HB 1477 Crisis Response Improvement Strategy Committee

September 24, 2024

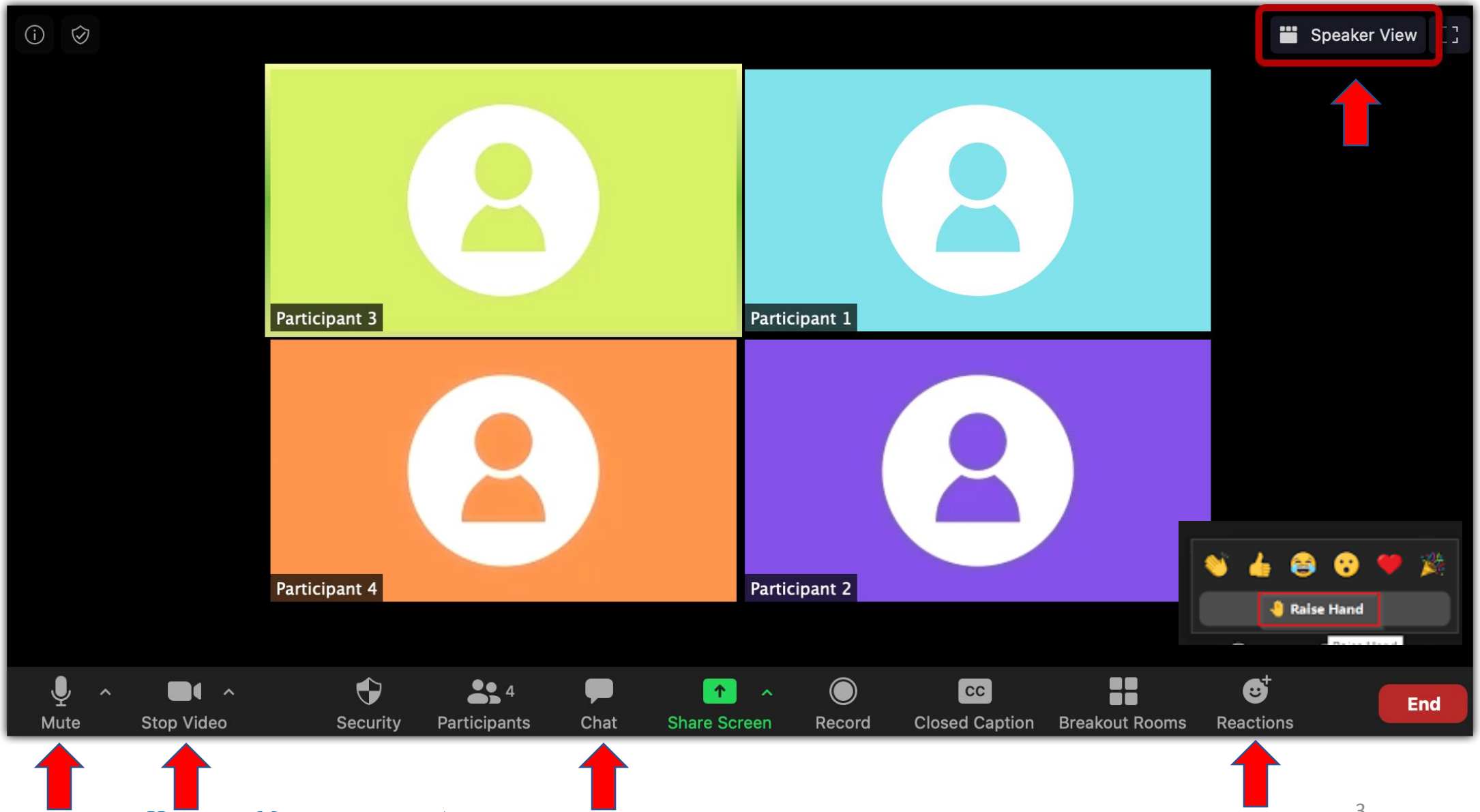
Health Management Associates

Harborview Medical Center
UW Medicine | King County

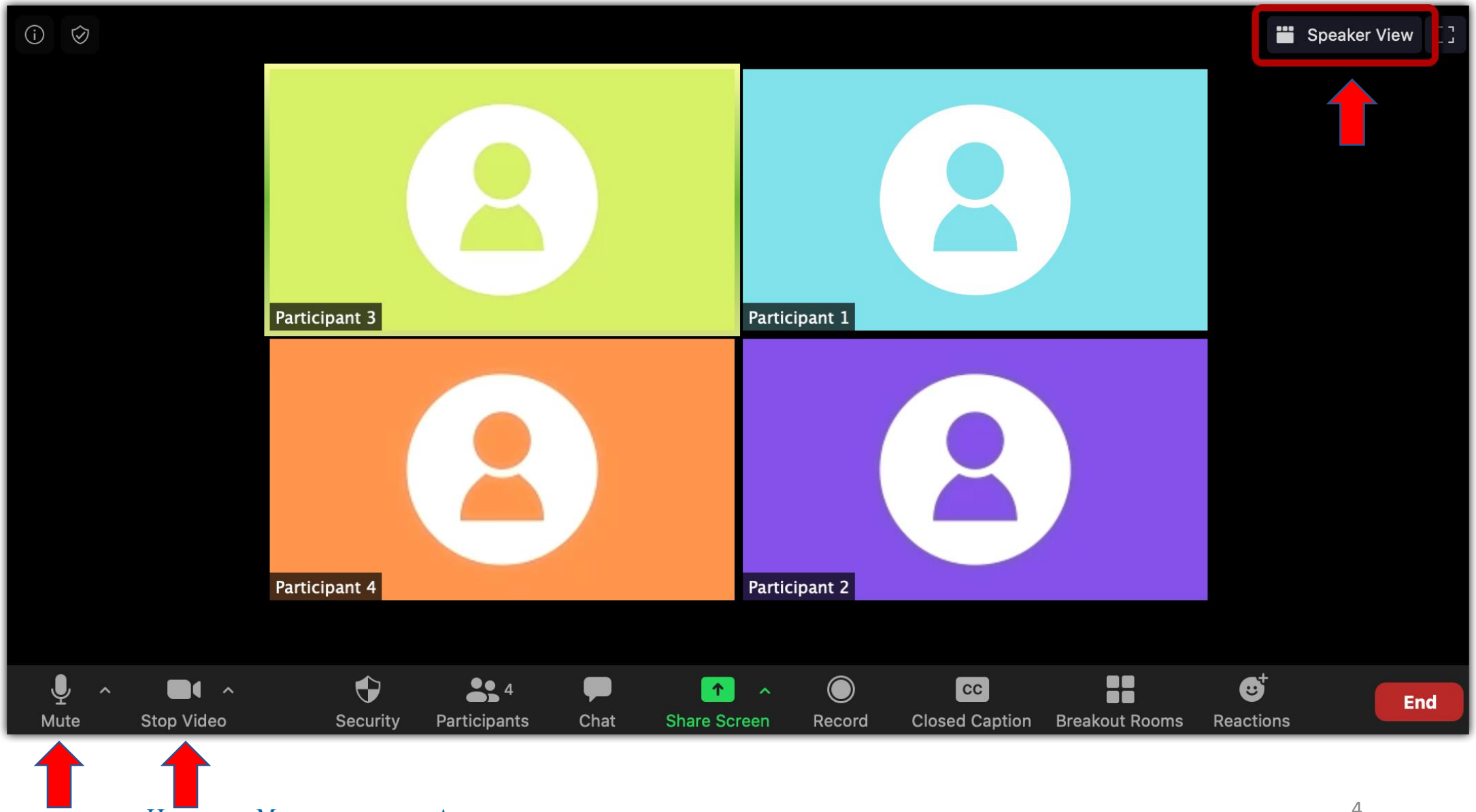
CRIS Committee In-Person Logistics

1. Wi-Fi available for attendees.
2. Power strips available on each table.
3. Please pick up a voucher from the HMA team if you parked in the DoubleTree parking.

Zoom Etiquette: CRIS Committee Members



Zoom Etiquette: Members of the Public



CRIS Committee Meeting Objectives

1. Ground our work in the personal stories and experiences of people who encounter the crisis response system.
2. Hear updates from state agencies and subcommittees relevant to the CRIS.
3. Learn about the unique needs of people with intellectual and developmental disabilities when it comes to behavioral health crisis response.
4. Learn about the key insights that have emerged from the Lived Experience Stories Project to inform CRIS Committee recommendations to improve the behavioral health crisis response system in Washington.
5. Refine CRIS committee recommendations for the Final Report.
6. Confirm action items and next steps.
7. Hear public comment.

