# Someone to Come:  Mobile Crisis Response for Adults and Youth

*Synthesis of 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 'Someone to Come', 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 identifying 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 MOBILE CRISIS RESPONSE SYSTEM**<br>*Gaps in mobile crisis response* | **PROGRESS TO DATE ON ADDRESSING GAPS**<br>*Progress on addressing gaps in mobile crisis response, including new legislation and agency work in progress* | **POTENTIAL OPPORTUNITIES FOR STATE AGENCIES AND LEGISLATORS**<br>*Opportunities for addressing gaps in mobile crisis response* | **POTENTIAL OPPORTUNITIES FOR CRIS**<br>*Opportunities for the CRIS Committee to advise and support actions to address gaps in mobile crisis response* |
|---|---|---|---|
| **DATA AND REPORTING** | | | |
| **Lack of Data on Service Capacity**<br>• Current estimates of mobile crisis response team distribution make it difficult to identify gaps that need to be addressed.<br>  ○ Lack of data on mobile crisis response team distribution serving youth vs. adults.<br>  ○ Lack of common performance metrics.<br>  ○ Lack of common definition of terms (e.g., co-responder) and crisis response models makes it difficult to create an accurate and comprehensive service landscape.<br>**Lack of Data on Individuals in Crisis**<br>  ○ Lack of centralized data on individuals receiving mobile crisis response services to identify and monitor disparities by population.<br>  ○ Lack of data collection on youth callers and barriers to identifying a caller requiring a mobile crisis response is a young person.<br>  ○ Lack of data available in terms of language barriers, e.g., number of people requiring an interpreter, different languages needed, languages that are not available.<br>  ○ There is no way to measure or track the number of people who go through crisis but don't engage with the system, and why.<br>  ○ Lack of data repository that tracks and analyses care for a single client across their pre-crisis period, crisis event, and post-crisis care.<br>  ○ Burden of repeating story over and over when seeking care. Families carry the burden of documenting information and developing "one-pagers" to share with crisis staff/providers so that important information is not missed.<br><br>Tribal 988 Subcommittee | **Performance Standards**<br>• HB 1134 creates an endorsement process that implements performance and staffing metrics for mobile crisis response.<br>• Mobile Crisis Response Program Guide creates performance and staffing standards for mobile crisis response (for adults) and mobile response and stabilization services (for youth).<br>**Data on Service Capacity**<br>• As part of a required actuarial analysis to improve funding stability of mobile crisis, HCA will work with system partners to better understand mobile crisis response capacity and address need.<br>• Based on standards in Mobile Crisis Response Program Guide, HCA created a map of number, location, and type of adult mobile crisis response teams and known needs.<br>**Data on Individuals in Crisis and Performance**<br>• HCA is working with national quality collaborative to provide technical assistance to support robust data collection in two regions (King and Thurston Mason) with existing Mobile Response and Stabilization Services for youth.<br>• Updates to data reporting in progress:<br>  ○ Whether response was to youth or adult.<br>  ○ Changes to how providers code mobile crisis response services.<br>• HCA added response time requirement to BH-ASO contract.<br>• As call centers become 988 hubs, they will track who responded and how long it took to get there, and will send that data either to BH ASOs or directly to HCA. This will give insight into how the teams are responding.<br><br>From Tribal 988 Subcommittee | • **Standardize terms and definitions** (e.g., mobile crisis response team, co-response, safety risk, youth, transition-age youth, etc.)<br>• Develop more **granular analysis of distribution of mobile crisis response team** (for adults) and mobile response and stabilization services (for youth).<br>• 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.<br>• **Leverage a census model to go into the communities to collect data**. Make system improvements based on system user experiences and feedback.<br>• **Develop core standards (i.e., performance metrics) for embedded co-response programs** that are consistent no matter the system.<br>• Set up **a hub where information can be entered and accessed** by all members of the care team and the individuals/families in crisis.<br>• 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.<br>• Ensure there is a **process to capture qualitative data** to document outcomes (patient satisfaction, barriers, unmet needs, etc.)<br><br>From Tribal 988 Subcommittee<br>• Development of best practices for data collection, requirements, training, and alignment across systems for early identification of individuals with tribal affiliation. | • Set **system performance targets and metrics and hold the behavioral health system accountable** for hitting those targets and metrics.<br>  ○ Advise state agencies on key metrics for the crisis system to ensure it is successful at addressing gaps.<br>  ○ Systems should be tracked and then held accountable to ensure their outcomes are resulting in meaningful access to services.<br>  ○ Leverage existing oversight boards (expand or add-on).<br>  ○ Carry out continuous process improvement on quantitative and qualitative data gathering methods and provide recommendations to course correct as needed. |

