HB 1477 Public Comments, Received Through the HCA Email Address

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Kathy Mutchler, June 17th, 2023

Dear Crisis Response Improvement Strategy (CRIS) committees,

Thank you for doing this effort!

My background is in the field of Social Work. I want to provide this written public comment please.

My name is Kathy and I live in Seattle. I am reaching out about a possible solution to the disabling drug use across the whole region.

Recently in the corner park in my neighborhood I witnessed a woman overdose on drugs, she collapsed unresponsive, and I called 911 for medics to resuscitate her. When I looked online to find out what happened to her, it listed the event as a drug overdose casualty. Also, I have recently met two mothers who have each lost a child to a Fentanyl overdose (a lethal street drug).

Aside from killing people, drugs are disabling people. I can see people disabled from drugs. People are warped from drugs, and many cannot function to take care of themselves. It is a public health crisis that is spreading.

I want to share a possibility for everybody's consideration who has the goal to get drugs, possession for sales, and the open illicit drug use off the streets, and save lives. You can please pass this along if you see fit. Maybe this can be a way that will get approved and be effective.

This could be viewed as a public health issue.

New talking points on illicit street drug use:

- Drug addiction/chemical dependency/substance use disorder:
- It is a medical disease.
- It is a disability as seen on the street exhibited by street occupants.
- It is a class action lawsuit waiting to happen.
- County Public Health can do street outreach to respond to the scale of proportion to provide for the amount of people dying from this medical disease of addiction.
- Housing First has no Second service for residents for drug treatment programs.
- County can scale up their involuntary 72 hour holds to include incapacitated street occupant drug users. This crux can be an intersection into drug treatment inpatient facilities.
- State DSHS Adult Protective Services can be heralded to respond to people disabled from drug use on the street exhibiting self-neglect from this medical disease. Adult Protective Services is overdue to get on board for street occupants.

If people on the street don't want these kinds of services, then they will not use illicit drugs in the open on the street or sell in the open on the streets.

Explanation of these points:

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- Drug addiction/chemical dependency/Substance Use Disorder is a disease. It is a medical condition.
- Drug use is disabling people who have this disease because they are not able to function, care for themselves, or perform the activities of daily living (ADL). This would give them official disability status.
- Possible examples to begin with, (In Seattle the people on the streets can be assessed anonymously as a survey, or formally assessed if people have identification. King County Public Health/ or King County Behavioral Health and Recovery Division can contract agencies to do outreach such as Therapeutic Health Services, Evergreen Treatment Center, or Valley Cities, or Navos, etc. and such agencies can hire on more outreach employees that are certified to make chemical dependency diagnosis, and disability assessment.) Also, in Seattle the Unified Care Team's contracted outreach organizations can do surveys and assessments. Also, The Third Avenue Project's group called We Deliver Care could add this to their data collection which they have been doing called the By Name List.
- Write the book. The ability to function matrix can include whether or not they are able to independently seek out, apply for human services. If that is a function criteria that they cannot perform then that indicates disability.
- So often the situation is that people on the street using drugs are disabled and not being provided treatment because there are no treatment beds available in the drug treatment facilities.
- People with chemical dependency/drug addiction disability can be a population with a protected class due to the disability status. Federal law mandates the Americans with Disabilities Act (ADA). This means that they are a protected class of population that must have access to treatment or else it is discrimination against the law.
- The people with drug addiction disability on the street can be the basis of a public health lawsuit. A class action lawsuit on their behalf can be raised for the Public Health of the protected class of the disabled population not getting into drug treatment programs because there are not any available on scale to the proportion of the population. The State can be leveraged to provide cooperation.
- King County Public Health is not providing outreach to assess people on the street for this Public Health crisis. The result is death from Fentanyl (a lethal popular street drug). County Public Health could be leveraged to get up to scale to hire outreach to get people off the street by getting people into treatment facilities. It can be the Public Health department instead of the Recovery Division because people are dying from this disease from overdose on the streets. King County can alter its system to align with and meet the current reality.
- For example, more people are dying on the streets of drug overdose in Seattle than the record of dying from homelessness. If a State of Emergency was declared in 2015 in Seattle for homelessness, then why are there no declarations of a State of Emergency for people dying on the street from drug overdose? Federal support could be leveraged for cooperation. That could be used for drug treatment facility creation and access.

- This is a life saving priority over 'housing first' which does not have enough openings for all the street occupant drug users. This would provide treatment for their medical disease and prevent self-harm or self-neglect. This would provide services for their drug related disability in order to provide stabilization enough to function. The organizational and jurisdictional diagnosis standards for disability can be altered to align with the current reality. Write the book.
- It is unethical to allow people to remain untreated without human services for their disease of addiction and allow them to die in the streets. The housing first concept says to house them first before other services such as drug treatment. That service model cannot serve the number of people in the streets with addiction because the scale of the amount of people on the street dying and becoming disabled from drug addiction is exponentially, far exceeding the housing first openings.
- Housing First is not an adequate plan for the public health drug crisis. Permanent Supportive Housing organizations do not have any program for what happens 2nd for drug treatment. Many residents with the disease of drug addiction/chemical dependency/substance use disorder are not staying housed, they are back out on the street using drugs. Housing First has no Second for drug treatment programs. After housing, it is leaving people's medical disease of drug addiction/chemical dependency untreated which can lead to death. This is against the ADA Federal Law to not provide access to medical disease/drug treatment services for people who are disabled from that disease. The contracts paying for Housing First Permanent Supportive Housing programs can legally require community drug recovery programs in the residence building.
- I believe that the City, County, State can coordinate to include disability status to people on the street who are incapacitated from the disease of drug addiction/chemical dependency. We can all see the people, and it is not about the economics of homelessness. It is about drugs.
- New human services laws can be coordinated. Jurisdiction law experts can be consulted to develop a response to the public health drug crisis. Human services access and mandates can be created; and outreach treatment to those on the street who are disabled from the disease of addiction.

Thank you for your work. This is a drug situation not a homeless situation.

go big...go State

Krista Milhofer, June 7th, 2023

After spending the night overthinking my public comments and wishing I could go back, I realized this avenue might give me some opportunity to do that. To start with, I want to say thank you. I love my roads, medical services, and all the government systems behind the scenes that make living in this beautiful state so easy. I do not doubt that your team will build a great technical system to interact with the public. It has been done before and this new expansion will make the system even more robust and will address some concerns that lead to its creation.