Meeting Agenda

TIME	TOPIC
10:15 am	Arrival Activity
10:30 am	Technology Review
10:35 am	Welcome, Introductions, Review Meeting Agenda
10:40 am	Agency updates
11:00 am	Panel Discussion: Crisis Response for People with Intellectual and Developmental Disabilities
12:15 pm	Lunch and Social Time
1:00 pm	Presentation and Discussion: Lived Experience Stories Project Outcomes
2:00 pm	Break
2:10 pm	Discussion: CRIS Committee Recommendations
3:45 pm	Action Items and Next Steps
3:48 pm	Public Comment Period
4:00 pm	Adjourn

System Updates and Q&A

Objectives:

- *Ensure transparency and demonstrate progress.*
- *Connect agency work to CRIS recommendations.*
- *Inform CRIS committee of what is happening so they can build on what is already progressing in 2024.*

HCA Bed Registry and Referral Project

September 24th, 2024

Washington State Health Care Authority

Updates

- Overview of Project
- Work to Date
- Key Findings
- Next Steps

Washington State Health Care Authority

Next Steps

- Communication materials to be posted on our website, delivered directly to providers, CRIS committee members, and users of the system (those with lived experience)
- Will be delivered to HCA from our vendor at the end of September
- Needs Assessment – compilation of the challenges, needs, risks, desires, etc. that were collected during the surveys and listening sessions. Also includes recommendations that BerryDunn has drafted as a result of this feedback for HCA to refer to during future development of the 988 system and bed registry/referral components.
- Will be delivered to HCA from BerryDunn in October, and available on the HCA website shortly thereafter
- RFP: requirements and other elements in the RFP are directly affected by the feedback received
- Will be published in Q2/3 of 2026
- Development and Implementation of 988
- Will begin following the RFP

Panel Discussion: Crisis Response for People with Intellectual and Developmental Disabilities

Objective: *Learn about the unique needs of people with intellectual and developmental disabilities when it comes to behavioral health and crisis response.*

Quick Intro

SOUND
The forefront of healthcare

What is Intellectual Disability?

- **IQ is 70 or less**
  - Recent recognition that the “number” alone can be misleading
  - Some people have IQ’s of 70 and are OK
  - Some people have IQ’s of 90 and cannot function in the world without significant help
- **Adaptive Skill Deficits**
  - May be the more critical component
  - Assessment about what people need for assistance to function in basic ways in the world

