CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE MEETING SUMMARY

Tuesday, September 19, 2023; 1:00 pm – 4:00 pm
Zoom

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

---

ATTENDEES

COMMITTEE MEMBERS

Anna Nepomuceno, National Alliance on Mental Illness (NAMI) Washington
Bipasha Mukherjee, Crisis Line Volunteer
Claudia D'Allegri, Sea Mar Community Health Centers
Connie Chapman, Suicide Prevention Program Manager, Washington Department of Veterans Affairs
Darcy Jaffe, Washington State Hospital Association (Ryan Robertson attended in her place)
Dillon Nishimoto, Asian Counseling and Referral Service
Fennec Oak, Fennec Oak Counseling
Heather Sanchez, American Lake Veterans Affairs
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
Keri Waterland, Washington State Health Care Authority (HCA)
Levi Van Dyke, Volunteers of America Western Washington
Marie Fallon, Member representing Lived Experience
Megan Celedonia, Office of Governor Jay Inslee
Michael Reading, Behavioral Health and Recovery Division, King County
Michael Robertson, Certified Peer Counselor
Michele Roberts, Washington State Department of Health (DOH)
Michelle McDaniel, Crisis Connections
Puck Kalve Franta, Access & Inclusion Consultant
Robert Small, Premera Blue Cross
Senator Manka Dhingra, Washington State Senate

COMMITTEE MEMBERS ABSENT

Adam Wasserman, State 911 Coordinator
Aleesia Morales, Tacoma Fire Department
Amber Leaders, Office of Governor Jay Inslee
Caitlin Safford, Amerigroup
Justin Johnson, Spokane County Regional Behavioral Health Division
Kashi Arora, Community Health and Benefit, Seattle Children's

Kimberly Mosolf, Disability Rights Washington
Larry Wright, University of Washington School of Social Work
Krystina Felix, The Kalispel Tribe
Linda Grant, Evergreen Recovery Centers
Representative Tina Orwall, Washington State House
Representative Tom Dent, Washington State House
Ron Harding, City of Poulsbo
Senator Judy Warnick, Washington State Senate
Summer Hammons, Treaty Rights/Government Affairs

AMERICAN SIGN LANGUAGE (ASL) INTERPRETERS

Laurie Reinhardt
Jackie Bruce

COMMITTEE STAFF

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

WELCOME, INTRODUCTIONS, AND TECHNOLOGY REVIEW

Jamie Strausz-Clark, 3Si, convened the meeting, which was held in-person at the Seatac DoubleTree by Hilton Hotel. Jamie also 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 joining virtually. Jamie then introduced new CRIS Committee member Fennec Oak, serving in the CRIS seat representing an organization specializing in facilitating behavioral health services for LGBTQIA+ individuals.

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. Strengthen relationships with fellow CRIS members.
2. Understand CRIS member perspectives on and criteria for determining priorities for recommendations.
3. Prioritize recommendations for addressing system gaps to propose to the CRIS Steering Committee to include in the 2024 progress report.
4. Confirm action items and next steps.

5. Hear public comment. Due to lower sign-up numbers, the comment period was shortened. Public comments are welcome in written form at any point throughout the process and may be submitted to HCAprogram1477@hca.wa.gov.

Betsy Jones, HMA, reviewed the CRIS Committee timeline and deliverables. The meeting today will focus discussion on the recommendations identified in the "synthesis documents" that were developed to summary the system gaps, progress made, and areas for continued improvement across the crisis service continuum – Someone to Call, Someone to Come, A Safe Place to Be. The documents incorporate input from the CRIS as well as the Lived Experience Subcommittee, Rural and Agricultural Communities Subcommittee, and the Tribal Subcommittee.

Betsy shared appreciation for Megan Celedonia in her role as the Governor's Office 988 Coordinator, and best wishes in her decision to join the Department of Corrections as the Director of Strategy and Innovation. The CRIS Committee members shared their gratitude for Megan's efforts to support 988 implementation and work with the CRIS Committee.

Matt Gower, HCA, provided an update on the availability of committee stipends, which were set up by Senator Dhingra's initiative through the Office of Equity. Individuals serving on the CRIS Committee and Subcommittees with lived experience or who are low income and not otherwise compensated for work on the Committee are eligible for Committee stipends dating back to January 2023. HCA will send an announcement with additional information, including the accompanying A20 form. Individuals can reach out to HCA for support filling out the form as needed.

