CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE MEETING SUMMARY

Wednesday, March 22, 2023; 3:30 pm – 6:30 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

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ATTENDEES

COMMITTEE MEMBERS

Adam Wasserman, State 911 Coordinator
Anna Nepomuceno, National Alliance on Mental Illness (NAMI) Washington
Bipasha Mukherjee, Crisis Line Volunteer
Caitlin Safford, Amerigroup
Claudia D'Allegri, Sea Mar Community Health Centers
Dillon Nishimoto, Asian Counseling and Referral Service
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
Michael Reading, Behavioral Health and Recovery Division, King County
Michele Roberts, Washington State Department of Health (DOH)
Michelle McDaniel, Crisis Connections
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

Amber Leaders, Office of Governor Jay Inslee
Darcy Jaffe, Washington State Hospital Association
Ellen Carruth, Resonant Relationships
Justin Johnson, Spokane County Regional Behavioral Health Division

Krystina Felix, The Kalispel Tribe
Megan Celedonia, Office of Governor Jay Inslee
Michael Robertson, Certified Peer Counselor
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

Mary Thornton
Rebecca Armentrout

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 Jan Tokumoto, Frontier Behavioral Health, welcomed everyone to the meeting, emphasizing appreciation for contributions by Committee members and people with lived experience to the statewide discussion on improving the crisis response system. Jamie acknowledged living on the traditional land of the Duwamish tribe and recommitted to pursuing opportunities to highlight work with tribes. Jamie shared the news of the passing of Diana Cortez Yanez, a member of the CRIS Lived Experience Subcommittee, and asked the group to pause for a moment of silence to remember Diana.

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 is shared in advance of calls and on the Washington State Health Care Authority CRIS Committee webpage.
3. Provide foundational understanding about Washington State Health Care Authority's current and planned work to implement behavioral health mobile crisis response teams aligned with SAMHSA best practices, to inform discussion about considerations related to the presence of first responders (e.g., police, fire, or emergency medical services) at a crisis.

4. With foundational understanding of HCA's behavioral health mobile crisis response model, discuss considerations related to the presence of first responders (e.g., police, fire, or emergency medical services) at a crisis.
5. Confirm action items and next steps.
6. Hear public comment. Due to lower sign-up numbers, the comment period was shortened to 10 minutes. Public comments are welcome in written form at any point throughout the process and may be submitted to HCAprogram1477@hca.wa.gov.

Jamie acknowledged the current CRIS decision process timeline is in flux due to HB 1134 and noted plans to share the CRIS decision process map with a clearer timeline during the next call.

PERSONAL STORY

CRIS and Steering Committee member, Bipasha Mukherjee, provided an introduction for Kristen Wells to share her personal story and experience with Washington's crisis response system. Kristen is a licensed social worker and member of the CRIS Lived Experience Subcommittee. Kristen shared her own experience with mental health challenges, her experience as a sibling with a sister with mental illness, and her experience with her partner's suicidal ideation and therapies [electroconvulsive therapy (ECT)] that have left him with memory loss. Kristen highlighted supports that would have helped, including early screening and treatment for herself and her sister, clear resources and peer support, in-state youth residential treatment, assistance navigating short- and long-term disability and Family Medical Leave Act protections, consistent access to services across various types of coverage, and coverage for couples counseling. Kristen's slides and a recording of her story are part of the March 22, 2023 meeting materials on the CRIS webpage (available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees)

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 and located on the CRIS Committee website).

- Is there statewide reporting and data collection for mobile crisis response? How is that data being processed and published?
    - Keri Waterland (HCA) noted her team will follow-up with this information if it is not otherwise addressed in the HCA presentation on mobile crisis response later in the agenda.
- How many of the increased calls to 988 are resulting in an in-person service rather than being resolved with a telephone? Is that being tracked? Note that this is helpful to see the increasing trend in calls. Interested in how many of these calls result in in-person response and how many are resolved over the phone.
    - 988 centers collect and track this data individually, , but data are not currently being collected in a standard way across all centers. The new Technology Platform will ensure standardized data collection in the future.

    - Currently, mobile crisis teams are deployed out of the Regional Crisis Lines rather than 988. The future-state vision in the legislation is that the teams will be deployed by the Crisis Center Hubs.
    - In some cases, the 988 centers also operate the Regional Crisis Line, allowing for increased integration of processes to request dispatch of mobile crisis teams.
- Note of appreciation that the three 988 call centers are meeting regularly with state agencies to discuss a unified approach to 988 implementation and planning on a range of topics.