| GAPS IN MOBILE CRISIS RESPONSE SYSTEM<br>*Gaps in mobile crisis response* | PROGRESS TO DATE ON ADDRESSING GAPS<br>*Progress on addressing gaps in mobile crisis response, including new legislation and agency work in progress* | POTENTIAL OPPORTUNITIES FOR STATE AGENCIES AND LEGISLATORS<br>*Opportunities for addressing gaps in mobile crisis response* | POTENTIAL OPPORTUNITIES FOR CRIS<br>*Opportunities for the CRIS Committee to advise and support actions to address gaps in mobile crisis response* |
|---|---|---|---|
| • Lack of current protocols for identifying individuals who are tribally affiliated so that crisis response entities can coordinate with tribal partners. | • HCA has established a bi-weekly Tribal Mobile Crisis Response Workgroup to develop the Tribal mobile crisis response model, including data and standards. | | |
| **DISPATCH** | | | |
| **Need for Behavioral Health Response**<br>• Many people in crisis must rely on emergency departments, law enforcement, emergency medical services, or fire, rather than behavioral health providers.<br>• Lived experience concern that response involving law enforcement can make crisis situations worse and result in further trauma; people end up in jail rather than receiving mental health support.<br>• Concern that a focus on response times for pay incentives can lead to unintentionally prioritizing speed over the best possible care.<br>**Lack of Standards for Types of Response**<br>• Lack of objective understanding of what constitutes a dangerous situation that would require law enforcement.<br>• Lack of a standard practice for managing risk when dispatching crisis response (e.g., do we err on the side of sending a behavioral-health focused response or a law enforcement response when it is unclear if there is a safety risk? Do we call the parents of a young person in crisis or not?)<br>• There is no set standard to determine who is the lead out in the field when there are multiple types of teams responding to a crisis.<br>**Gaps in Population-specific Services**<br>• Lack of consideration for the needs of older adults and disabled communities.<br>• Services lack proper accommodations for a range of populations, e.g., non-English speakers, hard of hearing or deaf.<br>**Barrers to Connect Youth to Mobile Response**<br>• Lack of standard practice for connecting a youth who calls 988 with mobile response.<br>  ○ Further complicated by the fact that 988 may not know the age of the caller unless disclosed.<br>  ○ Pathways for connecting youth and caregivers with mobile response and stabilization services remain unclear. | • HCA dispatch protocols update and toolkit (June 2023) address many standards for dispatch.<br>• HB 1134 includes provisions for joint training of first responders, 988, 911, and behavioral health.<br>• Collaboration Workgroup started addressing question of limits of law enforcement involvement in crisis response, and how different parts of the system can work together better.<br>• Mobile Crisis Response Program Guide and Dispatch guidelines addresses confidentiality, including for youth and an orientation to a behavioral health first response to behavioral health crises.<br>• HCA and DOH continuing to work on Mobile Response Stabilization Services (MRSS) continuum for youth and 988 role.<br>• DOH Note: 988 call transfers to 911 must meet specific criteria, accounting for fewer than 2% of calls nationally, and more than half of which are cases that the caller voluntarily accepts dispatch.<br><br><u>Tribal 988 Subcommittee</u><br>• Established process to appoint Tribal Designated Crisis Responders (funding began 7/1/2022); Updates to Washington's Designated Crisis Responder protocols to include coordination with Tribes/Indian Health Care Providers; Requirement for non-Tribal DCRs to notify Indian Health Care Providers of Involuntary Treatment Assessment.<br>• Tribal 988 Subcommittee provided review and input in the Mobile Crisis Response Program Guide regarding Tribal resources and coordination | • **Develop regional collaborations that convene system partners** to create regional plans and protocols for crises per HB 1134.<br>• Develop **standard protocols for how and when to engage MRSS teams for youth**. Will need flexibility for staff to make judgement calls.