CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE MEETING SUMMARY

Tuesday, May 16, 2023; 12:00 pm – 3:00 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

Amber Leaders, Office of Governor Jay Inslee
Anna Nepomuceno, National Alliance on Mental Illness (NAMI) Washington
Bipasha Mukherjee, Crisis Line Volunteer
Claudia D'Allegri, Sea Mar Community Health Centers
Darcy Jaffe, Washington State Hospital Association
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
Jessica Shook, Olympic Health and Recovery Services
Joan Miller, Washington Council for Behavioral Health
Justin Johnson, Spokane County Regional Behavioral Health Division
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
Michele Roberts, Washington State Department of Health (DOH)
Puck Kalve Franta, Access & Inclusion Consultant
Robert Small, Premera Blue Cross
Ron Harding, City of Poulsbo
Senator Manka Dhingra, Washington State Senate
Summer Hammons, Treaty Rights/Government Affairs

COMMITTEE MEMBERS ABSENT

Adam Wasserman, State 911 Coordinator
Caitlin Safford, Amerigroup
Ellen Carruth, Resonant Relationships
Krystina Felix, The Kalispel Tribe

Michael Reading, Behavioral Health and Recovery Division, King County
Michael Robertson, Certified Peer Counselor
Michelle McDaniel, Crisis Connections
Representative Tina Orwall, Washington State House
Representative Tom Dent, Washington State House
Senator Judy Warnick, Washington State Senate

AMERICAN SIGN LANGUAGE (ASL) INTERPRETERS

Jackie Bruce
Laurie Reinhardt

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 Joan Miller, Washington Council for Behavioral Health, welcomed everyone. The Council's members provide many of the current crisis response services across the state, including operating the 988 contact centers, regional crisis lines, mobile crisis outreach, involuntary treatment act (ITA) evaluations by designated crisis responders, and crisis triage and crisis stabilization services. As we explore crisis stabilization services at this meeting, and work together to identify system gaps, we'll be relying on each CRIS member to bring our observations and experiences to this discussion. One of the greatest strengths of the CRIS Committee is the diversity of perspectives and experiences, both personal and professional, that each of us bring to these discussions. Joan shared her appreciation for participation as a member of this committee and commitment to the committee's important work ahead.

In place of a land acknowledgement, Vicki Lowe, American Indian Health Commission, shared information about tribal-centric crisis stabilization later in the meeting.

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. Hear a wrap up of the legislative session, including the implications for 988 and crisis response improvement.

3. Identify and discuss system gaps related to crisis stabilization (a place to go), with the intent to inform HCA strategic planning as well as Steering Committee recommendations for addressing these gaps.
4. Confirm action items and next steps.
5. 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 noted that the person to share their story at today's meeting needed to reschedule to a future meeting.

Betsy reviewed the updated CRIS Committee timeline and deliverables, which was extended by one year by HB 1134. The Steering Committee, with input from the CRIS Committee and Subcommittees, will now submit a third progress report with on January 1, 2024, and the final report with recommendations on January 1, 2025. The CRIS Committee decision process map was adjusted as well to reflect the extended timeline and allows time to focus on areas of discussion needed. This year's focus has been on crisis response services continuum and resources needed to expand. In 2024, we will then turn attention to the two remaining areas of focus needed: 1) System goals, metrics, and oversight, and 2) System infrastructure (technology, workforce, cross-system coordination). Each of these areas are part of the committee recommendations called for by HB 1477.

The meeting today will focus on crisis stabilization services and gaps, with plans to move into services recommendations in the summer.

PRESENTATION: SYSTEM GAPS – CRISIS STABILIZATION

Senator Dhingra introduced this agenda topic, underscoring the importance of ensuring both access to services when a person is in crisis, as well as the simultaneous need for focus on early intervention and preventive services to prevent crises from happening in the first place. Senator Dhingra shared a recent personal story of a close family friend in crisis that brought into focus the experience of the current crisis system and the importance of ensuring of access to care before a crisis happens.