PRESENTATION: HCA'S IMPLEMENTATION OF MOBILE CRISIS TEAMS

Matt Gower with the Washington Health Care Authority provided an overview of HCA's work to build a delivery system approach to support behavioral health mobile response based on Substance Abuse and Mental Health Services Administration (SAMHSA) best practice guidelines. Historically, Washington's system was focused only on the highest acuity needs and involuntary services. With Behavioral Health Administrative Services Organizations (BH-ASOs), resources have been established at the local, regional levels to expand crisis services. Washington began to collect data statewide after the Trueblood settlement took effect and has been working to standardize data collection processes. Funding for crisis response services has not been available to support a robust network to serve everyone. Many people in crisis therefore utilize emergency departments and receive responses by first responders. Co-response models (teams of first responders with a behavioral health professional have developed to better address the needs of people accessing emergency services.

Matt provided an overview of how the behavioral health crisis system operates, the context of federal, state, and local requirements and funding sources. HCA contracts with BH-ASOs to provide crisis services in their region (there are 10 BH-ASO regions across Washington) in accordance with state and federal standards. The BH-ASOs then contract with providers for crisis services and may in addition leverage regional and local dollars to enhance crisis services in their regions.

SAMHSA established crisis response best practices for behavioral health crisis response. SAMHSA also recently created a youth-focused best practice, which will be further discussed during the April CRIS meeting. The SAMHSA best practices establish a framework to improve a state's crisis system based on three core elements, including 1) someone to talk to (e.g., 988 and regional crisis call centers), 2) someone to respond (e.g., mobile crisis response), and 3) a place to go (e.g., crisis relief centers, stabilization facilities, and peer respites). Matt noted the overall goal to move 911 behavioral health crisis calls to behavioral health crisis response, citing that 12% of 911 calls could be better served by 988 or regional crisis lines. Additionally, only 0.3% of all calls to a behavioral health crisis line (i.e., 988 or regional crisis lines) result in active rescue.

HCA has been working to implement SAMHSA's best practices through HB 1477's directive to expand mobile crisis response teams. In addition, HCA is developing a Crisis Response Best Practice Manual and crisis response dispatch protocols (see request in the CRIS Newsletter for CRIS members interested in joining a workgroup to review the dispatch protocols).

Committee Discussion:

- Jane Beyer, Washington State Office of the Insurance Commissioner added that with the implementation of HB 1688, mobile crisis response teams will receive funding from private health insurance. This effort will leverage existing contracts between BH-ASOs, payers, and providers, and utilize current infrastructure to get new revenue into the crisis system.
- How was it determined that 12% of calls through 911 might be better served through mental health?
    - This statistic came from a Seattle times article, and the data source was an impression based on calls and call outcomes. While the data is limited to the Seattle area, it illustrates that people could be better served through different systems.
- What training are first responders going through to determine whether a mental health provider or a mobile crisis response team is needed? What would it take to modify training programs to ensure providers are more ready to respond to crisis?
    - First responder training varies across the state depending on every region's practice and resources. Most of the training is done through Crisis Intervention Team (CIT) program training.
    - Mobile crisis response availability and resources is an important factor, in addition to the training on appropriate resources to engage.
    - Building a working relationship with familiarity and trust between law enforcement and various responders could create a quicker and more appropriate behavioral health response.
- How much funding has HCA received for mobile crisis teams and what is the breakdown on percentages of the sources? Has most of the funding come out of Trueblood?
    - 30% of the funding for mobile crisis response is from Medicaid in current models. Trueblood funding varies from region to region, and mobile crisis team funding is moving out of the Trueblood settlement toward the 988 program.
- Why are only 0.3% of calls to phone centers going to active rescue? Is that because people naturally call 911 if active emergency?
    - HCA noted there isn't a clear answer. It may be due in part to people calling regional crisis lines or 988 before escalating other needs, or that 988 emphasizes resolving issues over the phone. Additionally, people who are in an emergency still likely call 911.