I wish to revise my feedback and support the learning that was going on for much of the meeting about the inclusion of people with lived experience. This is actually one of the few areas where I am quite

familiar with the problem as an administrator of an organization run by people with intellectual and developmental disabilities. I don't have all the answers but here are a few things that I have found helpful that you might want to consider:

- meet in person and solve the barriers together that will come up for each individual to meet in person
- share experiences with each other, your work is personal and if you want people to help you then it's useful to be vulnerable yourself
- don't spend too much time on the technical things where outside input won't have any impact, keep the summary brief but provide detailed reports in audio format through email for access
- come with questions that will impact how you do your work so people feel that their feedback will be valuable
- check in with the assumptions that you are making about each person in the system when considering system operations, simple is always better, McDonalds can handle high turnover with quick training thanks to their picture ordering process and no one reads small print
- see how inclusive the final product will be (reading abilities, internet access, transportation, citizenship status, language, vision, hearing, mobility, comprehension, abilities to follow up independently, support system, family dynamics, housing, age, stigma involved, experience levels with systems, paperwork requirements, timetable involved, state of crisis, memory, mental health) The Uw Do-It program has accessibility lists.
- consider ways to support beyond a static meeting, can the steering committee test the end product to provide feedback for example, can they come up with a scenario for you to then test it, it there criteria they can develop that it needs to pass, can they shadow with the team and provide feedback to the prime sponsor to address barriers after implementation
- remember the goals beyond the system, is the team going to be empowered enough to resolve the crisis they encounter? is there going to be a way to address barriers that need high-level authority to address? How is this resource going to be solutions-oriented and prove that someone's needs were met satisfactorily with feedback that can only come from them?

I wish you all the best in your work. Please provide yourself grace and the opportunity to fix issues along the way. We are only human and we will all need 899 sometimes. Thank you for letting me sit in on your conversations. As a team, we will always have all the abilities we need in the room.

Krista Milhofer, June 6th, 2023

Thank you for allowing me to listen in on this session. My questions for consideration are below.

1. Customer feedback and satisfaction with crisis intervention?
2. Will crisis teams having the ability to gain access to limited resources?
3. Sustainability feedback loop of system improvement and reporting to CRIS team?
4. Inclusion of people with intellectual and developmental disabilities is available through People First of Washington.

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Rhonda Larson, March 22nd, 2023

I have a deep appreciation for this work and the challenging and professional discourse you engaged in tonight. In particular the conversation that surfaced tonight regarding a need to dedicate a specific focus on youth mental health. We are seeing youth in schools with so many behavioral, mental, and substance health needs and have such limited access to services even though we dedicate a substantial amount of funding in an effort to fill those needs (much of which goes unspent due to lack of access). In a perfect world, our partners would represent the cultures from which our students identify. When you do make space for this conversation, please invite school districts, as well as youth serving organizations, to hear our voices. Prevention and early intervention will come back to us in gold. We cannot reach and teach students who are not feeling safe and must have partners in this work. I thank you for listening and am available to support if you would like.

Rhonda Larson

Assistant Superintendent of Family Engagement and Student Success

Auburn School District

253-931-4712

Deb Blakeslee, March 22nd, 2023

Someone from the Lived Experience sub-committee sent me a link to SAMHSA's 80-page "best practices" report, "National Guidelines for Behavioral Health Crisis Care".[1]

From my lived experiences, I see gaping holes in this report:

1 – The only prevention mentioned was around ending one's life, not preventing harms perpetrators intentionally inflict onto innocent victims this week or decades ago.

2 – The definition of who the crisis response system helps leaves out my crises. I did not have mental health or substance use issues. Instead, someone was increasingly intentionally harming my life, and falsely accused me of something I thankfully had documentation to prove my innocence. Then he gave me an illegal 1-day eviction notice I couldn't afford to fight, leaving me homeless without transportation, without income, and without most of my possessions, but with boatloads of understandable anxieties.

3 – There was no empirical evidence offered or mentioned of expected outcomes for individuals in crisis, the steps taken to assess, de-escalate, or resolve their needs, and how outcomes for individuals are

[1] national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (samhsa.gov)

measured qualitatively, or quantitatively. Instead, the report offered LOCUS[2] (Level of Care Utilization System), which was developed strictly for psychiatric and addiction services of varying levels.

4 – Measurements did not focus on outcomes for individuals. Instead, measurements were about assessing infrastructures (pgs. 49 – 51), how much money was saved, and how many people were referred into or out of varying levels of psychiatric care (p. 44).

Please. We need a system that genuinely addresses crises – preferably long before they happen.

Sarah Hood, March 10th, 2023

CRIS Committee Training and Credentialing Subcommittee,

In 2012 Washington established itself as a national leader in legislating and implementing suicide prevention initiatives. In order to continue our progress in building a robust and resilient mental health system, we must fund & incentivize mental health training for clinicians to directly address the functional management and treatment of suicidality.

We have a significantly more robust system for handling acutely suicidal individuals including 988, Designated Crisis Responders, and the currently proposed 23-Hour Crisis Stabilization Facilities. However, our system of care stumbles sharply on the next step – longer term specific treatment of suicide risk. In 2012, HB2366 began the process of addressing the training gaps for mental health practitioners in assessing and treating suicide risk. In the proceeding years, a number of additional legislative efforts helped expand those educational requirements across other health professionals. To that end huge leaps forward have been achieved in terms of recognition and referrals for suicide risk. However, getting care for treating suicide risk after the acute crisis moment remains difficult.

I have worked in suicide prevention at a Lifeline Center for 8 years and we continually encountered clients who had few options for treatment beyond hospitalization or short term respite care. We can do better. There are a number of evidence-based, psychosocial treatments available to treat suicidal patients including Collaborative Assessment and Management of Suicidality (CAMS), Cognitive Therapy for Suicide Prevention (CT-SP), & Dialectical Behavioral Therapy (DBT). Additionally there are a number of short term interventions that could effectively be applied in the majority of clinical settings, including the Safety Planning Intervention (SPI). We need more clinicians specifically trained in these treatments to meet the needs of Washingtonians. I am recommending that the State legislature develop and fund a pilot program for mental health practitioners to receive these trainings. Growing the number of clinicians trained in direct treatment of suicidality will go a long way to closing service gaps in our suicide prevention infrastructure.