SOUND
The forefront of healthcare

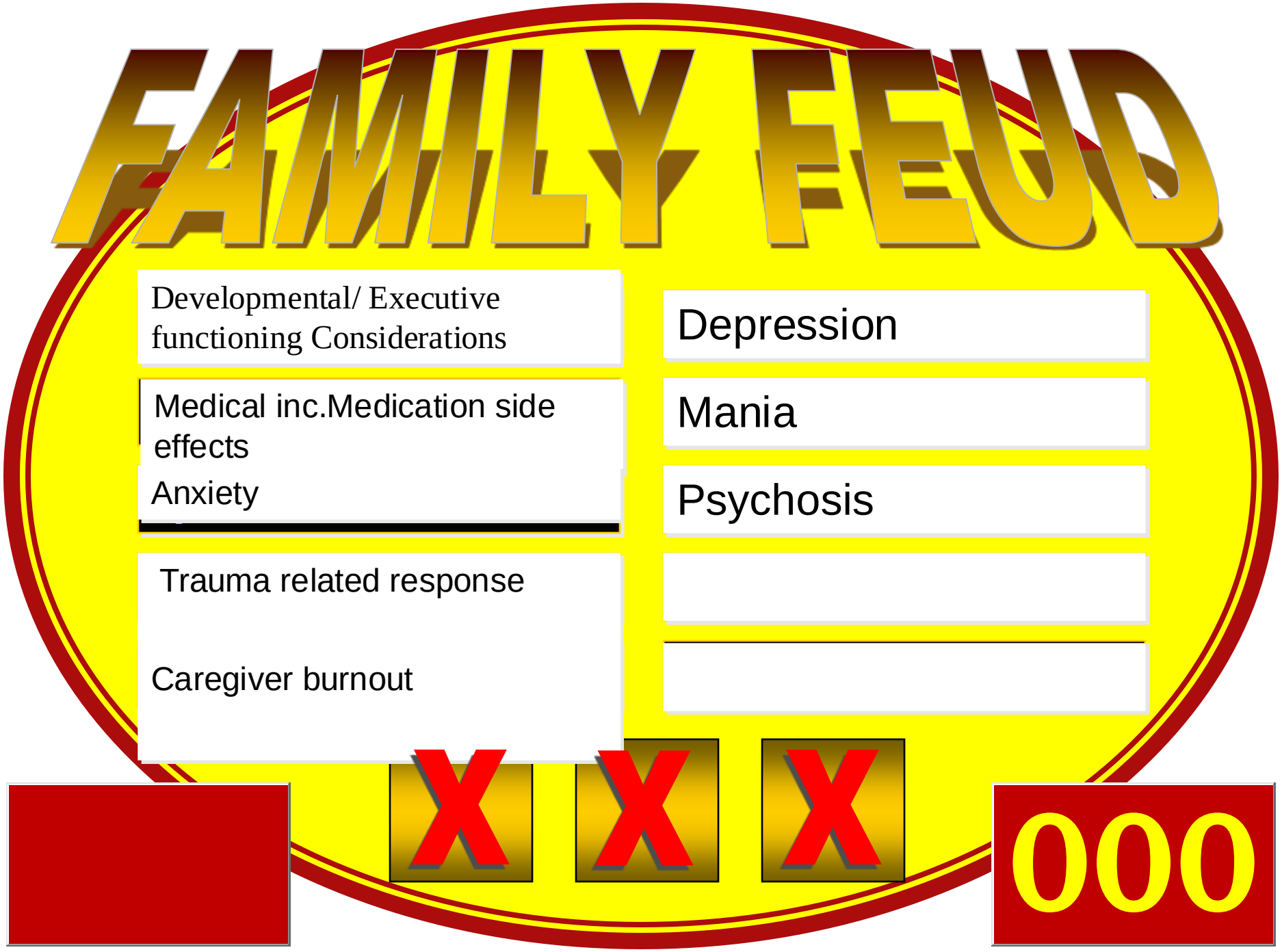
Executive Functioning Deficit Areas

- Ability to Inhibit
- Cognitive Flexibility
- Initiation
- Working Memory
- Plan/Organize
- Organization of Materials
- Monitor
- **Emotion Regulation**

Real Life Cases & Findings

Same Patient, Same Problem, Different day

Presenting Problem	Major influencing factor
> Aggression	Constipation
> Aggression	EPS and sedation
> Aggression	Reflux
> Aggression	Depression
> Aggression	Agitated Friend
> Aggression	Boredom
> Aggression	Family stress
> Aggression	Impacted wisdom tooth
> Aggression	Trauma Response


FAMILY FEUD
Developmental/ Executive functioning Considerations
Medical inc.Medication side effects
Anxiety
Trauma related response
Caregiver burnout
Depression
Mania
Psychosis
X
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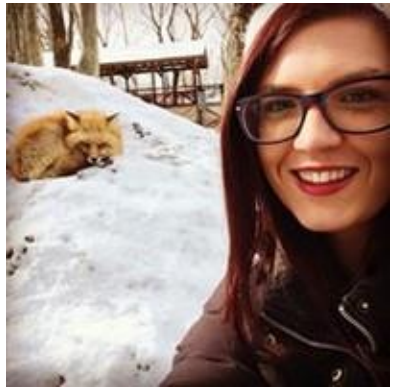
Crisis Response for People with Intellectual and Developmental Disabilities Panelists

DAVID O'NEAL
IDD Services Director, Sound Mental Health

DEANN ADAMS
Clinical Program Manager, Washington Developmental Disabilities Administration



DEBRA HUGHES
Clinical Supports Director, Hope Human Services

HEATHER GETHERS
Case Manager, Washington Developmental Disabilities Administration

JERMAINE AND MIKELLE HAYES
Parents of a 10-year-old boy with IDD

JIM OTT
Community Information and Outreach Manager, King County Developmental Disabilities Division

KATRINA DAVIS
Family Advocate and Case Manager, Seattle Children's; Parent Advocate and Resource Specialist, University of Washington

Break – Return at 1:00 pm

Presentation and Discussion: Lived Experience Stories Project Outcomes

Objectives:

- *Ground our work in the personal stories and experiences of people who encounter the crisis system.*
- *Learn about the key insights that have emerged from the Lived Experience Stories Project to inform CRIS committee recommendations to improve the behavioral health crisis response system in Washington.*

