# *Washington Behavioral Health Crisis Response and Suicide Prevention System: HB 1477 Committee Progress Report and Funding Recommendations for the 988 Line Tax*

FUNDING RECOMMENDATIONS AND PROGRESS REPORT PER HB 1477 SEC 103(11) & 104(4)

TO
GOVERNOR JAY INSLEE
HOUSE APPROPRIATIONS COMMITTEE
HOUSE HEALTH CARE AND WELLNESS COMMITTEE
SENATE HEALTH AND LONG-TERM CARE COMMITTEE
SENATE BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH AND LONG-TERM CARE COMMITTEE
SENATE WAYS AND MEANS COMMITTEE

FROM
THE STEERING COMMITTEE OF THE CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE

DECEMBER 31, 2022

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## Legislative Requirements

House Bill (HB) 1477, enacted July 25, 2021 following the 2021 regular session of the Washington State legislature, created a Crisis Response Improvement Strategy Committee (CRIS), a Steering Committee of the CRIS, and subcommittees to develop recommendations related to the funding and delivery of an integrated behavioral health crisis response and suicide prevention system in Washington.[1]

The Steering Committee – with input from the CRIS Committee and Subcommittees – is charged to deliver to the Governor and Legislature:

- **JANUARY 1, 2022**: a progress report, including results of the comprehensive assessment of the behavioral health crisis response and suicide prevention services systems and preliminary recommendations related to funding of crisis response services.
- **JANUARY 1, 2023**: a second progress report, including a summary of activities completed by the CRIS during CY 2022 and final recommendations related to funding of crisis response services from the 988 Account created by the line tax.
- **JANUARY 1, 2024**: a final report with recommendations addressing system elements outlined by the legislation. These elements fall within the following eight areas:
    1. Vision for Washington's crisis response and suicide prevention system
    2. Equity
    3. Services
    4. Quality and Oversight
    5. Cross System Coordination
    6. Staffing & Workforce
    7. Technology
    8. Funding & Cost Estimates

The first report in this series, *Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services in Washington and Preliminary Funding Recommendations*, was submitted on December 31, 2021.[2] This report serves as the second progress report and fulfills the requirements due January 1, 2023.

[1] House Bill 1477 (2021). Retrieved from https://app.leg.wa.gov/billsummary?BillNumber=1477&Initiative=false&Year=2021

[2] *Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services in Washington and Preliminary Funding Recommendations* (December 31, 2021). Retrieved from https://www.hca.wa.gov/assets/program/1477-assessment-of%20crisis-delivery-system-20211231.pdf

# Executive Summary

The HB 1477 Steering Committee is charged to develop recommendations for an integrated behavioral health crisis response and suicide prevention system that will be shared with the legislature and Governor. The Crisis Response Improvement Strategy (CRIS) Committee and the HB 1477 Subcommittees will advise the Steering Committee with their recommendations.

The CRIS Committee is comprised of 36 members with broad representation set forth by HB 1477 including: individuals with lived experience and representatives from state agencies, service providers, first responders, Medicaid and commercial health plans, tribal representatives, state legislators, population-specific representatives, advocacy groups, and other stakeholders across the crisis response system. In addition, the Steering Committee formed seven Subcommittees to provide professional expertise and community perspectives into the development of crisis system recommendations.

## 2022 Committee Progress Update

In 2022, the Steering Committee, CRIS Committee and Subcommittees' work focused on establishing a foundational understanding of Washington's current crisis response system and setting a vision to guide the development of recommendations for a future-state system in 2023. The committee work and input throughout 2022, as summarized in this this *January 1, 2023 Committee Progress Update,* will inform the Steering Committee and CRIS Committee's work for the coming year. Steering Committee, CRIS Committee, and Subcommittees 2022 meeting summaries, materials, recordings, and other information are posted on the CRIS webpage.[3]

It is important to note that further work is needed to analyze and interpret data presented in this report to understand the crisis system service gaps by geography and population across the state. This 2023 report presents progress of the Committee in developing an understanding of the current system but does not yet reflect a complete picture of the current system gaps and needs.

In carrying out the work of HB 1477, the Steering Committee is engaging with Tribes in a manner that recognizes the sovereign authorities of Tribal governments and recognizes the extensive work led by Tribes and Urban Indian Health Organizations (UIHOs) in Washington for over a decade to address the significant inequities in health and access to behavioral health crisis services experienced by American Indian and Alaska Natives (AI/AN) in the state. Upon request of the Tribes, the Steering Committee initiated a Tribal Consultation process in 2022 to review and ensure tribal perspectives are included in HB 1477 recommendations for integrated behavioral health crisis response and suicide prevention system in Washington.

[3] Washington State Health Care Authority, Crisis Response Improvement Strategy Committees, retrieved from https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees

A summary of committee progress and tribal partner input to develop recommendations in each of HB 1477's eight areas of recommendations is provided in Section II of this report and summarized below.

1. **Vision for Washington's crisis response and suicide prevention system:** In May 2022, the Steering Committee approved a vision statement and 10 guiding principles for Washington's integrated behavioral health crisis response and suicide prevention system. This vision and the guiding principles were developed by the CRIS Committee and Subcommittees, and establish the foundation for the Steering Committee, CRIS Committee, and Subcommittee's work to develop recommendations to improve the system.
2. **Promoting Equity:** There are significant disparities in the experiences of different populations regarding the current crisis response system. These disparities are wide-ranging and have major ramifications for the design of an improved system. In 2022, the CRIS and Subcommittee provided input on ways to promote equity across the crisis service continuum. This input will inform recommendations developed by the Steering Committee and CRIS Committee in 2023.
3. **Services:** Committees examined current services available in Washington across the crisis service continuum (A Place to Call; Someone to Come; A Place to Go; Pre- and Post- Crisis Care), identified key gaps, and began discussions to identify services that should be expanded and/or added to address these gaps. We note that this report includes information compiled to date regarding the current crisis system and services; however, it does not yet reflect a comprehensive understanding of the system gaps and service needs. Deeper analysis and interpretation of the data, including understanding services gaps by geography and population, is planned for work in 2023, as outlined in Section IV of this report.
4. **Quality and Oversight:** The identification of Washington crisis system goals, outcome measures, and improvement targets is foundational to the charge and the work of the Steering Committee to make recommendations to improve the system. The Washington State Health Care Authority (HCA) and the Department of Health (DOH) are developing an inventory of current system metrics in use in Washington that will be brought the CRIS and Steering Committee for input and discussion in the first quarter of 2023.
5. **Cross System Coordination:** Work focused on development of a cross-system process map to establish an important foundational understanding of the current system and future-state changes needed. HCA and DOH are carrying this work forward to develop protocols and other processes to support cross system coordination. This work also identified system policy decisions needed to guide collaboration across crisis system partners.
6. **Staffing & Workforce:** Subcommittees identified recommendations to support a well-trained, supported, and diverse crisis service workforce. To ensure equitable and consistent crisis response across the state, there is the need for development of standardized trainings across a core set of topic areas for providers across the crisis service continuum. Key components of a workforce development strategy include use of peers, recruiting staff that reflect the communities served, and prioritizing training and experience over minimum education requirements where appropriate.

7. **Technology:** HCA and DOH submitted a draft Technical and Operational Plan in February 2022, and a final Technical and Operational Plan was approved on October 25, 2022, by the Steering Committee. The Final Technical and Operational Plan provides analysis of HB 1477's technology requirements and Washington needs to inform the state's future approach for development of a Request for Information/Request for Proposals to identify technology vendors.
8. **Funding & Cost Estimates:** Crisis response services that a person may receive or be eligible for depends on their insurance source. There are current disparities in crisis system funding levels across the state. In 2023, the CRIS and Steering Committee will further address recommendations relating to crisis system service costs, equitable distribution of resources, and allocation of funding responsibilities across payers.

## Recommendations for Expenditures from the 988 Behavioral Health Crisis Response and Suicide Prevention Line Account

For this year's report, the Steering Committee has consulted with DOH on the refinement of the five-year cost estimate to support the 988 Lifeline crisis centers in Washington including ongoing operational costs. With the recognition that the final estimate of call volume to the 988 Lifeline in Washington is still in flux, DOH estimates that the five-year cost to support the 988 Lifeline crisis centers is approximately **$75.3 million** (See Appendix J for DOH cost model). With anticipated revenues of **approximately $238 million** in the first five years of the tax, this leaves approximately $162 million remaining to support services resulting from calls made to the 988 Lifeline. Activities that may be covered with these funds include personnel and the provision of acute behavioral health, crisis outreach, and crisis stabilization services provided in response to 988 Lifeline calls.[4] However, the next 5- year cost estimates are over $183 million as the number of calls and crisis centers mature to a "normal" state. Furthermore, costs are not known yet for future technology needs as outlined in the Final HB 1477 Technical and Operational Plan.

The Steering Committee recognizes significant unknown variables impacting the call volume to the 988 Lifeline, including impacts of active marketing efforts (this is planned for 2023), and potential increased 988 Lifeline call volume due to referrals of behavioral health crisis calls that are currently made to 911 and RCLs. The DOH current budget estimates do not account for referrals of calls from 911 and RCLs. Furthermore, the Native and Strong Lifeline just launched in November 2022, so it is too soon to understand ongoing call volume to that line.

Given the fluidity of estimating expenditures for calls into Washington's 988 Lifeline crisis centers in the first five years since the launch of 988, as well as the significant current gaps in mobile crisis response team resources across the state, the Steering Committee recommends the following:

1. Maintain the current tax rate, given the early stages of determining costs for the 988 Lifeline crisis centers and the significant current gaps in mobile crisis response across the state.
2. The Steering Committee recommends that expenditures from the account on mobile rapid response crisis teams or other allowable expenditures be informed by recommendations from the

[4] House Bill 1477, Section 205(2) (permissible uses of tax)

CRIS Committee in 2023 to ensure equitable distribution of these resources across the state. This recommendation aligns with HB 1477's charge to the Steering Committee and CRIS to develop recommendations to enhance and expand mobile rapid response teams in each region, (including specialized teams as appropriate to respond to the unique needs of youth, including AI/AN youth and LGBTQ youth, and geriatric populations, including older adults of color and older adults with comorbid dementia). The Health Care Authority is currently working to expand mobile crisis response teams and will bring updates to the CRIS Committee to inform these plans.

## Focus of Work to Undertake in 2023

In 2023, the Steering Committee and CRIS will build on the foundational committee work completed in 2022, and focus on the following areas to develop recommendations to guide improvements to Washington's behavioral health crisis response and suicide prevention system:

1) ***System goals and metrics:*** It is imperative that the committee identify the goals that will serve to provide direction for changes needed.
2) ***Crisis system services:*** Based on the system goals, the committee will evaluate gaps and identify services that need to be expanded and new services that need to be added to reach our system goals. In addition, further work is needed in 2023 to update and expand upon the data in this progress report, including deeper analysis of services available by region and access to services by population.
3) ***Funding:*** With an understanding of the services that need to be expanded and/or added, the Committee can then develop funding recommendations to support equitable distribution of these services across the state.
4) ***System Infrastructure:*** To support implementation of Washington's goals, critical system infrastructure including technology and workforce are needed. The committees will finalize any recommendations needed related to this infrastructure.

In Appendix K, we include CRIS member written comments on the draft progress report, including identification of priority areas for discussion in 2023 summarized in the table below:

| Areas of Work for 2023 | CRIS Member Comments |
|---|---|
| **System goals and metrics** | • Inventory of current data and metrics<br>• Consideration of variables impacting ability to meet goals/metrics<br>• Consequences for not meeting metrics |
| **Crisis system services** | • Deeper analysis of data to understand system gaps by population and geography (service maps by region), including co-response and first responder services, and transportation<br>• Clarify roles and expectations for law enforcement<br>• Clarify relationship between 911 and 988<br>• Focus on building on the existing system and adding best practices<br>• Create understanding of who is leading the system, and the role of BH-ASOs at the regional level<br>• Consider no show rates for next day appointments |

| | |
|---|---|
| **Funding** | • Funding for 988 Lifeline crisis centers to further diversity, equity & inclusion efforts |
| **System Infrastructure** | • Further discussion of geo-location and implications for confidentiality<br>• Recognition of Vibrant technology platform for future system design<br>• Workforce strategies will be critical<br>• Need for better understanding of current training for crisis response workers<br>• System efficiencies between 988 and RCLs, and coordination between 911 and 988 |

# Section I. Background

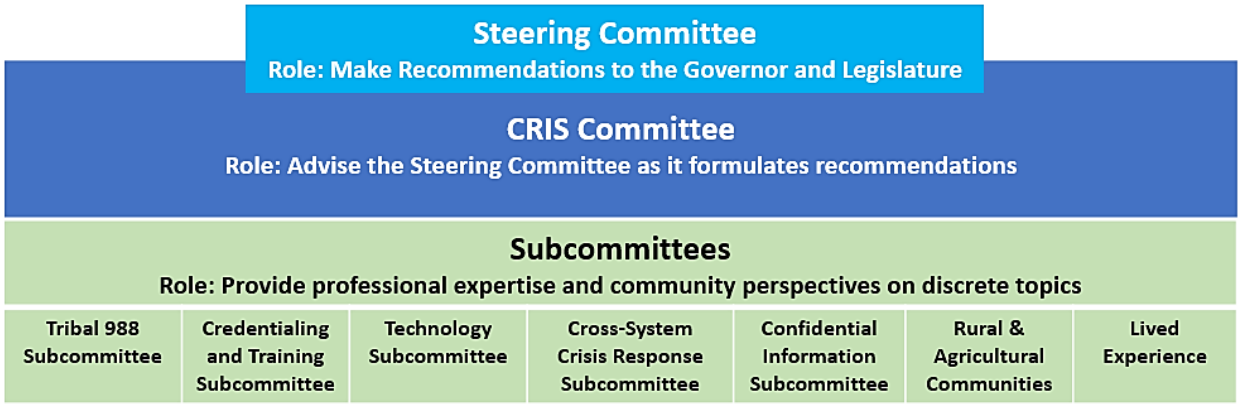
## Overview of Committee Structure

The Steering Committee is charged to develop recommendations for an integrated behavioral health crisis response and suicide prevention system that will be shared with the legislature and Governor. The CRIS Committee and Subcommittees will advise the Steering Committee with their recommendations.

The CRIS Committee is comprised of 36 members with broad representation set forth by HB 1477 including: individuals with lived experience and representatives from state agencies, service providers, first responders, Medicaid and commercial health plans, tribal representatives, state legislators, and other stakeholders across the crisis response system.[5] The Steering Committee is comprised of six members as a smaller subset of the broader CRIS Committee. The Steering Committee includes five voting members as outlined by HB 1477 serving in the following seats: House of Representatives, Senate, Governor's Office, Health Care Authority, Department of Health. In addition, the Steering Committee added a sixth member to represent individuals with lived experience on the Steering Committee.[6]

The Steering Committee formed the seven subcommittees below to provide professional expertise and community perspectives in the development of crisis system recommendations. The Subcommittees are comprised of members of the CRIS, state agency representatives, tribal partners and broad stakeholders offering community perspectives and/or professional expertise in the subcommittee areas of focus.[7]

*Figure A: HB 1477 Committee Structure*




* Five of the seven subcommittees are established by HB 1477. The Steering Committee established two additional subcommittees: Lived Experience, and Rural & Agricultural Communities

[5] A CRIS Committee member list is available on the CRIS webpage at https://www.hca.wa.gov/assets/program/cris-committee-member-list.pdf

[6] Because the lived experience representative on the Steering Committee was not identified in the legislation, the Steering Committee is not able to authorize voting rights for this member without legislative authority. Legislative amendments are being sought in 2023 to allow voting rights for the Lived Experience member.

[7] A HB 1477 Subcommittee member list is available on the CRIS webpage at https://www.hca.wa.gov/assets/program/cris-subcommittee-member-list.pdf

The charge of each Subcommittee is briefly described below:

1. **Confidential Information Compliance and Coordination –** To examine and advise on issues related to sharing and protection of health information needed for an effective behavioral health crisis response and suicide prevention system.
2. **Credentialing and Training Subcommittee –** To inform workforce needs and requirements related to behavioral health system redesign components outlined by HB 1477.
3. **Cross-System Crisis Response Subcommittee –** To examine and define complementary roles and interactions of specified crisis system partners, including mobile rapid response crisis teams, designated crisis responders, law enforcement, emergency medical services teams, 911 and 988 operators, public and private health plans, behavioral health crisis response agencies, nonbehavioral health crisis response agencies, and others needed to implement HB 1477.
4. **Lived Experience Subcommittee –** To provide diverse lived experience perspectives into the development of the Washington behavioral health crisis response and suicide prevention system.
5. **Rural and Agricultural Communities Subcommittee –** To provide rural and agricultural community perspectives into the development of the Washington behavioral health crisis response and suicide prevention system.
6. **Technology Subcommittee –** To examine and advise on issues and requirements related to the technology and platform needed to manage and operate the behavioral health crisis response and suicide prevention system.
7. **Tribal 988 Subcommittee –** To examine and make recommendations with respect to the needs of tribes related to the 988 system. (Note: The Tribal 988 Subcommittee is facilitated through the Tribal Centric Behavioral Health Advisory Board to align and build upon existing work already underway to improve the crisis response system for tribal populations.[8] Members include tribal health partners, tribal organizations, and state and federal partners focused on working with tribal and urban Indian health organizations.

In addition to the Subcommittees, two short-term workgroups were formed: the Ad Hoc Workgroup on Vision and the Crisis Service Provider Cost Workgroup. The Ad Hoc Workgroup on Vision was comprised of 10 members including CRIS members, individuals representing lived experience, and system subject matter experts available for consultation as needed (*See* Section II.1 for list of members). The Crisis Services Provider Cost Workgroup included 11 members providing crisis services across the continuum and identified through outreach with the Washington Council for Behavioral Health (*See* Section II.8).

## Relationship between HB 1477 Committees and State Agencies

HB 1477 charges the Steering Committee, with input from the CRIS Committee and Subcommittees, to make recommendations to improve Washington's behavioral health crisis response and suicide

[8] Meeting materials can be found through the TCBHAB website: https://drive.google.com/drive/folders/1ug4JHfIfeYoqoaKcg380oB1PKnjAK1k8.

prevention system. HB1477 additionally identifies HCA and DOH as the lead implementation authorities for this work.

In February 2022, the Steering Committee the CRIS High Level Workplan as an organizing framework for the work of state agencies and the HB 1477 committees to ensure the full continuum of crisis response. The High-Level Workplan is organized based on five overarching objectives that encompass activities needed to develop a comprehensive behavioral health crisis response system:

- Objective 1: A Place to Call – 988 Lifeline crisis centers
- Objective 2: Someone to Come – Mobile rapid response teams
- Objective 3: A Place to Go – Broad range of crisis stabilization services including in-home stabilization
- Objective 4: Pre- and Post-Crisis Care – Immediately upstream and downstream of crisis events
- Objective 5: Crisis system infrastructure and Oversight

The High level Workplan is provided in Appendix C, including a summary of the status of agency activities to lead implementation across the workplan.

## Tribal Consultation

Washington is home to 29 federally-recognized Indian tribes, which exercise sovereignty over tribal lands. The HB 1477 Steering Committee, in its work to develop recommendations to improve Washington's behavioral health crisis response and suicide prevention system, recognizes the extensive work led by Tribes and Urban Indian Health Organizations (UIHOs) in Washington for over a decade to address the significant inequities in health and access to behavioral health crisis services experienced by American Indian and Alaska Natives (AI/AN) in the state. In recent years, Tribes have led efforts to pass legislation in Washington to address these inequities through the Indian Health Improvement Act (RCW 43.71B)[9] and the Indian Behavioral Health Act (SB 6259).[10] It is important that the Steering Committee aligns its recommendations under HB 1477 in a manner that strengthens and builds upon the important work already underway and led by Tribes to address the behavioral health crisis needs in tribal communities. See Appendix D for a brief summary of the history of tribal work to address the barriers in access to behavioral health crisis services for tribal members.

In carrying out the work of HB 1477, the Steering Committee is engaging with Tribes in a manner that recognizes the sovereign authorities of Tribal governments and respects the existing processes and governing bodies in place to address tribal behavioral health and crisis system needs and gaps. Upon request of the Tribes, the Steering Committee initiated a Tribal Consultation process in 2022 to review and ensure tribal perspectives are included in HB 1477 recommendations for integrated behavioral health crisis response and suicide prevention system in Washington. This process recognizes the government-to-government relationship between Tribal and state government leaders that is distinct

[9] Washington State Senate Bill 5415, 2019. Accessed at: https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Senate%20Passed%20Legislature/5415.PL.pdf

[10] Washington State Senate Bill 6259, 2020. Accessed at https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/6259-S.SL.pdf?q=20211115124634

from the state's relationship with other system partners and stakeholders. For this *January 1, 2023 HB 1477 Committee Progress Report*, the consultation process included a series of four Tribal Roundtables held between September and November 2022, and a formal Tribal Consultation on December 14, 2022. A summary of tribal feedback through the Tribal Roundtables and Consultation is provided in Appendix E. All of the tribal feedback received has been addressed and integrated into this report.

In addition to the Tribal Consultation process, the HB 1477 Tribal 988 Subcommittee, through the work with the Tribal Centric Behavioral Health Advisory Board, has played an important advisory role to HB 1477 committee work regarding tribal perspectives and the existing tribal efforts to improve the behavioral health crisis response system for tribal members. In 2023, the Tribal 988 Subcommittee will continue to inform the development of HB 1477 recommendations to improve Washington's behavioral health crisis response system. In addition, a Tribal Consultation process will be established to review the HB 1477 Committee Final Recommendations due January 1, 2024.

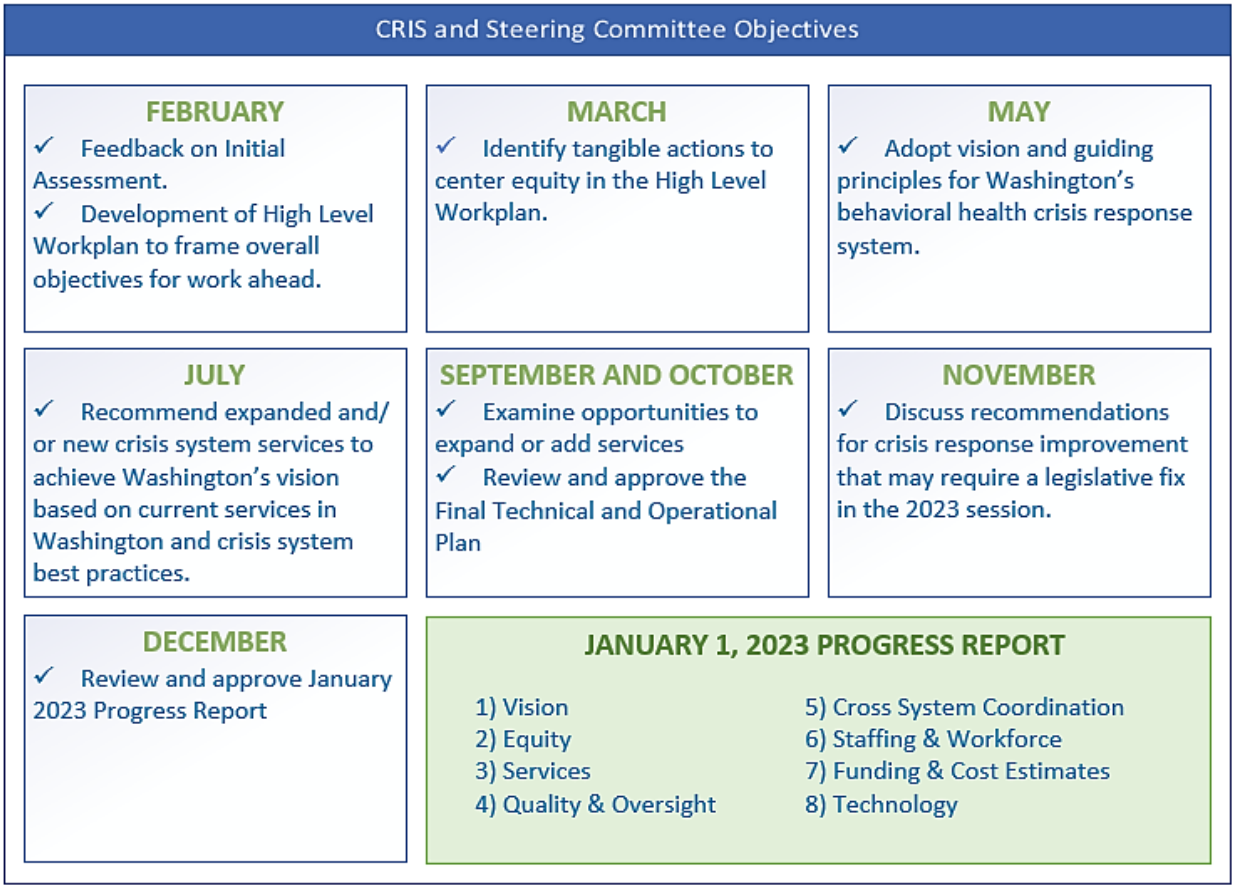
## Section II: Committee Progress Update

In 2022, the HB 1477 Steering Committee, CRIS Committee, and the seven subcommittees engaged in a combined total of about 58 meetings held throughout the year (see below). In addition, tribal review and input was gathered through Tribal Consultation, as described earlier in this report. This section provides a summary of committee progress to inform recommendations for Washington's crisis response and suicide prevention system across the eight areas outlined by HB 1477:

1. Vision
2. Equity
3. Services
4. Quality and Oversight
5. Cross-System Coordination
6. Staffing and Workforce
7. Technology
8. Funding

The Steering Committee and CRIS Committee met approximately every other month throughout 2022. Below is a high-level summary of Steering Committee and CRIS Committee meeting objectives addressed during these meetings. The Committee's work focused on establishing a foundational understanding of Washington's current crisis response system and setting a vision to guide the development of recommendations for a future-state system in 2023. The CRIS and Subcommittee work and input in each of the eight areas of recommendations in this Progress Update will inform the Steering Committee and CRIS Committee's work in 2023. Appendix F provides a link to the 2022 Subcommittee Report, which includes a compilation of all subcommittee meeting summaries in 2022. All Steering Committee and CRIS Committee meeting summaries are also available on the CRIS webpage.[11]

It is important to note that further work is needed to analyze and interpret data presented in this report to understand the crisis system service gaps by geography and population across the state. This 2023 report presents progress of the Committee in developing an understanding of the current system but does not yet reflect a complete picture of the current system gaps and needs.




[11] See Crisis Response Improvement Strategy (CRIS) webpage available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees

# 1. Vision

*HB 1477 calls on the Steering Committee, with input from the CRIS Committee and Subcommittees, to develop a recommended vision for an integrated behavioral health crisis response and suicide prevention system.*

In May 2022, the Steering Committee approved a vision statement and 10 guiding principles for Washington's integrated behavioral health crisis response and suicide prevention system. This vision and the guiding principles establish the foundation for the Steering Committee, CRIS Committee, and Subcommittee's work to develop recommendations to improve the system. The vision and guiding principles were developed through a robust committee process to gather input from the CRIS Committee, Subcommittees, and other groups, which is summarized further below and detailed in Appendix G.

***Vision: 988, Washington's Crisis Response: building understanding, hope, and a path forward for those in need, where and when they need it.***

**Guiding Principles**

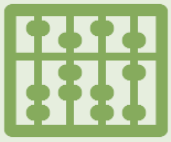
| *People in Crisis Experience:* | *The Crisis System is Intentionally:* |
|---|---|
| **1. Timely access to high-quality, coordinated care without barriers** | **5. Grounded in equity and anti-racism** |
| **2. A welcoming response that is healing, trauma-informed, provides hope, and ensures people are safe** | **6. Centered in and informed by lived experience** |
| **3. Person and family centered care** | **7. Coordinated and collaborative across system and community partners** |
| **4. Care that is responsive to age, culture, gender, sexual orientation, people with disabilities, geographic location, language, and other needs** | **8. Operated in a manner that honors tribal government-to-government processes** |
| | **9. Empowered by technology that is accessible by all** |
| | **10. Financed sustainably and equitably** |

## Process to Develop Vision and Guiding Principles

In March 2022, the Steering Committee formed a short-term Ad Hoc Workgroup on Vision to develop a draft vision statement as a starting point for input from the CRIS Committee, subcommittees, tribal representatives, and other groups. The Workgroup was comprised of CRIS members, individuals representing lived experience, and system subject matter experts available for consultation as needed (see box below with list of members). The workgroup met three times between March and May 2022 to develop a draft vision and guiding principles. This draft was then shared with HB 1477 subcommittees,

CRIS Committee, tribal representatives, and the Children and Youth Behavioral Health Workgroup for further input and feedback. The Ad Hoc Workgroup on Vision reviewed and integrated feedback from each of these groups and integrated it into a final draft Vision and Guiding Principles. At the Steering Committee meeting on May 19, 2022, Ad Hoc Workgroup members shared changes made to the draft to address the major theme areas of comments received (See Appendix G). The Steering Committee reviewed and approved the final vision and guiding principles at their meeting on May 19, 2022.

| **Ad Hoc Workgroup on Vision – Members** | |
|---|---|
| 1. Caitlin Safford – MCOs<br>2. Darcy Jaffe – Hospitals<br>3. Jan Tokumoto – 988 Lifeline crisis center<br>4. Jenn Stuber – UW Suicide Prevention Center of Excellence<br>5. Jolene Kron – BH-ASO (Salish)<br>6. Joan Miller – WA Council<br>7. Kashi Arora – Youth<br>8. Laura Van Tosh – lived experience representative<br>9. Michael Reading – BH-ASO (King County)<br>10. Michael Robertson – lived experience representative | ***Washington Crisis System SMEs***<br>1. Michele Roberts or delegate – DOH<br>2. Keri Waterland or delegate – HCA<br>3. Amber Leaders – Governor's Office<br>4. Tina Orwall – State Representative<br>5. Melanie Estes – legislative intern to Representative Orwall and lived experience representative |



## 2. Promoting Equity

*HB 1477 calls on the Steering Committee, with input from the CRIS Committee and Subcommittees, to develop recommendations to promote equity in services for individuals of diverse circumstances of culture, race, ethnicity, gender, socioeconomic status, sexual orientation, disability, and for individuals in tribal, urban, and rural communities.*

### What We Know Now / Current State

There are significant disparities in the experiences of different populations regarding the current crisis response system. These disparities are wide-ranging and have major ramifications for the design of an improved system. Communities who experience significant disparities in the crisis response system include tribal populations; youth; people who identify as LGBTQ+; black, indigenous and people of color (BIPOC); rural communities; immigrants, refugees, and non-English speaking people; people living with disabilities; older adults; people experiencing homelessness or housing instability; formerly incarcerated or justice-involved populations; survivors of trauma; and neurodiverse people. Examples of these disparities include:

- In Washington, 2021 suicide data shows a small decrease by 1% in suicide deaths compared to 2021.[12] However, not all communities have experienced this change:
    - American Indian and Alaskan Native communities (59% increase)
    - Black and African American communities (31% increase)
    - Asian and Pacific Islander communities (11% increase)
    - Youth/people 19 and under (21% increase)
    - Elders/people 65 and older (20% increase)
- American Indian and Alaska Natives (AI/AN) between the ages of 10 and 29 account for 63 percent of Washington State emergency department visits by AI/AN people for suicide attempts in 2020.[13] Since 2001, the suicide mortality rate for AI/AN in this state has increased by 58 percent which is more than 3 times the rate of increase among non-AI/AN. Nationally, in 2018, death by suicide accounted for 40% of overall deaths among AI/AN youth ages 10-17, the

[12] The overall decrease in suicide deaths in 2021, compared to 2020, is largely reflective of decreases in death by suicide among people who identify as white males. See May 10th CRIS Meeting Slides, available at https://www.hca.wa.gov/assets/program/cris-committee-meeting-presentation-20220510.pdf

[13] Northwest Portland Area Indian Health Board. (2021). *Trends in Suicide-related Emergency Department Visits Among American Indians & Alaska Natives in Washington during COVID-19*. Retrieved from https://www.npaihb.org/wp-content/uploads/2021/05/WA-Suicide-ED-fact-sheet.pdf

highest among any racial group.[14] Tribal partners have also highlighted that historical trauma experienced by tribal populations can be a challenge to identify through recognized behavioral health diagnoses and may lead to underdiagnosis of tribal member behavioral health needs. (Please see Appendix D for a fuller discussion of disparities in health and access to behavioral health crisis response services for tribal members.)