Throughout the last decade, Washington has made bold strides in building out its suicide prevention infrastructure daring to take on unprecedented challenges. It is this clarity and drive the makes Washington a leader in suicide prevention efforts across the United States. In 2023, the call is clear –

[2] LOCUS: https://cchealth.org/mentalhealth/pdf/LOCUS.pdf & http://dustinkmacdonald.com/level-care-utilization-system-locus/

that while much has been done – there is more work ahead of us. We can be leaders in supporting the development of a clinical work force specifically trained in treating suicidality and set a benchmark that the rest of the United States can follow.

Thank you for your time and attention to this matter. Please feel free to contact me with any comments or questions.

Sincerely,
Sara Hood
Social Work Masters Candidate, University of Washington
646-530-2483, sghood@uw.edu

Bonnie Morris, March 10th, 2023

Dear CRIS committee members,

Thank you for the excellent work you are doing to improve behavioral crisis response in our state, and for allowing me an opportunity to give feedback to your important committee work. I am a retired nurse who has spent 40 out of 41 years working on inpatient psychiatric units. 37 of my last years of work were on the inpatient psychiatric unit at University of Washington Medical Center. At the time I retired 8 years ago, I wasn't aware of any crisis response providers coming to someone's residence unless the person was a client of a mental health center or they needed to be evaluated for involuntary commitment to an inpatient hospital. Having crisis response teams at all that serve the general population is a huge improvement over what existed.

The above being said here's my general feedback on crisis response teams reported on in the February meeting:

1. It's clear to me that there should be some kind of registry where crisis teams across the state report data. Data might be reported monthly of number and types of crises responded to, adverse outcomes, use of co-response, makeup of responders, and other important information. This data makes it easier for the state to keep track of work being done by the teams and allows analysis of how effective their work is and what could be improved on.

2. It's also clear to me that co-response will be necessary in some cases. As long as a situation can be dealt with safely without law enforcement officers, crisis teams should try to avoid traumatizing or frightening clients with a police presence. However, realizing that responder's and client's safety could be compromised in certain cases that mental health responders aren't equipped to deal with, a co-response is essential. Knowing when to decide if a co-response is necessary, is very important and not always clear cut. My understanding is that the crisis mobilization program in Eugene, Oregon, called CAHOOTS has done a good job in this area and could be consulted.

3. I realize that most crisis response teams are not funded or don't have the staffing to do crisis stabilization. This work often takes place on an outpatient or inpatient basis. However, I feel it is extremely important that a follow -up call be made to the clients who used crisis response services about 2 weeks later to get feedback on how helpful the team's services were and how useful the follow-

up resources were that were offered to them. Also that caller should reinforce that the team is there, should there be future crises. Making connection with the clients after the crisis can be invaluable in conveying that the client is valued, respected and cared about, plus getting their feedback will help the response team evaluate their strengths and weaknesses and the effectiveness of follow-up resources.

Thank you,
Bonnie Morris

Eva Bowen, Sally Perkins, community members, Tacoma/Pierce County, January 18th, 2023

Dear Members of the CRIS Full Committee and the CRIS Steering Committee,

We are community members from Tacoma/Pierce County who work to improve mental health crisis response in our community. We served, as community members, on the Pierce County Trueblood Phase II Committee, which consisted of members from criminal justice, mental health, law enforcement, housing, and other services. When the responsibility for Trueblood was shifted to DSHS, we continued to serve on the local Data Driven Justice Committee, tracking the intersection of mental health, the criminal legal system, and crisis response locally.

We first want to thank each and every member of the CRIS for your hard work and your time commitment to a comprehensive and effective implementation of the 988 system here in WA State. We celebrate the Native and Strong 988 line for and by Native American people in WA State. We are excited about the impact your work can have on what we currently experience as a dysfunctional, overburdened, and poorly-understood crisis response "system."

Having read your meeting minutes and watched recent meetings, we wanted to offer our experiences in Tacoma/Pierce County as part of your context for setting up a truly effective crisis response system for mental health that is therapeutic and compassionate.

We will showcase one recent horrific example, and list others that we have personally experienced in trying to get help for friends and loved ones. This crisis occurred in November and the "response" played out over multiple days and weeks. A community member realized that a friend of theirs was experiencing a mental health crisis. Here is what happened next:

- Crisis line was called and they immediately referred caller to 911 to ask for wellness check.
- 911 called police to ask for wellness check; police arrived 4 hours later and refused to intervene.
- The MH providers (DCR's?) came and stayed until their shift was over. There were no MH providers to replace those whose shift was over. They were unable to persuade the person to let them into the apartment.
- Crisis line was called each day I had been at the scene. Often the caller had to wait on hold with the crisis line for 10 minutes or more, or no one answered the crisis line at all.
- Each time, the call was referred to police.

- Each day, the police took up to 6 hours to respond. Once at the scene, police chose to not intervene saying they were concerned about their (police's) safety.
- After seven days, the individual with MH crisis jumped out of their second-story window, unclothed, my friend and I ran to this person, helped them up, placed them in the back of my personal car. We drove them to Allenmore Hospital. Person with MH crisis did not want to get out of the car.
- Saying that they did not have the resources to help, workers at Allenmore referred him to Wellfound Hospital.
- Workers at Wellfound stated that they did not have the resources to support such individual. [Note that Wellfound is supposed to take crisis cases from within Pierce County.]
- Wellfound stated that we should take him to Tac. General Hospital since TG is a hospital for individuals in trauma.
- The individual was taken to TG. Once there, the individual was wrestled out of the car by police and hospital security guards.
- Individual was put on a gurney with restraints, taken to the emergency ward where he needed to wait for over an hour for an available room due to all the rooms being full.
- The individual was then held at the TG emergency room for multiple days, with a different social worker talking with the individual's friends each day (so no continuity of social work support).
- Even though this person's friends were authorized to get information about this person's condition, each time they called the ER, there was either no answer at all or a lengthy delay before the phone was answered.
- Wellfound continued to refuse to take this person despite their obvious mental health crisis.
- This person spent FOUR WEEKS in the emergency department due to lack of a willing crisis bed in the community.
- This person has returned to their apartment and it is not clear what supports they have in the community.

