CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE MEETING SUMMARY

Tuesday, June 20, 2023; 1:00 pm – 4:00 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

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ATTENDEES

COMMITTEE MEMBERS

Adam Wasserman, State 911 Coordinator
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
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
Joan Miller, Washington Council for Behavioral Health
Justin Johnson, Spokane County Regional Behavioral Health Division
Keri Waterland, Washington State Health Care Authority (HCA)
Kimberly Mosolf, Disability Rights Washington
Levi Van Dyke, Volunteers of America Western Washington
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
Representative Tom Dent, Washington State House
Robert Small, Premera Blue Cross
Ron Harding, City of Poulsbo
Senator Manka Dhingra, Washington State Senate

COMMITTEE MEMBERS ABSENT

Caitlin Safford, Amerigroup
Darcy Jaffe, Washington State Hospital Association
Jessica Shook, Olympic Health and Recovery Services
Kashi Arora, Community Health and Benefit, Seattle Children's
Krystina Felix, The Kalispel Tribe
Linda Grant, Evergreen Recovery Centers

Michael Robertson, Certified Peer Counselor
Michelle McDaniel, Crisis Connections
Representative Tina Orwall, Washington State House
Senator Judy Warnick, Washington State Senate
Summer Hammons, Treaty Rights/Government Affairs

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
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 Ron Harding, Chief of Police for the City of Poulsbo, welcomed everyone. Chief Harding shared his learnings from his time on the CRIS Committee, highlighting the benefits of differing perspectives among Committee members. He underscored his commitment, and the shared goal among all CRIS Committee members, to make a difference and contribute to positive change in the behavioral health crisis response system.

Jamie thanked Chief Harding and noted the group has been alternating between traditional land acknowledgement and using time to share information on the work Tribes are doing to strengthen and enhance a crisis response system in a manner that is Tribal centric. She thanked previous guests—including Vicki Lowe, Kathrine Akeah, Lucy Mendoza, and the Volunteers of America Western Washington colleagues—for providing updates to the committee. In place of a land acknowledgement or presentation, Jamie made a commitment to continue to keep Tribal-centric behavioral health, Tribal sovereignty, and the healthcare commitments the U.S. Federal Government has made to Tribes in the forefront of committee work.

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 updates from state agencies and Governor's Office relevant to CRIS work.

3. Hear outcomes from HCA update of Crisis Response Dispatch Protocols, including how CRIS feedback has been considered and addressed, and receive overview of the Crisis Response Best Practices Guide.
4. Begin discussing recommendations for addressing system gaps related to crisis stabilization, as captured in the root cause analysis.
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.

Betsy Jones, HMA, reviewed the updated CRIS Committee timeline and deliverables, which was extended one year by HB 1134. The Steering Committee, with input from the CRIS Committee and Subcommittees, will now submit a third progress report on January 1, 2024, and the final report with recommendations on January 1, 2025.

The CRIS Committee decision process map was adjusted to reflect the extended timeline and allows time to focus on areas of discussion needed. This year's focus has been on the crisis response services continuum and resources needed to expand. This summer moves into synthesizing the discussions and recommendations that have come out of the CRIS and workgroup discussions this year and will establish the foundation of recommendations for the Steering Committee to consider for the January 1, 2024 progress report. The draft recommendations developed in September will feed into writing the report in October, and the CRIS Committee will then provide feedback on the written draft report in November, allowing more time for review and feedback per request from last year. In December, Steering Committee approval will be sought for submission of the draft progress report by January 1, 2024. 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.

Jamie thanked Betsy and noted that per a suggestion from Dr. Snowden, CRIS Committee members will be asked to provide post-meeting feedback that will be used to continue to create a space for open and candid feedback on meetings. CRIS Committee members were encouraged to complete a survey that would be sent out after the meeting.

PERSONAL STORY

CRIS and Steering Committee member, Anna Nepomuceno, National Alliance on Mental Illness (NAMI) Washington, provided an introduction for Marilyn Roberts to share her personal story and experience with Washington's crisis response system. Marilyn is the Executive Director of NAMI Thurston/Mason and previously worked in healthcare for over 30 years. Her 37-year-old son has bipolar disorder and Marilyn shared their experience in Washington's current crisis response system, including calls to 911 while her son experienced psychosis, stays at multiple care facilities, and visits to emergency rooms. Her son was later arrested and sent to jail for 97 days, and ultimately joined the Trueblood vs. DSHS class action lawsuit where

Marilyn testified on his behalf. Her son has been progressing in his recovery; he now lives on his own on a small farm and meets with the Thurston County Program for Assertive Community Treatment (PACT) once a week. Finding NAMI and attending supports groups and classes has helped Marilyn as she interacted with people with the same lived experience and supported with tools for family members to navigate the system and advocate for change. Marilyn's slides and a recording of her story are part of the June 20, 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). CRIS and Steering Committee member, Bipasha Mukherjee, thanked Marilyn for sharing with the group, and noted her experience emphasized the need for crisis care and ongoing long-term care.

