CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE MEETING SUMMARY

Wednesday, April 26, 2023; 2:30 pm – 5:30 pm
Zoom

Meeting Agenda, Slides and Recording are available on the CRIS webpage: https://www.hca.wa.gov/about-hca/behavioral-health-recovery/crisis-response-improvement-strategy-cris-committees

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ATTENDEES

COMMITTEE MEMBERS

Adam Wasserman, State 911 Coordinator
Amber Leaders, Office of Governor Jay Inslee
Anna Nepomuceno, National Alliance on Mental Illness (NAMI) Washington
Bipasha Mukherjee, Crisis Line Volunteer
Caitlin Safford, Amerigroup
Claudia D'Allegri, Sea Mar Community Health Centers
Dillon Nishimoto, Asian Counseling and Referral Service
Jan Tokumoto, Frontier Behavioral Health
Jane Beyer, Washington State Office of the Insurance Commissioner
Jessica Shook, Olympic Health and Recovery Services
Joan Miller, Washington Council for Behavioral Health
Justin Johnson, Spokane County Regional Behavioral Health Division
Kashi Arora, Community Health and Benefit, Seattle Children's
Keri Waterland, Washington State Health Care Authority (HCA)
Kimberly Hendrickson, Poulsbo Fire CARES program
Kimberly Mosolf, Disability Rights Washington
Levi Van Dyke, Volunteers of America Western Washington
Marie Fallon, Associated Ministries
Megan Celedonia, Office of Governor Jay Inslee
Michael Reading, Behavioral Health and Recovery Division, King County
Michelle McDaniel, Crisis Connections
Puck Kalve Franta, Access & Inclusion Consultant
Robert Small, Premera Blue Cross
Ron Harding, City of Poulsbo
Senator Judy Warnick, Washington State Senate
Senator Manka Dhingra, Washington State Senate

COMMITTEE MEMBERS ABSENT

Darcy Jaffe, Washington State Hospital Association
Ellen Carruth, Resonant Relationships
Heather Sanchez, American Lake Veterans Affairs
Jennifer Stuber, UW School of Social Work & Co-Founder Forefront Suicide Prevention

Krystina Felix, The Kalispel Tribe
Linda Grant, Evergreen Recovery Centers
Michael Robertson, Certified Peer Counselor
Michele Roberts, Washington State Department of Health (DOH)
Representative Tina Orwall, Washington State House
Representative Tom Dent, Washington State House
Summer Hammons, Treaty Rights/Government Affairs

AMERICAN SIGN LANGUAGE (ASL) INTERPRETERS

Jackie Bruce
Catherine Thomas

COMMITTEE STAFF

Betsy Jones, Health Management Associates
Jamie Strausz-Clark, Third Sector Intelligence (3Si)
Mark Snowden, Harborview Medical Center
Nicola Pinson, Health Management Associates
Brittany Thompson, Health Management Associates
Chloe Chipman, Health Management Associates (Leavitt Partners)

WELCOME, INTRODUCTIONS, AND TECHNOLOGY REVIEW

Jamie Strausz-Clark, 3Si, convened the meeting and reviewed use of Zoom features to ensure understanding among meeting participants regarding use of Zoom meeting technology and expectations for committee members and public observers. CRIS Committee member Anna Nepomuceno, NAMI WA, welcomed everyone and noted the complex and urgent topic for the meeting: the unique needs of youth in crisis and how to better address those in a just and compassionate way. She shared that according to the Harborview Injury Prevention and Research Center, an average of 2.6 young people between the ages of 10 – 24 die by suicide each week in Washington State, yet over half of the young people between the ages of 12 – 17 who have depression do not receive the care they need. Anna encouraged CRIS Committee members to identify compassionate solutions to address the needs of youth from every community, especially those from BIPOC and LGBTQ+ communities.

In place of a land acknowledgement, Kathryn Akeah, American Indian Health Commission, shared information about working with the Tribal-Centric Behavioral Health Advisory Board and Tribal 988 Subcommittee to create tribal-centric considerations for crisis response. She shared maps of Native American Nations, including a map of Tribes in Washington and existing tribal health clinics. The Tribal Behavioral Health Advisory Board and Tribal 988 Subcommittee meet once per month and carry out activities including providing assessments and feedback on models (e.g., mobile crisis teams), trainings, information gathering, and sustainability planning.

Jamie thanked Kathryn and noted the group has been alternating between traditional land acknowledgement and using time to share information on the work Tribes are doing to strengthen and enhance a crisis response system in a manner that is Tribal centric. She encouraged others to send ideas for continued education on Tribal efforts for behavioral health crisis response.