Some other examples:

- The person needing MH services who was referred to a service provider, only to be told that he was not eligible for help.
- The man who sat for 68 days in Jail waiting for a competency restoration bed.
- A woman lost her housing, began experiencing mental health issues, committed a crime that injured her and property, got stable on MH meds in Jail. Had family and two church congregations supporting her and still struggled to follow through on all of her assigned responsibilities.
- A man in community experiencing an increasing MH crisis, CIT-trained officers called, this man was sent to the RC (all the while screaming "not the RC, not the RC"). Got out of the RC after 5 days, was back in Jail within the week.
- Referral phone numbers that are out of service, always busy, or only have voice mail, only the VM is full.
- Community members who use up all of the phone minutes on hold.
- Crisis lines that are not answered.

Specifically in Tacoma we are advocating for a non-police crisis response team for people experiencing mental health challenges. While there may be the occasional times when a law enforcement presence is needed for the safety of the person with the mental health crisis and the other responders, that decision should be made on a case-by-case basis, by the mental health people on the scene.

The following are our recommendations based on our experience in trying to help friends and loved ones experiencing a mental health crisis:

- **The 988 system needs to require skilled language capacity for the major languages spoken in WA State and additional capacity for additional languages.** No caller should be turned away because the 988 system cannot respond appropriately and sensitively in their language. Data should be gathered about languages needed and the 988 system's ability to respond.
- **The 988 system needs to require cultural responsiveness relative to mental health crises throughout the state.** Data should be gathered by gender/gender identity, age, geography, racial/ethnic background, income, LGBTQIA+, etc. There are significant disparities in both mental health crisis experiences and in access to services. 988 needs to document these so that they can be effectively addressed.
- **The person calling 988 (or designated local number) for a mental health crisis response team should be able to contact the team directly and request assistance.** Neither 911, law enforcement, nor EMT's should be gatekeepers for access to the mental health crisis response team. We agree that the technology needs to be interoperable but system access should prioritize 988 as widely accessible to community members as needed.
- **Jails are not mental health facilities.** Hospital emergency departments are not mental health facilities. Systems that default to these kinds of "solutions" should be required to correct the situation promptly and permanently.
- **When each mental health crisis response team is set up, that team should negotiate the conditions and process under which law enforcement will be called.** Clear protocols are essential.
- **When the situation calls for a law enforcement presence (as determined by the mental health personnel on site, following the negotiated protocols) then CIT-trained officers should be the law enforcement responders**. Whether this can happen in real life is unclear, given law enforcement staffing shortages and limited ability to free up staff time for CIT training.
- **The crisis response system should be tasked/authorized to both take and make complaints against other parts of the system when they do not do their jobs**, such as the Allenmore/Wellfound example above.
- **The State Department of Health and /or the Health Care Authority should establish accountability mechanisms that allow families, persons experiencing mental health crises, community members, and organizations to make complaints about inadequate or unavailable response or services.** The listing of complaints should be public, the timelines required for addressing complaints should be tight, and the actual response (linked to the complaint) published.

We appreciated the focus on shared training, co-location of call-takers and other staff, as ways to help break down the current silos in mental health, law enforcement, emergency medicine, incarceration, etc. While these shared experiences will be valuable, and will help some system participants develop greater understanding, they will not, by themselves, create the kind of system change that is needed for this 988 implementation to work the way you hope.

System change requires deep involvement by people with lived experience, credible data, the unencumbered ability to raise concerns and make complaints, and enforceable accountability.

We look forward to how this implementation will improve things in Tacoma/Pierce County.

Terri Pressly, October 21st, 2022

I have a recommendation that a dedicated portion of the opioid dollars allocated to our state go to fund EMS vehicles and personnel who respond to dual diagnosis calls. This gives relief to homeowner/tax payers in rural volunteer fire and EMT areas who fund this service.

Also we need something like the Deschutes model (Bend Oregon) where we have 23 hour beds or at least a walk in place where people in mental health crisis can walk in and be seen beside the emergency room or police. Calling a DCR and being told "we are on a call, no idea of when we can respond" is not acceptable.

An alternative is to embed a DCR at every mental health outpatient facility and hospital.

Kimber Rotchford, August 11th, 2022

I have two suggestions regarding preventing suicide within Washington State.

Medically supervised treatment free and readily accessible for any resident in need of SUD care. Even better if care was comprehensive and included medical, behavioral, and social services related to social determinants.

Change our laws regarding mandatory treatment for serious mental illnesses including SUDs. The denial of anosognosia especially among the young is grievously reinforced by our laws and even by some professionals.

Our current laws only aggravate the biases and prejudices ..related to "people should know better", "should just say no", and all the shame and blame that goes with serious mental illness and SUDs, which I consider only increases the likelihood of suicides. Our system treats many with serious mental illness and SUDs primarily through the criminal justice system. While many know this is dysfunctional, Band-Aids are applied because no one knows how to change at a more fundamental system standpoint. Leadership is indicated. We are not respecting individual rights when we imprison, indirectly promote suicide, and do not provide suitable care to help brains properly reason and promote appropriate insight. I think it is pretty well established that brain dysfunction is related to suicidal ideations in the vast majority of cases, especially the young without other serious comorbid health related conditions.

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Karen Kelly, July 20th, 2022

I want to highlight the importance of training responders who will be working with youth in understanding Family Initiated Treatment and the rights it provides parents in supporting their youth in behavioral health recovery. Specifically, being informed and educated on RCW 71.34.600 and RCW 71.34.650 so they can better support parents who are engaged in the recovery process of their youth.

The age of consent is 13 and was designed to allow youth to initiate treatment without parent consent, in that, it also allows them to decline treatment. Many times, both parents and system partners recognize the need for a youth to receive treatment and they can partner together to help support the youth in identifying the least restrictive setting to help meet their needs. This is often not happening.

In my experience, responders have been highly informed on the age of consent and not as informed on the rights parents have in supporting their youth in the midst of the age of consent. My experience with crisis responders was truly devastating for both me, as the mom, and my daughter who was in crisis. All the times we reached out to crisis response, it ended up with escalation rather than any de-escalation or resources being shared. They ended up being something that caused more harm than good. It ended with either the police coming out or us visiting the ER and my daughter being housed in the ER for lack of beds.

These are some of the reasons that those of us with lived experience MUST be included at all tables as this process moves forward. We have to stop making the excuse of "unintended consequences" when things don't as we planned. My daughter was classified as an unintended consequence of the age of consent law numerous times and she is not that, she is a living, breathing human being who easily could have died while system partners and loved ones watched her decline treatment when she clearly had a need of treatment. This was done with the misguided support of certain system partners who didn't understand the goal of the age of consent and weren't informed on how the law supports parents who are truly engaged and supporting their youth in recovery. They were unable to help and unintentionally brought more harm to our family.