2024 WA STATE CRIS LIVED EXPERIENCE STORIES PROJECT

ABOUT THE PROJECT

- **GOAL**: To broaden our ongoing work of elevating lived experience (LE) stories to inform the Washington Behavioral Health Crisis Response System
- Stories collected June 1- July 31, 2024
- Small sample from people who were able to submit. Not a representative sample.
- 65 valid stories coded - Some submissions not included
- Insights about various parts of the Washington Behavioral Health Crisis Response System drawn from these stories

Demographics Captured

Details in appendix

- Age Group
- Race
- Disability
- Veteran
- Gender Identity
- LGBTQIA2S+
- Housing Instability
- Accessing the BH system for self/others
- Engagement with following Systems:
  - Corrections
  - Foster Care
  - Immigration
  - Mental Health
  - Substance Use

What's Working

People are receiving help they need across the crisis continuum & beyond

[My] Friend ODd. I called 911. Needed urgent medical advise... immediately paramedics arrived and had some drugs to counter the overdose and my friend got stable

DCR was professional, kind and caring... DCR even called every hour until the agency opened up

[I was] diagnosed, by my primary care doctor, with life threating liver, kidney and pancreatitis disease, due to my alcoholism. When I got totally honest with my primary doctor and my therapist I was referred to a detox and in-patient treatment

I called 988 and gave them all the information I had. Two people [MCT] showed up, male and female in less than an hour. That was impressive.

INSIGHTS On What Could Be Better

INSIGHTS

1. **CRIMINAL JUSTICE SYSTEM** & **EDs** functioning as primary access points to behavioral health care
2. **BARRIERS TO ACCESS** include insurance, cost, lack of providers, & transportation
3. **PROTOCOLS** are unaligned, inconsistent, and often do not meet the needs of the community
4. **QUALITY** of **SUPPORT** is inconsistent
5. **CROSS-SYSTEM GAPS** lead to people falling through
6. **FOLLOW-UP** and **PREVENTION** pillar needs to be added to, integrated, and aligned with the crisis response system
7. **NATURAL SUPPORTS** need to be an integral part of the design and delivery of crisis response system

1. CRIMINAL JUSTICE SYSTEM (CJS) and **EDs** functioning as primary access points to behavioral health care

People are landing up in the CJS rather than getting the BH help they need

Had there been easier access to a program like drug court, I could have avoided the multiple felonies I have on my record and had a supportive program behind me.

The CJS can be/is traumatizing

My first stay in prison was devastating to my psyche, I found myself in a world of which I knew nothing about. The fear and depression was contagious it permeated every single day of my experience. Which I believe became the catalyst for the subsequent drug abuse and mental health problems.

Rehabilitation programs within the CJS are helpful

While incarcerated [I] was introduced into 'The Change' program, through progress house association. It was this program the ultimately helped me change the trajectory of my life. Knowing that there are programs, resources, housing and hope help me change my life. I am very eager and excited about the opportunity of a new life. It is my goal to tell others that they can make it just as I did

Transitions between CJS-BH and Community Based BH are problematic

[In the] seven years that I was incarcerated and took medication and saw a psychiatrist, Washington State Medicare would not accept that documentation from Washington Correcting Center for Women … psychiatrist [outside] tried to prescribe me a antipsychotic that was not available at WCCW. I went down to Kaiser to try to get the medication, and Molina Healthcare and Washington State Healthcare would not give me the medication … 9 mos into the process, I did everything that I was supposed to do and I was not given the medication that would have prevented a relapse.

Emergency Departments are not a good place for BH crisis care

They eventually called me back, took all of my clothes and possessions, put me on a stretcher in the hallway, and proceeded to leave me there alone with no sedatives or anything in the middle of the ED chaos while feeling suicidal.

[from a teacher] the student was held in the ER for about an hour. Then the ACTIVELY SUICIDAL CHILD WAS DISCHARGED TO THE STREET with no notification to their parent, no safety plan, no care plan, no follow-ups scheduled, and certainly no admission to inpatient.

SUGGESTIONS

- Allow BH intervention to take precedence over criminal justice especially when there is an arrest warrant for non-violent crimes

"A DCR was with the police and offered my son a mental health evaluation. My son declined. The DCR told me the arrest warrant [for missing a hearing] superseded her MH eval."

