Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services in Washington and Preliminary Funding Recommendations

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, 2021

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Legislative Requirement

House Bill 1477, enacted July 25, 2021 during 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 of the CRIS to make recommendations related to the funding and delivery of crisis response services, among other items. Preliminary recommendations from the CRIS Steering Committee are due January 1, 2022. Final recommendations are due January 1, 2023. The following items are due to the Governor and Legislature by January 1, 2022 related to the comprehensive assessment, as per Section 103, subsection 5:

1. *Develop an inventory of existing statewide and regional behavioral health crisis response, suicide prevention, and crisis stabilization services and resources, taking into account capital projects which are planned and funded.*
2. *Identify statewide and regional insufficiencies and gaps in behavioral health crisis response and suicide prevention services and resources needed to meet population needs.*
3. *Identify quantifiable goals for the provision of statewide and regional behavioral health crisis services and targeted deployment of resources, considering factors such as reported rates of detentions, single-bed certifications, suicide attempts and deaths, overdoses, and incarcerations due to behavioral health.*
4. *Identify a process for establishing outcome measures, benchmarks, and improvement targets for the crisis response system.*
5. *Identify potential funding sources for statewide and regional behavioral health crisis services and resources.*

Additionally, the CRIS Steering Committee is tasked with offering preliminary recommendations related to the use of funds from the statewide 988 behavioral health crisis response and suicide prevention line account (the 988 Account) established in Section 205 of the Act. In developing these preliminary recommendations, the CRIS Steering Committee is tasked with the following, as per Section 104:

6. *Analyze projected expenditures from the 988 Account established in the Act, accounting for call volume, utilization projections, and other operational impacts.*
7. *Analyze the costs of providing statewide coverage of mobile rapid response crisis teams or other behavioral health first responder services recommended by CRIS Committee, based on 988 crisis hotline utilization and taking into account existing state and local funding.*
8. *Analyze potential options to reduce the line tax, based on the expected level of costs.*
9. *Analyze the viability of funding for in-person mobile rapid response crisis services from the 988 Account.*
10. *If funds from the 988 Account are available, analyze options for the location and composition of crisis response services that would supplement, and not supplant, existing behavioral health crisis funding.*

HB 1477 charges the CRIS with additional duties that will be performed during Calendar Year 2022 in preparation for the report that will be delivered by January 1, 2023. These duties are enumerated in Appendix A. This report fulfills the requirements of HB 1477 due to the Governor and the legislature by January 1, 2022. The initial assessment is detailed in Section IV of the report. The analysis of forecasted expenditures and preliminary recommendations for use of funds from the 988 Account are detailed in Section V of the report.

Executive Summary

Introduction

The report serves as an initial assessment and preliminary recommendations of the crisis delivery system in Washington as required in House Bill 1477 enacted July 25, 2021. A variety of stakeholders have provided thoughtful feedback on what they envision could be the future of this delivery system that centers on the individuals being served. Of particular note is feedback provided that any redesigned system needs to be trauma-informed; that is, the delivery of services to those in crisis or at risk of crisis needs to be provided in a manner that does not re-traumatize the individual. Obtaining more feedback from individuals and families that have lived experience with crisis is just one way to inform the Steering Committee on ways to build a trauma informed response to crisis.

It is the aspiration of the Steering Committee of the Crisis Response Improvement Strategy Committee (the CRIS) to build a system that is considered a national standard. To achieve this, much work lies ahead in the next two to five years.

Through HB 1477, the Steering Committee is charged with setting the priorities for each subcommittee listed in the legislation and delivering reports to the Governor and the Legislature on progress being made. The first report is the one enclosed here and is due on January 1, 2022. Final recommendations of the Steering Committee are required in a report due January 1, 2023. A final report on the activities of the Steering Committee, the CRIS, and its subcommittees is due January 1, 2024.

Although feedback was garnered from a variety of stakeholders during the period of August to December 2021, additional feedback is still needed. Further, the data sources that will be used to refine budgetary estimates for the costs of the 988 crisis lines that will begin in July 2022 as well as service costs—both acute and preventative in nature—for the delivery of crisis services were not all available to deliver a complete cost estimate for this report. Consequently, elements of this report will be refined throughout Calendar Year 2022 as more information becomes available. It is the intent to of the Steering Committee to deliver more complete information as it becomes available but prior to our next report due January 1, 2023.

Background on Washington's Crisis Delivery System

The current patchwork system for the delivery of crisis services—and gaps and inconsistencies that result from it—should be no surprise to those who have been engaged in health and social services in the state in recent years. The system has been built from the best of intentions but is often dictated by the various sources of funding—federal, state, local, and private—rather than from a statewide population-based lens. There has also not been a comprehensive assessment of the actual needs of Washington's community members with respect to crisis services and prevention services that may assist in avoiding crises or that help to prevent crises from re-occurring.

In looking forward to the redesign process, it is important to understand how the current patchwork of the funding, management, and delivery of crisis services came to be. A background of Washington's crisis delivery system is explained in Section I of the report. In summary, the system has moved from a system primarily managed by county-based Regional Support Networks (RSNs) up until 2016 to the creation of Behavioral Health Organizations that served ten regions of the state. In effect, the county-

based system was rolled up to the regional level. Individual counties, however, were key contributors to the funding of crisis services (and other behavioral health services) after the Legislature passed Senate Bill 5763 in 2005 that gave local governments the authority to levy a 1/10th of 1 percent sales tax to raise funds for behavioral health services. Although many counties have done this, it means that the array of services available to community members of the state varies by region based on the level of funding available. Funding gaps often mean that acute services take priority over preventative services.

The expansion of Apple Health (Medicaid) changed some of this since more than 800,000 Washingtonians gained coverage through Medicaid and the federal government contributed more towards crisis services.

The state's Health Care Authority took additional steps to promote access to behavioral health for those enrolled in Apple Health by changing the way it contracted for behavioral health through "fully integrated managed care" which began in 2016. The HCA began contracting with the Medicaid Managed Care Organizations (MCOs) in each region to provide behavioral health services. With the implementation of fully integrated managed care, many of the BHOs transformed to serve as Behavioral Health Administrative Services Organizations (BH-ASOs). The MCOs are required to contract with the BH-ASOs.

Crisis lines underpin the crisis delivery system, and are often the front door to services. In 2017, Washington State began investing funding into the National Suicide Prevention Lifeline (NSPL, or Lifeline), which established limited availability of access to nationally accredited in-state crisis call center services for Washingtonians. The Lifeline, which will be the backbone of the 988 system, ensures that callers in Washington State have immediate access to a crisis call counselor with training and support through Lifeline that is informed by national suicide prevention experts, consumer advocates, NSPL Steering Committee leadership, and Lifeline's Standards, Training and Practices Committee. Since 2016, in-state utilization of NSPL services has increased by 91 percent. Starting in April of 2021, three member centers provide service coverage for the state of Washington.

Presently, there are numerous entities involved in the delivery of crisis services in Washington: payers (Medicaid, Medicare, commercial health plans, local governments, federal government grants), management entities (Medicaid MCOs, BH-ASOs, commercial health plans), service delivery providers, and crisis lines (including the National Suicide Prevention Lines, or Lifelines, and local BH-ASO crisis lines). Navigating the coordination and collaboration of these entities—in addition to 911 and law enforcement and emergency responders—will require careful thought given the various parties that interact with Washington's community members throughout the crisis delivery continuum.

A Path Forward

In March 2021, the National Council for Mental Wellbeing (the Council) published a comprehensive report titled "*Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response*". In the report, the Council outlines a framework for an ideal crisis system and offers considerations for its design and implementation. The Steering Committee is utilizing the Council's framework as well as the Vibrant national guidelines and best practices for crisis system service delivery (Vibrant Emotional Health is the administrator of the National Suicide Prevention Lifeline) as a jumping off point for the Steering Committee to consider as it advises and recommends approaches for a crisis delivery solution that is specific to the needs of Washington. More details on this Roadmap are discussed in Section II of the report.

The assessment has uncovered eight significant themes that will be used to inform the work of the CRIS subcommittees beginning in early 2022. The themes are discussed in detail in Section IV of the report but are shown below with the mapping to the strategic areas outlined in the National Council's Roadmap for an ideal crisis delivery system.

**Mapping of Themes in this Comprehensive Assessment to the Strategic Areas of Focus
in the National Council's Ideal Crisis System**

Accountability and Finance	Crisis Continuum Capacities and Services	Practice Guidelines (Clinical & Operational)
THEME #1 Responsibility and Accountability for Crisis Services	**THEME #4** Availability of Services Across the Crisis Continuum	**THEME #7** Person, Family and Community-Centered Approaches to Delivery of Crisis Services
THEME #2 Financing of Crisis Services	**THEME #5** Crisis Services Workforce	**THEME #8** Collaboration in the Delivery of Crisis Services
THEME #3 Outcomes from the Delivery of Crisis Services	**THEME #6** Use of Technology in Delivering Crisis Services	

The team at the Behavioral Health Institute at Harborview Medical Center and Health Management Associates (collectively, BHI-HMA) are serving as technical assistants to the CRIS Steering Committee. The BHI-HMA assisted in the development of the assessment of the current system contained in this report using the framework outlined by the National Council. The assessment was conducted in earnest during the months of September, October, and November 2021. Given this condensed timeline, the Steering Committee recognizes that this initial assessment is the beginning of our process to ground us

in the work ahead. A more thorough assessment—along with the activities conducted in Calendar Year 2022 that will be deeply informed by CRIS and subcommittee members, as well as through community input, to design a more robust delivery system—will be delivered by January 1, 2023.

Thus far, the assessment has included conducting one-on-one interviews with a number of key stakeholders (representatives within state government, each BH-ASO, each Medicaid MCO, each member of the CRIS Committee), requests for written feedback through online surveys of the BH-ASOs and crisis service providers, five community forums occurring via webinar in October and November 2021, analysis of metrics required by the Health Care Authority from BH-ASOs on a quarterly basis, and a review of the literature of national best practices. More information on this process is discussed in Section III of the report.

Each theme is introduced in Section IV using a one-page snapshot. On this page, sub-themes that were developed are also mentioned. "Key Takeaways" from the National Council's Roadmap have been matched to each of our eight themes. Stakeholder feedback related to each theme is also summarized. The planned activities of work by the CRIS and its subcommittees related to each is also mentioned on this page. However, it should be recognized that the work of the subcommittees will evolve over time, so the items listed on these one-page summaries is not considered an exhaustive list.

There is recognition that components remain that need further exploration before delivering a fully-vetted assessment. Specific activities scheduled for early 2022 include interviews with the three Washington National Suicide Prevention Lifeline (988) call centers, with Vibrant Emotional Health, with commercial insurers in Washington, with 911 and emergency responders, and with individuals with in-depth knowledge of the delivery of crisis services to children and adolescents, LGBTQ+, and BIPOC communities. It will be important to continue coordination efforts with the American Indian Health Commission for Washington on their activities related to the launch of the Washington Indian Behavioral Health Hub. Importantly, it is anticipated that there will be a deep-dive into historical utilization and expenditure patterns of crisis services and other behavioral health services, including preventative services, once data is made available. The baseline data will be used to refine budgetary estimates—including state taxpayer share—for the delivery of crisis prevention, acute crisis, and post-stabilization services. Baseline data will also be used to inform the critical work that begins in 2022 to design a more robust crisis delivery system.

Activities for 2022

The Steering Committee has identified tasks for each of the five subcommittees required as per HB 1477. The Steering Committee has also created five additional subcommittees using its authorization to do so as per HB 1477. The composition of the committee structure for work to be completed in 2022 and into 2023 is shown below.

CRIS Committee and Subcommittee Structure

CRIS STEERING COMMITTEE

CRIS COMMITTEE

SUBCOMMITTEES

Tribal 988 seated by the American Indian Health Commission of Washington	Credentialing and Training 19 members seated	Technology 20 members seated	Cross-system Crisis Response Collaboration 33 members seated	Confidential Information Compliance 13 members seated
Rural and Agriculture 19 members seated	Lived Experience open seating	Quality & Oversight Seats TBD	Regional Crisis Response Seats TBD	Service Delivery Costs Seats TBD

established in HB 1477	chosen by the Steering Committee

Responsibilities have been given to the CRIS and each subcommittee that align with the required deliverables outlined in HB 1477 as summarized below. More details on these responsibilities are listed in Section VI of this report.

1. **Washington Tribal 988**: Examine and make recommendations with respect to the needs of tribes related to the 988 system in alignment with American Indian Health Commission.

2. **Credentialing and Training**: Recommend workforce needs and requirements necessary to implement this act, including minimum education requirements.

3. **Technology**: Examine issues and requirements related to the technology needed to implement this act.

4. **Cross-system Crisis Response Collaboration**: Examine and define the complementary roles and interactions between mobile rapid response crisis teams, designated crisis responders, law enforcement, emergency medical services teams, 911 operators, 988 crisis line operators, public and private health plans, behavioral health crisis response agencies, nonbehavioral health crisis response agencies, and others needed to implement this act.

5. **Confidential Information Compliance and Coordination**: Examine issues related to sharing and protection of health information needed to implement this act.

6. **Rural and Agricultural Communities**: Examine the unique needs of rural and agricultural communities and inform recommendations outlined by HB 1477.

7. **Lived Experience**: Engage the perspectives of individuals and family members with lived experience related to recommendations outlined by HB 1477.

8. **Quality and Oversight**: Recommend options constituting a statewide crisis response and suicide prevention oversight board an oversight board. Identify quality measures to assist in developing dashboard reports for ongoing oversight.

9. **Regional Crisis Response**: Identify capacity and need at the regional level for the delivery of a full continuum of services to deliver to those in crisis and preventative services to those at risk of crisis. Utilize representatives from cities and counties to offer recommendations for localized solutions in conjunction with the Cross-system Crisis Response Collaboration Subcommittee.

10. **Service Delivery Costs**: Provide recommendations for the costs to deliver each discrete service in the crisis delivery system. Offer recommendations for the method of payment to providers for each service.

HB 1477 requires that the Steering Committee deliver preliminary estimates on the use of funds collected through the line tax that was also authorized in HB 1477. At this time, 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 call volume and cost estimates of the projected revenue of $239 million from the line tax will cover the costs of the 988 crisis lines in years four and five. Accordingly, additional data will be required after the implementation of the 988 lines in July 2022 to refine the estimate. 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 crisis teams until after the DOH has provided a more refined estimate for the costs of the 988 crisis call centers. Further, the Steering Committee is not prepared to make any recommendations to reduce the line tax at this time.

The methodology that is being used by the DOH to determine the costs of the 988 crisis lines appears in Section V of the report. Also in this section, the Steering Committee outlines a model that is being built to estimate the costs for the delivery of crisis services to include current service offerings for acute crisis services as well as services that are preventative in nature to reduce crisis events. Suffice to say, the current five-year estimate on crisis and other behavioral health services is a wide estimate at this time since the baseline data was not yet available to produce a more reliable estimate. Low, medium, and high estimates are offered. The Year 1 middle-range estimate (beginning July 1, 2022) is total funds of $704 million. By Year 5, this grows to $824 million, but it assumes substitution of expenditures for more expensive services to less-expensive services that are preventative in nature. Also note that these expenditure estimates are to pay for actual services, including prevention services, and do not include the costs of technology infrastructure improvements. Work will continue to determine what percentage of this $704 million cost estimate in Year 1 of the model is already being paid for by the federal government (through Medicaid and Medicare), through private insurers, or through local initiatives using the 1/10th of 1 percent tax. There may be additional opportunities for Washington to leverage additional federal funds starting in 2022. The Centers for Medicare and Medicaid (CMS) released guidance in late December that offers states the opportunity to apply for enhanced federal matching dollars for mobile crisis services delivered to Medicaid beneficiaries. All of this information will be factored into a refined cost estimate that will be available in mid-2022.

SECTION I: Background on Crisis Services in Washington

Washington's "Patchwork" Crisis System

The passage of HB 1477 is a long overdue recognition by Washington state lawmakers that the current "patchwork" of crisis services being delivered across Washington is an inadequate response to the behavioral health challenges Washington residents experience across the state. HB 1477 is an important vehicle to develop a comprehensive and cohesive response to designing a system that establishes a rationale for funding decisions and oversight, prioritizes interventions that are community-based rather than institutional in nature, (e.g., involuntary hospitalization and incarceration) and most importantly, is person-centered and designed within an equity lens, and is ultimately driven by improved client outcomes.

The current patchwork system—and gaps and inconsistencies that result from it—should be no surprise to those who have been engaged in health and social services in the state in recent years. The system has been built from the best of intentions but often dictated by the various sources of funding—federal, state, local, and private (e.g., health plan premiums to insurers)—rather than from a statewide population-based lens. There has also not been a comprehensive assessment of the actual needs of Washington's community members with respect to crisis services and those related services that may assist in avoiding crises or that help to prevent crises from re-occurring.

In looking forward to the redesign process, it is important to understand how the current patchwork of the funding, management, and delivery of crisis services came to be. With respect to the management of crisis services, prior to 2016, publicly-funded behavioral health services for individuals with serious mental illness (including crisis services) were overseen and managed by Regional Support Networks (RSNs, or county-run behavioral health agencies).[1] Some people were eligible for Medicaid-funded services while others were eligible for locally-funded or grant-funded services, but most were overseen and delivered by the RSNs. Crisis services (an extension of sorts to behavioral health) were available to all those who needed it (not just those eligible for Apple Health). But resources for these services was limited, largely due to a lack of sufficient funding.

In 2015, the legislature authorized the State's Department of Social and Health Services (DSHS) to create Behavioral Health Organizations (BHOs) to purchase and administer publicly-funded mental health and substance use treatment services. The BHOs replaced the RSNs in April 2016, effectively rolling up the management of these services into 10 regional service areas (RSAs) instead of 39 counties. The intent was to more effectively manage the public funds paid in these programs and to expand provider networks for individuals within each region.

The state's Health Care Authority (the HCA, the successor to the DSHS) took additional steps to promote access to behavioral health for those enrolled in Apple Health (another term for the Medicaid program) by changing the way it contracted for behavioral health through "fully integrated managed care" which began in 2016. The HCA began contracting with the Medicaid Managed Care Organizations (MCOs) in each region to provide behavioral health services. Prior to this, the HCA had contracted with the BHOs

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[1] Washington State Department of Social and Health Services, *Overview: Integrating Washington State's Behavioral Health System* (2016) available at:
https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/BHO/BHO_Overview.pdf

for these services. With the implementation of fully integrated managed care, many of the BHOs transformed to serve as Behavioral Health Administrative Services Organizations (BH-ASOs). The MCOs are required to contract with the BH-ASOs.

There are 10 BH-ASOs in the state, one for each defined region. The regions themselves are defined along county boundary lines as seen in Exhibit I.1 below.

Exhibit I.1
Map of Current Regional Service Areas (RSAs) that Define Each BH-ASO Catchment Area

In addition to the National Suicide Prevention Lifeline, there are other state crisis support lines, national lines (e.g., for veterans), and other key service providers, such as hospitals, 911 services, behavioral health providers, and resource centers that respond to crisis calls. Additionally, the BH-ASOs oversee other important crisis services in the state. Some components are now managed by the Medicaid MCOs or by the commercial health plans. The BH-ASOs contract with each MCO for services rendered to Apple Health members, and with the HCA for services to the uninsured, and with commercial health plans. Medicaid funds, other federal grant funds, and commercial health plan contract funds to the BH-ASOs are often supplemented with locally-raised funds. Variances in the sources and amounts from each source within a BH-ASO's regions can lead to significant variation in the array of services offered within a region and who may receive them. Oversight of the crisis system is also distributed across the HCA, the MCOs, the BH-ASOs, the DOH, Tribal Governments, and commercial health plans.

With respect to funding, in 2005, state lawmakers recognized that funding for crisis services (and behavioral health services more generally) was lacking. The legislature passed Senate Bill 5763 which gave local governments the authority to levy a 1/10th of 1 percent (0.1%) sales tax to raise funds to

support behavioral health in their communities. As of November 2021, 25 of 39 counties have passed local legislation authorizing the use of this sales tax. These local revenues have resulted in an array of locally-funded innovative interventions that help support the behavioral health needs of specific local communities.

Beginning in 2014, the implementation of the Affordable Care Act brought another significant change to the state. More than 800,000 Washingtonians gained health coverage as a result of the ACA's coverage expansions. Additional federal matching dollars to the state share of Medicaid funds provided additional access to behavioral health services to many for the first time.[2]

In 2017, Washington State began investing funding into the National Suicide Prevention Lifeline (NSPL, or Lifeline), which established limited availability of access to nationally accredited in-state crisis call center services for Washingtonians. Launched in 2005 and funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), the NSPL is a national network providing free and confidential emotional support and suicide prevention services, guided by best practices in crisis response care. The Lifeline ensures that callers in Washington State have immediate access to a crisis call counselor with training and support through Lifeline that is informed by national suicide prevention experts, consumer advocates, NSPL Steering Committee leadership, and Lifeline's Standards, Training and Practices Committee. Since 2016, in-state utilization of NSPL services has increased by 91 percent. Starting in April of 2021, three member centers provide service coverage for the state of Washington.

Exhibit I.2
Service Areas for the Three NSPL Member Centers in Washington
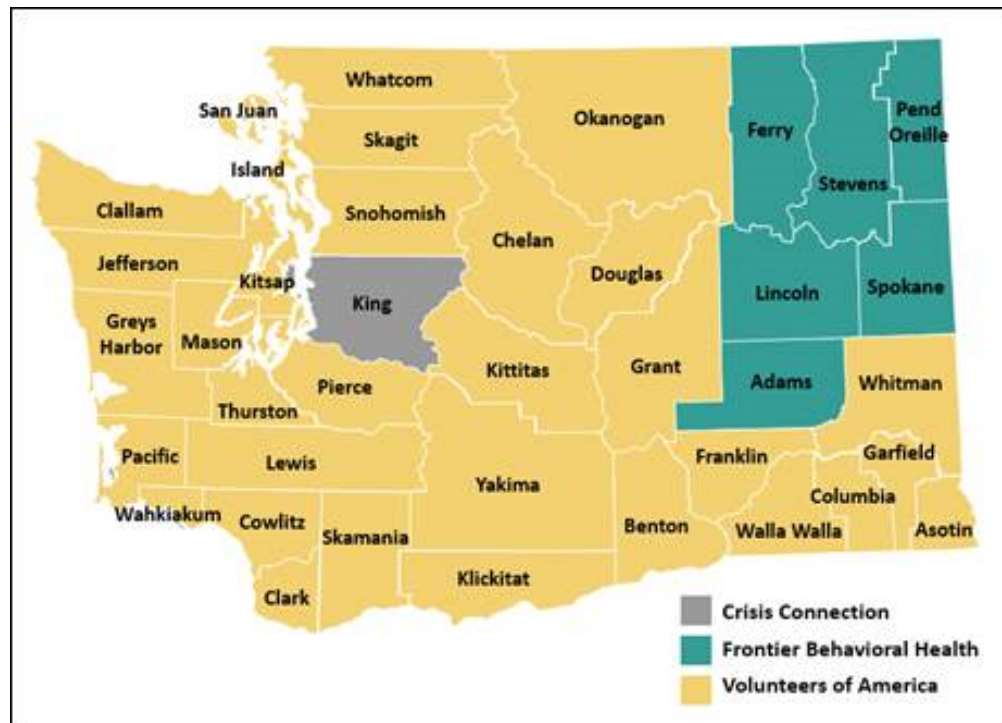
Despite these multiple initiatives to enhance revenue sources to fund crisis services, the need outweighs the current resources because the need is significant and growing. According to the Centers for Disease Control, nearly 6,000 Washington residents (adults and children) died by suicide over the last five years. Suicide is now the single leading cause of death for Washington residents ages 10 through 24. Data also indicate that suicide impacts some communities more than others, including veterans, American Indians/Alaska Natives, LGBTQ youth, and people living in rural counties across the state. More than one in five Washington residents are currently living with a behavioral health disorder. The COVID-19 pandemic has increased stressors and substance use among Washington residents.[3]

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[3] Statistics in this paragraph from the opening section of Washington State 67th Legislature, House Bill 1477 (2021). Accessed at https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1477-S2.SL.pdf?q=20211216183343

Delivery of Crisis Services in Washington

Numerous entities are involved in the delivery of crisis services. This will require careful thought in future coordination efforts given the various parties that interact with Washington's community members throughout the crisis delivery continuum. Exhibit I.3 below divides these entities between those that are receiving crisis calls, those that manage the services provided to those in crisis, and those that deliver the actual services.

The top of the exhibit shows that crisis calls come into 911, the National Suicide Prevention Lifeline (which will be transferred to Washington's 988 call centers in July 2022), to BH-ASO crisis lines set up in 10 regions of the state, and other local lines that social service agencies may have set up on their own.

Management of crisis services often is based on who is paying for the services. In the private sector, commercial health plans will manage—to some degree—the services delivered to their policyholders. The Health Care Authority within state government manages contracts to both the Medicaid MCOs and the BH-ASOs. The MCOs and BH-ASOs, in turn, manage contracts with individual providers. These entities will also manage the services delivered to individual Medicaid beneficiaries. The BH-ASOs also manage funds received to deliver services to the uninsured. Many services in the state, however, are not managed by anyone, particularly if the client is uninsured or underinsured.