Kashi Aurora July 18th, 2022

Regarding the proposal to form a Crisis System Outcome Measures and Targets Workgroup, I want to respectfully make two requests: first, that we include and prioritize the experiences of children and families in these metrics. Many of our current data sources are limited in terms of viewing by age-breakdown, they are often structured around metrics only relevant to the adult system (i.e. using ITA's as a proxy for need – kids under 13 y/o can't be ITA'd), or track outcomes from services only available to adults (i.e. mobile crisis outreach – few counties currently have youth-specific teams) – this confluence of factors can lead to data sets that insufficiently represent youth and thus create inaccurate perceptions of need/demand. As we think about outcome measures and targets, please ensure there is representation from child and youth serving providers so these metrics accurately track outcomes for children, youth, and families.

Secondly, as we think about tracking outcomes compared to targets, I think it is critically important to build this system with an equitable and anti-racist lens. We know there are disparities in mental health

outcomes by race/ethnicity and it's important to remember that's due to racism not race. As we build crisis system outcome measures/targets and a report-out mechanism, let's do so with equity and intention. Thank you

Pam Lewison May 19th, 2022

Good afternoon all,

First off I want to thank you all for the work you're doing. I imagine it's a difficult undertaking juggling all the subcommittees and everyone's input.

In the first subcommittee meeting for ag/rural folks last fall, I said my concern was that ag and rural people don't often get heard. I'm concerned that may be happening as we move through the latter part of this process. I can't speak about everyone's experience but I can speak about mine. As a farmer who juggles full-time farm work with my husband, two kids, and three off-farm jobs, I have taken anti-anxiety medication since a cardiac episode in early February. It was supposed to be temporary but with on-farm input costs doubling almost overnight, supply chain issues, and the continued regulatory pressures facing agriculture, I have continued to take the medication as a means to cope with not having the time for things like counseling or the gym.

Why am I telling you this? Because I am not an outlier.

Farmers and ranchers are generally like me. We work long hours at jobs that we do not step away from at the end of the day. I worry that our discussions of substance abuse, long-term care facilities, billing, and 11-person response teams, while important, are stepping away from how to help ag and rural people with immediate needs.

Ag and rural people need someone who understands us to pick up the phone and listen with empathy and compassion when we pluck up the courage to call. The person on the other end of the line needs to be a peer; not a clinical person or counselor but someone just like us.

There needs to be a fundamental understanding that ag and rural suicides are highly under-reported in part for insurance payouts. And that is why not having information about who is calling right up front is so crucial. Callers need to know, no matter what happens, their families will be protected, and paid, should they decide to make the worst decision. The security in knowing calling to ask for help won't make the financial burden worse, will encourage more people to call.

It's not just alternative partnerships. It is understanding that ag and rural people live in insular communities within a larger community and are habituated at a young age to "tough it out" and not ask for help. Extension was suggested in HB 1434 specifically because it is a familiar place/entity for ag and rural people through 4-H, the master gardeners, and other extension programs like Don McMoran's.

I've spent the last three years at Washington Policy Center explaining why the agricultural community and rural communities are different from all other communities. It is because of the stressors related to jobs that are primarily based in generational love for the land, not paychecks, and the almost continual bombardment of that pursuit through lack of understanding, legislation, and/or activism.

Attached is the most recent study highlighting suicide risk factors for famers in the U.S. What is unique about it is how few studies have been done about this topic in the U.S.; furthering my statements from last fall that ag and rural communities are rarely heard. In the conclusion, the following is the most telling: "Considering self-blame was the only variable that had significant association with suicide risk, the results demonstrate the continued need for further investigation of factors related to suicide risk among agricultural producers, specifically the types of self-blame; potential future studies could analyze the relationship of agriculture-specific stressors with suicide risk."

From my perspective, what ag and rural communities need most is empathy and compassion on the phone. The likelihood that a responder team will arrive before a producer pulls the trigger is extremely slim. Moreover, I believe the focus in this instance in particular, should be on proactive outreach rather than crisis response. Ag and rural people need to be taught to change our cultural norms about when to ask for help and when to "tough it out"; specifically, ag and rural people need to know there is no shame in saying they are struggling in today's world.

I hope these comments help. I am happy to discuss them further.

Thank you again for your efforts.

Pam

Julia Obermeyer, May 19th, 2022

I was in an involuntary inpatient facility at Cascade Evaluation and Treatment Center in Centralia, WA. The DCR required me to go to inpatient but I have chronic pain and was denied care that I regularly do to manage my pain because the doctors would not listen.

Kristin Lester, May 19th, 2022

My 19-year-old son experienced suicidal ideation on April 21, 2022. He told his therapist who told me to take him to the ER.

We went to one of the local ER's.

It took at least 3-4 hours to be triaged by the ER midlevel, another 4 hours before he was screened by the psychiatric evaluator in the ER, another 2 to get a bed in the ER, another 8 to be evaluated by the local crisis response team, who recommended inpatient hospitalization.

Then another 4 to get a bed in a local inpatient stabilization unit.

He was in the ER 22 hours prior to his transport to the inpatient unit.

He arrived there prior to noon on a Friday. By Friday evening, they didn't have the medication order so he was given ¼ of his normal medication dose.

This wasn't resolved for 16 hours.

We were told his shoelaces and drawstring from his sweats would be removed at the inpatient unit, but they weren't and he was allowed to continue wearing them like that.

While in the unit, someone checked in with him briefly each day, but he wasn't evaluated or treated. There wasn't individual therapy or group therapy.

He was basically housed and fed and what felt like imprisoned for the 74 ½ hours that he was there. Additionally, it was a very traumatizing experience for him.

My biggest concerns are the amount of time spent in the ER waiting to be seen/evaluated; the medication mismanagement, the questionable management of safety while in the inpatient stabilization unit, and the lack of evaluation and treatment while there.

Granted, we don't have previous experience with this, so perhaps our expectations need adjusting. But I would say my greatest concern is that based on that experience, my son might not reach out if he has suicidal ideation in the future as he will not want to go through it again.

Thank you for your time today and for your efforts to improve behavioral health services in the state of Washington.

Bonnie Morris, May 7th, 2022

Thank you for the opportunity to provide public comment to improve mental health crisis services to all people in our state. The last meeting agenda focused on looking at equity in providing crisis services. I've been thinking about my own situation, as a senior citizen seeking therapy for a mental health crisis.