Jamie walked through objectives for the presentation:

- Understand crisis stabilization services offered in Washington, and the current distribution of crisis stabilizations services.
- Discuss and surface barriers to getting from acute crisis to crisis stabilization to inform HCA strategic planning and future discussions on how to address those gaps.

Matt Gower, Sherry Wylie, Luke Wagoner, and Wyatt Dernbach (Washington State Health Care Authority) provided a background on the current state and critical gaps in crisis stabilization services in Washington for adults and youth. For adults, crisis stabilization includes a continuum of services ranging from care during an acute crisis to post-crisis stabilization services. These services may occur in a range of settings and are not limited to facility-based care. Services include for example:

- Crisis de-escalation services (Mobile rapid response; Crisis relief centers; Program of Assertive Community Treatment (PACT) teams);

- Stabilization services (in-home stabilization, next day appointments, and facility-based stabilization such as a crisis stabilization units, peer respite, withdrawal management for substance use disorder, and inpatient evaluation and treatment);
- Post-crisis services, including outpatient services (*e.g.,* Primary Care Provider, Behavioral health treatment), long-term social supports (*e.g.,* Supportive housing/employment, Social services), crisis planning (*e.g.,* Wellness Recovery Action Plan, Mental Health Advance Directive), and community supports (*e.g.,* NAMI, Peer-run support groups).

For youth, the ideal continuum of crisis stabilization care includes:

- Crisis de-escalation, including Mobile Response and Stabilization Services (MRSS) Teams; warm handoff to existing provider, physician, or Wraparound with Intensive Services (WISe) team' 23-hour stabilization units
- Stabilization services including MRSS in-home stabilization, wraparound principles, next day appointments, referrals, warm-handoffs to clinical supports, and Facility based stabilization (e.g., Crisis Stabilization Unit, Withdrawal Management, Adolescent Inpatient Evaluation and Treatment, Residential Crisis Stabilization Program (RSCP), Children's Long Term Inpatient Program (CLIP)).
- Post-crisis services, including natural supports, wraparound principles, crisis plan, resource connections, community resources, short and long-term assistance programs for families, parenting community supports, outpatient services, school-based Mental Health Professional, intensive outpatient, and WISe services

HCA noted some key differences between in-home and facility stabilization options, highlighting that often a person may recover best in their own home and does not necessarily need to be to be brought somewhere. In-home stabilization meets the individual in their own environment, provides stabilization services with minimal disruption to life, and is typically provided for up to 14 days by mobile crisis teams. Facility-based stabilization can be a safe environment with additional services, such as medication management, that typically last around one week.

HCA reviewed a number of existing gaps and challenges for current crisis stabilization services, including concerns surrounding coordination, funding stability, and capacity. A key issue is a lack of coordination. The behavioral health system doesn't coordinate with emergency medical and first responder systems. Emergency departments struggle to connect with outpatient providers for discharge follow-ups, and are seeing people with no stabilization step at discharge. For first responders, there is frustration when they take someone to the emergency department, only to see them on the street again a few hours later. This is often due to ineligibility or refusal of services. Coordination and cross-system understanding is critical to getting people the care they need. Additionally, due to the major shift into integrated managed care, crisis stabilization units have lost BH-ASOs as a central point of coordination, and have also struggled to maintain funding and support. For units to function, a "firehouse funding model" is needed to fund facilities on a capacity-basis rather than limited to a fee-for-service payment for available beds.