- There are higher suicide rates for those living in small towns and isolated rural areas, where agriculture is more prevalent, compared with urban and suburban populations. Suicide rates for individuals living in small rural towns were 20.9 per 100,000 compared to rates of 15.0 per 100,000 in urban areas. Washington rural and agricultural communities experience a variety of unique stressors that can increase risk of death by suicide, including stigma surrounding seeking help for behavioral health issues, financial burden, weather and climate change, on-the-job injuries, and geographic isolation in rural areas.[15]
- In 2021, Governor Jay Inslee issued an Emergency Proclamation on Children and Youth Mental Health Crisis in Washington, citing an alarming increase in pediatric patients with behavioral health diagnoses and acute inpatient admissions.[16] According to DOH's 2022 third quarter report tracking the behavioral health impacts of COVID-19, most recent reporting from hospitals in Washington that admit pediatric patients indicates that the surge of youth presenting to emergency departments for suicidal ideation and suspected suicide attempts remains an ongoing issue. The lack of outpatient behavioral health services and inpatient psychiatric beds have led to increasing numbers of youth "boarding" in emergency rooms and medical beds, sometimes for extended periods of time, and without treatment while waiting. Youth and young adults with additional complexities, such as autism with aggressive behaviors or significant developmental delay, have even more restricted access to appropriate treatment.[17]

  Trends in Washington regarding the youth mental health crisis are part of concerning trends nationally. In 2021, The American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children's Hospital Association (CHA) joined

[14] U.S. Department of Health & Human Services. (2020). *African American Youth Suicide: Report to Congress.* Retrieved from https://www.nimh.nih.gov/sites/default/files/documents/health/topics/suicide-prevention/african_american_youth_suicide-report_to_congress.pdf

[15] Washington State Department of Health. (2020). Report to the Legislature: Improving Behavioral Health & Suicide Prevention in the Agricultural Industry – Pilot Program Results and Recommendations. Retrieved from https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=Behavioral%20Health%20%20Suicide%20Prevention%20in%20Agriculture_a6a749d3-6c38-4878-83ac-c824ef9f73c6.pdf

[16] State of Washington, Office of Governor Jay Inslee, Emergency Proclamation of the Governor (21-05) – Children and Youth Mental Health Crisis. Retrieved from https://www.governor.wa.gov/sites/default/files/proclamations/21-05_Children%27s_Mental_Health_Crisis_%28tmp%29.pdf

[17] Washington State Department of Health. (September 2022.) Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19 – Third Quarter 2022 Update. Retrieved from https://doh.wa.gov/sites/default/files/2022-09/821103-COVID19BHForecastSummary-202209.pdf?uid=63a34bff6a76f . See also monthly Youth Behavioral Health Impact Situation Reports documenting continued trends in psychological distress, suicide ideation and suspected suicide attempt: https://doh.wa.gov/emergencies/covid-19/healthcare-providers/behavioral-health-resources

together to declare a National State of Emergency in child and adolescent mental health. A 2019 survey by the Centers for Disease Control and Prevention among high school students revealed higher risk for LGBTQ+ youth, with 23.4% making a suicide attempt in the year prior to the survey compared to 6.4% of heterosexual youths.[18] A 2022 survey by The Trevor Project, a suicide lifeline for LGBTQ+ youth, revealed that in the past year 50% of LGBTQ+ youth ages 13-17 considered suicide and 60% wanted mental health care but were unable to get it.[19]

## Committee and Tribal Partner Input: Known Gaps and Areas for Recommendations

Below is a synthesis of input gathered from the CRIS Committee, HB 1477 Subcommittees, Tribal Roundtables, and the Children and Youth Behavioral Health Workgroup on ways to embed equity within Washington's behavioral health crisis response system. This synthesis is organized within five domains:

1. Staffing, Training, and Workforce Development
2. Crisis System Oversight and Performance
3. Technology
4. Cross System Coordination & Community Partnerships
5. Funding

In addition to the synthesis in this section II.2 (Promoting Equity), Committee and Tribal partner input on ways to embed equity in Washington's crisis response system is integrated throughout the Section II Committee Progress Updates for each of the eight HB 1477 committee recommendations areas.[20] The input received also aligns with a growing body of literature shared by various committee members addressing ways to center equity within mental health crisis services and 988.[21] The Kennedy-Satcher Center for Mental Health Equity in partnership with Beacon Health Options, for example, has released a policy brief and national scorecard, *Embedding Equity into 988*, with the first quarterly report released for July-October 2022.[22]

[18] Ivey-Stephenson, A.Z., et. al.. (2020). Suicidal Ideation and Behaviors Among High School Students – Youth Risk Behavior Survey, United States, 2019. Retrieved from https://www.cdc.gov/mmwr/volumes/69/su/pdfs/su6901a6-H.pdf

[19] The Trevor Project. 2022 National Survey on LGBTQ Youth Mental Health. Retrieved from https://www.thetrevorproject.org/survey-2022/assets/static/trevor01_2022survey_final.pdf

[20] Note: This means that Committee input on ways to embed equity may appear twice in this report – both in this section providing a comprehensive summary of input received, as well as within the Section II Committee Progress Updates specific to the HB 1477 eight recommendation areas (e.g. funding, quality and oversight, etc.).

[21] *See:* Goldman, M.L.. (2022). *Centering equity in mental health crisis services.* World Psychiatry. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9077596/pdf/WPS-21-243.pdf

[22] Kennedy-Satcher Center for Mental Health Equity and Beacon Health Options. (2022.) Policy Brief – Embedding Equity into 988: Imaging a New Normal for Crisis Response. Retrieved from https://kennedysatcher.org/wp-content/uploads/2022/06/988-Policy-Brief_Final.pdf; National Scorecard Quarterly Report (July 2022-October 2022), retrieved from https://kennedysatcher.org/wp-content/uploads/2022/10/988-Quarterly-Update92.pdf

## Domain 1: Crisis System Staffing, Training, and Workforce

» ***Ensure an adequately trained, supported, and diverse workforce that can provide culturally responsive, linguistically appropriate, and confidential crisis response services across the full continuum of care.*** Key actions identified include:

- Establish a 988 Diversity, Equity, and Inclusion (DEI) Director. This position should include Tribal government to government relations with appropriate tribal liaisons across the state.
- Establish a clear commitment and goal to recruit mobile crisis response staff that reflect the communities served, a clear workforce diversity strategy and action plan for that recruitment including a workforce pipeline plan, and monitor progress to achieve goals.
- Ensure adequate staffing so that all parts of the state have access to mobile crisis response teams for adults and youth.
- Include Peers as a substantial part of our workforce development strategy (see below).
- Recognize Behavioral Health Aides as part of the workforce in the Indian Health Delivery System (see below).
- Include a strategy to embed more behavioral health providers into police response teams.
- Upgrade police Crisis Intervention Training (CIT) voluntary 40-hour training to mandatory training.
- Consider or advocate for a "Crisis Responder" certification for paramedics and other first responders to encourage more system integration.
- Leverage potential workforce of immigrants who bring important cultural affiliations for working with diverse populations but are limited to involvement in the workforce in un-paid volunteer positions due to immigration status.
- Ensure contracts with DEI considerations, including language addressing interpretation services, connections to culturally appropriate services including connection to tribal and urban Indian health care providers.

**Examples of training areas to promote equity identified:**

- Cultural responsiveness (cultural humility and culturally appropriate practices)
- Unconscious bias
- Identifying and interrupting microaggressions
- Working with interpreters
- How to collect demographic data effectively, appropriately, and respectfully
- Working with rural and farming communities (see Farm Rescue training program)
- Understanding Tribal sovereignty and Tribal crisis systems
- Understanding trauma in the Native community (historical, community, family, self)
- Cultural humility and working with tribal and indigenous people/communities
- Understanding impacts of historical and intergenerational trauma and trauma informed care/approaches
- Working with LGBTQ+ populations; Transgender and gender non-conforming populations
- Working with youth including legal landscape for youth under 13 and 14 – 18-year-old
- Best practices working with families of clients (children or other family members)
- Working with child welfare populations and DCYF caseworkers/guardians/caregivers
- Working individuals with disabilities including intellectual/development disabilities (IDD)
- Working with individuals with severe and persistent mental illness (SPMI)
- Working with unhoused and homeless/houseless populations
- Understanding Anosognosia and implications for crisis system response

- ***Peer workforce and Peer agencies and programs (e.g., respite centers) must be better integrated into overall Crisis Response System to better leverage this vital workforce.*** This includes integration into:
  - Statewide strategy
  - Workforce development strategies
  - Funding and partnerships
  - Operational considerations to ensure seamless access to Peer services regardless of insurance or payment
  - Education, messaging, and training on role, scope, value, and availability of Peers
  - Elevating recovery language and practices
  - DEI and tribal engagement practices
- ***Integrate behavioral health aides (BHA) into the tribal crisis response locally and regionally through the Indian Behavioral Health Hub and Native and Strong Lifeline.*** BHAs are counselors, health educators and advocates working within the Indian Health delivery system and certified by tribes or the Portland Area Community Health Aide Program (CHAP) Certification Board. This workforce is grown from tribal or urban Indian communities. BHAs undergo one to three years of training and are educated in traditional and spiritual healing as mentored by the tribal community they come from. WA State Health Care Authority is currently working with the Northwest Portland Area Indian Health Board to establish a Medicaid reimbursement rate for BHAs through a State Plan Amendment, and the NPAIHB is establishing the Portland Area Certification Board.
- ***Provide culturally and geographically appropriate respite care.***
  - For example, respite care needs to include an understanding that for agricultural communities there is someone who can fulfill the duties and responsibilities of the person seeking respite – either the primary operator or their loved ones; this is particularly critical in the case of livestock producers. Peers, community members, other familiar with the needs of agricultural operations need to be available to do baseline replacement work during the duration of in-person care or respite needs. Without knowing their farms or ranches will remain functioning in their absence, owner/operators will be less likely to avail themselves of these services. Other examples include support for multi-generational families living together, longer durations of respite care for remote locations, etc.
- ***Create standardized training and competency requirements on various topics to support the delivery of culturally responsive, linguistically appropriate, and confidential services.*** Examples of training areas are identified in the sidebar above.
  - Consider creating a web-based portal, clearinghouse, and/or calendar for shared access to all trainings.
  - Consider including training requirements in contracts and create systems to monitor compliance and address any findings
  - Ensure appropriate metrics and monitoring systems evaluate impacts of trainings.

## Domain 2: System Oversight & Performance

- ***Create a transparent oversight and accountability plan that is clear about how and when oversight will be conducted, how performance will be evaluated, and how any deficiencies or compliance issues will be addressed and remedied.***
  - Need to ensure we are conducting effective monitoring of the entire system to hold us accountable, and we should share that with our communities to be transparent.
  - Special attention is needed to address disparities experienced across populations. For example, in rural areas, attention is needed where geographic barriers, lack of access, and lack of resources are used as excuses for not providing services.
  - There is a wealth of federal funding available to communities to support crisis system research and evaluation. Is there work with higher education to develop research synergies? For example, while Initiative 502 remains controversial as it legalized limited possession and private use of marijuana by adults in Washington, it provides a model of where the law included requirements for the Washington State Institute for Public Policy to conduct benefit-cost evaluations of implementation of the law from its enactment in 2012 through 2032.[23]

- ***Ensure we are collecting and analyzing (at all points in the system) the necessary data elements to allow for the identification and monitoring of any disparities.*** If we don't have systems in place to do this, they should be built and rolled out with training and support and include requirements and technical assistance to partner with impacted communities to identify and understand drivers of disparities and develop clear action plans to address root causes. Some of the areas to be included/considered are:
  - Race
  - Ethnicity
  - Age
  - Geographical location (zip code)
  - Sexual orientation and gender identity
  - Physical and/or intellectual and developmental disabilities
  - Language
  - Other categories as identified

- ***Determine ways to share data and outcomes with the community to hold the crisis response system accountable – this includes how we are addressing disparities and advancing equity.*** Ideally this would be driven by the community and not the system – so what information would community members identify as needed to ensure the system is accountable and transparent? This commitment to transparency should extend to decision-making and process.

[23] See Initiative 502, Section 30 for overview of cost-benefit evaluations to be conducted. Retrieved from https://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Initiatives/Initiatives/INITIATIVE%20502.pdf

- Community engagement efforts should be prioritized on an ongoing basis to develop and monitor the crisis response system including:
  - Engaging diverse communities and people with lived experience (and their families) and service providers in all aspects of system design and accountability
  - Engaging in government-to-government relationship with Tribes to inform ongoing engagement and outreach, education, and messaging
  - Consider hosting regularly scheduled Regional Crisis Response System Community Forums to share progress and updates as well as solicit ongoing community input

» ***Data collection efforts must recognize that calls to the 988 Suicide & Crisis Lifeline are confidential and people contacting the Lifeline are not required to provide any personal data to receive services.*** The caller does not have to disclose any demographic information to the crisis counselor unless they want to.
  - Recognize Tribal Data Sovereignty

## Domain 3: Technology

» ***Technology should promote equitable access for callers.*** Examples include:
  - Platforms must support assistive technologies and services that enable interaction with callers with different abilities (i.e., services that support deaf and hard of hearing such as TTY, IP relay, ASL video relay, and IP CST) and these requirements are included in any relevant contracts.
  - Despite the 988 Lifeline's current use of a standardized recorded greeting for all callers, Washington should consider discussing with Vibrant the potential to have a live person answer the call with message scripts.
  - Allow for text or chat technology and in multiple languages.
  - Ensure smooth interoperability with interpretation and language access services.
  - Consider infrastructure investments/community investments in areas across the state that have no or inadequate access to the internet, including rural areas to increase technology infrastructure and improve access
  - Add in geographic information system (GIS) capabilities so callers are routed to centers in their region, not all over the country or based just on their area code (which may no longer reflect where they reside), and crisis response services can be dispatched, when needed. We note the important confidentiality and privacy considerations that are raised with the use of geo-location capabilities. According to Vibrant's position statement on geo-location, 988 caller privacy and confidentiality will continue to be protected with the use of geo-location.[24] We note that the issue of geo-location and the relationship to maintaining caller privacy will be further explored by the HB 1477 CRIS and Steering Committee in 2023.

[24] See Vibrant's Position on Geolocation for 988, available at: https://www.vibrant.org/geolocation-and-988/

- ***Interoperable technology should promote equitable access for crisis service providers.*** Examples include:
  - Select and provide technology for mobile crisis response teams that work well enough in low network bandwidth situations so that there is seamless access to services regardless of location infrastructure limitations.
  - Ensure tribal crisis providers are able to seamlessly access the system.
  - Support small providers who may not have access to the technology or infrastructure necessary to operate effectively through the provision of free IT support and training and access to technology platforms.
  - Ensure crisis response providers across the continuum have up-to-date access to system and resource databases, including aligning with requirements of SB 6259 that requires that IHCPs are able to access bed registry.

- ***Ensure technology supports patient, family, and system partner feedback in real time so improvements can be made in a timely manner***.
  - This includes interoperable technology to enable the active engagement, input, and direction from the patient, family, and system partner.

- ***Leverage technology to maximize opportunities to expand telehealth to support access to care.***
  - Emphasis on telehealth to support access to care among tribal populations when services are not available directly through tribal providers.
  - Increase use of telehealth to enable access to care on behalf of persons living in rural communities.
  - Efforts are also needed to address implementation and contracting barriers for telehealth, such as working with out-of-state telehealth providers.

- ***Ensure data collection software and requirements support whole-person focused care and the provision of adequate context of the person and situation to support a holistic approach.***
  - Ensure any technology algorithms are built/designed with anti-racism lens
  - Ensure data sharing agreement incorporate Tribal Data Sovereignty principles and be compatible with Tribal and UIHO electronic health records (EHRs) and align with requirements of SB 6259.
  - Ensure information sharing between call receivers and dispatch, including language access and other information about a person's needs so that they don't have to repeat multiple times.
  - Ensure crisis related documentation is available to providers of ongoing services and stabilization (to decrease need for repetition of information).

## Domain 4: Cross-System Coordination & Community Partnerships

- ***Ensure entire Crisis Response System adopts a "no wrong door approach" and that it takes a minimum "rule out approach"***
  - Develop recommendations on how crisis stabilization facilities can be designed and resourced to increase diversion from hospital emergency departments where appropriate.

- ***Establish cross-system protocols to ensure consistent response across populations, rather than application of differential standards to guide practice in a manner that promotes best practice and equity***. Examples of actions include:
  - Include/ensure bias-reduction in handoff between crisis call centers and Mobile Crisis Response teams – hand off critical "need to know" information without handing off bias or assumption.
  - Determine who will have the final authority in a crisis situation and when law enforcement is involved and ensure transparent communication about these protocols.
  - Develop clear criteria and implement systems for effective and appropriate 988 and 911 intersections/handoff and monitor on a regular basis.
  - Put in safeguards to ensure there is no *harmful* differential response based on zip codes (i.e., ensure that communities of color are not having their calls routed to police) or youth versus adults.
  - Guide mobile crisis response teams to maximize clinical best practice and safety in a variety of settings.
  - Prioritize voluntary processes whenever possible and be prepared to use involuntary processes to preserve and protect life.
  - Outline expectations for when mobile crisis response teams should interact with law enforcement, emergency departments, and other system partners.
  - Guide staff on the appropriate use of language interpretation.
  - Include specific guidelines for "co-response" teams involving a First Responder and a trained behavioral health professional.
  - Develop protocols and systems to support warm handoffs between pre and post services and crisis services to increase referral uptake.
  - Review the definition of "medical clearance" to reduce delays in obtaining services

- ***Ensure Cross-System Interfaces that are tailored to systems specific to certain populations, such as youth, tribal, and rural populations.***
  - *Tribal System Interfaces examples:*
    - Use of the HCA-Tribal Crisis Coordination Protocol.
    - Recognize Tribal sovereignty (through government-to-government relationship and process)
    - Tribal-specific agreements and partnership needs.
    - Consider developing formal agreements with neighboring states or Tribes for areas along border regions as people may decide to seek services in another state if they are closer or more convenient for them.

- Include Urban Indian Health Organizations in county and regional crisis response protocol planning.
- Include Tribal providers in the process maps to define referral processes between 911, 988, the Native and Strong Lifeline, Washington Indian Behavioral Health Hub, Regional Crisis Lines, Indian Health Care Providers (IHCPs), Tribal Public Safety, and Tribal First Responders. Identify intake points and processes that identify people with tribal affiliation.

- *Youth System Interfaces examples:*
  - Address cross system connections specific to youth populations. Promote care in order from least restrictive to most restrictive by implementing in-home crisis response and stabilization whenever possible over facility-based care. E.g. Need to determine if crisis stabilization providers are open to youth and should youth shelters be connected to crisis call center hubs. Need to assess overall youth and family friendliness/appropriateness of services to ensure adequate and responsive services to youth and families.

- *Rural System Interfaces examples:*
  - Mobile response system must take into account rural and agricultural settings. Locations are often rugged and can be distant from roads and other access points, requiring special equipment, technology, and vehicles to access people, services, and locations. Ensure these barriers are addressed so individuals in rural settings can receive in-person care when needed.

» ***Develop and support partnerships across broad partners and stakeholder groups to leverage family and community resources and strengths.*** Examples actions include:
- Develop and cultivate a broader definition of "family" to go beyond blood and legal relatives (i.e., families of choice).
- Develop a more robust "pre-crisis" approach to this work – elevate the role of outreach and engagement for prevention and connect it with family and community support.
- Consider including telecommunications providers as possible stakeholders or system partners to encourage digital expansion to increase access.
- Ensure partnerships with local community resources and experts (especially in rural areas) that can help with training and communications and outreach (agronomists and community partners).
- Partnering with local community colleges to support staffing needs, especially in rural areas and tribal communities.
- Ensure support for the Native and Strong Lifeline across the system at a state and federal level
- Partnerships with groups like Grange, WSU Extension, Agribility, private ag businesses, and others would be extremely helpful in getting the word out both actively and passively to ag and rural communities regarding services. A counter rack of brochures on a parts counter that can be easily picked up along with brochures about lubricants, maintenance, etc. somewhat quietly

may feel less intrusive than having public conversations with some farmers and ranchers who are struggling. Having both active and passive means of providing information to reach a broad audience would be helpful among members of the ag and rural community.
- Engage with Family Resource Centers as system partners as they are often driving the conversation of needed services and supports especially in rural communities.
- Ensure that Veteran's Services are included as systems partners.

» ***Community outreach, marketing, and promotion of 988 Lifeline services should build trust, be available in multiple languages, and include images tailored to specific communities.***
- Create a sense of community – that when people call, they get to talk to a real person from their community – not just a robot or stranger, and they will not be put on hold.
- Message about confidentiality and that even in small towns your information will be protected
- Make it clear that calling the 988 Lifeline is not the same thing as calling 911 and there will be a different response
- Provide clear, accessible, and transparent explanation of what happens when you call the 988 Lifeline (from start to finish) including when other system partners may be engaged (law enforcement). This can raise awareness about how many issues can be addressed or deescalated over the phone.
- Be available in multiple languages and formats including ADA accessible formats
- Include images and language that reflects the communities being served and is tailored to specific communities; for example, Tribal (Native and Strong Lifeline promotion) and rural communities.
- Addresses stigma related to crisis and mental health – with messages tailored to communities

» ***Ensure awareness campaigns and discussions about normalizing discussions of stress, mental health needs and care, and stressors particularly in agricultural and rural communities where such discussions are still considered taboo.***
- Partner with diverse community partners, people with lived experience, providers, etc. to design education and anti-stigma campaigns as well as in trusted messengers for promotion and distribution

## Domain 5: Funding

» ***Address disparity of services based on funding (e.g., between Medicaid fee-for-service, Medicaid Managed Care, commercial insurance, uninsured).***
- Ensure Tribal partners and systems are included equitably in funding requests (see below).
- Assess distribution of funding to programs and services by population focus (youth and elderly/older adults) to determine equitable resourcing of programs and services including by mental health and substance use services.
- Develop a braided funding model so Medicaid and non-Medicaid funds are braided at the state level then appropriated to regional ASOs and Tribes on more equitable population and need based formulas. It also needs to include capacity-based funding (aka firehouse model). The

current system balkanizes funding and requires BH-ASOs to individually negotiate payment reimbursement from 5 different MCOs using what is largely a fee for service basis.
- Farm families often access insurance through faith-based programs and/or private insurers that overlook mental health needs. Providing financial support counseling/support to agricultural and rural families (and perhaps members of other communities) should be taken into consideration.
- Establish payment parity at the service level across payers and across disciplines, where appropriate. Launch a workgroup to explore payment parity and to make recommendations.

» ***Ensure Tribal partners and systems are included equitably in funding requests.***
- Health care on tribal lands is provided through an Indian Health Care Delivery system supported by the Indian Health Service and distinct from the state Medicaid program. In 2016, Tribal governments requested that AI/ANs are not required to be covered by a Medicaid managed care entity and may receive services through the fee-for-service system. Today, about 60% of AI/AN Medicaid enrollees remain in the fee-for-service Medicaid program instead of managed care. Given the distinct funding streams for Medicaid managed care versus fee-for-service systems, Tribes have emphasized the critical importance of ensuring that tribes are explicitly included in funding allocations for Washington's behavioral health crisis response system.

» ***Expand resources (funding and technology) to increase capacity to provide next day appointments in all areas of the state (could include telehealth in some areas) AND ensure commercial plans comply with next day appointment requirements.***
- Consider adding a day-of appointment in addition to next day to help with transitions out of care to the home but before the next day appointment.

# 3. Services

*HB 1477 calls on the Steering Committee, with input from the CRIS Committee and Subcommittees, to develop recommendations for an integrated behavioral health crisis response and suicide prevention system, including quantifiable goals for the provision of statewide and regional behavioral health crisis services and targeted deployment of resources.*

## What We Know Now / Current State

This section includes a summary of what we know about Washington's current services available across the crisis response continuum: A Place to Call; Someone to Come; A Place to Go; and Pre and Post Crisis Care follow up. It is important to note that this section does not yet reflect a comprehensive understanding of the current system service gaps and needs. Further work is needed 2023 to update and expand upon the data in the report, including deeper analysis of services available by region and access to services by population, as discussed in Section IV of this report.

### A Place to Call

There are currently multiple crisis lines in Washington, including the 988 Suicide & Crisis Lifeline, regional crisis lines (RCLs), 911, tribally-operated crisis lines, youth crisis lines, and several population-specific and additional crisis and behavioral health support lines operated within Washington and nationally.

***A Place to Call***

- 988 Lifeline crisis centers, including the Native and Strong Lifeline (Future state: Crisis Call Center Hubs)
- RCLs in each of the 10 BH-ASO regions
- 911
- Population-specific and additional crisis and behavioral health support lines including but not limited to: tribally-operated crisis lines, Veterans Crisis Line, Teen Link, Crisis Text Line, Trevor Project Lifeline, Trans Lifeline, National Maternal Mental Health Hotline, Farm Aid hotline, Disaster Distress Line, Washington Listens, Washington State mental health crisis lines

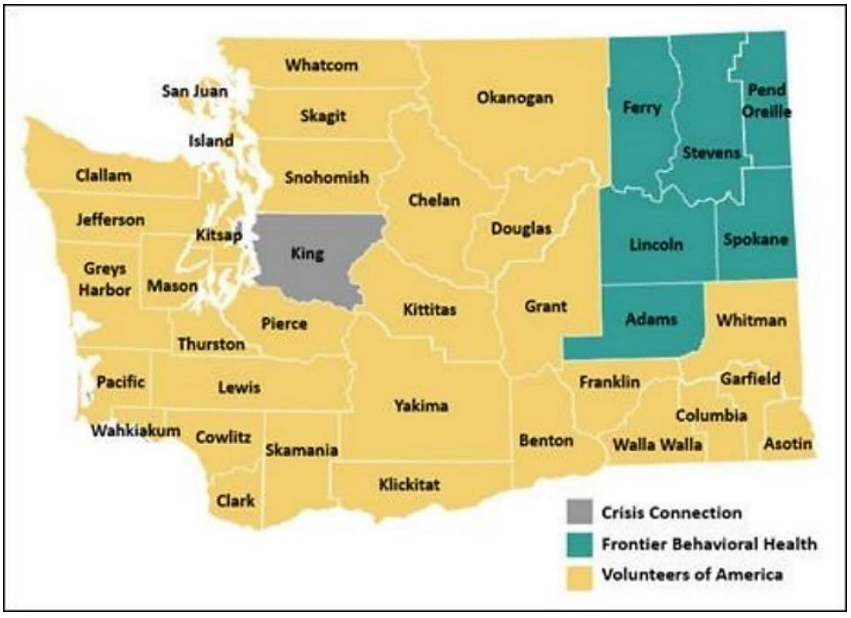
Crisis lines often serve as a front door to crisis services, although there may be multiple points of entry into the system, including emergency departments, outpatient providers, the justice system, school systems, and first responders. This section focuses on the 988 Lifeline, RCLs, and 911 as key system stakeholders to consider as Washington works to expand enhance and expand behavioral health crisis response and suicide prevention services statewide.

***988 Lifeline Crisis Centers***

There are three 988 Lifeline crisis centers in Washington (Crisis Connections, Volunteers of America Western Washington, and Frontier Behavioral Health) that receive 988 Lifeline calls from people with Washington areas codes. In addition, Volunteers of America Western Washington is accredited for, and currently provides, 988 Lifeline text and chat services. When a person dials 988, there are also options to elect lines dedicated to Spanish speakers, Veterans, and Washington's new Native and Strong Lifeline serving American Indian and Alaska Native people, as described further below.

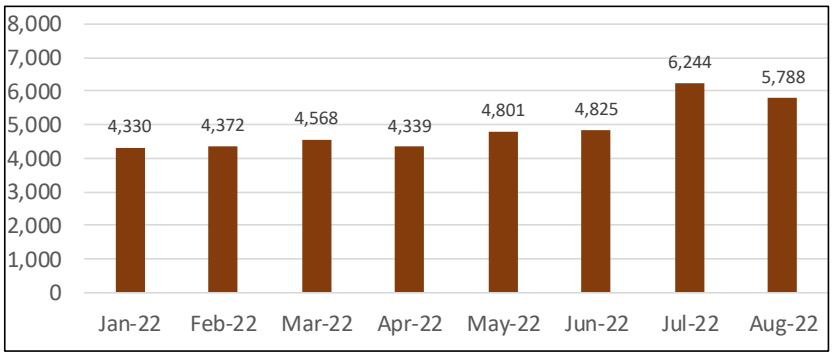
The 988 Lifeline crisis centers are part of a nationwide network of over 200 crisis call centers across the country that provide 24/7 access to free, confidential support for people in suicidal crisis or emotional distress, as well as prevention and crisis resources for people or their community support systems. Washington's three 988 Lifeline crisis centers each serve a distinct area of the state as displayed in the map below.

**Service Areas for the Three 988 Lifeline Crisis Centers in Washington**



Since the official 988 Suicide & Crisis Lifeline launch on July 16, 2022, there has been increase in calls from Washington area codes that are routed to Washington's 988 Lifeline crisis centers. As shown in the bar chart above, the volume of calls in July 2022 was 38 percent higher than the monthly average of calls for January to June 2022; in August 2022, the volume of calls was 28 percent higher. Even prior to the launch of the 988 Lifeline, calls from Washington area codes to the 988 Lifeline crisis centers have increased. Call volume increased 13 percent in the first six months of calendar year 2022 compared to the first six months of CY 2021. According to SAMHSA, fewer than 2% of Lifeline calls require connection to emergency services. Most calls are de-escalated over the phone, and in-person services can be dispatched when the counselor determines that the caller is in imminent risk to themselves or others, or intervention is needed or requested. The 988 coordinated response is intended to promote stabilization and care in the least restrictive manner.

**Call Volume to NSPL from Washington in CY2022**



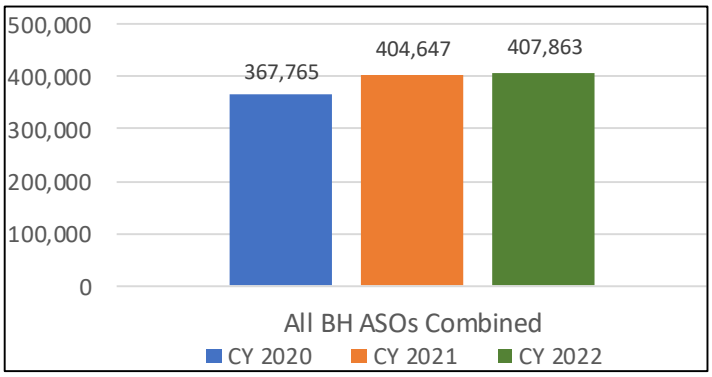

Source: V!brant Emotional Health report to WA Department of Health
Latest data available is August 2022.

In November 2022, Washington launched the Native and Strong Lifeline, the first program of its kind in the nation dedicated to serving American Indian and Alaska Native people. As of November 10, 2022, individuals who call the 988 Lifeline from a Washington State area code can press 4 to be connected to a Native and Strong Lifeline counselor who is trained and experienced in work with tribal populations. Volunteers of America Western Washington is the 988 Lifeline crisis center that administers the Native and Strong Lifeline. The Native and Strong Lifeline may connect callers with the Washington Indian Behavioral Health Hub to provide callers with further support and follow up with their Indian Health Care Provider.

***Regional Crisis Lines***

Each of the 10 BH-ASO regions are contracted by the State to provide Regional Crisis Lines (RCLs). RCLs provide a key point of access for individuals in crisis or seeking behavioral health services. Eight of the ten BH-ASO regions have agreements with a 988 Lifeline crisis center to operate their region's RCL. Although there has been an increase seen in calls to 988 with its introduction in July 2022, the volume of calls to the regional crisis lines in Washington remains steady. In fact, the call volume is forecasted to increase slightly between CY2021 and CY 2022 at just over 400,000 calls.

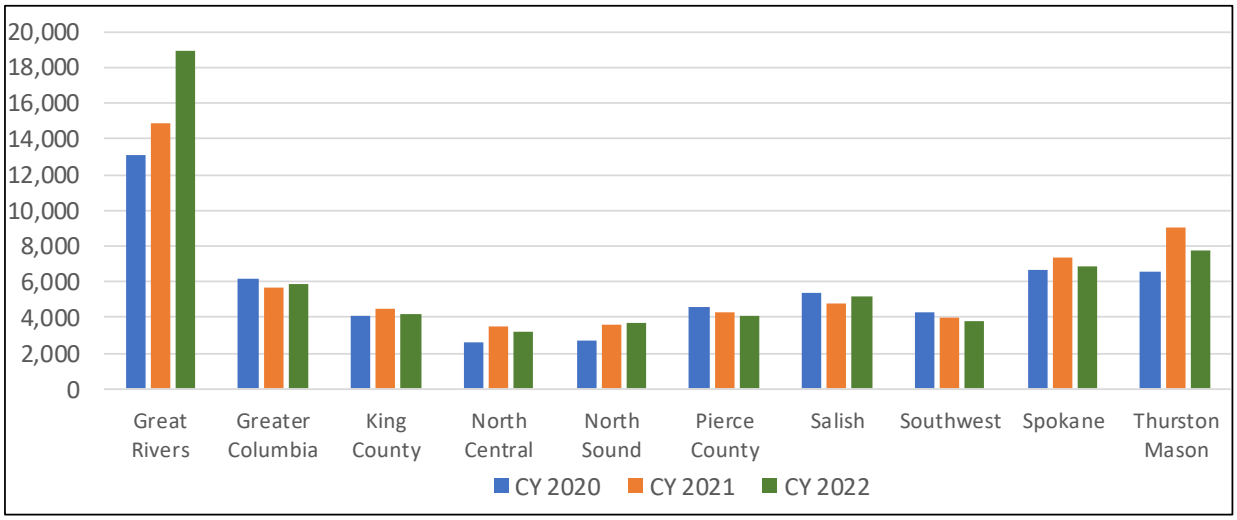
**Call Volume to BH ASO Crisis Hotlines**




For CY2022, the data for Jan-Sept is actual. Oct-Dec was forecasted using actual values from the July-Sept period.
Source: BH ASO reports submitted to Health Care Authority

There is variation in the volume of calls within each region and the impact that 988 may or may not have had in this volume. Because the population varies by region, calls are tracked on a per 100,000 resident basis. Four regions are expected to have an increase in call volume in CY2022 compared to CY2021. Six regions are expected to have a decrease. Statewide, calls to the BH ASO lines are approximately 5,000 calls per 100,000 residents, or 1 in 20 residents, on average, calling a Regional Crisis Line at least once in each year.

**Call Volume to BH ASO Crisis Hotlines Per 100,000 Residents for each BH ASO Region**




For CY2022, the data for Jan-Sept is actual. Oct-Dec was forecasted using actual values from the July-Sept period.
The statewide values for calls per 100,000 residents in each year are: CY2020 - 4,803; CY 2021- 5,209; CY2022- 5,186
Source: BH ASO reports submitted to Health Care Authority

***911***

From the most recent data available, there were just over five million calls to 911 by Washington residents in 2020. However, there is not a consistent way to track 911 calls that are related to mental

health or substance use disorder, with estimates ranging between 10 percent and 50 percent of 911 calls. As the 988 Lifeline is further implemented, including additional outreach and marketing to promote use of the line, it is anticipated that some of the call volume that is currently directed to 911 will transfer to the 988 Lifeline as the primary resource for callers with behavioral health and crisis needs.

**A Place to Call: Gaps in Data**

- It is important to note that this section does not yet reflect a comprehensive understanding of the current system service gaps and needs. Further work is needed in 2023 to analyze and interpret data presented in this section, including reasons for variation in RCL call volume by region.
- Analysis of demographic data with equity lens is needed to determine who is accessing the 988 Lifeline.
- There is an overall lack of centralized demographic data to identify and monitor disparities among callers (e.g. client race, ethnicity, age, geographical location, sexual orientation and gender, language, and other categories).
- The potential future call volume to Washington's 988 Lifeline crisis centers is still not precise due to the unknown impact of future marketing of 988 at both the federal and state level. This includes both the amount of marketing and when it will occur.
- The delineation of the volume of where people will call in the future (e.g., 988, 911, or RCLs) is still not precise due to the unknown impact of future marketing of the 988 Lifeline.
- There is not a consistent way to track mental health/substance use disorder crisis calls within the 911 call volume today. This makes the current estimate of 10% to 50% of call 911 calls attributed to mental health or substance use disorder hard to pinpoint with a greater degree of precision.
- There are different metrics tracked between 911, the 988 Lifeline, and the RCLs with respect to crisis-related calls.

## Someone to Come

Someone to come may consist of Mobile Crisis Teams, Designated Crisis Responders, First Responder Co-response teams, tribal first responders and other entities. An overview of Washington's current crisis response providers is provided below.