Last winter my adult daughter decided to estrange herself from my husband and her father, which created a very difficult family situation for me, leaving me in a situation where I felt emotionally stuck, feeling that no matter what I did, I or someone else in the family would be hurt. I felt emotionally paralyzed. I wasn't suicidal, but I was experiencing some of the highest distress, anxiety, and sadness that I have ever experienced. I knew I needed therapy and so using the list of therapists who accepted Medicare patients, I searched for a therapist, finding out very soon that every therapist who replied back was full or not accepting clients at the time. My wait took me 1.75 months. Thankfully, I was not in an unsafe situation and I did have the support of friends. Also, I am a retired psychiatric nurse and I was able to at times use some positive coping skills, but it was incredibly hard. I had a Wellness appointment with my doctor during this time and told her my situation, but knowing I had a therapist appointment in 2 weeks, she didn't have anything to offer me.

My situation as a senior citizen on traditional Medicare with a supplement, having to wait too long to get into therapy I'm learning is very common. I have a friend who is far from wealthy but decided to pay out of pocket for her therapy because she had little success. (This is something I considered, but at $100-$250 a session I didn't feel comfortable incurring the cost.) If my situation was different and I was without support, or in an unsafe environment, I could see distress turning into suicidal feelings, waiting to get into therapy.

Our state needs to do something to incentivize more therapists to take Medicare. Presently only MSW's and psychologists are allowed to take Medicare. Licensed mental health counselors can't take Medicare, yet they are very qualified to do therapy with seniors. This is definitely an equity issue. Also, it would have been very helpful, while waiting for therapy, if someone perhaps a paraprofessional, could have had check in sessions with me, to help with coping skills and assess if my situation was worsening. Nothing like that exists now. I ask that you consider these suggestions when redesigning crisis response for our state.

Elizabeth Ross, April 19th, 2022

Thank you for the opportunity to share my lived experience with the mental healthcare and housing industries.

I filled out the survey today through the link that HCA sent to me via email. Although I wanted to attend the subcommittee meeting yesterday, I had a prior engagement which made it impossible to attend.

The changes that are already being made in these industries are very noticeable. I still see people every day who have not been able to become adequately housed here in Spokane. I hope the changes being made will be for the benefit of all.

Jerri Clark, April 4th, 2022

I have additional information to add related to crisis response.

The same young man I mentioned in my previous correspondence (who was discharged from inpatient less than 2 weeks ago), mentally devolved into severe psychosis this weekend. He called me Sunday morning about 8 times in an hour and left angry, threatening, mostly incoherent messages. I answered one of those calls and he screamed at me, accused me of stalking him, before cussing me out and hanging up. In several messages he said he wanted to go back to the hospital and needed help. He indicated he was self-harming. Despite my experience in this arena, I was terrified.

I contacted his parents out of state; after that, his threats against me got worse as he connected the dots that his parents were in contact with me. It felt very dangerous—his apartment is about 3 miles from my home and he knows where I live (from childhood friendship with my son). I was deeply afraid to call 911 because I'm pretty sure law enforcement would have killed him, arrested him, or ignored him. All three options put me in further danger. I didn't block his calls because the danger felt bigger if I stopped tracking his progression into paranoia. We were all trapped in a dangerous situation with no logical way out.

I called County Crisis. Mobile crisis response would not go to assess him unless I was willing to go to his apartment and confirm that he WANTED medical transport. They require another person present and they require any patient to be voluntary. I guess I had not understood until yesterday that our Mobile Crisis Teams DO NOT participate in the Involuntary Treatment Act system…? The person on the phone said he understood my reluctance to call police. He said he understood the level of danger. He said he would do nothing with the information I was sharing. Crisis Response was, in effect, a shrug of indifference.

The young man himself eventually called 911 and asked for medical transport due to self-inflicted physical injury. He is way too sick to be able to see the illness in his brain. He doesn't believe he is mentally ill. He called because "his face hurt," according to one of his rambling messages to me… I believe he may have broken his nose with pliers.

Is it true statewide that Mobile Crisis will not check on a person who is dangerously unwell unless there is someone else physically with that person to verify they WANT help and will go to the hospital voluntarily?

If this is true, the Cahoots ride-along model is the only option that seems to make any sense at all. I think we will need to press for this type of system statewide. Police have made it clear that they don't want full responsibility for administration of ITA law. Mental health has made it clear that they don't want full responsibility for administration of ITA law. NO ONE wants to respond to these calls. How will the system require response to calls like this? How will public safety be protected?

Thank you for "hearing me." I will share this with the CRIS committee in whatever format is most helpful.

Kassy Parker, March 24th, 2022

My name is Kassy Parker. I attended a Steering Committee meeting today. I was pleasantly surprised to find a very inclusive and constructive atmosphere. I enjoyed that the meeting was opened with various committee members sharing what native lands they were currently streaming from. Everyone was very polite and gave me the impression that they are enjoying their part in this program committee and are passionate about the impact they are making.

Suicide prevention has a very special spot in my heart, having battled suicidal thoughts in my life. I have also had people close to me struggle with suicide and a few who have passed away due to suicide. In June of last year, I used the public suicide prevention resources and have since started talk therapy. So it makes me happy to see the state take behavioral health seriously and work toward making current structures even better. I am also a current psychology student and plan on specializing in family therapy, so seeing my home state take behavioral health so seriously warms my heart and makes me even more eager to get my degree and start working! I would like to know of future ways community members can help this program become a success. Thank you for your time, and all of your hard work.

Jerri Clark, March 24th, 2022

I'm trying to help a young man who was friends with my son. He's 23. He's super psychotic. He just got out of a 10-day inpatient hospital stay and came out MUCH worse. He called 5 times today and left increasingly angry, incoherent messages the include the words suicide, weapon, and fire. I called the hospital that discharged him yesterday and waited on hold almost an hour, all the while listening to a circular public service message that includes a statement about their services--including wellness checks for recently discharged patients. Got my attention! When a human person finally got on the line, I said I was recommending a wellness check for a recently discharged patient. She told me patients who have

left are no longer their patients and not their responsibility. She told me to call county crisis or 911 if I wanted someone to respond.