PERSONAL STORY

CRIS Committee member, Bipasha Mukherjee, provided an introduction for Michael Robertson to share his personal story and experience with Washington's crisis response system. Michael is a member of the CRIS Committee and the CRIS Lived Experience Subcommittee, and he has been working as a certified peer counselor (CPC) with Peer Kent for three years. Michael shared his experience as a 53-year-old man of color, and a person in long-term recovery from SUD. CRIS Committee member, Michael Reading, thanked Michael for sharing with the group in-person, and noted the value of his personal story and perspective.

DISCUSSION: Prioritization Criteria

Michele Roberts, Washington State Department of Health (DOH), set the context for the CRIS discussion of prioritization criteria. The Steering Committee is looking to CRIS for insights on what to recommend in the 2024 progress report. Throughout this year, CRIS Committee members have identified system gaps, learned about the progress that's been made on these gaps to date, and started brainstorming recommendations for addressing remaining gaps. While there are a lot of good opportunities, they are not all feasible for addressing within one year. The CRIS Committee will help with setting priorities.

Jamie asked the CRIS Committee members to spend a few minutes considering criteria or rationale they each are using to prioritize recommendations. She provided the following prompts for possible criteria underlying member priorities:

- Urgency of the system gap that needs to be addressed
- Addresses critical roadblock
- Recommendation that is supported by people with lived experience
- Easy "win"/feasible to implement
- Other ideas

CRIS Committee members discussed the following criteria informing member recommendation priorities:

- **Urgency** of the system gap that needs to be addressed
- Addresses **critical roadblock** that would otherwise stop other work from happening
- Recommendation that is **supported by people with lived experience** since we are committed to prioritizing/centering lived experience.
- **Easy "win"/feasible** to implement
    - Tie together existing resources but in a productive and supportive way (build on what works)
- Look for recommendations **that build standards, sustainability, and infrastructure** (invest in things that can live on beyond this, and promoting standards across regions
- Is it pinpointing diversity and geo-ethnic severity – is the **recommendation tailored ethnic, geographical and behavioral health needs**
    - Looking at everything through an equitable (DEI) lens
    - Promoting equity
    - Does it further **equity and safety**
    - Does it address a root cause
- Is it a modification of something that already exists
    - Lift up the **existing best practices and then innovate** from there
    - Using intentionality when doing this
- Prioritize recommendations that **result in the outcomes** we want to see.
- We want to prioritize recommendations **that will mitigate the stigma against people with mental illness**
- **New and innovative**
- **Crisis centered** rather than other parts of the system
- Addressing **emergency conditions** first – but also need to define what "emergency" is – what will address the pieces that are the very closest to what individuals in crisis are experiencing
- Look at the **systems readiness to change** or implement – prioritize recommendations that have some momentum
- Providing **support and technical assistance** to make these changes to happen
- Does the recommendation **support prevention**
- Consider issues that should be addressed during the short session versus the long session; **Align with legislative seasons**
- Expanding telehealth infrastructure – or recommendations that **result in increased infrastructure**

In addition, the CRIS discussed a few prioritization criteria that have tensions or potential conflicts with other prioritization criteria:

- **Reconceptualizing Elements of the System vs. Building on What We Already Have**

Many CRIS members support the idea of building on what we already have in place, for three key reasons: 1) it will save resources and time, 2) overhauling an entire system may not be feasible, and 3) people are in crisis now and if we wait until we have a new system built, we will lose more lives. Similarly, the CRIS discussed system readiness as a prioritization criteria (in other words, is there the necessary will to implement the recommendation?).

On the other hand, several CRIS members have raised the concern that the existing system does not work for many people. They make the point that we must seek to understand and address the root causes of system failure for many people—which may require a reconceptualization of elements of the crisis response system rather than just modifying what we already have.

- **Crisis-Centered vs. Prevention**

Some CRIS members propose focusing on recommendations that are crisis centered (i.e., over recommendations that are focused on other parts of the behavioral health system). Other CRIS members proposed prioritizing recommendations that address prevention upstream of the crisis response system. There may be different points of view about whether some prevention services are part of or outside of the crisis response system, but either way, this is a tension worth noting.