2. BARRIERS TO ACCESS

Access Barriers: Insurance / Cost of Care, & Transportation

my daughter has received a bill for over $5,500 from Capital Medical Center [ED]

I can't drive a violent kid, nor drive in night, nor safely transport…

Access Barriers: Lack of Resources

no other teams or services for our remote area in Gold Bar

I wish we had "drop in" centers/clinics where people could access mental health counselors to talk to

in the year prior to him going into the clip facility, [he] spent probably about almost 40 days sitting in Sacred Heart in their emergency room

3. PROTOCOLS are unaligned, inconsistent, confusing, and often do not meet the needs of the community

Protocol Issues Across the System

911 literally would not come even when he was trying to kill me and himself because they were legally not allowed to restrain minors

In the state of Washington, the only medications that can be legally compelled are antipsychotics. Mood stabilizers cannot. This is a real problem for someone who needs mood stabilizers to stay stable.

A nurse drew blood, not telling me why, and I was shocked to get the notification through MyChart that they had done a tox screen looking for substance use.

I ran out of medication, had seizures for several months, almost died because nobody titrated me off any medication. Nobody had any ability to get me my medication again.

Protocol Issues Around ITA & DCRs

officer called me back letting me know my son didn't qualify for an ITA under Ricky's Law since he hadn't physically assaulted anyone in our home or committed a crime

I was thinking he [crisis center social worker] would start the ITA process. He parked outside our house and then left without letting us know why. I called the crisis line back and was told he felt unsafe going by himself so he contacted Skagit County Sheriff's office asking them to come to the house.

SUGGESTIONS

Educate community & be transparent on what people can expect

- *"end up with us calling the police because we didn't know what else to do"*
- *"Crisis lines are 50-50. Often you just run out of time before you're deescalated and feel abandoned when they hang up on you."*

SUGGESTIONS

- Standardize education for all service providers on how the system works, in their domain, and other related/relevant domains
- Consider changing/improving protocols to better support the community

"improve the ITA requirements gearing more toward prevention rather than someone having to commit a crime in order to be ITA'd"

4. QUALITY of **SUPPORT** is inconsistent

Quality of Support: Someone to Call

Just talking to someone [at RCL] because I was very isolated and alone really had helped a lot

He [Crisis Counselor] did tell me about the Ricky's Law (ITA for chemical dependency), which we both felt was the best option.

When I contacted 988 they contacted the EMT's and police to respond to my house. I'm very frightened by Law Enforcement and First Responders. I asked them to please leave my house. One officer stepped aside and told me that they also where a veteran and they wanted to help. I did reach out after and spoke with them

Quality of Support: Someone to Come

They [MCT] spent a long time listening to his story and in the end, they gave him advise. Which was to go voluntarily or be ITA. These two professionals were the best part of all the services

I wish that the mobile crisis team had been more responsive to us and had actually came out to see her.

Quality of Support: Safe Place to Be/Go

I would have never guessed that being diagnosed with schizophrenia and going to Transitional Resources would give me a future and save my life. Getting a diagnosis felt like a restart.

[Inpatient] It was a horrific, caged animal experience. They threatened him with being sent to Eastern in a straight jacket and told him he'd get ECT.

[Inpatient] When she finally came home she said they did not help her in any way, and she will never ask for help again as she felt she was in jail there.

Bias Might be Impacting Quality of Support

The system also ignored my suicidality because I am in a wheelchair. My problems were minimized and ignored because I am in a wheelchair. My PTSD was being aggravated but ignored because I am in a wheelchair. I was not hospitalized because I am in a wheelchair and unable to take care of myself/ADL's

dismiss her because of her race or apparent drug use. She needed more workers familiar with trafficking

SUGGESTIONS

- Agencies adequately staffed to minimize burnout
- Adequate pay & personal time off for staff
- TRAINING for STAFF on
  - Secondary Trauma education and support
  - Unconscious Bias
  - Special needs/Minority/Underserved population care
  - Trauma Informed Care
- Enable consumers to rate quality of care

"Harborview has the most doctors, beds, and because they pay the best, some of the best staff"

5. CROSS-SYSTEM GAPS lead to people falling through

Cross System Gap: Follow up not given or if promised does not come through

In the end he [youth] was discharged with a PRN and no way to move forward or anyone to check in on him or his family in the following days, as it was a weekend.

988 told [me] to call 211 which was a loop of numbers having to answer question never getting anywhere ending with asking if I want to answer a 4 questions [survey]

Cross System Gap: Parts of the system don't talk well to each other. There are big gaps.

There needs to be a service between WISe and CLIP. When WISe isn't enough but the ER nor 911 are appropriate where can a family get help.

