Safe Place to Be: Washington Behavioral Health Crisis Response System

System Gaps, Progress to Date, and Potential Actions and Opportunities (Working Draft - MASTER)

This matrix documents gaps in Washington Behavioral Health Crisis Response System for 'A Safe Place to Be', progress to date on addressing these gaps, and potential actions and opportunities to further address these gaps. This document is a working draft that will continue to be updated and will serve as a foundation for recommendations to include in the CRIS 2024 Progress Report. The synthesis includes input from CRIS Committee, Lived Experience Subcommittee, Rural & Agricultural Communities Subcommittee, Tribal Subcommittee, and the Behavioral Health Crisis Response & First Responder Collaboration Workgroup.

GAPS IN 'A SAFE PLACE TO BE ' *Gaps in 'A Place to Go'*	**PROGRESS TO DATE ON ADDRESSING GAPS** *Progress on addressing gaps in '***A SAFE PLACE TO BE***' including new legislation and agency work in progress*	**POTENTIAL OPPORTUNITIES FOR STATE AGENCIES AND LEGISLATORS** *Opportunities for addressing gaps in 'A Safe Place to Be'*	**POTENTIAL OPPORTUNITIES FOR CRIS** *Opportunities for the CRIS Committee to advise and support actions to address gaps in 'A Safe Place to Be'*
DATA AND REPORTING			

• There is a **lack of centralized statewide data tracking the attributes of the number of facilities**, including:
  ○ Total count of beds/chairs and other characteristics of each of the types of crisis stabilization centers (current and planned).
  ○ Hours available.
  ○ Maximize duration of
  ○ Specific populations that can be served (or not served) at each location.
  ○ Real-time data on current availability of beds/chairs, appointments, etc.
  ○ Although the 2021/2022 Behavioral Health Provider Survey collected data on crisis stabilization services, there was only a 35% response rate, so the data is limited.
• There is **limited demographic data to** identify and monitor disparities in crisis stabilization services (e.g. client race, ethnicity, age, geographical location, sexual orientation and gender, language, and other categories).
  ○ Children are undercounted and we likely do not have a good picture of youth population needs.
  ○ There is no **updated data on youth emergency department and psychiatric inpatient care** utilization.
  ○ 2019 is being used as a baseline for data on emergency department usage for youth in mental health crisis, but 2019 was an outlier year (there was an extremely high number of such emergency department visits that year). Consequently, the comparisons are less helpful.
	• HCA is working with national quality collaborative for existing Mobile Response and Stabilization Services (MRSS) for youth teams to provide technical assistance to support robust data collection in two regions (King and Thurston Mason) with existing MRSS teams. Data considered will include youth and family specific data points such as referral sources, presenting problem, demographics, hospital and ED diversion, justice system diversion, maintaining home placements, and outcomes. This work will remain ongoing and will support data collection on youth across the state.
	• HCA is implementing changes to the Behavioral Health Data System (BHDS) to better track mobile crisis services. This includes introducing new modifiers for youth and adult teams to identify services provided by those teams. It also includes more detailed referral, disposition, and service level data.
	• Plans are in place to include new service codes and require modifiers for expanded crisis stabilization and peer services provided by mobile crisis.
		• Use **2018 or earlier as a baseline for youth visits to emergency departments** for a mental health crisis.
		• Creation of dashboard to display mobile crisis data and track service outcomes.	