<br>• Develop **protocols for determining who is "lead" in the field based on safety issues**.<br>  ○ Start with behavioral health as lead unless safety concerns are present.<br>  ○ Address how implicit bias and racism impact staff of color in the field and interactions/dismissal by first responders.<br>• Set requirements that would **ensure all first responders take Crisis Intervention Training (CIT);** create standards for training that would allow for regional adaptation.<br>• Develop **protocols around determining voluntary vs. involuntary services.**<br><br><u>Tribal 988 Subcommittee</u><br>• Implement HCA-Tribal Crisis Coordination Plans for coordinating with Tribal entities.<br>• Finalize new crisis coordination protocols that include National Suicide Prevention Line and Regional Crisis Line protocols.<br>• Finalize Tribal Mobile Crisis Response dispatch protocols through the Tribal Mobile Crisis Response workgroup. | • Advise state agencies on **strategies (e.g., training) to help the system work together better.**<br>• Advise state agencies on **training curricula for behavioral health and first responders.**<br>• 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**.<br>• Advise state agencies on the **standards for endorsement** of mobile rapid response crisis teams and community-based crisis response teams.<br>• Advise state agencies on core **standards for embedded co-response programs.** |

| GAPS IN MOBILE CRISIS RESPONSE SYSTEM<br>*Gaps in mobile crisis response* | PROGRESS TO DATE ON ADDRESSING GAPS<br>*Progress on addressing gaps in mobile crisis response, including new legislation and agency work in progress* | POTENTIAL OPPORTUNITIES FOR STATE AGENCIES AND LEGISLATORS<br>*Opportunities for addressing gaps in mobile crisis response* | POTENTIAL OPPORTUNITIES FOR CRIS<br>*Opportunities for the CRIS Committee to advise and support actions to address gaps in mobile crisis response* |
|---|---|---|---|
| ○ Mobile response and stabilization services are currently dispatched through regional crisis line; there may be multiple transfers before a young person can get connected with these services.<br><br><u>From the Tribal 988 Subcommittee</u><br>• Need for cross-system coordination protocols include clearly defined warm handoff process between Tribal and Urban Indian Health Organizations and state and local systems (including 911, 988, Native and Strong Lifeline, Tribal Resource Hub, local tribal crisis lines, Indian Health Care Providers, and Tribal Public Safety and Tribal First Responders.) | | | |
| **CAPACITY** | | | |
| **Gaps in Mobile Crisis Response Services**<br>Current estimates: only 40% of the need for mobile crisis response teams for adults is being met; there are not nearly enough mobile response and stabilization services to meet current need for youth.<br>• Rural areas are chronically underfunded and urban areas face long wait times.<br>• Rural and agricultural settings are often rugged and can be distant from roads and other access points and may require special equipment, technology, and vehicles to access people, services and locations.<br>• Consistent funding for mobile crisis response teams for adults has not been available to support adequate and equitable distribution of mobile response teams.<br>• Proviso funds stand up at least one mobile response and stabilization services team for youth in each region, but resources are different across counties and regions and many teams are not yet fully functional and are still recruiting staff.<br>• Families and individuals are calling in crisis, but response time may be 1 month or more away.<br>• Slow response times from calling 988 (due to capacity constraints) will encourage responses by first responders.<br>• Lack of parity in funding for crisis system (at systems level) result in 911/emergency rooms as the default.<br>**Gaps in Workforce**<br>• Crisis response workforce does not have capacity to meet the need.<br>○ Staff retention has been a major challenge. | **Expanded Teams**<br>• HB 1134 establishes an endorsement for mobile rapid response crisis teams and community-based crisis teams that meet staffing, vehicle, and training standards, as well as a performance payment program to support them.<br>• Increased number of youth teams from 4 to 12 with proviso funding. Every region in the state is building youth teams. County coverage has expanded from 5 previously to 15 of 39 Washington counties.<br>• Budget proviso requires an actuarial analysis of mobile crisis and crisis facilities to build a more stable funding mechanism for the crisis system. Will include analysis of need/unmet need in each region.<br>• HCA created an implementation plan to guide the expansion of mobile crisis resources<br>**Workforce**<br>• 2023 legislation will help address workforce capacity:<br>○ HB 1069 adopts Mental Health Counselor compact, making it easier for behavioral health specialists from out of state to work in Washington.