***Someone to Come***

- **Mobile Crisis Response Teams**
  - **53 Adult Mobile Crisis Response Teams** (one in each region; 38 of 39 counties)[25, 26]
  - **10 Youth Mobile Crisis Response Teams** (one in each region; 12 of 39 counties); two regions (King County and Thurston-Mason) currently deliver services under the Mobile Response and Stabilization Service (MRSS) model, an evidence-based crisis response and stabilization model focused on the developmental needs of youth and families.[27] Two additional regions (Pierce and Spokane) will begin piloting MRSS this year.[28]
  - **Tribal Mobile Crisis Response Team pilot** (HCA is currently seeking to pilot a MCR with a Tribe or Tribal consortium to provide culturally adapted services)
- **Designated Crisis Responders**
  - DCRs available in every county
  - Tribal Designated Crisis Responders, effective 1/1/2022
- **First Responders**
  - **59 police- and fire-based co-response teams** (please see Appendix H for further detail)
  - **First responders** (police, fire, emergency medical services)
  - **Tribal public safety and first responders** (tribal police, fire, EMS)

[25] An overview of HCA's work to expand adult MCR teams with legislative proviso funding authorized in 2021 is provided in the following pre-recorded presentation shared with the CRIS Committee in advance of their July 12, 2022 meeting. See *Adult Mobile Crisis Response and Facility Based Stabilization*: https://www.youtube.com/watch?v=2LGmm6hc94A.

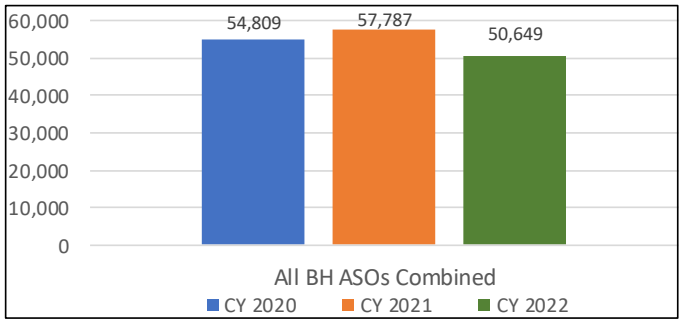
[26] Note: HCA has requested funds for an additional 17 adult teams in the 2023-25 budget.

[27] An overview of HCA's work to expand youth MCR teams with legislative proviso funding authorized in 2021 is provided in the following pre-recorded presentation shared with the CRIS Committee in advance of their July 12, 2022 meeting. See *Youth Mobile Response and Crisis Stabilization Services*: https://www.youtube.com/watch?v=rR-D1PgO0hI.

[28] Note: HCA has requested funds for an additional 17 youth teams in the 2023-2025 budget, including expansion of the MRSS model statewide, insurance blind for youth.

Based on data available through BH-ASOs, although call volume to both 988 and the regional crisis lines has increased statewide between CY2021 and CY2022, the number of mobile crisis response teams deployed has decreased during this time from 57,787 in CY2021 to an estimated 50,649 in CY2022.

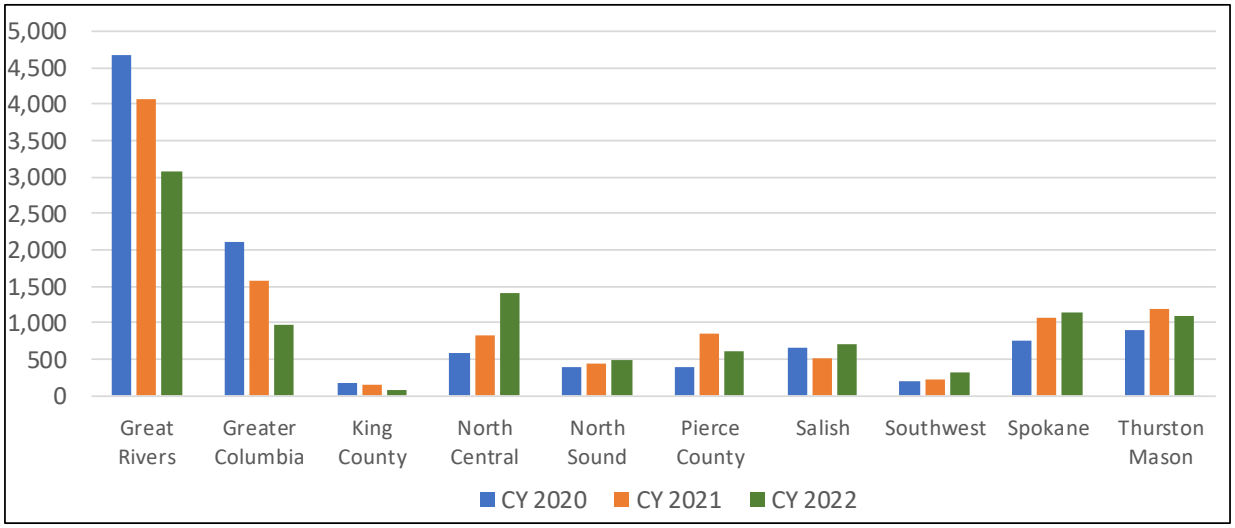
**Mobile Crisis Team Outreach through BH ASO Contracted Providers**




For CY2022, the data for Jan-Sept is actual. Oct-Dec was forecasted using actual values from the July-Sept period.
Source: BH ASO reports submitted to Health Care Authority

Access to MCR continues to vary widely across the state. When measured on a per 100,000 resident population, MCR use is greater in the Great Rivers and Greater Columbia regions than in other regions of the state. MCR use is expected to increase in five regions of the state in CY2022 compared to CY2021 and decrease in five other regions. Access to youth MCR services varies greatly across the state with the highest access to initial response plus 8 weeks in-home stabilization in Thurston/Mason, insurance blind through braided funding, followed by King County for Medicaid youth only.

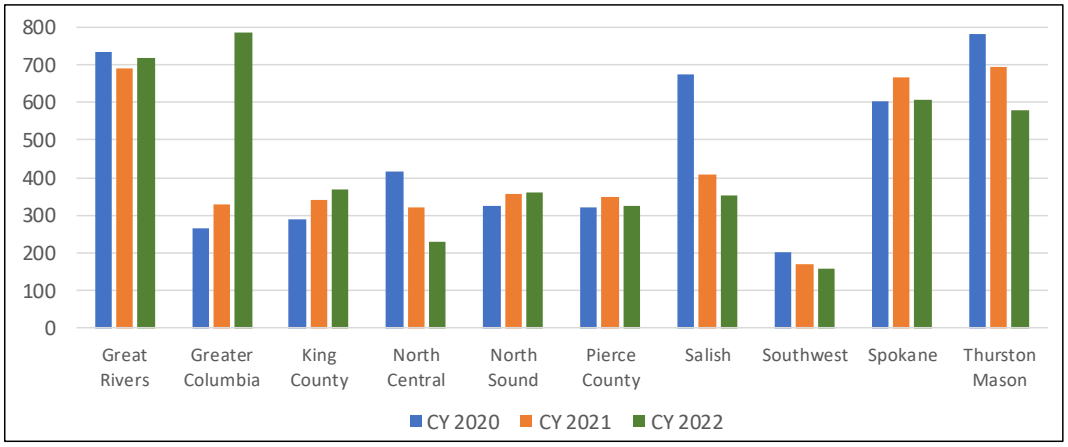
**Mobile Crisis Team Outreach Per 100,000 Residents for each BH ASO Region**




For CY2022, the data for Jan-Sept is actual. Oct-Dec was forecasted using actual values from the July-Sept period.
The statewide values for mobile teams per 100,000 residents each year are: CY2020 - 716; CY 2021- 744; CY2022- 644
Source: BH ASO reports submitted to Health Care Authority

Meanwhile, the use of Designated Crisis Responders has increased during CY2022. When measured on a per 100,000 resident basis, DCR investigations increased from 390 per 100,000 in CY2021 to 425 per 100,000 residents in CY2022. The use of DCRs varies greatly by region.

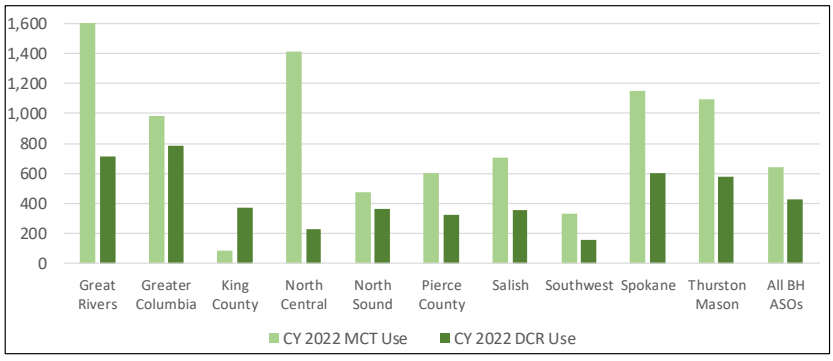
**Designated Crisis Responder Investigations Per 100,000 Residents for each BH ASO Region**




For CY2022, the data for Jan-Sept is actual. Oct-Dec was forecasted using actual values from the July-Sept period.
The statewide values for DCR investigations per 100,000 residents each year: CY2020 - 379; CY 2021- 390; CY2022- 425
Source: BH ASO reports submitted to Health Care Authority

The reliance of DCRs compared to MCRs also varies by region within the state. King County is the only region where the use of DCRs outpaces MCRs. In the remaining regions, DCR investigations range from a low of 16% (North Central) to 80% (Greater Columbia) of MCR deployments. We note the need for further exploration of what this data means and understanding of how DCR and MCR services are managed in different regions. For example, in some instances, a case may have both a MCR and DCR case open. The staffing levels, staff types, and ability to respond rapidly can also vary widely by region.[29] Regions may also have the same staff providing DCR and MCR services, or may have separate DCR, adult MCR and children and youth MCR teams.

**Comparing Mobile Crisis Team and Designated Crisis Responder Use in CY2022, by BH ASO Region**
All Values are Shown on a per 100,000 Resident Basis in each Region



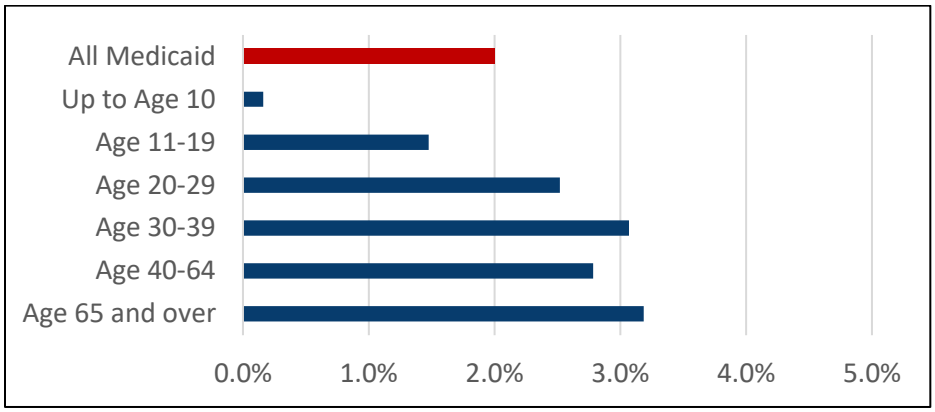

For CY2022, the data for Jan-Sept is actual. Oct-Dec was forecasted using actual values from the July-Sept period.
Note that Great Rivers MCT Use is above what is displayed here at 3,088 per 100,000 residents.
Source: BH ASO reports submitted to Health Care Authority

[29] Note: For new teams that were deployed this year using proviso funding from 2021, HCA defined teams as having 11 members, made up of 1 MHP supervisor, 5 MHPs and 5 CPCs. Outside of those teams, we do not know the number of FTEs that are currently part of our mobile crisis response system.

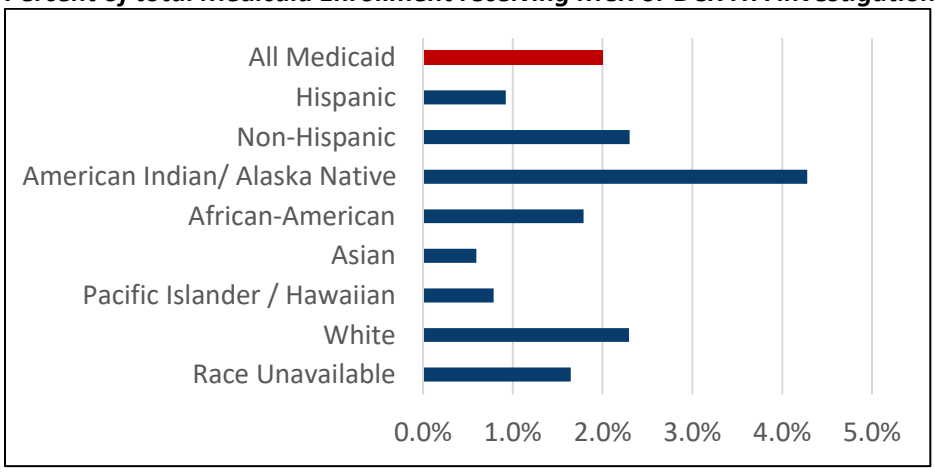
To provide a reference point for crisis service needs across the state, Medicaid claims data was also analyzed based on diagnosis (mental health primary diagnosis, substance use disorder primary diagnosis); by region; by age group; and by race and ethnicity.[30] Approximately one in four individuals (23.3%) that live in Washington are enrolled in Apple Health, Washington's Medicaid program. Below are several key findings from this data with respect to MCR and DCR response.

- 2.0% of the total Medicaid enrollment (34,118 individuals) received either a mobile crisis team service or DCR ITA investigation. Although the statewide average is 2.0%, the proportion of Medicaid users by region varies from less than 1% to up to 4%.
- The percent of users was found to be similar across different age bands of adults, with lower utilization among youth populations.
- MCRs and DCR ITAs are disproportionately used by American Indian / Alaska Native Medicaid enrollees (4.3%) compared to the overall average and other racial and ethnic groups.
- Further investigation is warranted to determine if there is under-reporting for certain population groups, and to understand what these differences in rates of utilization mean.

***Percent of total Medicaid Enrollment receiving either a MCR or DCR ITA investigation***




***Percent of total Medicaid Enrollment receiving MCR or DCR ITA investigation by race and ethnicity***




[30] Medicaid claims data was analyzed for the 12-month period July 1, 2020 to June 30, 2021.

**Someone to Come: Gaps in Data**

- It is important to note that this section does not yet reflect a comprehensive understanding of the current system service gaps and needs. Further work in 2023 is needed to analyze and interpret data presented in this section, including deeper analysis of services by region (including reasons for variation in MCR and DCR rates by region), and access to services by population.
- We note that since only Medicaid data is being used, people over 65 years old (non dual eligible Medicare), commercial and uninsured people are not part of the analysis.
- There is no centralized mechanism to track MCR and DCR ITA investigations across all payers and uninsured.
- There is a lack of centralized data regarding first responder co-response team services.
- There is a lack of consistency in coding for mobile teams, DCR ITA investigations, and crisis stabilizations services among BH-ASOs, Medicaid MCOs, and commercial MCOs.
- The metric of time-to-reach for mobile crisis response is currently not available in one tracking system. Although each BH ASO may track time-to-reach at greater granularity, at the statewide level, the results reported are limited to either 'under two hours' or 'greater than two, but under 24 hours'. More specific data is needed for collection in the future to get a more precise response time by region, including within 60 minutes.
- There is currently no data compiled at the statewide level on time-to-reach for DCR investigations.
- There is currently no data compiled at the statewide level on time-to-reach for law enforcement/co-responder units.
- There is a gap in the data for place of services for the DCRs and MCRs (e.g., services provided in the field versus at hospitals).
- There is no centralized location to track data on individuals receiving MCR services to identify and monitor disparities in MCR, DCR and first responder crisis response (e.g., client race, ethnicity, age, geographical location, sexual orientation and gender, language, and other categories).
- Children are undercounted and we likely do not have a good picture of youth population needs, particularly for those under 13 years old.

## A Place to Go

Crisis stabilization services come in a variety of forms which many include walk-in services, short term residential treatment, Crisis Stabilization Units, 23-hour crisis stabilization units, the Living Room Model, and peer respite.


- Crisis stabilization units
- 23-hour crisis stabilization
- Living Room Model
- In-home Stabilization
- Peer Respite
- Emergency Departments
- Psychiatric inpatient units and Evaluation and Treatment (E&T) facilities
- Secure withdrawal management and stabilization
- SUD Residential treatment
- AI/AN Behavioral Health Facilities (Tribal Evaluation and Treatment, Secure Withdrawal Management or crisis stabilization facility) (in development)

A 2022 survey of community based mental health and substance use disorder treatment agencies in Washington provides a measure of the scope and type of crisis stabilization services offered in the state.[31] Of the 231 agencies that responded to the survey, 76 agencies (35%) provide crisis stabilization services.[32] Among those providing crisis stabilization services, services offered include:

- Crisis outreach (76%)
- Crisis telephone support (66%)
- Crisis peer support (41%)
- Emergency involuntary detention (37%)
- Crisis stabilization unit (35%)
- 23-hour crisis stabilization (9%)
- Living Room Model (3%)
- Ten percent of the agencies specified other forms of crisis stabilization services such as: "24-hour mobile crisis response team;" "assisted outpatient treatment;" "same-day

[31] Rodriguez, F.I. & Miller, K.J.. (2022*). Crisis Stabilization Services Offered by Behavioral Health Treatment Agencies in Washington State – Results from the 2021/2022 Behavioral Health Provider Survey.* Washington State Health Care Authority and Washington State University, Social & Economic Sciences Research Center.

[32] Of the total 662 agencies surveyed, 231 agencies responded yielding a 35% response rate. The survey was available December 2021 – April 2022. We note limitations of data on crisis stabilization services based on survey with only 35% response rate.

appointments, regular follow-ups, peer services, case management services, medication management;" "crisis stabilization in a home-like setting (in facility);" "coordination of hospitalization, crisis interventions during business hours;" and "crisis evals, interventions, monitoring."

Behavioral health treatment agencies receive referrals to their crisis stabilization services from a variety of sources, including self-referral (77%), clients' family (76%), other behavioral health agencies/providers (67%), designated crisis responders (65%), acute care hospitals and emergency departments (62%), police departments (60%), schools (56%), mobile crisis response units (52%), physicians (52%), and 911 (38%).

As of the end of CY2022, there are approximately 182 crisis stabilization unit (CSU) beds available in the entire state.[33] These beds are available to adults only; there are no current crisis stabilization beds for youth and in-home stabilization under the MRSS model is currently available in only 3 of 39 counties. There are also no CSU beds available in the King County and Thurston-Mason BH ASO regions. In its 2023-25 biennium budget request, HCA has requested funding for the operational costs of three additional crisis stabilization units. The HCA has also made a request for state general funds to cover the costs of peer respite or other crisis stabilization services.

Emergency departments are often the only place to go. Among the Medicaid population, during the 12-month period July 2020 to June 2021, 8.5 percent of all emergency department visits (or 1 in 11.7) are related to conditions with a primary diagnosis for mental health or substance use disorder. For children and adolescents ages 11 to 18, the rate is 6.8 percent (or 1 in 14.7).

For youth and adults, limited options for a place to go in the outpatient setting results in presenting to the ED, ED boarding, or inpatient admissions. Notably, for youth, there are only six inpatient units that focus on youth and adolescents in the state (located in Spokane, Tacoma, Lacey, Yakima, Brush Prairie, and Marysville). Kirkland closed its unit in CY 2022. Youth and young adults with additional complexities, such as autism with aggressive behaviors or significant developmental delay, have even more restricted access to appropriate treatment.

In 2021, the Governor issued an Emergency Proclamation on Children and Youth Mental Health Crisis, citing alarming increases in pediatric patients with behavioral health diagnoses and acute inpatient admissions.[34] For example:

- At Sacred Heart Children's Hospital in Spokane, acute care admissions to its Inpatient Adolescent Psychiatric Unit increased 73% in 2020 as compared to 2019, and acute care

[33] This number can vary due to staffing shortages and funding availability.

[34] State of Washington, Office of Governor Jay Inslee, Emergency Proclamation of the Governor (21-05) – Children and Youth Mental Health Crisis. Retrieved from https://www.governor.wa.gov/sites/default/files/proclamations/21-05_Children%27s_Mental_Health_Crisis_%28tmp%29.pdf

admissions to its General Pediatric Floor for behavioral health issues increased 68% in 2020 compared to 2019;

- At Seattle Children's Hospital, the Psychiatric Unit is currently the most over-capacity/over-stressed part of the hospital; and unlike before the COVID-19 pandemic, it is now normal for 1 to 2 children to be admitted every night at Seattle Children's for attempted suicide;
- At Swedish Medical Center, despite a lack of designated pediatric inpatient psychiatry beds, the percentage of pediatric inpatient admissions in its hospital for behavioral health reasons and/or suicide attempt has dramatically increased from 7.5% in 2018 to 24.5% in the first 2 months of 2021;
- At Mary Bridge Children's Hospital, the 14-day medical admission rate for mental health reasons increased approximately 67% from March 2020 to February 2021; and 60% of patients admitted to medical wards for mental health reasons are age 15-18 and 40% of these patients are age 14 and younger.

According to DOH's 2022 third quarter report tracking the behavioral health impacts of COVID-19, most recent reporting from hospitals in Washington that admit pediatric patients continues to indicate that the surge of youth presenting to emergency departments for suicidal ideation and suspected suicide attempts remains an ongoing issue. [35] Monthly DOH Youth Behavioral Health Impact Situation Reports also show continued trends in youth psychological distress, suicide ideation and suspected suicide attempts.[36]

The Washington Behavioral Health Facilities (BHF) Program, started in 2013 and administered by the Department of Commerce, awards grants for capital projects to expand community-based behavioral health facilities throughout Washington.[37] The 2021-2023 projects that have been funded to date, for example, include the creation of new and/or renovated beds in the following facility types (note this list includes beds that have received funding support, but may not be yet be operational):[38]

- 90 to 180 day civil commitment: 80 beds
- Crisis stabilization: 112 beds
- Intensive behavioral health: 160 beds
- Residential treatment: 80 beds
- Enhanced services facilities: 136 beds

[35] Washington State Department of Health. (September 2022.) Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19 – Third Quarter 2022 Update. Retrieved from https://doh.wa.gov/sites/default/files/2022-09/821103-COVID19BHForecastSummary-202209.pdf?uid=63a34bff6a76f .

[36] See also monthly Youth Behavioral Health Impact Situation Reports documenting continued trends in psychological distress, suicide ideation and suspected suicide attempt: https://doh.wa.gov/emergencies/covid-19/healthcare-providers/behavioral-health-resources

[37] Washington State Department of Commerce. (2022). Behavioral Health Facilities Program. Retrieved from https://www.commerce.wa.gov/building-infrastructure/capital-facilities/behavioral-health-bed-grants/

[38] See Appendix B for definitions of various facility types for the beds listed above. Note that these figures may increase based on with additional BHF Program list of awarded projects at: https://deptofcommerce.app.box.com/s/l44dbnexjgw3me3hnnd8ikwhh64pi02x

- Secure withdrawal management and stabilization: 32 beds
- Substance abuse treatment: 108 beds
- Peer respite: 11 beds

Commerce also recently closed the application period of a funding round for a new type of facility called Residential Crisis Stabilization Programs, which are short-term (30 days, max of 90 days) beds for children and youth.[39] Announcement of these awards has not yet been released.

In the Behavioral Health Facilities Program 2020 report to the legislature, program recommendations highlighted that while the BHF Program has significantly increased the number of community-based facilities in Washington, there is a lack of data to estimate the overall demand.[40]

The University of Washington is also building a new Behavioral Health Teaching Facility that will be at UW Medical Center–Northwest. The facility will have a total of 150 psychiatric beds, including 75 beds for long-term civil commitment patients (ITA holds), and 50 medical/surgical beds for patients with acute physical and psychiatric care needs. There will be an additional 39 beds on campus (25 in the facility, the rest in the main hospital) that will house voluntary psychiatric and geriatric psychiatric services. The new facility is slated to open to patients in mid-2024.

There are currently no inpatient mental health services provided by Indian Health Care Providers, although tribes have been moving in the direction of developing capacity to provide inpatient mental health services by IHCPs on tribal lands. This includes development of a Tribal Evaluation and Treatment/Secure Detox Facility.

**Place to Go: Gaps in Data**

- It is important to note that this section does not yet reflect a comprehensive understanding of the current system service gaps and needs. Further work is needed in 2023 to update and expand upon the data in this section, including deeper analysis of services available by region and access to services by population.
- We note limitations of data on crisis stabilization services based on the 2021/2022 Behavioral Health Provider Survey with only a 35% response rate.
- Updates to data regarding youth emergency department and psychiatric inpatient care utilization are needed.
- There is a lack of centralized statewide data tracking the attributes of the number of facilities, count of beds/chairs, and other characteristics of each of the types of crisis stabilization centers online today or coming on board in CY2023. Additional information needed is hours available, maximize duration of stay for clients, and specific populations that can be served (or not served) at each location.

[39] Washington State Health Care Authority. (2022). Residential Crisis Stabilization Programs. Retrieved from: https://deptofcommerce.app.box.com/s/xlnat6ii8485jjxu7qcl6nro0ikiuot1

[40] Washington State Department of Commerce. (2020). Behavioral Health Facilities Report. Retrieved from https://deptofcommerce.app.box.com/v/bhf2020legreport

- Average time (in hours or days) needs to be collected for clients at each crisis stabilization facility to better understand available capacity within each facility and across regions in the state.
- Information on the referral sources from which each crisis stabilization facility receives clients is not collected in a systematic way today on a statewide basis. The referral source may be useful to assist in capacity planning as mobile crisis response teams continue to be added and as more attention is made to emergency department diversion in appropriate circumstances.
- There is limited demographic data to identify and monitor disparities in crisis stabilization services (e.g. client race, ethnicity, age, geographical location, sexual orientation and gender, language, and other categories).
- Children are undercounted and we likely do not have a good picture of youth population needs.

## Pre/Post Crisis Care

Pre- and Post-Crisis Services include services immediately upstream and downstream of crisis events. These may include services such as next day appointments, post-crisis services, warmlines, peer and family supports, and navigation supports to support individuals and families to avoid situations escalating and cycling in and out of the crisis system.

***Pre- and Post-Crisis Services***

- Next day appointments
- Follow up outpatient care
- MRSS and In-home stabilization
- Peer support
- Indian Health Care Providers and Urban Indian Health Programs
- Washington Indian Behavioral Health Hub
- Provider resource directories
- Crisis Call Center Hubs (future state)
- Washington 2-1-1 Resource Directory

Analysis of Medicaid claims data for the period June 2020 to July 2021 showed that there is limited follow up post crisis care:

- For 39% of enrollees who had a mobile crisis service there was no evidence of follow-up within 30 days. Approximately, 33% of enrollees who had a mobile crisis service received a mental health service within 1 day, 53% within 7 days, and 61% within 30 days.
- A higher percentage of enrollees who had a DCR ITA investigation received a mental health service within 1 day (46%). Like those who had a mobile team service, for 38% there was no evidence of follow-up within 30 days.

  Only 20% of enrollees who had a hospital emergency department visit related to mental health or substance abuse received a mental health service within 1 day. For 66%, there was no evidence of follow-up within 30 days.

In the future state system, Crisis Call Center Hubs will also play an important role to link individuals to follow up care. We note that the final Technical and Operational Plan outlines the technology system needs for Crisis Call Center Hubs to support crisis calls, coordinate information across crisis system entities, and provide referrals to follow up care and other resources for individuals accessing the 988 Lifeline. In 2023, the Department of Health will be initiating its rulemaking process to establish standards for Crisis Call Center Hubs. Further CRIS and Steering Committee discussion on this topic is planned for 2023.

***Next Day Appointments***

A workgroup convened by HCA and comprised of commercial carriers, BH-ASOs, and crisis service providers concluded in November with a plan to implement next day appointment requirements for commercial carriers, beginning January 1, 2023. The plan is to create a singular referral tool that will

capture reasons for the NDA and clinical presentation of the person in crisis.[41] This tool will be sent to commercial carriers using a contact directory for either a warm hand off or for plans to follow up.

Final meetings are underway to examine the tool and start training staff on this process. The focus will be to develop a workstream for crisis workers and plans to adopt in January. Trainings on the tools will be ongoing for crisis workers and carrier staff throughout January, including a process for feedback and continuous improvement.

Work is still ongoing to expand capacity and ensure coverage of NDAs on the weekends and evenings with plans. Key issues to identified to address also include reducing reliance on a person knowing their health plan during a crisis and improving overall system coordination. Work will also continue to ensure NDA capacity is increased to better serve the community. We also note further discussion requested by the CRIS in 2023 regarding strategies to address next day appointment no show rates.

***Follow Up Outpatient Care***

Outpatient behavioral health system capacity and behavioral health workforce shortages continue to be significant issues that impact access to services in Washington and will be explored further in 2023. The 2022 survey of community based mental health and substance use disorder treatment agencies in Washington reported that seventy-seven percent (76%) of agencies offering crisis stabilization services provide outpatient MH services following a clients experience of an immediate crisis. Agencies also report providing crisis outreach (73%), crisis telephone support (63%), MH peer service (57%), referral to substance use disorder (SUD) residential program (57%), referral to inpatient MH services (57%), same-day walk-in behavioral health services (56%), SUD intensive outpatient program (42%), mobile crisis response follow-up (41%), and SUD peer services (23%). Fewer than 10% offer acute detox (9%) and sub-acute detox (7%), while 3% offer sobering unit, and 1.3% provide peer-run respite centers. In regions with MRSS, youth that do receive facility-based treatment benefit from connection to youth MRSS for post-discharge support and stabilization.

**Tribal Behavioral Health Crisis Services**

Washington is home to 29 federally-recognized Indian tribes, which exercise sovereignty over tribal lands. Health care on tribal lands is provided through an Indian Health Care Delivery system supported by the Indian Health Service and distinct from the state Medicaid program. Behavioral health services including outpatient mental health, outpatient SUD, and inpatient SUD programs are provided by over 75 different Indian Health Care Providers (IHCPs) and Urban Indian Health Programs (UIHPs).[42] In tribal communities, engaging social networks to outreach to families and communities when a suicide or other

[41] Note: Initially, this tool will be a standard PDF form built internally at HCA. As we start to roll out the technical platform, the form can be built out into the platform. Because it is created by HCA there is no need for a procurement, but this form and others like it will be part of the RFI evaluation process to ensure it can be supported by the technology platform.

[42] Map of Washington State Tribes and Tribal Health Clinics, Retrieved from https://www.hca.wa.gov/assets/program/wa-tribes-and-tribal-clinics.pdf

crisis occurs is also an important activity to prevent additional suicides or behavioral health crises. IHCPs and UIHPs have provided integrated care for many years, and serve as the health home, or central coordinating entity for many AI/AN people.

American Indian and Alaska Natives who call the Native and Strong Lifeline will be connected with the Washington Indian Behavioral Health Hub to provide access to follow up resources and care. The Washington Indian Behavioral Health Hub is working with IHCPs to have up to date IHCP points of contact to support follow up care and other resources for AI/AN individuals.

**Washington 2-1-1 Resource Directory**

In 2000, the Federal Communications Commission designated 2-1-1 as the 3-digit number for information and referrals to social services and other assistance. In Washington, 2-1-1 has operated in the state since 2006, and provides callers with information and referral to a variety of social services including services and supports for: crisis and emergency services, housing, food, health (including mental health and substance use), financial assistance, and transportation. Washington 2-1-1 is working with 988 Lifeline crisis centers to consider opportunities to support individuals contacting the 988 Lifeline with referrals to resources.[43]

**Pre and Post Crisis Care: Gaps in Data**

- It is important to note that this section does not yet reflect a comprehensive understanding of the current system service gaps and needs. Further work is needed in 2023 to update and expand upon the data in this section, including deeper analysis of services available by region and access to services by population.
- There is no data repository where data is tracked and analyzed for a single client across their continuum of care during the pre-crisis period, crisis event, and post-crisis care.
- There is no data collected to track individuals who are recurring users of the crisis system to better assess opportunities for pre- and post-crisis care for these individuals.
- Measures are yet to be agreed upon and defined to track and trend follow-up care for individuals in crisis (e.g., follow-up appointment within 1 day, 3 days, or 7 days from a mobile crisis team outreach or an ED visit related to crisis).
- Measures are yet to be agreed upon to measure the effectiveness of the different modalities for pre-crisis care and how well they prevent crisis events from occurring.

[43] See Final Technical and Operational Plan discussion of 2-1-1 technical infrastructure in relationship to development of technology to support Crisis Call Center Hubs. Retrieved from file:///C:/Users/npinson/Documents/Harborview/January%202023%20Report/final-technical-and-operational-plan-988.pdf

## Suicide Prevention

Suicide is a preventable public health problem. In addition to transforming the crisis response system, work to address the root causes that contribute to suicidality is also critical. Primary prevention attempts to prevent suicidal thoughts or behaviors from happening in the first place. In public health, this is achieved by identifying and changing the factors we know contribute to suicide risk, such as childhood trauma, isolation in our communities, access to lethal means, and lack of access to appropriate behavioral healthcare. Primary prevention also works to increase protective factors, including the skills and characteristics that build resiliency and help mitigate the impacts associated with experiencing risk; they are the skills (e.g., skills in problem solving, conflict resolution, nonviolent handling of disputes, and help seeking behaviors, etc.) and supports (e.g., strong connection to family and community support, easy access to appropriate care, safe housing, nutrition and access to social supports, restricted access to lethal means, etc.) that help people get through difficulties with their health and wellness intact.

Over the years, Washington State and local partners have made critical investments toward reducing risk factors and strengthening protective factors, as well as investments into the behavioral health system. Community and state-wide strategies often fall within the four key strategic directions of the Washington State Suicide Prevention Plan. As outlined in House Bill 2315 (2014), the Department of Health, with the help of a large steering committee and many people who participated in local listening sessions, developed the Washington State Suicide Prevention Plan. The plan sets an important vision for Washington, and outlines four key strategic directions:

1. **Healthy and Empowered Individuals, Families and Communities:** in a healthy and empowered community, everyone understands their role in prevention and suicide is prevented upstream, before a crisis.
2. **Clinical and Community Prevention Services:** suicide prevention programs directed to those who need them most can help identify people at risk and keep them safe.
3. **Treatment and Support Services:** when a person in crisis seeks treatment, it should be accessible, appropriate, and respectful.
4. **Suicide Surveillance, Research and Evaluation:** research, data and evaluation should inform all suicide prevention programming.