Services are rendered by a wide variety of providers as seen in the lower section of the exhibit. The definition for each type of provider appears in **Appendix B**.

Exhibit I.3
Current Delivery System for Crisis Services in Washington

Crisis Calls	911	National Suicide Prevention Lifeline	BH-ASO Crisis Lines	Other Social Service Lines

		Health Care Authority		
Management of Crisis Services	Commercial Health Plans	Medicaid MCOs	BH-ASOs	Fee-for-Service (15% of Medicaid)

Service Delivery of Crisis Services	Police and EMS Responders	Mobile Crisis Teams	Designated Crisis Responders	Evaluation & Treatment Facilities
	Hospital Emergency Departments	Secure Detox Facilities	Crisis Stabilization Units	Residential Treatment Facilities
	Hospital Inpatient Units	Community Mental Health Centers	Community Based Practitioners (mental health, substance use disorder, and primary acute care)	

In 2019, 57,635 calls from Washington were made to NSPL, of which 34,613 calls were connected to a member center in Washington state. In 2020, 60,738 calls were made from Washington and 34,941 were answered by a Washington-based member center.[4] Among the 2020 calls, 21 percent of callers pressed "1" to be transferred to the Veterans Crisis Line and one percent of callers pressed "2" for the Spanish Language Line. Routing to crisis lines from the national hotline to each state is currently based off of zip code, but this will transition to routing via geolocation in the future. All calls to NSPL-accredited centers must be answered within 30 seconds by a credentialed crisis call center counselor, who will immediately take the call and address the caller's concerns. NSPL member centers follow best practice guidelines informed by a wide body of research and prevention science specific to the management of crisis call response and follow-up services and protocols.

Calls reported by the BH-ASOs to their crisis lines during Calendar Year (CY) 2020 were 367,765. Based on the data available to date in CY 2021, the total annualized calls to these lines will be 388,099, an increase of 5.5 percent from CY 2020.[5] The calls by BH-ASO region vary significantly. In CY 2020, the range was from a low of 2,571 calls per 100,000 residents during the year to a high of 13,059 per 100,000 residents. It does not account for the fact that some individuals may have made multiple calls during the year. It does not imply that every call made to the BH-ASO is related to a crisis.

The three Lifeline providers in Washington (Crisis Connections, Volunteers of America, and Frontier Behavioral Health) also serve as the call centers for the BH-ASOs in seven of the ten regions. Three other entities staff the BH-ASO call centers in the remaining three regions (Columbia Wellness in the Great Rivers Region), Protocall Services in the Greater Columbia Region, and Olympic Heath and Recovery Services in the Thurston-Mason Region).

From the most recent data available, there were just over five million calls to 911 by Washington residents in 2020. This is actually lower than the near six million calls in recent years, potentially due to the pandemic. There are no specific data sources to pinpoint the percentage of 911 calls that are related to mental health or substance use disorder, but 911 directors in the state contemplate that the estimate could be as high as 50 percent of call 911 calls.

Once a call is received by the BH-ASO, the rate of calls that result in a mobile team crisis outreach also varies significantly by region. In CY 2020, there were a total of 54,809 mobile teams dispatched by the BH-ASOs. This was 16.0 percent of all calls to BH-ASO crisis lines statewide. The volume of mobile team dispatch is expected to be flat for all of CY 2021 even though the volume of calls is increasing. The rate of mobile teams dispatched as a percent of all calls to BH-ASOs varied from a low of 4.5 percent (King County) to a high of 35.8% of calls (Great Rivers). The BH-ASOs reported contracting with 41 mobile crisis teams across the state. There are likely other mobile teams in the state as well (e.g., embedded with law enforcement), but the final count is not yet available.

The use of Designated Crisis Responders (DCRs) also varies by region. (DCRs are mental health professionals appointed by the county or the BH-ASO who are authorized to conduct investigations and detain persons for up to 120 hours or pending a hearing.) On a statewide basis, the BH-ASOs reported a total of 29,046 DCRs dispatched in CY 2020. This represents 8.5 percent of all answered calls to the BH-

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[4] 2019 Vibrant report: https://suicidepreventionlifeline.org/wp-content/uploads/2020/10/Washington-State-Report-V2.pdf 2020 Vibrant report: PowerPoint Presentation (suicidepreventionlifeline.org)
[5] Data on this page of the report is as reported to the HCA by each BH-ASO on a Crisis System Quarterly Report.

ASO crisis lines during this period. For CY 2021, the forecast is a steady rate of DCR dispatch (8.4% of all answered calls). The rate of DCR dispatches in CY 2020 varied from a low of 4.3 percent of answered calls in the Greater Columbia Region to a high of 19.4 percent of answered calls in the North Central Region.

The use of crisis stabilization units varies by region because some regions do not have any CSUs. More information on each BH-ASO and their results against statewide averages appears in dashboard reports in **Appendix C**.

Financing of Crisis Services in Washington

Multiple sources fund crisis services in the state as seen in Exhibit I.4 on the next page. Currently, the services that a person may receive or be eligible for may depend upon the payer that the person is enrolled with (if any). For example, the Medicaid program has the most comprehensive array of services covered under the crisis services umbrella. Although this does not imply that every Medicaid beneficiary is receiving the crisis support services that they need, they have the potential to do so because of Medicaid's broad benefit package compared to other payers.

Experts in Washington are currently participating in a national learning collaborative (called the Crisis Jam) to learn from other states how they have or are planning to maximize federal reimbursement for services through the Medicaid program. This work is ongoing to determine if there are opportunities for more federal matching funds in Washington.

The Medicare program covers some, but not all, crisis services. Therefore, in addition to challenges to the available provider base to deliver services that the Medicaid program faces, Medicare beneficiaries do not even have all crisis delivery services covered by the Medicare program. In this example, Medicare beneficiaries are considered "underinsured" for the purposes of crisis services.

A similar situation is true for commercial health plans and self-funded plans. Private insurers have discretion on which crisis services are covered in their health insurance products, and most do not cover the full array of services in the same manner as, for example, the Medicaid program. Therefore, many privately-insured policyholders are also considered "underinsured" for the purposes of crisis services.

Funding from the federal government's Substance Abuse and Mental Health Administration (SAMHSA) is available to pay for services to the uninsured or underinsured, but this funding is very limited when compared to the current need. There are new funding initiatives becoming available to states, however, most notably for mobile crisis teams.

Exhibit I.4
Financing for Crisis Services in Washington

Source	Who Covers the Payment	What 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	New 988 Crisis Hubs
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
Local Government Funding	Local Governments	Services to local residents, including new immigrants and undocumented
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

SECTION II: A Model for the Way Forward

In March 2021, the National Council for Mental Wellbeing (the Council) published a comprehensive report authored by its Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry titled "Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response".[6] In the report, the Council outlines a framework for an ideal crisis system and offers considerations for its design and implementation. The Steering Committee is utilizing the Council's framework as a jumping off point for the CRIS Committee to consider as it advises and recommends approaches for a crisis delivery solution that is specific to the needs of Washington State.

Outline of the National Council's Framework for an Ideal Crisis System

The Council's framework is comprised of three key strategic areas with numerous operational areas underneath each strategic area. The three strategic areas are shown in Exhibit II.1 below.

Exhibit II.1
Strategic Areas of Focus in the National Council's Ideal Crisis System

Accountability and Finance	Crisis Continuum Capacities and Services	Practice Guidelines (Clinical & Operational)

Community Support

The three strategic areas are Accountability and Finance, Crisis Continuum Capacities and Services, and Practice Guidelines (both Clinical and Operational). Threaded throughout the strategy development for each is an expectation of gaining community support for the design of the ideal crisis system. The Steering Committee is mindful of this as it has solicited participants for the CRIS Subcommittees and recommended areas for each subcommittee to review. More is discussed on this in Section VI of this report.

In the Council's Roadmap, each of these strategic areas of focus have numerous operational components to consider. The Council offers "Key Takeaways" related to each strategic area. In essence, these takeaways are concepts that can help inform the Vision Document that the Steering Committee is developing over the coming year with the advisement of the CRIS Committee.

The Steering Committee recommends addressing each of the operational components suggested in the Council's Roadmap to consider the key takeaways identified for each strategic area. This information is shown on pages 17 through 21 and summarized in the pages below.

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[6] Group For The Advancement Of Psychiatry, *Roadmap To The Ideal Crisis System* (2021) Available here: https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56

Accountability and Finance

The Council identified ten operational areas for consideration in the Accountability and Finance strategic area.

Exhibit II.2
Operational Considerations Under the Accountability and Finance Strategic Area

Accountability and Finance

Financing	Comprehensive Client Tracking Data System	Geographic Access and Network Adequacy

Standardized Utilization Management and Level of Care Determination	Relationship of Crisis System to the Rest of the System

Eligibility (All Payer)	Quality Metrics	Performance Incentives

Flow and Throughput of Information	Formal Assessment of Customer Satisfaction

Key Takeaways from the Accountability and Finance Strategic Area for the CRIS to consider:

- There is an entity accountable for behavioral health crisis system performance for everyone and for the full continuum of system capacities, components, and best practices.

- There is a behavioral health crisis system coordinator and a formal community collaboration of funders, behavioral health providers, first responders, human service systems, and service recipients.

- There is a stated goal that each person and family will receive an effective, satisfactory response every time.

- Geographic access is commensurate with that for emergency medical services in each region.

- Multiple payers collaborate so that there is universal eligibility and access.

- There are multiple strategies for successfully financing community behavioral health crisis systems.

- Service capacity of all components is commensurate to population need.

- Individual service rates and overall funding are adequate to cover the cost of the services.

- There is a mechanism for tracking customers, customer experience, and performance.

- Data is shared among all responsible parties for performance improvement.

- Quality standards are identified, formalized, measured, and continuously monitored.

Crisis Continuum Capacities and Services

The Council identified five operational areas for consideration in the Crisis Continuum strategic area. For one area (elements of the continuum), this assessment maps the current elements in Washington's service continuum (at least in some parts of the state) and adds the components recommended by the Council for what would be considered a more robust continuum of services.

Exhibit II.3
Operational Considerations Under the Crisis Continuum Strategic Area

Crisis Continuum Capacities and Services				
Overall Design Elements		**Population Capacities**	**Service Components**	
	Elements of the Continuum (see below)		**Staffing Capacity**	
Current Continnum of Services (not all parts of continuum are in every region of the state)	Police and EMS Responders	Mobile Crisis Teams	Designated Crisis Responders	Evaluation & Treatment Facilities	Indian Health Care providers
	Hospital Emergency Departments	Secure Detox Facilities	Crisis Stabilization Units	Residential Treatment Facilities	
	Hospital Inpatient Units	Community Mental Health Centers	Community Based Practitioners (mental health, substance use disorder, and primary acute care)		
Potential New Delivery Options (to support crisis prevention or post-crisis supports)	Crisis Respite Centers	Crisis Urgent Walk-in Clinics	Warm Lines	Deployed Crisis-trained First Responders	
	Additional Residential Treatment	Peer Supports		Transportation Costs and Modes of Transport	

Key Takeaways from the Crisis Continuum Capacities and Services Strategic Area for the CRIS to consider:

- The system has welcoming and safe access for all populations, all levels of acuity, and for those who are both voluntary and involuntary.

- There is a full continuum of crisis components, including a crisis call center, mobile crisis, walk-in urgent care, secure crisis center, 23-hour observation, residential crisis services, hospitalization, and intensive crisis outpatient services.
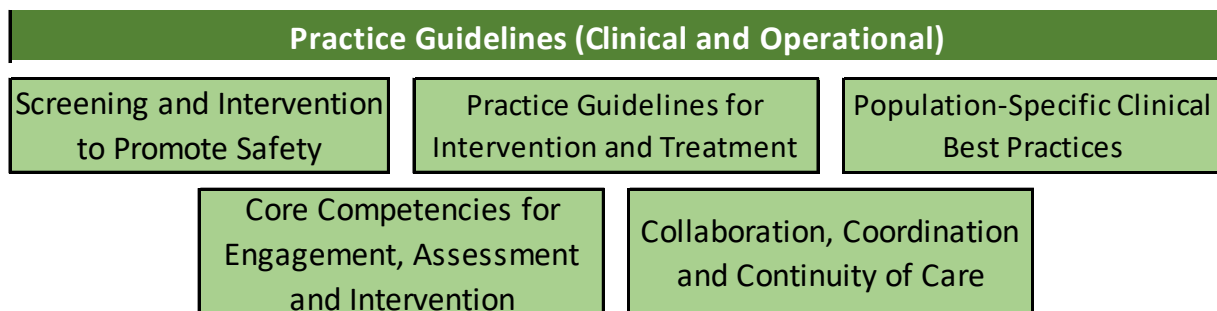
- Family members and other natural supports, first responders, and community service providers are priority customers and partners.

- Crisis response begins as early as possible, well before a person contact 911 (or 988) and continues until stability is regained.

- There is capacity for sharing information, managing flow, and keeping track of people through the continuum.

- There is a service continuum for all ages and people of all cultural backgrounds.

- All services respond to the expectation of comorbidity and complexity.

- Welcome all individuals with active substance use and those taking medications for the treatment of substance use disorders in all settings in the continuum.

- Medical screening is widely available and is not burdensome.

- Telehealth is provided for needed services not available in the local community.

- Program components are adequately staffed by multidisciplinary teams, including peer support providers.

- There is clinical/medical supervision, consultation, and leadership available commensurate with provisions for emergency medical care.

Practice Guidelines (Clinical and Operational)

The Council identified five operational areas for consideration in the Practice Guidelines strategic area.

Exhibit II.4
Operational Considerations Under the Practice Guidelines Strategic Area

Practice Guidelines (Clinical and Operational)		
Screening and Intervention to Promote Safety	Practice Guidelines for Intervention and Treatment	Population-Specific Clinical Best Practices
	Core Competencies for Engagement, Assessment and Intervention	Collaboration, Coordination and Continuity of Care

Key Takeaways from the Practice Guidelines Strategic Area for the CRIS to consider:

- The system has expectations of universal competencies based on values. Welcoming, hope and safety come first.

- Engagement and information sharing with collaterals, as permitted, is an essential competency.

- Staff must know how to develop and utilize advance directives and crisis plans.

- Essential competencies include formal suicide and violence risk screening and intervention.

- "No force first" is a required standard of practice.

- Risk screening guidelines for medical and substance use disorder (SUD)-related issues must facilitate, rather than inhibit, access to behavioral health crisis care.

- Utilizing peer support in all crisis settings is a priority.

- Behavioral health crisis settings must initiate medications for opioid use disorder (MOUD).

- Formal practice guidelines for the full array of ages and populations, including integrated treatment for mental health, SUD, cognitive and medical issues, are available.

- Utilize best practices for crisis intervention, such as critical time intervention, to promote successful continuity and transition planning.

Tribal Behavioral Health System Redesign

Our approach to the path forward for the Tribal Behavioral Health System Redesign recognizes the unique relationship between the State and the 29 federally recognized Tribes as sovereign governments and the extensive work that has been led by Tribes and Urban Indian Health Organizations in Washington for more than a decade to address the significant health and access to behavioral health and crisis services inequities experienced by American Indian and Alaska Natives in the state.

In recent years, there has been significant legislative activity in Washington through the Indian Health Improvement Act (RCW 43.71B)[7] and the Indian Behavioral Health Act (SB 6259)[8] to address health inequities experienced by Tribal populations. According to the Northwest Tribal Epidemiology Center, American Indians and Alaska Natives in Washington experience:

- A drug overdose death rate in 2016 that is three times higher than the national American Indian and Alaska Native rate. This rate has increased 36 percent since 2012 and almost tripled since 2000 in contrast to a relatively stable rate for the state overall population.

- A suicide mortality rate that is more than 1.8 times the rate for non-American Indians and Alaska Natives. Since 2001, the suicide mortality rate for American Indians and Alaska Natives in this state has increased by 58 percent. This rate is three times the rate of increase among non-American Indians and Alaska Natives.

- Nationally, the highest suicide rates among American Indians and Alaska Natives are for adolescents and young adults, while rates among non-Hispanic whites are highest in older age groups, suggesting that different risk factors might contribute to suicide in these groups.

Washington legislators have recognized that these health disparities are a direct result of both historical trauma leading to adverse childhood experiences across multiple generations and inadequate levels of federal funding to the Indian Health Service. The federal government has a responsibility and legal obligation to pay for Indian Health Services for eligible American Indians or Alaska Natives.

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[7] Washington State Senate Bill 5415, 2019. Accessed at: https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Senate%20Passed%20Legislature/5415.PL.pdf
[8] 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

In carrying out the work of HB 1477, the Steering Committee will engage 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. We have engaged in an introductory meeting with the Tribal Centric Behavioral Health Advisory Board (TCBHAB) as well as reviewed background resources documenting the history and current work on the Tribal Behavioral Health System. As illustrated in Exhibit II.5 below, the Tribal Behavioral Health System involves a complex array of federal, state, and tribal laws and requires clear delineation of roles and responsibilities in providing services to Tribal members experiencing a behavioral health crisis.

Exhibit II.5
Navigating Tribal Behavioral Health Law and Policy
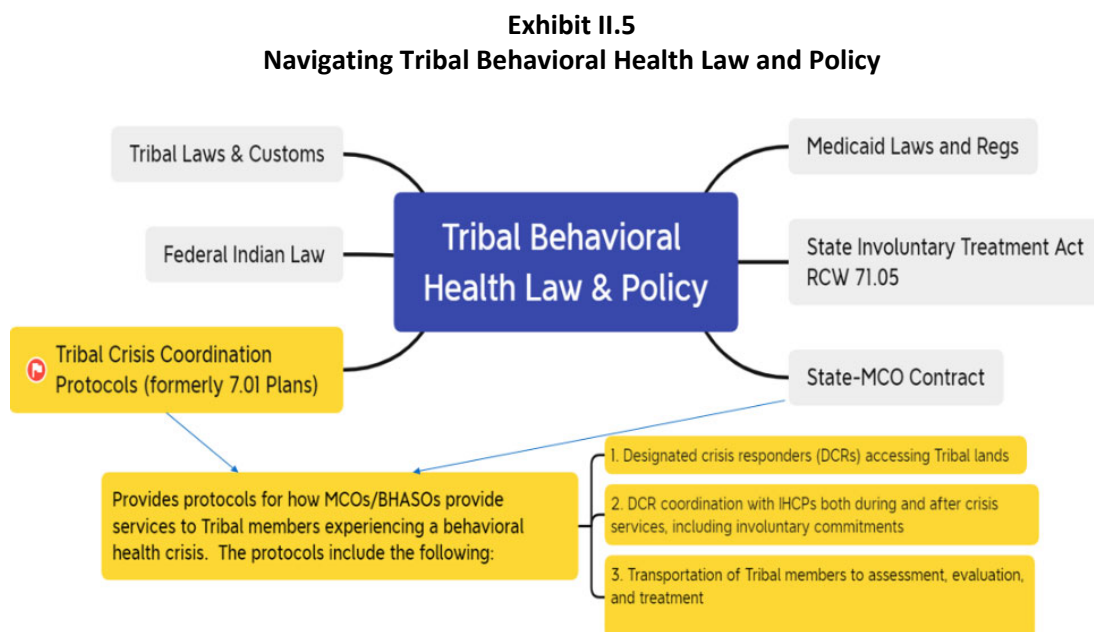
In 2022, we will engage the Tribal 988 Subcommittee through the work with the TCBHAB to examine and make recommendations with respect to the needs of the 988 system as well as other priority areas identified by the TCBHAB. We will align work of the Tribal 988 Subcommittee with current activities addressing Tribal behavioral health crisis system needs. These include, but are not limited to, the following activities:

- Operation of an Indian Behavioral Health Crisis Hub to provide culturally-appropriate response and resources to Tribal members experiencing a behavioral health crisis.

- Implementation of Tribal Designated Crisis Responders, as authorized by new Washington administrative code effective January 1, 2022 (WAC 182-125-0100).

- Authority of Tribes to petition for initial involuntary detention of a tribal member.

- Oversight and development of a Tribal Evaluation and Treatment/Secure Detox Facility.

- Development of policies tailored to Tribal behavioral health services that strengthen Tribal sovereignty through the Tribal Behavioral Health Code Project.

- Development of HCA Tribal Crisis Coordination Protocols to outline how MCOs and BH-ASOs coordinate services with providers who serve Tribal members experiencing a crisis.

SECTION III: Approach to Conducting the Assessment

The technical consultants (the Behavioral Health Institute at Harborview Medical Center and Health Management Associates, or BHI-HMA) used the framework outlined by the National Council in Section II to conduct the assessment that this approach informs. The assessment was conducted in earnest during the months of September, October, and November 2021. Given this condensed timeline, the Steering Committee recognizes that this assessment is not as comprehensive as it could be. However, HB 1477 requires a preliminary assessment to be delivered to the Governor and Legislature by January 1, 2022. A more thorough assessment—along with the activities conducted in Calendar Year 2022 to design a more robust delivery system—will be delivered by January 1, 2023. This section outlines the approach and activities conducted in the assessment thus far, as well as what is planned for continuation in early 2022.

Methods Used for this Assessment

The BHI-HMA team used five methods to conduct the assessment completed to date:

- One-on-one interviews with a variety of stakeholders;
- Release of surveys to obtain written feedback—one survey to the BH-ASOs, one to service providers;
- Community forums (five in total) held in November 2021;
- Analysis of data provided by BH-ASOs on measures that they report to the HCA; and
- A review of the literature and current resources used by national leaders, advocacy groups, and the federal government related to best or promising practices in the delivery of crisis services

Interviews

The HMA team conducted orientation meetings with each of the CRIS members at the start of the engagement. Later, the team conducted 1:1 interviews with a variety of stakeholders in order to gain their perspectives on what they perceive is working in the current delivery system, what areas need the greatest improvement, and what they believe are essential elements of an "ideal crisis system". Interviews were conducted with:

- Representatives from the Department of Health, the Health Care Authority, and the Department of Social and Health Services' research staff
- Each of the ten BH-ASOs
- Each of the five Medicaid Managed Care Organizations

Surveys

Online surveys were released in the field on September 13. One survey was released to BH-ASOs and the other to crisis service providers. The questions on each survey were tailored to the point of view of the respondents. A request was made for responses back by September 27. All ten of the BH-ASOs responded to their survey. There were 25 responses to the provider survey.

Community Forums

Five community forums were held in October and November 2021 to solicit additional input from Washingtonians about the efforts to redesign the crisis system. Participation was open to all attendees, but the forums were advertised in a manner to allow for discussion with targeted stakeholder groups.

These forums were held during late afternoon and evening hours via Zoom to encourage wide participation. The five forums conducted included the following:

- General Community Forum #1, October 28, 64 participants
- General Community Forum #2, November 3, 99 participants
- Forum for Individuals and Families with Lived Experience, November 3, 84 participants
- Forum for First Responders, October 27, 177 participants
- Forum for the Rural and Agricultural Community, November 4, 37 participants

Data Analysis

The BH-ASOs are required to complete and submit to the HCA a 'Crisis System Quarterly Report'. As the name states, the report captures information on a quarterly basis on a number of measures including:

- Calls to the BH-ASO's crisis line
- Calls answered or abandoned
- The number of mobile crisis teams deployed
- The number of DCR investigations completed
- The outcomes after a mobile team has been deployed (e.g., involuntary commitment, voluntary hospitalization, outpatient treatment received, etc.)

Data was reviewed for from Quarter 1- 2020 to Quarter 3-2020 (where available). The data was compiled and resubmitted to each BH-ASO for validation. Data was then compiled to measure trends across quarters and to compare measures across the BH-ASOs and against statewide averages.

Literature Search

HMA team members who are subject matter experts on crisis delivery systems canvassed nationally-recognized sources to build a library of resources for future use by the CRIS Committee and its subcommittees as a means of gaining a more thorough understanding of current thought leadership on the delivery of crisis services and the implementation of the 988 crisis call centers. In Section IV of this report, many of the promising practices are introduced and the citations of sources used where these practices were identified is provided in the footnotes.

Areas Yet to Uncover in the Assessment

Time constraints did not allow for as complete an assessment as desired. There are still components that are important to the Steering Committee that will be priority items at the start of 2022 to continue the assessment process. They include the following:

- 1:1 interviews with the three Washington Lifeline member centers, with Vibrant, with consultants to the DOH's agricultural suicide prevention work, with large commercial insurers in Washington, with 911 and emergency responders, and with individuals with in-depth knowledge of the delivery of crisis services to children and adolescents, LGBTQ+ and BIPOC community members;

- A more defined plan for coordination with the Tribal-Centric Behavioral Health Advisory Board on their activities related to the launch of the Washington Indian Behavioral Health Hub and the implementation of Tribal Designated Crisis Responders;

- Obtain more feedback from crisis service providers within each region using multiple formats;

- A deep-dive into historical utilization patterns of crisis services and other behavioral health services (including substance use disorder services) prior to an acute crisis episode, during the crisis, and during the post-stabilization period. Utilization and expenditures will be mapped at the region level, the payer level, and for various discrete populations in an effort to better assess the gaps within and across regions; and

- More analysis of historical reporting of mental health and substance use-related crisis calls to 911 to better understand how, where, and when coordination will need to occur with the 988 Lifelines.