I don't know if the community providers we were working with just dropped the ball or if they didn't know either. And it seemed to us like everywhere we went, there was just kind of like this confusion on what the information was or the answer we got, oh, I'm not sure about resources. I have to check with this person and then I'm going to have to double check with this other person. And it was always like a ball being passed from one person to the next until finally we had kind of reached a point where we had been struggling so long

SUGGESTIONS

- 988 hubs need to be the repository of knowledge on all aspects of the BH crisis response system so they can act as a one stop shop to connect people to other parts of the system as needed. They should warm transfer clients to programs like WISe, CLIP, MRSS, MCT, DCRs, BeST, PACT etc. They can also inform people about options like Joel's law or Ricky's law.
- The 988 Tech Platform should house standardized information so both the community and service providers can access it as needed

"Basically, I feel like there is support available, but it's too spread out between a million different organizations and navigating that is a difficult process"

6. FOLLOW-UP and **PREVENTION** pillar needs to be added to, integrated, and aligned with the crisis response system

Follow-up & Prevention: Without it people are cycling in and out of the BH crisis response system

Where are the peer support counselors? Where are the people that link my ability to stay stable and well?

ensuring seamless transition to ongoing care and support beyond the initial crisis. I hope they intergrate substance use crisis response with long-term recovery resources

After three months at a long-term treatment facility, Telecare in Shelton, he was released to a homeless shelter in University district. He was arrested 6 hours later after smoking "something", taking off all his clothes and dancing in the street nude. It was clear he was not stable when he was released even though he was at the place for three months. This was utterly stupid—releasing someone as mental ill as my son to a homeless shelter in University district is negligent care.

Follow-up & Prevention: Lack of Basic Needs Triggers BH crises

Housing was another issue, though, and while everyone else seemed to get free housing after a time, I could never figure out how. The issue was that they were always reward-based or contingent on sobriety/completion of a drug treatment. You could get something like housing, but you had to be clean and stay that way. There were too many hoops to jump through for basic necessities, so eventually I gave up trying. I was on the streets of Seattle battling drug addiction and homelessness.

It is common for the closest family members to cut off all contact and withhold any money or direct support, once there is a serious crisis… What follows are years of difficulty getting health care, dental care, food assistance from the state, etc. [story submitted by someone who works in field]

7. NATURAL SUPPORTS

need to be an integral part of the design and delivery of crisis response

Natural Supports: The balance between personal agency and family engagement

Another weakness is that there is little family involvement with the treatment plan.

Harborview—someone on John's team calls me and asks for his history, and the circumstances of this particular hospitalization. Almost no other mental health facility does this. Sometimes I wait over a week or two before a social worker calls me