Current examples of prevention strategies in Washington include:

- Community coalitions and partners that implement programming to decrease stigma and promote help seeking behaviors, and increase social connectedness, social emotional learning, and resilience (e.g., implementing Sources of Strength, HOPE Squad, other social emotional learning programming).
- The Native and Strong campaign which promotes resilience and suicide prevention for tribal communities. The campaign also provides resources (videos, social media posts, posters, digital graphics) for tribes and partners to use to inform tribal communities about suicide prevention. Suicide Prevention | it starts with one (watribalopioidsolutions.com)
- Death reviews to identify strategies and opportunities for prevention to keep others safe.

- Education for physicians and other professionals to recognize warning signs of suicide risk and refer people to local resources.
- Implementing community specific suicide prevention programming tailored to address the unique needs most appropriate for those communities. Examples include suicide prevention programming for rural and agricultural communities; House Bill 1477 directs Washington to implement geographically, linguistically, and culturally appropriate and relevant 988 and expanded services.
- Prevention is a core aspect of the Mobile Response and Stabilization model (MRSS). This model recognizes the developmental needs of youth, includes upstream interventions to prevent crisis, and provides law enforcement, ED, and hospital diversion through immediate in-person crisis response, warm hand-offs, coordination of care, and in-home stabilization extending up to 8 weeks. Youth MRSS teams can respond to primary care provider clinics, ED's, schools, juvenile justice or the community. Increasing funding and capacity for early interventions, including MRSS is a fundamental strategy for early identification and prevention of exacerbating symptoms and improved outcomes.

## Committee and Tribal Partner Input: Known Gaps and Areas for Recommendations

In 2022, Committees engaged in review of current system services and gaps, and identification of areas to expand and add services. Below is a summary of key gaps and areas of recommendations discussed to date. Further work is planned in 2023 to develop recommendations of services that should be expanded or added to meet Washington's crisis response system goals.

### *Overall*

» ***We need to listen to Washington providers in the field and invest in and build upon existing best practices in the state.*** Providers who are currently operating successful programs are promising, but this is not what happens across the state, and we need to find ways to expand and distribute services equitably.

» ***Further discussion and alignment are needed on what are considered best practices across the crisis service continuum.*** Committees engaged in initial discussions and review of best practices within Washington, other states, such as Arizona, and national best practices, such as models recognized by SAMHSA models. It would be helpful identify best practices that are endorsed, and whether they are currently available in Washington. Work is also needed to review where legal and regulatory changes are needed to support these best practices.

» ***Peer support should be attached to services across the crisis continuum.*** Peer agencies and programs (e.g., respite centers) must be better integrated into overall crisis response system to better leverage these vital services.

» ***Expansion of resources to support tribal crisis response services across the crisis continuum is needed.*** It is critical that the HB 1477 Committees support and build upon the extensive work led by

Tribes and Urban Indian Health Organizations (UIHOs) in Washington for over a decade to expand behavioral health and crisis response services for AI/AN populations. See Appendix D for a brief summary of the history of tribal work to address the barriers in access to behavioral health crisis services for tribal members.

### *A Place to Call*

» ***Building trust in the 988 Lifeline with diverse communities will be critical to success and expanded use of the line. There is still a lot of uncertainty around 988.*** Many populations fear police involvement and are unclear about confidentiality and their safety. There needs to be education and transparency around the 988 Lifeline, and what callers or people who text or chat with the Lifeline can expect. Key components of this include:

- Make clear that the 988 Lifeline is not automatically connected to law enforcement.
- Ensure confidentiality is maintained for people who call, particularly in rural communities.
- Rural communities may end the call if they are greeted with a recording and dial pad options. Washington should consider working with Vibrant on options for a live person to answer. This concern applies to other populations as well.

» ***There are multiple points of entry into the crisis system. We need to recognize access points outside of the 988 Lifeline and ensure a No Wrong Door approach to accessing crisis supports.***

- Individuals may enter the crisis system through emergency departments, outpatient providers, schools, interaction with law enforcement and the justice system and other avenues. The system needs to be set up to ensure access to care when individuals enter the system outside of the 988 Lifeline as well.
- There are currently multiple crisis lines, including Regional Crisis Lines in each region. System policy decisions are needed regarding the roles of Regional Crisis Lines in relationship to the 988 Lifeline and the Crisis Call Center Hubs to guide discussion about future-state planning. See Progress Update, Section II.5 (Cross System Collaboration) for further discussion of this.

### *Someone to Come*

» ***Expansion of mobile crisis response tailored to specific populations, such as AI/AN people, youth, rural communities, LGBTQ+, and older adults, is a priority.*** Access to mobile crisis response continues to be limited and varies widely across the state. Access for youth mobile crisis response is particularly lacking in most regions of the state.

- Given geographic limitations, models for mobile crisis response teams in rural communities may need greater reliance on first responders.
- We need to have quicker response times. 30 minutes is even too long, let alone 60-90 minutes.

» ***Expanded transportation options are needed for individuals in crisis.*** The lack of transportation options for individuals in crisis creates a higher reliance on transportation by law enforcement and

emergency medical services. Currently, mobile crisis response teams do not have resources to provide transport during crisis services.

» ***The role of law enforcement in the crisis response system needs to be clearly addressed and defined.*** It is important to recognize that law enforcement involvement in crisis response raises equity issues for communities that are traumatized by police force. At the same time, law enforcement plays an important role in the crisis response system to maintain safety in dangerous circumstances. These considerations will be further discussed by the CRIS and Steering Committee in 2023.

### *A Place to Go*

» ***There are three types of services gaps areas in a Place to Go: 1) Services that don't exist in Washington state, 2) Services that exist in Washington but don't have the capacity/capability to meet demand, 3) Services that are in Washington that have so many rule-out criteria that they are effectively inaccessible.***

- Youth uniquely but not exclusively face the third barrier. Children and youth get ruled out by places to go because of age and places that do accept them, or because of autism or a medical concern, and then they end up at the hospital.
- Expanded drop off locations are needed besides the emergency department and hospitals. These may include peer respite, or 23-hour facilities.

» ***Medical clearance is a key issue that needs to be addressed in considering expanded crisis stabilization options.*** We need to create a system where we can medically clear people so that they don't have to go to the emergency department before going to a community-based crisis stabilization center. This system must also assure crisis stabilization facilities that people are medically stable enough to be there.

### *Pre and Post Crisis Care*

» ***Leverage technology to maximize opportunities to expand telehealth to support access to care.***

- Emphasis on telehealth to support access to care among tribal populations when services are not available directly through tribal providers, as well as for people living in rural communities.
- Efforts are also needed to address implementation and contracting barriers for telehealth, such as working with out-of-state telehealth providers.

# 4. Quality and Oversight

*HB 1477 charges the Steering Committee, with input from the CRIS Committee and Subcommittees, to make recommendations with respect to the quality outcome goals and oversight of Washington's crisis response and suicide prevention system. Specifically, key areas of recommendations include:*

a. *Identify quantifiable goals for the provision of statewide and regional behavioral health crisis services and targeted deployment of resources.*
b. *Identify a process for establishing outcome measures, benchmarks, and improvement targets for the crisis response system.*
c. *Make recommendations for constituting a statewide behavioral health crisis response and suicide prevention oversight board or similar structure for ongoing monitoring of the behavioral health crisis system and where this should be established.*

## What We Know Now / Current State

The identification of Washington crisis system goals, outcome measures, and improvement targets is foundational to the charge and the work of the Steering Committee to make recommendations to improve the system. The identification of goals, measures, and targets is also foundational in identifying additional crisis system services and associated resources needed to enable and achieve that performance. As the lead implementation authorities for this work, HCA and DOH are currently developing an inventory of:

a. Measures and targets already in use in Washington State, and
b. Measures and targets are considered national best practice in crisis response, including those based on the SAMSHA and MRSS best practice models.

The HCA and DOH inventory will establish a baseline of current measures in use in Washington, including measures and targets already in use under current BHASO, MCO, and 988 Lifeline crisis center contracts; as well as national best practice measures to consider. Important considerations in the evaluation of measures, as identified in the *2021 Initial Assessment*, are that few measures are currently used to measure the *quality* of the services delivered across the full crisis response continuum (current measures focus on process, not client outcomes); and none of the measures are applied across all payers. The agencies will identify gaps within current measures and targets used in the state and make recommendations for how to address in goal setting. This work will be presented to the CRIS and Steering Committee in 2023 for feedback and recommendations. Additionally, the Steering Committee and CRIS will address recommendations in 2023 with respect to formation of a behavioral health crisis response and suicide prevention oversight board to hold the system accountable to progress toward meeting established goals, measures, and targets.

## Committee and Tribal Partner Input: Known Gaps and Areas for Recommendations

In 2022, the CRIS and subcommittees provided input on way to promote equity in the crisis system quality and oversight, summarized in the box below. As noted above, Steering Committee and CRIS work on recommendations relating to system quality and oversight will be a focus area for 2023.

***Quality and Oversight – Summary of CRIS and Subcommittee Input on Ways to Embed Equity***

- ***Create a transparent oversight and accountability plan that is clear how and when oversight will be conducted, how it will be evaluated, and how any deficiencies or compliance issues will be addressed and remedied.***
  - Need to ensure we are conducting effective monitoring of the entire system to hold us accountable, and we should share that with our communities to be transparent.
  - Special attention is needed to address disparities experienced across populations. For example, in rural areas, attention is needed where geographic barriers, lack of access, and lack of resources are used as excuses for not providing services.
  - There is a wealth of federal funding available to communities to support crisis system research and evaluation. Is there work with higher education to develop research synergies? While I-502 remains controversial from a funding perspective, it is an example of situating basic and applied research into the process.

- ***Ensure we are collecting and analyzing (at all points in the system) the necessary data elements to allow for the identification and monitoring of any disparities.*** If we don't have systems in place to do this, they should be built and rolled out with training and support and include requirements and technical assistance to partner with impacted communities to identify and understand drivers of disparities and develop clear action plans to address root causes. Some of the areas to be included/considered are: race, ethnicity, age, geographical location (zip code), sexual orientation and gender identity, physical and/or intellectual and developmental disabilities, language, and other categories as identified.

- ***Data collection efforts must recognize that 988 Lifeline calls are confidential and people contacting 988 are not required to provide any personal data to receive services.*** The caller does not have to disclose any demographic information to the crisis center unless they want to.
  - Recognize Tribal Data Sovereignty

- ***Determine ways to share data and outcomes with the community to hold the crisis response system accountable – this includes how we are addressing disparities and advancing equity.*** Ideally this would be driven by the community and not the system – so what information would community members identify as needed to ensure the system is accountable and transparent? This commitment to transparency should extend to decision-making and process.
  - Community engagement efforts should be prioritized on an ongoing basis to develop and monitor the crisis response system including:
    - Engaging diverse communities and people with lived experience (and their families) and service providers in all aspects of system design and accountability
    - Engaging in government-to-government relationship with Tribes to inform ongoing engagement and outreach, education, and messaging
    - Consider hosting regularly scheduled Regional Crisis Response System Community Forums to share progress and updates as well as solicit ongoing community input

*Note: A fuller description and examples of actions identified by the CRIS and Subcommittees to promote equity is provided in the Section II.2 Committee Progress Update on Promoting Equity.*

# 5. Cross System Coordination

*HB 1477 charges the Steering Committee to establish as cross-system crisis response collaboration subcommittee to examine and define complementary roles and interactions between crisis system partners, including mobile rapid response crisis teams, designated crisis responders, law enforcement, emergency medical services teams, 911 and 988 operators, public and private health plans, behavioral health crisis response agencies, nonbehavioral health crisis response agencies, and other partners.*

## What We Know Now / Current State

Presently there are numerous entities involved in the delivery of crisis response services across the crisis response continuum: A Place Call, Someone to Come, A Place to Go, and Pre and Post Crisis Services.

| | |
|---|---|
| ***A Place to Call*** | ➢ 988 Lifeline crisis centers, including the Native and Strong Lifeline (future state: Crisis Call Center Hubs)<br>➢ Regional Crisis Lines<br>➢ 911 Operators<br>➢ Population specific crisis line including Tribal Crisis Lines, Veterans Crisis Line, Teen Link, The Trevor Project, the National Maternal Mental Health Hotline, Trans Lifeline, the Farm Aid crisis line, and the Disaster Distress Line |
| ***Someone to Come*** | ➢ Mobile Crisis Response Teams and Tribal Mobile Crisis Response<br>➢ Designated Crisis Responders and Tribal Designed Crisis Responders<br>➢ First responder co-response teams<br>➢ First responders (police, fire, emergency medical services)<br>➢ Tribal public safety and first responders (tribal police, fire, EMS) |
| ***A Place to Go*** | ➢ Crisis stabilization facilities<br>➢ Community-based crisis stabilization<br>➢ Emergency Departments<br>➢ Psychiatric inpatient units and E&T facilities<br>➢ AI/AN Behavioral Health Facilities (Tribal Evaluation and Treatment, Secure Withdrawal Management, or crisis stabilization facility) (in development) |
| ***Pre- and Post-Crisis Services*** | ➢ Next day appointments<br>➢ Follow up outpatient care, provider resource directory<br>➢ Outreach and engagement by MCR and in-home stabilization<br>➢ Indian Health Care Providers and Urban Indian Health Programs<br>➢ Washington Indian Behavioral Health Hub<br>➢ Crisis Call Center Hubs (future state) |

In 2022, committee work focused on the development of crisis response system process maps to bring together an understanding of current system interfaces, gaps, and changes needed. This work will serve as a foundational tool to inform future state improvements to cross-system coordination and collaboration.

In March and May, a series of two 2-day work sessions were held with representatives from 988 Lifeline crisis centers, 911, and Regional Crisis Lines. Representatives brought expertise in current system and operational intersections across crisis response partners. This work focused, as a start, on aspects of the system involving a Place to Call and Someone to Come. Cross system process steps were developed addressing several common questions across system partners, such as:

- What happens when someone contacts the 988 Lifeline? When they call 911? A regional crisis line?
- What criteria are used to determine a person needs an in-person response? What are criteria for dispatch of mobile crisis response teams? What are criteria for dispatch of first responders?
- What information is gathered and shared to enable the response?

In addition, work was engaged with Tribal representatives to integrate key tribal systems and intersections into the system process maps. It is also recognized that further system process map development is needed to bring in the system partners specific to youth, rural and other potential populations. This work resulted in agreement around shared goals for cross-system coordination, identification of areas for further development of common definitions and standards, and recognition of policy decisions needed to support future-state process mapping, as described further below. The work in 2022 provides a starting point for deeper work into these multi-faceted and complex system relationships.

## Committee and Tribal Partner Input: Known Gaps and Areas for Recommendations

Below is a synthesis of key gaps and areas for recommendations to support cross-system coordination identified through the CRIS, Cross-System Collaboration Subcommittee, other HB 1477 Subcommittees, and the Tribal Roundtables.

» ***Development of a cross-system process map provides important foundational understanding of the current-system and future-state changes needed. Key cross-system coordination goals include:***

1. Establish a standard process to identify where calls belong and transfer calls between 911, the 988 Lifeline, RCLs, and Tribal System Partners
2. Support smooth interface with tribal systems, structures, processes, including recognition of tribal government-to-government relationships where appropriate
3. When possible, develop reliability in processes across the regions
4. Establish reliability between 988, 911, RCL, and Tribal System Partners
5. Begin to develop an understanding of each other's objectives and differences
6. Establish a process that increases automation and reduces manual decisions

7. Establish back-end processes that provide "no wrong door" for callers
8. Establish processes and protocols to promote equity in services and culturally competent care across populations
9. Develop a process that results in the least restrictive response for callers
10. Improve Consumer experience
11. Until new policies are established 911 will continue to do their work the same way.
12. Keep in place what's working.

» ***System policy decisions are needed regarding the roles of Regional Crisis Lines in relationship to the 988 Lifeline and the Crisis Call Center Hubs to guide discussion of cross system interactions to support Washington's future-state crisis response system goals.*** Currently, each of the 10 BH-ASOs support Regional Crisis Lines to respond to calls from individuals in behavioral health crisis. The RCLs have functioned historically as a place to call for individuals in crisis. In addition, RCLs have worked closely with BH-ASO mobile teams and other resources to refer for in-person services to individuals when needed. As the system shifts into expansion of the 988 Lifeline and the development of Crisis Call Center Hubs, policy decisions are needed regarding the roles of RCLs in the system. Any changes to the current roles will require careful transition planning to the new system partners, and recognition of the decades of relationships that RCLs and BH-ASOs have built in developing regionally-based crisis response systems tailored to local partners and resources.

» ***Regional 911 centers and first responders will continue transfer behavioral health calls to their local RCLs, pending policy decisions providing direction on the future-state expectations*.** Regional 911 centers and first responders have developed long-standing relationships with RCLs and BH-ASOs to dispatch mobile crisis response teams and other local resources to individuals in behavioral health crisis. Further policy direction on the roles of RCLs, 988 Lifeline crisis centers and Crisis Call Center Hubs is needed before 911 plans to move forward with changes to these current relationships and systems.

» ***Development of common definitions and criteria for decisions is needed across crisis-response system partners.*** Key examples of areas for development include:

1. Common definition of "Imminent Risk" for transfers to 911 across all entities – 911, the 988 Lifeline, and RCLs
2. Common criteria for 988 Lifeline referrals to RCLs for dispatch of mobile crisis response teams when necessary.
3. Alignment on minimum datasets for knowledge transfers across all entities
4. Common standards for RCL dispatch decisions and transfer processes
5. Common tools, such as job aides and screening guides, across partners
6. Common standards for when handoffs are complete
7. Alignment on best practice under MRSS on when to send in-person help for youth

8. Using interoperable technologies that embed the standard definitions and common criteria, enable the creation and exchange of the shared minimum data set and other documents, and enable referrals and closed loop referrals.

» ***Washington's crisis response system must have clearly defined warm handoff processes between Tribal and Urban Indian Health Organizations and state/local systems (911, the 988 Lifeline, Native and Strong Lifeline, the Washington Indian Behavioral Health Hub, local tribal crisis lines, Indian Health Care Providers, Tribal Public Safety and Tribal First Responders).*** There are many specific intersection points with tribal providers throughout the crisis response continuum. Tribal representatives identified a number of key areas of work needed to support systematic connections between tribal, state, and local crisis systems. A summary of these intersections and key process and policy considerations are summarized in Appendix I. We note also that this work aligns with proposed legislation for the 2023 session introduced by HCA and the American Indian Health Commission focused on improving coordination between the state and tribal behavioral crisis system.

» ***Ensure Cross-System interfaces that are tailored to systems specific to certain populations, such children and youth and rural communities.*** For example,
- Mobile response system must take into account in rural and agricultural settings the importance of confidentiality in small towns as well as the rugged geography in isolated areas that may require special equipment or vehicles to access.
- Youth cross system coordination must recognize youth-focused crisis response system partners and stakeholders, such as schools, system of care partners, and families.

***Cross-System Coordination and Community Partnerships – Summary of CRIS and Subcommittee Input on Ways to Embed Equity***

» Ensure entire Crisis Response System adopts a "no wrong door approach" and that it takes a minimum "rule out approach"
» Establish cross-system protocols to ensure consistent response across populations, rather than application of differential standards to guide practice in a manner that promotes best practice and equity.
» Ensure Cross-System Interfaces that are tailored to systems specific to certain populations, such youth, tribal, and rural populations.
» Develop and support partnerships across broad partner and stakeholder groups to leverage family and community resources and strengths.
» Community outreach, marketing, and promotion of 988 crisis line services should build trust, be available in multiple languages, and include images tailored to specific communities.
» Ensure awareness campaigns and discussions about normalizing discussions of stress, mental health needs and care, and stressors particularly in agricultural and rural communities where such discussions are still considered taboo.

*Note: A fuller description and examples of actions identified by the CRIS and Subcommittees to promote equity is provided in the Section II.2 Committee Progress Update on Promoting Equity.*

# 6. Staffing and Workforce

*HB 1477 charges the Steering Committee to develop recommendations addressing workforce needs and requirements relating to HB 1477 requirements. The Steering Committee established the Credentialing and Training Subcommittee to examine and advise on these issues, in addition to the CRIS and other Subcommittees.*

## What We Know Now / Current State

Subcommittee work in 2022 focused on understanding current crisis system provider staffing and training practices across the crisis services continuum (A Place to Call; Someone to Come; A Place to Go). This foundational understanding, as summarized below, is important for informing recommendations to support Washington's crisis system workforce.

### A Place to Call

- ***988 Suicide & Crisis Lifeline Crisis Centers:*** In 2022, the Department of Health (DOH) worked with the three Washington State 988 Lifeline crisis centers who provide 988 Suicide & Crisis Lifeline services to expand their staffing capacity to receive 988 Lifeline calls. In total, the crisis centers hired approximately an additional 100 full time equivalent staff and report that they are adequately staffed to respond to current 988 Lifeline call volumes.[44] If calls, texts, and chats to the 988 Lifeline continue to increase, capacity will need to be scaled at the same rate to ensure an in-state answer rate of 90% of higher. The ramp-up of staffing at Washington's three 988 Lifeline crisis centers has enabled more calls originating from within Washington to be answered by Washington-based crisis centers. In the first six months of CY2022 prior to the launch of the 988 Lifeline, an average of 66 percent of calls originating in Washington were answered by Washington-based crisis centers. Since July, this has increased to between 85 and 90 percent each month.[45] Current 988 Lifeline staffing qualifications and training expectations include:
  - Each 988 Lifeline crisis center currently establishes its own staffing qualifications and training policies, guided by 988 Suicide &Crisis Lifeline and Washington provider-specific training requirements.
  - While the 988 Suicide & Crisis Lifeline requires staff training around a similar set of topics (e.g., confidentiality, crisis intervention, diversity and cultural humility, and other topics) to meet their accreditation standards, the trainings may vary by content and depth. However, it is important to note that Vibrant Emotional Health, the national administrator of the 988 Lifeline, has been

[44] Note that this figure is an aggregate number of FTE staff, and incudes Lifeline crisis center part-time staffing numbers that may be combined into the overall 100 FTE figure.

[45] Vibrant Emotional Health report to Washington Department of Health (latest data available is August 2022)

developing trainings for crisis centers implementing 988 Lifeline services and Washington will continue to monitor the development of those trainings and utilize them as appropriate.

- Each crisis center has also established its own staffing qualifications and educational requirements for various staff positions. Historically, the crisis centers have relied on a workforce that included volunteers and student interns. As they shift into a staffing model that relies more heavily on a paid workforce, the crisis centers have each developed requirements for staff education, experience, and credentials specific to their center's staffing models. For example, crisis centers may require that all staff who answer 988 Lifeline calls to have a bachelor's degree or recognize two years of direct crisis experience in place of a bachelor's degree. All crisis centers require extensive training to conduct 988 Lifeline services.
- Washington established the Native and Strong Lifeline, which provides American Indian and Alaska Native people the option of calling the 988 Lifeline, choosing option 4, and connecting to Native crisis counselors who are tribal members and descendants closely tied to their communities. These counselors are fully trained in crisis intervention and support, with special emphasis on cultural and traditional practices related to healing. Volunteers of America Western Washington is the 988 Lifeline crisis center that administers the Native and Strong Lifeline. The Native and Strong Lifeline may connect callers with the Washington Indian Behavioral Health Hub to provide further support and follow up with an Indian Health Care Provider.

### Someone to Come

» ***Mobile Crisis Response Teams:*** Currently there are 53 MCR teams in the state that support adults and 10 MCR teams that support youth. HCA worked to expand MCR teams in 2022 and distributed funds to regions to ensure at least one youth and one adult team in each region.[46] Funds have also been requested under the 2023-2025 budget for an additional 17 adult and 17 youth MCR teams. Below is a summary of current MCR staffing and training practices:

- Currently, MCR staffing models and training are determined at the provider level and therefore varies across Washington regions. The teams may include a range of staffing models made up of Mental Health Professionals (MHPs), Certified Peer Counselors, Crisis Case Managers, Designated Crisis Responders, and other providers.
- HCA is moving towards development of standardized staffing and training for youth and adult MCR teams, including the following key efforts:
  - Request for the 2023-2025 legislative budget to include funding to support development of standardized crisis system workforce trainings.
  - Development of a Mobile Crisis Response program guide that includes team staffing and training standards based on SAMHSA and MRSS best practices adapted to Washington.
  - Development of training for Mobile Crisis Response providers to enable enhanced federal matching dollars for Medicaid and provide developmentally appropriate de-escalation, assessment, trauma informed care and safety planning for youth and families.

[46] Currently, there is an adult team in 38 of 39 counties; at a minimum DCR services are available in every county.

- Two regions (King and Thurston-Mason) deliver services under the Mobile Response and Stabilization Service (MRSS) model, an evidence-based crisis response and stabilization model focused on youth. Two additional regions will pilot this model (Pierce and Spokane) through a system of care grant. HCA and youth serving partners are enrolled a national MRSS Quality Learning Collaborative to implement the MRSS model, including engaging leadership, stakeholders, workforce, training, evaluation, and other aspects of implementation.[47]
- HCA is seeking to pilot a MCR team with a Tribe or Tribal consortium to provide culturally adapted services where there is a need.
- HCA is developing a crisis best practice guide that will include MCR teams along with crisis call lines and facilities. This guide will include how to work with high-risk populations and national best practices in crisis services adapted to work in Washington in line with requirements from E2SB 1477.

» ***Co-Response Teams:*** Currently, there are 59 police- and fire-based co-response teams throughout Washington (see Appendix H). In March 2022, Washington passed Senate Bill 5644 to enable the development of model training and workforce recommendations for co-response teams comprised of first responders (911, fire, police) and behavioral health practitioners.[48] The legislation calls for an assessment of current co-response team workforce capacity and training practices, and identification of recommendations to align co-responder teams with training best practices and behavioral health MCR standards.

### A Place to Go

» ***Crisis Stabilization Providers:*** Crisis stabilization providers are currently trained at the provider level, and there is a lack of statewide standardized training. These providers include a range of levels of care for crisis stabilization, including crisis stabilization units, 23-hour crisis stabilization facilities, living room model centers, and peer respite providers, as called for in HB 1477. Crisis stabilization units, at minimum, have 24/7 access to an MHP. HCA's 2023-2025 funding request includes the development of standardized trainings for these providers aligned with the SAMHSA behavioral health crisis care best practice toolkit.[49]

» ***Emergency Departments:*** Emergency Department staff currently play a significant role in the crisis response system, and yet have limited training in working with populations in behavioral health crisis. Some EDs are equipped with specific psychiatric services and staffing.

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[47] *Mobile Response and Stabilization Services Quality Learning Collaborative*, Institute for Innovation and Implementation at the University of Maryland, Baltimore School of Social Work. See: https://theinstitute.umaryland.edu/our-work/national/mrss/mobile-response-and-stabilization-services-quality-learning-collaborative/

[48] *Washington Senate Bill 5644*, effective June 9, 2022. Retrieved from: https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5644-S.SL.pdf#page=1

[49] *National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit*. (2020). SAMHSA. Retrieved from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

## Committee and Tribal Partner Input: Known Gaps and Areas for Recommendations

HB 1477 Subcommittees and CRIS Committees identified the overarching need to ensure an adequately trained, supported, and diverse workforce that can provide culturally responsive, linguistically appropriate, and confidential crisis response services across the full continuum of care. Below is a summary of key gaps and recommendation themes identified.

- ***To ensure equitable and consistent crisis response across the state, there is a need for development of standardized trainings across a core set of topic areas for Crisis Call Center Hubs, Mobile Crisis Response Teams, Crisis Stabilization, Emergency Department staff, tribal crisis providers, and other crisis system providers:*** Standardized training and competency requirements should include a core set of topics for all crisis system providers. These trainings should include a specific focus on competencies needed to promote equity in the delivery of services to diverse populations, including but not limited to rural and agricultural communities, children and youth, people with intellectual and developmental disabilities, LGBTQ+, BIPOC, and tribal communities (see additional examples of training areas to promote equity identified by subcommittees listed in the call out box). Trainings should include care providers; for example, for youth in crisis, families play a significant role in their care and need training on how to provide this support. This work should also include opportunities to leverage evidence-based or national standardized training models and should ensure appropriate metrics and monitoring systems to evaluate impacts of trainings. Cultural adaptations to these models may also be necessary based on specific populations and culturally relevant services provided.

**Examples of training areas to promote equity identified:**

- Cultural responsiveness (cultural humility and culturally appropriate practices)
- Unconscious bias
- Identifying and interrupting microaggressions
- Working with interpreters
- How to collect demographic data effectively, appropriately, and respectfully
- Working with rural and farming communities (see Farm Rescue training program)
- Understanding Tribal sovereignty and Tribal crisis systems
- Understanding trauma in the Native community (historical, community, family, self)
- Cultural humility and working with tribal and indigenous people/communities
- Understanding impacts of historical and intergenerational trauma and trauma informed care/approaches
- Working with LGBTQ+ populations; Transgender and gender non-conforming populations
- Working with youth including legal landscape for youth under 13 and 14-18-year-olds
- Best practices working with families of clients (children or other family members)
- Working with child welfare populations and DCYF caseworkers/guardians/caregivers
- Working individuals with disabilities including intellectual/development disabilities (IDD)
- Working with individuals with severe and persistent mental illness (SPMI)
- Working with unhoused and homeless/houseless populations
- Understanding Anosognosia

*Note: A fuller description and examples of actions identified by the CRIS and Subcommittees to promote equity is provided in the Progress Update on Promoting Equity.*

- ***Training and experience should be prioritized over establishing minimum education requirements for the crisis response workforce.*** Subcommittees emphasized that skills developed through experiential processes are just as valuable and important as academic experience. Subcommittees indicated that a robust training program will meet Washington's crisis system workforce needs rather than setting a standard for education requirements. Opportunities to create a professional certification that are tailored to this field of work exist, and they should not be an academic-based certification. In addition, Washington should have a clear commitment and goal to recruit staff that reflect the communities served, a clear workforce diversity strategy and action plan for that recruitment including a workforce development plan and monitor progress in achieving workforce goals.

- ***Peers should be included as a key component of the workforce development strategy across the crisis service continuum.*** Peer workforce and peer agencies should be better integrated into overall crisis response system to leverage this vital workforce. This work should include integration of peer services into the statewide crisis response system recommendations, workforce development and training recommendations, funding and payment models that recognize peer workers as crisis providers (includes increasing compensation for peers, recognizing they are often the lowest paid among crisis workers), and operational considerations to ensure seamless integration into the system to access peer services. Currently, use of peer support varies from region to region. The peer workforce has also faced challenges in accessing existing certified peer counselor training and testing since the onset of COVID. A new training developed by HCA for peers working in the crisis system was offered in June 2022, and HCA plans to offer additional training as funding allows. The Washington State Community Connectors also provides certified peer trainings for those working families and youth.[50]

- ***Cross-system training and appropriate protocols are needed across 988 Lifeline crisis centers (in Washington and nationally), RCLs, 911, first responders and other entities to ensure connections to the Native and Strong Lifeline and the Washington Indian Behavioral Health Hub.*** As the administrator of the Native and Strong Lifeline, Volunteers of America Western Washington is developing best practices to ensure tribal members are connected to these resources and has provided training content to each of the other Washington 988 Lifeline crisis centers to train their staff in what the services entail and how to connect callers to the Native and Strong Lifeline if they would like to be connected. Volunteers of America Western Washington and Vibrant Emotional Health are developing training for 988 Lifeline crisis centers across the United States to ensure that they are aware of the line and know how to transfer individuals as appropriate.

[50] https://wsccsupport.org/training-and-technical-support/

***Crisis Response Staffing & Workforce – Summary of CRIS and Subcommittee Input on Ways to Embed Equity***

- ***Ensure an adequately trained, supported, and diverse workforce that can provide culturally responsive, linguistically appropriate, and confidential crisis response services across the full continuum of care.***
- ***Peer workforce and Peer agencies and programs (respite centers and such) must be better integrated into overall Crisis Response System to better leverage this vital workforce.***
- ***Integrate behavioral health aides (BHA) into the tribal crisis response locally and regionally through the Indian Behavioral Health Hub and Native and Strong Lifeline.***
- ***Provide culturally and geographically appropriate respite care.***
- ***Create standardized training and competency requirements on various topics to support the delivery of culturally responsive, linguistically appropriate, and confidential services.***

*Note: A fuller description and examples of actions identified by the CRIS and Subcommittees to promote equity is provided in the Progress Update on Promoting Equity.*

- ***Behavioral health aides (BHA) are a key aspect of the tribal crisis system response workforce and should be integrated into the crisis response system.*** Behavioral Health Aides are counselors, health educators and advocates working within the Indian Health delivery system. This workforce is grown from tribal or urban Indian communities. The practitioners are educated in traditional and spiritual healing as mentored by the tribal community they come from. Their integration should be supported into the Tribal crisis response locally and regionally through the Indian Behavioral Health Hub and the Native and Strong Line.

- ***Cross-system training and staffing needs are important to ensure first responders have core competencies in behavioral health crisis response.*** This work should build on training efforts directed by SB 5644 to support the development of training recommendations for first responder co-response teams and to align co-responder teams with training best practices and behavioral health MCR standards. Subcommittees also recommended consideration of increasing the expectation of the police Crisis Intervention Training (CIT) from a voluntary 40-hour training to mandatory training (this training currently includes mandatory 8 hours/voluntary 40 hours).

- ***Training and workforce strategies are needed to address the secondary trauma and workforce burnout out experienced by crisis system providers***. Frontline behavioral health crisis workers support individuals and families to navigate some of the most challenging life experiences. Yet, this workforce is paid significantly less than other health care professionals, and there is little support for supporting this workforce to manage the secondary trauma and burnout experienced.

# 7. Technology

*The Steering Committee is charged to review and approve the HB 1477 Technical and Operational Plan, to be developed jointly by the Washington State Health Care Authority and the Washington Department of Health and submitted in 2022. The Steering Committee established the Technology Subcommittee to examine and advise on requirements relating to the technology and platform needed to manage and operate the behavioral health crisis response and suicide prevention system. In addition, the CRIS Committee and Subcommittees, including the Lived Experience, Rural & Agricultural Communities, and Tribal Roundtables, raised important crisis system workforce and training considerations throughout the course of 2022.*[51]

## What We Know Now / Current State

HB 1477 calls on the investment in new technology to create a Crisis Call Center Hub system to receive calls and connect individuals to follow-up care. To plan for this investment, HCA and DOH were directed by HB 1477, Section 109 to develop a Technical and Operational Plan that critically analyzes the development and implementation of technology needed to support HB 1477's requirements and the integration of the multiple systems involved in an integrated behavioral health crisis response.

