



STATE OF WASHINGTON

DCR Protocols Consultation

September 24, 2024, from 2:05 pm to 4:00 pm

Hosted by the Health Care Authority Office of Tribal Affairs

Consultation Attendees:

<i>Entity</i>	<i>Name</i>	<i>Title</i>
Colville Tribes	Dana Seymour	Councilwoman and Health & Human Services Chair
	Zachary Feist	Clinical Director / LMHC
Lower Elwa Klallam Tribe	Becca Sampson-Weed	Social Services Director
Lummi Nation	Maureen Curley	General Manager
	Cara Grisham	Behavioral Health Department
Shoalwater Bay Tribe	Coleen Chapin	Chemical Dependency Program Manager
Squaxin Island Tribe	Erika Thale	Tribal Executive
	Julie Owens	Director of Operations
Swinomish	Sarah Sullivan	Health Policy Director
	Karen Gott	Director of Social Services at Didgwalic
Suquamish Tribe	Steve Kutz	Policy and Self Governance Director
	DesaRae Sterns	Director of Tribal Health Programs
Tulalip Tribes	Summer Hammons	Legislative Policy Analyst
	Gina Skinner	Chemical Dependency Clinical Administrator
Upper Skagit Tribe	Brent Pritchard	Behavioral Health and Social Services Director
Tribal Organizations/non-Tribal Indian Health Care Provider Attendees	Vicki Lowe, AIHC Executive Director Kathryn Akeah, AIHC Tribal Health Consultant	
State Agency: Healthcare Authority	Ryan Moran, HCA Director Aren Sparck, Assistant Director, Office of Tribal Affairs Teesha Kirschbaum, Division Director, Division of Behavioral Health & Recovery Christine Winn, Deputy Administrator, Office of Tribal Affairs Lucilla Mendoza, HCA OTA Tribal Behavioral Health Administrator Maddie Wrolson, HCA OTA Tribal BH Crisis Response Coordinator Lisa Westlund, HCA DBHR Involuntary Treatment Act (ITA) Administrator Luke Waggoner, HCA DBHR Involuntary Treatment and Crisis System Supervisor Jeff Landon, HCA DBHR Section Manager Adult Services and Involuntary Treatment Mike Longnecker, HCA OTA Claims and Billing Technician	

State Agency: DOH, DSHS	None
Other Partners	Christina Diego- Social Services and Health Policy & Legislative Affairs Director, Governor's Office of Indian Affairs

Welcome, Acknowledgement, and Blessing

Welcome and Introductions: Aren Sparck

Blessing by: Christine Winn

Opening statement HCA: Aren Sparck spoke about the importance of this work and the collaboration with the Tribes and the RCW which requires the Protocols for DCRs be updated every 3 years

Opening statement Tribe: None

Opening statement HCA: Aren provided and made a call for any elected Tribal staff in attendance. None were identified. Confirmed there were some behavioral health staff. Director Ryan Moran was confirmed in attendance. One last call for elected officials.

Review of the Agenda: Maddie Wrolson

HCA Leadership Opening Statements:

Ryan Moran provided a thank you for intro and for joining. For welcoming me on this important work. Part of our standard work of how designated responders are performing this work. First and foremost, HCA recognizes Tribes are subject matter experts on the subject, and HCA is committed to supporting them on development of these protocols. Listening closely to ensure aligns with the work.

Teesha Kirschbaum shared updates on ongoing work with Tribal government on DCR protocols. RCW since 1999, developed protocols to be updated every 3 years. HCA will continuously work to update with Tribes. Support in treatment. Teesha reviewed RCW and HCA's position and responsibilities. Ensure our DCR protocols support and partner with Tribes.

DCR Protocols Background:

Maddie began the presentation with Lisa Westlund and the background slides.

Lisa Westlund gave introduction and background. RCW requires statewide protocols to be developed to be utilized pertaining to involuntary treatment on a 3-year cycle. Some info was in protocols from 2020 but wanted to ensure was included to review if needed to be changed. Incorporated House Bill 1877.

Walkthrough and Discussion of DCR Protocols:

An overview of the document was reviewed [dcr-protocol-2026-draft.docx](#).

Tribe Comment - Managed care plans are contracting for BHAs to manage crisis. Where are their responsibilities? Crisis is not responding in a timely manner so have to take to ER.

HCA Response - For crisis services, contract to BHASO and we contract with them. Stipulated times must respond in contract (BH 1 hour, Emergent 2 hours, urgent 24 hour, etc.)

HCA Response - There are sections of the protocols that discuss timelines and we will go over those sections as we walk through the document. (in Teams chat)

Tribe comment - Tribal Attorneys need to take a look (in Teams chat)

HCA Response - will follow up on the Tribal Attorney comment from Sarah Sullivan.