SECTION IV: Assessment of the Current Crisis Delivery System

This assessment draws on the framework laid out in the National Council's Roadmap as introduced in Section II. Based on the feedback received from stakeholders and the information collected thus far, nine themes resonated based on what has been learned to date. These themes were introduced to CRIS Committee members in their meeting held on November 16, 2021. CRIS Committee members were invited to provide feedback on these themes to Health Management Associates (HMA), the Steering Committee's technical consultant, by November 30, 2021. Feedback from those CRIS Committee members who responded has been incorporated into the themes presented in this section.

There are eight themes in total that are introduced in Section IV.[9] Each theme is mapped to a strategic area identified by the National Council. This mapping is shown in Exhibit IV.1 below.

Exhibit IV.1
**Mapping of Themes in this Comprehensive Assessment to the Strategic Areas of
Focus in the National Council's Ideal Crisis System**

Accountability and Finance	Crisis Continuum Capacities and Services	Practice Guidelines (Clinical & Operational)
THEME #1 Responsibility and Accountability for Crisis Services	**THEME #4** Availability of Services Across the Crisis Continuum	**THEME #7** Person, Family and Community-Centered Approaches to Delivery of Crisis Services
THEME #2 Financing of Crisis Services	**THEME #5** Crisis Services Workforce	**THEME #8** Collaboration in the Delivery of Crisis Services
THEME #3 Outcomes from the Delivery of Crisis Services	**THEME #6** Use of Technology in Delivering Crisis Services	

Each theme is introduced in a one-page summary format in the pages that follow. The summary includes the identification of sub-themes, recognized practices to consider (reflecting on the Key Takeaways identified by the Council and mentioned in Section II), stakeholder perspectives learned from a discussion of the theme, and known items that will be worked on related to the theme throughout CY 2022. After each one-page summary is introduced, more information about each theme is offered.

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[9] Nine themes were introduced to the CRIS Committee. One theme related to utilization has been subsumed under the theme related to availability of services in the crisis continuum.

Themes Related to the Accountability and Finance Strategic Area

Theme #1: Responsibility and Accountability for Crisis Services

WHERE WE ARE TODAY

THEME 1:   Responsibility and Accountability for Crisis Services

1.1 There is no centralized locus of responsibility for the accountability and monitoring of the delivery of crisis services. This responsibility is spread across multiple entities.

1.2 Limitations on the level of information sharing today limits the amount of accountability and oversight that can even be conducted.

1.3 Within Medicaid, the introduction of integrated managed care changed the accountability and monitoring responsibilities than what was in place before this occurred.

1.4 There are no dashboards or other transparent reporting to the public to indicate how the crisis delivery system in the state is performing.

1.5 Oversight and accountability of existing services can be strengthened to understand where regional differences in crisis service utilization may be more or less appropriate.

RECOGNIZED PRACTICES TO CONSIDER

REFLECTING ON THE COUNCIL'S 'KEY TAKEAWAYS'

1   A single entity accountable for crisis system performance for everyone for the full continuum of services.

2   There is a formal community collaboration between funders, delivery systems, behavioral health providers, first responders, and recipient clients.

3   Service capacity of all components is commensurate with population need.

WHAT WE HAVE HEARD

STAKEHOLDER PERSPECTIVES

1   The State needs to provide an overarching philosophy and approach to the crisis system of care that aligns with national best practices.

2   Set standards regarding capacity and access to the array of crisis services.

3   Improve the ombudsman process to help resolve issues in the moment of accessing crisis care. Then publicly report outcomes.

OPTIONS FOR MOVING FORWARD

Items that will be addressed by the CRIS Committee and Subcommittees includes, but not limited to:

1   Develop the vision for an integrated crisis network that includes 911 and the 988 crisis line hubs, mobile crisis teams, and the array of services in the continuum defined by the Steering

2   Steering Committee will make recommendations for ongoing oversight after the CRIS term ends.

3   Inventory measures that may be considered for ongoing quality reporting of the system.

4   Propose and design dashboards for public-facing reporting on the effectiveness of the crisis delivery system.

With the HCA's implementation of integrated managed care starting in 2016, the accountability for and monitoring of the crisis services delivery system from the perspective of the public payer system changed. There was a shift in which entity was responsible for overseeing different aspects of the crisis service in each region—the local BH-ASO or the MCO that the Medicaid beneficiary was enrolled with. Further complicating this is the fact that BH-ASOs contract with crisis providers in their region regardless of payer—federal/state (Medicaid), Medicare, commercial plans, local funds, or other federal grants (for the uninsured). The Medicaid MCOs also contract with some crisis providers directly and, for other services, with the BH-ASOs. Running parallel to these processes is the national effort led by Vibrant in partnership with states to expand access to Lifeline services.

Funding variations and multiple arms of responsibility and accountability means non-standardized accountability across the state. In fact, the services offered to clients in a region may be tied to the funder that they are "attached to" (e.g., Medicaid, Medicare, commercial health plan, or uninsured).

Limitations in the availability of data has further weakened the ability to hold parties accountable. Prior to 2018, the BHOs had real-time data on crisis-related encounters for Apple Health members for all crisis services they might pay for. This is no longer true because some crisis services are now the responsibility of the Medicaid MCOs. At the same time, the MCOs do not have all information about the crisis services their Apple Health members might receive due to varied levels of tracking and reporting by the BH-ASOs to the MCOs. There is no reporting upstream on utilization and outcomes of crisis services across payers. This is a critical challenge that must be addressed because these issues have a significant impact on the ability of providers to deliver effective care that is coordinated and to ensure that there is continuity of care for the individual receiving services.

National Promising Practices

Over the past few decades, there have been many publications outlining the vision, principles, and goals regarding developing and sustaining accountability and structures to support effective *systems of care*[10]. Most recently there have been publications about accountability and structures for systems of care specific to crisis systems. The Roadmap to the Ideal Crisis System published by the National Council offers suggestions on how to approach accountability and oversight as seen on the previous page.

Additional items cited for consideration in the Roadmap include:

- Measurable criteria are established to assess the crisis system's network adequacy such as time and distance and wait and travel times to receive a crisis service.
- Measurable criteria are defined to assess equity in the services offered and delivered.
- Quality metrics are established to measure structure, process, and outcomes. Metrics are developed in collaboration with community stakeholders.
- Formal assessment of customer satisfaction is conducted routinely, including assessing the following customer segmentations: individuals and families, law enforcement, emergency departments, behavioral health providers, and human services providers.
- Rewards and penalties are balanced to incentivize and achieve desired outcomes.

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[10] Pires, Sheila for the National Technical Assistance Center for Children's Mental Health, *Building Systems of Care A Primer* (2002) available at https://gucchd.georgetown.edu/products/PRIMER_CompleteBook.pdf

Theme #2: Financing of Crisis Services

WHERE WE ARE TODAY

THEME 2: Financing of Crisis Services

2.1 Total financing appears to be disproportionately balanced to more restrictive care then less restrictive care. The imbalance is towards acute crises and less toward prevention of crises.

2.2 Medicaid payments are made to managed care companies based on a historical cost per person in each region. Historical costs in each region may not align with the current needs in each region.

2.3 Financing by the Medicare program and commercial health plans that offer a smaller menu of crisis-related services can restrict who within each region of the state can receive services.

2.4 Although the funding through local initiatives (the 1/10th of 1% tax) can strengthen service offerings in a region, this inherently brings inequities statewide because localities fund

2.5 The rate and method of payment to crisis service providers can directly impact the access to services.
   (a) Some services are paid on a per service basis while others are paid on a 24/7 availability basis.
   (b) Under both methods, there is a wide range in the rate of payment to providers who are delivering the same type of service.

RECOGNIZED PRACTICES TO CONSIDER

REFLECTING ON THE COUNCIL'S 'KEY TAKEAWAYS'

1 Multiple payers collaborate so that there is universal eligibility and access.
2 Individual service rates and overall funding are adequate to cover the cost of services.
3 There are multiple strategies for successfully financing community crisis delivery systems.
4 Funding supports capacity, not just individual services.
5 Payments should cover all populations, including those with comorbidities.

WHAT WE HAVE HEARD

STAKEHOLDER PERSPECTIVES

1 Adequate funding of services was named highest priority in 4 of 5 community forums.
2 Standardize the funding approach to ensure capacity and responsiveness.
3 Commercial health plans need to contribute more to reduce reliance on Medicaid.
4 Expand funding through non-Medicaid resources such as the local tax.
5 Guidelines for payment need to be revised to incentivize less restrictive setting options.

OPTIONS FOR MOVING FORWARD

Items that will be addressed by the CRIS Committee and Subcommittees includes, but not limited to:

1 Compile additional data on baseline expenditures for crisis services by payer and within payer by region, by population age groups, and by race/ethnicity.
2 Release a survey to crisis service providers to obtain information on the costs to deliver services.
3 Review survey results and make recommendations for revised rates of payments, factoring in capacity and cost differences across regions of the state.
4 Provide recommendations on alternative methods to pay for crisis services, including incentives.
5 Provide recommendations on targets for more equitable funding across payers.

Current funding for the crisis services continuum tends to be disproportionately directed towards services that are more restrictive rather than less restrictive and to acute crisis events rather than towards preventive services. This may be manifested by how funding has traditionally been allocated across the wide variety of types of services, how the BH-ASOs are paid by the MCOs, and how the BH-ASOs and the MCOs pay crisis providers.

BH-ASOs are responsible for ensuring that their suite of crisis services are available for the entire community, both Apple Health enrollees and the general population in the region regardless of one's ability to pay. As a result, the BH-ASOs often pay their local crisis providers based on capacity for 24/7 availability ("the firehouse model"). This can differ with how the Medicaid MCOs pay the BH-ASOs or individual crisis providers (such as "fee-for-service"). Additional research needs to be conducted to learn the ways that commercial insurers pay the BH-ASOs or individual providers.

From the service provider perspective, payment for the same service can vary depending upon who the payer is (Medicaid, Medicare, commercial, funding through grants for the uninsured population) or even within payer (for Medicaid, between what a BH-ASO will pay the provider versus an MCO; for commercial, between what different carriers will pay a provider). This can make provider business sustainability challenging and more averse to expanding service capacity based on unknown future financing. Different funding mechanisms can also lead to additional administrative complexity.

Underlying all of these payment arrangements is that current funding formulas are not directly connected to the anticipated population health crisis needs of each region.

National Promising Practices

The first well-known publication regarding crisis services funding was published by SAMHSA in 2014.[11] This publication outlined that crisis systems need to be funded through integrated and collaborative funding approaches, which was defined to mean access to and coordination of multiple sources of financing as an essential component for the provision of crisis services. Moreover, the concept of *braided funding* was discussed which was described as bringing together multiple funding sources to pay for more services than any one stream can support. Later, the services can be segmented in order to report to funders on how the money was spent for "their share". The publication outlined the economic impact of crisis services and the studies reviewed which showed that significant cost savings can result from more use of community-based behavioral health services to reduce costs in more expensive setting such as inpatient utilization and hospital emergency departments.

The National Association of Medicaid Directors recently published a concept paper[12] crafted by a group of Medicaid leaders and national behavioral health experts to outline core strategies to promote the health and wellbeing of Medicaid members. One core strategy outlined for states was to strengthen and broaden the crisis response system including utilizing Medicaid funding for crisis call centers, mobile teams, and specialized crisis settings to divert expenditures from hospital EDs and the justice system.

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[11] Substance Abuse and Mental Health Services Administration, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* (2014) available at https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848

[12] National Association of Medicaid Directors, *Medicaid Forward Behavioral Health* (2021) available at https://medicaiddirectors.org/wp-content/uploads/2021/02/NAMD_MedicaidForwardReport_FEB2021.pdf

Theme #3: Outcomes from the Delivery of Crisis Services

WHERE WE ARE TODAY

THEME 3:   Outcomes from the Delivery of Crisis Services

3.1   To date, there has been limited focus on the outcomes from the delivery of crisis services in Washington. There are some process measures collected, but even these are limited.

3.2   There is little data collected today at the overall system level to assess the effectiveness of crisis service delivery (e.g., mobile crisis team response times, diversion to less restrictive care).

3.3   There is limited fidelity monitoring to determine if Washington's crisis delivery system aligns with national best practices.

3.4   Information to assess individuals' or families' experiencs with care is limited.

3.5   Service utilization data is not being aggregated and analyzed at the statewide level to drive improvement.

RECOGNIZED PRACTICES TO CONSIDER

REFLECTING ON THE COUNCIL'S 'KEY TAKEAWAYS'

1   Quality standards are identified, formalized, measured, and continuously monitored.
2   Each person/family will receive an effective and satisfactory response every time.
3   There is a mechanism for tracking customer experience and performance.

4   There are shared data for performance improvement.

WHAT WE HAVE HEARD

STAKEHOLDER PERSPECTIVES

1   Scorecards should be developed that cut across the continuum to include 911/988 calls, police dispatch data, hospital ED visits, community crisis providers.
2   Prioritize data collection to align with metrics developed and ensure transparency of reporting.
3   Measure and track recruitment and retention within the behavioral health workforce.
4   Measure capacity for delivery of community behavioral supports as an indicator of need.

OPTIONS FOR MOVING FORWARD

Items that will be addressed by the CRIS Committee and Subcommittees includes, but not limited to:

1   Build reporting to ensure a balanced reporting of both process and outcome measures.
2   Build technical specifications to ensure consistent results in measure reporting.
3   Build education and training to payers and providers on reporting measures decided upon.
4   Recommend approaches to ensure client and family feedback is incorported into outcome
5   Propose targets for each measure recommended to be met over time.

To date, there has been a limited focus on monitoring and reporting outcomes about crisis system services in Washington, particularly for services that are not subject to accreditation criteria. There are numerous opportunities to develop, monitor, and report out to the public the outcomes from recent and future investments in Washington's crisis delivery system. Three areas where outcome metrics need to be developed and reported on include system effectiveness, patient satisfaction, and fidelity to national best practices.

Currently, the only published state reports about the crisis system are focused on data about the involuntary process. This includes bed capacity, the single bed certification process, and the rate of DCR investigations. Meanwhile, there is little data collected and synthesized at the state level from across the regions today about the effectiveness of crisis service delivery services (e.g., mobile team response time, diversion to less restrictive care, measures to assess if and how crises are being prevented). There is also little information available to assess client experiences of the crisis delivery services that are utilized. Finally, there is no monitoring or reporting about whether Washington's crisis services are delivered in manner that is in fidelity with national best practices.

Further complicating matters is that different funders often require different types of measures to be reported and these measures may not be aligned. For example, SAMHSA may require specific measures as conditions of its grant funding, while the Centers for Medicare and Medicaid (CMS) may require different measures for its reporting requirements. Commercial payers may require yet different measures than public payers.

National Promising Practices

The Roadmap to an Ideal Crisis System from the National Council suggests that crisis system metrics should be established to measure different aspects of the crisis system:

- *Structure*: the environment in which care is delivered (e.g., organizational structure, resources, staffing).
- *Process*: the techniques and processes used to deliver care (e.g., use of screening tools or specific interventions).
- *Outcome*: the outcome of the patient's interaction with the health care system (e.g., days in the community, housing, and employment status).

Themes Related to the Crisis Continuum Capacities and Services Strategic Area

Theme #4: Availability of Services Across the Crisis Continuum

WHERE WE ARE TODAY

THEME 4:   Availability of Services Across the Crisis Continuum

4.1   There appears to be a reliance on involuntary processes in many regions of the state for mental health services. More discovery is required for involuntary processes for substance use disorder.

4.2   Mobile crisis teams are present in every region, but the availability and responsiveness can vary across the state.

4.3   Crisis stabilization units are not available in some parts of the state. In other parts, they are not easily accessible or available to all who need them.

4.4   Service options are challenged in many regions for the adult population, but even further challenged for services to children and adolescents as well as specialized populations.

4.5   Preventative services and less-restrictive programs such as warmlines, walk-in clinics, crisis respite, and peer supports are not consistently available across the state.
Where they are available, the services are funded by local-based initiatives (such as the 1/10th of 1% tax), resulting in inequities across the state for services available.
The Lifeline call center hubs is one service offered consistently across the state.

RECOGNIZED PRACTICES TO CONSIDER

REFLECTING ON THE COUNCIL'S 'KEY TAKEAWAYS'

1   The system has welcoming and safe access for all populations and levels of acuity.
2   Family members, first responders, and community providers are priority customers.
3   Crisis response begins ASAP, well before 911 (or 988) and continues until stability regained.
4   Services are available for all age groups and people of all cultural backgrounds.
5   A full continuum of crisis components is available statewide, including telehealth, that includes preventative and post-stabilization services.

WHAT WE HAVE HEARD

STAKEHOLDER PERSPECTIVES

1   Clarify and align the components of the system, starting with clear service definitions.
2   Balance the continuum to include more crisis prevention and post-crisis stabilization.
3   Improve the 24/7 responsiveness of first responders, mobile crisis teams, and DCRs.
4   Transportation to services is often a barrier to access services in rural communities.
5   Expand services such as peer and family supports, current Assisted Outpatient Treatment pilots, supported housing, telehealth, text/chat options.

OPTIONS FOR MOVING FORWARD

Items that will be addressed by the CRIS Committee and Subcommittees includes, but not limited to:

1   Continue to inventory current crisis providers by region, their current staffing, and potential availability to scale up.
2   Query existing provider base and potential new entrants on the feasability of delivering additional preventative services if they were offered (e.g., warmlines, crisis drop-in, respite).
3   Assess, to the extent possible, from providers/clients/families which regions of the state have the greatest transportation barriers to accessing needed care.
4   Meet with key informants to learn more about the gaps in services to children and adolescents.

As described earlier, the financing for crisis services varies across the state and is a combination of federal, state, local funding. Methods of payment to service providers also varies. Each funder/payer has its own expectations and requirements. These factors, in addition to the current workforce crisis, can impact what services are available in the crisis continuum and how those services are delivered in each region. Moreover, access to services on the continuum can be varied based on the payer that each client is "attached to".

Services considered as the minimum baseline of the crisis service delivery model (e.g., mobile crisis teams, crisis stabilization units) were found to have considerable variability across regions of the state. A full array of crisis services that are more preventative in nature (e.g., warmlines, walk-in clinics and respite programs) are not consistently available across the state. In fact, very few regions in the state have the full array of preventative/crisis diversion options. Further, there are inconsistencies in how peers are used throughout the continuum of crisis care (if they are used at all).

Another response to both the lack of crisis stabilization services and inpatient psychiatric bed capacity across the state is the ongoing and daily use of the Single Bed Certification (SBC) process across most regions. This process was originally in place with the intention to allow for medical treatment of a detained individual in an acute hospital (non-E&T) setting. Its use was then expanded to allow for E&Ts to care for patients on long-term (90/180) court orders as Western State began to limit capacity for these individuals. As psychiatric boarding gained more public attention in the early 2010s, the Washington Supreme Court ruled in 2014, declaring psychiatric boarding to be illegal and unconstitutional. The SBC process was then expanded to allow hospitals and emergency departments to "legally" care for detained individuals across all regions, as the ruling did not immediately resolve the psychiatric boarding crisis, although it drew the state's attention and resources to the expansion of both prevention/diversion and inpatient psychiatric capacity. The SBC process has also allowed for better data tracking relating to lack of resources/psychiatric beds, with required reporting now in place. Regardless, it is acknowledged that it is not a replacement for appropriate psychiatric care, but a method to legally allow for community alternatives to treatment in an E&T or long-term hospital bed for the detained individual. The continued reliance on the SBC process relieves some pressure but also the sense of urgency to develop community-based prevention/diversion options.

National Promising Practices

Some states and communities have built a robust continuum of crisis services and their data collection over time informs what service utilization predictions across the crisis continuum might look like when a robust continuum of crisis services exists. One example of this is the data collected for a community in Southern Arizona. The data collection from crisis dispositions of crisis care informs future utilization of crisis services trends that includes appropriately addressing individual needs and accounts for diverting from 911, law enforcement, emergency departments and jails.[13]

The figure below provides statistics on the percent of individuals in which their crisis is resolved and those that need to move through the crisis care continuum in order to have their needs addressed.

(Balfour, 2020)

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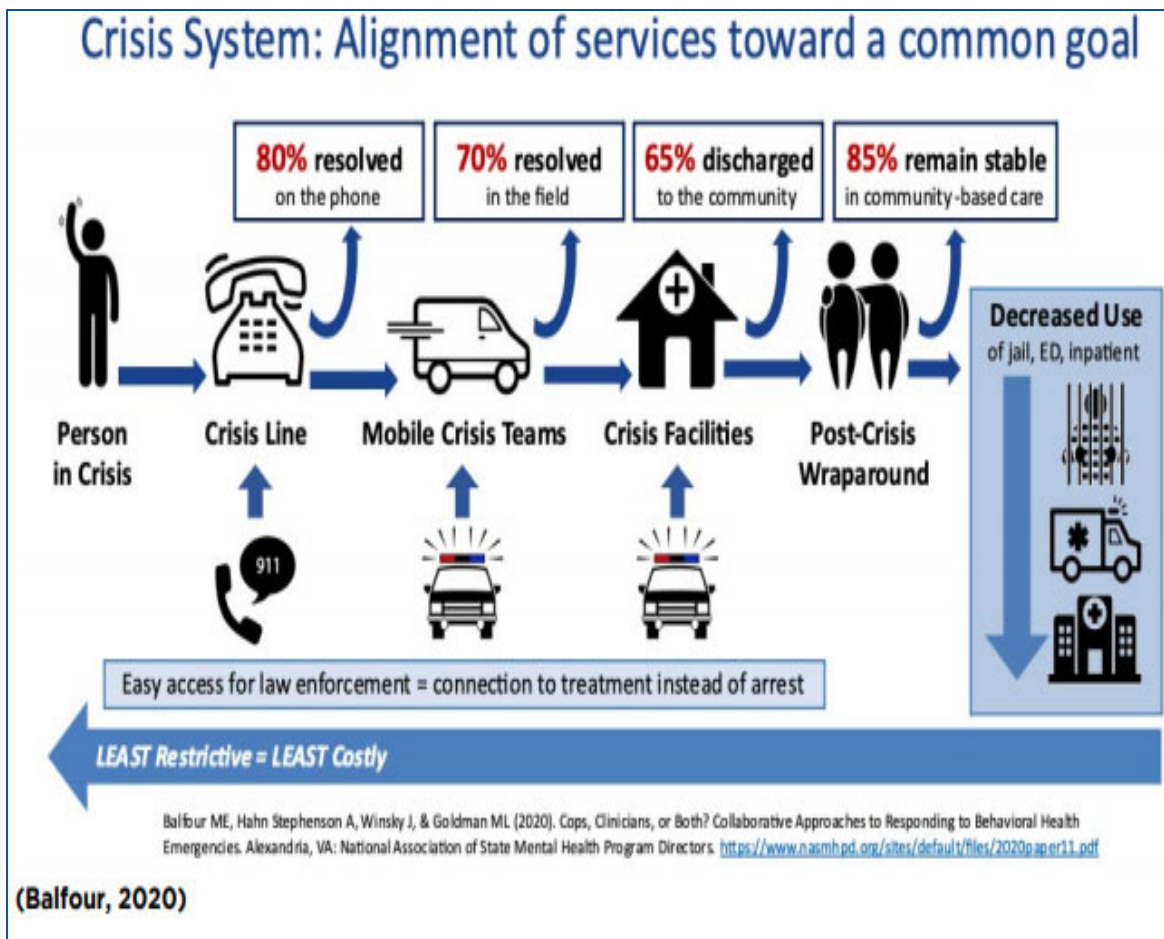
[13] Balfour, Stephenson, Winsky, and Goldman for National Association of State Mental Health Program Directors, *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies* (2020) available at https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

Over the past several years, there has been a growing consensus about how the core crisis services continuum is defined, which includes crisis call centers, crisis mobile response teams, and crisis receiving and stabilization facilities.[14] [15] [16] [17] [18] The continuum must not just exist, but truly *provide access* for *all* at the time needed.

Further, there is growing consensus on an *expanded view* of a crisis continuum that includes early engagement to avoid crisis as well as post crisis care to support individuals and families to remain stable in their communities. The figure below illustrates how this expanded concept is envisioned to include prevention and post crisis care.[19] Examples of these services include warmlines, transportation, crisis respite, crisis step-down, and peer navigators. [20] [21] [22] [23]

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[14] Substance Abuse and Mental Health Services Administration, *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit, Knowledge Informing Transformation*, 2020, available at https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[15] Ibid.