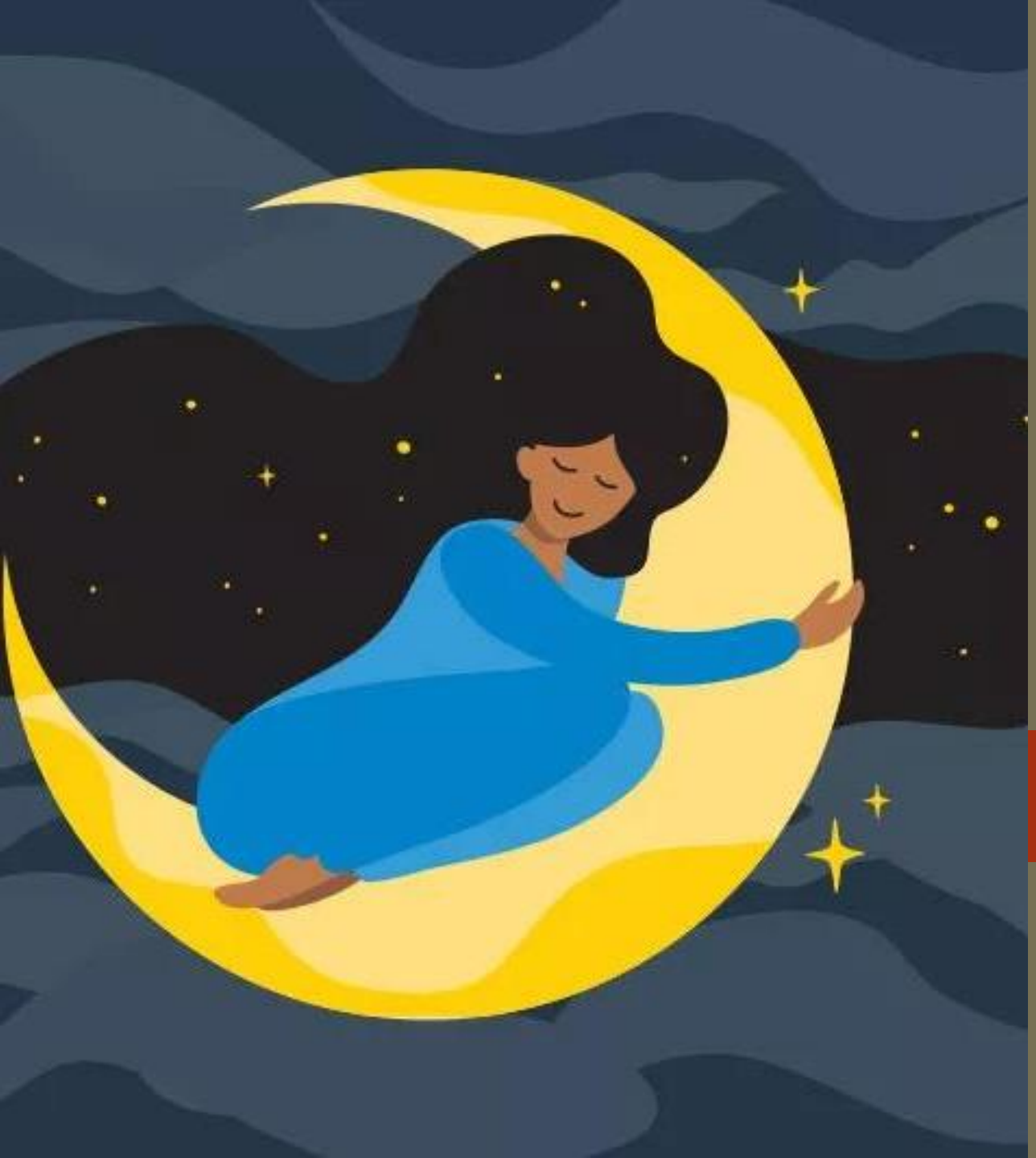
She would go to treatment , do better, get out, relapse. That was a repeated cycle. She was clearly ... not able to make informed decisions. She continued to check herself out of rehab every time we got her into a substance use and/or mental health facility... If we had a way to make her stay in treatment until she was stabilized on medication and in the right frame of mind, I feel like this could've been prevented

I have had to overcome serious trauma from childhood situations and instances.

Natural Supports: Natural Supports are also in crisis and need support

When there is physical violence beyond the ability of a parent to handle who can physically come? Literally no one would could help during attacks. He had the legal right to kill me. I'm disabled and lived alone with him. Restraining him requires 3 people. He broke down doors to attack me, I had no safe place.

I would have benefited from mental health and support systems for myself in managing my codependency and trauma. I could have used some support to get connected with CODA [coda.org], peer support groups, a counselor, information on codependency and how to handle situations of emotional abuse.



I HAVE A DREAM...

“I want a place for my son that doesn’t exist but if it did….

- It would have doctors who listen, not overmedicate.
- It would have treatments like individual therapy.
- It would have a nice room with sound proofing so he would not be bothered by screaming of others.
- It would have wonderful, healthy brain healing food not the cheapest slop.
- He would have access to the outside.
- It would provide a step like system that he would gradually be reintroduced to the “real world”. Like a single room in a locked ward to room in an unlocked ward at night to a studio apartment with medication management.
- This mythical place would be close enough so his family could visit and he could do things he wants like re-enter community college.”

THANK YOU!

To everyone who supported and provided input for this project

- HMA and Related Staff
- HCA Staff
- DOH Staff
- LE Subcommittee Members
- CRIS members
- Folks who helped with outreach
- Our human and non-human natural supports
- Most importantly, to everyone who dedicated time and emotional labor in submitting a story to us

LET'S TALK…

1. **CRIMINAL JUSTICE SYSTEM** & **EDs** functioning as primary access points to behavioral health care
2. **BARRIERS TO ACCESS** include insurance, cost, lack of providers, & transportation
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7. **NATURAL SUPPORTS** need to be an integral part of the design and delivery of crisis response system

THE END

Break

Discussion: CRIS Committee Recommendations

Objectives:

- *Refine CRIS committee recommendations for Final Report.*

Action Items & Next Steps

Public Comments

Public Comment

	Name
1.	Jean Ross
2.	Jay Worley
3.	
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