MEETING OBJECTIVES AND AGENDA

Jamie reviewed the meeting agenda and objectives for each agenda item. This meeting of the Washington Crisis Response Improvement Strategy Committee had six objectives:

1. Understand where we've been, where we are now, and where we are going in the CRIS process.
2. Answer questions from CRIS committee members about updates in the monthly CRIS e-newsletter.
3. Provide foundational understanding about Washington State Health Care Authority's youth-focused crisis response model, to inform CRIS discussion about youth crisis response.
4. Discuss considerations related to youth-focus crisis response, to inform future Steering Committee recommendations.
5. Confirm action items and next steps.
6. Hear public comment. Due to lower sign-up numbers, the comment period was shortened to 10 minutes. Public comments are welcome in written form at any point throughout the process and may be submitted to HCAprogram1477@hca.wa.gov.

Jamie acknowledged the current CRIS decision process timeline is still in flux and noted plans to share the CRIS decision process map with an updated timeline during the next meeting. CRIS Committee discussions and the adjacent Subcommittee and Workgroup discussions will contribute to policy recommendations by the Steering Committee.

PERSONAL STORY

CRIS and Steering Committee member, Bipasha Mukherjee, provided an introduction for Brittany Miles to share her personal story and experience with Washington's crisis response system. Brittany's 15-year-old daughter Jaime (pseudonym) has early onset schizophrenia and Brittany shared their experience of failures in Washington's current crisis response system. Brittany serves on the CRIS Technology Subcommittee and has published several recent opinion pieces (read Brittany's piece in *The Seattle Times* here: https://www.seattletimes.com/opinion/as-the-mother-of-a-mentally-ill-teen-i-know-the-gaps-in-care-that-must-be-fixed/; read Brittany's piece in *Publicola* here: https://publicola.com/2023/03/27/to-help-kids-like-mine-pass-the-king-county-crisis-care-centers-levy/. Brittany's slides and a recording of her story are part of the April 26, 2023 meeting materials on the CRIS webpage (available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees). CRIS members expressed deep appreciation to Brittany for sharing her perspectives and recommendations. Based on challenges Brittany highlighted, CRIS members offered resources to help support, including:

- Keri Waterland, Washington Health Care Authority (HCA), thanked Bipasha and Brittany for sharing and offered to connect to support access to available supports.
- Jane Beyers, Office of the Insurance Commissioner (OIC), shared the complaint line and noted OIC's efforts around access to behavioral health services for individuals with private health insurance. She added that the OIC also takes complaints for people enrolled in public employees benefits (PEB) and school employees benefits (SEB) uniform medical plans. Behavioral Health Agencies can also assist

individuals with submitting a complaint. The OIC also enforces behavioral health parity and other insurance laws and can look into potential violations.

Agency Q&A

CRIS members received the CRIS Newsletter with state agency and committee updates in advance of the meeting. Members did not have further questions for the state agencies.

In advance of an in-depth legislative discussion planned for May, Senator Dhingra provided brief legislative session updates, noting a tremendous year for behavioral health in the legislature with nearly $1 billion spent on behavioral health issues. She highlighted funding for capital projects and Washington 211, and bills passed for 988 and crisis relief centers. Many of the recommendations from the children and youth taskforce were funded as well. To address Brittany's presentation, Senator Dhingra noted efforts from the poverty reduction taskforce to increase the amount of allowances for families receiving state services, and bill 5300 which ensures insurance companies cannot change prescription rate tiers for the amount they charge beneficiaries for prescriptions to treat serious mental health conditions.

PRESENTATION: MRSS Model for Youth Crisis Response

Sherry Wylie, HCA, provided an overview of HCA's Mobile Response and Stabilization Services (MRSS) model, focusing on how youth crises are currently addressed, including touchpoints in the system, and how the MRSS model aspires to address youth crises. The goal of MRSS is to bring the crisis continuum into the home, reducing the need for restrictive facility-based care, and assisting families by linking them to community and clinical services through warm handoffs. During the initial MRSS response, teams respond 24/7 in pairs and provide developmentally appropriate de-escalation and engagement to establish rapport. If needs persist beyond three days, MRSS provides up to eight weeks of intensive in-home stabilization, including skill building, brief interventions, and psychoeducation, while connecting the family to natural and community supports as well as ongoing clinical care if needed. System partners, including primary care, schools, police, emergency departments, inpatient units, behavioral health providers, juvenile justice, and the Department of Children, Youth, and Families can all refer youth to MRSS, and MRSS teams often provide outreach to partners to make direct referrals.