CRIS Member Questions/Answers:

- Where do step-down facilities fit in this continuum?
    - These services are part of the facility-based stabilization services. HCA noted there are a lot of step-down facilities being built, including intensive behavioral health treatment facilities, enhanced service facilities, and other stabilization facilities.
    - There are also around four or five withdrawal management programs that are voluntary while also providing crisis services for the same issues and concerns.
- Are 23-hour facilities accessible to youth? They weren't in SB 5120.
    - HCA explained that while SB 5120 is only for adults, the 23-hour model has existed as a licensing type for some time. There is nothing that excludes providers currently from operating a 23-hour facility for youth, and there is a unit currently being built in Whatcom County.
- It seems that the focus is on people that can be cared for in shorter-term crisis stabilization facilities as opposed to people who need a higher level of care in inpatient settings. Is that the conversation we are having? There wasn't any information about challenges related to discharge and capacity during hospital stays.
    - HCA's presentation was focused on short-term stabilization, not hospital stays.
- How does assisted outpatient treatment (AOT) fit into the ideal continuum of care? AOT has been prioritized by legislation, with funding going to behavioral health administrative service organizations (BH-ASOs), and may prevent individuals from cycling through the system and crisis stabilization.
    - HCA noted AOT is still fairly new to Washington and there is work to be done to implement these services. It is designed to be a lower barrier of entry to the behavioral health system, without needing to go to the hospital first.
- Highlighted the need for discussion on individuals encountering the behavioral health system through the criminal and violent behavior side and don't fall in the Trueblood class. There is a need to build up the crisis response system in a way that it can be used to avoid initial law enforcement interactions as well as provide alternatives to arresting individuals.
    - HCA noted that law enforcement are partners in youth crisis response. Ideally, they would be referring to youth teams to connect the youth to behavioral health supports rather than transporting youth to juvenile justice or the emergency department.
- Consider capturing 988 call, text, and chat as crisis stabilization tools, and supporting planning and resource allocation for next-day follow-up for individuals calling 988.

Vicki Lowe, Jamestown S'Klallam and Bella Coola First Nations from Canada and Executive Director for the American Indian Health Commission, presented on Tribal-centric crisis stabilization. Vicki shared a report to the legislature with recommendations for improving access to crisis stabilization services for American Indian/Alaska Native (AI/AN) populations, including standing up a tribally-operated evaluation and treatment facility (E&T) (read the 2013 Tribal Centric Behavioral Health Report here: https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=5732%20Tribal%20Centric%20Behavioral%20Health%20Nov%20%2013_2b0af5bd-fe74-4c32-a890-ebdbb62c6c27.pdf).

A workgroup with subcommittees was stood up to support the work, discussing topics such as ensuring culturally appropriate practices and funding opportunities. The COVID-19 pandemic paused the work, but work

is starting again. The Indian Behavioral Health Act in 2020 established a process to appoint tribal designated crisis responders. As part of the Indian Behavioral Health Act, tribal governments can also petition for involuntary treatment under Joel's Law, and one tribe has successfully done that. A coordination hub is also in the process of being renamed to be the "Native Resource Hub" to support Native people in crisis, as well as families and providers in finding beds. Additionally, the 988 line now has the Native and Strong Crisis line, as well as support to train non-tribal responders to work with AI/AN patients and tribal governments. Looking ahead, two tribes are opening their own E&T facility and a secure withdrawal facility.

Outstanding questions:

- What is the best way to stand up a statewide governing board?
- How do crisis stabilization facilities fit into the plan?
- Is the need more for statewide facilities or individual Tribes/regional facilities?
- What about contracting with hospitals for beds to increase current access?

What is still needed:

- Update possible funding sources
- Clearly laid out licensing/approval process
- Updated building/remodel costs
- Updated operations cost - establishing cost- based Medicaid rates
- Understanding court costs and reimbursements

DISCUSSION: IDENTIFY BARRIERS TO GETTING FROM ACUTE CRISIS TO STABILIZATION

Jamie introduced discussion plans to engage in a root cause analysis exercise to identify barriers to getting from acute crisis to crisis stabilization (i.e., access to the full crisis stabilization service continuum including crisis de-escalation, a place to go, and post-crisis stabilization).