[16] National Association of Mental Health Program Directors, *Crisis Now Transforming Crisis Services* (2021) available at https://crisisnow.com/

[17] Gordon for Milbank, *Building State Capacity to Address Behavioral Health Needs Through Crisis Services and Early Intervention* (2020) available at https://www.milbank.org/publications/building-state-capacity-to-address-behavioral-health-needs-through-crisis-services-and-early-intervention/

[18] National Governors Association, *Improving Outcomes and Reducing Cost of Care for Complex Care Populations with Behavioral Health and Social Support Needs: Toolkit for Governors* (2020) available at https://www.nga.org/center/publications/complex-care-populations-behavioral-health-social-support/

[19] Wellbeing Trust, *Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System* (2021) available at https://wellbeingtrust.org/wp-content/uploads/2021/11/988-Crisis-Response-Report-November-FINAL.pdf

[20] Ibid.

[21] ComTrans, *Services Behavioral Health Crisis Transport Information*, (2021) available at https://www.gocomtrans.com/services-transport

[22] Zero Suicide Suicide Prevention Resource Center, *The Role of Peer Support Services in Caring for Those at Risk of Suicide* (2021) available at https://zerosuicide.edc.org/resources/resource-database/role-peer-support-services-caring-those-risk-suicide

[23] Gillard and Holley for Advances in psychiatric treatment, *Peer workers in mental health services: literature overview* (2018) available at https://www.cambridge.org/core/journals/advances-in-psychiatric-treatment/article/peer-workers-in-mental-health-services-literature-overview/125C82E25477D186BB9CC39A55AB207C

Crisis Response Continuum of Care

Outreach & engagement of people at risk

Crisis call center hubs

Mobile crisis teams

Crisis stabilization options

Post-crisis, community-based support

Current literature also conveys that the crisis continuum is designed to serve *anyone, anywhere, and anytime*.[24] The crisis services continuum must be accessible by *all* and there should not be criteria applied to who has access. Further, any factor contributing to the non-availability of a core crisis services should be addressed systemically.

There is also a growing understanding of having a **"no wrong door"** crisis continuum design. The no wrong door concept is multi-faceted. For example, systems of care are being designed to address the whole-health needs of individuals and that it is the responsibility of the service delivery system to be designed to address the complexity of needs that individuals and families present with (e.g., mental health and substance use disorder). In this way, the systems is not divided with different doors or facilities for treatment of these issues.[25]

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[24] Ibid.

[25] National Association of Mental Health Program Directors, *Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit* (2020) available at
https://www.nasmhpd.org/sites/default/files/2020paper4.pdf

Practical hand-offs from stakeholder to the different crisis services across the continuum is advancing across the nation. One example of this is conveyed in the figure below from Los Angeles County which outlines the preferred pathways for how first responders (911, law enforcement, fire, and emergency medical services) can access crisis call centers, mobile response, and crisis facility services.[26]
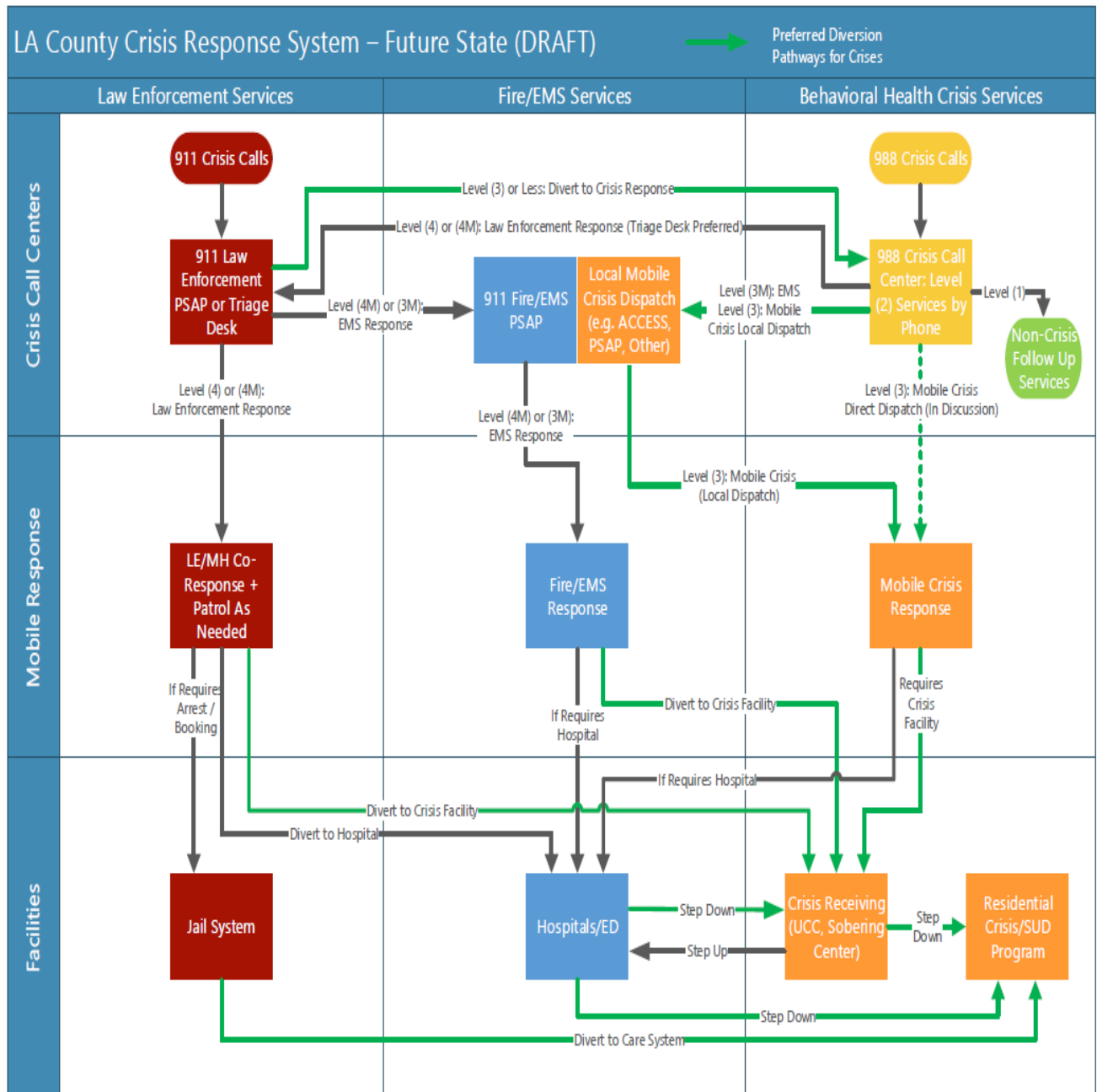
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[26] LA County, *LA County Crisis Response System – Future State*, available at https://talk.crisisnow.com/wp-content/uploads/2021/07/18-ACR-System-Diagram-Future-State.pdf

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There is currently a national debate about when and how law enforcement should be involved in the crisis continuum. This dialogue has been accelerated by the discourse of community policing overall including the impact on communities of color and other underserved populations. Crisis systems are being designed to accelerate access to the core crisis continuum with an emphasis to divert from either pre-law enforcement engagement or from law enforcement when they have responded to crisis.

SAMHSA's GAINS (Gather, Assess, Integrate, Network, and Stimulate) Center for Behavioral Health and Justice Transformation amended their Sequential Intercept Model which outlines opportunities to divert individuals away from the criminal justice system to now include an Intercept 0 to depict that intervention should happen prior to law enforcement engagement. The figure below[27] depicts the additional intercept added.
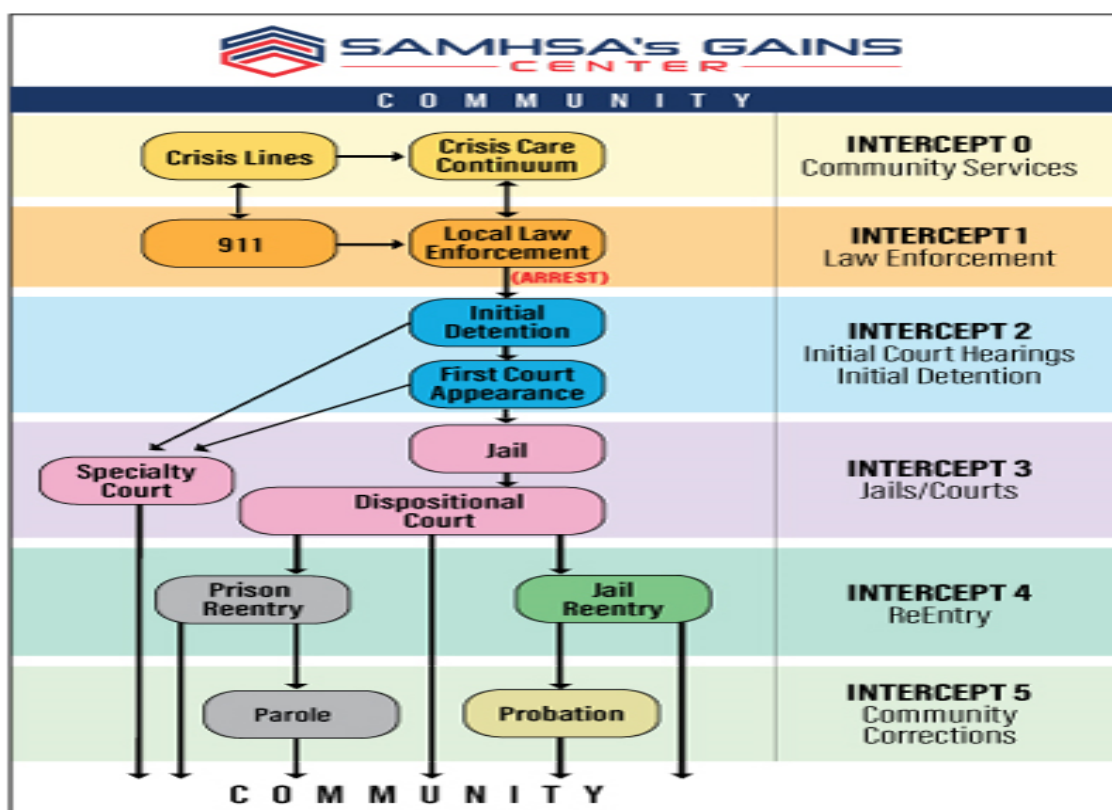
Part of the national debate includes a tension between having co-responder models that include a police officer and crisis professional to respond to crisis calls, versus avoiding police officer involvement unless there is an unsafe situation. CIT International, a law enforcement driven organization focused on promoting safe and humane responses to those experiencing a mental health crisis, has historically advocated to avoid involvement of law enforcement. Most recently, they have become more vocal with firm convictions to not involve police officers all together unless it is a dangerous situation that police are needed.

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[27] SAMHSA Gains Center, *Sequential Intercept Model* (2021) available at https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

Theme #5: Crisis Service Workforce

WHERE WE ARE TODAY

THEME 5: Crisis Services Workforce

5.1 Workforce among behavioral health practitioners in many parts of the state is severely challenged and impedes the expansion of the continuum of crisis service delivery.

5.2 Recruitment and retention of behavioral health practitioners impacts the access to and availability of crisis services in Washington.

5.3 Regulations and licensure requirements can serve as an additional impediment to crisis service delivery.

5.4 Behavioral health workforce training and standards are varied across the state.

5.5 Peer support specialists are under-utilized in many portions of the crisis service continuum.

RECOGNIZED PRACTICES TO CONSIDER

REFLECTING ON THE COUNCIL'S 'KEY TAKEAWAYS'

1 Program components are adequately staffed by multidisciplinary teams, including peers.
2 There is clinical/medical supervision, consultation, and leadership available commensurate with the provisions for emergency medical care.
3 All services respond to the expectation of comorbidity and complexity.
4 Medical screening is widely available and is not burdensome.

WHAT WE HAVE HEARD

STAKEHOLDER PERSPECTIVES

1 The State should develop recruitment and retention strategies for the crisis workforce.
2 Provide more training for first responders and crisis staff across the continuum in trauma-informed care, stigma, de-escalation, mental health first aid, other best practices.
3 Make more training options available online.
4 Expand the availability of peer trainings across the state.

OPTIONS FOR MOVING FORWARD

Items that will be addressed by the CRIS Committee and Subcommittees includes, but not limited to:

1 Review assessments of the current workforce related to crisis provider staff. Make recommendations on ways to enhance or retain the workforce at the statewide and region level.
2 Inventory licensure requirements in place today and make recommendations where requirements could be adjusted in an effort to expand the workforce.
3 Inventory best practice training materials and provide recommendations for the development of curricula to train crisis provider staff and first responders.
4 Make recommendations on the content and cadence of training to the workforce.

The assessment revealed significant workforce challenges for those who are directly providing crisis services as well as for the Lifeline call centers. At the provider level, the workforce among behavioral health practitioners in many parts of the state is severely challenged. This will impede expansion of the crisis continuum while, at the same time, increases the number of people who are unable to receive services sooner and may end up in crisis.

Workforce challenges have been exacerbated by the pandemic and the delivery of crisis services has been jeopardized further by the need for face-to-face client interaction for most crisis services. Some providers pointed to the requirements of the level of staffing for the delivery of specific services (e.g., Lifeline centers and mobile crisis teams) as another potential impediment to quickly growing the crisis delivery workforce. A long-term solution proposed by some stakeholders was to build a workforce "pipeline" that ensured appropriate training early in a person's career, fair and competitive salaries and benefits, and a framework where workers with different levels of training or credentialing can see a growth path forward in their career in this industry.

Recent publications show the rise in mental health and substance misuse conditions since the public health emergency (PHE) has increased demand for services as a result of the pandemic. This is further impacting the need to expand the crisis services workforce. Here is a summary of recent publications:

- The CDC reported that from August 2020 to February 2021, the percentage of U.S. adults with recent symptoms of anxiety or depression increased from 36.4 to 41.5 percent. The percentage reporting unmet mental health need increased from 9.2 to 11.7 percent, the largest increase among young adults (18-29).[28]
- A recent Kaiser Family Foundation poll found similar results. Nearly half (45 percent) of adults in the United States reported that their mental health has been negatively affected by worry and stress over the virus.[29]
- The Household Pulse Survey, conducted in September 2021 by Census.gov, indicated that roughly 13 percent of Americans age 18 and older reported that they felt nervous, anxious, and on edge nearly every day.[30] Due to increased stress during the PHE, heightened mental health risks and needs and potential disruptions in mental health care[31] are apparent among youths who had pre-existing mental health conditions.
- The US has seen an increase in the number of drug overdose deaths during the pandemic.[32]

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[28] Vahratian, Blumberg, Terlizzi, Schiller, *Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021*. MMWR Morb Mortal Wkly Rep 2021;70:490–494. DOI: http://dx.doi.org/10.15585/mmwr.mm7013e2

[29] Panchai, Kamal, Cox, and Garfield for Kaiser Family Foundation, *The Implications of COVID-19 for Mental Health and Substance Use* (2021) available at https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

[30] United States Census Bureau, *Week 37 Household Pulse Survey: September 1 – September 12* (2021) available at https://www.census.gov/data/tables/2021/demo/hhp/hhp37.html#tables

[31] Golberstein, Wen, Miller. *Coronavirus disease 2019 (COVID-19) and mental health for children and adolescents*. JAMA Pediatrics, 174 (2020), pp. 819-820. Available at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2764730

[32] Panchai, Kamal, Cox, and Garfield for Kaiser Family Foundation, *Substance Use Issues are Worsening Alongside Access to Care* (2021) Available at https://www.kff.org/policy-watch/substance-use-issues-are-worsening-alongside-access-to-care/

National Promising Practices

As of 2020, there are national publications outlining an approach regarding the levels of preparedness and credentials that crisis service providers should have. For example, SAMHSA has given guidance on staff qualifications for the core crisis services that encourage the use of clinicians overseeing clinical triage and other trained members to respond to calls.[33] Another recent report published by the US Department of Health and Human Services, Office of the Assistance Secretary for Planning and Evaluation (ASPE) explores staffing models used across the crisis continuum of care, finding that crisis services rely on a mix of licensed and unlicensed staff (including peer support specialists) to address the full range of needs within the crisis continuum and also provides for efficiencies.[34] The report discusses models for crisis call lines, mobile crisis teams, and crisis centers. The report found that using a robust mixed team of staff with strong engagement skills may allow for faster stabilization at the lowest service level without the situation escalating to need higher levels of care.

Although these are recommended approaches in ASPE's report, there is recognition that more research is needed on this topic to identify policy solutions to encourage more widespread adoption. States should examine and adopt policies that allow for flexible staffing with clinical oversight and supervision. This strategy may be one tool to solve staffing shortages often experienced by rural communities.

There is a growing body of literature that endorses the use of peer and family support workers overall and within the crisis services continuum. SAMHSA endorses the following peer support services for:

- **Warmlines** – Warmlines are call support lines for anyone who just wants to talk. Warmlines can be staffed by peers with lived recovery experience who have mental health and/or substance use disorders. The peers answering calls on the warmlines actively listen to callers, empathize with their concerns, and empower callers to choose their path to wellness and recovery.

- **Peers on Crisis Mobile Teams** – Peers on mobile teams are becoming more common across the nation. These peers receive advanced training to learn additional skills beyond traditional peer support services such as how to engage in a crisis situation, how to engage with law enforcement, and other critical skills needed for working in unknown situations.

- **Peer-Operated Crisis Response Support and Respite Services** – Crisis respite services are warm, safe, and provide a supportive home-like setting that offers a place for an individual to rest and recover after being in a distressed emotional state and/or to prevent a situation from escalating further. Peer-operated respite services are provided by individuals with lived experience with a mental health or substance use disorder. Often they also have been involved with the justice system.

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[33] Ibid.

[34] US Department of Health and Human Services, Office of the Assistance Secretary for Planning and Evaluation, *Issue Brief: Crisis Services and the Behavioral Health Workforce* (2021) available at
https://aspe.hhs.gov/reports/crisis-services-behavioral-health-workforce-issue-brief

Theme #6: Use of Technology in Delivering Crisis Services

WHERE WE ARE TODAY

THEME 6: Use of Technology in Delivering Crisis Services

6.1   There is limited technology used today in the delivery of crisis services across the continuum. This results in the lack of real-time data to initiate coordination and to monitor client outcomes.

6.2   While the crisis call centers have call routing agreements, there is no technological connection between call centers and 911.

6.3   Health information technology platforms (e.g., bed registry, available outpatient appointments, client-specific hospital ED use or other history) are not being universally used and not to their full potential to assist in coordinating and delivering services.

6.4   Information on services used by clients before, during, and after a crisis event is fragmented and inconsistent. Where it does occur, the information is not real-time or close to real-time. Use of real-time information is also limited by the availability of broadband in some parts of state.

RECOGNIZED PRACTICES TO CONSIDER

REFLECTING ON THE COUNCIL'S 'KEY TAKEAWAYS'

1   There is capacity for sharing information, managing flow, and keeping track of clients across the continuum.

2   Telehealth is provided for needed services not available in the local community.

WHAT WE HAVE HEARD

STAKEHOLDER PERSPECTIVES

1   Incorporate technology to support cross-system sharing of allowable information.
2   Technology needs to be able to track capacity and provide accurate information to 911/EDs.
3   Standardize mobile team dispatching through use of technology.
4   Use technology to identify high client utilizers and capacity predictions.
5   Develop apps/tools for individuals and families to convey preferences to care (e.g., crisis plans, advance directives).

OPTIONS FOR MOVING FORWARD

Items that will be addressed by the CRIS Committee and Subcommittees includes, but not limited to:

1   Make recommendations on the minimum requirements for the crisis call center platforms, the integrated client referral system, and any other platforms that will share demographic and clinical information.
2   Assess the current technological capabilities of the entities that will share information to determine the gaps to meet the desired future state.
3   Recommend realistic timeframes to migrate technology use to the desired future state.
4   Offer feedback on state agency implementation efforts to share confidential information as allowed under federal and state law.
5   Identify and recommend safeguards for entities that will be sharing client information.

There is a matrix of siloed, non-interoperable technology being used in the delivery of prevention and crisis services in Washington, resulting in a lack of real-time data to initiate coordination and to monitor client outcomes. There are multiple crisis call centers operating throughout the state (BH-ASO regional call centers, Lifeline call centers, and other call centers that serve distinct populations or regions), some of which are serving overlapping regions but not the always the same regions. While all of the call centers are using management systems to provide crisis services, route crisis calls, track and report call metrics, they are not integrated across the state. The BH-ASO region-based crisis lines are not connected electronically to the three Lifeline call centers in an inter-operable manner that will fulfill the requirements under HB 1477; however, the capacity and potential for this collaboration exists.

Health information technology platforms are not being used to any extensive degree for the purposes of care coordination and delivery of crisis services. Although there are tools available that would allow call centers and providers to access real-time information such as bed availability, scheduling for outpatient appointments, and information about client-specific ED usage, the use of these tools in Washington today is fragmented and inconsistent. There are pilot programs, however, that could yield promising results to expand on a statewide basis in the future.

National Promising Practices

Over the past several years, publications about the use of technology for supporting the delivery and monitoring of crisis systems have begun to surface. The following is a summary of these publications that include guidelines for core expectations, examples of the technology in applications, and examples of contract expectations from states.

SAMHSA outlines several core technologies for use in real-time coordination across a crisis system of care, including[35]:

- Recording outcome status disposition for every call, especially to understand the resolution for a call with high acuity;
- 24/7 scheduling for community-based services to ensure that there are next steps in place after a crisis call has concluded;
- Bed tracking technology to know in real-time the availability for urgent care/ crisis stabilization services;
- High-tech, GPS-enabled mobile dispatch in which a call center and community mobile service providers electronically communicate, enabling the call center to see a visual representation of the availability and location of mobile teams in the community;
- Use of real-time and static dashboards to know the current performance of the crisis system;
- Use of caller ID functioning to identify the place where a person is at imminent risk of harm; and
- Connections with local 911 systems.

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[35] Ibid.

The National Association of Mental Health Program Directors' *Crisis Now* website contains a video that conveys the use of call center technology and its integration with mobile teams.[36] The technology highlights a documentation platform that collects clinical information to support the assignment of risk scores, electronically shares clinical information with mobile teams, drives follow-up activity, uses dispatch technology, tracks the mobile team's locations, and electronically dispatches a team to a community location, and automatically tracks time stamp information such as travel time and on-scene time for performance monitoring. Dashboards are built to support management decision making with real-time information.

States are advancing what and how they are purchasing technology for use within the delivery of crisis services. One example of this is the State of Virginia, which issued an RFP to purchase crisis technology with requirements for a vendor to have all of the following:

- Chat, text (youth-friendly), with short code (SMS) to confirm receipt of messages, and direct phone call features (VoIP) to connect to call/contact center support staff;
- Bed-registration module which displays real-time vacancies at various support sites, such as community service boards, private hospitals, and crisis stabilization units;
- Outpatient appointment scheduler to support individuals;
- Configurable user provisioning tools to manage access to authorized users;
- Reporting on all data fields within each module and ability to export data from the system in multiple formats;
- Support various call measurement tools to assist with agency assessment of service levels, response times, and call hold times;
- Reliable infrastructure including ongoing upgrades, maintenance, back-ups, and performance such as page load times and database queries;
- Call recording and play-back feature for inbound/outbound calls;
- Supervisor call monitoring in order to support staff training and evaluations;
- Ability to transfer inbound calls seamlessly to another number/location for answer, including the National Suicide Prevention Lifeline;
- Option of displaying data in a dashboard view in real time; and
- Capability to interface with other programs via Application Programming Interface (API) such as an Electronic Health Record (EHR) system, the Emergency Department Care Coordination program platform, REACH Data Store, 911 platform, and local 211 data base.

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[36] National Association of Mental Health Program Directors Crisis Now website video, *Crisis Now: Transforming Crisis Services in Arizona* (2017) available at https://www.youtube.com/watch?app=desktop&v=ORq1MkODzQU

Themes Related to the Practice Guidelines Strategic Area

Theme #7: Person, Family and Community-Centered Approaches to Delivery of Crisis Services

WHERE WE ARE TODAY

THEME 7:   Person, Family and Community-Centered Approaches to Delivery of Crisis Services

7.1   Person-centered, culturally-responsive, and trauma-informed approaches are inconsistently applied across the state.

7.2   In some regions, services are often rendered in a more-- not less--restrictive setting due to the lack of alternative options for less-restrictive settings for those in crisis.

7.3   The options for individual and family empowerment (e.g., crisis warmlines, crisis drop-in centers, crisis respite centers) are limited in many regions. This can limit the ability to proactively prevent a crisis and results in a higher reliance on the crisis system itself.

7.4   Significant variations exist across rural communities in the state for crisis service offerings.

7.5   There are no systematic standard practices to support the person and family-centered approach within the current crisis system. This impacts both access and best practices for intervention.

RECOGNIZED PRACTICES TO CONSIDER

REFLECTING ON THE COUNCIL'S 'KEY TAKEAWAYS'

1   The system has expectations of universal competencies based on values.
2   Welcoming, hope and safety come first.
3   "No force first" is a required standard of practice.
4   Utilizing peer support in all crisis settings is a priority.

WHAT WE HAVE HEARD

STAKEHOLDER PERSPECTIVES

1   Build a "no wrong door" approach for accessing care regardless of diagnosis.
2   Create a public education campaign addressing mental health stigma and trauma-informed approaches.
3   Expand the use of peer supports throughout the crisis delivery continuum.
4   Expand the role of Tribal DCRs who can effectuate crisis stabilization in their community.