Four regions and five counties had youth teams prior to 988 and proviso funds last year stood up at least one youth team in each region. King and Thurston counties provide MRSS for the full 8 weeks through braided Medicaid and local funding, and the SAMHSA System of Care Grant is funding the stabilization phase in Pierce and Spokane counties. HCA is working to amend the current Medicaid State Plan from 14 days of in-home stabilization to the full 8 weeks; providers will need to contract with MCOs. HCA and other stakeholders are also participating in a quality learning collaborative with national MRSS leaders to receive technical assistance and develop robust partnerships and cross training for the entire behavioral health system.

Kashi Arora, Seattle Children's, presented key considerations for youth crisis response. She highlighted the need to understand pathways for youth and caregivers calling 988 to get connected to a MRSS team.

Embedded in that discussion is the need to ensure 988 call center staff are trained to be responsive to and inclusive of a diverse group of youth, including youth at a wide range of developmental levels. 988 call center staff will also need to support parents and caregivers in distress or crisis that are responsible for keeping the youth safe. Additionally, allowing the youth and families to define the crisis will empower the MRSS teams and systems to be more preventative. Kashi also shared two examples from her own experience where youth callers could have benefitted from a MRSS team.

Kristen Wells and Bipasha Mukherjee presented key themes from the Lived Experience Subcommittee's discussion about youth crisis services. Subcommittee members typically include caregivers, parents, and people dealing with their own behavioral health issues; Bipasha and Kristen highlighted that youth rarely attend the meetings. They noted the complexity of the space, and added that peers are instrumental in helping families come together. Themes included:

- The system is siloed, opaque, and very hard to navigate
    - Even people who know the system have a hard time navigating it
    - Caregivers are asked to become case managers
    - Central system where records are kept could be helpful
- Inadequate resources lead to gaps in the system
    - Rural areas never see enough investment
    - Urban areas seeing long waits
    - Urgent need to develop well trained and supported work force
    - Resources In Between: Youth that is not in acute crisis but not doing well
- Building trust with disenfranchised communities (e.g., LGBTQIA+, people of color) is imperative
    - Houseless persons, People of Color – Especially Black and Hispanic persons; LGBTQ+; People on the spectrum, neurodivergent, other developmental issues.
    - Deep distrust of law enforcement and government
    - Bad experience as youth results in not seeking help as adults, deepening behavioral health issues.
- Who offers help matters
    - People turn to communities they are familiar with
    - Youth needs support. But so do adult caregivers and siblings
    - Peers/People with Lived Experience **must** be part of who responds.
    - Peers help address deep sense of shame, guilt, and stigma. Vital to bridging divides
    - Skill set of responders makes a big difference. Adequate training is a must
- There is a delicate balance between the caregiver voice and the youth/child voice
    - A tender and delicate issue
    - Caregivers feel they are not trusted by the system and crucial information is not shared with them
    - Youth seeking help on their own without caregiver/parental knowledge
    - When families think youth needs help, but youth doesn't agree

CRIS Member Questions/Answers:

- Are young people taken at their word that they are not comfortable with their parents involved? Is there a risk of a check-in with their parents? Can young people be assured their parents won't be involved?
    - Generally, youth remain anonymous; if they aren't willing to share information or have parents involved, the only way the parents would be involved is with active rescue or emergency intervention through 911. Each 988 call center has a different practice for gathering information about callers. There are clear Washington laws that all regional crisis lines and 988 need to follow regarding the rights of youth callers and circumstances to notify parents.
- Is the goal to establish a standard practice for risk tolerance? Everyone will have a different comfort level – some supervisors want to call 911 or activate the emergency contact, while others have a higher risk tolerance. This might be a potential barrier as youth who are seeking help will hold back certain levels of information to avoid having parents involved.
    - HCA noted adolescents 13+ in Washington have a right to seek behavioral health or substance use disorder treatment without consent of the parent or caregiver. MRSS teams will meet youth 13+ where they agree to meet; it's not always safe for parents or caregivers to know they are receiving services. The youth should be aware of limits of confidentiality; response teams should communicate mandatory reporting requirements consistently throughout the intervention. Parents or caregivers are brought in when there is a safety issue.
- Highlighted issue that if youth are under 13 when they call 988, how do we know that and how do we ensure parents are involved.
- Noted need for discussion with the Washington Office of the Insurance Commissioner to ensure private insurance coverage of MRSS services.

DISCUSSION: CONSIDERATIONS FOR YOUTH CRISIS RESPONSE

Jamie facilitated the group discussion and provided the following discussion questions for committee members to consider:

- Based on what you have heard about the MRSS model, the Lived Experience Subcommittee feedback, and your own personal and/or professional experiences, how can we better ensure that youth calls to 988 result in the outcomes we aspire to (i.e., MRSS engagement)?
- What are the current barriers to these outcomes?
- What are some ideas for how we can address these barriers?