Problem Statement: Crisis stabilization services offer the community no-wrong-door access to mental health and substance use care. The goal of these services is to quickly stabilize the person in crisis, avoid hospitalization or incarceration, and help the person transition back into the community. The problem is that in Washington State, not everyone who is experiencing a crisis gets stabilized. In this exercise, please consider a range of crisis stabilization services, including crisis de-escalation, a 'place to go' crisis stabilization units, and post crisis stabilization. Please see attached root cause analysis exercise engaged by the committee at the bottom of this document.

Jamie thanked the CRIS Committee members for their engagement in the discussion and willingness to share experiences. Discussions from this meeting will inform HCA strategic planning in June and future Steering Committee deliberations about recommendations to address the gaps.

Legislative Wrap-Up

Sen. Dhingra provided an overview on legislation passed in the 2023 session that affects behavioral health—specifically crisis response—and the implications for CRIS Committee work. Sen. Dhingra noted the large amount of funding for behavioral health in the past few years—including $1 billion in investments in

behavioral health in 2023—as well as investments in addressing children with special needs in schools. The biggest barrier in the state is building up the workforce to support the new programs and initiatives.

Mental health bills passed during the 2023 Legislative Session:

- HB 1134 – provides a longer timeline as a follow-up to the original 988 bill (HB 1477). Incentivizes quicker response times by providing additional funding to mobile rapid response crisis teams that meet standards.
- SB 5120 – ensures the creation of crisis relief centers (formerly 23-hour crisis relief centers) without requiring medical clearance. Kirkland city to open one soon.
- SB 5300 – ensures medications for individuals with serious mental illness (SMI) won't change when they switch health plans. This will create stability for individuals with SMI.
- SB 5228 – includes occupational therapists as part of the mental health system, allowing their services to be billed as a part of the mental health team moving forward. This will support individuals in learning skills around taking medications and daily living, allowing them to stay in their homes and/or receive support after being discharged from the hospital.
- SB 5440 – provides timely competency evaluations and restoration services within the framework of the forensic mental health system consistent with Trueblood. This will support individuals in the community, in jail settings, and at the state hospital.

Behavioral health workforce bills passed during the 2023 Legislative Session:

- HB 1069 – adopts the mental health counselor compact. This will permit professional counselors to move to Washington to work.
- SB 5884 – ensures education for behavioral support specialists through a partnership between the Department of Health and the University of Washington. This will provide additional opportunities for individuals in the field with less than a master's degree.
- SB 5555 – establishes the new professions of certified peer specialists and certified peer specialist trainees to be certified by the Department of Health. This will address the behavioral health workforce shortage and expand access to peer services.
- HB 1724 – ensures qualified behavioral health providers can work in the field as quickly and safely as possible. This will strengthen the behavioral health workforce and address the shortage.

Sen. Dhingra highlighted available funding for crisis relief centers and encouraged providers to apply for a grant to set up centers. There is also funding available for youth crisis centers. Dhingra noted housing efforts, including work through the Blake Bill, housing vouchers for individuals struggling with substance use disorder, youth housing outreach, and opening up community beds for civil commitment and Trueblood populations. The bill on AOT died in the House, but Sen. Dhingra hopes to ensure this as an option for the community in the future. The University of Washington teaching hospital is also opening and will support increases in the workforce.

Jamie facilitated a Q&A session for CRIS members to ask any clarifying questions about the legislative updates.

CRIS Member Questions/Answers:

- With regard to HB 1069, is that specific to behavioral health specialists? Or does it include substance use disorder providers, licensed mental health therapists, etc.?
    - Sen. Dhingra noted that the mental health counselor compact is specific to the provider licenses that comply.
- Can you explain the Blake bill mentioned surrounding housing efforts?
    - Sen. Dhingra explained the Blake bill came out of the *State v. Blake* ruling by the Supreme Court three years ago which found the existing drug possession laws unconstitutional. The bill also set up infrastructure to provide additional support for individuals with substance use disorder.
- Thanked Sen. Dhingra for her efforts to pass the AOT bill and encouraged her to continue her efforts.
- SB 5555 is a huge victory – had not been able to bill for peer specialist services previously.