I called county crisis and explained the situation (Clark County). Despite this young man calling crisis practically daily, having MANY encounters with law enforcement, and having JUST left a psych hospital yesterday they explained that they could not possibly find him unless I know exactly where he is. I do not and will not compromise my own safety by putting myself into his space. I explained that. She said a DCR would not go to a location unless there is another person there to verify the location and talk to the DCR upon arrival. I said, so a person who is alone/isolated because of their illness cannot get any response unless another person is willing to compromise their own safety to go sit with that person until a DCR team shows up? She then said she was just a volunteer and really wasn't totally sure but that yes that's what she thinks is true. OMG.

I had this young man's mom from Tennessee call to provide his address and additional information… she texted to let me know that crisis told her they are there for emotional support by phone only and do not respond in person for anyone. (untrue—we have mobile crisis teams down here).

- ☐ Inconsistent service and messaging.
- ☐ Catch-22s abound (can't get help unless you're a dangerous mess. If you're a dangerous mess someone has to be there with you for you to be assessed as a dangerous mess…the illogical spiral goes deep)
- ☐ A hospital will not do a "wellness check" on a patient they just discharged, despite messaging that this service is something they offer?
- ☐ Crisis cannot communicate with a psychiatric hospital in the same community in behalf of a patient who just left the hospital?

Pam Burwell, March 17th, 2022

I have already gone on record to express my grave concerns related to this proposed facility, so I will not waste time restating these. You have stated that Snohomish County has an urgent need for such a facility so that those in need of such care would be close to their homes. If that is the case, why are you not locating it in central Snohomish County? The proposed facility is approximately two miles from the border of Skagit County! How is that meeting the needs of those who live in the far end of south Snohomish County? You are forcing this on people who desire to live in a rural community and seek a quiet way of life, which is exactly why I moved from Edmonds to Stanwood 9 months ago. Shame on you for your lack of transparency! Not only do I have to live a mile south of this but I have to pay for it as well. I have seen how well DSHS has managed their responsibilities and it is not an impressive record.

Laura Van Tosh, February 10th, 2022

These are my comments and I know I am not alone but tonight I speak for myself.

At a meeting this week where one of our brand new Crisis Stabilization Unit's was on screen to kick off a national weekly dialogue. I gulped.

The reliance of using CSU's worries me. Where there's a facility, it seems it must be used.

What are the pathways to using a CSU? What crisis prevention services will be in place that doesn't necessarily steer a crisis to a CSU?

If we are anticipating crisis in Washington, what are we anticipating to stem the tide? What tools will be in place, like mobile crisis units? Peer respites which are inherently recovery focused.

Talk of community based non facility services seems quiet. Mobile, peer support that is available at home or at community based programs must not be at a high level but planned from the ground up.

Focus should be on preventing crises from happening to start…this needs a multi level discussion with plans.

Moz Benado, February 9th, 2022

I saw on the news this evening that a nurse will be screening calls to decide what intervention is needed in and if the call progresses to need a 911 call it will be transferred. If this is apart of the HCA program and crisis calls I feel good about that change.

With this very serious strong condition. That the nurses hired are compassionate and fluid in people skills. I can not emphasize enough that the sadistic nurses that repeatedly kept my meds from me and constantly yelled in my face and made up lies to justify their abhorrent behaviour …

Those that are comfortable with harming their patients who are more often hired for psychiatric emergency rooms and hospitals

are PREVENTED from being hired.

My best wishes are that a review of psychiatric assumptions and practices be completed annually. That every doctor and nurse be scrutinized who are currently treating emotional conditions. That no matter their status there be a paradigm shift in the thoughts of making life harsh for anybody. For no reason this behaviour by providers be tolerated.

I know their premise is to deter repeat ER visits and make sure the hospital stay is NOT comfortable to deter people seeking hospitalization as an escape. But this is not the way to deter. The way to deter repeat visits is RESPECT, PROVIDING THE NEEDS OF THE PERSON AS THEY SEE IT INSTEAD OF THE PROTOCOLS OF THE PROVIDER. THE WAY TO DETER IS TO TREAT ACTUAL CHALLENGES AS SERIOUS AND WITH KINDNESS. ANY SLIGHT HOSTILITY such as taking away blankets in the psych units at night and turning up the air conditioning be stopped. Patients should be treated as guest to help guide them back to participating in society. Any other perspective is wrong and creates a dynamic that the patient cannot escape and thus becomes permanently entrenched in the emotions that brought them to seek help.

MY BEST HOPES is that any nurse or doctor who lacks kindness in any interactions needs to be stopped immediately. absolutely those nurses hired to perpetrate damage be fired immediately. Creating more harm in a person fragile and already traumatized by life should never be taunted and be put in terror further. For too long wrong education is given in order to keep hospital cost down by repeat patients. If the patient is a repeat then someone is NOT DOING THEIR JOBTO ADDRESS THE PATIENTS NEEDS. IT IS NOT THE OATIENT THAT US IN THE WRONG IT IS ALL THE PROVIDERS THAT ARE FAILURES.

I sent a slew of emails and feel I have completed what I have to offer. I won't be participating in any more meetings since I feel I expended what I came to share and given the news about a nurse screener in crisis calls I feel you are headed in a positive direction. Just the quality of the personalities that are hired and awareness of the ignorance most doctors especially psychiatric be emphasized.

Please note people with Tbi can not refer to their past to solve their challenges and NEED PROMPTING. The whole therapy to get the person to come up with their answers and only be a sounding board is problematic because of our deficits. We need concrete information and told exactly what to do. Otherwise the game playing is torture.

Thank you for allowing me to participate to help give you an insiders perspective and say what no one cares to hear.

Good luck to future implementations.

Marcie Dillard, February 7th, 2022

To whom it might concern,

My name is Marcie. In 2011 a series of horrible events happened in my life. I was just a mom, wife and community member never experiencing events that would create a mental health crisis and in turn expose me to our current system for years.

My experience started with a police intervention that ended with a suicide attempt and me being admitted to Harbor Veiw in 2013. The horrible state of our current system itself has almost cost me my life multiple times. I've been failed in every way imaginable. I have been in multiple hospitals and utilized our suicide and domestic violence hotlines. All are costing people there lives.

I have to get involved. I have to use my understanding to not be critical but to hopefully help educate so we can instead save them.

I received this email because I have attended the online peer counseling course and am waiting to finish the training. My experiences and suffering can't be wasted. Knowledge is learned but wisdom is earned the hard way through experience. I wanted to write and see if my testimony might help our providers serve others like myself that find themselves in such a crisis to survive and thrive again.