EXERCISE: Prioritization of 2024 Recommendations

Following discussion of the varied prioritization criteria, CRIS members engaged in an exercise to identify their top recommendations for improving crisis services in Washington. Recommendations were divided into three groups – Someone to Call, Someone to Go, and A Safe Place to Be – and aligned with the opportunities identified in the synthesis documents that CRIS members received in advance of the meeting for review.

Keri Waterland, Washington State Health Care Authority (HCA), set the context for the prioritization activity. The purpose of the activity is to get insights on which recommendations should be prioritized for 2024 and why.

Jamie highlighted that the CRIS and Steering Committee have committed to centering lived experience in this work. As such, the Steering Committee would like a visual way to highlight the priorities that come from our four representatives with lived experience. These representatives will have green dots, while other CRIS members will have yellow dots. While the members representing lived experience are the only people with green dots today, CRIS Committee members are invited to consider what they've heard from people with lived experience in their own decisions about priorities. Keep in mind, this activity is not a vote. How many dots a particular recommendation gets is just one piece of data. The Steering Committee is also seeking to understand which CRIS members prioritize a particular recommendation and why. For example, if a recommendation gets support from all four of our members with lived experience, that is an important data point.

CRIS members were given five yellow-colored dots—plus an option to request two more dots—for each of the three groups of recommendation across the crisis service continuum (i.e., a total of 15-21 dots across recommendations covering Somone to Call, Someone to Come, A Safe Place to Be). CRIS members with lived experience were given the same number of dots in the color green with the purpose of creating a clear visual understanding of priorities for members representing lived experience (note: in advance of the meeting, this approach was discussed with and supported by member representing lived experience). CRIS members were then asked to attach their dots to their highest priorities for 2024.

State Agency employees who serve on the CRIS Committee—Jane Beyer (OIC), Megan Celedonia (Governor's Office), Michele Roberts (DOH), and Keri Waterland (HCA) did not receive dots. They focused on listening to what their fellow CRIS members had to say. Staff also highlighted that gaps and opportunities identified by the Tribal 988 Subcommittee are included in the recommendations for CRIS member awareness, but that priorities are being determined through the Tribal 988 Subcommittee and Tribal Consultation process in honor of the state's government-to-government relationship with Tribes.

In follow up to the September 19th meeting, CRIS members who were not able to join the meeting were invited to submit their "dots" to identify priority recommendations. Three CRIS members who did not attend the meeting submitted their priorities via email.

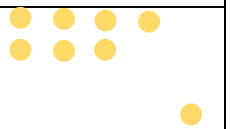
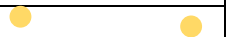
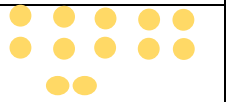
Below is a table of all recommendations considered, and the dots assigned to each recommendation by CRIS member present as well as the members who were not able to attend but submitted their priorities via email after the meeting. The recommendations are organized into the following five topic areas:

1. Data and Reporting
2. Capacity
3. Cross-System Coordination and Alignment
4. Equity and Safety
5. System Navigation and Accessibility

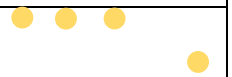
Within each of these categories, the recommendations are ordered based on the number of dots attached to each recommendation, with recommendations receiving dots from Lived Experience CRIS members ordered first. In addition, the recommendations are color coded **green (Someone to Call), blue (Someone to Come),** and **purple (Safe Place to Be)**. All of the original recommendation numbers are included in parenthesis if needed to track back to the original location of the recommendation.