DISCUSSION: CONSIDERATIONS FOR THE ROLE OF FIRST RESPONDERS IN A CRISIS

Jamie introduced the objective of this agenda topic:

1. Highlight equity-related recommendations last year (in the Committee Progress Report) that included concerns around role of law-enforcement as part of crisis response system.
2. The Steering Committee would like to hear CRIS member perspectives on this topic, to inform its deliberations and recommendations about if, when, and how mobile crisis response teams coordinate or collaborate with first responders.
3. Today we want to listen to you. We also want to clarify where we have common ground and where there are diverging perspectives.
4. Finally, we want to agree on some next steps for providing guidance to the Steering Committee, which may include some further discussion on the areas where CRIS members diverge.

Representative Tina Orwall thanked everyone for joining. She noted the opportunity to improve upon the existing system and partnerships. Rep. Orwall also emphasized the need to make 988 callers feel safe, highlighting past focus groups that revealed concern among communities of color regarding calling 911 and 988.

Jamie framed the discussion, noting HCA's presentation highlighted mobile crisis response teams that do not include first responders. HB 1134 includes new crisis response teams that do include first responders, but not law enforcement. 911 also receives many behavioral health crisis calls and coordinates dispatch. The group reviewed a slide with potential definitions for the three types of response—first responder, co-responder, and mobile crisis—and walked through who responds, when they respond, and SAMHSA's best practice for each. Jamie then facilitated the large group discussion and provided the following discussion questions for committee members to consider:

- Under what—if any—conditions would it be appropriate to engage first responders?
- Based on your personal and/or professional experience and knowledge, what are some considerations around collaboration between behavioral health and first responders in crisis?

Committee Discussion
CRIS Committee members shared their input and feedback on considerations for utilizing first responders in crisis response:

Conditions where it would be appropriate to engage first responders

- Situations where it is unsafe for crisis staff to respond without support (i.e., safety and security) from law enforcement.
- Situations where people with serious mental illness are calling to receive help with crimes committed against them may warrant a mixture of law enforcement and behavioral health professionals.
- Situations of grave disability, where it is unclear if a person will cause harm, and there is limited ability for designated crisis responders to go into those community-based settings.

Considerations around collaboration between behavioral health and first responders in crisis

- Need a better understanding of existing crisis response training for first responders, and in the future, we will need to standardize and improve upon training.
    - Note that law enforcement offices in WA receive crisis intervention training every year. New standard is 40 hours of training. Most in state have moved to that as standard for officers in field.
- Responses should be humane, patient-centered, and trauma-informed.
- Partnership and collaboration with first responders can allow behavioral health crisis staff to provide care in situations where they would not have been able to help alone.
- Fear of contacting law enforcement; the arrival of an officer on the scene can be an escalating event.

- Rather than presuming a situation is unsafe and initially engaging law enforcement, need to shift to a presumption that the situation is safe, starting with behavioral health support, then determining if there is a need to contact law enforcement.
- Need to define what a dangerous situation is rather than leaving it up to subjectivity.
- 988 callers—particularly Black, Indigenous, and People of Color (BIPOC), immigrant, and LGBTQ+ communities—need to be assured that other steps will be taken before law enforcement steps in.
- Law enforcement should be the last resort, and work needs to be done to ensure crisis response is a trusted experience.
- Leverage co-response teams with fire and EMS—these first responders are more comfortable going to a crisis scene without knowing what to expect and can connect with law enforcement if it is not safe.
- Think about the youth crisis system as separate from the adult system; the role of law enforcement in the youth system should be minimized as much as possible.
- First responders and the crisis team should stay separate so that first responders can leave the scene and the crisis team can stay to work with the person in crisis as long as needed.
- Response is a continuum; need to look at what criteria makes sense for the type of response to keep teams safe.
- Meet clients where they are; ask if they are comfortable with law enforcement and other first responders before dispatching.
- Do not lump together all first responders; fire, emergency medical services, and law enforcement are different professionals. Callers may be more comfortable with some first responders than others.
- Existing considerations for public and media perceptions of fire, EMS, and law enforcement.
- CRIS Committee member shared experience on co-response ride-alongs. Highlighted that people with serious mental illness are more likely to be victims of crime than perpetrators of crime. Additionally, in situations of grave disability, where it is unclear if a person will cause harm, there is limited ability for designated crisis responders to go into those community-based settings. This necessitates a law enforcement response.
- Lived Experience committee members shared experiences with law enforcement responding to crisis calls.
    - Transgender, BIPOC, and immigrant communities do not feel safe calling 988 because law enforcement can respond to the call.
    - Negative experience with a co-responder transporting their child to a hospital, noting their child is black, LGBTQ+, and an army veteran.
    - Personal and professional experience in peer support with suicide and crisis response situations has been that law enforcement does not help the situation. In a few instances, an officer would intervene, override the peer, and take the person in crisis to jail due to an outstanding warrant. This can lead to relapse and decompensation. Experiencing a mental health crisis should not lead to being sent to jail.
    - Experience where they called 911 first, then 988 when their 16-year-old daughter made a suicide gesture. The 988 line was in Spanish, and while they were waiting, 911 called back and

sent law enforcement. Their daughter was arrested and then admitted to a hospital, which is not the outcome they were looking for.