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CAPACITY			
Service Gaps • There are three types of services gaps areas in a Place to Go: 1) Services that don't exist in Washington state, 2) Services that exist in Washington but don't have the capacity/capability to meet demand, 3) Services that are in Washington that have so many rule-out criteria that they are effectively inaccessible. • Youth uniquely but not exclusively face the third barrier. Children and youth get ruled out by places to go because of age and places that do accept them, or because of autism or a medical concern, and then they end up at the hospital. • Expanded drop off locations are needed besides the emergency department and hospitals. These may include peer respite or 23-hour facilities. • Crisis receiving centers have restrictive eligibility criteria. • We don't have a continuum of care; we only really have two points of service: dire needs or 'doing okay' outpatient needs. E.g., Child is not safe at home, but not acute enough for ED, and inpatient has a 6 month wait list. Where do we go? • There are major gaps in residential services. • Lack of system support to ensure access to medication in situations where someone is in psychosis. • System of 'A Place to Go' is really designed to separate families or place people in different places to address their needs versus bringing services and interventions to the home to make that a Safe Place to Be. • Local community concerns about facilities can cause delays/barriers to building new facilities. **Rural Area Gaps** • Some people—particularly those who live outside the I-5 corridor—do not have crisis stabilization services in their local area. • Need for 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. **Workforce** • Limited resources impact staffing and services available to address someone's needs.	• SB 5120, passed during the 2023 legislative session, directing DOH to establish rules to license or certify Crisis Relief Centers by January 1, 2024. (Crisis Relief Centers will offer access to behavioral health care to adults for no more than 23 hours 59 minutes at a time per patient, and accept all behavioral heath walk-ins and drop-offs. ○ Crisis relief centers will be required to triage a person when they arrive and connect them with a prescriber to assess for medication needs and dispense medications. • DOH is engaging rulemaking workshops to inform the development of draft Crisis Relief Center rules. • Youth crisis teams have expanded across the state (*See also* Someone to Come). Teams are also attending the monthly Mobile Response and Stabilization Services (MRSS) workgroup meetings facilitated by HCA and working toward model fidelity in MRSS best practices, which includes stabilization services. • Additional funding authorized in the 2023 legislative session for crisis stabilization services supports the expansion of crisis stabilization units, 23-hour facilities for youth, and crisis relief centers created in SB 5120. • Provisos were passed that require a full actuarial analysis of the crisis system including facilities, mobile crisis and endorsement, and other crisis services. The goal of these provisos are to create a more stable funding model for crisis services and to maximize Medicaid and commercial insurance. Funding models will be scalable to ensure services are available in rural areas. This process will also examine gaps in the system and recommend where resources should go. • SB 5555, passed during the 2023 legislative session, established certified peer specialists and certified peer specialist trainees as new health professions that may engage in the practice of peer support services beginning July 1, 2024. • HB 1724, passed during the 2023 legislative session, creates programs and other changes to increase behavioral health workforce.	• Anticipate and prepare for response to local community concerns and potential delays due to litigation when building new crisis centers and facilities. To avoid or mitigate concerns, **be prepared on legal challenges and create public relations campaigns to educate communities** about behavioral health and the importance of services in advance of proposed facilities being built around the state. ○ Consider partnerships state and local officials and people lived experience to engage in forums to help the public understand the importance of the services. ○ Recognize that cities are key partners, and the importance of engaging early on the development of these efforts before decisions are made. • 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). • **Expansion of peer respite** as an alternative to crisis stabilization units. • **Expand Mobile Response and Stabilization Services (MRSS)** in-home support crisis stabilization services for youth • **Research in-home stabilization services as a promising model for adults** as well. • Consider outreach and education to **recruit community groups to support their work to start their own crisis stabilization program or facility.** • Review stabilization services to **ensure they adequately address substance use as well as mental health needs.** • 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? • Develop system **capacity to follow up with people** to make sure they have what they need. • Ensure **training for organizations on how to use peer supports**, including how to access current HCA trainings on this topic.	• **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. • Advise agencies on **developing a holistic approach** and the ability to address patient physical, mental, substance use issues for Crisis Receiving Centers. • 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 • 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.

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• Agencies lack understanding of how to fully utilize peer support staff in their care teams. **Emergency Department Resources** • Emergency departments are currently the primary point of access for youth in crisis. Ideally, emergency departments should be a place where the decision is whether the person needs to be admitted or not (physical or mental health situations). • Emergency departments/ Hospitals are lacking the necessary resources—such as Social Workers, Alcohol and Drug Counselors, and Mental Health Providers with offices in the buildings. • In some rural areas there is nowhere to go – so people end up in the emergency department and this might deter them from accessing help in the future if they know they have to go to the emergency department. **Unpaid Caregivers** • Unpaid caregivers in the home for people with intellectual and developmental disabilities can go into crisis themselves. • working with other systems for services. **Discharge and Follow Up Care** • Cycle of people getting discharged and then ending right back into crisis – so how do we tackle that cycle – is discharge connecting people with various resources and services to make sure they don't end back up in crisis…even if that means • Next day appointments are needed to help people avoid being in crisis. **Lack of Access to Broader Continuum of Care** • Lack of access to care due to significant waits (e.g. 7 months) for outpatient behavioral health appointments. • Lack of services to prevent people from reaching a crisis point in the first place. This includes access to outpatient behavioral health services, as well as services to address basic needs, such as housing are not met, which can also be factors that can trigger a mental health crisis.	• SB 5189, passed during the 2023 legislative session, require DOH to develop certification of Behavioral Health Support Specialists (BHSS) by January 1, 2025. • HCA and the Office of Insurance Commissioner (OIC) are working to implement changes to the current processes to connect individuals to next-day appointments. A Next Day Appointment (NDA) directory is being developed and hosted by OneHealthPort. • A workgroup convened by OIC and HCA, called the Next Day Appointment Workgroup, continues to meet to improve the process for people with commercial coverage to access Next Day Appointments from either a call center or mobile crisis team. • State plan amendment is being put in place pending CMS approval that will: ○ Allow peer support to be provided by mobile crisis and crisis facilities. ○ Removed limits on the timeframe for stabilization services allowing for 8-weeks of stabilization per the MRSS model. ○ Future state plan amendments will potentially address other gaps and expand providers who can provide crisis services under Medicaid. • Training for peers who work in crisis has been developed and is being delivered. This training focuses on providing the necessary skillsets and wellbeing tools for peers to work in the crisis system. <u>Tribal 988 Subcommittee/ Tribal Centric Behavioral Health Advisory Board</u> • Continued planning on the development of a culturally appropriate Tribal inpatient behavioral health facility overseen by the Tribal Centric Behavioral Health Advisory Board. Led by the Tribal Evaluation and Treatment Facility Workgroup and five subcommittees: Clinical & Cultural Models, Facilities & Siting, Operations, Legislative, and Governance.	• Need **investments in behavioral health services** across regions and **plan for evaluating adequate distribution of resources**. • Develop recommendations related to **prevention services, including investments in basic and social services** and ensure equity in prevention services across the state. <u>Tribal 988 Subcommittee/ Tribal Centric Behavioral Health Advisory Board</u> • Areas of action needed: ○ Updated possible funding sources ○ Clearly laid out licensing/approval process ○ Updated building/remodel costs ○ Updated operations costs (establishing cost-based Medicaid rates) ○ Understanding court costs and reimbursements • Further exploration of the following questions: ○ Best approach to stand up a statewide governing board. ○ How do crisis stabilization facilities fit into the plan? ○ Is the need for more statewide facilities or individual Tribal/regional facilities. ○ Evaluate options to contract with hospitals for beds to increase current access.	
CROSS SYSTEM COORDINATION & ALIGNMENT			
• **Overreliance on law enforcement to respond to behavioral health crises**, rather than behavioral health specialists. People in crisis are sent through the criminal justice system (i.e., arrested,	• SB 5440 establishes forensic mental health evaluation requirements for adults consistent with the Trueblood settlement (to divert adults involved with	• 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).	