Committee Discussion

CRIS Committee members shared their input and feedback on considerations, barriers, and ideas related to youth crisis response:

Confidentiality considerations for youth and ways in which 988 can address those considerations

- Everyone calling 988 should have the opportunity for informed consent around their participation.

- Important to inform youth about confidentiality requirements and limitations.
- Need to flesh out standards for contacting the parents or caregivers.
    - Important to recognize that some families will want to be involved in a harmful way or have broken the trust of the youth caller.
- Would peer volunteers be covered as mandated reporters? What is the law around that?
- There is no way to contact the parent if the youth doesn't share their information or contact number; the only option is to work through 911 and local law enforcement.
- If 988 can determine the location of the contact, they can work through regional crisis line partners or direct relationships with providers to initiate contact or mobilize resources.

Current barriers to improved outcomes

- There is no standardized mechanism to directly connect youth to MRSS when they call 988; connections are currently made through regional crisis lines.
- Handoffs to youth services vary depending on area, region, agency, and service; it's not standardized.
    - This can result in redundancy and inefficiencies for the callers.
- 988 is limited by the ability to identify the age of the caller. If a caller is hesitant to provide information, 988 staff are challenged to gather that information voluntarily.
- Recognition of different system priorities and barriers based on different cultural perspectives and values. For example, some communities of color want the support of law enforcement, while others do not. Immigrant and newcomer families may experience additional difficulties while navigating a new system.
    - Noted that there is no integrated text translation for languages other than English for 988.
- The system needs to respond to the needs of youth while also welcoming and aiding families that want to support their children.
- Consider existing family fears around child protective services engagement in addition to law enforcement presence.

Ideas to address barriers

- Modalities such as chat and text are more highly utilized by youth. There are voluntary pre-chat and text surveys that ask for the age of the individual contacting 988, which could better position the intervention.
    - Note that 80% of individuals contacting 988 via chat and text across the country are under the age of 25.
- There are trainings on how to engage the caller and natural supports to gather additional information from callers; it is also helpful to have additional staff, such as a supervisor, present to process the call.
- Include law enforcement and other partners in trauma-informed and youth-informed trainings to minimize potential harms and build trust across communities.
    - Especially in rural areas where law enforcement is all that is available, need to ensure law enforcement is on the team and not the enemy.

- Share clear guidelines with and provide training to 988 staff around rules for when parents or youth call.
- Potential integration with the teen youth suicide hotline so youth can talk to peers.
- Consider suggesting an "opt-in" button or dial option for youth 17 or under to put standards in place to connect youth to MRSS or other youth-appropriate resources.
    - The caveat is that resources are different across counties and regions. A lot of teams are not yet fully functional and are still recruiting staff.
    - Another challenge is that the mobile response teams for youth are currently dispatched through the regional crisis line. Not ideal to transfer callers back and forth to achieve outreach.
    - Department of Health staff noted that there may be challenges with what Vibrant would endorse, as it does not allow caller screenings. Similar challenges were raised during the legislative session with proposed screening to identify rural and agricultural callers.
- Consider developing standard protocols for how and when to engage MRSS teams.
    - The Crisis Response Dispatch Protocols Workgroup will investigate this further; there are children and youth representatives in the Workgroup as well.
    - Will need flexibility for staff to handle the situation while also following professional training and making judgement calls.

Additional items for follow-up

- Could Hubs transfer youth to a system with deeper knowledge on working with youth? Ideally 988 would have a button for minors, but in the meantime, can Washington do something in terms of youth wanting to speak to someone that works closely with youth and knows the system?
- How will system partners (e.g., emergency department, adolescent inpatient, juvenile justice, schools) access youth crisis services (i.e., MRSS) through 988?
- What level, if any, of standards do we want across the system to support in making the connection between 988 and MRSS?

Jamie thanked the CRIS Committee members, including the presenters and Lived Experience Subcommittee representatives, for their engagement in the discussion and willingness to share experiences.

ACTION ITEMS AND NEXT STEPS

Next steps and action items for the meeting:

- The Department of Health will follow-up on Vibrant considerations for a dedicated youth line or dial option for youth callers.
- The Office of the Insurance Coordinator will continue to connect with HCA on coordinating with respect to MRSS and coverage, particularly for private payers.
- HCA and the Dispatch Protocols Workgroup will investigate developing standard protocols for how and when to engage MRSS teams for youth.

PUBLIC COMMENT PERIOD

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

MEETING ADJOURNED