Jamie thanked Senator Dhingra for her efforts during the legislation and for sharing the updates with the group.

ACTION ITEMS AND NEXT STEPS

Next steps and action items for the meeting:

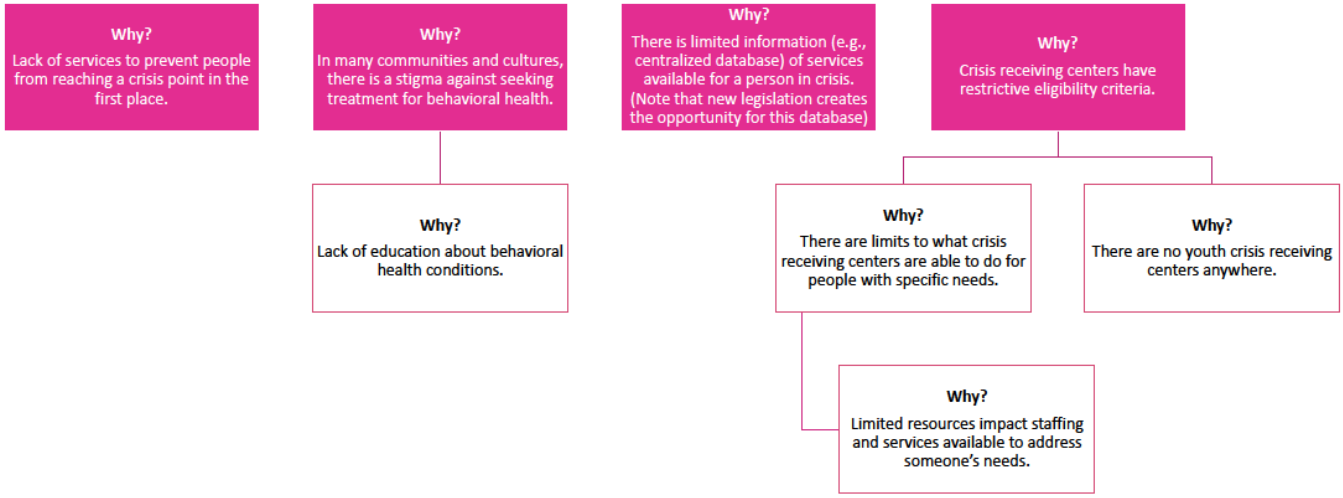
- HMA will synthesize and format the root cause analysis discussion and disseminate to the group.