<br>○ SB 5189 creates certification for behavioral health support specialists who can deliver evidence-based interventions under the supervision of licensed providers.<br>○ SB 5555 establishes a new state-certified profession of peer specialists. | • Pursue **consistent funding for mobile crisis response**, rather than braided local funding to expand workforce and improve response times.<br>• Due to geographic limitations and barriers in **rural areas, may need to have a greater reliance and partnership with first responders** in these areas.<br>• Advocate for **limiting Criminal Justice Information Services (CJIS) laws**, which prevent peers from working within law enforcement.<br>• 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.<br>• 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.<br>○ Learn from other states (e.g., AZ, TX, MI, GA) about funding approaches and strategies for supporting workforce and capacity to help meet need.<br>• Crisis response **teams should be comprised of people with lived experience** as well as clinical staff.<br>• System capacity to **respond to co-occurring mental health and substance use disorders** is essential.<br>• 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.<br><br><u>Tribal 988 Subcommittee</u> | • |

| GAPS IN MOBILE CRISIS RESPONSE SYSTEM<br>*Gaps in mobile crisis response* | PROGRESS TO DATE ON ADDRESSING GAPS<br>*Progress on addressing gaps in mobile crisis response, including new legislation and agency work in progress* | POTENTIAL OPPORTUNITIES FOR STATE AGENCIES AND LEGISLATORS<br>*Opportunities for addressing gaps in mobile crisis response* | POTENTIAL OPPORTUNITIES FOR CRIS<br>*Opportunities for the CRIS Committee to advise and support actions to address gaps in mobile crisis response* |
|---|---|---|---|
| ○ Substantial staffing gaps can exacerbate other system gaps.<br>○ Additional staffing related concerns include low compensation, staff burnout, and limited training.<br>• Some Medicaid policies may prevent peers from participating in crisis response.<br><u>Tribal 988 Subcommittee</u><br>• Need for expansion of mobile crisis response services tailored to AI/AN populations. | ○ HB 1724 helps get qualified behavioral health providers into the field as quickly and safely as possible.<br>• Working on adding peers to Medicaid state plan for HCA-contracted mobile crisis teams.<br><br><u>Tribal 988 Subcommittee</u><br>• Ten percent of the 988 Line Account will be dedicated to the Mobile Crisis Team performance program and endorsement activities; up to 30 percent of these funds must be dedicated to crisis teams affiliated with a tribe in Washington.<br>• The Tribal Mobile Crisis Response Workgroup has been created to establish Tribal Mobile Crisis Response model.<br>• HCA received two (2) SAMHSA grants to work with Tribes to develop tribal Mobile Crisis Response model. | • Establish endorsement standards specific to Tribal Mobile Crisis Response models.<br>• 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.<br>• Ensure Tribes have access to capacity building funds for tribal Mobile Crisis Response teams.<br>• Coordinate training as requested by the Tribal Mobile Crisis Response Workgroup. | |
| **EQUITY AND SAFETY** | | | |
| • **Lack of trust and relationships** between systems, between systems and communities, etc. (behavioral health, first responder, hospital/ER systems).<br>• **Insufficient diversity among crisis response staff** (not reflective of the populations served or their needs) contributing to either lack of culturally-responsive services or overburdening of certain staff to carry work for clients with shared identities.<br>• **Lack of standards and standardized training** for determining who receives what response and why.<br>○ Bias impacts determinations about who gets what response, particularly for BIPOC and LGBTQ+ populations.<br><br><u>From Tribal 988 Subcommittee</u><br>• Tribes have a longstanding history with barriers in accessing needed crisis services for their tribal members (see 2013 Tribal Centric Behavioral Health report to the legislature). | • Collaboration Workgroup has started addressing how to collaborate to ensure that people feel—and are—safe calling for help in a crisis.<br>• Mobile crisis response teams are receiving standardized training in harm reduction, de-escalation, and trauma informed approach.<br>• Youth teams are completing training in developmentally appropriate modules for harm reduction, de-escalation, and trauma informed care.<br>• Youth providers are attending the monthly Mobile Response and Stabilization Services (MRSS) workgroup meetings facilitated by HCA and working toward model fidelity in MRSS best practices.<br>• Applied for a SAMHSA grant to implement Community Crisis care model in Washington to create teams to respond to their communities.<br>• HCA is working on implementing changes to the State's Medicaid State Plan to incorporate peers into crisis services. Target is a state plan amendment in place in January 2024 that will allow peer support.