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
DATA & REPORTING			
1.	Set **system performance targets and metrics and hold the behavioral health system accountable** for hitting those targets and metrics. (F9) i. Advise state agencies on key metrics for the crisis system to ensure it is successful at addressing gaps. ii. Systems should be tracked and then held accountable to ensure their outcomes are resulting in meaningful access to services. iii. Leverage existing oversight boards (expand or add-on). iv. Carry out continuous process improvement on quantitative and qualitative data gathering methods and provide recommendations to course correct as needed.		
2.	Advise state agencies on **key metrics for the crisis system** to ensure it is successful at addressing gaps. (A4)		
3.	Set up **a hub where information can be entered and accessed** by all members of the care team and the individuals/families in crisis. (F6)		
4.	Leverage a census model to go into the communities to collect data. Make system improvements based on system user experiences and feedback. (F4)		
5.	**Standardize terms and definitions** (e.g., mobile crisis response team, co-response, safety risk, youth, transition-age youth, etc.) (F1)		

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
6.	Provide trainings to 988 contact center staff on **how to engage the caller to gather additional information** about the person in crisis. (DOH note: Vibrant currently provides these trainings to 988 call centers.) (A1)		●●
7.	Develop more granular analysis of distribution of mobile crisis response team (for adults) and mobile response and stabilization services (for youth). (F2)		● ●
8.	Make a policy to have **additional staff (e.g., supervisor) present to process the call and gather more information** about the person in crisis. (A2)		●
9.	Explore data sharing agreements and criteria to connect and **share data across school systems and crisis systems** in order to provide students with better follow up care (all within appropriate patient confidentiality safeguards) (A3)		● ●
10.	Set targets to determine additional gaps in language accessibility. This could help to ensure mobile crisis teams are staffed appropriately depending on the populations being served. (F3)		
11.	Develop core standards (i.e., performance metrics) for embedded co-response programs that are consistent no matter the system. (F5)		
12.	Set up system to **allow people to tailor their own crisis system response** before they are in crisis. Having a treatment plan would help prevent bad experiences with the crisis teams. (F7)		
13.	Ensure there is a **process to capture qualitative data** to document outcomes (patient satisfaction, barriers, unmet needs, etc.). (F8)		
14.	Use **2018 or earlier as a baseline for youth visits to emergency departments** for a mental health crisis. (K1)		

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
15.	Creation of **dashboard to display mobile crisis data** and track service outcomes. (K2)		
16.	Tribal 988 Subcommittee (A5) i. Develop best practices for data collection, requirements, training, and alignment across systems for early identification of individuals with tribal affiliation. ii. System recognition of Tribal data sovereignty iii. Develop best practices for data collection, requirements, training, and alignment across systems for early identification of individuals with tribal affiliation		
CAPACITY			
1.	**Expansion of peer respite and peer support services** is key to providing people access to crisis care to meet them where They are at. (L3)		
2.	Support development of **crisis response workforce—including peer support—that has shared language, cultural background**, and other shared life experience as populations served. (H6)		
3.	Ensure **training for organizations on how to use peer supports**, including how to access current HCA trainings on this topic. (L10)		
4.	Develop recommendations related to **prevention services, including investments in basic and social services** and ensure equity in prevention services across the state. (L16)		
5.	Provide **additional funding to behavioral health crisis systems in rural communities. Consider enabling "payer blind" crisis services** (i.e., services not just for Medicaid clients or commercially-insured clients). (L2)		

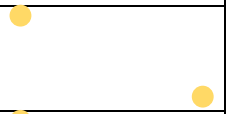
#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
6.	Consider changing or reframing "some place to go" to "a safe place to be" or at least add "safe place to be" as the initial goal. **Prioritize stabilizing in the home** where the focus is on helping people experience a sense belonging and avoiding the need for removal from the home and family system. (L14)	●	● ● ● ●
7.	**Expand Mobile Response and Stabilization Services (MRSS)** in-home support crisis stabilization services for youth. (L4)	●	● ● ● ●
8.	Consider **quality control initiative** and training to ensure consistent level of services across call centers. (B1)	●	● ● ●
9.	Develop system **capacity to follow up with people** to make sure they have what they need. (L9)	●	● ● ●
10.	System capacity to **respond to co-occurring mental health and substance use disorders** is essential. (H8)	●	● ●
11.	**Tribal 988 Subcommittee** (H 10) i. Establish endorsement standards specific to Tribal Mobile Crisis Response models. ii. Continued support for the Tribal Mobile Crisis Response Workgroup to develop the Tribal Mobile Crisis Response model and best practices, informed by the Tribal Mobile Crisis Response pilots. iii. Ensure Tribes have access to capacity building funds for tribal Mobile Crisis Response teams. iv. Coordinate training as requested by the Tribal Mobile Crisis Response Workgroup.	●	●
12.	**Research in-home stabilization services as a promising model for adults** as well. (L5)	●	●
13.	Consider outreach and education to **recruit community groups to support their work to start their own crisis stabilization program or facility. (L6)**	●	●