HCA and DOH submitted a draft Technical and Operational Plan in February 2022, and a final Technical and Operational Plan was accepted on October 25, 2022.[52, 53] The Final Technical and Operational Plan provides analysis of HB 1477's technology requirements and Washington needs to inform the state's future approach for development of a Request for Information (RFI)/Request for Proposals (RFP) to identify technology vendors, including:

- Technology tools currently used in Washington and other states to support crisis call and response systems.
- The technical functional requirements needed to achieve the vision of HB 1477.
- Research conducted of the vendor landscape to meet these requirements.

[51] A summary of 2022 Subcommittee meetings is available on the CRIS webpage at https://www.hca.wa.gov/assets/program/cris-subcommittee-report.pdf

[52] Washington State Health Care Authority (November 16, 2022). Final Technical and Operational Plan. National 988 System: Crisis Call Center and Behavioral Health Integrated Referral System. Retrieved from https://www.hca.wa.gov/assets/program/final-technical-and-operational-plan-988.pdf

[53] Washington State Health Care Authority and Washington State Department of Health (January 1, 2022). Draft Technical and Operational Plan. National 988 System: Crisis Call Center & Behavioral Health Integrated Referral system. Retrieved from https://www.hca.wa.gov/assets/program/draft-leg-report-988-operational-plan.pdf

- Technical considerations relating to implementing crisis call and response services including security, privacy, data access and management, interoperability, and other considerations.

The final Technical and Operational Plan includes an analysis of information available regarding the Vibrant Unified Platform (Vibrant UP) and its capabilities to support the integrated crisis system functionalities envisioned for Washington. The Vibrant UP system will support the over 200 988 Lifeline crisis centers across the country and is described as being provided at no cost to states.[54] In January 2022, Vibrant announced the vendors selected for the Unified Platform; since then, Vibrant has released some information about functional requirements that the system is expected to support, but the final technology is not yet fully specified nor operational.[55] Pending the final release of the Vibrant Unified Platform, the Final Technical and Operation Plan includes an evaluation of the information available and the functionalities that Vibrant's Unified Platform may be able to support in the context of Washington State requirements and functionalities the system is not expected to support.[56]

To meet the requirements of HB 1477, the Final Technical and Operational Plan found overall that currently a single platform with all of the system functionalities required by HB 1477 does not exist. The Final Technical and Operational Plan therefore presents three "categories" of options for selecting and implementing technology systems required by HB 1477, and recommends proceeding with Category 2:

1. **Category 1 (single vendor solution):** Select a single vendor solution to provide all of the functionality required under HB 1477.
2. **[Recommended] Category 2 (primary vendor and partner vendors):** Select a primary vendor (Vibrant UP or another commercial solution) who would meet most of the critical functional requirements and who would partner with other vendors to offer a solution that meets all of the requirements in HB 1477. This option includes exploring use of the NENA i3 solution architecture to support geo-location of callers. We note that Vibrant is also exploring use of geo-location and working with the Federal Communications Commission regarding this capability.[57] Washington's three 988 Lifeline crisis centers have also requested that the Vibrant UP is considered as a preferred option, pending further release of information about the system's capabilities to determine any additional functionalities needed to support Washington's requirements.
3. **Category 3 (completely modular):** Select several modules that would be integrated to meet the requirements of HB 1477.

[54] While the Vibrant Unified Platform will be offered at no-cost, there will be costs that are not yet known associated with acquiring additional modules and integrating the core Vibrant UP components with other needed module(s) that are not a part of the Vibrant UP.
[55] Vibrant selected two vendors: Salesforce will support Customer Relationship Management (CRM), and Genesys PureCloud will provide the Contact Center System (CCS) functionality.
[56] See Final Technical and Operational Plan, Appendix P: Vibrant Unified Platform – Functional Requirements and Timeline. Available at: https://www.hca.wa.gov/assets/program/final-technical-and-operational-plan-988.pdf
[57] See Vibrant's Position on Geolocation for 988 available at: https://www.vibrant.org/geolocation-and-988/

The Steering Committee approved the Technical and Operational Plan on October 25, 2022, including the agencies' recommendation to proceed with the Category 2 option (a summary of key issues discussed as part of this approval is provided below).[58] Their review and approval was informed by comments submitted by the Technology Subcommittee, as well as CRIS Committee and subcommittee discussions throughout 2022.[59] The HCA and DOH also engaged in Tribal Consultation on September 14, 2022, which included a series of five roundtables held May through September 2022 to ensure the Final Plan addresses issues specific to the needs of tribal populations and providers. The Technical and Operational Plan was also approved by the Office of Financial Management and the Governor's Office. The Washington Office of the Chief Information Officer (OCIO) also approved the Technical and Operational Plan and placed the entire 988-1477 Crisis Call Center and Service Program (including business and technical projects and workstreams) under OCIO oversight to ensure the Program's ability to execute on the Plan.

Moving forward, the Final Technical and Operational Plan lays out an Implementation Plan, draft timeline and key milestones, including a RFI and RFP process to identify and secure technology vendors and allow for the launch of the system by July 2024. The Final Technical and Operational Plan provides a draft timeline to meet the statutorily specified July 2024 launch date of the system. However, the Plan notes that the combined HCA and DOH teams have advised this may be an aggressive timeline given the complete of the technical solutions needed. Given the complexity of the system required, the Final Plan recommends a phased implementation approach beginning with the Call Center Platform (Phase I) and integrating the additional functionalities in future phases, such as bed registries, resource directories, and referral system.

## Committee and Tribal Partner Input: Known Gaps and Areas for Recommendations

» ***It is critical to closely track and evaluate the Vibrant Unified Platform, once released, to determine its viability to serve as the foundation for Washington's technology system, with additional system components added as needed to support the requirements of HB 1477.*** Understanding the Vibrant UP is a core piece of understanding Washington's future system needs and options. Although the Vibrant Unified Platform is not yet operational, and there is further information needed to assess it compatibility with Washington's requirements, there is a strong desire to leverage this national system that will be used by 988 Lifeline crisis centers across the country. At the same time, to avoid delays in the identification of appropriate technologies, it is also critical to gather additional

[58] Steering Committee members voted 4-1 to approve the Final Technical and Operational Plan. Representative Orwall dissented and recommended instead that the state pause on efforts to identify technology vendors and related investments until more information about the Vibrant Unified Platform is available.

[59] Throughout the development of the Technical and Operational Plan, HCA and DOH provided updates and engaged input from the Technology Subcommittee through the subcommittee's monthly meetings held March through August 2022. At the September Technology Subcommittee meeting, members discussed formal comments on the draft Final Technical and Operational Plan. The CRIS committee was also provided opportunity (September 15-September 23) to submit comments. HCA and DOH then addressed these comments and submitted an updated Final Technical and Operational Plan for the Steering Committee's review and approval at their October meeting.

information regarding the interoperable technology platform and systems that are available and the associated costs for these platforms and tools to support the enhanced crisis call and response system envisioned in HB 1477.

- ***It is critical to ensure that the 988 Lifeline and Washington's crisis response system is distinct from 911 and a law enforcement response, particularly for building trust and ensuring access to the system for BIPOC and other marginalized groups who have experienced trauma associated with law enforcement.*** Many communities who have experienced trauma with law enforcement will not access the 988 Lifeline if they feel it will result in a law enforcement response. It is therefore critical to clearly address the relationship between these systems to build trust among communities to support access. This issue will be further addressed by the CRIS and Steering Committee in 2023.

- ***It is critical for Washington's crisis call and response system be interoperable and support appropriate information access, exchange and re-use across call centers, crisis responders, behavioral health and other providers, and individuals and families who experience crises. This technology should enable seamless information exchange and use:***
  - Individuals and families who may experience crises have the ability to create, exchange, access, and revoke information to plan for a future crisis (e.g., mental health advance directives, safety plans).
  - Crisis responders and other behavioral health providers have access to technology that enables the interoperable creation, exchange and access to information needed to respond to individuals in crisis (e.g., mental health advance directives, safety plans, resource directories).

- ***Washington's crisis system response technology must have capabilities, funding, and technical assistance to ensure that crisis system providers, including tribal crisis system providers, can seamlessly access the system and include use of data sharing agreements. For tribal crisis data, data sharing agreements must apply the principles of Tribal Data Sovereignty.*** Platforms, for example, must comply with SB 6259 requiring that Indian Health Care Providers are able to access the bed registry. The platforms must also honor Tribal Data Sovereignty protection and be compatible with IHCP electronic health records (EHRs). HCA and DOH engaged Tribal Consultation to gather review and input from tribal representatives. This feedback is integrated throughout the Final Technical and Operational Plan and summarized in Appendix G of the Final Plan.[60]

- ***It will be critical for Washington's technology system to have capabilities to route callers to centers in their region, not all over the country based just on their area code which may no longer reflect where they reside.*** Callers to the 988 Lifeline are currently routed to a 988 Lifeline crisis center based on their area code. This means that Washington residents without a Washington area code will be routed to a 988 Lifeline crisis center outside of Washington; similarly, callers with Washington area codes who reside outside of the state will be routed to a Washington crisis center.

[60] See Final Technical and Operational Plan, Appendix G: Summary of Feedback from Roundtables.

Vibrant is currently working with the Federal Communications Commission to explore the use of geo-location at the federal level and they are seeking to address this issue in 2023. HCA and DOH recognize geo-location as a key functionality for the Washington's crisis response technology system, both for routing calls to a local center closest to the caller, as well as enabling timely dispatching of services if needed based on the caller's location. We note the important confidentiality and privacy considerations that are raised with the use of geo-location capabilities. According to Vibrant's position statement on geo-location, 988 caller privacy and confidentiality will continue to be protected with the use of geo-location.[61] We note that the issue of geo-location and the relationship to maintaining caller privacy will be further explored by the HB 1477 CRIS and Steering Committee in 2023.

» ***It is critical that people contacting the 988 Lifeline have the ability to maintain privacy, particularly with the consideration of geo-location technology to identify a caller location and dispatch services if their lives are in imminent risk.*** Many marginalized populations may not access the 988 Lifeline if they feel their privacy is not protected. Rural communities, for example, identified privacy as a paramount concern for callers. We note that the issue of geo-location and the relationship to maintaining caller privacy will be further explored by the HB 1477 CRIS and Steering Committee in 2023.

» ***Consider technical infrastructure and community investments in unserved and under-serviced areas, including rural areas, to increase access and use of the internet to ensure access to crisis call and response services across the state, including for rural communities.*** It is important to recognize areas of the state with limited cellular reception, such as in rural and tribal communities, and take steps to ensure that we have technology that will serve communities across the state. The Federal Government has made significant resources available across the country to increase availability of broadband. Unserved and under-served areas across the state may require assistance in applying for these federal funds and accessing the often-required minimal matching dollars.

» ***Subcommittees identified ways to embed equity to ensure technology*** is designed to support real time feedback and improvements, allows for appropriate data sharing, is accessible to all including areas with limited bandwidth or technology infrastructure, allows for comprehensive data collection and sharing in support of holistic care and avoiding re-traumatization, and supports multiple modalities. A summary to subcommittee input to embed equity within the technology system is identified in the box below, as well as summarized in the progress update on *Promoting Equity*.

[61] See Vibrant's Position on Geolocation for 988, available at: https://www.vibrant.org/geolocation-and-988/

***Crisis Response Technology – Summary of CRIS and Subcommittee Input on Ways to Embed Equity***

- ***Technology should promote equitable access for callers.*** Examples include:
  - Platforms must support assistive technologies and services that enable interaction with callers with different abilities (i.e., services that support deaf and hard of hearing such as TTY, IP relay, ASL video relay, and IP CST) and these requirements included in any relevant contracts.
  - Despite the 988 Lifeline's current use of a standardized recorded greeting for all callers, Washington should consider discussing with Vibrant the potential to have a live person answer the call with message scripts.
  - Allow for text or chat technology and in multiple languages.
  - Ensure smooth interoperability with interpretation and language access services.
  - Consider infrastructure investments/community investments in areas across the state that have no or inadequate access to the internet, including rural areas to increase technology infrastructure and improve access
  - Add in GIS capabilities so callers are routed to centers in their region, not all over the country or based just on their area code (which may no longer reflect where they reside) and crisis response services can be dispatched, when needed
- ***Interoperable Technology should promote equitable access for crisis service providers.*** *Examples include:*
  - Select and provide technology for mobile crisis teams that work well enough in low network bandwidth situations so that there is seamless access to services regardless of location infrastructure limitations.
  - Ensure tribal crisis providers are able to seamlessly access the system.
  - Support small providers who may not have access to the technology or infrastructure necessary to operate effectively through the provision of free IT support and training and access to technology platforms.
  - Ensure crisis response providers across the continuum have up-to-date access to system and resource databases, including aligning with requirements of SB 6259 that requires that IHCPs are able to access bed registry.

» ***Ensure interoperable technology supports patient, family, and system partner feedback in real time so improvements can be made in a timely manner***.
  - This includes interoperable technology to enable the active engagement, input, and direction from the patient, family, and system partner.

» ***Leverage technology to maximize opportunities to expand telehealth to support access to care.***
  - Emphasis on telehealth to support access to care among tribal populations when services are not available directly through tribal providers, as well as for people living in rural communities.

» ***Ensure data collection software and requirements support whole-person focused care and the provision of adequate context of the person and situation to support a holistic approach.***
  - Ensure any technology algorithms are built/designed with anti-racism lens
  - Ensure data sharing agreement incorporate Tribal Data Sovereignty principles and be compatible with Tribal and UIHO electronic health records (EHRs) and align with requirements of SB 6259.
  - Ensure information sharing between call receivers and dispatch, including language access and other information about a person's needs so that they don't have to repeat multiple times.
  - Ensure crisis related documentation is available to providers of ongoing services and stabilization (to decrease need for repetition of information)

*Note: A fuller description and examples of actions identified by the CRIS and Subcommittees to promote equity is provided in the Progress Update on Promoting Equity.*

# 8. Funding

*HB 1477 charges the Steering Committee, with input from the CRIS Committee and Subcommittees, to provide recommendations related to cost estimates for each of the components of the integrated crisis response and suicide prevention system, statewide equitable distribution of resources, and allocation of crisis system funding responsibilities among Medicaid MCOs, commercial insurers, and BH-ASOs.*

## What We Know Now / Current State

### Crisis Service Funding Sources & Distribution

Current funding for crisis services relies on multiple federal, state, and local sources, as detailed in the Exhibit 1. Financing for Crisis Services in Washington. The crisis response services that a person may receive or be eligible for depend upon their insurance source, if any. While 988 Lifeline crisis centers, the Native and Strong Lifeline, RCLs, and other crisis lines are available regardless of insurance status, other crisis response services are paid for through Medicaid, Medicare, commercial and private payers, and other funding sources for uninsured populations. The Medicaid program has the broadest array of services covered under the crisis services umbrella compared to Medicare and commercial payers, although this does not imply that Medicaid coverage is comprehensive or that Medicaid beneficiaries have access to the services they need.

For Tribal crisis providers, it is also important to understand that many tribal members enrolled in the Medicaid program are covered through the fee-for-service program rather than managed care. Medicaid and state dollar payments for crisis services have flowed primarily through Medicaid MCOs and BH-ASOs, and Tribal providers have not received direct allocations for these services other than Medicaid billable services. During legislative session 2022, the HCA did receive funding to pass down to IHCPs with Tribal Designated Crisis Responders.

In addition to state and federal payer sources, crisis services are also funded through local county sales taxes. Approximately 25 of 39 Washington counties have passed local legislation authorizing the use of a local 1/10 of 1 percent (0.1%) sales tax to support behavioral health and crisis services in their communities.[62] While these funds may support services for uninsured individuals and services that are

[62] In 2005, Washington Senate Bill 5763 gave local governments the authority to levy a 1/10$^{th}$ of 1 percent (0.1%) sales tax to raise funds for behavioral health and crisis services.

not covered by insurance, the local nature of this tax has led to wide disparities in the level of crisis service funding available across the state.

Total financing for crisis services has also historically been weighted more towards more restrictive care than least restrictive care and is largely adult focused. For Washington's 2023-25 budget, HCA has requested funding to enhance support for less restrictive, community-based care, including:

- Funding for 34 new Mobile Crisis Response (17 teams to serve youth, 17 teams to serve adults)
- Funding to enhance services to the 63 existing Mobile Crisis Response (10 that serve youth, 53 that serve adults)
- Funding for 10 new crisis stabilization programs (5 to serve youth, 5 to service adults)
- Funding for peer respite programs

The Department of Commerce has also funded capital projects to start up new programs for crisis services that focus primarily on less restrictive, community-based care (*See* Section II.3 Progress Update on Services).

### Crisis Provider Payments and Service Costs

In addition to the disparities in funding levels across the state, crisis service payments to providers vary in amount as well as type of payment arrangement, depending on the payer source. For example, payments are made from Medicaid MCOs to the BH-ASOs for the regional crisis lines, mobile crisis response, designated crisis responders, and crisis respite programs (where offered). The methods of payments from the MCOs to the BH-ASOs for these services are varied, and can be made on a per service basis, a capacity-based payment (also called the firehouse model), or a prospective payment that is reconciled later based on actual volume.

Further, because the BH-ASOs are the intermediary, the BH-ASOs in turn pay service providers for the regional crisis lines, mobile crisis response, designated crisis providers, and crisis respite programs. Payments to providers may be made on a per service basis or as a capacity-based payment. The Medicaid MCOs pay service providers directly for crisis stabilization units, in-home stabilization, voluntary inpatient treatment, and involuntary commitments. The payments for these services are usually made on a per service basis.

In 2022, initial work was engaged with a Crisis Provider Cost Workgroup to evaluate the costs to provide crisis services. A workgroup of 11 service provider organizations convened for five meetings during June through October 2022. The service providers represented entities that deliver services related to the regional crisis lines, mobile crisis response, designated crisis responders, crisis stabilization, and evaluation & treatment facilities. Feedback was collected from these providers on the costs to deliver each service, the recommended approach for reimbursing for each service, and the challenges to expanding the service offerings in Washington. A summary of initial provider feedback and recommendations from this work is provided below in the section on committee and tribal partner input.

In 2023, the CRIS and Steering Committee will further address recommendations related to crisis system service costs, equitable distribution of resources, and allocation of funding responsibilities.

*Exhibit 1: Financing for Crisis Services in Washington*

| Source | Who Covers the Payment | Who It Pays For |
|---|---|---|
| 988 Behavioral Health Crisis Response and Suicide Prevention Line Account | A new dedicated revenue stream paid by taxpayers starting Oct 2, 2021 | Services to Washinton residents |
| Federal HHS: Medicaid | Federal Government, Dept of Health and Human Services, Centers for Medicare and Medicaid | Services to Medicaid eligibles |
| Federal HHS: Medicare | | Services to Medicare eligibles |
| Federal HHS: SAMHSA Grants | Federal DHHS, Substance Abuse & Mental Health Admininstration | Services to Uninsured |
| State Share of Medicaid | Legislative Appropriation (State Taxpayers) | Services to Medicaid eligibles and Uninsured |
| Local Government Funding | Local Governments | Services to local residents, and Uninsured |
| Commercial Insurers | Health Insurers (through premiums) | Services to Policyholders |
| Self Funded Private Health Insurance Plans | Employers | Services to Employees |
| Private Sector / Individuals | Private Endowments | Various Targeted Initiatives |

## Committee and Tribal Partner Input: Known Gaps and Areas for Recommendations

In 2022, the CRIS and subcommittees provided input on ways to promote equity in the crisis system funding. In addition, the Provider Cost Workgroup members identified several recommendations for crisis service reimbursement. This input is summarized below and will inform further work by the Steering Committee and the CRIS in 2023 to make recommendations related to the costs and equitable distribution of resources based on Committee recommendations for service targets and goals.

- The Provider Cost Workgroup members identified several recommendations related to the cost of crisis services, including providing reimbursement methods:
  - The method of reimbursement for most, if not all, crisis services should be based on a capacity payment (firehouse model) because the staffing for crisis services reflects 24/7/365 coverage. Payment on a per service basis does not cover the 'on call' costs incurred when services are not provided but staffing is required in the event that the service is needed.
  - When factoring in capacity-based payments, payers need to recognize that total costs (mostly staffing) will be dependent on the standards set for each service offered, e.g., the expected time for mobile crisis response to reach clients after the initial call from the client, the expected duration of time allowed in crisis stabilization units.
  - Payers also need to account for real-time wage adjustments for staff hired to deliver crisis services. The costs to hire and retain staff in CY2023 will be significantly higher than CY2022 or CY2021 due to the tight labor market and the intensity of the work that is delivered (i.e., staff burnout).

***Funding – Summary of CRIS and Subcommittee Input on Ways to Embed Equity***

- ***Address disparity of services based on funding (e.g., between Medicaid fee-for-service, Medicaid Managed Care, commercial insurance, uninsured.)***
  - Ensure Tribal partners and systems are included equitably in funding requests (see below).
  - Assess distribution of funding to programs and services by population focus (youth and elderly/older adults) to determine equitable resourcing of programs and services including by mental health and substance use services.
  - Develop a braided funding model so Medicaid and non-Medicaid funds are braided at the state level then appropriated to regional ASOs and Tribes on more equitable population and need based formulas. It also needs to include capacity-based funding (aka firehouse model). The current system balkanizes funding and requires BH-ASOs to individually negotiate payment reimbursement from 5 different MCOs using what is largely a fee for service basis.
  - Farm families often access insurance through faith-based programs and/or private insurers that overlook mental health needs. Providing financial support counseling/support to agricultural and rural families (and perhaps members of other communities) should be taken into consideration.
  - Establish payment parity at the service level across payers and across disciplines, where appropriate. Launch a workgroup to explore payment parity and to make recommendations.

*(Cont'd on next page)*

***Funding – Summary of CRIS and Subcommittee Input on Ways to Embed Equity (cont'd)***

- ***Ensure Tribal partners and systems are included equitably in funding requests.***
  - Health care on tribal lands is provided through an Indian Health Care Delivery system supported by the Indian Health Service and distinct from the state Medicaid program. In 2016, Tribal governments requested that AI/ANs are not required to be covered by a Medicaid managed care entity and may receive services through the fee-for-service system. Today, about 60% of AI/AN Medicaid enrollees remain in the fee-for-service Medicaid program instead of managed care. Given the distinct funding streams for Medicaid managed care versus fee-for-service systems, Tribes have emphasized the critical importance of ensuring that tribes are explicitly included in funding allocations for Washington's behavioral health crisis response system.

- ***Expand resources (funding and technology) to increase capacity to provide next day appointments in all areas of the state (could include telehealth in some areas) AND ensure commercial plans comply with next day appointment requirements.***
  - Consider adding a day-of appointment in addition to next day to help with transitions out of care to the home but before the next day appointment.

*Note: A fuller description and examples of actions identified by the CRIS and Subcommittees to promote equity is provided in the Section II.2 Committee Progress Update on Promoting Equity.*

# Section III: Recommendations for Expenditures from the 988 Behavioral Health Crisis Response and Suicide Prevention Line Account

## Background

House Bill 1477 Section 104 requires that the Steering Committee submit recommendations on the funding of crisis response services from revenues generated by the 988 Behavioral Health Crisis Response and Suicide Prevention Line Account (Account) established by HB 1477 Section 205. Preliminary recommendations were submitted on January 1, 2022 per legislative requirement, and final recommendations are due January 1, 2023, and contained within this section. With respect to development of funding recommendations, the Steering Committee is charged to examine specifically:

a. The projected expenditures from the account created under section 205 of this act, taking into account call volume, utilization projections, and other operational impacts;

b. The costs of providing statewide coverage of mobile rapid response crisis teams or other behavioral health first responder services recommended by the crisis response improvement strategy committee, based on 988 crisis hotline utilization and taking into account existing state and local funding;

c. Potential options to reduce the tax imposed in section 202 of this act, given the expected level of costs related to infrastructure development and operational support of the 988 Lifeline and crisis call center hubs;

d. The viability of providing funding for in-person mobile rapid response crisis services or other behavioral health first responder services recommended by the crisis response improvement strategy committee funded from the account created in section 205 of this act, given the expected revenues to the account and the level of expenditures required under (a) of this subsection.

## Recommendations for the HB 1477 988 Line Tax

In the report delivered January 1, 2022, the Steering Committee made the following preliminary recommendations with respect to expenditures from the Account:

1. *In consultation with the Department of Health, the Steering Committee is prepared to comment that it appears that the line tax will cover the costs of the 988 crisis call centers in the first three of five years projected. More refinement of the cost projection model is required in 2022 to determine if the line tax will cover the costs of the 988 crisis lines in years four and five. Because of this uncertainty, the Steering Committee is not prepared to make any recommendations on the deployment of resources from the line tax for mobile rapid response crisis teams until after the Department of Health has provided a more refined estimate for the costs of the 988 crisis call centers.*

2. *Because additional refinement of the cost projections for the 988 crisis lines is needed, the Steering Committee is not prepared to make a recommendation to lower the line tax at this time.*

For this year's report, the Steering Committee has consulted with DOH on the refinement of the five-year cost estimate to support the 988 Lifeline crisis centers in Washington including ongoing operational costs. With the recognition that the final estimate of call volume to the 988 Lifeline in Washington is still in flux, DOH estimates that the five-year cost to support the 988 Lifeline crisis centers is approximately **$75.3 million** (See Appendix J for DOH cost model). With anticipated revenues of **approximately $238 million**[63] in the first five years of the tax, this leaves approximately $162 million remaining to support services resulting from calls made to the 988 Lifeline. Activities that may be covered with these funds include personnel and the provision of acute behavioral health, crisis outreach, and crisis stabilization services provided in response to 988 Lifeline calls.[64] However, the next 5- year cost estimates are over $183 million as the number of calls and crisis centers mature to a "normal" state. Furthermore, costs are not known yet for future technology needs as outlined in the Final HB 1477 Technical and Operational Plan.

The Steering Committee recognizes significant unknown variables impacting the call volume to the 988 Lifeline, including impacts of active marketing efforts (this is planned for 2023), and potential increased 988 Lifeline call volume due to referrals of behavioral health crisis calls that are currently made to 911 and RCLs. The DOH current budget estimates do not account for referrals of calls from 911 and RCLs. Furthermore, the Native and Strong Lifeline just launched in November 2022, so it is too soon to understand ongoing call volume to that line. Given the fluidity of estimating expenditures for calls into Washington's 988 Lifeline crisis centers in the first five years since the launch of 988, as well as the significant current gaps in mobile crisis response team resources across the state, the Steering Committee recommends the following:

1. Maintain the current tax rate, given the early stages of determining costs for the 988 Lifeline crisis centers and the significant current gaps in mobile crisis response across the state.
2. The Steering Committee recommends that expenditures from the account on mobile rapid response crisis teams or other allowable expenditures be informed by recommendations from the CRIS Committee in 2023 to ensure equitable distribution of these resources across the state. This recommendation aligns with HB 1477's charge to the Steering Committee and CRIS to develop recommendations to enhance and expand mobile rapid response teams in each region, (including specialized teams as appropriate to respond to the unique needs of youth, including AI/AN youth and LGBTQ youth, and geriatric populations, including older adults of color and older adults with comorbid dementia). The Health Care Authority is currently working to expand mobile crisis response teams and will bring updates to the CRIS Committee to inform these plans.

[63] Washington Department of Revenue Forecast for Statewide 988 Behavioral Health Crisis Response and Suicide Prevention Line Tax, retrieved from https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fdor.wa.gov%2Fsites%2Fdefault%2Ffiles%2F2022-11%2FNov_2022_NonGeneral_Fund_Forecast.xlsx%3Fuid%3D637a227e4c7bf&wdOrigin=BROWSELINK

[64] House Bill 1477, Section 205(2)

## Section IV. What We Need to Explore in 2023

In 2023, the Steering Committee and CRIS will build on the foundational committee work completed in 2022, and focus on the following areas to develop recommendations to guide improvements to Washington's behavioral health crisis response and suicide prevention system:

1) ***System goals and metrics:*** It is imperative that the committee identify the goals that will serve to provide direction for changes needed.
2) ***Crisis system services:*** Based on the system goals, committee will evaluate gaps and identify services that need to be expanded and new services that need to be added. In addition, further work is needed in 2023 to update and expand upon the data in this progress report, including deeper analysis of services available by region and access to services by population.
3) ***Funding:*** With an understanding of the services that need to be expanded and/or added, the Committee can then develop funding recommendations to support equitable distribution of these services across the state.
4) ***System Infrastructure:*** To support implementation of Washington's goals, critical system infrastructure including technology and workforce are needed. The committees will finalize any recommendations needed related to this infrastructure.

In Appendix K, we include CRIS member written comments on the draft progress report, including identification of priority areas for discussion in 2023 summarized in the table below:

| Areas of Work for 2023 | CRIS Member Comments |
|---|---|
| **System goals and metrics** | • Inventory of current data and metrics<br>• Consideration of variables impacting ability to meet goals/metrics<br>• Consequences for not meeting metrics |
| **Crisis system services** | • Deeper analysis of data to understand system gaps by population and geography (service maps by region), including co-response and first responder services, and transportation<br>• Clarify roles and expectations for law enforcement<br>• Clarify relationship between 911 and 988<br>• Focus on building on the existing system and adding best practices<br>• Create understanding of who is leading the system, and the role of BH-ASOs at the regional level<br>• Consider no show rates for next day appointments |
| **Funding** | • Funding for 988 Lifeline crisis centers to further diversity, equity & inclusion efforts |
| **System Infrastructure** | • Further discussion of geo-location and implications for confidentiality<br>• Recognition of Vibrant technology platform for future system design<br>• Workforce strategies will be critical<br>• Need for better understanding of current training for crisis response workers<br>• System efficiencies between 988 and RCLs, and coordination between 911 and 988 |

# Appendices

## Appendix A: List of Acronyms Used in this Report

| Acronym | Meaning | Acronym | Meaning |
|---|---|---|---|
| ADA | The Americans with Disabilities Act | LE | Lived Experience |
| AI/AN | American Indian or Alaskan Native | LGBTQ | Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning |
| AIHC | American Indian Health Commission | MCO | Managed Care Organization |
| ASL | American Sign Language | MCR | Mobile crisis response |
| BH-ASO | Behavioral Health Administrative Services Organization | MH | Mental Health |
| BHF | Behavioral Health Facilities | MI | Motivational Interviewing |
| BIPOC | Black, Indigenous, or People of Color | MRSS | Mobile Response and Stabilization Service |
| CIT | Crisis Intervention Team | NDA | Next Day Appointments |
| CMHC | Community Mental Health Center | NPAIHB | Northwest Portland Area Indian Health Board |
| CRIS | Crisis Response Improvement Strategy Committee | NSPL | National Suicide Prevention Lifeline |
| CSU | Crisis Stabilization Unit | OCIO | Office of the Chief Information Officer |
| CY | Calendar Year | PSAP | Public Safety Answering Point (911 Call Center) |
| DCR | Designated Crisis Responder | RCL | Regional crisis line |
| DEI | Diversity, Equity, and Inclusion | RFI | Request for information |
| DOH | Department of Health | RFP | Request for proposal |
| E&T | Evaluation and Treatment | RT | Round table |
| ED | Emergency Department | SAMHSA | Substance Abuse and Mental Health Services Administration |
| EHR | Electronic Health Record | SB | State bill |
| EMS | Emergency Medical Service | SME | Subject Matter Expert |
| GIS | Geographic information system | SUD | Substance Use Disorder |
| HB | House Bill | TBD | To Be Determined |
| HCA | Health Care Authority | TCBHAB | Tribal Centric Behavioral Health Advisory Board |
| HHS | Health and Human Services | UIHO | Urban Indian Health Organization |
| HMA | Health Management Services | UIHP | Urban Indian Health Program |
| IHCP | Indian Health Care Provider | UW | University of Washington |
| IP | Internet Protocol | WA | Washington |
| IT | Information technology | WG | Work Group |
| ITA | Involuntary Treatment Act | WSU | Washington State University |

## Appendix B: Definitions for Terms Related to Crisis Delivery

*90/180 Day Civil Commitments:* Individuals who are civilly committed to inpatient treatment for a defined period of time.[65]

*23-Hour Crisis Stabilization Facilities:* 23-hour crisis stabilization facilities offer an alternative to emergency department and psychiatric hospitalization admission by providing 23-hour observation and crisis stabilization services in a home-like, non-hospital environment. These facilities are also referred to by SAMHSA as crisis receiving centers.[66] 23-hour facilities in Washington are licensed as outpatient behavioral health facilities, with a certification for crisis outreach services. Facilities offering only 23-hour services in Washington are unable to accommodate law enforcement drop offs.[67]

*Community Mental Health Centers (CMHCs):* Organizations that deliver services in a community setting related to case management, psychiatric care including medication management, individual and group therapy, other day treatment (e.g. drop-in center) and peer support services. Some CMHCs may also deliver Assertive Community Treatment (ACT) models of care (including Program of Assertive Community Treatment/PACT and Forensic Assertive Community Treatment/FACT), walk-in clinics, after-hours crisis response, next day appointments, and oversight of less restrictive orders.

*Crisis Call Center Hubs:* As outlined by HB 1477, Crisis Call Center Hubs shall provide crisis intervention services, triage, care coordination, referrals, and connections to individuals contacting the 988 crisis hotline from any jurisdiction within Washington 24 hours a day, seven days a week, using the integrated behavioral health crisis response technology platform.

*Crisis Stabilization Facility:* A short-term facility or portion of a facility that has been designed to assess, diagnose and treat persons experiencing an acute crisis without the use of long-term hospitalization. Also referred to as Crisis Stabilization Units (CSU).[68]

*Crisis Triage:* short-term facility or a portion of a facility designed to assess and stabilize an individual or determine the need for involuntary commitment of an individual.[69]

*Enhanced Services Facilities:* A facility that provides support and services to persons for whom acute inpatient treatment is not medically necessary.[70]

*Evaluation and Treatment Facility:* A facility that can provide emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from mental disorders.[71]

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[65] See facility definitions in the Washington Behavioral Health Facilities Report (2020), available at: file:///C:/Users/npinson/Downloads/bhf-Behavioral-Health-Facilities-2020-Leg-Report-2020.pdf
[66] SAMHSA. (2020). National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit. Retrieved from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
[67] See Crisis Triage/ Crisis Stabilization Facilities Fact Sheet. (May 2022). Retrieved from file:///C:/Users/npinson/Downloads/BHF%20HCA-external-fact-sheet-Crisis%20Triage%20and%20Stabilization%20Facilities%20Adult%20Youth%20FInal%20(2).pdf
[68] Washington Behavioral Health Facilities Report (2020)
[69] Id.
[70] Id.
[71] Id.