Agency Q&A

CRIS members received the CRIS newsletter with state agency and committee updates in advance of the meeting. Members in attendance did not have questions for the state agencies. One member sent in a comment via email: "Regarding the policy statement on the roles of 988 call centers and regional crisis lines: As part of this comprehensive review, it seems critical to examine the difference in access to resources between 988 and Regional Crisis Lines (RCLs) - specifically for RCLs being able to identify youth callers and dispatch Mobile Response and Stabilization Services (MRSS) or mobile crisis teams whereas 988 may not identify a youth. This is a key difference in access to care and access to best practice, which this comprehensive review may inadvertently omit if not intentionally called out."

Megan Celedonia, Governor's Office, provided an overview of her role as the Governor's Office 988 Hotline & Behavioral Health Crisis System Coordinator. This position was created in HB 1477 and extended in HB 1134 to oversee statewide implementation of 988 with behavioral health system partners. Megan coordinates with lead state agencies accountable for the work, including Washington State Health Care Authority (HCA) and Washington State Department of Health (DOH) to create a cross-agency project structure. She is also the Governor's representative on the CRIS Committee and subcommittees, and she works with the 911 Advisory Committee as well as other stakeholders.

Megan highlighted HB 1134 and SB 5120 implications for cross-agency work. The lead state agencies are integrating HB 1134 and SB 5120 work into project scope and adjusting deadlines to support the CRIS extension. Additional staff and contractors are also being onboarded to support efforts, particularly those related to the technology solution.

Megan highlighted the 988 State Affinity Group spearheaded by Washington state. This group includes a representation from 44 states, D.C., and two territories responsible for implementing the 988 line, and provides a venue for states to report-out, share information, and take on challenging topics to support 988 implementation.

- Representative Orwall thanked Megan for her overview and emphasized the efforts to make the behavioral health system more robust and improve the ability to respond quickly. She is hopeful that the regions will come together to make the work happen.
- Bipasha asked about attendance at the 988 State Affinity Group and whether the meetings include people with lived experience. Megan responded that she would follow up on this question. (Note: Megan followed up on this question by email, noting that the group is comprised of program staff from each state and that she is not able to comment on how each state or territory is incorporating the voices of lived experience in their work.)

Keri Waterland, HCA, highlighted the three CRIS Committee seat vacancies and HCA's efforts to fill them. The CRIS Committee is currently looking for representatives from an organization specializing in facilitating behavioral health services for the LGBTQI+ population, a university-based suicide prevention center of excellence, and an emergency medical services department with a CARES program. HCA advertised the first vacancy at the Saying it Out Loud conference for the LGBTQI+ population, reached out to the University of Washington and Washington state about the second vacancy, and continues to work to address all three of the vacancies. Keri encouraged current CRIS Committee members and meeting attendees to send in any ideas for filling vacancies, including outreach suggestions, to HCAprogram1477@hca.wa.gov.

Michael Anderson-Nathe, consultant, shared updates from the Behavioral Health Crisis Response & First Responder Collaboration workgroup process. The workgroup was charged with developing recommendations for the CRIS Steering Committee to ensure appropriate, effective, equitable, and safe collaboration between the behavioral health system and first responders. It is made up of approximately 22 members with representatives from the CRIS Committee and Lived Experience Subcommittee, first responders, the behavioral health crisis system, state agencies, and additional subject matter experts. The workgroup began by identifying barriers, fears and concerns, followed by developing recommendations to address those barriers. It also plans to get input and feedback from the Lived Experience Subcommittee. Moving forward, the workgroup will map recommendations onto six pillars of system change and provide a formal update in July.