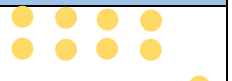
#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
14.	Advocate for increased resources for all systems supporting the crisis response system to **ensure a living wage, adequate resources, and workforce stability** with a focus on behavioral health. (H4)		
15.	Pursue **consistent funding for mobile crisis response**, rather than braided local funding to expand workforce and improve response times. (H1)		
16.	Review stabilization services to ensure they **adequately address substance use as well as mental health needs. (L7)**		
17.	Ensure there are **adequate services available in all regions (including/especially in rural areas)** so that people have access to services – why call if and ask for help if there are not resources to actually help? (L8)		
18.	Create a **workgroup to research and develop recommendations to build and sustain behavioral health workforce, including workforce pipeline programs that help to diversify the workforce**. Learn from other states (e.g., AZ, TX, MI, GA) about funding approaches and strategies for supporting workforce and capacity to help meet need. (H5)		
19.	**Train 988 staff in protocols to help family members** calm down and solicit helpful information about the person in crisis to help responders respond appropriately and effectively. (B3)		
20.	Partner with **local community colleges to support staffing needs. (B2)**		
21.	Anticipate and prepare for response to local community concerns and potential delays due to lititgation when building new crisis centers and facilities. To avoid or mitigate concerns, be **prepared on legal challenges and create public relations campaigns to**		

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
	educate communities about behavioral health and the importance of services in advance of proposed facilities being built around the state. (L1) i. Consider partnerships state and local officials and people lived experience to engage in forums to help the public understand the importance of the services. ii. Recognize that cities are key partners, and the importance of engaging early on the development of these efforts before decisions are made.		
22.	**Develop performance metrics and hold the behavioral health crisis response system accountable**. It is important to **establish metrics to tell us when rural areas** aren't getting level of services urban areas are and then focus on investing and improving services in those areas. (L12)		
23.	Need **investments in behavioral health services** across regions and **plan for evaluating adequate distribution of resources**. (L11)		
24.	Advise agencies on **developing a holistic approach** and the ability to address patient physical, mental, substance use issues for Crisis Receiving Centers. (L13)		
25.	Due to geographic limitations and barriers in **rural areas, may need to have a greater reliance and partnership with first responders** in these areas. (H2)		
26.	Advocate for **limiting Criminal Justice Information Services (CJIS) laws**, which prevent peers from working within law enforcement. (H3)		
27.	Consider the **creation of systems to support families of a person in crisis** that can include resources to mitigate loss of income and resources to help families learn skills to support their loved one in crisis. (L15)		

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
28.	Crisis response **teams should be comprised of people with lived experience** as well as clinical staff. (H7)		
29.	Consider expanding efforts to **provide mental health first aid trainings** and education for lay persons. Consider mandating everyone in school take a mental health first aid training. (H9)		
CROSS SYSTEM COORDINATION & ALIGNMENT			
1.	**Cross-system collaboration, including coordination between 988 and 911, is a significant role CRIS should advise on.** The goal is to ensure that we have systems that can communicate to ensure the caller receives appropriate responses and care needed. We need recommendations to support collaboration, partnership, and trust between 911 and 988 system to better facilitate coordination and handoffs across systems. This work should: (C6) i. Recognize 988 and 911 co-location efforts, and potential areas for CRIS to recommend ways to support 988 and 911 collaboration while recognizing concerns raised among populations who will not reach out to 988 if they fear this will trigger engagement with 911 or law enforcement; ii. Education regarding training that law enforcement personnel receive regarding behavioral health crisis response; iii. Recognition of fundamental societal root causes that have shaped the inequities, injustices and fear of law enforcement experienced in our current system.		