- Highlighted that SAMHSA's best practice for crisis systems for children and youth recommend that law enforcement should be avoided unless absolutely necessary, as the presence of law enforcement can be triggering and increase risk for children and families.
- Highlighted difference in training and purpose for 911 and 988. The role of the 911 operator is to quickly understand a call and make the best possible decision about dispatching a resource. For 988 and regional crisis lines, the purpose is to spend more time with the caller and establish deeper assessment of the situation and crisis resolution.

After CRIS Committee members shared their input and feedback on considerations (above), Jamie provided the following discussion questions for committee members to synthesize the discussion:

- *What did you hear that sounded like potential common ground?*
- *What did you hear that sounded like there may be diverging perspectives?*

Committee Discussion

CRIS Committee members mainly focused on common ground and additional considerations:

Common Ground:

- Considerations for involving law enforcement, fire, or emergency medical services are different. Consequently, we should not group them as first responders or co-responders for the purpose of this discussion.
- The presence of law enforcement in a mental health crisis should be a last resort, and only if there are safety concerns for the person having the crisis, the people around, them, and/or the responders and/or a crime is being committed.
- Realistically, as long as people are calling 911 rather than 988 for mental health crises and as long as the capacity of mobile crisis teams remains constrained, there will be instances where law enforcement, fire, and/or EMS are present at a crisis. Consequently, the CRIS should focus on *how* they show up (including how they are trained), not *if/when* they show up.
- Behavioral health experts are needed in every response system
- Overall goal to increase calls to 988 for behavioral health issues
- Focus on training law enforcement with behavioral health considerations to improve trust with behavioral health experts when a law enforcement response is warranted

Additional Considerations:

- CRIS Committee members felt it would be helpful to be more focused in future discussions about when to engage first responders.
- Who decides if there are safety concerns, and what are the criteria for making that decision? Noted it will be important to understand how the initial assessment and decision is made by the dispatcher on which entity to send.
- If there is ambiguity about safety or whether a crime is being committed, what is the default position?

- When a call goes to 911, the presumption is often that there is a safety concern requiring the presence of law enforcement. Is it possible/realistic/reasonable to start from a position of addressing the behavioral health needs and only call for law enforcement once it has been determined that there is truly a safety risk?
- What should the training for all potential responders to a crisis—including 911 operators, mobile crisis team members, law enforcement, fire, and EMS look like? Can we create opportunities for cross training?
    - Highlighted need for joint training opportunities. (Rep Orwall noted HB 1134 includes provisions for joint training of first responders, 988, 911, and behavioral health.)
- How do we make it possible for vulnerable people—particularly people of color, people who identify as transgender and LGBTQ+, and youth--to feel safe calling for help in a crisis? How do we build and sustain more trust in the crisis response system.

Jamie thanked the CRIS Committee members for their engagement in the discussion and reiterated that the Steering Committee will draw from the discussions. The Committee supported the proposal to continue the discussion through a time-limited workgroup of 8 – 10 CRIS Committee members, with considerations brought back to the full committee. The goal would be to provide the Steering Committee with guidance and key consideration for collaboration between first responders and behavioral health crisis staff.

ACTION ITEMS AND NEXT STEPS

Next steps and action items for the meeting:

- HMA will follow up with HCA about available statewide mobile crisis response data that can be shared with the group.
- HMA will follow up by email with outreach for the first responder involvement workgroup.
- HMA noted a request for volunteers to participate in a workgroup listed in the March newsletter.

PUBLIC COMMENT PERIOD

Jamie reviewed the public comment process and opened the public comment period: one person signed up for public comment and three members of the public commented. Individuals were allowed two minutes to provide comment. For individuals with additional comments or time needed, Jamie highlighted the opportunity to submit public comment via email to: HCAprogram1477@hca.wa.gov.

MEETING ADJOURNED