PUBLIC COMMENT PERIOD

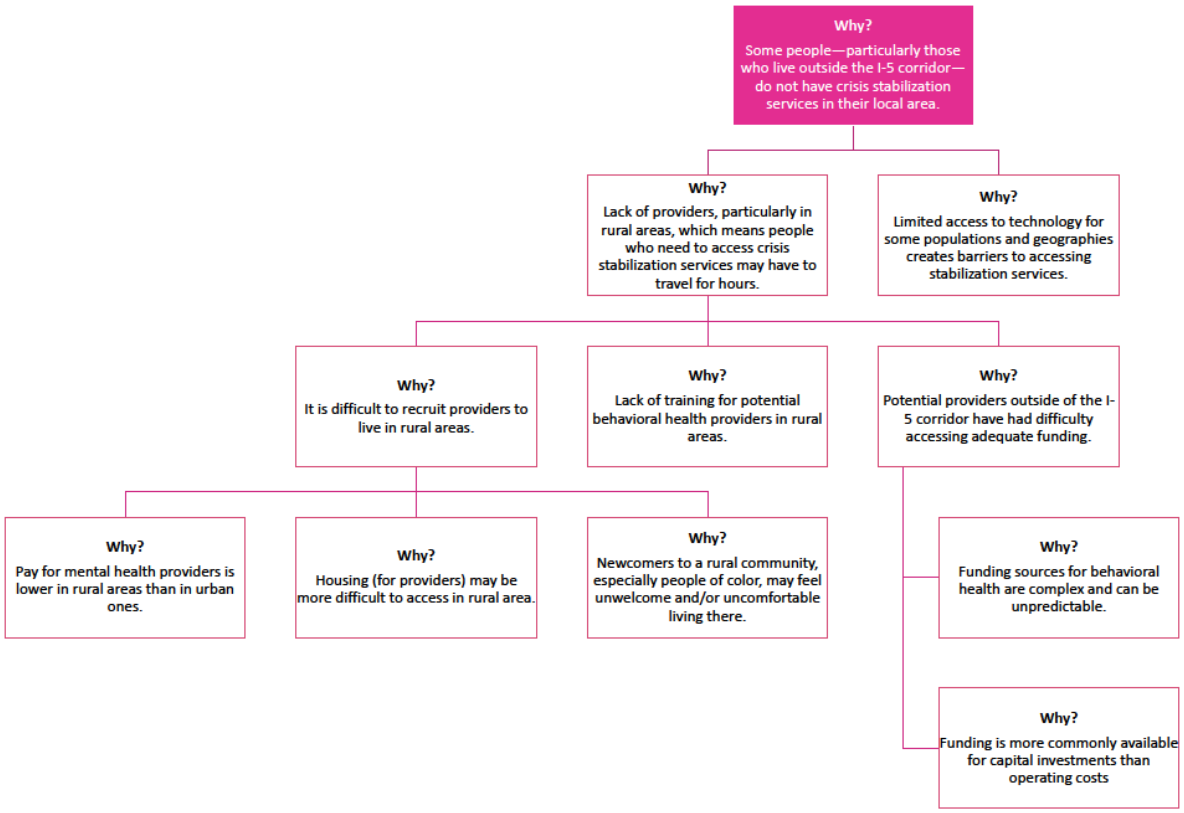
Jamie reviewed the public comment process and opened the public comment period: one person signed up for public comment. The individual was allowed two minutes to provide comment. For individuals with additional comments or time needed, Jamie highlighted the opportunity to submit public comment via email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