*Intensive Behavioral Health Facilities:* A specialized residential treatment facility for individuals with behavioral health conditions, including individuals discharging or being diverted from state and local hospitals, whose impairment or behaviors do not meet, or no longer meet, criteria for involuntary inpatient commitment, but whose care needs cannot be met in other community placement settings.[72]

*Peer Respite:* A peer-run facility to serve individuals in need of voluntary, short-term, non-crisis services that focus on recovery and wellness.[73]

*Psychiatric Hospital Beds:* Inpatient mental health facilities where individuals may go voluntarily or involuntarily.[74]

*Designated Crisis Responder (DCR):* A mental health professional appointed by the county or the BH-ASO who is authorized to conduct investigations, detain persons for up to one hundred twenty hours or pending an LRA revocation hearing, to the proper facility, and carry out the other functions identified in chapters 71.05 and 71.34 RCW. To qualify as a designated crisis responder, a person must also complete substance use disorder training specific to the duties of a designated crisis responder.[75]

*Emergency line 911:* The universal emergency number across the US, that typically dispatches to local police, fire, or sheriff departments.

*Emergency Medical Services (EMS):* Also considered first responder services, EMS are typically ambulance or paramedic services, and operate within a system of coordinated response and emergency medical care that is integrated with other services and systems with the goal to maintain and enhance the community's health and safety.[76]

*Evaluation and Treatment Facilities (E&Ts):* E&Ts are free-standing or hospital-based facilities that are certified by the Department of Health to provide acute psychiatric inpatient care to individuals who are detained under the Involuntary Treatment Act (RCW 71.05 and 71.34). This level of care provides evaluation, diagnosis, treatment, and stabilization of individuals' acute symptoms.[77]

*Historical Trauma:* A definition is provided in the Washington Community Behavioral Health Services Act for "historical trauma," meaning situations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were perpetuated by outsiders with a destructive or genocidal intent.

[72] Id.

[73] Id.

[74] Id.

[75] Law Insider, *Designated crisis responder definition*, available at https://www.lawinsider.com/dictionary/designated-crisis-responder

[76] Office of EMS, *What is EMS?*, Available at https://www.ems.gov/whatisems.html

[77] Washington State Health Care Authority, *Health Care Supports and Services* (2021) available at https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/acute-mental-health-care-inpatient

*Hospital Emergency Departments (ED):* The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. The emergency department is also called the emergency room or ER.[78]

*Involuntary Treatment Act Investigation:* The DCR conducts an evaluation and investigation pursuant to chapters 71.05 and 71.34 RCW. This investigation is conducted to determine if an individual presents a harm to self, others, property or is gravely disabled and is at imminent risk; or if there is a nonemergent risk due to a substance use disorder or mental disorder or is in need of assisted outpatient behavioral treatment.[79]

*Living Room Model:* The Living Room Model is a walk-in respite centers for individuals in crisis. The goal of treatment in the Living Room Model is to provide a safe and secure home-like environment where multidisciplinary professionals and peers with similar experiences provide treatment services. The Living Room Model highlights peers working or collaborating directly with clients to assist with symptom relief. According to Saxon et. al., the Living Room Model is distinctly different from the 23-hour crisis stabilization units. The Living Room Model provides crisis resolution and treatment for those who need more than 24 hours to resolve the issues that brought them into crisis, are short term and provide intensive treatment.[80]

***Mobile Crisis Response Team:*** Mobile crisis response teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner.[81] These teams often work closely with the police, crisis hotlines and hospital emergency personnel. Mobile teams may provide face to face developmentally appropriate de-escalation, risk assessments, safety plans, and determine next steps together with the person in crisis. They can check on that person for the next few days, assist the person to access higher levels of care if needed and connect an individual with community-based programs and other services.[82]

***Outpatient Treatment Facilities:*** Facilities that provide behavioral health services to patients who live in the community. These facilities do not provide inpatient beds.[83]

***Residential Treatment Facilities:*** Residential treatment facilities (RTFs) are licensed, community-based facilities that provide 24-hour inpatient care for people with mental health and/or substance use

[78] MedicineNet, *Medical Definition Of Emergency Department* (2021) available at https://www.medicinenet.com/emergency_department/definition.htm
[79] Washington State Health Care Authority, *Designated Crisis Responders* (2021) available at https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/designated-crisis-responders-dcr
[80] See definition in Saxon, V., Mukherjee, D., Thomas, D. (2018). Behavioral Health Crisis Centers: A New Normal. Journal of Mental Health and Clinical Psychology. Retrieved from https://www.mentalhealthjournal.org/articles/behavioral-health-crisis-stabilization-centers-a-new-normal.pdf
[81] Ibid.
[82] National Alliance on Mental Illness, *Getting Treatment During a Crisis* (2021) available at https://www.nami.org/Learn-More/Treatment/Getting-Treatment-During-a-Crisis
[83] Washington Behavioral Health Facilities Program Report (2020).

disorders in a residential treatment setting.[84] This license is often combined with endorsements to provide services in the RTF that include E&Ts, CSUs, and withdrawal management.

***Secure Withdrawal Management and Stabilization:*** A facility that provides care to voluntary individuals and individuals involuntarily detained and committed for whom there is a likelihood of serious harm or who are gravely disabled due to the presence of a substance use disorder.[85]

***Substance Abuse Treatment Facilities:*** All other substance abuse treatment facilities that provide treatment to individuals with substance use disorders.[86]

***Warmlines:*** Unlike a hotline for those in immediate crisis, warmlines provide early intervention with emotional support that can prevent a crisis. The lines are typically free, confidential peer-support services staffed by volunteers or paid employees who have may have lived-experienced with mental health.[87]

[84] Washington State Department of Health, *Residential Treatment Facilities* ( 2021) available at https://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/ResidentialTreatmentFacilities#:~:text=Residential%20treatment%20facilities%20(RTF)%20are,in%20a%20residential%20treatment%20setting.

[85] Washington Behavioral Health Facilities Program Report (2020).

[86] Washington Behavioral Health Facilities Report (2020)

[87] National Alliance on Mental Health, *It's Not A Hotline, It's A 'Warmline': It Gives Mental Health Help Before A Crisis Heats Up* (2019) available at https://www.nami.org/Press-Media/In-The-News/2019/It-s-not-a-hotline-it-s-a-warmline-It-gives-mental-health-help-before-a-crisis-heats-up

## Appendix C. High Level Workplan – 2022 Status Updates

| Crisis Response Improvement Strategy – High-Level Workplan 2022 Status Updates | Status Update |
|---|---|
| **Objective 1: Place to contact – National Suicide Prevention Lifeline crisis centers can effectively receive and respond to 988 calls, chats, and texts in a manner that is culturally responsive and tailored to meet the needs of diverse individuals and families across all ages, and deliver services according to national best practices, standards, and guidelines.** | |
| • Objective 1.1. Appropriate technology is in place for 988 calls to be answered by National Suicide Prevention Lifeline crisis centers. (Per Federal legislation and Washington's HB 1477) | • Current 988 Lifeline crisis center technology is in place for launch.<br>• HCA and DOH submitted Final Technical and Operational Plan with evaluation of future-state Crisis Call Center Hub technology needs. |
| • Objective 1.2. National technology system is in place to support text and chat services in Washington State. | • Volunteers of America of Western Washington is accredited for, and currently provides, 988 Lifeline text and chat services. |
| • Objective 1.3. Standardized process flows between 988 National Suicide Prevention Lifeline crisis centers, regional crisis call centers, crisis services, and 911 are established and there is a plan for implementation. | • Two 2-day work sessions held with 988 Lifeline crisis centers, 911, and RCLs to establish understanding of current-state cross system coordination as foundation for committee input on future state processes. |
| • Objective 1.4. Appropriate National Suicide Prevention Lifeline crisis center staffing levels are in place to respond to the volume of calls, text, and chat associated with 988. | • DOH distributed funding to 988 Lifeline crisis centers to expand staffing.<br>• DOH awarded SAMHSA grant. Contracts with crisis centers will support capacity to develop and coordinate a student internship and follow-up programs. |
| • Objective 1.5. 988 National Suicide Prevention Lifeline crisis center staff have skills to provide services that are person- and family-centered, culturally responsive, and trauma-informed. | • DOH summarized 988 Lifeline crisis center current staffing and training requirements as foundation for Committee recommendations. |
| • Objective 1.6. Establish standards for designation of Crisis Call Center Hubs; establish expectations for crisis call centers to provide high-quality crisis intervention services, triage, care coordination, referrals, and connections to individuals contacting | • DOH engaged rule making listening sessions and work sessions in November and December 2022 to develop draft Crisis Call Center Hub rules. |

| Crisis Response Improvement Strategy – High-Level Workplan 2022 Status Updates | Status Update |
|---|---|
| the 988 crisis Lifeline. Standards will be in accordance with national requirements and best practices (SAMHSA and Vibrant Emotional Health). | |
| • Objective 1.7. Crisis Call Center Hubs have access to state-of-the-art Crisis Call Center Hub technology that is interoperable with 911 and Vibrant's National Unified Platform, adheres to forthcoming national requirements, complies with data privacy and security laws (including text and web-based data sharing), has a disaster preparedness plan, and is able to dispatch mobile teams, identify bed availability, schedule and conduct follow up and community service referrals, and support all system partners in navigating the crisis system. | • HCA and DOH submitted Final Section 109 Technical and Operational Plan and plan for RFI/RFP process to identify technology vendors to meet Washington's needs. The Steering Committee reviewed and approved, with input by Technology Subcommittee, CRIS and other Subcommittees. |
| **Objective 2: Someone to come – Mobile crisis response teams are available 24/7 and positioned to quickly travel to the locations of individuals to deliver best practice care that is culturally responsive, tailored to the needs of diverse individuals and families across all ages, and reduces the need for unnecessary ER visits and arrest.** | |
| • Objective 2.1. Mobile rapid response crisis teams are connected to the Crisis Call Center Hub technology in a manner that maximizes clinical best practice, efficiencies, and interoperability. | • HCA and DOH submitted Final Section 109 Technical and Operational Plan and plan for RFI/RFP process to identify technology vendors to meet Washington's needs (See Obj. 1.7). |
| • Objective 2.2. Clear protocols are established to guide mobile crisis teams in a manner that maximizes clinical best practice and safety in a variety of settings, including support for voluntary processes over involuntary, reserving involuntary processes only in extreme situations. Protocols are developed on how crisis teams work with law enforcement, emergency departments, and other system partners. | • HCA developed Mobile Crisis Response program guide based on SAMHSA best practices adapted for Washington.<br>• Two 2-day work sessions held with 988 Lifeline crisis centers, 911, and Regional Crisis Lines to establish understanding of current-state cross system coordination to inform committee input on future state processes. |
| • Objective 2.3. There is equitable access to mobile response team services across the state that are accessible within designated timeframe standards established. | • HCA distributed $38 million in legislative proviso funding to expand adult and youth mobile crisis response teams.<br>• HCA 2023-2025 budget request included request for additional funding for 17 adult and 17 youth MCR teams. |

| Crisis Response Improvement Strategy – High-Level Workplan 2022 Status Updates | Status Update |
|---|---|
| • Objective 2.4. Mobile crisis team staff have skills to provide services that are person- and family-centered, culturally responsive, trauma informed and non-coercive. | • HCA developed Mobile Crisis Response guide based on SAMHSA best practices adapted for Washington.<br>• HCA participating in MRSS Learning Collaborative for on youth mobile crisis response.<br>• HCA is working to adapt best practice models to rural areas, tribes, and other cultural needs.<br>• HCA is seeking to incorporate bachelor level clinicians and exploring crisis responder training programs.<br>• HCA 2023-2025 budget request included request funds to support standardized training. |
| • Objective 2.5. Mobile crisis response teams are multidisciplinary and include peer and family support. | • HCA has developed a crisis peer training to assist peers in understanding their role, developing resiliency and selfcare, and finally orienting them to service models.<br>• HCA distributed proviso funding to BH-ASO for MCR teams to add peers to their current teams. |
| **Objective 3: A Place to go – A broad range of walk-in and crisis stabilization services are accessible, culturally responsive, tailored to the needs of diverse individuals and families across all ages, and provide all individuals with a no-wrong door access to mental health and substance use care and crisis stabilization services.** | |
| • Objective 3.1. Crisis stabilization providers are connected to the Crisis Call Center Hub technology in a manner that maximizes clinical best practice, efficiencies, and interoperability. | • HCA and DOH submitted Final Section 109 Technical and Operational Plan and plan for RFI/RFP process to identify technology vendors to meet Washington's needs. (See Objective 1.7). |
| • Objective 3.2. Clear protocols are established to guide crisis stabilization providers that maximizes clinical best practice and safety in a variety of settings. Protocols are developed on how crisis facility providers work with law enforcement, emergency departments, and other system partners. | • HCA is currently working on standards for in home stabilization services provided by MCR or follow up teams.<br>• HCA is working on developing standards and programmatic framework for facilities. |

| Crisis Response Improvement Strategy – High-Level Workplan 2022 Status Updates | Status Update |
|---|---|
| • Objective 3.3. There is equitable access to a broad range of walk-in and crisis stabilization services across the state, and individuals are connected to ongoing care. These services will include peer-run services and peer-run respite centers. | • Department of Commerce implemented the Behavioral Health Facilities Funding Program to expand behavioral health capital projects in local communities for crisis stabilization services.<br>• HCA's 2023-2025 budget request included funds to expand crisis stabilization services, peer respite programs, 23-hour models, and crisis stabilization units.<br>• HCA is developing 23-hour models to provide walk-in support to people to avoid needing to go to an emergency department or other behavioral health crisis system for support. |
| • Objective 3.4. Crisis stabilization provider staff have skills to provide services that are person- and family-centered, culturally responsive, trauma informed and non-coercive. | • HCA is looking at other state's models and trainings to develop a proposed curriculum to meet these goals.<br>• HCA has developed a training for peer crisis workers. |
| • Objective 3.5. Standardized process flows are developed for coordination with law enforcement and there is a plan for implementation. | • HCA is working with co-responder and law enforcement groups to develop coordination plans. |
| **Objective 4: Pre- and Post-Crisis Care – Services immediately upstream and downstream of crisis events are culturally responsive, tailored to diverse individuals and families across all ages, and accessible to all and support individuals and families to avoid cycling in and out of the crisis system.** | |
| • Objective 4.1. Pre- and Post-Crisis Care providers are connected with Crisis Call Center Hub technology in a manner that maximizes clinical best practices, efficiencies and information sharing to support next steps for the person's transition to follow-up non-crisis care. | • HCA and DOH submitted Final Section 109 Technical and Operational Plan and plan for RFI/RFP process to identify technology vendors to meet Washington's needs. (See Objective 1.7).<br>• 988 Lifeline crisis centers' current resource/info management is in place. |
| • Objective 4.2. Services such as next day appointments, post-hospitalization and post-crisis services, warmlines, peer and family supports, and navigation supports are culturally responsive and developed to address the needs of diverse individuals and families | • HCA is working with OIC and providers to make necessary connections for post-crisis care.<br>• HCA concluded a work group to implement next day appointments for commercial carriers and build the |

| Crisis Response Improvement Strategy – High-Level Workplan 2022 Status Updates | Status Update |
|---|---|
| across all ages to avoid whenever possible situations from escalating and to not cycle in and out of the crisis system. | infrastructure for crisis workers to refer a person for an NDA. Ongoing work will focus on improving capacity and coordination.<br>• HCA has recommended implementing statewide warm lines to serve various populations and meet them where they are.<br>• HCA is coordinating with recovery navigator and family navigator programs to integrate them into the crisis system. |
| • Objective 4.3. Expanded use of community education programs or campaigns are used to educate the community about where and how to access services. | • DOH and HCA are developing a communication plan that will educate stakeholders and partners as resources become available. |
| **Objective 5: A statewide crisis system is designed, administered, and monitored with oversight that ensures equitable, efficient, and person-centered behavioral health crisis system that demonstrates quality outcomes and performance.** | |
| • Objective 5.1. A vision and principles for the crisis system is developed and drives administrative oversight and local operational and clinical practices across the state. | • Steering Committee approved Crisis System Vision and Guiding Principles developed by Ad Hoc Workgroup on Vision with input from multiple subcommittees. |
| • Objective 5.2. Sovereign tribal authorities – crisis system is designed in a manner that respects the existing processes and governing bodies of tribal governments to address tribal behavioral health and crisis system needs and gaps. | • Engaged Tribal Roundtables and Consultation Process for Section 109 Tech/Op Plan.<br>• Engaged Tribal Roundtables and Consultation Process for HB 1477 Committee Recommendations. |
| • Objective 5.3. System partners – including individuals and family members with lived experience, first responders, emergency, crisis and community providers, government, and managed care plans – collaborate to design, implement, and oversee an effective and equitable behavioral health crisis system. | • HCA and DOH prepared updated for HB 1477 committees for input on system design and implementation. |
| • Objective 5.4. Cross-system metrics are developed in collaboration with system partners that allow for crisis system transparency and oversight through report disseminated and improvement strategies implemented. Metrics include satisfaction ratings by individuals, family members, and system stakeholders. | • HCA and DOH developing inventory of current system metrics/data and identification of gaps based on national best practices. |

| Crisis Response Improvement Strategy – High-Level Workplan 2022 Status Updates | Status Update |
|---|---|
| • Objective 5.5. Shared data is developed to evaluate overall crisis system performance and support performance improvement across the system. | • Same as above. |
| • Objective 5.6. Appropriate levels of braided funding (including Medicaid, Medicare, commercial, local and other dollars) are available to support a high functioning system, include sufficient access to crisis lines, mobile teams, and walk-in and crisis stabilization services as well as and prevention and post crisis services. | • HCA and the Office of the Insurance Commission convened a workgroup comprised of commercial carriers, BH-ASOs, and crisis service providers to develop recommendations on how to integrate commercial carrier coverage of behavioral health crisis services into the behavioral health crisis system. The workgroup concluded its first phase of discussions in Novembers, and recommendations have been shared with each group for feedback. Conversations will continue to achieve the goals in the recommendations and possibly integrate further service coverage. |
| • Objective 5.7. Recommendations related to behavioral health workforce needs by each region across the state are developed. These recommendations include minimum licensure, education, and training requirements for staff delivering crisis services, as well as strategies to support the existing workforce and recruit new staff. | • HCA and DOH shared information with Training and Credentialing Subcommittee regarding current-state crisis system staff and workforce requirements to inform future-state recommendations. |
| • Objective 5.8. Reimbursement approaches incentivize a highly-coordinated system of care across system partners that results in quality outcomes and supports provider viability and sustainability. | |
| • Objective 5.9. Statewide minimum standards of operational and clinical practices are developed that foster use of best and promising practices while also allowing for tailored implementation at the local level. | |

# Appendix D. History of Tribal Centric Behavioral Health Crisis System Efforts

*Note: this section is excerpted from the HB 1477 Final Technical and Operational Plan (Appendix E)[88] to ensure a summary of the history of tribal work to address the behavioral health crisis system is recognized within HB 1477 committee recommendations to improve Washington's behavioral health crisis response and suicide prevention system.*

Tribes have a longstanding history with barriers in accessing needed crisis services for their tribal members. Washington State's movement towards managed care and crisis services supported through a county and regional system did not provide resources to Tribal governments to fund services to members within their communities. Issues are related to access to timely services, honoring of tribal court orders and clinical assessments, and funding to support tribal crisis resources. The Tribes have worked with the state to advocate and develop plans to improve crisis services to tribal members and urban Native individuals across the state and to address longstanding barriers to access to care and the significant crisis and behavioral health outcomes for AI/AN individuals. AI/AN individuals and tribal members experience extensive wait times for ITA evaluations and mobile crisis response to tribal communities and difficulties in individuals and families navigating crisis on their own. There are also times when the tribe does not agree with the DCR's ITA evaluation of a tribal members.

In 2013, the Tribes, Indian Policy Advisory Committee, and the Department of Social and Health Services developed a report to the legislature that outlined the following crisis improvement recommendations to improve the Tribal Centric Crisis System. Recommendations included: timely and equitable access to crisis services for AI/AN, improved connections and ability to have designated crisis responders (formally DMHPs), notification and coordination by evaluation and treatment facilities when discharging AI/AN patients, legislation to allow tribal courts to issue ITA commitments for tribal citizens, training for non-Tribal DCRs for evaluations of AI/AN individuals, conduct feasibility study for one or more E&T facilities to serve AI/AN individuals in need of inpatient psychiatric care.

Between the years of 2016 – current date, the State has supported work to establish and maintain planning efforts to support the feasibility study for one or more E&T facilities per the recommendation of the 2013 report. The Tribes met to establish a workgroup in 2017 and have been working on realizing this plan since its development in 2019. The plan was robust and outlined goals and activities to address crisis services for AI/AN that would provide the infrastructural support needed to create a successful culturally appropriate behavioral health crisis facility. Below are activities that have been implemented by the workgroup to date. This includes establishment of a formal Tribal Centric Behavioral Health Advisory Board (TCBHAB) to oversee these activities.

- Continued planning on the development of a culturally appropriate tribal inpatient behavioral health facility managed by the TCBHAB.

[88] Washington State Health Care Authority. (2022). *Final Technical and Operational Plan – National 988 System: Crisis Call Center and Behavioral Health Integrated Referral System*. Retrieved from https://www.hca.wa.gov/assets/program/final-technical-and-operational-plan-988.pdf

- Development of tribal DCRs (T-DCR), appointed by the tribe and appointed by HCA for state jurisdiction processes, that can evaluate anywhere and with anyone in the state.
- Funding support for T-DCR services.
- Legislation to enhance tribes' ability to provide crisis services to their tribal and community members including notification to tribes for ITA investigations of tribal members and AI/ANs with an Indian Health Care Provider (IHCP) as a medical home.[89]
    - Training and technical assistance to tribes and IHCPs on enhancing crisis services, including development of T-DCR tribal Codes, DCR processes and procedures/T-DCR protocols, operationalization of T-DCR, tabletop exercise for tribes.
    - Training and technical assistance to non-tribal crisis providers and DCRs on working with AI/ANs and tribal communities, including reviewing and providing feedback on the DCR protocols.
    - Improvements to the Tribal Crisis Coordination Protocols template and processes.
    - Washington Indian BH Hub and the Native and Strong Lifeline.

In addition to the statewide Tribal/state crisis improvement projects, the 29 tribes are at different stages of implementation of crisis services. Under the self-determination act, strength and resiliency, Tribes have moved toward implementation of crisis services to provide to their tribal and community members. Several Tribes have crisis lines available either on a workday basis and 24/7 basis. Several tribes are working on establishing Tribal designated crisis responders that will conduct ITA evaluation and investigations through the state system as well as through their tribal court systems. Tribes are also exploring mobile crisis response teams and crisis facilities.

The state is working to ensure that we account for the diversity of Tribal and Urban Indian Health Organization resources and protocols for engaging with Tribes and urban Indian organizations when serving AI/ANs in crisis and in need of behavioral health resources. Some of these efforts include, completing the State/Tribe Tribal Crisis Coordination Protocols, ensuring others working in the crisis system are aware of these protocols and the development of the Native and Strong Lifeline and the Indian Behavioral Health Hub.

[89] Senate Bill 6259 (2020, enrolled). Retrieved from https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/6259-S.SL.pdf?q=20221127130523

## Appendix E: Summary of Tribal Consultation Process and Tribal Feedback

Upon request of Washington's Tribes, the HB 1477 Steering Committee initiated a Tribal Consultation process in 2022 to review and ensure tribal perspectives are included in HB 1477 committee recommendations for an integrated behavioral health crisis response and suicide prevention system in Washington. For this *January 1, 2023 HB 1477 Committee Progress Report*, the Tribal Consultation process included a series of four (4) Tribal Roundtables held between September and November 2022, and a formal Tribal Consultation on December 14, 2022.[90]

In addition to the Tribal Consultation process, the HB 1477 Tribal 988 Subcommittee, through the Tribal Centric Behavioral Health Advisory Board, has played an important advisory role to HB 1477 committee work regarding tribal perspectives and the existing tribal efforts to improve the behavioral health crisis response system for tribal members. A summary of tribal feedback through the Tribal Roundtables and Consultation, as well as through the Tribal 988 Subcommittee, is provided below in Table E.1. In addition, Table E.2 includes a summary of feedback from the American Indian Health Commission (March 16, 2022) on the *Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services in Washington and Preliminary Funding Recommendations* (submitted December 31, 2021), and how this feedback has been addressed in this HB 1477 Committee Progress Report.

All of the tribal feedback received has been addressed and integrated into this report.

| **Table E.1. Summary of Tribal Feedback and References Integrated Throughout the HB 1477 Committee Progress Report (January 1, 2023)** | | |
|---|---|---|
| **Executive Summary** | | |
| **2022 Committee Progress Update** | ○ Tribal Consultation process to review and provide input into HB 1477 recommendations.<br>○ Recognizes extensive work led by Tribes and Urban Indian Health Organizations (UIHOs) in Washington for over a decade to address behavioral health crisis system gaps and significant inequities for AI/AN populations in the state. | Page 4 |
| **Section I. Background** | | |
| **Background** | ○ Tribal 988 Subcommittee<br>○ Tribal Consultation process, including recognition of the government-to-government relationship between Tribal and state government leaders that is distinct from the state's relationship with other system partners and stakeholders.<br>○ History of tribal work to address significant inequities in health and barriers in access to behavioral health crisis | Pages 9-12 |

[90] Four (4) Tribal Roundtables regarding updates to HB 1477 Comprehensive Assessment were held on the following dates: September 21, 2022; October 19, 2022; November 16, 2022; and November 30, 2022.

| **Table E.1. Summary of Tribal Feedback and References Integrated Throughout the HB 1477 Committee Progress Report (January 1, 2023)** | | |
|---|---|---|
| | services for tribal members and AI/AN individuals (also in Appendix D). | |
| **Section II: Committee Progress Update** | | |
| **Introduction** | ○ Tribal 988 Subcommittee and Tribal Consultation meeting dates included in calendar overview of HB 1477 meetings throughout 2022 | Page 13 |
| **1. Vision** | ○ 10 Guiding Principles include "Operated in a manner than honors government-to-government processes"<br>○ Vision and Guiding Principles informed by Tribal 988 Subcommittee feedback and Tribal Roundtable #1. | Page 15 |
| **2. Equity** | ○ Recognizes significant disparities and increasing rates of suicide among AI/AN population. Recognition of historical trauma and challenges to diagnose.<br>○ Section on Committee and Tribal Partner Input incorporates tribal feedback received through AIHC, 988 Subcommittee (TCBHAB), and the Tribal Roundtable #1 on ways to embed equity from a tribal perspective. (Note: also integrated throughout sections below.) | Pages 17-26 |
| **3. Services** | ○ *A Place to Call:*<br>▪ Native and Strong Lifeline<br>▪ Tribally-operated crisis lines<br>○ *Someone to Come:*<br>▪ Tribal Mobile Crisis Team pilot<br>▪ Tribal Designated Crisis Responders<br>▪ Tribal public safety and first responders<br>○ *A Place to Go:*<br>▪ AI/AN Behavioral Health Facilities (Tribal Evaluation and Treatment Facility, Secure Withdrawal Management, or Crisis Stabilization Facility)<br>○ *Pre- and Post- Crisis Care*<br>▪ IHCP outpatient behavioral health services and integrated care. Highlighted importance of outreach to social networks in tribal communities.<br>○ Expansion of resources to support tribal crisis response services across the crisis continuum is needed.<br>○ Expand telehealth to support access to care among tribal populations when services are not available directly through tribal providers, as well as for people living in rural communities. | Pages 29, 31, 34, 37, 39, 42,, 45-46, 48-50 |
| **4. Quality and Oversight** | ○ Recognize Tribal Data Sovereignty. | Page 52 |

| **Table E.1. Summary of Tribal Feedback and References Integrated Throughout the HB 1477 Committee Progress Report (January 1, 2023)** | | |
|---|---|---|
| | [*This will be HB 1477 Committee focus area for 2023*] | |
| **5. Cross-System Coordination** | ○ Tribal entities to be included in cross system coordination: Native and Strong Lifeline, tribally-operated crisis lines, Tribal Mobile Crisis Team (pilot), Tribal DCRs, tribal public safety and first responders, Indian Health Care Providers and Urban Indian Health Programs, Tribal behavioral health facilities.<br>○ Need for development of clearly defined warm handoff processes and coordination between tribal system and state and local crisis response systems.<br>○ Use and adherence of the HCA-Tribal Crisis Coordination Protocol.<br>○ Appendix I: summary developed by AIHC regarding key intersections between tribal, state, and local crisis response systems and key process and policy development needed. Reviewed during Tribal Roundtable #2. | Pages 53-56 |
| **6. Staffing and Workforce** | ○ Standardized training to be available to tribal behavioral health and crisis providers.<br>○ Examples of training areas to promote equity and tribal sovereignty.<br>▪ Cultural responsiveness (cultural humility and cultural appropriate practices);<br>▪ Understanding Tribal sovereignty and Tribal crisis systems;<br>▪ Understanding trauma in the Native community (historical, community, family, self);<br>▪ Cultural humility and working with tribal and indigenous people/communities;<br>▪ Understanding impacts of historical and intergenerational trauma and trauma informed care/approaches.<br>○ Cross system training across 988 Lifeline crisis centers (in Washington and nationally), RCLs, 911, first responders and other entities to ensure connections to the Native and Strong Lifeline and Indian BH Hub.<br>○ Behavioral Health Aides integrated into the crisis response workforce. | Pages 58-62 |
| **7. Technology** | ○ Tribal Consultation process engaged on the HB 1477 Technical and Operational Plan; Reference to Appendix | Pages 65-68 |

| **Table E.1. Summary of Tribal Feedback and References Integrated Throughout the HB 1477 Committee Progress Report (January 1, 2023)** | | |
|---|---|---|
| | G in the Final Tech/Op Plan with summary of Tribal Consultation process and feedback addressed.<br>○ Washington's crisis system response technology must have capabilities, funding, and technical assistance to ensure tribal crisis system providers can seamlessly access the system and include use of data sharing agreements that apply the principles of tribal data sovereignty. Includes compliance with SB 6259 (IHCP access to future bed registries) and compatibility with tribal EHRs.<br>○ Leverage technology to maximize opportunities to expand telehealth; emphasis of this approach for tribal populations when services are not available through tribal providers. Address implementation barriers, such as contracting with out of state providers. | |
| **8. Funding** | ○ Ensure tribal partners and systems are included equitably in funding requests.<br>○ Approximately 60% of tribal members enrolled in the Medicaid program are covered through the fee-for-service program rather than managed care.<br>○ Medicaid payments for crisis services have flowed primarily through Medicaid MCOs and BH-ASOs, and Tribal providers have not received direct allocations for these services other than Medicaid billable services. | Page 69-73 |
| **Section III. Funding Recommendations for the 988 Line Tax** | | |
| Recommendations relating to overall behavioral health crisis system funding will be addressed by HB 1477 Committees in 2023. The 2022 Committee Progress Update includes recommendations specific to the 988 Line Tax established by HB 1477 Section 205. The 988 Line Tax provides dedicated funding to support the Native and Strong Lifeline.<br>Given the fluidity of estimating expenditures for calls into Washington's 988 Lifeline crisis centers in the first five years since the launch of 988, as well as the significant current gaps in mobile crisis response team resources across the state, the Steering Committee recommends the following:<br>1. Maintain the current tax rate, given the early stages of determining costs for the 988 Lifeline crisis centers and the significant current gaps in mobile crisis response across the state.<br>2. The Steering Committee recommends that expenditures from the Account on mobile rapid response crisis teams or other allowable expenditures be informed by recommendations from the CRIS Committee in 2023 to ensure equitable distribution of these resources across the state. This recommendation aligns with HB 1477's charge to the Steering Committee and CRIS to develop | | Page 75 |

| **Table E.1. Summary of Tribal Feedback and References Integrated Throughout the HB 1477 Committee Progress Report (January 1, 2023)** | | |
|---|---|---|
| recommendations to enhance and expand mobile rapid response teams in each region, (including specialized teams as appropriate to respond to the unique needs of youth, **including AI/AN youth** and LGBTQ youth, and geriatric populations, including older adults of color and older adults with comorbid dementia). The Health Care Authority is currently working to expand mobile crisis response teams and will bring updates to the CRIS Committee to inform these plans. | | |
| **What We Need to Explore in 2023** | | |
| This January 1, 2022 Committee Progress Report is the second in a series of three reports due to the Legislature and Governor. Next year, further work will be engaged with the HB 1477 Committee, Tribal 988 Subcommittee and TCBHAB to develop recommendations for the Final Report, due January 1, 2024.<br><br>Tribal Roundtables and Consultation will be engaged in 2023 for review and feedback on the Final HB 1477 Committee Report. | | Page 76 |
| **Appendices** | | |
| Appendix A: Acronyms | ○ AI/AN American Indian or Alaska Natives<br>○ AIHC American Indian Health Commission<br>○ IHCP Indian Health Care Provider<br>○ TCBHAB Tribal Centric Behavioral Health Advisory Board<br>○ UIHO Urban Indian Health Organization (also referred to an Urban Indian Health Program or UIHP) | Page 77 |
| Appendix B: Definitions | ○ Historical Trauma | Page 79 |
| Appendix C: High Level Workplan – 2022 Status Updates | ○ Mobile Crisis Response - HCA is working to adapt best practice models to rural areas, tribes, and other cultural needs.<br>○ Sovereign Tribal authorities – engaged Tribal Consultation processes for the Technical and Operational Plan and the HB 1477 Committee Report. | Pages 86 |
| Appendix D: History of Tribal Center Behavioral Health Crisis System Efforts | ○ Note: this section is excerpted from the HB 1477 Final Technical and Operational Plan (Appendix E) to ensure a summary of the history of tribal work to address the behavioral health crisis system is recognized within HB 1477 committee recommendations to improve Washington's behavioral health crisis response and suicide prevention system. | Pages 88-89 |
| Appendix E: Summary of Tribal Consultation Process and Feedback | ○ Summarizes Tribal feedback received through the 2022 Tribal Consultation Process, the 988 Tribal Subcommittee, TCBHAB, and the AIHC. | Pages 90-97 |

| **Table E.1. Summary of Tribal Feedback and References Integrated Throughout the HB 1477 Committee Progress Report (January 1, 2023)** | | |
|---|---|---|
| Appendix F: Subcommittee Report | ○ Includes link Tribal 988 Subcommittee meeting information through the TCBHAB. | Page 98 |
| Appendix G: Summary of Major Comments Received on Draft Vision and Guiding Principles | ○ Documents feedback to add "Operated in a manner that honors tribal government-to-government processes." | Pages 99-100 |
| Appendix I: Example of Tribal Crisis Response Paths and Key Process and Policy Considerations | ○ Outlines 3 paths for crisis response for tribal affiliated individuals through the 988 system, including key policy and process considerations and needs. | Pages 105-107 |
| Appendix J: DOH Cost Model to Project 988 Costs | [Provides overview of assumptions and elements that are part of the DOH model to estimate costs for the 988 Lifeline centers, including Native and Lifeline | |