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
2.	**Expand juvenile justice programs that provide wrap-around services to youth** with behavioral health diagnosis and other needs. (M2)		
3.	Consider an **"opt-in" button or dial option for youth who call 988 to connect youth to Mobile Response and Stabilization Services** or other youth-appropriate resources. (DOH Note: Federal requirements restrict the ability of 988 Lifeline centers to use triage options, such as opt-in buttons.) (C4)		
4.	Convene a workgroup with representatives from first responders, behavioral health staff, people of color, and people with lived experience (and intersections of these identities) with purpose to make **recommendations about how to assess safety risk in behavioral health crisis and appropriate response.** (G8)		
5.	System needs to be set up to recognize access points to the crisis system outside of the 988 Lifeline and ensure a **No Wrong Door approach** to accessing crisis supports. (C3)		
6.	Develop **protocols for determining who is "lead" in the field based on safety issues.** (G3) i. Start with behavioral health as lead unless safety concerns are present. ii. Address how implicit bias and racism impact staff of color in the field.		
7.	Develop **regional collaborations that convene system partners** to create regional plans and protocols for crises per HB 1134. (G1)		
8.	Set requirements that would ensure **all first responders take Crisis Intervention Training (CIT);** create standards for training that would allow for regional adaptation. (G4)		

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
9.	Advise state agencies on **strategies (e.g., training) to help the system work together better**. (G6)		
10.	Pursue legislation and policy changes that address **forensic diversion for youth** (i.e., behavioral health focused care for youth with mental health issues that have involvement with law enforcement). (M1)		
11.	Consider **integration of 988 with the [EXISTING] teen youth suicide hotline** so youth can talk to peers. (C5)		
12.	Develop **standard protocols for how and when to engage MRSS teams for youth**. Will need flexibility for staff to make judgement calls. (G2)		
13.	Advise state agencies on the **standards for endorsement** of mobile rapid response crisis teams and community-based crisis response teams. (G9)		
14.	Advise state agencies on core **standards for embedded co-response programs. (G10)**		
15.	Clarify understanding of **regional vs. state decision-making authority** over crisis response services. (C1)		
16.	Investigate **how other states facilitate coordination and handoffs across systems** and reduce friction between 988 and 911 and identify best practices. (C2)		
17.	Develop **protocols around determining voluntary vs. involuntary services**. (G5)		

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
18.	Advise state agencies on **training curricula for behavioral health and first responders**. (G7)		
19.	**Tribal 988 Subcommittee (G11)** i. Implement HCA-Tribal Crisis Coordination Plans for coordinating with Tribal entities. ii. Finalize new crisis coordination protocols that include National Suicide Prevention Line and Regional Crisis Line protocols. iii. Finalize Tribal Mobile Crisis Response dispatch protocols through the Tribal Mobile Crisis Response workgroup.		
EQUITY & SAFETY			
1.	Advise on **how to make it possible for vulnerable people—particularly people of color, people who identify as transgender and LGBTQ+, and youth--to feel safe calling** for help in a crisis and build and sustain more trust in the crisis response system. (I5)		
2.	Advise on how to make it possible for **vulnerable people—particularly people of color, people who identify as transgender and LGBTQ+, and youth--to feel safe calling** for help in a crisis and build and sustain more trust in the crisis response system. (D11, I5)		
3.	Create **public relations campaigns to address stigma against behavioral health conditions** and seeking help. (D3) i. Emphasis is needed on helping public to understand behavioral health crisis and how it manifests versus true safety risks.		

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
	ii. Address stigma and normalizing discussions about stress, mental health needs and care, and stressors for agricultural communities. iii. Tailor messaging and distribution methods to best reach marginalized communities (e.g., people of color, immigrant communities, LGBTQI+), and translate into multiple languages. iv. Print informational materials about behavioral health and crisis response to distribute in medical practices and other locations. v. Engage input from subcommittee/group comprised of people of color and other marginalized communities to advise on how to best communicate information and address stigma or other barriers to access in their communities.		
4.	Provide resources (i.e., capacity, funding, including paying people with lived experience for their time and expertise) to support engagement with people with lived experience on developing a **"Caller Bill of Rights"** with the following elements: (Consider partnering with the Lived Experience Subcommittee) (D2) i. Focus on informed-consent for community. (include consideration of circumstances when informed consent doesn't work and why, e.g. individuals diagnosed with anosognosia). ii. Develop information for communities on what to expect when they call. iii. Include monitoring plan to assess trends. iv. Is not just performative (i.e., requires accountability and enforcement).	● ●	● ●
5.	Do **root cause analysis on lack of trust between systems and systems and propose solutions. (I9)**	● ●	●
6.	Advise state agencies on **regional collaborations to address equity and systemic failures**. (I6)	● ●	