PRESENTATION: CRISIS RESPONSE DISPATCH PROTOCOLS AND BEST PRACTICES GUIDE

Matt Gower, HCA, provided an overview of the Crisis System Toolkit, including the process to develop the Crisis Response Best Practice Guide, the purpose, and plans to update and implement. HB 1477 mandated the creation of the crisis system best practices by July 1, 2023. With the passage of HB 1134 and changes in timeline for the launch of Crisis Contact Hubs, the HCA team adapted the Toolkit to support implementation of Substance Abuse and Mental Health Services Administration (SAMHSA) and current system best practices, and will allow integration of Crisis Contact Hubs and other changes to the system as they are implemented. The system-level goals for the Toolkit include:

- Standardizing dispatch systems across regions to ensure individuals can recognize resources
- Improving coordination between system partners

- Changing current process to improve service outcomes and equity
- Teaching system partners to improve relationships and communication

Toolkit components include:

- Overview of the Crisis Redesign Project
- System Best Practices
- Crisis Contact Hub Best Practice Program Guide
- Mobile Crisis Outreach Best Practice Program Guide
- Standardized Dispatch Protocols
- High-Risk Guidelines

HCA developed the Toolkit using input from system experts (e.g., staff experts working in mobile crisis response, call centers). The Crisis Response Dispatch Protocols were developed through the Mobile Crisis and Call Center Best Practice Workgroups and following templates from Georgia, Los Angeles County, Virginia, and Michigan. HCA then integrated feedback from the Lived Experience Subcommittee and the CRIS Dispatch Protocols Workgroup, completed internal and external review processes, and is currently working on formatting. HCA plans to share the Toolkit with CRIS Committee members to review in more detail and provide feedback as needed, with a goal of publishing by July 1.

DISCUSSION: BEGIN EXPLORING POTENTIAL RECOMMENDATIONS TO ADDRESS SYSTEM GAPS FOR CRISIS STABILIZATION

Jamie introduced discussion plans to start generating ideas for potential recommendations to address root causes of system gaps developed during the May 16 CRIS Committee meeting (*Note:* the root cause discussion during the May 16 meeting addressed the following: 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. Why?)

Keri Waterland (HCA) set the context for how CRIS's input on this topic will influence future recommendations, noting that CRIS Committee members' voices are highly valued by agencies leading efforts to implement system changes and encouraging members to speak up during the discussion.

CRIS members were given 10 minutes to review the root cause discussion summary (available on the CRIS webpage at: https://www.hca.wa.gov/assets/program/cris-root-cause-analysis-20230612.pdf).

Jamie facilitated the group discussion and provided the following prompt questions (also sent via email in advance) for committee members to consider:

- Which of these root causes do you think are within the CRIS's scope to address or influence?

- What are some ideas or potential best practices that state agency staff could investigate to address a problem that you identified as within the CRIS scope?
- What are some potential policy, funding, or legislative solutions to the problem(s) that you identified as within the CRIS scope?

Committee Discussion

CRIS Committee members shared their input and feedback on root causes to address, potential best practices to investigate, and potential solutions:

Root Causes & Recommendations

Root Cause:

- *Lack of education about behavioral health conditions.*
- *In many communities and cultures, there is a stigma against seeking treatment for behavioral health.*

Potential recommendations:

- Leverage existing networks to support outreach and education about behavioral health, crisis response, and the 988 line.
- Translate into multiple languages and print out informational materials about behavioral health and crisis response to distribute in medical practices and other locations.
- Tailor messaging and distribution methods to best reach marginalized communities (e.g., people of color, immigrant communities, LGBTQI+). Create a subcommittee comprised of people of color and other marginalized communities to advise on how to best communicate information and address stigma or other barriers to access in their communities.
- Create public relations campaigns to address stigma against behavioral health conditions and seeking help. Highlight positive ways to frame behavioral health differences. Members underscored that as long as we continue to have strong mental health stigma, this impacts everything we do. If people are afraid to get help, they will end up with lack of services.
- Something adjacent to stigma but different, are the harms that can happen to individuals when mainstream models don't work for them, when providers are harmful (accidentally or intentionally). There is so much fear, so much exhaustion, from people trying to access help but instead getting harmed further. Recommendations need to recognize and address this concern.
- Consider expanding efforts to provide mental health first aid trainings and education for lay persons. Consider mandating everyone in school take a mental health first aid training.
- Use tools from the public health world to create a messaging campaign or awareness to catalyze behavior change (e.g., behavioral health crisis alternatives to 911, when to call 988 versus 911). Emphasis is needed on helping public to understand behavioral health crisis and how it manifests versus true safety risks.
- While public education address stigma and provide information about available resources is important, it is critical recognize that this is not enough. Even people with extensive knowledge of the system are encountering barriers to care where more education will not fix the problem. In addition to education,

therefore, it is critical to set system performance targets and metrics and hold the behavioral health system accountable for hitting those targets and metrics. One of the big differences between calling 911 and 988, for example, is how quick the response would be if you are a person seeking an in-person response. It is important to be honest about this reality and set expectations of our behavioral health crisis response system to respond more quickly to people choosing it. This work also includes ensuring equity in services across populations, such as in rural areas, and implementing population metrics to tell when certain regions or populations aren't getting the same level of services and then focus on investing and improving those areas.