***Table E.2 Feedback Received from the AIHC on the Initial Assessment and How it is Addressed***

| | ***Concern identified by AIHC with the Initial Assessment (December 31, 2021)*** | ***Updates in the HB 1477 Committee Progress Report (December 31, 2022)*** |
|---|---|---|
| 1. | Tribes need to be **included as a partner in a government-to-government relationship**. Consultation is a cornerstone of the government-to-government relationship. Consultation should begin soon, not after the plan is submitted to the State Legislature. *[Applicable sections: Planning timeline; Work plan (see Addendum A. for consultation best practices)]* | A Tribal Consultation process was established per the Dear Tribal Leader Letter sent on April 1, 2022 (HB 1477 Crisis Response Improvement Strategy Committee Request for Feedback on Comprehensive Assessment and Technical and Operations Plan). |
| 2. | Tribes and Urban Indian Health Organizations perform similar duties to BH-ASOs and should be **included in the overall analysis** of the crisis response system. Additionally, many Tribes also have first responders and public safety officers involved in crisis response. *[Applicable section: Section I. Delivery of Crisis Services in Washington (p 9)]* | Recognition of the crisis system services and roles played by Tribes and Urban Indian Health Organization is integrated through the Section II Committee Progress Updates, including but not limited to progress updates in Section II.3 (Services) and Section II.5 (Cross System Coordination). |
| 3. | Tribal and Urban Indian Health Organization programs are an under-resourced and underutilized partner in the BH crisis response system. They use a mix of funding sources and have **substantial funding needs that should be included** in the system analysis. | The Section II.8 Committee Progress Update (Funding) highlights the need to ensure tribal partners are included equitably in funding requests. |

| | ***Concern identified by AIHC with the Initial Assessment (December 31, 2021)*** | ***Updates in the HB 1477 Committee Progress Report (December 31, 2022)*** |
|---|---|---|
| | *[Applicable sections: Section II. Funding of Crisis Services in Washington (p 11); Section V. Funding Crisis Response Services (p 51)]* | |
| 4. | Washington State BH crisis response system services need to have **clearly defined warm handoff process** between Tribal and Urban Indian Health Organizations and state/local systems. For example, notification of a case generated by a co-response or crisis unit call should include the Washington Indian Behavioral Health Hub and the applicable Indian Health Care Provider.<br>*[Applicable sections: Section II: A Model for the Way Forward (p 18-19)]* | The Section II.5 Committee Progress Update (Cross-System Coordination) highlights the need for clearly defined warm hand off process between tribal systems and state and local crisis response system. Appendix I summarizes key intersections between tribal, state and local crisis systems and key process and policy development needed. |
| 5. | Indian Health Care Providers, including Tribal and Urban Indian Health Organization Behavioral Health departments are the **health home**, the central coordinating entity, for many AI/AN people and should receive notifications, updates and be involved early in planning for services.<br>*[Applicable section: Section II: A Model for the Way Forward (p 18-19)]* | The Section II Committee Progress Updates recognize the roles of IHCP and Urban Indian Health Program behavioral health departments to provide crisis response services to AI/AN individuals, including but not limited to Section II.3 (Services). Section II.7 (Technology) also highlights importance that Washington's crisis response technology system is accessible by tribal crisis system providers. |
| 6 | All staff in BH crisis response systems should be trained in cultural humility, and culturally appropriate practices. Training should be institutionalized and include both **culturally specific training for working with Indigenous people** and **training in Tribal Sovereignty.**<br>*[Applicable section: Section VI. Credentialing and Training subcommittee recommendations (p 72), or Subcommittee Work Plan]* | The Committee Progress Update in Section II.6 (Staffing and Workforce) recognizes needs for culturally specific training for working with Indigenous people and training in Tribal Sovereignty. |
| 7 | A system wide gathering of data will improve accountability and lead to the need to include **Tribal Data Sovereignty** principles in planning.<br>*[Applicable section: Section IV. Accountability and Finance; A sample data sharing agreement between Washington State DOH and Tribes will be available soon.]* | The Committee Progress Update in Section II.7 (Technology) recognizes the need to include use of data sharing agreement that apply the principles of Tribal Data Sovereignty. |
| 8 | Tribes and Urban Indian Health Organizations need to be **included in planning and funding for group 2 services** (existing crisis lines, DCR | The Section II.8 Committee Progress Update (Funding) highlights the need to ensure tribal |

| | ***Concern identified by AIHC with the Initial Assessment (December 31, 2021)*** | ***Updates in the HB 1477 Committee Progress Report (December 31, 2022)*** |
|---|---|---|
| | investigations, inpatient hospital stays, mobile crisis teams, crisis stabilization units, emergency department visits.)<br>*[Applicable section: Section V: Funding Crisis Response Services; Group 2 models and funding recommendations. (p 56 for budgeting graphic, p 60 for cost projections graphic)]* | partners are included equitably in funding requests.<br><br>Recommendations relating to crisis system funding will be addressed by HB 1477 Committees in 2023. The 2022 Committee Progress Update includes recommendations specific to the 988 Line Tax established by HB 1477 Section 205. |
| 9 | Tribes and Urban Indian Health Organizations need to be **included in planning and funding for the expansion of group 3 services** (warm call lines, walk-in clinics, crisis respite centers, peer supports, residential treatment, supported housing)<br>*[Applicable section: Section V: Funding Crisis Response Services. Group 3 models and funding recommendations. (p 56 for budgeting graphic, p 60 for cost projections graphic)]* | Same as response to #8. |
| 10 | Include a comprehensive summary of the historical and ongoing **activities and policies that have created the current system.** For example,<br>- Land displacement, historical trauma and violence against Indigenous peoples;<br>- The history of segregated systems of care, and the unbalanced splitting of mental health, substance use, physical health, and community health; and<br>- Structural racism, interpersonal racism, stigma, and war on drugs policies.<br>*[Applicable section: Section I: Background on Crisis Services in Washington; See LA County Jail system summary (pages 33-37) as an example.]* | The Background section and Appendix D include a summary of the history of tribal work to address significant inequities in health and barriers in access to behavioral health crisis service for tribal members. |

## Appendix F: 2022 Subcommittee Report

The 2022 Subcommittee Report includes a compilation of all HB 1477 subcommittee meeting summaries in 2022, and is available on the CRIS webpage: https://www.hca.wa.gov/assets/program/cris-subcommittee-report.pdf

## Appendix G: Summary of Major Comments Received on Draft Vision and Guiding Principles and Changes Incorporated into the Final

The HB 1477 Ad Hoc Workgroup on Vision developed a draft vision and guiding principles statement for consideration by the CRIS Committee, subcommittees, tribal representatives, and the Children and Youth Behavioral Health Workgroup. Comments received fell into a number of major theme areas that the Workgroup considered and addressed in changes to develop the final vision and guiding principles. This appendix includes a summary of changes in the final vision and guiding principles to address the major comment themes.

| Comment Theme Area | Summary of Changes Made to the Final Vision and Guiding Principles |
|---|---|
| **Vision** | |
| *Summary:*<br>Revised: 988, Washington's Crisis Response: building understanding, hope, and a path forward for those in need, where and when they need it.<br><br>Original presented to CRIS (5/10): 988 offers a connection to anyone who is struggling, meeting them with acceptance and empathy, offering hope and recovery. | |
| 1. Clarify focus on 988 vs. comprehensive crisis system that is broader than a single call point. | Added: "988, Washington's Crisis Response" |
| 2. Recognize populations experiencing crises, such as the agricultural community and LGBTQ+, that are not limited to mental health or substance use disorder conditions. | Removed the term "recovery" given relationship to substance use disorder conditions. |
| 3. Too much jargon – needs more direct, plain language<br>○ *Remove term recovery*<br>○ *Hope and recovery sounds amorphous - be more specific about connecting people to the right resources.*<br>○ *Concern with term "struggling" and how it is received culturally – suggested use of word "need"* | Removed "acceptance and empathy, offering hope and recovery" and replaced with: "building understanding, hope, and a path forward for those in need, when and where they need it."<br><br>Removed "struggling" and replaced with "need" |
| 4. Remove the term "them" in the vision statement | Removed the term "them" |
| 5. Use more action-oriented language | Added the term "building" in place of "offering" |
| 6. Caregivers/family don't see themselves in the vision | Replaced "anyone who is struggling" with "those in need" |
| 7. Question about whether to include the term crisis or behavioral health needs | Included the term "988, Washington's Crisis Response" |
| 8. Add access to timely and appropriate care/rapid response | Added "when and where they needed it" (see also language added in principles – "timely access") |

| Comment Theme Area | Summary of Changes Made to the Final Vision and Guiding Principles |
|---|---|
| **Guiding Principles** | |
| *Summary (revision in tracked changes)*<br><br>***People in crisis experience:***<br>▪ Timely access to high-quality, coordinated care without barriers ~~A seamless system without barriers~~<br>▪ A welcoming response that is healing, trauma-informed, provides hope, and ensures people are safe<br>▪ Person and family centered care<br>▪ Care that is responsive to age, ~~developmental~~, culture, gender, sexual orientation, people with disabilities, geographic location, language, ~~linguistic~~, and other needs | ***The Crisis System is intentionally:***<br>▪ Grounded in equity and anti-racism<br>▪ Centered in and informed by lived experience<br>▪ Coordinated and collaborative across system and community partners<br>▪ Operated in a manner that honors tribal government-to-government processes (moved)<br>▪ Empowered by technology that is accessible by all<br>▪ Financed sustainably and equitably |
| 1. Tribal recommendation for explicit recognition of government-to-government processes as part of system principles | Added "Operated in a manner that honors tribal government-to-government processes." |
| 2. Add access to high-quality care regardless of geographic location | Added "timeline access to high-quality care regardless of geographic location." |
| 3. Missing concept of trauma-informed care | Added term "trauma-informed" |
| 4. Add care that is responsive to gender, sexual orientation, and people with disabilities | Expanded language: care that is responsive to culture, gender, sexual orientation, people with disabilities, geographic location, language, and other needs |
| 5. Varying feedback to shorten/simplify versus add more detail | Language was kept brief based on operating understanding of principle statements as short phrases. |
| 6. Recognize lack of access to technology in rural communities | Added "that is accessible by all" to the phrase "Empowered by technology" |
| 7. Add concept of safety and keeping people safe | Added "ensures people are safe" |
| 8. Include concept of community | Added "and community" so that statement reads "Coordinated and collaborative across system and community partners" |
| 9. Visual makes it seems like the people and the system are separate and there is no intersection/ nothing in common. | Removed visual for purposes of development of statements. |

## Appendix H: Co-Response Programs

*Source:* Information in the table below is provided by the University of Washington (Jennifer Stuber, Associate Professor) based on a survey of co-response teams across the state.

| Program Name | Organization | Address | Type | Responds to 911 |
|---|---|---|---|---|
| "MOT" - Mobile Outreach Team | Lacey Police Department | 420 College Street SE, Lacey, WA 98503 | Police | Yes |
| Anacortes Fire Department | Anacortes Fire Department | 1016 13th Street | Fire | No |
| Bainbridge Island Police Department | Bainbridge Island Police Department | 625 Winslow Way East, Bainbridge Island, WA 98110 | Police | No |
| Behavioral Health Contact Team | Multicare/Lakewood Police | 9401 Lakewood Dr SW, Lakewood, WA 98499 | Police | Yes |
| Behavioral Health Navigator | Hoquiam Police Department | 215 10th St, Hoquiam, WA 98550 | Police | Yes |
| Behavioral Health Unit | Chelan County Sheriff's Office Behavioral Health Unit | 401 Washington Street, #101, Wenatchee, Wa 98801 | Police | Yes |
| Behavioral Health Unit | Spokane Police Department | 1100 W Mallon, Spokane WA | Police | Yes |
| Belingham Fire MIH | Bellingham FD | 1800 Broadway Bellingham, 98225 | Fire | Yes |
| Bellevue Fire CARES | Bellevue Fire Department | 450 110th Ave NE, Bellevue, WA 98004 | Fire | No |
| CARES | South King Fire and Rescue | 31617 1st ave S Federal Way, WA 98003 | Fire | No |
| CARES | Spokane Fire Department CARES | 1618 N Rebecca St. Spokane WA 99217 | Fire | Yes |
| CCFR CARES | Clark-Cowlitz Fire Rescue | 911 N. 65th Ave., Ridgefield, WA 98642 | Fire | No |
| CK CARES | Central Kitsap Fire | 5300 Newberry Hill Rd, Silverdale WA 98383 | Fire | Yes |
| COET, Mental health Response Pilot | City of Everett- COET | 3002 Everett WA 98201 | Police | Yes |
| Community Crisis Assistance Team (CCAT) | Bellevue Police Department | 450 110th Ave NE Bellevue, WA 98004 | Police | Yes |

| Program Name | Organization | Address | Type | Responds to 911 |
|---|---|---|---|---|
| Community Outreach Team | Arlington Police Department | 110 East Third Street, Arlington, WA 98223 | Police | Yes |
| Community Outreach Team | Monroe Police Department | 818 W. Main Street; Monroe, WA 98272 | Police | Yes |
| Community resource paramedic | South Snohomish fire and rescue regional fire authority | 12425 meridian ave s Everett wa 98208 | Fire | Yes |
| Community resource paramedicine | Compass Health / Community Transitions partnered with South County Fire | 4526 Federal Ave, Everett, WA 98203 | Fire | Yes |
| Community Response Team (CRT) | City of Burien/Human Services | 400 SW 152nd St. Suite 300, Burien, WA 98166 | Police | No |
| Community Transitions | Compass Health | 4526 Federal Ave, Everett, WA M/S #12 | Police | No |
| CORE | Eastside Fire & Rescue | 175 Newport Way NW, Issaquah, WA 98027 | Fire | No |
| CORE Program (Community, Outreach, Response, Engagement) | City of Omak/Omak Police Department | 8 N. Ash, Omak WA 98841 | Police | No |
| Co-responder | Vancouver Police Department | 2800 Stapleton rd., Vancouver, wa 98661 | Other entity | Yes |
| Crisis Intervention Coordinator/Team | Kitsap County Sheriff's Office | 614 Division St., Port Orchard, WA 98366 | Missing | Yes |
| Crisis Response Unit (CRU) | Olympia Police Department | 601 4th Ave. E Olympia, WA 98507 | Police | Yes |
| Eastside Fire & Rescue Core Connect | Woodinville Police Department | 17301 133rd Ave NE, Woodinville, WA, US | Fire | No |
| Embedded MHP | Marysville Police | 501 Delta Ave | Police | Yes |
| ESW (Embedded Social Worker) | Mukilteo PD/Compass Health | 10500 47th Pl W Mukilteo WA 98275 | Police | Yes |
| FD CARES | Puget Sound Regional Fire Authority | 24611 116th Ave SE. Kent 98030 | Fire | Yes |
| FD CARES | Renton Regional Fire Authority | 18002 108th Ave SE Renton, WA 98055 | Fire | Yes |

| Program Name | Organization | Address | Type | Responds to 911 |
|---|---|---|---|---|
| GPS Team | Des Moines Police Department | 21900 11th Ave s. Des Moines Wa 98198 | Police | Yes |
| Ground-level Response and Coordinated Engagement (GRACE), Alternative Response Team (ART), Co-Response Program | Whatcom County Health Dept. | 800 E Chestnut, Suite 1B, Bellingham, WA 98225 | Police | Yes |
| Health One | Seattle Fire Department | 301 2nd Ave S, Seattle WA | Fire | Yes |
| Integrated Outreach Services | Mount Vernon Police Department | 1805 Continental Place, Mount Vernon WA 98273 | Police | Yes |
| Island County Human Services | Island County Human Services | 1NE 7th Street, Coupeville, WA 98239 | Police | Yes |
| Kirkland Police Department | Kirkland Police Department | 11750 1118th ST NE, Kirkland WA | Police | Yes |
| Kitsap Fire CARES | Poulsbo Fire Department | 911 NE Liberty Rd, Poulsbo, WA 98370 | Fire | No |
| Mason County Behavioral Health Navigator | Mason County Sheriff Office | 322 N. 3rd Street | Police | Yes |
| Merit - Care Navigator | KVFR | 400 E Mountainview Ave - Ellensburg | Fire | Yes |
| North King Mobile Integrated Health | Shoreline Fire Dept/North King MIH | 7220 NE 181st Street Kenmore 98028 | Fire | No |
| North Sound RADAR Navigator Program | North Sound RADAR Navigator Program | 18410 101st Ave NE, Bothell WA 98011 | Police | No |
| PAFD Community Paramedicine Division | Port Angeles Fire Department | 102 E 5th St, Port Angeles, WA 98362 | Fire | Yes |
| PCSD Co-Responder Program | Pierce County Sheriffs Co-Responder program | 14113 Pacific Ave S, parkland, WA 98444 | Police | Yes |
| Poulsbo Police Department | Poulsbo Police Department | 200 NE Moe St, Poulsbo WA. 98370 | Police | Yes |
| PTPD Navigator Program | Port Townsend Police Department | 1925 Blaine Street, Suite 100 | Police | Yes |
| REdisCOVERY | OPCC / REdisCOVERY | 819 Georgiana St., PO Box 639, Port Angeles, WA 98362 | Police | Yes |
| REdisCOVERY | Clallam County Sheriff's Office | 223 E. 4th St. suite 12, Port Angeles, WA 98362 | Missing | Yes |

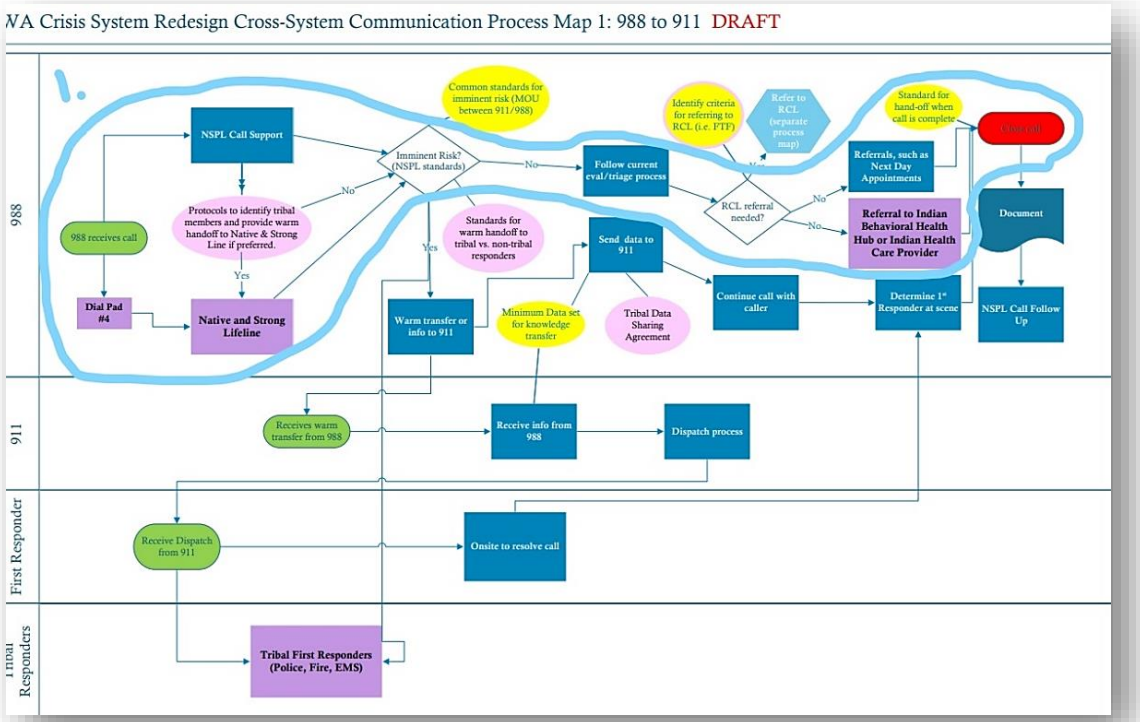
| Program Name | Organization | Address | Type | Responds to 911 |
|---|---|---|---|---|
| Redmond PD | Redmond PD | 8701 160th Ave NE Redmond WA 98073 | Police | Yes |
| SCOUT - Snohomish County Outreach | Snohomish County Human Services | 3000 Rockefeller Ave., Everett WA 98201 | Other entity | No |
| Sea Mar chc | Sea Mar chc | 2502 E 4th plain blvd vancouver wa 98661 | Police | Yes |
| Seattle Police Department's Crisis Response Team | Seattle Police Department/DESC | 610 5th Ave, Seattle, WA 98104 | Police | Yes |
| Sequim Police Department | Sequim Police Department | 152 W. Cedar St. Sequim WA 98382 | Police | No |
| Sheriff's Community Outreach Utilization Team (SCOUT) | Thurston County Sheriff's Office | 2000 Lakeridge Dr SW Olympia, WA 98502 | Police | Yes |
| Skagit County Public Health | Skagit County Public Health | 700 South 2nd Street | Police | Yes |
| Spokane County Fire District 8 | Spokane County Fire District 8 | 12100 E Palouse Hwy, Valleyford, WA 99036 | Missing | No |
| Tacoma Police Department | Tacoma Police Department | 3701 S Pine St Tacoma, WA 98409 | Police | No |
| Tukwila Police Department | Tukwila Police Department | 15005 Tukwila International Boulevard, Tukwila WA 98188 | Missing | No |
| Valley Regional Fire Authority CARES | Valley Regional Fire Authority | 2905 C Street SW Auburn, WA 98002 | Fire | No |

| Co-response Team Type | Responds to 911 | | Totals |
|---|---|---|---|
| | Yes | No | |
| Police | 27 | 7 | 34 |
| Fire | 10 | 9 | 19 |
| Other entity | 1 | 1 | 2 |
| Missing | 2 | 2 | 4 |
| **Total** | **40** | **19** | **59** |

# Appendix I: Examples of Tribal Crisis Response Paths and Key Process and Policy Considerations

Health Management Associates work with the American Indian Health Commission (AIHC) to identify key intersections between tribal, state and local crisis system. The AIHC developed the summary below to identify key process and policy consideration relevant to three crisis system "paths" a caller may experience depending on the acuity of their needs when they call 988 or the Native & Strong Lifeline.

**Path 1:** *A caller dials 988, presses option 4, and is connected to a Native and Strong Lifeline counselor. The call is resolved on the phone with a plan to follow up with an outpatient provider within a few days.*




**Process Considerations**

- In 16 counties the process to connect Native & Strong Lifeline with the Washington Indian Behavioral Health Hub is internal at Volunteers of American Western Washington.
- The Hub will work with Indian Health Care Providers to have up to date IHCP points of contact for follow up care on file.

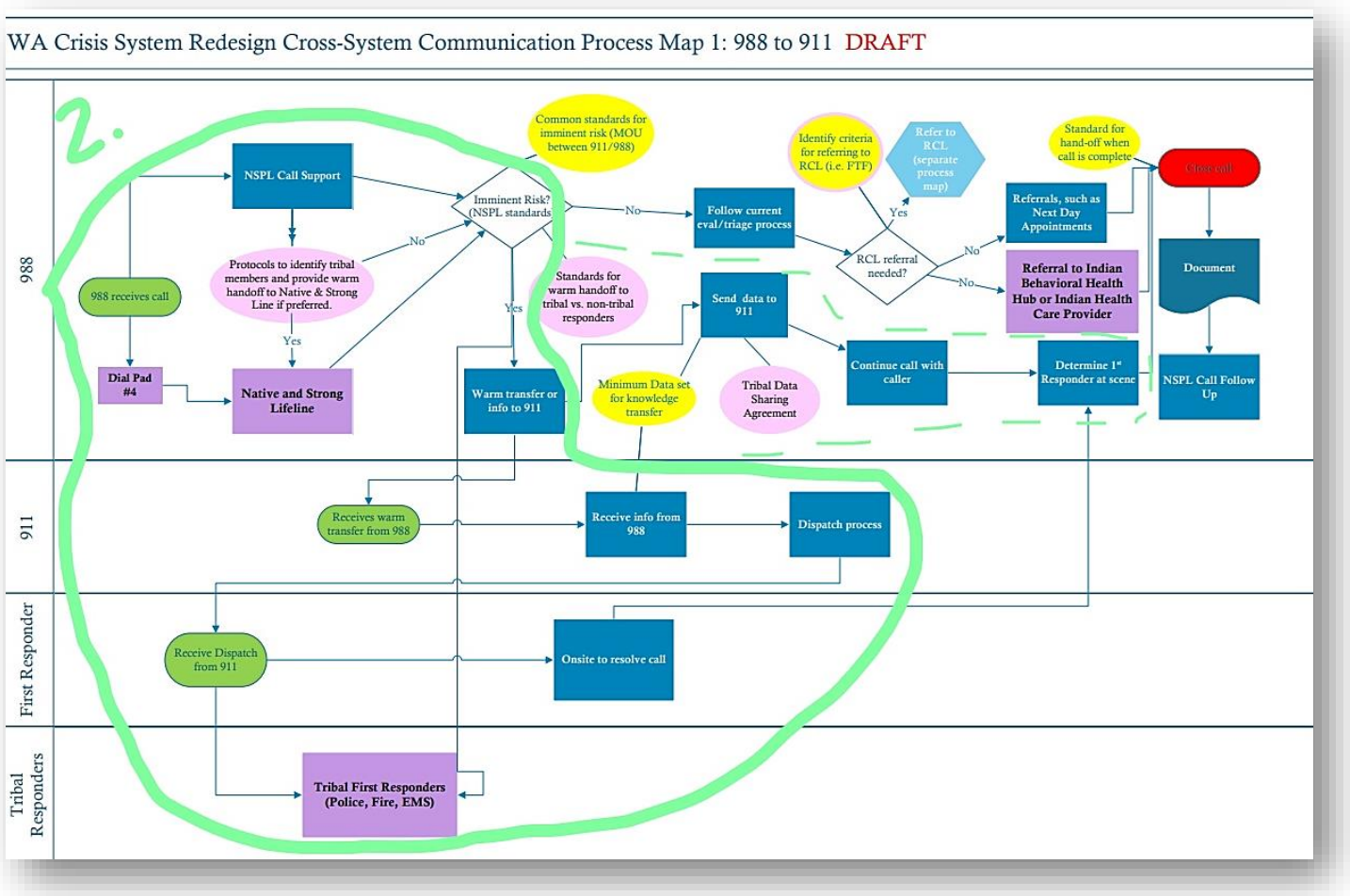
**Policy Considerations**

- DOH contracts with Crisis Connections and Frontier Behavioral Health should include expectations and protocol for connecting callers with the Native & Strong Lifeline, as 988 Lifeline crisis centers and as RCLs.
- DOH contract with VOA for Native & Strong Lifeline should include data sharing agreement template clauses aligned with Tribal Data Sovereignty principles.
- HCA contract with Columbia Wellness and Olympic Health & Recovery Services regional crisis lines should include expectations and protocol for connecting with Native & Strong Lifeline.

**Path 2:** *A caller dials 988, presses option 4, and is connected to a Native & Strong Lifeline counselor. The counselor determines that there is imminent risk and the call is transferred to 911. A 911 operator follows local protocol and moves to dispatch a county sheriff officer. However, it is determined that the person is a Tribal community member on Tribal land and the 911 operator calls Tribal Police dispatch. Tribal Police respond to the address.*

**Process Considerations**

- Native & Strong counselors will look to Tribal Crisis Coordination Plans for guidance on when to transfer calls to 911 or Tribal Police dispatch.




**Policy Considerations**

- Is there anything in 911 policy that prevents 988 counselors from directly connecting with Tribal Police dispatch?
- At this point there is no known data sharing agreements in place with 911 PSAP (call centers).

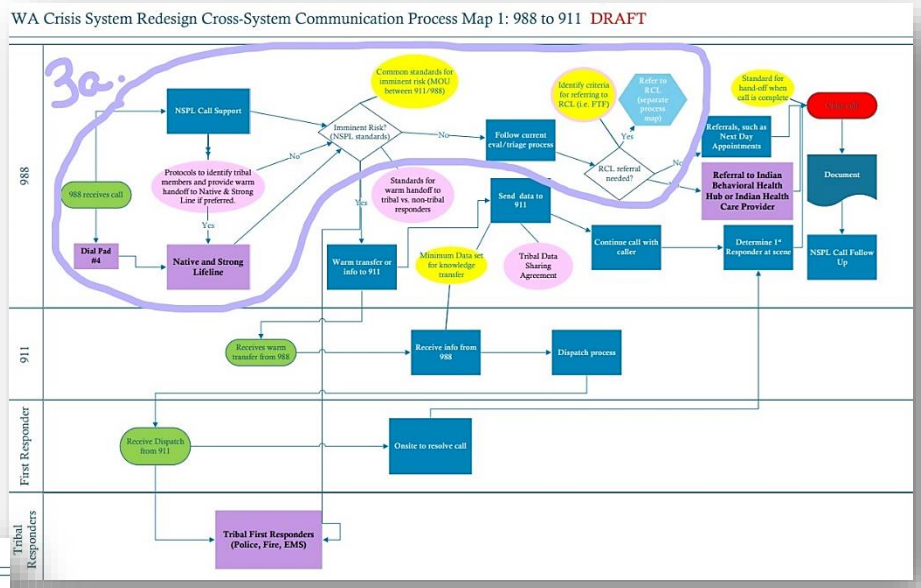
**Path 3:** *A caller dials 988, presses option 4, and is connected to a Native & Strong Lifeline counselor. The counselor sees there is not an imminent risk, but that quick follow up is needed. The counselor transfers the call to a Regional Crisis Line (RCL). The RCL dispatches a mobile crisis team that may or may not include a designated crisis responder, to the address.*

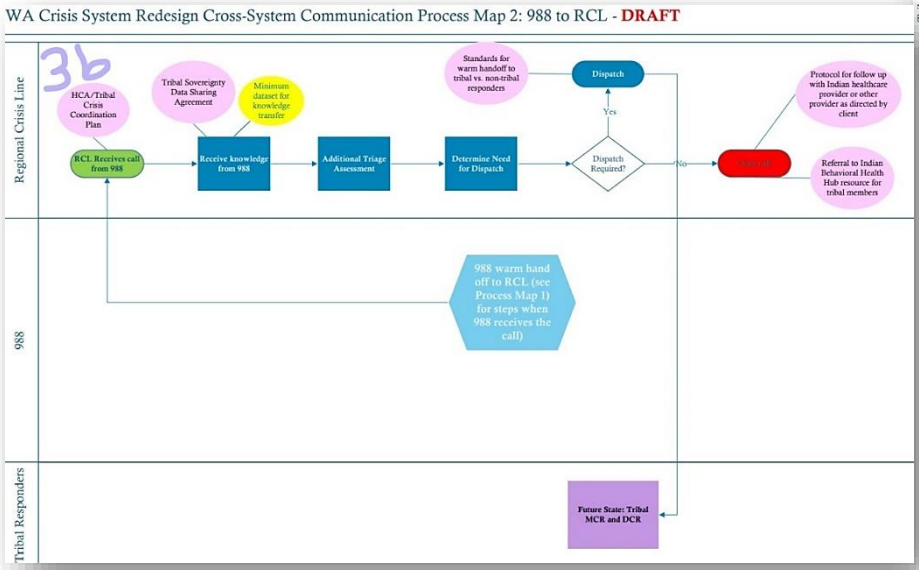
**Process Considerations**

- In a future state, this is where also where a Tribal mobile crisis response team could be dispatched.

**Policy Considerations**

- HCA contracts with Regional Crisis Lines (Columbia Wellness and OHRS) should include expectations and protocol for connecting with Tribal mobile crisis response teams or other plans outlined in the Tribal Crisis Coordination Plans.



## Appendix J: DOH Cost Model to Project 988 Costs

The Department of Health has been charged with the development of the cost estimate to support the 988 crisis call centers. Cost estimates are being built on an ever-increasing call volume over a five-year period while still maintaining a minimum response rate of 90 percent of all calls received.

The DOH has been utilizing the analysis and technical expertise of Vibrant Emotional Health (Vibrant) to build the estimate of costs for the 988 crisis lines. Vibrant was contracted by the federal government to assist states nationwide with research and analysis to stand up their local 988 call centers. Vibrant has offered estimates for the average cost per voice call, average cost per chat call, and average cost per text call. Vibrant has also provided projections of the call volume that will come into the 988 crisis lines based on the historical use of the National Suicide Prevention Lifeline from those living in Washington. The DOH has used the research conducted by Vibrant in inform the cost estimate for the 988 crisis lines that are specific to Washington.

The DOH model is built out with assumptions for the first five years after the launch of 988 which began on July 16, 2022. There are over 70 inputs into the model, each with its own assumptions. Exhibit 2 below shows a representation of the inputs into the 988 crisis call center cost model. The inputs that influence the costs in the 988 crisis line cost model include:

- The volume and pace of calls that come directly into the 988 lines in Washington,
- The volume and pace of calls that are redirected from other lines, such as 911 or regional crisis lines that have been in place in Washington for many years, and
- The cost per call (differentiated between cost per voice call, cost per chat call, and cost per text call)

The projected revenue from the line tax through the end of State Fiscal Year 2027 is expected to be $238 million.[91]

As of the publication of this report, the call volume estimates for Washington's 988 Lifelines are below what was budgeted for at this time last year. Also, the transfer of calls from other call centers such as 911 and regional crisis lines has not yet been realized. As a result, the updated projection for the first five years of Washington's 988 lines is lower than what was projected in last year's report.

There is uncertainty, however, in what may ultimately be the call volume to the 988 lines. The final estimate of calls is dependent upon both the timing and intensity of the marketing campaign to publicize the national 988 line, both at the federal and state level. Additionally, although preliminary estimates for the projection of calls that will be redirected from 911 or from the call centers that are in place at the regional level are not yet occurring in any meaningful way, the timing of when these transfers may occur (i.e., the technology will be in place to seamlessly conduct the transfers) will also influence the final estimate of calls taken by staff at the 988 call centers in Washington.