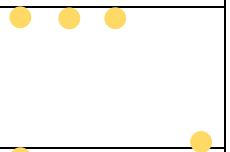
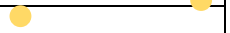
#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
7.	Support **development of crisis response workforce—including peer support—that has shared language, cultural background**, and other shared life experience as populations served. (I1) i. Seek policy changes and legislation to make it easier for **peers to participate in crisis response**, because this can help destigmatize seeking help in a crisis.		
8.	Invest in workforce development initiatives that focus on filling gaps in representation in **workforce to better reflect diverse communities served**.(D10) i. Include requirements for translation/ interpretation services for crisis response services and invest in culturally-specific service providers.		

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
9.	**Advise on community outreach and education campaign on 988 (D12)** i. Community outreach, marketing, and promotion of 988 Lifeline services should build trust, be available in multiple languages, and include images tailored to specific communities. ii. Communication about 988—especially the 988 co-location pilot—needs to emphasize that the intention is to reduce unnecessary engagement with law enforcement for behavioral health crises and help address the concerns and fears that people have in calling for help. iii. Address relationship between 988, 911 and co-response. iv. Create behavioral health glossary of terms and share across systems and for community education campaigns. v. Address concerns of populations who are afraid to access the system due to previous harms. vi. Support both passive and active information sharing for farmers and ranchers, such as brochure racks and educational materials in stores that cater to farmers and ranchers that can easily and discretely picked up. vii. Make sure images used on marketing materials reflect agricultural communities.	●	● ● ● ● ● ●
10.	Research **why people with developmental/intellectual disabilities have no place to go and identify strategies to address gaps. (N2)**	●	● ● ●
11.	**Include law enforcement and other partners in trauma-informed and youth-informed trainings** to minimize potential harms and build trust across communities. (I3) i. Develop cross-county standards for trainings, acknowledging that there may be some specific tailoring needs among individual communities. ii. Include evaluation components to measure training outcomes and results.	●	● ●

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
	iii. Beyond adding new trainings, update existing trainings to reflect best practices for engaging with those experiencing mental health issues.		
12.	Conduct **research to understand why the crisis response system is not working for some people**. (I4) i. Review existing data across state agencies (e.g., National Violent Death Reporting System, quality improvement data on who is not being served) ii. Engage in research (e.g., a statewide "Death Review" forum) to determine why people are still losing their lives and identify needs. This should be done in a sensitive and culturally respectful way. iii. Quantitative data also needs to be supplemented with qualitative data, such as interviews with loved ones of people who lose their lives to suicide.	●	● ●
13.	Since youth tend to use chat and text, emphasize chat and text options and integrate translation. (D5)	●	●
14.	Workforce **training should include how to respond to/support individuals with intellectual and/or developmental disabilities. (N1)**	●	●
15.	Advise on Crisis Relief Center rulemaking to further discuss **whether or not solitary isolation and restraints should be used in 23-hour crisis relief** centers and if it is a best practice. (N3)	●	●
16.	Ensure 988 call center staff are **trained to be responsive to diverse group of youth**, including youth at a wide range of developmental levels, and trained to support parents and caregivers in crisis to keep youth safe. (D4)	●	●

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
17.	Ensure **partnerships with local community resources and experts (especially in rural areas)** that can help with training, communications, and outreach (agronomists, community partners, family resource centers) (I7)	●	
18.	Advise state agencies on **training curricula for behavioral health and first responders that includes**: (I8) i. Overview of roles, authority, requirements, training, and approaches for responding to behavioral health crisis for both behavioral health and first responders. ii. Implicit bias and recognizing and addressing power and privilege. iii. Best practices for engaging with people who are appear erratic or non-compliant. iv. Understanding difference between safety issues and behavioral health crisis. v. Person-first and respectful interactions (cultural responsiveness and trauma-informed).	●	●
19.	Ensure **partnerships with local community resources and experts (especially in rural areas)** that can help with training, communications, and outreach (agronomists and community partners - especially family resource centers). (D8)		● ●
20.	Establish a 988 **Diversity, Equity, and Inclusion (DEI) Director**. This position should include Tribal government to government relations with appropriate tribal liaisons across the state. (D1)		● ● ●
21.	Establish requirements for translation/ interpretation services for crisis response services and invest in **culturally-specific service providers. (I2)**		● ●