OPTIONS FOR MOVING FORWARD

Items that will be addressed by the CRIS Committee and Subcommittees includes, but not limited to:

1   Make recommendations to promote equity in services for individuals of diverse circumstances of culture, race, ethnicity, gender, socioeconomic status, sexual orientation, and for individuals in tribal, urban, and rural communities.
2   Engage the perspectives of individuals and family members with lived experience related to recommendations outlined by HB 1477.
3   Make recommendations for expansion of peer services, such as in peer-run respite programs or peers embedded in mobile crisis teams.
4   Make recommendations for including behavioral health advance directives as part of the person-centered planning approach to the delivery of care.

Looking across the state, no systematic standard practices were found to support the person and family-centered approach in the delivery of services. This impacts both access to services and the best practices for how services are delivered (e.g., services delivered in a more restrictive setting than is actually necessary). A statewide system with agreed-upon established standard practices across service providers would encourage improved outcomes for the client receiving services and for the system at large. This absence of systemic standards can often result in a lack of trust vertically and horizontally across the crisis system. This impedes communication, collaboration, and continuity of care.

Options for individual and family empowerment (e.g., peer services, respite, warm line, drop-in) were found to be limited in most regions. Moreover, person-centered, culturally responsive, and trauma-informed approaches are inconsistently applied across the state. The consequences of this limits the ability of the system to proactively prevent a crisis because an individual's needs are not fully understood early on. This often results in a more intensive intervention later on which is not only more expensive, but it is also more traumatic for the individual needing assistance.

The prevalence of services that specifically address the needs of subpopulations receiving crisis services (both preventative and acute in nature) are lacking, particularly for children and adolescents, Tribal communities, rural and agricultural communities, and pregnant women.

Finally, although peers are used in many settings in many parts of the state and are considered a key element of the crisis service continuum, there is no accepted standard about their role in the delivery of services across the crisis continuum. There is significant opportunity to leverage peers, especially given the challenges with the crisis workforce overall.

National Promising Practices

Person and family-centered care is healthcare provided in a manner that supports and empowers individuals and families to make their decisions about the care their receive.[37] This concept involves a partnership between the provider and the individual and/or family. The provider supports the individual and/or family by offering options, using shared decision-making approaches that include a sensitivity to cultural needs and preferences. Ultimately, this results in an understandable care plan that the individual and/or family desires to utilize and meets their unique needs and preferences. Healthcare and behavioral health care practitioners often need to obtain training and coaching with feedback to move their approaches from a "do as I say as I am the professional" to a more collaborative stance.

Some of the core concepts of individual and family-centered care include[38]:

- Dignity and Respect – Healthcare practitioners listen to and honor the individual and family perspectives and choices.
- Information Sharing – Healthcare practitioners communicate and share complete and unbiased information in ways that are affirming and useful to support their decision making.

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[37] National Quality Forum, *Person and Family -Centered Care* (2021) available at
https://www.qualityforum.org/topics/person-_and_family-centered_care.aspx

[38] Institute for Patient- and Family-Centered Care, *Patient- and Family-Centered Care Defined*, available at
https://www.ipfcc.org/bestpractices/sustainable-partnerships/background/pfcc-defined.html

- Participation – Individuals are encouraged and supported in participating in care and decision-making at the level they choose.
- Collaboration – Individuals, families, health providers, and healthcare leaders collaborate on policy and program development.

Peron and family-centered care involves the use of essential skills. Examples of this include motivational interviewing (MI)[39] which, at its core, is a purposeful conversation to elicit and explore the person's own reasons for change within an atmosphere of acceptance and compassion.

The literature further emphasizes the importance of using person and family-centered care while providing crisis response care. A recent publication by the World Health Organization, Mental Health Crisis Services[40] offers approaches to advance services that are person- and rights-based. Other publications speak to the ability to support an individual's personal decisions through the information that they volunteer. A recent Institute of Medicine Health Care Quality Initiative report emphasized findings to help examine how best to maximize persons with mental illness or substance use disorders in feeling more in control of decisions regarding their treatment.[41]

Over the past decade, Madelyn S. Gould, Ph.D., MPH at Columbia University within the Department of Psychiatry, has researched the effectiveness of the National Suicide Prevention Lifeline on many dimensions. A summary of her research presented a recent learning webinar showed that[42]:

- Callers to the Lifeline Center whose counselors inquired about current suicidal ideation, recent ideation, and past attempts were more likely to experience reduced distress.
- Crisis counselors using *Imminent Risk* (of suicide attempts) protocols were able to secure the caller's collaboration on an intervention over 75 percent of the time.
- On 19.1 percent of imminent risk calls, the counselors sent emergency services (police, sheriff, EMS) with the collaboration of the callers. On a quarter of these calls, the counselors sent emergency services without the caller's collaboration.
- Collaborative interventions not involving emergency services included getting rid of means, involving a third party, collaborating on a safety plan, and agreeing to receive follow-up from the crisis center.
- "Third-party callers" calling the Lifeline when they are worried about someone deemed to be at imminent risk provided a range of interventions which can supplement or replace calling 911. Two-thirds of chatters reported that chat was helpful and that they were significantly and substantially less distressed at the end of the chat intervention than they were at the beginning.

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[39] Motivational Interviewing Network of Trainers, *Understanding Motivational Interviewing,* retrieved at https://motivationalinterviewing.org/understanding-motivational-interviewing

[40] World Health Organization, *Mental Health Crisis Services – Promoting Person-Centered and Rights -Based Approaches,* (2021) available at https://www.who.int/publications/i/item/9789240025707

[41] National Association of Mental Health Program Directors, *Beyond Borders: Lessons from the International Community to Improve Mental Health Outcomes*, (2019), available at https://www.nasmhpd.org/sites/default/files/Paper1International_508C.pdf

[42] National Association of Mental Health Program Directors, webinar presentation, *Suicide Prevention and 988: Effectiveness of the National Suicide Prevention Lifeline,* (2021), available at https://talk.crisisnow.com/wp-content/uploads/2021/11/38-Lifeline-Evaluation.pdf

Theme #8: Collaboration in the Delivery of Crisis Services

WHERE WE ARE TODAY

THEME 8:   Collaboration in the Delivery of Crisis Services

8.1 Although there are a variety of collaborative efforts underway to create a system of care for crisis services, collaboration is fragmented and not always consistent across the state.

8.2 The lack of real-time information to crisis providers and law enforcement/EMS across the continuum of services can impede more cohseive collaboration.

8.3 There are some promising collaborative efforts underway within regions today. Further examination could reveal those efforts that can be scaled to a statewide level.

8.4 The information flow of services used by clients before, during, and after a crisis event is fragmented and inconsistent. Where it does occur, the information is not real-time.

RECOGNIZED PRACTICES TO CONSIDER

REFLECTING ON THE COUNCIL'S 'KEY TAKEAWAYS'

1 Engagement and information sharing is an essential competency in the system.
2 Utilize quality improvements methods (such as Lean) to develop triage protocols and information protocols across continuum.
3 Build documentation templates to eliminate redundancy.
4 Develop a continuous quality improvement mechanism to refine workflows after initial implementation.

WHAT WE HAVE HEARD

STAKEHOLDER PERSPECTIVES

1 The roles between Medicaid MCOs, BH-ASOs, and other collaborators is ambiguous.
2 There are some collaboration pilots underway, but they are the exception.

3 Re-imagine local community leadership and collaboration structures.
4 Collaborators often come together to discuss ideas for moving forward, but these ideas often fall short of full implementation.

OPTIONS FOR MOVING FORWARD

Items that will be addressed by the CRIS Committee and Subcommittees includes, but not limited to:

1 Provide recommendations on the rules of engagement among the entities that need to collaborate on the delivery of crisis services.
2 Write and recommend procedures using case study scenarios that can be used for training purposes on collaboration in the future.
3 Identify elements that will be used to define when cross-system collaboration is successful.
4 Recommend methods of how to audit the system to measure the effectiveness of collaboration.
5 Identify subject matter experts for recommendations on shareable practice guidelines.

Although there are a variety of collaborative efforts underway in Washington to create a system of care for crisis services, collaboration is fragmented and not always consistent in how it is done, what it is trying to address, and how it is monitored and measured in each region of the state. Washington's history of providing behavioral health and crisis services through the Regional Service Networks (RSNs), which became the Behavioral Health Organizations (BHOs), meant that collaborative efforts were oftentimes bolstered by local sales tax levies. This allowed for many innovative and localized approaches to addressing gaps in the crisis continuum. Many of these innovative and localized approaches could be considered for a larger systemwide approach to building the crisis continuum. However, the level of collaboration among partners is currently varied based on the goals that are trying to be achieved—and if there is consensus on these goals—and who is driving the effort. This varied approach has carried forward in how the HCA, the MCOs and the current BH-ASOs are working together today. For example, today there is not a consistent collaborative approach in between the HCA, the MCOs and the BH-ASOs to track the follow-up of clients after a crisis-related event.

It is important to recognize that, in many instances, while there may be good intentions to collaborate on behalf of patients among payers and across providers, these efforts are often hindered because there is a lack of real-time information available to providers across the continuum that would enhance their ability to work together.

National Promising Practices

Based on a scan of the literature, the definition of community collaboration generally includes the idea of *individuals working together as a collective to achieve shared goals and objectives.* Across the nation, community collaborations have been formed and implemented with a focus on changing how a system of care addresses the needs of the individuals and families they serve. *Systems of Care* collaborations have their origins in addressing the needs of children[43] and include *cross-system participation.* Collaborations specific to crisis systems have been forming around the nation for many years and often address the needs of those involved with the criminal justice system. These collaborations are sometimes supported by national organizations[44], but other times are formed as grassroots approaches.

Crisis system collaborations include many different types of stakeholders including, but not limited to, peers and family members with lived experience, crisis service providers, behavioral health services providers, physical health care providers, emergency departments, fire/EMS, police, protective services, probation, parole, social service providers such as homeless providers, faith-based organizations, community foundations, higher-education institutions, and other community members. There are many examples of best practice guides, videos, and webinars that convey how to form effective collaborations to address the needs of those experiencing a crisis. For example, in August of 2019, CIT International published a best practices guide outlining effective practices to address the needs of individuals who interface with law enforcement. Although many think CIT is a "training for police", this document

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[43] Ibid.

[44] Council of State Governments Justice Center, *Justice and Mental Health Collaboration Program and Implementation Guides* (2021) available at https://csgjusticecenter.org/projects/justice-and-mental-health-collaboration-program-jmhcp/planning-and-implementation-guides/

conveys that collaboration is the cornerstone of the work.[45] Another example of this is a video on the National Association of Mental Health Program Directors' *CrisisNow* website that demonstrates how formalized crisis collaborations across a state achieved outcomes for individuals and families experiencing a mental health emergency.[46]

One effective strategy that is often written about is where collaborations use data to monitor and understand where problems exist and to monitor progress that is being achieved. There are examples of crisis collaborations that have established *crisis system metrics* that measure responsiveness to individuals as well as to cross-system partners. For example, in Arizona, monthly system metrics include but are not limited to:

- Number of calls transferred from 911;
- Number of mobile teams that respond to emergency rooms for disposition of individuals back to the community;
- Number of mobile teams that respond to police officers in the community;
- Average response times of mobile teams to police officers in the community;
- Number of police drop-offs at crisis facilities; and
- Average time taken for police officers to return to the community following a "drop off" at crisis facility.

State Medicaid agency contracts with health plans are now considering ways to require that their contracted health plans support and participate in mental health system collaboratives including those focused on crisis services. Arizona Medicaid's contract with health plans includes the following terms:

> *The Contractor shall work in partnership … to meet, agree upon and reduce to writing joint collaborative protocols with local law enforcement and first responders, which, at a minimum, shall address jail diversion and safety, strengthening relationships between first responders and providers when support or assistance is needed in working with or engaging members, and procedures to identify and address joint training needs.*
> *… The collection, analysis, and use of crisis service data …is critical to the effectiveness of the overall crisis delivery system.[47]*

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[45] CIT International, *Crisis Intervention Training Program: A Best Practice Guide for Transforming Community Responses to Mental Health Crisis* (2019) available at https://www.citinternational.org/bestpracticeguide

[46] National Association of Mental Health Program Directors, *Crisis Now Successes in Arizona* (2017) available at https://www.youtube.com/watch?v=ORq1MkODzQU

[47] Arizona Health Care Cost Containment System, *AHCCCS Contract Amendments* (2021) available at https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/contracts.html

Section V: Funding Crisis Response Services

Introduction

House Bill 1477 Section 104 requires that the CRIS Steering Committee submit a preliminary recommendation to the Governor and the Legislature by January 1, 2022 on the funding of crisis response services from revenues generated by the line tax also established in HB 1477. The Steering Committee is required to assess the costs to stand up the 988 crisis call centers in Washington including ongoing operational costs. If there are resources available after the 988 crisis lines are funded, the Steering Committee is to make recommendations on how to use the remaining funds, in particular, for statewide coverage of mobile rapid response crisis teams (Section 104, (1)(b)). The Steering Committee is to recommend the priority areas of the state where funds should be directed for mobile rapid response crisis teams should there be available resources from the line tax fund. The Steering Committee is also required to analyze potential options to reduce the line tax over time.

In addition to items above, the Steering Committee must identify potential funding sources to provide statewide and regional crisis services and resources (Section 103, (5)(d)) and cost estimates for each of the components of the integrated crisis response and suicide prevention system (Section 103, (6)(m)).

The Department of Health has been charged with the development of the cost estimate to stand up 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 by July 2022. The intent is for the 988 crisis call centers to build interoperability and other emergency response systems in the state such as 911.

Final recommendations on revenue sources, costs, and allocation of resources from the line tax fund are due to the Governor and Legislature by January 1, 2023. Significant work will be undertaken during Calendar Year (CY) 2022 to refine cost estimates (for the 988 crisis lines, for service delivery costs, and for technology improvement costs). As such, in this report, an explanation of how the budget models are being constructed are introduced in lieu of absolute dollar figures. Key inputs that are built into the models are described. If and when baseline data on the utilization and users of crisis services becomes available to the Steering Committee for analysis, the model will be continually refined throughout CY 2022. The revenue and cost estimates in this section should be considered **preliminary**.

Development of the Model to Forecast Crisis Service Delivery Costs

The model that has been built for this initiative inventories all of the potential revenue sources and the categories of expenditures that are considered in the model. A detailed schematic of this design is shown in Exhibit V.1 on the next page. The left side of the exhibit shows all of the revenue sources. The right side shows all of the expenditure (cost) categories. Costs are assigned to one of three groups:

- Group 1 is for the ongoing costs of the 988 crisis call centers.

- Group 2 is for the costs of services in place today (at least in most regions of the state) that relate to the immediate resolution of either calls to a crisis line or when the client presents to a hospital emergency department with a mental health crisis.

- Group 3 is for the costs of new services that are likely envisioned in a crisis delivery model that is considered a best practice. It also includes the costs for services that may be delivered to those in crisis beyond the immediate crisis at hand, such as residential treatment, supported housing, or peer supports.

The services shown in Group 3 are not intended to be an exhaustive list of what may be included in this category. It is anticipated that the CRIS Committee will contemplate the services to include in the model under Group 3 for the final recommendations put forth in January 2023.

It should also be noted that the cost estimates thus far in Groups 2 and 3 reflect the costs to deliver services. Infrastructure costs, such as technology improvements, have not yet been factored into the estimate. The Steering Committee will be working closely with HCA in early 2022 to determine the costs of technology and other infrastructure improvements.

Exhibit V.1

Schematic of Building the Fiscal Budget for Crisis-Related Services

REVENUES	EXPENDITURES

GROUP 1: IMPLEMENTING THE 988 CRISIS LINES

988 Behavioral Health Crisis Response and Suicide Prevention Line Account

→

988 call center operations, training, and technology

Washington Indian Behavioral Health Hub

GROUP 2: SERVICES RELATED TO THE IMMEDIATE RESPONSE FROM THE CRISIS CALL OR ED VISIT

Federal HHS: SAMHSA Grants

Federal HHS: Medicaid

Federal HHS: Medicare

State Share of Medicaid

Local Government Funding

Commercial Insurers

Self Funded Private Insurance Plans

→

Existing Crisis Lines	Mobile Crisis Teams
DCR Investigations	Crisis Stabilization Units
Inpatient Hospital Stays	Emergency Dept Visits

*Federal HHS is the Department of Health and Human Services, home of Medicare and Medicaid
SAMHSA is the Substance Abuse and Mental Health Services Administration*

**GROUP 3: NEW & EXPANDED SERVICES PART OF THE IMMEDIATE CRISIS RESPONSE AND
LONGER-TERM PREVENTATIVE AND TREATMENT SERVICES**

Federal HHS: SAMHSA Grants

Federal HHS: Medicaid

Federal HHS: Medicare

State Share of Medicaid

Local Government Funding

Commercial Insurers

Self Funded Private Insurance Plans

→

Warm Call Lines	Peer Supports
Walk-in Clinics	Residential Treatment
Crisis Respite Centers	Supported Housing

LEGEND

Tax paid by State taxpayers

Funds from the federal government

Funds from state or local government

Funds from the private sector

As stated in the introduction, the Washington Department of Health (DOH) has led the charge to build the cost estimate for Group 1 costs.

The DOH has been utilizing the analysis and technical expertise of Vibrant Emotional Health 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, per chat call, and 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.

Uncertainty remains, however, in the total volume for the 988 crisis lines in the next five years based on volume of calls within Washington today from sources other than the National Suicide Prevention Lifeline. For example, estimates are still being refined as to the projection of calls that will be redirected from 911 or from the call centers that are in place at the regional level under the responsibility of the BH-ASOs. Further, the impact of future marketing of the 988 crisis lines—both at the federal and state level—that will increase awareness of the existence of 988 will be a key influence on future call projections.

For these reasons, as well as final decisions by the federal government about the mandatory requirements of each 988 crisis line, a final cost estimate for the 988 crisis lines in Washington is not yet finalized. The DOH will be consulting with the Legislature in January 2022 about the cost projection. Exhibit V.2 on the next page shows an illustration of the inputs into the cost projection that is still under refinement. Although the DOH will have a refined estimate by late January 2022, this estimate will still be preliminary. A further refinement will be completed later in 2022 after the 988 crisis lines have come online. Post-implementation, actual call volume will be tracked as well as the method of call (e.g. by voice, by chat, or by text). The volume of calls requiring Spanish translation and calls that will be transferred to the Washington Indian Behavioral Health Hub will also be refined. Most significantly, a better estimate of transfers of calls from other crisis lines (e.g., 911 or the BH-ASO lines) will be refined in order to better estimate the 988 crisis lines costs in the first five years of the 988 lines. These costs will be compared to the projected revenue from the line tax through the end of State Fiscal Year 2027, which is expected to be $239.4 million (source: fiscal note summary from HB 1477).

Exhibit V.2

Developing Cost Projections for the 988 Crisis Lines

Estimating VOLUME of Calls					
Calls Directly to 988 Lines	Year 1	Year 2	Year 3	Year 4	Year 5
Calls Redirected from 911 to 988	Year 1	Year 2	Year 3	Year 4	Year 5
Calls Redirected from Other Lines	Year 1	Year 2	Year 3	Year 4	Year 5

Estimating METHOD of Call Contact					
Contact by Voice Call	Year 1	Year 2	Year 3	Year 4	Year 5
Contact by Chat	Year 1	Year 2	Year 3	Year 4	Year 5
Contact by Text	Year 1	Year 2	Year 3	Year 4	Year 5

Estimating Volume of ENHANCED SUPPORTS					
Spanish Translation Required	Year 1	Year 2	Year 3	Year 4	Year 5
Transfer to Indian Beh. Health Hub	Year 1	Year 2	Year 3	Year 4	Year 5

Estimating COSTS Per Call					
Contact by Voice Call	Year 1	Year 2	Year 3	Year 4	Year 5
Contact by Chat	Year 1	Year 2	Year 3	Year 4	Year 5
Contact by Text	Year 1	Year 2	Year 3	Year 4	Year 5
Additional Costs Spanish Translation	Year 1	Year 2	Year 3	Year 4	Year 5
Additional Costs Transfer to Indian BH Hub	Year 1	Year 2	Year 3	Year 4	Year 5

Estimating COSTS for State Administration and Oversight					
Contact by Voice Call	Year 1	Year 2	Year 3	Year 4	Year 5

For services in Group 2 (Services Related to the Immediate Response from the Crisis call or ED Visit), high-level cost estimates have been developed in the model thus far. For services in Group 3 (New & Expanded Services for the Immediate Response and Longer-Term Preventative & Treatment Services), no cost estimates have been developed because the CRIS Committee as a whole has not had the opportunity to consider what services would be considered "in scope" for this budget estimate. There are plans to have this discussion with CRIS Committee members in early 2022.

Exhibits V.3 and V.4, which appear on the next two pages, lay out a schematic of how the cost portion of the model will be developed. In Exhibit V.3, the costs for services assigned to Group 2 and Group 3 will be tracked separately in the model. The top portion of Exhibit V.3 lays out the foundation for developing costs for Group 2 services. The bottom portion of the exhibit does the same for Group 3 services. The current services mapped to each group are shown in the boxes below the header for Group 2 and Group 3.

Within each group, the cost model has been developed to forecast costs over the same five-year period that was shown of the 988 crisis call centers. A forecast of the utilization of crisis-related services will be developed *by region by year* as well as for the state overall. Exhibit V.3 depicts the 10 regions within each year. Each box will represent the costs for either Group 2 or Group 3 services in that region in that year. At the top of the column for each year, a box for the Entire State is shown, representing the sum of the costs across all 10 regions.

The regions shown in Exhibit V.3 represent the regions that each BH-ASO is responsible for. Each of Washington's 39 counties map to one of the 10 regions. Exhibit V.4 shows representations of other ways in which cost estimates are intended to be developed if the data is available to the Steering Committee. At the top of Exhibit V.4, it shows the intent to divide the entire state population into three categories of demographically-defined populations:

- Population by Age: children and adolescents or adults
- Population by Insurance Status: Medicaid, Medicare, Private Insurance, or Uninsured
- Population by Race or Ethnicity: Caucasian, African-American, Hispanic, Asian American, Native American, and All Other

HB 1477 requires examination of current inequities in the delivery of crisis-related services for Black, Indigenous, and People of Color (BIPOC) populations as well as other populations (e.g., LGBTQ, homeless, veterans). The Steering Committee will make every effort to be inclusive in its examination of the current state of services for all subpopulations, but the manner in which some subpopulations may be able to be identified in any baseline data could be limited.

To date, there have been multiple mentions by CRIS Committee members of the interest in examining crisis-related services (and current gaps in services) for the child and adolescent population separate and distinct from the adult population. The budget model will address this distinction wherever possible.

Finally, the insurance status of the population will be tracked in the model not only for the cost side but, importantly, for the sources of revenue to fund crisis services. In the current state, payers have very different levels of funding for crisis services. It will be important to track the baseline data of users by insurance status to assess the funding contributions of each payer. The bottom portion of Exhibit V.4 illustrates that not only will costs for services be tracked at the regional level, but it is also the intent to track costs at the subpopulation levels *within each region*.