[91] Washington Department of Revenue Forecast for Statewide 988 Behavioral Health Crisis Response and Suicide Prevention Line Tax, retrieved from https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fdor.wa.gov%2Fsites%2Fdefault%2Ffiles%2F2022-11%2FNov_2022_NonGeneral_Fund_Forecast.xlsx%3Fuid%3D637a227e4c7bf&wdOrigin=BROWSELINK

*Exhibit 2: Developing Cost Projections for the 988 Crisis Lines, July 2022 - June 2027*

| Estimating Volume of Calls | | | | | |
|---|---|---|---|---|---|
| Calls Directly to 988 Lines | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| **Estimating METHOD of Call Contact** | | | | | |
| Proportion of Calls Coming in by Voice | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Proportion of Calls Coming in by Chat | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Proportion of Calls Coming in by Text | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| **Estimating Volume of ENHANCED SUPPORTS** | | | | | |
| Proportion of Calls Requiring Spanish Translation | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Proportion of Calls Transferred to Native & Strong | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| **Estimating COSTS Per Call** | | | | | |
| When Contacted by Voice | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| When Contacted by Chat | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| When Contacted by Text | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Additional Costs for Spanish Translation | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Additional Costs to Transfer to Native & Strong | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| **Estimating COSTS for State Administration and Oversight** | | | | | |
| 988 Call Center Contract Oversight and Reporting | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |

# Appendix K: CRIS Member Written Comments – Draft HB 1477 Committee Progress Report

- **Behavioral Health Administrative Service Organizations,** CRIS representatives
- **Bipasha Mukherjee**, CRIS and Steering Committee member representing Lived Experience
- **Darcy Jaffe,** CRIS member representing the Washington State Hospital Association
- **Jan Tokumoto,** CRIS member representing 988 Lifeline Crisis Call Center in Washington
- **Jenn Stuber**, CRIS member representing university based suicide prevention center of excellence
- **Joan Miller**, CRIS member representing Washington Council for Behavioral Health
- **Kashi Aurora**, CRIS member representing the Children and Youth Behavioral Health Work Group
- **Kim Hendrickson**, CRIS member representing an EMS department with a CARES program
- **Michelle McDaniel**, CRIS member representing 988 Lifeline Crisis Call Center in Washington
- **Representative Tina Orwall**, CRIS and Steering Committee member representing Washington State House of Representatives
- **Ron Harding**, CRIS member representing Law Enforcement

## Behavioral Health-Administrative Service Organizations (CRIS member representatives)

Dear Steering Committee Members,

On behalf of the Behavioral Health Administrative Services Organizations (BHASOs), thank you for your passion and leadership in endeavoring to successfully integrate the 988 crisis line into our State's community behavioral health system, and indeed to better the entire behavioral health continuum of care.

The BHASOs would like to offer the following points of consideration with regards to the report:

1. Washington State has chosen a regional approach for its community behavioral health system. Its critical that the State look to the BHASOs to serve as regional leaders, conveners, and coordinators for the behavioral health continuum of care. Moreover, efforts need to be made to clarify, support, and empower this important regional framework. Community based systems require strong community based leaders. The BHASOs stand ready to play that role.
2. The report notes crisis services available in WA state, but does not reflect of how these are distributed across regions. Especially reflecting the reality of resources available in our rural regions.
3. The report does not reflect the current state of crisis services, how they are delivered and administered. Furthermore, it only vaguely references the needs and challenges of rural regions, but does not specifically outline the current status – what is available for youth and adults. This includes what investments are being made or will be planned in the near future.
4. When reflecting on amount of crisis services, what are we measuring against? What is the target? Example – report notes 53 Mobile Crisis Teams. In terms of an improvement strategy, what are we aiming to target for – is 53 enough? Aiming to increase by XXX? The report does not tell us what we are striving towards nor does it clarify how or when this data was collected. Clear distinction on how the report was derived is imperative to ensure informed decision making.
5. A deeper evaluative look at the available data would be helpful – how was it derived, what is the current landscape, and what is the desired goal.
6. When addressing crisis facilities, it could be helpful to look at data that could tell us what the need is. Example – if crisis facilities will alleviate volume of individuals presenting at hospital EDs, can we look at hospital data to show us what the need is regarding individuals who present at the ED with a primary BH need?
7. Although realistically this report isn't in real time, it fails to not fully address the closure/loss of critical facilities across the state. This impacts the provision of available services and paints a more realistic picture of the needs across the state.
8. There are a number of very important, but less flashy, barriers that remain to be mitigated (like reliable and fully funded transportation, nagging problems with liability and medical clearance, capacity based funding instead of a fee for service model, adequately training our first responders, facilities cherry picking the clients they'll take, etc). This core issues must be addressed if real progress is going to be made.

It is the sincere hope of the BHASOs that these issues will be at the forefront of policy makers in the upcoming legislative session and for the ongoing work of this group.

Thank you again for your consideration and for providing a space and opportunity for this important dialogue. The BHASOs remain committed to continued participation and remain committed to improving our behavioral health system and the people it serves daily.

## Bipasha Mukherjee, CRIS and Steering Committee member representing Lived Experience

- Giving members a week to read a dense report is not nearly enough. This feedback was echoed by many people of the CRIS. I appreciate that this year the CRIS has been consulted before it comes to the Steering. What needs to change to give people more time to go through the documents? Having said that it takes a lot of time to go through the report, I want to then acknowledge that it must have taken a huge amount of effort to generate it – thanks for that hard work to the whole team.
- Pg. 5 says 'HCA and DOH are developing an inventory of current system metrics in use in Washington that will be brought the CRIS and Steering Committee for input and discussion in the first quarter of 2023.' This somewhat explain why this report felt inadequate in painting a clear picture. Data is good but without the context of metrics is doesn't help us determine gaps and how to address them. That we've gone a year without this gives me pause. Glad it is stated as a Q1 priority, but it is critical to get it done sooner than later.
- The report could have been more concise. Multiple sections keep repeating verbatim. Sen. Dhingra said (and it's common knowledge) that the report will likely not be ready by the legislators, keeping it shorter would be more effective. Things that could have been clearer:
    - There was conversation when the vision statement was developed that it would be good to have a graphic that conveys the essence of it. The venn diagram used at that time was removed but nothing new was floated.
    - Visual maps to indicate the counties, areas BH-ASOs cover, where MCRs (adult and youth) are located, and other such data would help with grasping the data. The map on what the 3 call centers cover on pg. 27 was helpful.
    - What is I-502 mentioned first on pg. 19 and then again, a couple more times?
    - There are multiple bed types mentioned on pg. 37 but it was not clear what they all mean/do.
    - The data on call volumes, use of DCRs etc. is not entirely clear, for e.g., why is DCR use in KC so high compared to other counties? Why are the bars in the diagrams for Great Rivers so high? Starting pg. 29
    - Some of the data (e.g., related to the Governor's proclamation pg. 36) are outdated. The pandemic shifted things rapidly and it would have been good to have fresher data.
    - It says 2 regions have MRSS but does not name them on pg. 30, but names the ones (Pierce, Spokane) that are trying the pilot models on pg. 53
    - What is the difference between Crisis Stabilization Unit and Crisis Respite programs given it seems both are paid for differently? Mentioned on pg. 64
    - There are terms/acronyms used with no clarification on what they are or mean. It does say appendix A & B need to be added and it would have made reading the document easier.
- The issue of privacy vs using geolocation is confusing. There are two contradictory statements made on pg. 20. Would help to clarify that this is a vital and nuanced area of discussion at the federal level and should also be a high priority discussion in 2023 within the state.
- The role of first responders is mentioned in the report and the need to clarify their role vs that of other teams. It would be good to clarify that this, like and related to geolocation, is a delicate area that needs to be talked about openly and respectfully in 2023 within our state.
- Crisis hubs should be mentioned in sections involved in post and prevention starting on pg. 38. If 98% of calls are handled at the call-center level, it implies people are calling call centers to get help to prevent or lower the chance of a crisis.
- Pg. 39 mentioned 'a plan to create a singular referral tool that will capture reasons for the NDA and clinical presentation of the person in crisis. This tool will be sent to commercial carriers using a contact directory for either a warm hand off or for plans to follow up.' How will this work with the 988 Tech platform being developed? Is this an internal tool that will be used, or will it be one that an RFI and then RFP will be put out for?
- On pg. 5 there is a list of some things that the 988 line-fee can cover. Would be good to specifically state training of staff.
- On pg. 40 the section on Suicide prevention mentions trauma as a reason, but nowhere does it capture access to safe housing, food, water, heat in winter/cooling in our increasingly hot

summers. These stressors often are very much a part of the lives of people who live in poverty and can be triggers to BH issues. In the same vein it's important to mention 211 as place to call and needs to interoperate with the 988 tech platform. It's an ask of those with lived experience to acknowledge that basic needs are part of behavioral healthcare even though the focus of CRIS is BH. Could be mentioned on pg. 26 and on pg. 8.

- The Equity section was excellent. I could see that all the feedback from the meetings have been diligently recorded. Big kudos on this one! The difficult task, and it should be named as such, is how will WA meet those lofty equity goals?
- Glad the issue of medical clearance is mentioned. It's a big step that needs to be addressed if we are to divert lot of behavioral health clients away from EDs and hospitals.
- Glad to see mentioned that the fee will continue.

Thanks,
Bipasha

### Darcy Jaffe, CRIS member representing the Washington State Hospital Association

Note that written comments were provided as embedded comments within the report document. All comments have been addressed and are on file with the project team.

### Jan Tokumoto, CRIS member representing 988 Lifeline Crisis Call Center in Washington

Thank you for the opportunity to provide feedback on the Report. I chose to focus on Section IV of the Report since it is related to how we move forward. My feedback is a combination of questions and suggestions. I appreciate the work that went into this report and as a provider of crisis response services and 988, we are very invested and willing to participate at any level of the planning process especially if ad hoc groups are formed. I apologize that I did not have more time to provide feedback on every domain.

1. System goals and metrics
    a. Can we have actual data collected by agencies as required by contracts for current performance indicators? Are there other data collected that may not be reported but could help inform and shape our thinking related to goals and metrics?
    b. What is the breakdown of data according to region and county? Does the lack of resources in more rural or smaller areas contribute to the low success rates or skew the results? It would also be helpful to look at who is successful and what contributes to their success and if it would be possible to standardize resources, partnerships, and process so more counties can be successful.
    c. If goals/metrics are standardized, will there be consideration for how counties are different and may lack what larger counties have available to them? Will consideration be given to workforce issues that will impact goals/metrics?
    d. Are there going to be consequences when goals/metrics are not met so services can be improved?
2. Crisis System Services
    a. Who are the successful crisis response services providers in our state and why are they successful? If they are successful, could funding be directed towards those successes if they can be replicated in other counties?
    b. I would suggest including current crisis response service providers in discussions so gaps can be identified and changes can be tailored to county's needs. For example, if crisis providers are to respond in 30 minutes or less, will there be funding to support enough staff to meet this goal/metric? What attention will be paid to staff safety if expedited dispatching is a goal/metric? What level of acuity/risk were the Arizona teams being dispatched to when they were out in 4 minutes or less from their office? Is the expedited response targeted to mobile crisis teams and not DCRs? What infrastructure was in place so records could be reviewed and/or information provided to responders prior to contact with the person? The recent murder of a Providence health care worker has resulted in heightened staff concerns about their safety.
    c. Is there a way to be deliberate about the use of co-responder teams with law enforcement and fire so they are part of the continuum of response to those in crisis?
    d. How will community partners participate in these discussions since they are part of the crisis continuum?
3. Funding

   a. It would be helpful to know what is on the list for possible funding and is there flexibility to tailor these resources to meet a community's needs?
   b. I would suggest flexible funding to crisis responders so they can develop dedicated resources for their staff to help stabilize individuals such as withdrawal management beds, shelter beds, immediate access to inpatient/outpatient SUD treatment, immediate access to outpatient services for children, youth, and adults, etc.?
4. System Infrastructure
   a. I would suggest funding that is earmarked for stabilizing the current workforce. Our current workforce continues to leave for better paying jobs and less challenging clients or they are being hired for new mobile outreach teams.
   b. Having technology that is geared to accessing information for expedited response times will be critical especially related to safety. We have co-responder staff who do not feel safe even with an officer at their side which is concerning since many of our crisis responders contact people who are unknown to them, have a history of violence, are using substances, and can be impulsive and unpredictable.

Jenn Stuber, CRIS member representing university based suicide prevention center of excellence

Dear Steering Committee Members,

As we head into 2023, this letter reflects my overarching feedback on the report and the 988 planning process to date. I am thrilled that the 988 Call Centers are fully funded with the telecom fee. I am impressed by the ingenuity of the Native and Strong Line as a critical component of our crisis system. I am excited that there is the start of a real conversation in the report and in statute to have Medicaid MCOs and commercial plans pay for their enrollees who use the crisis system and, a developing framework to extend connections to same-day and next-day appointments. If we don't have financial disincentives in place for commercial and MCO plans to keep people out of the crisis system, they will not be incentivized to do prevention work further upstream.

Below is my feedback about the report and the status of our planning to date:

> (1) I am concerned that at the end of year 1 of this process we have what appears to be a reification of the existing system, as opposed to a deep dive into a conversation about whether the design of the existing system is what we want. This concerns me because the 2023-2025 biennium was supposed to be when we focus on strengthening the crisis care continuum. To do that we really need to put hard consideration into the foundation of our 988 behavioral health crisis system. The metaphors I keep using, who is (are) the orchestra conductors for the 988 system? What's the foundation of the crisis system house of services that we are building?
>
> We refer to a regional system without putting any real parameters on what we mean by a regional crisis system. What regions are we talking about? Is it the ASO regions? If so, are they the leads of this system? Are they empowered and funded to play this role? What are their roles and responsibilities in this new day? Is ten ASO regions too many? What will be their accountability? Without these kinds of questions being talked about publicly and resolved, I fear we will not get to where we are all aspiring to go.
>
> The biggest factors of success in designing any crisis system, as stated many times during our visit to Arizona and repeatedly on the weekly National Crisis Jams include: accountability, public transparency, designing towards equity, and collaboration among all the system providers, all informed by a lens of lived experience. The ASOs or whatever regional administrator(s) are envisioned in WA, need to be front and center in this process; right now, they are backstage.
>
> (2) I am concerned that we are standing up mobile crisis teams and crisis stabilization facilities, but don't really know much about where they are geographically, what they do, or what they need. In the current report, it is not clear to me, do we need more of these crisis services as a state or not? I feel strongly we do not have enough of these crisis services, but there are no established goals for what we need based on our population census. What do we want to signal to the legislature with this report? There is a radical difference in how these teams and centers currently operate across the state. Bean counting won't get us to a place where we have standards for effective crisis care.

In the last six months, UW has been able to map the landscape of the state's 64 co-response teams working closely with CROA, fire chiefs, and WASPEC. UW has fielded a quantitative survey and they are conducting interviews with co-response programs to not only get a landscape of what co-response teams are doing, but what their training and funding needs are, and what their perceived collaboration/ integration is with the 988 crisis system. I suggest a similar process be completed with the mobile crisis teams and crisis stabilization centers to give us a better sense of what's needed, not just counting numbers.

(3) I am concerned that we keep acting like the 911 emergency response system is separate and somehow walled off from the 988 behavioral health crisis system. Of course, the 988-activated system should provide a clear alternative to the 911-activated system. But, we need to recognize that the same individual in crisis could need services from both systems and, oftentimes will, because of individual needs and, some of our state's existing statutes around ITA and medical clearance.

In my opinion, the report should talk equally about both systems and focus a lot more on their integration, regionally organized and led with state standards to back it up. Collaboration is needed with city and county officials and with the ACHs. We need to talk about what types of crisis services are needed under what circumstances. Right now, we have a shadow system in operation that often feels demonized in our CRIS conversations. This is tragic to me because first responders and co-responders are largely doing the work of meeting the needs of the many people in a behavioral health crisis in our state today. We can value their inevitable role, no matter how perfectly designed our 988 system becomes, while simultaneously acknowledging they should not be needed in many circumstances.

This is big feedback and with two days to make changes, I am not optimistic it will all be taken into account before a report to the legislature is submitted. I am hopeful, however, that in 2023 we can get to these challenging conversations.

In my view, it's okay to hear an impassioned plea or a challenge or to look to an outsider in another state for consultation, or for things to be uncomfortable, as long as we figure out what drives the discomfort. We need to build a planning culture where there's a growth mindset, where new ideas are put forward, and, where it's okay to disagree because we are working towards a brighter future. More in-person meetings will facilitate the dialogue and the relationships that will be needed to transcend the present state, which has improved with time. A streamlining of subcommittees, perhaps organized around the categories of crisis services (911 dispatch/ 988 call centers, mobile crisis/ co-response, emergency departments/ crisis triage and stabilization) and, a newsletter about their deliberations would likely help keep everyone informed and in the loop between CRIS meetings. The newsletter could also include state agency updates so that the limited planning time we have together can be used to have these important conversations.

Thanks for the commitment to this work. Happy holidays to all of you,

Jenn

Joan Miller, CRIS member representing Washington Council for Behavioral Health

## Feedback on the HB 1477 Committee Progress Report and Funding Recommendations for the 988 Tax Line – December 2022

Thank you for the opportunity to provide feedback on the funding recommendations and progress report for our state's behavioral health crisis response and suicide prevention services. I am thrilled that our state has had such a successful soft launch of 988, due in part to the telecom fee that has enabled our call centers to hire staff and prepare for the increase in call volume. The Native and Strong Lifeline is a success that we should also be enormously proud of. Our vision statement and guiding principles are a solid framework for our state to work toward. It has been a privilege to be a member of the CRIS Committee.

There are a lot of wonderful things in this report (e.g., the promoting equity section; the recommendation for a "firehouse model" financing approach; the recommendation to maintain the telecom tax) but, in the interest of time, I will focus my comments on suggestions for improvement. I know that all of us have heavy workloads and are balancing multiple responsibilities, but I'd like to reiterate that it is extremely difficult to provide meaningful advice and recommendations when CRIS Committee members had only six days (including the weekend) to read and digest this 100-page report. It's unclear to me how there will be enough time for the Steering Committee to take any written feedback from CRIS Committee members into account. Therefore, I will arrange my comments in two different sections: (1) suggestions to clarify the content of this current report, which hopefully can be included in the final report; and (2) feedback for what we need to address in more depth in 2023.

### Suggestions for Clarifying the Content Before the Report is Finalized

- Page 19: Under Domain 2, there is a reference to I-502, I would suggest adding a footnote to explain that initiative to readers.
- Pages 23 & 24: In the section related to community outreach and marketing, we need to be careful about overpromising. There are statements about maintaining confidentiality while at the same time there are discussions about adding GIS capabilities, which seems contradictory. Similarly, while it's important that people know contacting 988 won't *automatically* result in a law enforcement response, there will be a small number of situations that will require the police. We don't want to mislead communities.
- Page 24: Under Domain 5, in the last bullet, I'm not sure what is meant by establishing "payment parity at the service level across payers and across disciplines." It would be helpful to have that recommendation further explained.

- Page 25: I think it is premature to consider adding day-of appointments in addition to next-day appointments. Many community behavioral health agencies have instituted waitlists for outpatient treatment due to a lack of workforce. Next-day appointments as required by HB 1477 are already a heavy lift, and we should focus first on ensuring that capability, both for providers and insurers.
- Page 30: Related to Mobile Crisis Response Teams, it would be helpful to see those teams listed on a map or at least by region. It's unclear where those teams are located, or even if they are fully staffed and operational.
- Page 35: Under the list of places to go, it was my understanding that "23-hour hour crisis stabilization" and the "Living Room Model" were the same thing? Parts of this report were challenging to understand because the definitions section was not completed.
- Page 35: The report should acknowledge that a survey with a 35% response rate is not going to provide a complete and accurate picture of services across the state.
- Pages 36 & 37: The bed counts were extremely confusing. Page 36 states we have 183 crisis stabilization beds, but the following page says there are 112. Does the 183 number include that 112? Or is it 112 beds in addition to the 183? And are these adult beds only, or are we mixing youth beds into this count? Should the report mention that we're building a new teaching hospital that will have 150 beds for 90- to 180-day civil commitments?
- Page 42: The first bullet under A Place to Call should be revised to say, "Make clear that 988 is not *always* [or not usually] connected with law enforcement." Again, we should be careful about overpromising that the police will never be called to respond to someone who has contacted 988.
- Page 65: The financing chart on this page feels a little misleading. The third column related to "What It Pays For" does not specify exactly what crisis services each payer covers for their enrollees. Only the telecom fee section has that specificity. It gives the impression that Medicaid, Medicare, SAMHSA block grants, local funding, and commercial insurers all cover the same services for their respective enrollees, which we know is not the case.

## Issues that Need a Deeper Dive in 2023

**A Gaps Analysis and Comprehensive Assessment/Mapping of Services is Greatly Needed.**

It's essential that we have baseline data of what services we currently have in which regions of our state, as well as some understanding of what services are still needed based on population and incidence. It's very hard to make sense of the inventory cited in this progress report. At this point, it's unlikely that there's enough time to add the necessary context to make sense of these data. For example, 53 adult mobile crisis teams sound like a lot, but there's no information that allows us to understand if that's enough or if we need more. Similarly, the bed counts are almost meaningless as they are not broken down by region, and there is no discussion about how many more beds (and what types of beds) are needed to ensure that when someone contacts 988 they will always have "A Place to Go" (that's *not* an emergency department). If the goal is to build on what we have, then we need to be clear on what we have and what we need. This report simply does not satisfy the legislative

requirement in HB 1477 Section 103 (5)(a)–(d). This section of the bill was intended to be a foundational step for enhancing and building out our crisis response system, and it still has not been fully completed. I strongly suggest we determine, as soon as possible, what tangible next steps are needed to complete a true assessment and gaps analysis of our crisis system.

**The CRIS Committee Needs a Better Understanding of Current Training for Crisis Response Workers.** I recognize the importance of having certain statewide competency requirements and standardized trainings for individuals who are providing crisis response services. However, I'm concerned about recommendations that seem to suggest adding additional training requirements on top of what is already expected. Most community behavioral health agencies have robust training programs for their staff, and they need some flexibility to conduct these trainings specific to an agency's policies and procedures. There is a plethora of training requirements prescribed in WAC and statute, both for behavioral health agencies to ensure their staff complete, and also those required for providers to

maintain their individual clinical licensure. I strongly recommend that the CRIS Committee and Steering Committee get a better understanding of what training is already occurring, so we can ensure that we're not duplicating requirements or adding requirements that are unduly burdensome.

**The CRIS Committee Needs to Have a Policy Discussion about Geographic Information System (GIS) Mapping.**

There were several statements throughout this report related to community outreach, marketing, confidentiality, and GIS that gave me pause. And it made me realize that the CRIS Committee has not had any discussions about implementing GIS for 988. I recognize that this decision could potentially be decided for us by the federal government, but I also think it's important for the CRIS to discuss the implications. If we do choose to implement it, how we would ensure confidentiality of the caller whenever possible, and how would we market it within our communities? From a call center perspective, I know it's very challenging when calls are routed by area code, but the caller no longer lives in Washington State. We want to make sure individuals feel comfortable to contact 988 when they need help, and we also need the call centers to be able to offer local resources and assistance without delay. This is a balancing act that should be discussed sooner rather than later, before the 988 marketing campaign gets fully underway.

Thank you again for the opportunity to provide feedback on this year's progress report. Please feel free to reach out with any questions. I look forward to the work we have ahead!

### Kashi Aurora, CRIS member representing the Children and Youth Behavioral Health Work Group

1. I am concerned that the sharing of data re: current state does not fully help the reader interpret that data. For example, the report states there are 53 mobile crisis response teams – is that enough? Do those teams have capacity to meet the need? How many teams are needed? This report will be most useful if there is an interpretation of data available to the reader of the report.
2. There are places in the report where it's unclear who can access the services outlined in the current state. For example, the report mentions resources such as 182 crisis stabilization unit beds but doesn't make it clear which populations have access to those services (i.e. I believe none of those 182 beds are open to youth, unless I'm mistaken).
3. The visualizations of the data shared are very high level and rarely broken down by race/ethnicity and language of care or by age.
4. The data about youth seems to be out of date and I think especially the children's hospitals' data does not accurately capture the current level of crisis we're experiencing and witnessing. Using data from March of 2021 woefully underrepresents the level of need among our children and youth over the past 18 months.

Lastly, a process note – I truly appreciate the quantity of work it takes to produce a report like this and I wish we'd had more time to review between the CRIS meeting and when our comments were due. Thanks for all your work

## Kim Hendrickson, CRIS member representing an EMS department with a CARES program

Dear Steering Committee Members,

Thank you for the opportunity to comment on the 1477 Committee Progress Report. I'm writing to share some general feedback.

I was appointed to the CRIS as a representative of Fire CARES programs. What I try to do as a CRIS member is to offer the perspective of first responders and co-responders who specialize in behavioral health response, both in the fire and police service. I work in city government, so I also offer the perspective of a city employee working to address the behavioral health needs of our residents.

From a first responder, co-responder, and city perspective, this report does not address the service needs that I see or the crisis response that many people that I know experience. My work is largely in the area of emergency crisis response, which involves 911, police, fire/EMS, and emergency room admission. There is very little in this report about this kind of crisis response: how it works, when it is activated, meaningful data (or even anecdotal stories) about it, or the failures in our health care system that lead to its over-usage.

The absence of emergency crisis response in the report, I think, may be the result of wishful thinking. Many of us involved in the CRIS—including me—think that the emergency system is relied on too often to address behavioral health issues. There is an understandable temptation to focus on other approaches. It is clear to me, though, that while emergency responses to crisis can be reduced, they will always be needed, since many people in crisis are a danger to themselves or others, require immediate aid, or need medical attention. By ignoring the "emergency" part of the system we miss the opportunity to improve it—by identifying standards, discussing best practices, and insisting on higher levels of performance through training, financial support, and accountability measures. Ignoring this part of the system also reduces the chance we get more of what people in crisis desperately need: cross agency communication and collaboration so they don't fall through the cracks of our fragmented health care system.

A further thought on this topic. Emergency response need not be a grudging reality but, instead, an opportunity for us to excel. Washington state is a national leader in first responder-led behavioral health outreach programs. There are over 60 co-response programs in the state that are innovating with nurse practitioners, social workers, and geriatric outreach. These programs are engaged in crisis work, and also preventative/post-crisis services that reduce the need for emergency systems. There is nothing in this report about the excellent and creative work being done in this area, or the investments state legislators (like Sen Dhingra and Rep. Orwall) have made to support these programs. I find this silence unfortunate.

Thank you, again, for the opportunity to comment. I appreciate the difficulty of the task ahead of us and am pleased to be part of the process.

Kimberly Hendrickson
Housing, Health and Human Services Director, City of Poulsbo
Chair, Washington State Co-Responder Outreach Alliance (CROA)
(o) 360 394 9794

## Michelle McDaniel, CRIS member representing 988 Lifeline Crisis Call Center in Washington

**2023 Workplan Recommendations - Michelle McDaniel, CEO, Crisis Connections**

- **Add a System Efficiency section**: 1) Address / resolve redundancies and parallel systems issues that result from operating 988 and RCLs, 2) Determine process for rolling out 988/911 coordination programs between 988 contact centers and 911 providers, and 3) Finalize process map, determine and roll out SOPs for 988/911 coordination.

- **Add to System Infrastructure section:** Address workforce crisis through 1) increase in pay for front line and support staff, 2) research and implement benefits that would attract and retain workforce, and 3) implement programs/initiatives utilizing best practice that result in appropriate representation of BIPOC front-line staff and leadership.

- **Add Diversity, Equity & Inclusion specific section:** Fund technical support and resources for 988 call centers to further diversity, equity & inclusion efforts including: 1) funding DEI staff, training, consultation, and 2) investments to implement data systems (consultants, software, SME staffing) to evaluate baseline and track progress (internal HR data, program data).

## Representative Tina Orwall, CRIS and Steering Committee member representing Washington State House of Representatives

Dear 988 team,

I want to beginning with a huge thank you for the hard work done on the report. Clearly, your staff spend significant timed gathering data and conducting analysis. Below is some of my feedback on the report.

I deeply appreciate the detailed work including:

1. Training needs with an emphasis on cultural sensitivity/humility and cross system training (it aligns with my 988 bill that has a training component and I'd would like to add some of your language);
2. the vision work (love the table on page 13);
3. the emphasis on no wrong door (though not much mention on creating/expanded 23 hour centers as a missing resource in our system that would complement our other crisis alternative entities in our system);
4. Acknowledging tribal sovereignty in regards to services and funding.
5. We are all proud of the 988 Native and Strong Line. I do not see this as a pilot but I critical component of our 988 system with ongoing stable funding. In regards to rapid response teams, I do think we need to carve out funding for the tribes. Again, not as a pilot (language the report uses this term) but as an ongoing resource in our system.

Areas not covered: I did not see recommendations on how we may transport people during a crisis in more trauma informed ways (not in the back of a police car). It notes that our current crisis system does not have this ability.

Concerns:

1. Your report has a strong undercurrent on our state bypassing the Vibrant system (see sections below with comment)
    a. The report does not acknowledge the current descending vote on the IT report or the concerns raised
    b. The report does not note that Vibrant is seeking FCC approval to receive telecom information to route calls via location instead of by area code and their confidence of addressing this issue in 2023.
    *c.* It highlights the sensitivity that people are voicing concerns on calling 988 especially communities of color but in other sections speaks to embrace geo-location to identify the person. *(I want to propose we have a 988 subcommittee in 2023 to discuss this and bring back recommendations to the legislature in 2024 session—and it needs to include our 988 call centers, behavioral health leaders/clinicians, and persons with lived experience, and community leaders of communities of color).*
    d. Your report notes have a person answer the 988 call instead of a range of call options to route the caller to the best location. The clinical intervention begins the moment a human being answers the call. This recommendation (not sure where it came from—sounds like a 911 dispatch model) needs scrutiny by clinicians. We can add this to the work of the 988 subcommittee noted in c. above.

Also, extension of timelines is not noted in the report (but will be in the legislation). I do appreciate the phased report in regards to the IT components.

Thanks, Tina

**[Recommended] Category 2 (primary vendor and partner vendors):** Select a primary vendor (Vibrant UP or another commercial solution) who would meet most of the critical functional requirements and who would partner with other vendors to offer a solution that meets all of the requirements in HB 1477. This option includes exploring use of the NENA i3 solution architecture to support geo-location of callers. (*Note:* Because the Unified Platform has not yet been released, there is not yet enough information to recommend the Unified Platform as the primary vendor.) (Please note that the 988 call centers have requested that we consider adopting the Vibrant UP and that it is no cost to the state)

Many communities who have experienced trauma with law enforcement will not access the 988 Lifeline if they feel it is connected with 911. It is therefore critical to assure that these response systems are distinct and separate to build trust among these communities to access. The final Technical and Operational Plan highlights plans to further explore the underlying technology infrastructure used by 911 that would allow the routing of calls based on geo-location of callers (rather than by the caller phone number area code), as well as to deploy resources to a caller in situations where there is imminent risk to their life. Use of this underlying technology does not mean that 988 system would be connected to 911. (Vibrant not noted, geolocation of an individuals needs to include the clinical issues and ramification of adding this component)

***It will be critical for Washington's technology system to have capabilities to route callers to centers in their region, not all over the country based just on their area code which may no longer reflect where they reside.*** Callers to the 988 Lifeline are currently routed to a 988 Lifeline crisis center based on their area code. This means that Washington residents without a Washington area code will be routed to a 988 Lifeline crisis center outside of Washington; similarly, callers with Washington area codes who reside outside of the state will be routed to a Washington crisis center. HCA and DOH recognize geo-location as a key functionality for the Washington's crisis response technology system, both for routing calls to a local center closest to the caller, as well as enabling timely dispatching of services if needed based on the caller's location. (can you add Vibrant's work with FCC to address this issue)

*Tina L. Orwall*

Representative Tina L. Orwall, M.S.W.
33rd legislative district
tina.orwall@leg.wa.gov

## Ron Harding, CRIS member representing Law Enforcement

**Response to CRIS committee draft report**

Every CRIS committee meeting I have attended has had one common theme expressed during the breakout sessions: First Responders are part of the states crisis response system and they need to remain part of it.

This sentiment was expressed last night as well. People who work in crisis response understand that Law Enforcement and Fire responders have a vital role in crisis response and their role in the system can not and should not be eliminated. The idea that a system (988) can be created where no first responders will need to be involved is misguided and utopian. There will always be an unpredictable dynamic to crisis response which means there will always be a level of risk to those responding to people in crisis. This reality has to be recognized and accepted as part of this work. Law Enforcement has the training and experience to work in a dangerous environment where social workers and peers do not. We should be focused on ways to partner these workers, not ways to exclude Law Enforcement based on ignorance and bias.

In keeping with another theme expressed last night, it is time to start having this conversation directly, and stop having it by inference. The role of first responders, especially law enforcement, needs to be accepted and defined if the 988 system is going to be successful. There were several comments in the draft that reflect a premise that Law Enforcement can be excluded from response to 988. I acknowledge this will most likely be the case for the vast majority of 988 calls. However, when people are in a crisis event, there will be no responsible way to exclude law enforcement response. In order to assure the safety of the workers (especially field response teams) in this system it will not be possible to exclude law enforcement. Effort must be made, for transparency, to acknowledge this reality and work on education and training to help people understand what law enforcement's role will be.

There are real fears and concerns expressed by groups who will be using 988 and these concerns must be addressed. However, they need to be addressed with a goal of acknowledging law enforcement is part of crisis response. There have been huge strides taken to better equip law enforcement for this work. And, law enforcement has been on the front line, doing this work, for decades. The focus should be on partnerships. Presenting any notion that Law Enforcement will not be part of 988 is a mistake. It is the wrong approach.

A few comments in the draft (see below) acknowledge the tension listed above, but seem to indicate the answer to alleviate this fear is to exclude law enforcement response. Because there is no responsible way to actually do this, I think the committee will need to shift to an education and marketing approach that embraces law enforcement's role. It is true that law enforcement will not be the primary service providers in the 988 system, but we will be part of it.

Ron Harding

> *Determine who will have the final authority in a crisis situation and if/when law enforcement is involved and ensure transparent communication about these protocols. Pg. 22*
> ***Building trust in 988 with diverse communities will be critical to success and expanded use of the line. There is still a lot of uncertainty around 988**. Many populations fear police involvement*

*and are unclear about confidentiality and their safety. There needs to be education and transparency around 988, and what callers can expect. Key components of this include*: *Make clear that 988 is not connected with law enforcement. Pg. 42*

*It is important to recognize that law enforcement involvement in crisis response raises equity issues for communities that are traumatized by police force. Law enforcement should not be the first response, and they should only be involved in a response if needed*. Pg. 43

***It is critical to ensure that the 988 Lifeline and Washington's crisis response system is separate and distinct from 911 and a law enforcement response, particularly for building trust and ensuring access to the system for BIPOC and other marginalized groups who have experienced trauma associated with law enforcement.*** *Many communities who have experienced trauma with law enforcement will not access the 988 Lifeline if they feel it is connected with 911. It is therefore critical to assure that these response systems are distinct and separate to build trust among these communities to access*. Pg. 59-60