment for people with anosognosia and symptoms of psychosis is Assisted Outpatient Treatment. Our state has made baby steps toward AOT development, but I'm concerned that AOT might prove itself a failure if it's not rolled out with the robust resources necessary for it to operate correctly.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is awarding \$250 million in [Community Mental Health Services Block Grants](#) as part of the country's \$800 million allotted through the [Bipartisan Safer Communities Act](#) to get the 988 Lifeline up and running. Adults with Serious Mental Illness are a targeted population for these grants, which have flexibility to support new and existing programs. The grants are designed to support the most evidence-based programs, positioning AOT as a logical use of these funds. A Certified Community Behavioral Health Clinic can include AOT and is an excellent model for growing a functional behavioral health infrastructure, which these SAMHSA grants encourage.

Using 988 funds for AOT makes logical sense because AOT is a protocol that can turn a crisis into a moment of change in the trajectory of someone's severe mental illness. It's the most compassionate and ethical option to help someone recover control over their mind and their life.

During his illness, my son was frequently discharged from a hospital with a less restrictive order. No crisis responder ever cared that Calvin had an LRO. Dangerousness was required, with or without an LRO, and jail was always encouraged over treatment.

I support our state's call to develop Crisis Response Centers. A CRC could be a safe landing place for a person to be evaluated and considered for Assisted Outpatient Treatment. A referral to AOT could stop the revolving door of failed hospitalizations, crisis after crisis, incarcerations, and suicide attempts.

NOTES:

SAMHSA resource on 988 community block grants: <https://www.samhsa.gov/grants/block-grants/mhbg>

Article about Tacoma woman killed by her son with untreated schizophrenia:

<https://www.kentreporter.com/news/son-charged-with-killing-kent-teacher-to-receive-competency-evaluation/>

Because this young man wasn't properly treated before he committed an act to enter the criminal justice system (and destroyed his family), he now becomes part of the bottleneck of very ill people waiting in jail for almost a year before any help at all is possible: "Currently, about 870 people are waiting for a competency restoration bed at Western and Eastern state hospitals."

Clear evidence of his untreated schizophrenia to anyone who understands severe mental illness: He told detectives had had to, "Pop the robot's head off."

MOMI website, <https://momi-wa.org/>

The easiest place to learn more is to watch the [PBS/Brief But Spectacular documentary](#) that aired two months before Calvin killed himself. The video shows that he FINALLY got what almost worked. I can see clearly now that the help was years too late. The lack of appropriate response in past caused too much lasting damage to his brain, his willpower, his relationships, and his access to meaningful work. The most comprehensive article is the one I wrote for my alma mater: [My Son's Story](#), published in Kansas Alumni Magazine. There are details of crisis calls described.

Short Bio:

Jerri Clark has lived in Washington State since 1995, moving here shortly before her son Calvin was born. She raised her son and step-daughter while teaching yoga and dance throughout Southwest Washington and Portland for about 20 years. When her son became ill with severe bipolar disorder, she began advocacy work with NAMI and took a job at PAVE, helping families whose children need special education services. Her work with PAVE ends March 17, a day before the 4th anniversary of Calvin's suicide death. On April 1, she begins a new job as Family Resource and Advocacy Manager for the national non-profit Treatment Advocacy Center. TAC is narrowly focused on treatment access, policies and laws that prioritize appropriate care for people with the most severe and disabling mental illness conditions. Jerri is happy to be a grandma to two little boys and surfs the Oregon Coast on a pink-and-white longboard whenever possible.

Final Words:

In her new role as an employee of the Treatment Advocacy Center, Jerri Clark plans to focus on resources for families trying to navigate a disordered system and advocacy toward treatment policies that acknowledge the symptom of anosognosia. She wants society to understand that the ethical thing to do when someone is dangerously disconnected from reality is to treat them, not leave them to suffer on their own. Expanding access to Assisted Outpatient Treatment (AOT) is a priority. Another priority for Jerri is to share her idea for a federal law to incentivize the most evidence-based care protocols for the most vulnerable individuals. She's happy to speak with anyone interested about her work and priorities. She can be reached through an email link on her website, MOMI-WA.org or directly at Jerri.clark@momi-wa.org.