Exhibit V.3
Developing a 5-Year Cost Projections for Crisis Services at the Regional Level

GROUP 2: SERVICES RELATED TO THE IMMEDIATE RESPONSE FROM THE CRISIS CALL OR ED VISIT

Existing Crisis Lines	Mobile Crisis Teams	Inpatient Hospital Stays
DCR Investigations	Crisis Stabilization Units	Emergency Dept Visits

YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
July 2022 - June 2023	July 2023 - June 2024	July 2024 - June 2025	July 2025 - June 2026	July 2026 - June 2027
ENTIRE STATE	ENTIRE STATE	ENTIRE STATE	ENTIRE STATE	ENTIRE STATE
Great Rivers	Great Rivers	Great Rivers	Great Rivers	Great Rivers
Greater Columbia	Greater Columbia	Greater Columbia	Greater Columbia	Greater Columbia
King County	King County	King County	King County	King County
North Central	North Central	North Central	North Central	North Central
North Sound	North Sound	North Sound	North Sound	North Sound
Pierce	Pierce	Pierce	Pierce	Pierce
Salish	Salish	Salish	Salish	Salish
Southwest	Southwest	Southwest	Southwest	Southwest
Spokane	Spokane	Spokane	Spokane	Spokane
Thurston-Mason	Thurston-Mason	Thurston-Mason	Thurston-Mason	Thurston-Mason

GROUP 3: NEW & EXPANDED SERVICES, LONGER-TERM PREVENTATIVE & TREATMENT SERVICES

Warm Call Lines	Crisis Respite Centers	Residential Treatment
Walk-in Clinics	Peer Supports	Supported Housing

YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
July 2022 - June 2023	July 2023 - June 2024	July 2024 - June 2025	July 2025 - June 2026	July 2026 - June 2027
ENTIRE STATE	ENTIRE STATE	ENTIRE STATE	ENTIRE STATE	ENTIRE STATE
Great Rivers	Great Rivers	Great Rivers	Great Rivers	Great Rivers
Greater Columbia	Greater Columbia	Greater Columbia	Greater Columbia	Greater Columbia
King County	King County	King County	King County	King County
North Central	North Central	North Central	North Central	North Central
North Sound	North Sound	North Sound	North Sound	North Sound
Pierce	Pierce	Pierce	Pierce	Pierce
Salish	Salish	Salish	Salish	Salish
Southwest	Southwest	Southwest	Southwest	Southwest
Spokane	Spokane	Spokane	Spokane	Spokane
Thurston-Mason	Thurston-Mason	Thurston-Mason	Thurston-Mason	Thurston-Mason

Exhibit V.4
Additional Cost Estimates Contemplated in the Crisis Delivery System Budget Model
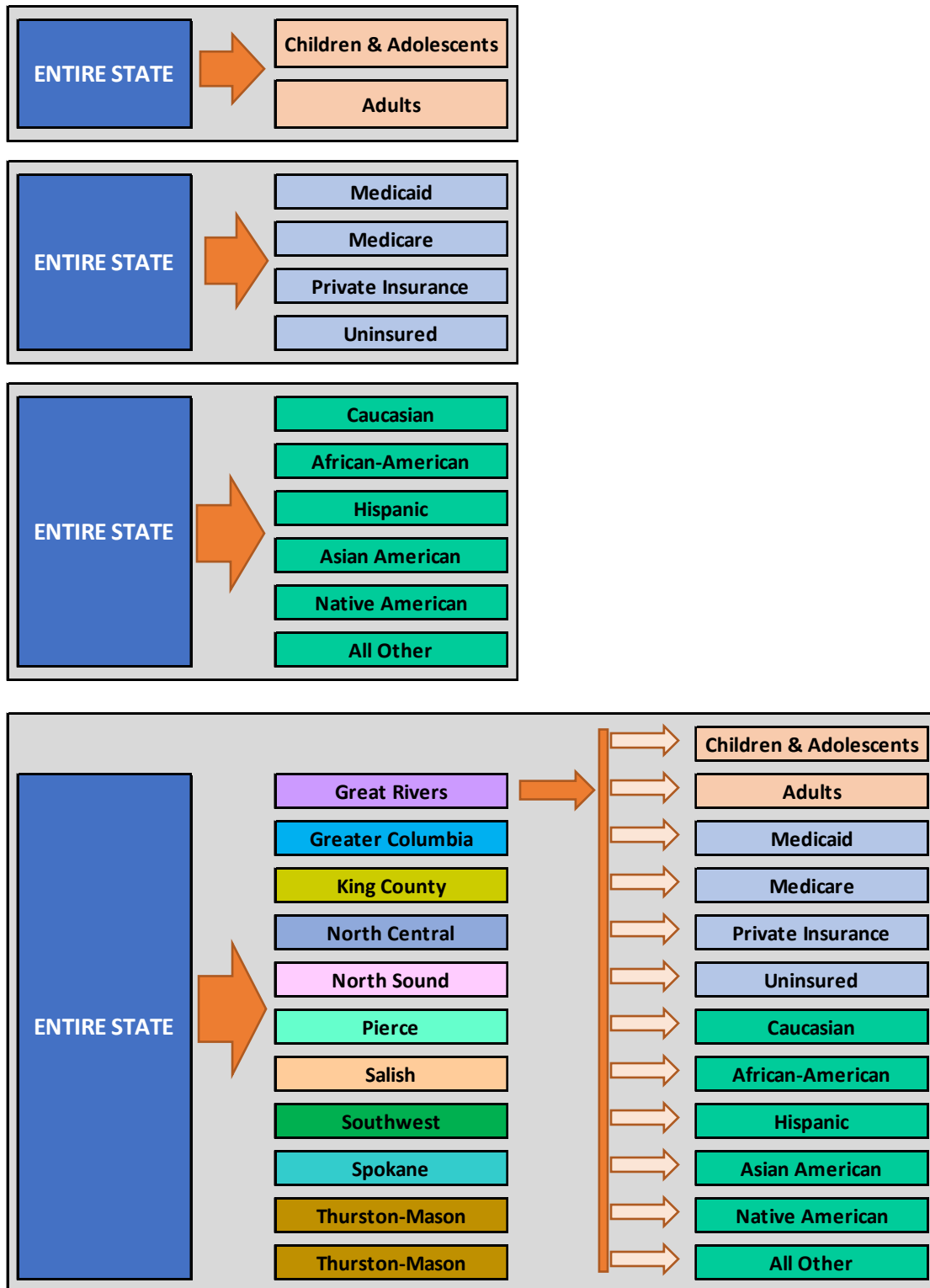
A preliminary estimate of the services defined in Group 2 of the model has been prepared, but this estimate is subject to considerable refinement when and if more baseline data is made available to the Steering Committee. As such, a low-middle-high estimate is shown for each of the five years in the model. Exhibit V.5 shows a middle estimate of $703.9 million in Year 1 which grows to $824.2 million in Year 5. The low and high estimates are 80 percent and 120 percent, respectively, of the middle estimate in each year.

It is important to note that Exhibit V.5 represents projected costs only. It does not factor in the payments to cover these services, including the federal government (through the Medicaid program, the Medicare program, and SAMHSA grants), private insurers, local funds, and state general funds. It also does not include the costs of the 988 crisis call centers.

Exhibit V.5
Draft Preliminary Cost Forecasts for Group 2 Services in Washington's Crisis System

| Group 2: Services Related to the Crisis Call or ED Visit and Immediate Response				
Does not include Group 3 Costs (new and expanded services, longer term crisis-related supports)				

	Year 1 July 2022 - June 2023	Year 2 July 2023 - June 2024	Year 3 July 2024 - June 2025	Year 4 July 2025 - June 2026	Year 5 July 2026 - June 2027
Total costs shown in millions. Does not reflect matching funds from other sources.					
Low Estimate	$563.1	$573.9	$612.2	$641.0	$659.4
Middle Estimate	$703.9	$717.4	$765.2	$801.2	$824.2
High Estimate	$844.7	$860.9	$918.2	$961.4	$989.0

As seen in the exhibit, the model assumes an absolute increase in costs to the crisis system statewide over time. The model also assumes a substitution of costs within Group 2 services over time as well. Namely, the model assumes an accelerated increase in mobile crisis teams and crisis stabilization units but a reduction in hospital emergency department visits, inpatient hospital stays, and Designated Crisis Responder investigations. The intent is, over time, to migrate services away from more restrictive (and more expensive) settings toward less restrictive (and less expensive) settings.

Intended Model Refinement in Calendar Year 2022

The current model uses a series of utilization and cost inputs for a baseline period to future each of the five years in the model. Utilization for each service is trended upward or downward on an annual basis. For example, as mentioned above, emergency department visits for mental health conditions are trended down modestly each year while the deployment of mobile crisis teams trends upward each year.

At the moment, the utilization trends are based mostly on the overall population in each region of the state, the number of calls currently to crisis lines (either the National Suicide Prevention Line, the BH-ASO lines, and estimates from 911), and the use of each crisis service as reported quarterly by the BH-ASOs. Because the BH-ASOs are responsible for only a limited array of the crisis service delivery system, the services outside the BH-ASO purview (e.g. inpatient hospital stays, emergency department visits, and crisis stabilization units) are estimated. Further, the BH-ASOs will only report on utilization paid either by Medicaid or through grant funds for the uninsured. Utilization data for Medicare beneficiaries and the privately insured is currently an estimate since baseline information is not available at present.

The ability to intake more complete baseline information from other sources is not the only consideration in the refinement of the model, but it would be useful to help refine utilization trend rates by payer. Additionally, having information on the payments for each service delivered would be useful to capture where the system is today in the rate of payment for each service. However, the model as it is designed will not rely solely on historical payments because feedback received in the assessment process thus far indicates that the current rates of payment may be too low and are discouraging new providers from entering the delivery system.

During CY 2022, it is the Steering Committee's intent to work with the DOH on the refinement of its model to project the costs of the three Washington 988 Lifeline call centers and the Washington Indian Behavioral Health hub. Data from the beginning months of the implementation of 988 as of July 2022 will help to inform refinement of the number and types of calls to the Lifeline calls centers and how this also impacts 911 and the BH-ASO crisis lines.

The cost model for other crisis-related service will be continually refined during 2022 in anticipation of better estimates to deliver to the Governor and Legislature by January 1, 2023. Work will be ongoing throughout the year and budget development will be iterative in nature—that is, the budget estimate from both the revenue and cost side, will be continually updated throughout the year. A mid-year update of the budget estimate is plausible.

Exhibit V.6 on the next page shows the current inputs into the budget model for service delivery costs. Information from only a few sources has been made available thus far (indicated with an *). Other potential sources for baseline information in the model that can be further explored in early 2022 appear in the exhibit. The Steering Committee will be working closely with HCA in early 2022 on the development of estimates for technology improvement costs that will support the entire crisis delivery system.

Exhibit V.6

Inputs Into Current Budget Model for Crisis Services and Potential Sources to Refine the Model

Type of Input	Source(s) [an * means data already received]
Population Estimates	
Total State Population	Washington Office of Financial Management*
Medicaid Population	Health Care Authority website for All Payer Claims Database*
Medicare Population	Centers for Medicare and Medicaid or Census Bureau
Commercial Insured Population	Office of Insurance Commissioner or Census Bureau
Utilization of Crisis Services (rate of use by region and by subpopulation)	
Mobile Teams	*Potential sources for all inputs in this section include:*
DCR Investigations	HCA Medicaid database of utilization and enrollment
Crisis Stabilization Units	Washington All Payer database of utilization and enrollment
Mental Health Emergency Dept Visits	Behavioral Health ASOs*
Mental Health Inpatient Hospital Stays	Medicaid MCOs and Private Commercial carriers
Crisis Respite Centers	
Peer Support Services	
Residential Treatment Centers	
Supported Housing	
Average Length of Stay for Crisis Stabilization	
Average Length of Stay for Inpatient Hospital Stays	
Average Length of Stay for Residential Treatment Centers	
Average Length of Stay for Supported Housing	
Cost of Crisis Services	
Mobile Teams	*Potential sources for all inputs include the following:*
DCR Investigations	HCA Medicaid database of utilization and enrollment
Crisis Stabilization Units	Washington All Payer database of utilization and enrollment
Mental Health Emergency Dept Visits	Behavioral Health ASOs
Mental Health Inpatient Hospital Stays	Medicaid MCOs and Private Commercial carriers
Crisis Respite Centers	Survey or input from providers who deliver these services
Peer Support Services	
Residential Treatment Centers	
Supported Housing	

Preliminary Recommendations for Funding Crisis Service Delivery Costs

1. At this time, 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 call volume and cost estimates will determine if the projected revenue of $239 million from the line tax over the next five years will cover the costs of the 988 crisis lines in years four and five. Additional data will be required after the implementation of the 988 lines in July 2022 to refine the estimate. 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 crisis teams until after the DOH 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.

Section VI: Recommendations for Activities for the Crisis Response Improvement Strategy Committee and its Subcommittees in CY 2022

Introduction

The report serves as the preliminary assessment of the crisis delivery system in Washington. There has already been thoughtful feedback from a variety of stakeholders on what they envision could be the future of this delivery system that centers on the individuals being served. It is this Steering Committee's aspiration to build a system that is considered a national standard. To achieve this, much work lies ahead in the next two years.

Through HB 1477, the Steering Committee is charged with setting the priorities for each subcommittee listed in the legislation. The Steering Committee also has the authority to establish additional subcommittees that it deems necessary. Five subcommittees were established in the legislation. The Steering Committee has already established two additional subcommittees (Rural & Agriculture and Lived Experience). The subcommittees met for the first time in a plenary session on December 2. Each subcommittee will begin its work in earnest starting in early 2022.

The Steering Committee is also recommending two additional subcommittees for a total of nine subcommittees. The new proposed subcommittees are Quality & Oversight and Service Delivery Costs. More information on these new subcommittees appears later in this section.

The Steering Committee will set the tasks for each subcommittee and its meeting schedule. In general, it is assumed that each subcommittee will meet no more than once per month throughout 2022. The work of each subcommittee will be to perform required tasks in HB 1477 and to inform the updated progress report to the Governor and Legislature due January 1, 2023. Subcommittees will continue to meet during 2023 as well since the final report of the Steering Committee is due to the Governor and Legislature on January 1, 2024. For now, our focus in this report is on Calendar Year 2022 activities.

Not all subcommittees may need to meet each month of CY 2022. Regardless, placeholder meetings will be set for each subcommittee monthly in the event that they are needed. Subcommittees may request to meet more often than monthly, but this will be at the discretion of the Steering Committee.

All subcommittee meetings will be open to the public. From a scheduling perspective, this means that subcommittee meetings will not be held at concurrent times. It is currently envisioned that monthly subcommittee meetings will be held on a dedicated day each month (e.g., the 3rd Tuesday of every month). All subcommittees that need to meet in a month will meet over a three day period (e.g., the Tuesday, Wednesday, and Thursday of the 3rd week of the month). The meeting schedule for each subcommittee will be published on the Crisis Response Improve Strategy Committee homepage at https://www.hca.wa.gov/about-hca/behavioral-health-recovery/crisis-response-improvement-strategy-cris-committees. Materials will be provided in advance to each subcommittee member for their meeting. Agendas will be published on the CRIS homepage in advance of each meeting. Materials provided to subcommittee members will also be published on the homepage after each meeting along with notes from each meeting.

The team at Health Management Associates and the Behavioral Health Institute at Harborview Medical Center will serve as technical assistants to each subcommittee. A staff member will be dedicated to each

subcommittee to ensure that the subcommittee members are responded to for additional materials or analyses to do their work. All requests of this nature by subcommittee members will be vetted by the Steering Committee. The subcommittee members themselves are also being asked to play an active role throughout the duration of the subcommittee. This may include volunteering to bring forth their own research or analysis to assist their subcommittee.

During CY 2022, it is envisioned that the CRIS Committee as a whole will meet six times, once every other month. On alternating months, the Steering Committee will meet. Progress Reports from each subcommittee will be due for presentation to the CRIS Committee in the July and November CRIS Committee meetings. Some subcommittees may be invited guests to present at other CRIS meetings depending upon the topics on the agenda at CRIS Committee or CRIS Steering Committee meetings.

Proposed Activities for the CRIS Steering Committee and CRIS Committee

HB 1477 identified specific requirements that must be completed for inclusion in the reports due to the Governor and Legislature on January 1, 2023 and January 1, 2024. The Steering Committee has reviewed these tasks and has divided responsibilities between the Steering Committee, the CRIS Committee, and the subcommittees. Some tasks in the legislation are the specific responsibility of the Department of Health or the Health Care Authority. These state agencies will manage these tasks, where applicable, but will coordinate their activities with the Steering Committee. Representatives from both state agencies sit on the Steering Committee.

Although the Steering Committee is ultimately responsibility for all activities authorized to it under HB 1477, the Steering Committee will take primary responsibility for the following activities:

- Develop the vision for an integrated crisis network that includes 911 and the 988 crisis line call centers, mobile rapid response crisis teams, and the array of services supporting the crisis delivery system as defined by the Steering Committee.

- Direct the responsibilities of each subcommittee as well as setting meetings and agendas for each subcommittee.

- Select CRIS Committee members who will serve as liaisons to each subcommittee.

- Receive progress reports and synthesize the work and feedback from each subcommittee.

- Identify linkages across subcommittees where coordination will be required.

- Refine the cost projections presented in this report for delivery in the January 2023 report.

- Make recommendations to promote equity in services along the crisis delivery continuum.

- Make recommendations on financing and the distribution of available funds for crisis services.

- Make recommendations related to ongoing oversight of the crisis delivery system.

- Deliver a progress report and recommendations related to crisis call centers, funding of the crisis delivery system, and other items required in HB 1477 by Jan 1, 2023.

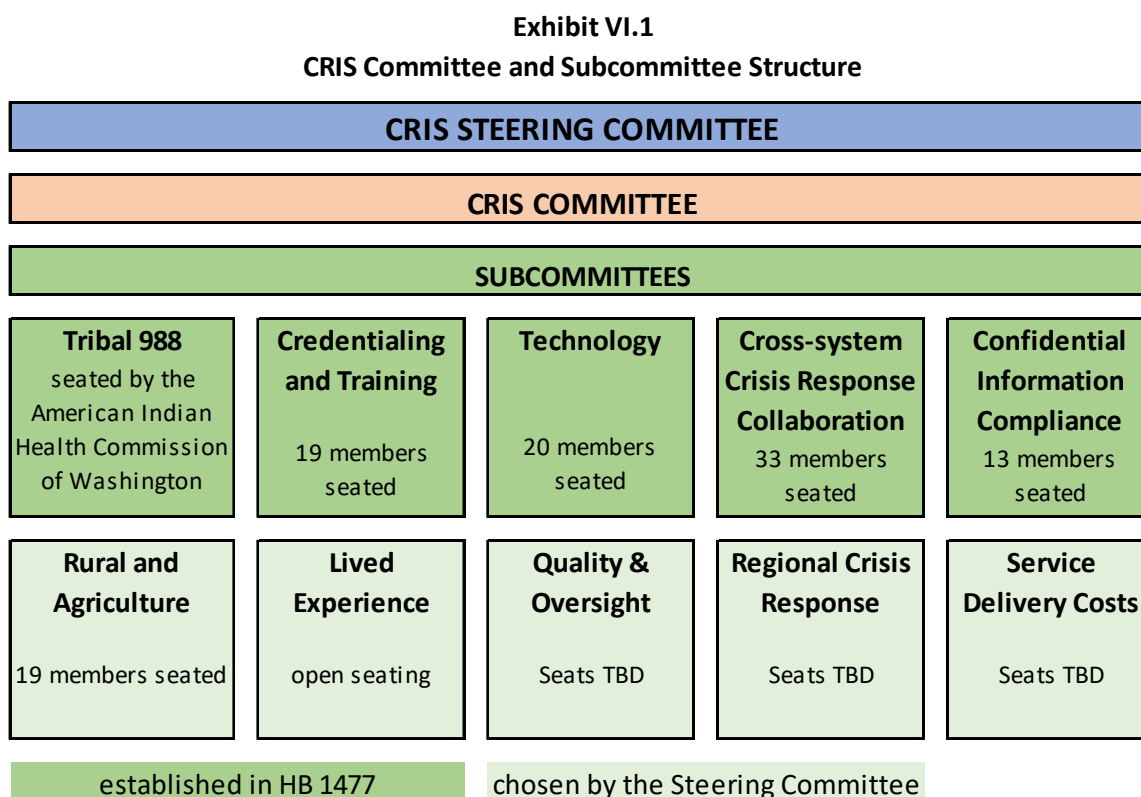- Deliver a final report to the Governor and Legislature by Jan 1, 2024.

The CRIS Committee will support the Steering Committee by providing feedback and recommendations on activities conducted by the subcommittees and other items required in HB 1477. Specifically, the CRIS Committee will:

- Provide feedback on the vision for an integrated crisis network.

- Receive progress reports from each subcommittee and provide feedback and recommendations to the Steering Committee about what has been learned.

- Participate in discussions to promote equity in services along the crisis delivery continuum and make recommendations to the Steering Committee on this topic.

- Receive drafts of components of the reports due January 1, 2023 and January 1, 2024 and provide feedback on these drafts before each report is finalized.

Proposed Activities for the CRIS Subcommittees

CRIS Subcommittees

The CRIS Subcommittee structure is shown in Exhibit VI.1 below. A description of each subcommittee appears below the exhibit.

Exhibit VI.1
CRIS Committee and Subcommittee Structure

CRIS STEERING COMMITTEE

CRIS COMMITTEE

SUBCOMMITTEES

Tribal 988 seated by the American Indian Health Commission of Washington	Credentialing and Training 19 members seated	Technology 20 members seated	Cross-system Crisis Response Collaboration 33 members seated	Confidential Information Compliance 13 members seated
Rural and Agriculture 19 members seated	Lived Experience open seating	Quality & Oversight Seats TBD	Regional Crisis Response Seats TBD	Service Delivery Costs Seats TBD

established in HB 1477	chosen by the Steering Committee

For the first five subcommittees, the language highlighted in maroon identifies the responsibilities for the subcommittee as outlined in HB 1477. For the last five subcommittees, the language highlighted in green represents the responsibility of each subcommittee as identified by the Steering Committee.

1. Washington Tribal 988 (TR): Examine and make recommendations with respect to the needs of tribes related to the 988 system in alignment with American Indian Health Commission.

2. Credentialing and Training (CT): Recommend workforce needs and requirements necessary to implement this act, including minimum education requirements.

3. Technology (TE): Examine issues and requirements related to the technology needed to implement this act.

4. Cross-system Crisis Response Collaboration (CS): Examine and define the complementary roles and interactions between mobile rapid response crisis teams, designated crisis responders, law enforcement, emergency medical services teams, 911 operators, 988 crisis line operators, public and private health plans, behavioral health crisis response agencies, nonbehavioral health crisis response agencies, and others needed to implement this act.

5. Confidential Information Compliance and Coordination (CI): Examine issues related to sharing and protection of health information needed to implement this act.

6. Rural and Agricultural Communities (RA): Examine the unique needs of rural and agricultural communities and inform recommendations outlined by HB 1477.

7. Lived Experience (LE): Engage the perspectives of individuals and family members with lived experience related to recommendations outlined by HB 1477.

8. Quality and Oversight (QO): Recommend options constituting a statewide crisis response and suicide prevention oversight board an oversight board. Identify quality measures to assist in developing dashboard reports for ongoing oversight.

9. Regional Crisis Response (CR): Identify capacity and need at the regional level for the delivery of a full continuum of services to deliver to those in crisis and preventative services to those at risk of crisis. Utilize representatives from cities and counties to offer recommendations for localized solutions in conjunction with the Cross-system Crisis Response Collaboration Subcommittee.

10. Service Delivery Costs (SDC): Provide recommendations for the costs to deliver each discrete service in the crisis delivery system. Offer recommendations for the method of payment to providers for each service.

The Steering Committee has proposed the addition of the ***Quality and Oversight Subcommittee*** because it was determined that significant work needs to be conducted in the area of quality measurement and oversight. Currently, there are few metrics used to measure the quality of the services delivered in the crisis continuum. None of the metrics are applied across all payers. Current metrics focus on process, not client outcomes. The Steering Committee proposes to seat this subcommittee with no more than 20 members which will include representation from the Health Care Authority, the Department of Health, WaTech, Behavioral Health ASOs, Medicaid managed care organizations, and commercial health plans.

The Steering Committee has proposed the addition of the ***Regional Crisis Response Subcommittee*** to learn more from regional jurisdictions about what options for the delivery of acute and preventative crisis services are best suited using a statewide approach and which are best suited using a region-based solution. The Steering Committee also wants to learn more from those delivering services on the frontline at each region about the capacity, technology, and infrastructure challenges in their region.

The Steering Committee has proposed the addition of the ***Service Delivery Costs Subcommittee*** in order to gain a better understanding of the costs that crisis service providers bear to render the services across the crisis continuum. It will be important for the Steering Committee to understand costs that are borne out by current workforce shortages in the state, the licensure or other minimum credentials for certain staffing categories, and the differences in costs between urban and rural portions of the state. The Steering Committee proposes to seat this subcommittee with no more than 20 members that will include representation from urban-based and rural-based providers for the following services: mobile crisis teams, DCR investigations, crisis stabilization units, residential treatment centers, supported housing, hospitals, and counseling practitioners. Subcommittee members will also include representation from provider associations, behavioral health ASOs, Medicaid managed care organizations, DOH staff, and HCA staff (representing the fee-for-service portion of Medicaid).

Mapping of Legislative Requirements to CRIS Subcommittees

HB 1477, Section 103, Subsections 5 and 6, identify specific tasks that are required for the Steering Committee to include in its reports to the Governor and Legislature in January 2023 and January 2024. The items in Subsection 5 are a continuation of work reported in preliminary format in this report. The items in Subsection 6 are new tasks that will begin in earnest in CY 2022 and will continue into CY 2023.

Exhibit VI.2, which begins on the next page, maps these legislative requirements to each subcommittee that the Steering Committee that has been assigned the task. The Steering Committee itself, the CRIS Committee, the Health Care Authority, and the Department of Health are also included in this exhibit since each of these groups also has responsibility for tasks.

On each row in the exhibit, boxes that are shaded in means that the group listed at the top of each column will take responsibility for completion of work related to each legislative requirement. In some cases, more than one subcommittee is assigned responsibility. The Steering Committee recognizes that there will be linkages and dependencies across subcommittees for some tasks. As a result, the Steering Committee will identify the responsibilities for each subcommittee for these tasks and will require deadlines for progress reports if one subcommittee's tasks is dependent upon the work of another subcommittee.

After Exhibit VI.2, some more information about the assignments for each subcommittee is discussed.