Additional Doc Review - There was further review of the 2026 DCR Protocols document with focus on offering less restrictive alternatives to inpatient treatment, legislation passed in 2022 and 2024, Washington crisis services system of care, reviews the broad coverage of services, DCR service overview, and the ITA process flowchart section & graphic.

Tribe Question/Comment - voluntary vs involuntary, under all circumstances, is it required they discuss all options for both? Some things happen that affect their rights and try to explain why it is preferred to voluntary commit.

HCA Response - They notify them of their rights and that involuntarily are held against their will. Informing individual will have DCR assess the person. Will identify rights and defense attorneys will notify and inform of rights.

HCA Response – Provided with a copy of rights? Correct. It is provided in their court documents.

Tribe Comment – It is easier and better to go voluntarily. Changes their demeanor.

HCA Response – goal is to prevent involuntary commitment. Come up with safety plan, etc and a less restrictive method.

HCA Response - DCRs cannot intrude on civil liberties as a DCR. Must meet criteria and ensure they are met. Need to ensure they have someone to call who asks lots of referral info to get into appropriate crisis services. This is built into the document to increase knowledge. During the Roundtable there was a question regarding duty to warn. Identified in document and included in statutory requirements. The document will have hyperlinks.

Noted that page 26 of the document has a list of what that screening may look like, what might get asked, and does include active military and veterans. AI/AN section making sure language to be in sync with what the statute says. Considerations that happen for different places, ER vs BHA office. Page 47 addresses medical clearance which isn't required before a DCR investigation in a community. For Emergency room, will need in order to be transferred, medical complications with intoxications. Working internally in HCA to see what options are available

AIHC Comment – On medical clearance and ERs, is it encouraged to, in crisis, be taken to the ER?

HCA Response - Depends on the situation, case by case consideration. The questions that will be asked in screening. Safety, medical concerns, yes or no. Best to see in their own environment community outreach is very beneficial. Has there been any community outreach? Utilize community resources?

AIHC Comment – Direct to ER to get evaluated by DCR; ER saying not needing and releasing.

Tribe Comment – many times, if its own BH and DCR staff, refuse to take Rx, and destabilize. Outside DCR comes in and prescribes, still doesn't take. DCR won't come in until another crisis. Can take to 16 bed units and bypass the hospital. Shouldn't be the ER's DCR. It should be any DCR that can be admitted such as the Tribal DCR.

HCA Response– Facility operations side. It is a real barrier and systems challenge. Privately operated and own protocols and own risk. All have certain set of requirements prior to being admitted to their facilities.

Tribe Comment - Guarantee ER is not having conversations with them. State needs to set up some common rules and guidelines. No state funds if they aren't following. Hospitals should not be able to override the Tribe DCR unless there is a medical condition.

AIHC Comment: Tribal Court Orders should be accepted by any facility in the same way they accept a Superior Court order.

HCA Comment: IHCPs can provide Medical Clearance as well.

HCA Comment - ER should go through standard process and not override the DCR. House Bill 1877 statute requires them to accept Tribe court orders the same as state court order.

Conversation continued on carceral settings section. Important aspect, if incarcerated, they cannot be considered to remain in facility and stay because it is safe. It is not an alternative to them needing to be placed in a less restrictive alternative. Seeing an increase in this.

Tribal Leader Consensus to complete next steps for the DCR Protocols:

Next question, do leaders and those able to vote, do we have consensus to move forward? Objections? Concerns?

HCA commits to follow up on ER discussion and request for guidance for families and discussion on medical guidance through the Tribal Centric BH Advisory Board. These are complicated subjects.

Tulalip Tribes Delegate Comment (Summer Hammons) –Concurs with Vicki's comment that Tribal court orders should be enforced/accepted as state court orders. Let's move the work forward. I appreciate all the work.

HCA commits to take a look to see if it is embedded or where it can be embedded. We will re-address all comments and follow up.

Suquamish Tribe Leadership Comment (Steve Kutz)– no concerns, move forward. When will have finality? Need to get the training going.

HCA Comment will need to be revised every 3 years, so nothing gets overlooked and work on updating starts very soon after this version is posted.

Consultation Closeout Decision:

HCA will add language about Tribal court orders into DCR Protocols or highlight where it is already embedded.

Move forward to leadership review/document publishing. Get document training going.

Continue discussion on ERs and request for guidance for families and discussion on medical guidance with TCBHAB.

Closing/Next Steps Statements:

No final comments from Tribal elected officials

HCA thanks Tribal leaders and Tribal staff for their time in participating and providing feedback today.

Meeting Adjourned by: 3:55 pm

Meeting Length: 1 hour and 50 minutes