MEETING ADJOURNED

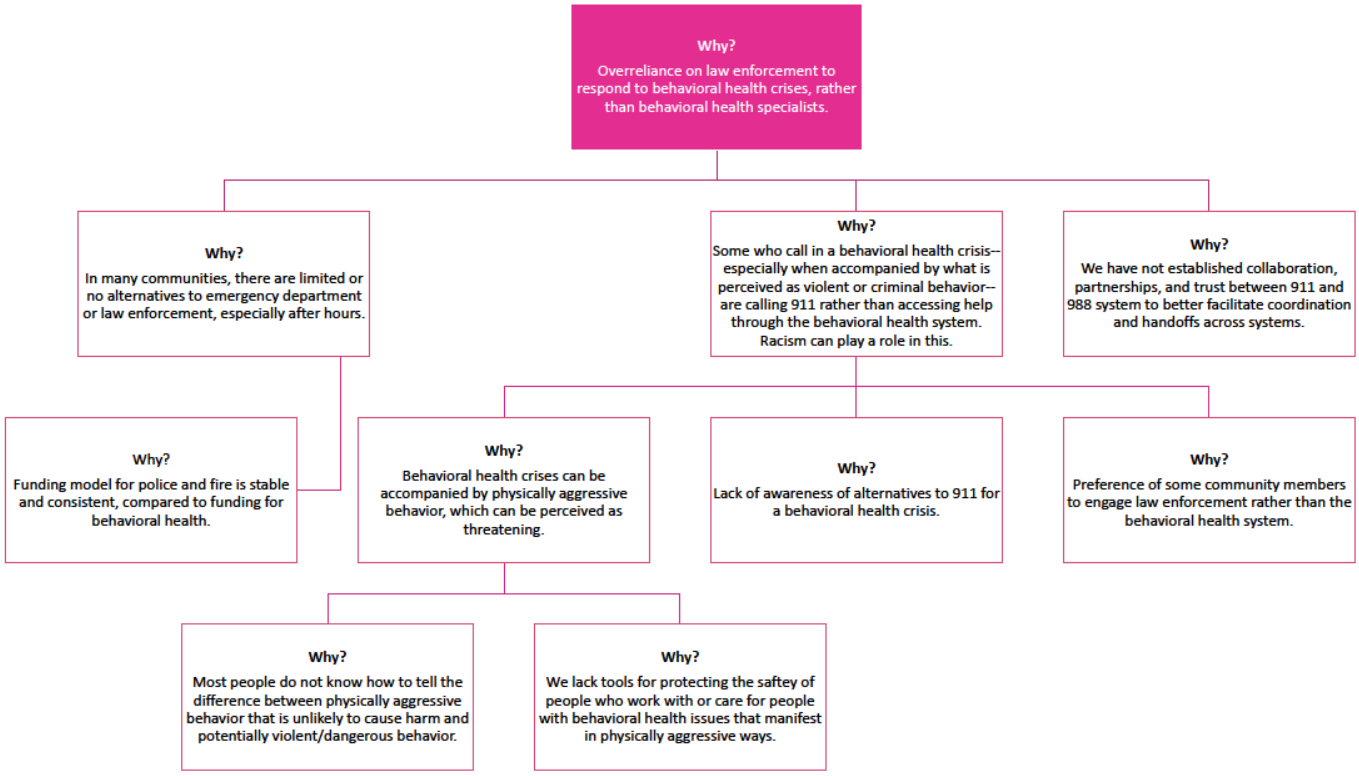
Crisis stabilization services offer the community no-wrong-door access to mental health and substance use care. The goal of these services is to quickly stabilize the person in crisis, avoid hospitalization or incarceration, and help the person transition back into the community. The problem is that **in Washington State, not everyone who is experiencing a crisis gets stabilized**.