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incarcerated) rather than referred to the behavioral health system. • Often, when kids are in crisis, they are violent, and in those cases, they need to be taken care of and listened to. Sending them to the **Juvenile Detention center is not the place** for that. A program where those kids are embraced instead of turned away is something people want to see more of. • Some **people call in crisis and end up going to jail** rather getting mental health services. For the person in crisis, this exacerbates the crisis and results in a loss of faith in the system.	law enforcement to appropriate mental health services in the community, if recommended). • HB 1134 requires the creation of regional dispatch protocols, creating recommended training standards, and regional crisis forums. Co-location programs will help build trust and procedures for hand off calls from people in crisis. Through these processes new procedures and practices will be used to divert response to crisis response resources.	• **Expand juvenile justice programs that provide wrap-around services to youth** with behavioral health diagnosis and other needs.	
EQUITY AND SAFETY			
• For **individuals with intellectual disabilities, autism spectrum disorder, dementia, and/or traumatic brain injury,** crisis response often escalates and exacerbates the crisis. They are taken to the emergency department and the crisis is made worse. There is no place for them to go in the existing systems. • **Concern about use of solitary confinement** and constraints in 23-hour crisis centers. Concern that this might be overused and whether or not this is best practice and helpful to people in crisis; may result in more fear of accessing services.		• Workforce **training should include how to respond to/support individuals with intellectual and/or developmental disabilities.** • Research **why people with developmental/intellectual disabilities have no place to go and identify strategies to address gaps**	• 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.
SYSTEM NAVIGATION & ACCESSIBILITY			
• **Discharge planning is a huge gap**. The status quo often means discharge to nothing. • People have to go to the **emergency department to get "medical clearance"** before going to a community-based crisis stabilization center.	• HB 1580 requires that the Governor maintain a Children and Youth Multisystem Care Coordinator (Care Coordinator) to serve as a state lead on addressing complex cases of children in crisis to support the safe discharge from hospitals and long-term, appropriate placement for children in crisis. • 1688 workgroup continues to work on implementing its recommendations to support processes to ensure commercial payer coverage of behavioral health emergency response services. • SB 5120 exempts Crisis Relief Centers from medical clearance requirements. It also requires centers to do triage a person and provide onsite medical care for minor medical issues to reduce barriers to care.	• Review current requirements for **discharge planning and identify gaps.** • Create a **user-friendly centralized website or database with comprehensive, payer-blind behavioral health crisis-related resources.** ○ Could be available to professionals and the public ○ 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. ○ Information about prevention and other resources for people with behavioral health crisis needs. ○ Invest resources into ongoing efforts to compile information and maintain the database, so that it	

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	<u>Tribal 988 Subcommittee/ Tribal Centric Behavioral Health Advisory Board</u> • Implementation of the Tribal Resource Hub to connect 988 and Native and Strong Lifeline callers with resources for AI/AN populations and follow up with their Indian Heath Care Provider. Includes access to available beds and reporting. • DOH Crisis Contact Center Hub Rulemaking Tribal Listening Sessions.	does not become just another source of potentially confusing and outdated information. • 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. • 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. • 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. <u>Tribal 988 Subcommittee/ Tribal Centric Behavioral Health Advisory Board</u> • Ensure Indian Health Care Providers have access to system resources and information (*i.e.,* new technology platform). • Incorporate Tribal input into Crisis Contact Center Hub Rulemaking.	