Root Cause: *There is limited information (e.g., centralized database) of services available for a person in crisis.*

Potential recommendations:

- Create a user-friendly centralized website or database with comprehensive, payer-blind behavioral health crisis-related resources. available to professionals and the public. The database could be available to professionals and the public and could include a list of all behavioral health providers and they services they provide, information about prevention resources, and other information for people with behavioral health crisis needs. Important to also recognize the need to invest resources into ongoing efforts to compile information and maintain the database, so that it does not become just another source of potentially confusing and outdated information. Consider mandating that providers and their services are listed in the database.

Root Cause: *Lack of services to prevent people from reaching a crisis point in the first place.*

Potential Recommendations:

- While recognizing the importance of the CRIS's focus on improving the behavioral health crisis response system to address the needs of people in crisis, our recommendations long-term should look at upstream prevention in the state to help people avoid reaching the crisis stage in the first place. Prevention services across the state are not consistent, and this is something to recognize in the committee's recommendations. Recommendations relating to prevention should include investments in basic services and social needs that contribute to stress and behavioral health crises. This could also include support to navigate and simplify access to these services. People with lived experience face significant challenges in navigating the complexity of the system and accessing services and may experience a sense of hopelessness in their ability to obtain services that they are eligible for.

Root Cause:

- *Some people—particularly those who live outside the I-5 corridor—do not have crisis stabilization services in their local area.*
- *Crisis receiving centers have restrictive eligibility criteria.*
- *Limited resources impact staffing and services available to address someone's needs.*

Potential Recommendations:

- Anticipate and prepare for response to local community concerns and potential delays due to litigation when building new crisis centers and facilities. To avoid or mitigate concerns, be prepared on legal challenges and create public relations campaigns to educate communities about behavioral health and the importance of services in advance of proposed facilities being built around the state. Consider partnerships state and local officials and people lived experience to engage in forums to help the public understand the importance of the services. Recognizes that cities are key partners, and the importance of engaging early on the development of these efforts before decisions are made.
- Provide additional funding to behavioral health crisis systems in rural communities. Consider enabling "payer blind" crisis services (i.e., services not just for Medicaid clients or commercially-insured clients).
- See recommendations above about performance metrics for services in rural areas and holding the behavioral health crisis response system accountable. It is important to establish metrics to tell us when rural areas aren't getting level of services urban areas are and then focus on investing and improving services in those areas.

Root Cause:

- *Overreliance on law enforcement to respond to behavioral health crises, rather than behavioral health specialists.*
- *People in crisis are sent through the criminal justice system (i.e., arrested, incarcerated) rather than referred to the behavioral health system.*

Potential Recommendations:

- Cross-system collaboration, including coordination between 988 and 911, is a significant role CRIS should advise on. The goal is to ensure that we have systems that can communicate to ensure the caller receives appropriate responses and care needed. We need recommendations to suppport collaboration, partnership, and trust between 911 and 988 system to better facilitate coordination and handoffs across systems. This work should: recognize 988 and 911 co-location efforts, and potential areas for CRIS to recommend ways to support 988 and 911 collaboration while recognizing concerns raised among populations who will not reach out to 988 if they fear this will trigger engagement with 911 or law enforcement; education regarding training that law enforcement personnel receive regarding behavioral health crisis response; recognition of fundamental societal root causes that have shaped the inequities, injustices and fear of law enforcement experienced in our current system. The work could engage input from subcommittee raised earlier to include people of color and other marginalized groups.

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

ACTION ITEMS AND NEXT STEPS

Next steps and action items for the meeting:

- CRIS Committee members to provide feedback to HCA on ideas for filling CRIS vacancies.
- CRIS Committee members to respond to the post-meeting survey.
- HCA to format the Crisis System Toolkit and share with CRIS Committee members.

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