Exhibit VI.2
Distribution of Assignments Based on HB 1477 Requirements

HB 1477, Section 103, Subsection 5 provision
HB 1477, Section 103, Subsection 6 provision

		CRIS Steering Committee	CRIS Committee	HCA	DOH	CRIS Subcommittees									
						Tribal 988	Creden-tialing and Training	Tech-nology	Cross-System Crisis Response	Confi-dential Info Com-pliance	Rural & Agri-cultural	Lived Exper-ience	Quality and Over-sight	Regional Crisis Response	Service Delivery Costs
1	Develop an inventory of existing statewide and regional behavioral health crisis response, suicide prevention, and crisis stabilization services and resources, taking into account capital projects which are planned and funded.	■												■	
2	Identify quantifiable goals for the provision of statewide and regional behavioral health crisis services and targeted deployment of resources.	■											■	■	
3	Identify a process for establishing outcome measures, benchmarks, and improvement targets for the crisis response system.			■	■								■		
4	Recommend a vision for an integrated crisis network that includes the 988 hotline, mobile rapid response crisis teams, a range of crisis services, integrated involuntary treatment.	■	■			■									
5	Make recommendations to promote equity in services for individuals of diverse circumstances of culture, race, ethnicity, gender, socioeconomic status, sexual orientation, and for individuals in tribal, urban, and rural communities.		■			■					■	■			
6	Make recommendations for a work plan with timelines to implement appropriate local responses to calls to the 988 crisis hotline in Washington.								■						

HB 1477, Section 103, Subsection 5 provision
HB 1477, Section 103, Subsection 6 provision

		CRIS Steering Committee	CRIS Committee	HCA	DOH	CRIS Subcommittees									
						Tribal 988	Creden-tialing and Training	Tech-nology	Cross-System Crisis Response	Confi-dential Info Com-pliance	Rural & Agri-cultural	Lived Exper-ience	Quality and Over-sight	Regional Crisis Response	Service Delivery Costs
7	Identify the necessary components of each of the new technologically advanced behavioral health crisis call center system platform and the new behavioral health integrated client referral system, with specified questions for analysis.			■				■		■					
8	Identify the necessary systems and capabilities that licensed or certified behavioral health agencies, behavioral health providers, and any other relevant parties will require to report, maintain, and update inpatient and residential bed and outpatient service availability in real time to correspond with the crisis call center system platform or behavioral health integrated client referral system.							■	■						
9	Create a work plan to establish the capacity for the crisis call center hubs to integrate Spanish language interpreters and Spanish-speaking call center staff into their operations.				■										
10	Create a work plan to ensure the availability of resources to meet the unique needs of persons in the agricultural community who are experiencing mental health stresses, which explicitly addresses concerns regarding confidentiality.										■				

HB 1477, Section 103, Subsection 5 provision
HB 1477, Section 103, Subsection 6 provision

		CRIS Steering Committee	CRIS Committee	HCA	DOH	CRIS Subcommittees									
						Tribal 988	Creden-tialing and Training	Tech-nology	Cross-System Crisis Response	Confi-dential Info Com-pliance	Rural & Agri-cultural	Lived Exper-ience	Quality and Over-sight	Regional Crisis Response	Service Delivery Costs
11	Create a work plan with timelines to enhance and expand the availability of community-based mobile rapid response crisis teams based in each region, including specialized teams as appropriate to respond to the unique needs of youth, including AI/AN and LGBTQ youth, and geriatric populations, including older adults of color and older adults with comorbid dementia.	■				■								■	
12	Identify other personal and systemic behavioral health challenges which implementation of the 988 crisis hotline has the potential to address in addition to suicide response and behavioral health crises.				■	■									
13	Develop a plan for the statewide equitable distribution of crisis stabilization services, behavioral health beds, and peer-run respite services.	■													
14	Recommend how health plans, MCOs, and BH ASOs shall fulfill requirements to provide assignment of a care coordinator and to provide next-day appointments for enrollees who contact the behavioral health crisis system.			■					■						

HB 1477, Section 103, Subsection 5 provision
HB 1477, Section 103, Subsection 6 provision

		CRIS Steering Committee	CRIS Committee	HCA	DOH	CRIS Subcommittees									
						Tribal 988	Creden-tialing and Training	Tech-nology	Cross-System Crisis Response	Confi-dential Info Com-pliance	Rural & Agri-cultural	Lived Exper-ience	Quality and Over-sight	Regional Crisis Response	Service Delivery Costs
15	Recommend allocation of crisis system funding responsibilities among Medicaid MCOs, commercial insurers, and behavioral health administrative services organizations.	X													
16	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.	X											X		
17	Cost estimates for each of the components of the integrated behavioral health crisis response and suicide prevention system.	X													X
18	Make recommendations related to workforce needs by region. Make recommendations related to licensure or minimum education requirements for the staff delivering crisis services. [This item added by Steering Committee.]						X								

Activities for Each CRIS Subcommittee

All tasks for each subcommittee have yet to be fully envisioned. The tasks shown below include those items that are already known to be each subcommittee's responsibility. The Steering Committee will be accepting feedback about other topics that may be added to each subcommittee's responsibility.

Tribal 988

The Steering Committee has consulted with the American Indian Health Commission for Washington (AIHC). The AIHC had already undertaken a review of crisis response prior to the enactment of HB 1477. Recognizing the sovereignty of the tribes and the work that the AIHC has already conducted, the Steering Committee agreed that the committee already developed by the AIHC to address this topic will serve as the subcommittee for the work related to HB 1477. The Steering Committee will coordinate with the AIHC's committee on their work to ensure that it is incorporated into future reports delivered by the Steering Committee.

Specific areas that will require coordination include, but are not limited to, the following:

1. Implementing the Washington Indian Behavioral Health Hub housed within Volunteers of America, which provides services for navigating behavioral health systems and crisis systems for anyone who self-selects these services (available to all Tribal community members and those who serve Tribal communities).

2. Development of a tribal Designated Crisis Responder program and develop government-to-government protocols.

3. Create workflows between AIHC and Evaluation and Treatment (E&T) facilities.

Credentialing and Training

Specific items that this subcommittee will address include the following:

1. Inventory the licensure requirements of staff delivering crisis services in the field. Make recommendations of where licensure requirements should be adjusted.

2. Inventory best practice training materials and provide recommendations for the development of curricula to train crisis provider staff and first responders.

3. Make recommendations pertaining to the content and cadence of training for crisis provider staff.

4. Review assessments of the current workforce related to crisis provider staff. Make recommendations on ways to enhance the existing workforce at the statewide and regional level.

Technology

Specific items that this subcommittee will address include the following:

1. Make recommendations on the minimum requirements for the crisis call center platforms, the integrated client referral system (including bed tracking), and any interoperability platforms on the sharing of clinical and demographic data across crisis providers. Identify additional requirements that are considered optimal in a state-of-the-art system.

2. Assess the current technological capabilities of the entities that will share information (e.g., hospitals, crisis stabilization units, residential treatment centers, office-based mental health providers, BH-ASOs, Medicaid MCOs) to determine the gap between the current state and what is envisioned for the future.

3. Prepare a recommendation of a timeline for different entities to adapt their technology to what is envisioned for the future.

4. Make recommendations on readiness review scoring to test that each entity that migrates to new technology is ready to do so.

5. Make recommendations on testing strategies for entities to use in preparing their new technology implementations.

6. Develop a dashboard for the Steering Committee that tracks the progress of each impacted entity making technological changes on their transition to the new technology.

Cross-System Crisis Response

Specific items that this subcommittee will address include the following:

1. Provide recommendations on the rules of engagement among the entities that need to collaborate on the delivery of crisis services, from the call centers (988, 911, other) to the providers delivering services to the entities managing and coordinating services (BH-ASOs, MCOs).

2. Write and recommend procedures using case study scenarios that can be used for training purposes on collaboration in the future.

3. Work with the Technology Subcommittee on the identification of information that can be shared in the future using technology. Make recommendations to the Steering Committee on the type of information that will be shared in the collaboration process and the timing of when this information will be shared.

4. Identify elements that will be used to define when cross-system collaboration is fully successful, partially successful, or unsuccessful.

5. Recommend methods of how to audit the system to determine the rate of success of cross-system collaboration.

Confidential Information Compliance and Coordination

Specific items that this subcommittee will address include the following:

1. Offer feedback on state agency implementation efforts to share confidential information as allowed under federal and state law.

2. Where allowable by law, make recommendations on the agreements that must be put in place in order for entities to share confidential information.

3. Identify and recommend safeguards to the Steering Committee that entities who are sharing confidential information must put in place before any information is shared.

4. Make recommendations for a mechanism to easily identify the circumstances under which entities are authorized to share confidential information.

Rural and Agricultural

Specific items that this subcommittee will address include the following:

1. Examine the specific behavioral health crisis needs of farmers, farm workers, and rural communities.

2. Make recommendations related to equitable access to crisis services and timely response.

3. Identify missing services in rural areas and make recommendations for access to these services.

4. Identify ongoing mechanisms for the inclusion of rural and agricultural voices in the delivery of behavioral health crisis services.

Lived Experience

Specific items that this subcommittee will address include the following:

1. Assure that the voice of individuals with lived experience and their families, including those with a history of involuntary treatment, are included in the process and inform policy recommendations.

2. Make recommendations that assure a trauma-informed crisis delivery system.

3. Provide feedback and recommendations about where those with lived experience would enhance the delivery of crisis services.

4. Provide specific examples of both successful and difficult engagement with the current crisis delivery system to help shape policy and program recommendations.

Quality and Oversight

Specific items that this subcommittee will address include the following:

1. Inventory measures that may be considered for ongoing quality reporting of the crisis delivery system. Both process and outcome measures will be considered. Examples include metrics for NSPL best practices and guidelines on call metrics, turnaround time for the deployment of mobile crisis teams, immediate outcome of clients that received mobile outreach or a DCR investigation, prevalence and turnaround time of follow-up appointments after a call to the crisis line or a hospital ED visit, transitions of care to and from less restrictive settings, satisfaction of the receiving client, satisfaction of the providers delivering services, reduction in the rate of suicide, and reduction in the rate of overdose deaths.

2. Review technical specifications or develop Washington-specific specifications for measures nominated and approved by the Steering Committee for moving forward.

3. Determine where and how there are current gaps in data to collect the measures nominated for moving forward. Propose recommendations to mitigate these gaps.

4. Build education and training to payers and providers on the measures selected for moving forward.

5. Provide recommendations to the Steering Committee on financial or other incentives/disincentives based on the results of quality measures.

6. Provide feedback on the design and content of dashboard reports that will be available to the public on the oversight of the crisis delivery system.

7. Propose targets for each measure recommended to be met over time.

8. Consider options for the design of an oversight board of the crisis delivery system to be established after the CRIS Committee concludes, including the board's responsibilities, representation, and public reporting.

9. Make recommendations to the Steering Committee on the structure of the future oversight board.

Regional Crisis Response

Specific items that this subcommittee will address include the following:

1. Identify the areas of greatest need in the service delivery continuum for crisis services, with a particular focus on preventative services.

2. Gather information and share best practices on collaboration across providers, police and emergency responders as examples for consideration in the statewide model of cross-system collaboration.

3. Identify and share with the Steering Committee the most pressing challenges in each region in the delivery of preventative and acute crisis services for consideration by the CRIS of statewide priorities.

Service Delivery Costs

Specific items that this subcommittee will address include the following:

1. Release a survey to providers of crisis services to obtain information on labor, program, technology, and administrative costs as well as time spent client-facing and not client-facing performing other tasks such as training, record keeping, or travel to and from client locations.

2. Review the results of the survey fielded to understand variations in costs within each service but across providers due to variables such as location in the state or the level of credentials of the staff performing the service.

3. Provide recommendations on building new rates of payment for each service "from the ground up" using the information from the provider survey or other market-based sources.

4. Provide recommendations to the Steering Committee on the manner in which services are paid currently and preferred methods going forward.

Appendix A: List of Acronyms Used in this Report

Abbreviation	Meaning	Abbreviation	Meaning
ACA	Affordable Care Act	HB	House Bill
ACCESS	LA County Department of Mental Health's 24 Hour Call Center	HCA	Health Care Authority
AI/AN	American Indian or Alaska Native	HHS	Health and Human Services
AIHC	American Indian Health Commission	HMA	Health Management Associates
API	Application Programming Interface	LE	Lived Experience
ASPE	Assistance Secretary for Planning and Evaluation	LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer or Questioning
BH-ASO	Behavioral Health Administrative Services Organization	MAT	Medication-Assisted Treatment
BHI-HMA	Behavioral Health Institute at Harborview Medical Center and Health Management Associates	MCO	Managed Care Organization
BHO	Behavioral Health Organization	MH	Mental Health
BIPOC	Black, Indigenous, and People of Color	MI	Motivational Interviewing
CDC	Centers for Disease Control and Prevention	MPH	Master of Public Health
CI	Confidential Information Compliance and Coordination	Ph.D.	Doctor of Philosophy
CIT	Crisis Intervention Team	PHE	Public Health Emergency
CMHC	Community Mental Health Center	PSAP	Public Safety Answering Point (911 Call Center)
CRIS	Crisis Response Improvement Strategy Committee	QO	Quality and Oversight
CS	Cross System Crisis Response Collaboration	RA	Rural and Agricultural Communities
CSU	Crisis Stabilization Unit	RSN	Regional Support Network
CT	Credentialing and Training	SAMHSA	Substance Abuse and Mental Health Services Administration
CY	Calendar Year	SBC	Single Bed Certification
DCR	Designated Crisis Responder	SDC	Service Delivery Costs
DOH	Department of Health	SMS	Short Message Service
DSHS	Department of Social and Health Services	SUD	Substance Use Disorder
E&T	Evaluation and Treatment	TBD	To Be Determined
ED	Emergency Department	TE	Technology
EMS	Emergency Medical Service	TR	Washington Tribal 988
EHR	Electronic Health Record	UCC	Behavioral Health Urgent Care Center
GPS	Global Positioning System	VoIP	Voice Over Internet Protocol

Appendix B: Definitions for Terms Related to Crisis Delivery

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 Mobile Team Response: Mobile crisis 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.[48] These teams often work closely with the police, crisis hotlines and hospital emergency personnel. Mobile teams may provide pre-screening assessments or act as gatekeepers for inpatient hospitalization and can also connect an individual with community-based programs and other services.[49]

Crisis Receiving and Stabilization Facilities: Crisis stabilization facilities provide short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.[50] Also referred to as Crisis Stabilization Units, CSUs may be designed to admit on a voluntary or involuntary basis when the person needs a safe, secure environment that is less restrictive than a hospital. CSUs try to stabilize the person and get him or her back into the community quickly.[51]

Crisis Respite: These programs are designed to be 24/7 and individuals can stay longer than one day. Crisis respite services can take a variety of forms including residential and short-term inpatient. An emerging form of residential crisis respites are Peer-Run (PRCR) and Peer-Hybrid Crisis Respites[52] (PHCR; one example is The Living Room[53]).

Crisis Urgent Walk-in Center: These are clinics or psychiatric urgent care centers that offer immediate attention to the individual walking-in. They focus on resolving the crisis in a less intensive setting than a hospital, though they may recommend hospitalization when appropriate. Walk-in clinics may serve as drop-off centers for law enforcement to reduce unnecessary arrests.[54]

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

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[48] Ibid.

[49] 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

[50] Ibid.

[51] Ibid.

[52] Pierotti, Alei and Pacheco, *Literature Review: Crisis Stabilization and Crisis Respite* (2016) available at http://isr.unm.edu/centers/center-for-applied-research-and-analysis/behavioral-health-initiative-reports/summarized-literature-reviews/crisis-stabilization-and-crisis-respite-care.pdf

[53] Heyland, Emery, and Shattell, *The Living Room, a Community Crisis Respite Program: Offering People in Crisis an Alternative to Emergency Departments* (2013) available at https://www.gjcpp.org/pdfs/2013-007-final-20130930.pdf

[54] Ibid.

person must also complete substance use disorder training specific to the duties of a designated crisis responder.[55]

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.[56]

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.[57]

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.[58] Individuals in behavioral health crises are also seen in EDs, and some EDs are equipped with specific psychiatric services and staffing, often referred to as Psychiatric Emergency Services (PES).

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.[59]

Police/Sheriff/Fire Departments: First responder services, often dispatched via 911. Some police departments have Crisis Intervention Teams (CIT) that are specially trained and deployed to events that may require a specialty behavioral health intervention.

Regional Crisis Call Center: Regional 24/7 clinically staffed crisis call center that provides crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer air traffic control (ATC) - quality coordination of crisis care in real-time.[60]

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

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

[57] 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

[58] MedicineNet, *Medical Definition Of Emergency Department* (2021) available at
https://www.medicinenet.com/emergency_department/definition.htm

[59] 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

[60] Ibid.

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 disorders in a residential treatment setting.[61]

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.[62]

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

[62] 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: Dashboard Reports of the Crisis Delivery System and Utilization Statistics for Each Behavioral Health Administrative Service Organization Region

Behavioral Health Administrative Services Organization   Great Rivers

Counties in the BH ASO's Catchment Area: Cowlitz, Grays Harbor, Lewis, Pacific, Wahkiakum
Population Estimate for the Catchment Area: CY2020: 291,520   CY2021: 294,850

Profile of Crisis Providers in the Region

Crisis Line Services Delivered by	Columbia Wellness
Number of Mobile Crisis Teams	5
Number of Crisis Stabilization Facilities	0
Number of Crisis Stabilization Beds for Region Across All Facilities	0

Trend in Number of Calls to this BH ASO's Crisis Line
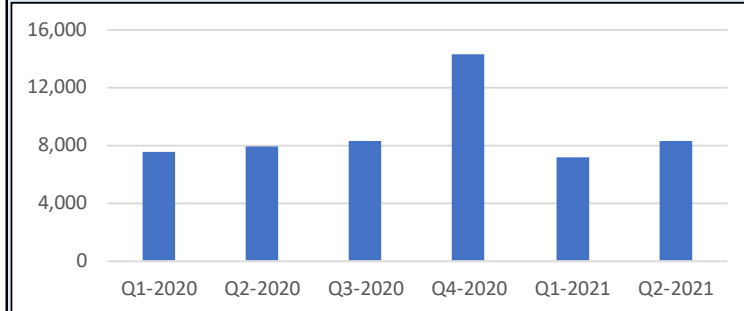
	BH ASO	Statewide
CY21 Annualized	39,687	388,099
CY20 Total	38,071	367,765
Percent Change	4.2%	5.5%

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

Percent of Calls Answered Live within 30 Seconds

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

	BH ASO	Statewide
CY21 Annualized	99.0%	95.7%
CY20 Total	98.3%	93.1%
Change from 2020	0.7%	2.6%

Mobile Crisis Outreach Events Per 100,000 Residents

After calls are answered from the crisis line, a determination is made whether or not to deploy a mobile crisis outreach team.

	BH ASO	Statewide
CY21 Annualized	2,694	709
CY20 Total	4,679	716

Mobile Crisis Outreach Events as a Percent of Answered Calls

The percentage shows reflects the percentage of calls to the BH ASO's crisis line that result in the deployment of a mobile crisis team.

	BH ASO	Statewide
CY21 Annualized	20.1%	14.8%
CY20 Total	35.8%	16.0%
Change from 2020	-15.7%	-1.1%

Designated Crisis Responder (DCR) Events Per 100,000 Residents

The number of events where a responder as defined by state statute conducts an investigation.

	BH ASO	Statewide
CY21 Annualized	710	400
CY20 Total	733	379

Designated Crisis Responder Events as a Percent of Answered Calls

The number of events where a responder as defined by state statute conducts an investigation to determine if involuntary treatment is warranted for the individual.

	BH ASO	Statewide
CY21 Annualized	5.3%	8.4%
CY20 Total	5.6%	8.5%
Change from 2020	-0.3%	-0.1%

Disposition of Involuntary Treatment Act Investigations from DCR Events, CY 2020
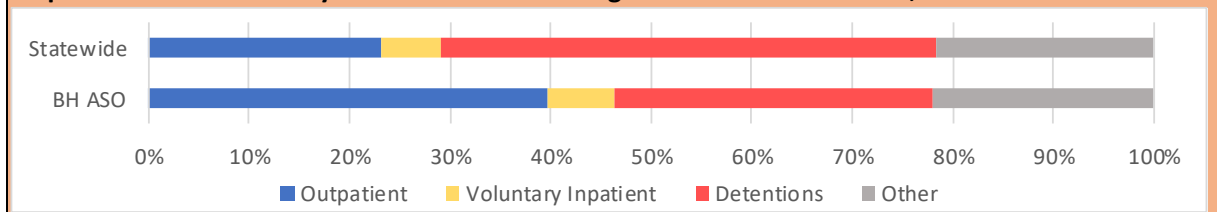
Behavioral Health Administrative Services Organization	Greater Columbia

Counties in Catchment Area: Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima
Population Estimate for the Catchment Area: CY2020: 750,910   CY2021: 757,300

Profile of Crisis Providers in the Region

Crisis Line Services Delivered by	Protocall Services
Number of Mobile Crisis Teams	4
Number of Crisis Stabilization Facilities	3
Number of Crisis Stabilization Beds for Region Across All Facilities	48

Trend in Number of Calls to this BH ASO's Crisis Line

	BH ASO	Statewide
CY21 Annualized	40,522	388,099
CY20 Total	46,042	367,765
Percent Change	-12.0%	5.5%

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

Percent of Calls Answered Live within 30 Seconds
This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

	BH ASO	Statewide
CY21 Annualized	93.3%	95.7%
CY20 Total	95.1%	93.1%
Change from 2020	-1.9%	2.6%

Mobile Crisis Outreach Events Per 100,000 Residents
After calls are answered from the crisis line, a determination is made whether or not to deploy a mobile crisis outreach team.

	BH ASO	Statewide
CY21 Annualized	2,127	709
CY20 Total	2,110	716

Mobile Crisis Outreach Events as a Percent of Answered Calls
The percentage shows reflects the percentage of calls to the BH ASO's crisis line that result in the deployment of a mobile crisis team.

	BH ASO	Statewide
CY21 Annualized	39.9%	14.8%
CY20 Total	34.5%	16.0%
Change from 2020	5.4%	-1.1%

Designated Crisis Responder (DCR) Events Per 100,000 Residents
The number of events where a responder as defined by state statute conducts an investigation.
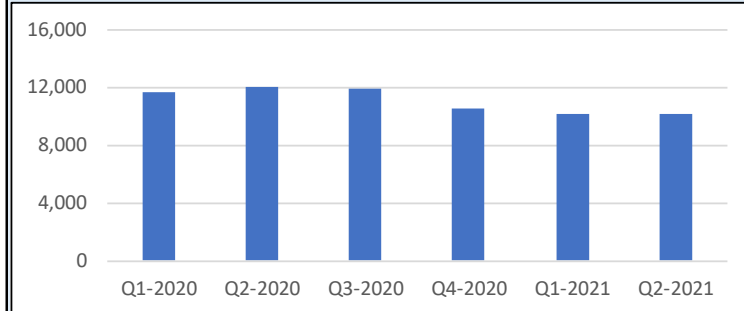
	BH ASO	Statewide
CY21 Annualized	314	400
CY20 Total	264	379

Designated Crisis Responder Events as a Percent of Answered Calls
The number of events where a responder as defined by state statute conducts an investigation to determine if involuntary treatment is warranted for the individual.

	BH ASO	Statewide
CY21 Annualized	5.9%	8.4%
CY20 Total	4.3%	8.5%
Change from 2020	1.6%	-0.1%

Disposition of Involuntary Treatment Act Investigations from DCR Events, CY 2020
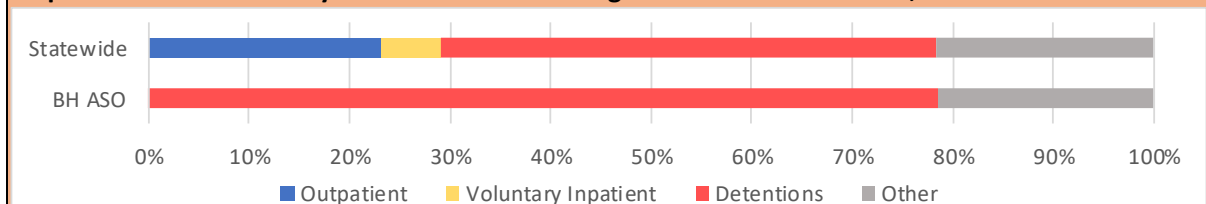
Behavioral Health Administrative Services Organization	King County

Counties in the BH ASO's Catchment Area:	King	
Population Estimate for the Catchment Area:	CY2020: 2,260,800	CY2021: 2,293,300

Profile of Crisis Providers in the Region

Crisis Line Services Delivered by	Crisis Connections
Number of Mobile Crisis Teams	3
Number of Crisis Stabilization Facilities	0
Number of Crisis Stabilization Beds for Region Across All Facilities	0

Trend in Number of Calls to this BH ASO's Crisis Line

	BH ASO	Statewide
CY21 Annualized	97,884	388,099
CY20 Total	91,753	367,765
Percent Change	6.7%	5.5%

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

Percent of Calls Answered Live within 30 Seconds

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

	BH ASO	Statewide
CY21 Annualized	99.0%	95.7%
CY20 Total	95.1%	93.1%
Change from 2020	3.9%	2.6%

Mobile Crisis Outreach Events Per 100,000 Residents

After calls are answered from the crisis line, a determination is made whether or not to deploy a mobile crisis outreach team.