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
22.	Put in extra safeguards around **caller confidentiality** and communicate about those safeguards, especially to callers in **rural areas**. (D7)		●
23.	Ensure that call center staff receive specific **training on understanding and interacting with rural/agricultural** communities. (D6)		●
24.	Develop options for answering calls by a person directly (vs. listening through recording first), especially for rural and agricultural communities. (D9)		●
SYSTEM NAVIGATION & ACCESSIBILITY			
1.	Set up a **centralized hub/database for information on available services** that can be accessed by all members of the care team and the individuals/families in crisis. (E2)	●●●●	●
2.	Strengthen **system support to navigate and simplify access to these services**. People with lived experience face significant challenges in navigating the complexity of the system and accessing services and may experience a sense of hopelessness in their ability to obtain services that they are eligible for. (O3)	●●●●	
3.	~~Create a~~ **Invest in current 211 database, a user-friendly centralized website or database with comprehensive, payer-blind behavioral health crisis-related resources. (O2)** i. Could be available to professionals and the public. ii. Include a list of all behavioral health providers and the services they provide; Consider mandating that providers and their services are listed in the database.	●●●	●●●

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
	iii. Information about prevention and other resources for people with behavioral health crisis needs. iv. Invest resources into ongoing efforts to compile information and maintain the database, so that it does not become just another source of potentially confusing and outdated information.		
4.	Expand, redefine, or clarify "this is what crisis is," i.e., show the whole range of crisis experience and why and when people may access services, so that **system is responsive to the full range of crisis situations and needs**. People in constant crisis may not recognize their circumstance as crisis; Paradigm shift on what crisis is and how our system can meet those needs. (E5)		
5.	Develop a **centralized, user-friendly database with all services in Washington**. This resource could include information about services, meetings, job opportunities, and other relevant information in a central location. (J1)		
6.	Review current requirements for **discharge planning and identify gaps. (O1)**		
7.	Provide **centralized information and education on who to call** (e.g. 911, 988, or regional crisis lines). (E1)		
8.	Consider infrastructure investments/community investments in areas across the state that have limited or no **access to internet. (E3)**		
9.	Increase use of **telehealth** to enable access to care on behalf of persons living in rural communities. (E4)		
10.	Advise state agencies on ways to improve **work with caregivers** and support diverse approaches to supporting caregivers. (E6)		

#	RECOMMENDATION	LIVED EXPERIENCE DOTS	OTHER CRIS MEMBER DOTS
11.	Advise state agencies on **strategies (e.g., training) to help the system work together** better. (E7)		
12.	Advise state agencies on **ways to improve work with caregivers** and support diverse approaches to supporting caregivers. (J2)		
13.	**Tribal 988 Subcommittee (J3)** ii. Ensure Indian Health Care Providers have access to system resources and information (i.e., new technology platform). iii. Incorporate Tribal input into Crisis Contact Center Hub Rulemaking.		
14.	Agency request legislation has been created to provide **liability protection to crisis responders and facilities** to reduce the barriers to providing services, transportation, and reduce the need for medical clearance. (O4)		
15.	Provide **funding and require facilities to be able to manage activities of daily living (ADLs)** for people in crisis who need assistance to reduce the need for medical clearance and admission denials. (O5)		

MEETING SUMMARY

ACTION ITEMS AND NEXT STEPS

Next steps and action items for the meeting:

- HMA to further synthesize and summarize recommendations and priorities identified.
- Steering Committee to review recommendations and priorities during the 9/26/23 Steering Committee meeting to establish the foundation for the 2024 progress report.

PUBLIC COMMENT PERIOD

Jamie reviewed the public comment process and opened the public comment period: No one signed up for public comment. Jamie highlighted the opportunity to submit public comment via email to: HCAprogram1477@hca.wa.gov.

MEETING ADJOURNED