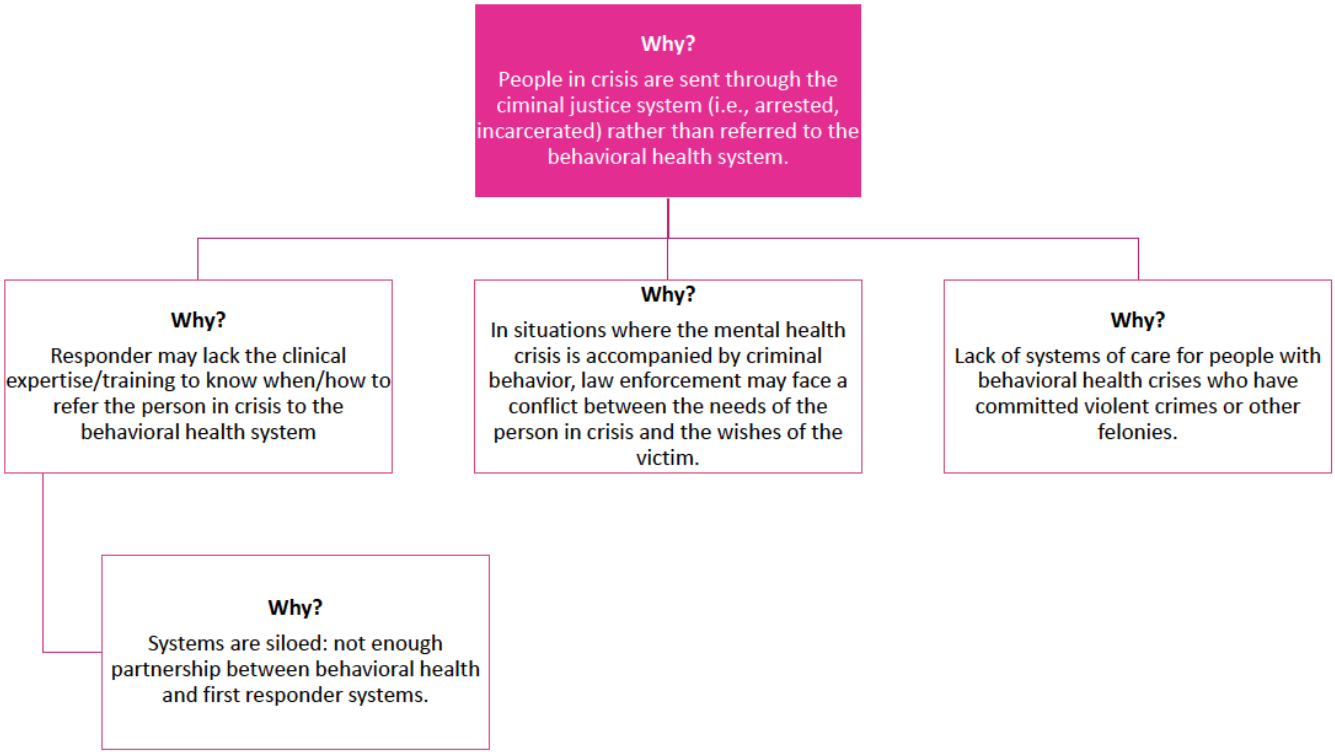
1


Why?
Some people—particularly those who live outside the I-5 corridor—do not have crisis stabilization services in their local area.
Why?
Lack of providers, particularly in rural areas, which means people who need to access crisis stabilization services may have to travel for hours.
Why?
Limited access to technology for some populations and geographies creates barriers to accessing stabilization services.
Why?
It is difficult to recruit providers to live in rural areas.
Why?
Lack of training for potential behavioral health providers in rural areas.
Why?
Potential providers outside of the I-5 corridor have had difficulty accessing adequate funding.
Why?
Pay for mental health providers is lower in rural areas than in urban ones.
Why?
Housing (for providers) may be more difficult to access in rural area.
Why?
Newcomers to a rural community, especially people of color, may feel unwelcome and/or uncomfortable living there.
Why?
Funding sources for behavioral health are complex and can be unpredictable.
Why?
Funding is more commonly available for capital investments than operating costs

2


Why?
Overreliance on law enforcement to respond to behavioral health crises, rather than behavioral health specialists.
Why?
In many communities, there are limited or no alternatives to emergency department or law enforcement, especially after hours.
Why?
Some who call in a behavioral health crisis--especially when accompanied by what is perceived as violent or criminal behavior--are calling 911 rather than accessing help through the behavioral health system. Racism can play a role in this.
Why?
We have not established collaboration, partnerships, and trust between 911 and 988 system to better facilitate coordination and handoffs across systems.
Why?
Funding model for police and fire is stable and consistent, compared to funding for behavioral health.
Why?
Behavioral health crises can be accompanied by physically aggressive behavior, which can be perceived as threatening.
Why?
Lack of awareness of alternatives to 911 for a behavioral health crisis.
Why?
Preference of some community members to engage law enforcement rather than the behavioral health system.
Why?
Most people do not know how to tell the difference between physically aggressive behavior that is unlikely to cause harm and potentially violent/dangerous behavior.
Why?
We lack tools for protecting the saftey of people who work with or care for people with behavioral health issues that manifest in physically aggressive ways.

3


Why?
People in crisis are sent through the ciminal justice system (i.e., arrested, incarcerated) rather than referred to the behavioral health system.
Why?
Responder may lack the clinical expertise/training to know when/how to refer the person in crisis to the behavioral health system
Why?
In situations where the mental health crisis is accompanied by criminal behavior, law enforcement may face a conflict between the needs of the person in crisis and the wishes of the victim.
Why?
Lack of systems of care for people with behavioral health crises who have committed violent crimes or other felonies.
Why?
Systems are siloed: not enough partnership between behavioral health and first responder systems.

4