Something has to change. We are at a crossroads as a culture. Listening to criticism honestly from those who have lived it will make it possible to do better.

I would welcome the opportunity to share my experiences to help you better serve those in crisis.

Thank you for your consideration

Phyllis Cavens, November 22nd, 2021

"Thank you for allowing me to make public comment to the CRIS committee. I am Phyllis M. Cavens, MD, Pediatrician and Medical Director of the Child and Adolescent Clinic in Longview and Vancouver,

Washington. Child and Adolescent Clinic is a Patient Centered Medical Home serving over 15,000 patients, 20% with a Behavioral Health diagnosis.

We partner with our families to provide whole child, family centered, community-based, team care for children and youth with Behavioral Health concerns and diagnoses. In this prevention, early intervention model we provide upstream care and collaborate with our community partners for treatment, diagnosis and suicide prevention of our patients who are vulnerable, high risk, or in crisis, especially now in the time of COVID. We provide care coordination in integrated behavioral health in response to families in crisis, who are referred to us by parents, emergency room, schools or other behavioral health agencies.

In the state of Washington, ninety-five percent (95%) of pediatric patients have insurance and eighty-five (85%) have seen their doctor in the past year. So, these gaps in care have been addresses and should not hinder collaboration. We find the biggest gap in the present delivery system is communication, coordination, information exchange, and access to care, especially in the management of youth 8 to 18 years of age in Behavioral Health Crisis. We ask the question: How well will a redesigned system of crisis response address youth in their initial episode of a Behavioral Health crisis, so that all their needs are met and the crisis is averted and not repeated in their long-term life trajectory. "

Alice Doyle, November 16th, 2021

A portion of my personal health issues is epilepsy. As a group, and myself personally, we experience mistreatment and trauma from medical professionals who do not understand how our brains react to a seizure. We are often considered dangerous and incompetent. I am a 77 year old widow who is 4'10" and just over 100 pounds. I am not dangerous just because I have a seizure that affects my manner and speech. I am the sole kinship caretaker of my grandson, but I was threatened to be taken away from him. I am his only safe place. I have been suicidal when given medication for my seizures that adversely affected me. It had a Black Box warning, but I still was not taken seriously. I am alive because I called my grandson's former therapist at SOUND. She knew me, guided me, and saved my life...and saved my grandson from losing the one home in which he was safe and is unconditionally loved.

Tricia Rodman, October 29th, 2021

"I was on the call last night but did not engage as I didn't feel it was the right time. A few thoughts I wanted to express coming not only from a consumer but as a current behavioral health consultant are:

1. The State of Washington needs to put together crisis training for all providers interested in becoming a crisis responder. It seems each agency completes their own training trying to follow the WAC and RCW's.
2. The mobile crisis teams do not require a certain education level. Crisis responders should have their education in psychology/mental health/SUD and they should also be partnered with a master level therapist in the field who has a certain # of hours under their belt dealing in crisis response.

3. The State of Washington needs to do a better job in tracking the crisis programs to ensure they are following all laws.
4. Perhaps in order to make it easier on all parties, the Department of Health could create a crisis response certification/licensure just like they have with their MHP designation or DCR designation. This certification/licensure would require certain education requirements, trainings, # of CEU's.
5. And of course, funding needs to be there to support these programs."

Lilyan Kay, October 20th, 2021

"I am mother to a mentally I'll adult son. I only got help when he had deteriorated to the point of wielding an axe, and I was obliged to call police. When I had called MHPs multiple times during the previous weeks, I was told there was nothing they could do, or if things were so dangerous that they would actually respond, I would hear back from them within 24 hours.

I endorse ensuring that people who call needing help will get help.

If, in the past, I have called needing help and am told there is no help available unless someone is dead or bleeding, what will be different if I need help in the future? If there is anything different, how will people know that there is now a point in calling for help?"

Danny Capps, October 12th, 2021

Hi my name is Danny I'm a Pathfinder outreach specialist and certified peer counselor with the Capital Recovery Center. I wanted to highlight the comment from Michele Roberts about accountability and need for metrics and just wanted to see that defined in future meetings so that we the public are sure things are moving forward in the space. I also wanted to say I appreciate Amber Leaders' comment on making sure lived experience is represented in the leadership that makes these recommendations- as a very interested member of the public due to my work and lived experience I'm interested in seeing how this will be followed through with. Thank you and take care.

Marc Stern, October 7th, 2021

"I would like to suggest that at some point during its deliberations, the CRIS team consider the issue of response to cases of Excited Delirium Syndrome (EDS), an issue which lies, among other places, at the nexus between 1477 and 1310. As opposed to most of the other behavioral health issues 1477 was meant to address, EDS is different in that it may very well require the response of law enforcement personnel in addition to a purely health care-facing mobile rapid response crisis team. Further, even with improvements in 911 dispatching the appropriate team to a crisis, law enforcement officers may still find themselves as the first responder to episodes of EDS. EDS carries a high risk of mortality, but there is strong belief in the EMS/ED community, and some evidence to support, that the mortality level can be markedly reduced by better identification of cases by first responders and better management.

Well before the last Session, we had a preliminary meeting of interested parties (DOH, representatives of county emergency medical response directors, fire departments, law enforcement, Criminal Justice

Training Commission) to explore ways in which law enforcement and EMS might work together in such emergencies, including possibly developing a statewide model policy for joint training and response, and incorporating training regarding EDS management in the Basic Law Enforcement Academy for police officers as well as EMT training. There has not been any more work on this since that meeting; 1477 might serve as a catalyst to move the work forward.

If the Committee agrees that this issue is within its scope, and you would like to discuss it any further, please feel free to reach out."

Vanna Sing, September 30th, 2021

I noticed that millions and millions of dollars have been invested with little ROI. Is there going to be an opportunity for grass roots organizations to offer their energy through proper compensation or will they have to continue to volunteer for free while other organizations are being compensated and have no impact? Money is not being spent well and there is proof!

Jim Bloss, September 29th, 2021

Just trying to let the group know that as a parent of a seriously mentally ill adult son that our family has had plenty of experience with the crisis system in our state and am available anytime to advise/inform the group as to our experiences, both good and bad. And as we've been with working my son's illness for over 2 decades I've been very involved with trying to help improve the crisis system, at all levels - I know at least 10 people on the CRIS committee, personally and a few others by name so again, I believe I may be able to help inform the process in some positive ways - hope so, anyway."