	BH ASO	Statewide
CY21 Annualized	205	709
CY20 Total	166	716

Mobile Crisis Outreach Events as a Percent of Answered Calls

The percentage shows reflects the percentage of calls to the BH ASO's crisis line that result in the deployment of a mobile crisis team.

	BH ASO	Statewide
CY21 Annualized	5.1%	14.8%
CY20 Total	4.5%	16.0%
Change from 2020	0.6%	-1.1%

Designated Crisis Responder (DCR) Events Per 100,000 Residents

The number of events where a responder as defined by state statute conducts an investigation.

	BH ASO	Statewide
CY21 Annualized	299	400
CY20 Total	290	379

Designated Crisis Responder Events as a Percent of Answered Calls

The number of events where a responder as defined by state statute conducts an investigation to determine if involuntary treatment is warranted for the individual.

	BH ASO	Statewide
CY21 Annualized	7.4%	8.4%
CY20 Total	7.8%	8.5%
Change from 2020	-0.4%	-0.1%

Disposition of Involuntary Treatment Act Investigations from DCR Events, CY 2020
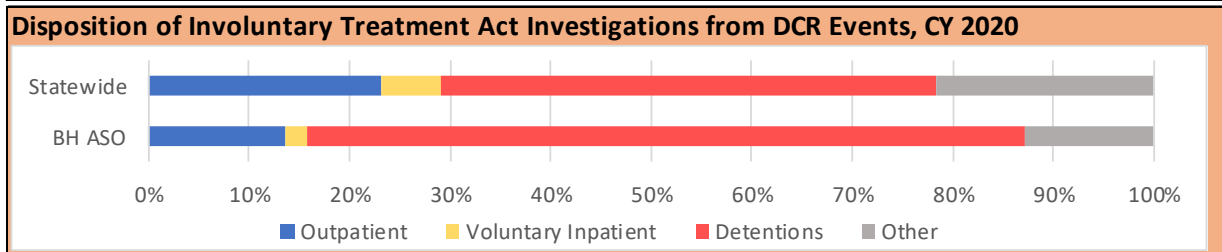
Behavioral Health Administrative Services Organization	North Central

Counties in the BH ASO's Catchment Area:	Chelan, Douglas, Grant, Okanogan
Population Estimate for the Catchment Area:	CY2020: 266,670 CY2021: 272,125

Profile of Crisis Providers in the Region

Crisis Line Services Delivered by	Crisis Connections
Number of Mobile Crisis Teams	3
Number of Crisis Stabilization Facilities	1
Number of Crisis Stabilization Beds for Region Across All Facilities	10

Trend in Number of Calls to this BH ASO's Crisis Line
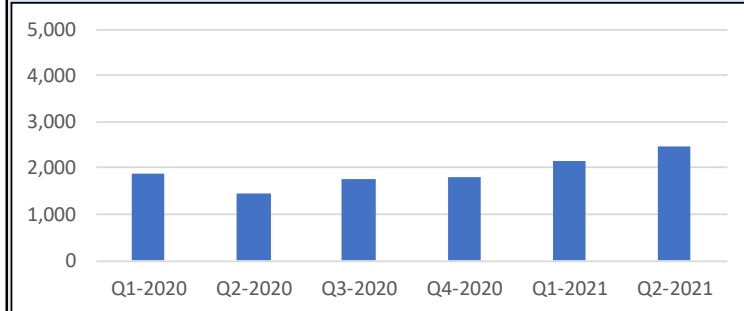
	BH ASO	Statewide
CY21 Annualized	9,194	388,099
CY20 Total	6,855	367,765
Percent Change	34.1%	5.5%

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

Percent of Calls Answered Live within 30 Seconds
This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

	BH ASO	Statewide
CY21 Annualized	96.3%	95.7%
CY20 Total	87.0%	93.1%
Change from 2020	9.4%	2.6%

Mobile Crisis Outreach Events Per 100,000 Residents
After calls are answered from the crisis line, a determination is made whether or not to deploy a mobile crisis outreach team.

	BH ASO	Statewide
CY21 Annualized	840	709
CY20 Total	585	716

Mobile Crisis Outreach Events as a Percent of Answered Calls
The percentage shows reflects the percentage of calls to the BH ASO's crisis line that result in the deployment of a mobile crisis team.

	BH ASO	Statewide
CY21 Annualized	28.1%	14.8%
CY20 Total	27.3%	16.0%
Change from 2020	0.8%	-1.1%

Designated Crisis Responder (DCR) Events Per 100,000 Residents
The number of events where a responder as defined by state statute conducts an investigation.

	BH ASO	Statewide
CY21 Annualized	398	400
CY20 Total	415	379

Designated Crisis Responder Events as a Percent of Answered Calls
The number of events where a responder as defined by state statute conducts an investigation to determine if involuntary treatment is warranted for the individual.

	BH ASO	Statewide
CY21 Annualized	13.3%	8.4%
CY20 Total	19.4%	8.5%
Change from 2020	-6.0%	-0.1%

Disposition of Involuntary Treatment Act Investigations from DCR Events, CY 2020
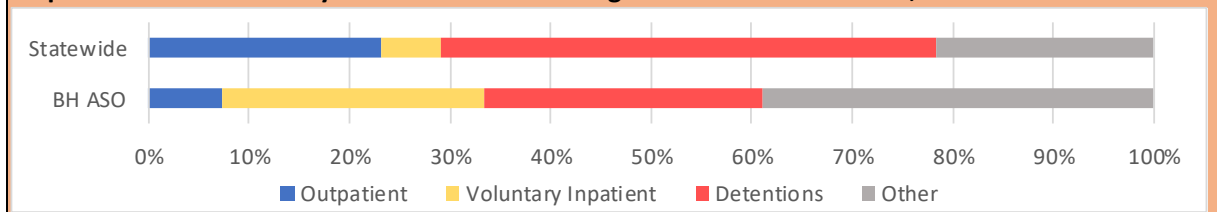
Behavioral Health Administrative Services Organization	North Sound

Counties in the BH ASO's Catchment Area:	San Juan, Skagit, Snohomish, Whatcom
Population Estimate for the Catchment Area:	CY2020: 1,291,820 CY2021: 1,308,750

Profile of Crisis Providers in the Region

Crisis Line Services Delivered by	Volunteers of America
Number of Mobile Crisis Teams	5
Number of Crisis Stabilization Facilities	6
Number of Crisis Stabilization Beds for Region Across All Facilities	90

Trend in Number of Calls to this BH ASO's Crisis Line

	BH ASO	Statewide
CY21 Annualized	45,479	388,099
CY20 Total	35,224	367,765
Percent Change	29.1%	5.5%

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

Percent of Calls Answered Live within 30 Seconds
This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

	BH ASO	Statewide
CY21 Annualized	62.9%	95.7%
CY20 Total	85.3%	93.1%
Change from 2020	-22.3%	2.6%

Mobile Crisis Outreach Events Per 100,000 Residents
After calls are answered from the crisis line, a determination is made whether or not to deploy a mobile crisis outreach team.

	BH ASO	Statewide
CY21 Annualized	433	709
CY20 Total	388	716

Mobile Crisis Outreach Events as a Percent of Answered Calls
The percentage shows reflects the percentage of calls to the BH ASO's crisis line that result in the deployment of a mobile crisis team.

	BH ASO	Statewide
CY21 Annualized	12.8%	14.8%
CY20 Total	15.2%	16.0%
Change from 2020	-2.4%	-1.1%

Designated Crisis Responder (DCR) Events Per 100,000 Residents
The number of events where a responder as defined by state statute conducts an investigation.

	BH ASO	Statewide
CY21 Annualized	360	400
CY20 Total	325	379

Designated Crisis Responder Events as a Percent of Answered Calls
The number of events where a responder as defined by state statute conducts an investigation to determine if involuntary treatment is warranted for the individual.

	BH ASO	Statewide
CY21 Annualized	10.6%	8.4%
CY20 Total	12.7%	8.5%
Change from 2020	-2.1%	-0.1%

Disposition of Involuntary Treatment Act Investigations from DCR Events, CY 2020
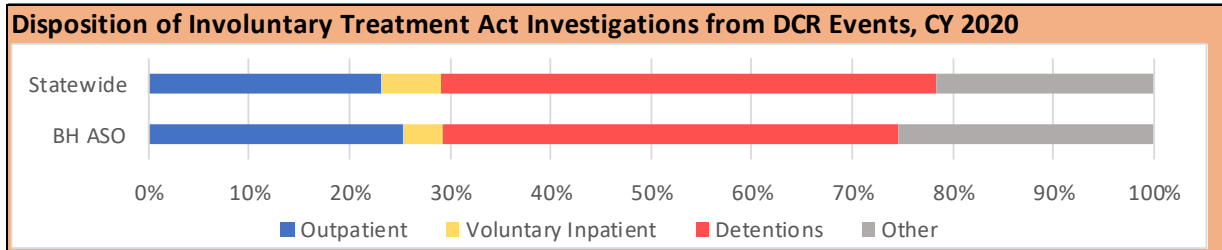
Behavioral Health Administrative Services Organization	Pierce County

Counties in the BH ASO's Catchment Area:	Pierce		
Population Estimate for the Catchment Area:	CY2020: 900,700	CY2021:	917,100

Profile of Crisis Providers in the Region

Crisis Line Services Delivered by	Crisis Connections
Number of Mobile Crisis Teams	3
Number of Crisis Stabilization Facilities	1
Number of Crisis Stabilization Beds for Region Across All Facilities	16

Trend in Number of Calls to this BH ASO's Crisis Line

	BH ASO	Statewide
CY21 Annualized	38,270	388,099
CY20 Total	41,600	367,765
Percent Change	-8.0%	5.5%

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

Percent of Calls Answered Live within 30 Seconds
This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

	BH ASO	Statewide
CY21 Annualized	96.3%	95.7%
CY20 Total	86.3%	93.1%
Change from 2020	10.0%	2.6%

Mobile Crisis Outreach Events Per 100,000 Residents
After calls are answered from the crisis line, a determination is made whether or not to deploy a mobile crisis outreach team.

	BH ASO	Statewide
CY21 Annualized	641	709
CY20 Total	390	716

Mobile Crisis Outreach Events as a Percent of Answered Calls
The percentage shows reflects the percentage of calls to the BH ASO's crisis line that result in the deployment of a mobile crisis team.

	BH ASO	Statewide
CY21 Annualized	17.0%	14.8%
CY20 Total	10.2%	16.0%
Change from 2020	6.9%	-1.1%

**Designated Crisis Responder (DCR) Events Per 100,000 Residents**
The number of events where a responder as defined by state statute conducts an investigation.

	BH ASO	Statewide
CY21 Annualized	389	400
CY20 Total	320	379

Designated Crisis Responder Events as a Percent of Answered Calls
The number of events where a responder as defined by state statute conducts an investigation to determine if involuntary treatment is warranted for the individual.

	BH ASO	Statewide
CY21 Annualized	10.3%	8.4%
CY20 Total	8.3%	8.5%
Change from 2020	2.0%	-0.1%

Disposition of Involuntary Treatment Act Investigations from DCR Events, CY 2020
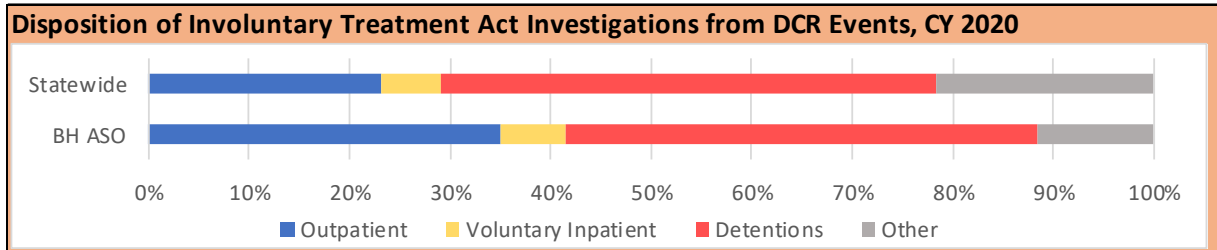
Behavioral Health Administrative Services Organization	Salish

Counties in the BH ASO's Catchment Area:	Clallam, Jefferson, Kitsap
Population Estimate for the Catchment Area:	CY2020: 381,160 CY2021: 385,600

Profile of Crisis Providers in the Region

Crisis Line Services Delivered by	Volunteers of America
Number of Mobile Crisis Teams	4
Number of Crisis Stabilization Facilities	2
Number of Crisis Stabilization Beds for Region Across All Facilities	22

Trend in Number of Calls to this BH ASO's Crisis Line

	BH ASO	Statewide
CY21 Annualized	18,564	388,099
CY20 Total	20,516	367,765
Percent Change	-9.5%	5.5%

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

Percent of Calls Answered Live within 30 Seconds
This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

	BH ASO	Statewide
CY21 Annualized	89.9%	95.7%
CY20 Total	87.1%	93.1%
Change from 2020	2.7%	2.6%

Mobile Crisis Outreach Events Per 100,000 Residents
After calls are answered from the crisis line, a determination is made whether or not to deploy a mobile crisis outreach team.

	BH ASO	Statewide
CY21 Annualized	694	709
CY20 Total	648	716

Mobile Crisis Outreach Events as a Percent of Answered Calls
The percentage shows reflects the percentage of calls to the BH ASO's crisis line that result in the deployment of a mobile crisis team.

	BH ASO	Statewide
CY21 Annualized	15.2%	14.8%
CY20 Total	12.8%	16.0%
Change from 2020	2.4%	-1.1%

**Designated Crisis Responder (DCR) Events Per 100,000 Residents**
The number of events where a responder as defined by state statute conducts an investigation.

	BH ASO	Statewide
CY21 Annualized	530	400
CY20 Total	673	379

Designated Crisis Responder Events as a Percent of Answered Calls
The number of events where a responder as defined by state statute conducts an investigation to determine if involuntary treatment is warranted for the individual.

	BH ASO	Statewide
CY21 Annualized	11.6%	8.4%
CY20 Total	13.3%	8.5%
Change from 2020	-1.7%	-0.1%

Disposition of Involuntary Treatment Act Investigations from DCR Events, CY 2020
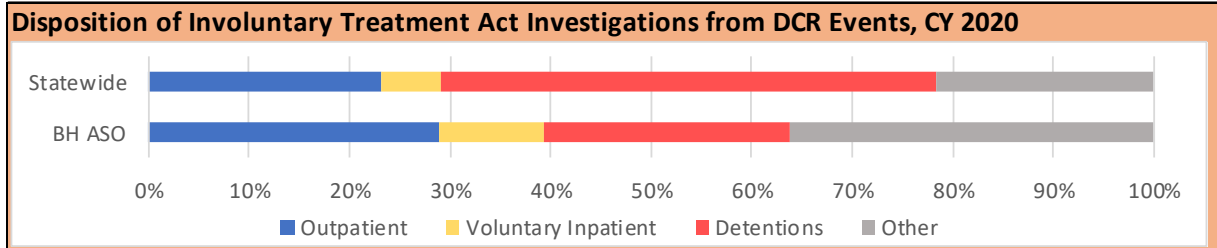
Behavioral Health Administrative Services Organization   Southwest

Counties in the BH ASO's Catchment Area: Clark, Klickitat, Skamania
Population Estimate for the Catchment Area: CY2020: 534,190   CY2021: 548,400

Profile of Crisis Providers in the Region

Crisis Line Services Delivered by	Crisis Connections
Number of Mobile Crisis Teams	4
Number of Crisis Stabilization Facilities	1
Number of Crisis Stabilization Beds for Region Across All Facilities	16

Trend in Number of Calls to this BH ASO's Crisis Line

	BH ASO	Statewide
CY21 Annualized	22,174	388,099
CY20 Total	22,799	367,765
Percent Change	-2.7%	5.5%

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

Percent of Calls Answered Live within 30 Seconds

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

	BH ASO	Statewide
CY21 Annualized	96.8%	95.7%
CY20 Total	87.0%	93.1%
Change from 2020	9.8%	2.6%

Mobile Crisis Outreach Events Per 100,000 Residents

After calls are answered from the crisis line, a determination is made whether or not to deploy a mobile crisis outreach team.

	BH ASO	Statewide
CY21 Annualized	224	709
CY20 Total	200	716

Mobile Crisis Outreach Events as a Percent of Answered Calls

The percentage shows reflects the percentage of calls to the BH ASO's crisis line that result in the deployment of a mobile crisis team.

	BH ASO	Statewide
CY21 Annualized	6.3%	14.8%
CY20 Total	5.8%	16.0%
Change from 2020	0.5%	-1.1%

Designated Crisis Responder (DCR) Events Per 100,000 Residents

The number of events where a responder as defined by state statute conducts an investigation.

	BH ASO	Statewide
CY21 Annualized	209	400
CY20 Total	203	379

Designated Crisis Responder Events as a Percent of Answered Calls

The number of events where a responder as defined by state statute conducts an investigation to determine if involuntary treatment is warranted for the individual.

	BH ASO	Statewide
CY21 Annualized	5.9%	8.4%
CY20 Total	5.9%	8.5%
Change from 2020	0.0%	-0.1%

### Disposition of Involuntary Treatment Act Investigations from DCR Events, CY 2020
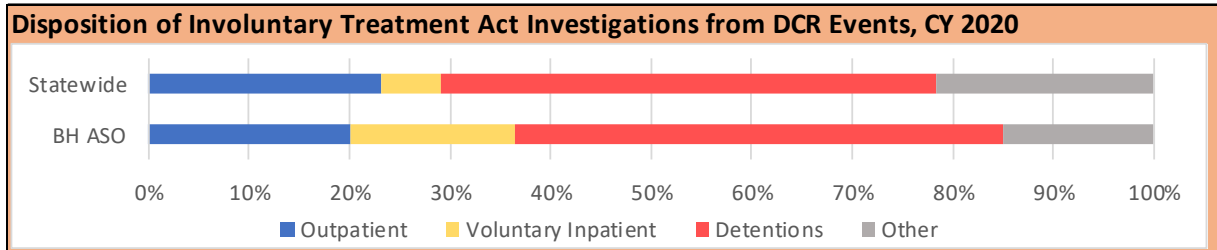
Behavioral Health Administrative Services Organization — Spokane

Counties in the BH ASO's Catchment Area: Adams, Ferry, Lincoln, Pend Oreille, Spokane, Stevens
Population Estimate for the Catchment Area: CY2020: 621,780   CY2021: 627,950

Profile of Crisis Providers in the Region

Crisis Line Services Delivered by	Frontier Behavioral Health
Number of Mobile Crisis Teams	8
Number of Crisis Stabilization Facilities	2
Number of Crisis Stabilization Beds for Region Across All Facilities	32

Trend in Number of Calls to this BH ASO's Crisis Line
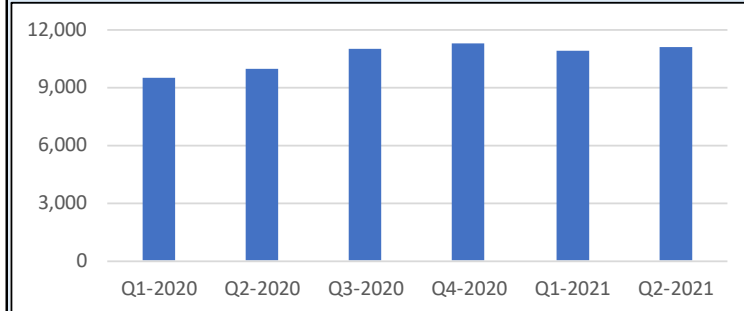
	BH ASO	Statewide
CY21 Annualized	44,010	388,099
CY20 Total	41,615	367,765
Percent Change	5.8%	5.5%

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

Percent of Calls Answered Live within 30 Seconds

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

	BH ASO	Statewide
CY21 Annualized	98.9%	95.7%
CY20 Total	99.0%	93.1%
Change from 2020	-0.1%	2.6%

Mobile Crisis Outreach Events Per 100,000 Residents

After calls are answered from the crisis line, a determination is made whether or not to deploy a mobile crisis outreach team.

	BH ASO	Statewide
CY21 Annualized	760	709
CY20 Total	756	716

Mobile Crisis Outreach Events as a Percent of Answered Calls

The percentage shows reflects the percentage of calls to the BH ASO's crisis line that result in the deployment of a mobile crisis team.

	BH ASO	Statewide
CY21 Annualized	10.9%	14.8%
CY20 Total	11.3%	16.0%
Change from 2020	-0.4%	-1.1%

Designated Crisis Responder (DCR) Events Per 100,000 Residents

*The number of events where a responder as defined by state statute conducts an investigation.*

	BH ASO	Statewide
CY21 Annualized	686	400
CY20 Total	601	379

Designated Crisis Responder Events as a Percent of Answered Calls

The number of events where a responder as defined by state statute conducts an investigation to determine if involuntary treatment is warranted for the individual.

	BH ASO	Statewide
CY21 Annualized	9.8%	8.4%
CY20 Total	9.0%	8.5%
Change from 2020	0.8%	-0.1%

Disposition of Involuntary Treatment Act Investigations from DCR Events, CY 2020
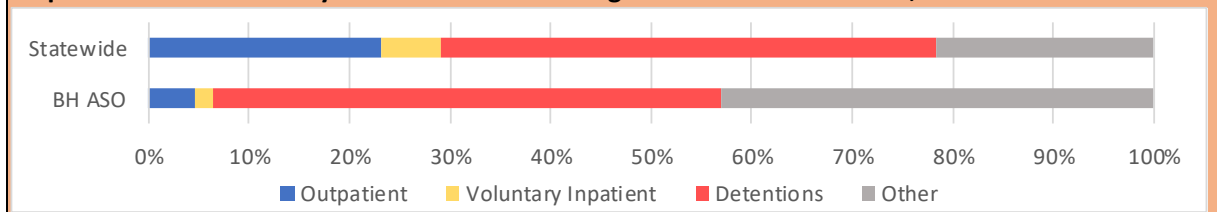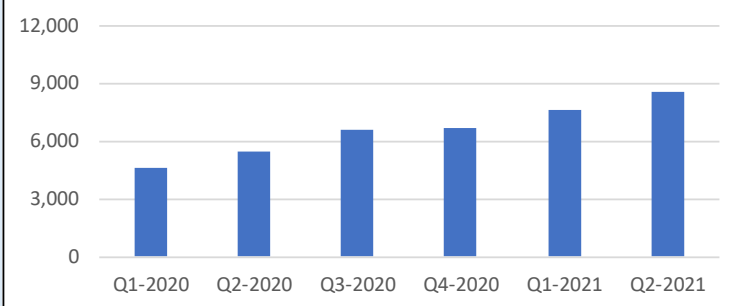
Behavioral Health Administrative Services Organization	Thurston-Mason

Counties in the BH ASO's Catchment Area: Mason, Thurston
Population Estimate for the Catchment Area: CY2020: 356,650   CY2021: 361,550

Profile of Crisis Providers in the Region

Crisis Line Services Delivered by   Olympic Health and Recovery Services
Number of Mobile Crisis Teams   2
Number of Crisis Stabilization Facilities   0
Number of Crisis Stabilization Beds for Region Across All Facilities   0

Trend in Number of Calls to this BH ASO's Crisis Line

	BH ASO	Statewide
CY21 Annualized	32,316	388,099
CY20 Total	23,290	367,765
Percent Change	38.8%	5.5%

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

Percent of Calls Answered Live within 30 Seconds

This statistic reflects crisis calls into the BH ASO's crisis line only. It does not reflect other lines that are in place such as 911.

	BH ASO	Statewide
CY21 Annualized	95.7%	95.7%
CY20 Total	96.0%	93.1%
Change from 2020	-0.3%	2.6%

Mobile Crisis Outreach Events Per 100,000 Residents

After calls are answered from the crisis line, a determination is made whether or not to deploy a mobile crisis outreach team.

	BH ASO	Statewide
CY21 Annualized	1,058	709
CY20 Total	908	716

Mobile Crisis Outreach Events as a Percent of Answered Calls

The percentage shows reflects the percentage of calls to the BH ASO's crisis line that result in the deployment of a mobile crisis team.

	BH ASO	Statewide
CY21 Annualized	12.4%	14.8%
CY20 Total	14.5%	16.0%
Change from 2020	-2.1%	-1.1%

Designated Crisis Responder (DCR) Events Per 100,000 Residents

The number of events where a responder as defined by state statute conducts an investigation.

	BH ASO	Statewide
CY21 Annualized	790	400
CY20 Total	783	379

Designated Crisis Responder Events as a Percent of Answered Calls

The number of events where a responder as defined by state statute conducts an investigation to determine if involuntary treatment is warranted for the individual.

	BH ASO	Statewide
CY21 Annualized	9.3%	8.4%
CY20 Total	12.5%	8.5%
Change from 2020	-3.2%	-0.1%

Disposition of Involuntary Treatment Act Investigations from DCR Events, CY 2020