<br>• HCA created a training for crisis peers.<br>• HCA is working on developing a crisis response model for older adults based on the Geriatric Regional Assessment Team (GRAT) program in King County. | • Support **development of crisis response workforce—including peer support—that has shared language, cultural background**, and other shared life experience as populations served.<br>○ 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.<br>• Establish requirements for translation/ interpretation services for crisis response services and invest in **culturally-specific service providers.**<br>• **Include law enforcement and partners in trauma-informed and youth-informed trainings** to minimize potential harms and build trust across communities.<br>○ Develop cross-county standards for trainings, with flexibility to tailor to individual communities.<br>○ Include evaluation components to measure training outcomes and results.<br>○ Beyond adding new trainings, update existing trainings to reflect best practices for engaging with those experiencing mental health issues.<br>• **Conduct research to understand why the crisis response system is not working for some people.** | • 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.<br>• Advise state agencies on **regional collaborations to address equity and systemic failures**.<br>• 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)<br>• **Advise state agencies on training curricula for behavioral health and first responders that includes**:<br>○ Overview of roles, authority, requirements, training, and approaches for responding to behavioral health crisis for both behavioral health and first responders.<br>○ Implicit bias and recognizing and addressing power and privilege.<br>○ Best practices for engaging with people who are appear erratic or non-compliant.<br>○ Understanding difference between safety issues and behavioral health crisis. |

| GAPS IN MOBILE CRISIS RESPONSE SYSTEM<br>*Gaps in mobile crisis response* | PROGRESS TO DATE ON ADDRESSING GAPS<br>*Progress on addressing gaps in mobile crisis response, including new legislation and agency work in progress* | POTENTIAL OPPORTUNITIES FOR STATE AGENCIES AND LEGISLATORS<br>*Opportunities for addressing gaps in mobile crisis response* | POTENTIAL OPPORTUNITIES FOR CRIS<br>*Opportunities for the CRIS Committee to advise and support actions to address gaps in mobile crisis response* |
|---|---|---|---|
| | **Tribal 988 Subcommittee**<br>• Note: progress made on Tribal mobile crisis response services integrated throughout this summary. | ○ Review existing data across state agencies (e.g., National Violent Death Reporting System, quality improvement data on who is not being served)<br>○ 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.<br>○ Quantitative data should be supplemented with qualitative data, such as interviews with loved ones of people who lose their lives to suicide. | ○ Person-first and respectful interactions (cultural responsiveness and trauma-informed).<br>• Do **root cause analysis on lack of trust between systems and systems and propose solutions**. |
| **SYSTEM NAVIGATION & ACCESSIBILITY** | | | |
| **System Complexity / Barriers to Access**<br>• The behavioral health crisis response system is siloed, opaque, and very hard to navigate. Even people who know the system have a hard time navigating it.<br>• The "crisis system" is not consumer or community centered or easy to access, nor is there consistency or a baseline level of services between all the regions.<br>• Lack of understanding and relationships across systems.<br>• Experience of receiving a response that caller's situation doesn't meet the definition of a crisis, or that response to the situation is "not their job".<br>**Lack of Caregiver Supports**<br>• Caregivers often find themselves in the position of being case managers.<br>• Caregivers of youth have trouble getting information because of both privacy laws and providers may not know whether it is safe to share information with the caregiver (i.e., it is not always safe for parents or caregivers to know that a young person is seeking care). | • HCA is working on restructuring of crisis services webpages.<br>• Implementation of HB 1477 tech platform—which will centralize records and information about behavioral health services—in progress.<br><br><u>Tribal 988 Subcommittee</u><br>• 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.<br>• DOH Crisis Contact Center Hub Rulemaking Tribal Listening Sessions. | • 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.<br><br><u>Tribal 988 Subcommittee</u><br>• Ensure Indian Health Care Providers have access to system resources and information (*i.e.,* new technology platform).<br>• Incorporate Tribal input into Crisis Contact Center Hub Rulemaking | • Advise state agencies on **ways to improve work with caregivers** and support diverse approaches to supporting caregivers. |