Washington Behavioral Health Crisis Response and Suicide Prevention System: Crisis Response Improvement Strategy Steering Committee Final Report

COMMITTEE PROGRESS REPORT PER RCW 71.24.892

TO
GOVERNOR JAY INSLEE
SENATE WAYS AND MEANS COMMITTEE
SENATE HEALTH AND LONG-TERM CARE COMMITTEE
SENATE HUMAN SERVICES COMMITTEE
HOUSE APPROPRIATIONS COMMITTEE
HOUSE HEALTH CARE AND WELLNESS COMMITTEE

FROM
THE STEERING COMMITTEE
OF THE CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE

DECEMBER 31, 2024

Letter from the Steering Committee

[To be inserted once approved by the Steering Committee]

[Lived Experience quote to be inserted]

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List of Acronyms Used in this Report

Acronym	Meaning	Acronym	Meaning
AI/AN	American Indian or Alaskan Native	MRRCT	Mobile Rapid Response Crisis Team
AIHC	American Indian Health Commission	MRSS	Mobile Response and Stabilization Service
BH	Behavioral Health	MRRCT	Mobile Rapid Response Crisis Team
BH-ASO	Behavioral Health Administrative Services Organization	NDA	Next Day Appointment
CJIS	Criminal Justice Information Services	NASMHPD	National Association of State Mental Health Program Directors
CRC	Crisis Relief Center	NSLL	Native and Strong Lifeline
CRIS	Crisis Response Improvement Strategy Committee	NSPL	National Suicide Prevention Lifeline
CSU	Crisis Stabilization Unit	OCIO	Office of the Chief Information Officer
DCR	Designated Crisis Responder	OIC	Washington State Office of the Insurance Commissioner
DEI	Diversity, Equity, and Inclusion	PSAP	Public Safety Answering Point (911 Call Center)
DOH	Department of Health	RCL	Regional crisis line
E&T	Evaluation and Treatment	RCW	Revised Code of Washington
ED	Emergency Department	RFI	Request for information
EMS	Emergency Medical Service	RFP	Request for proposal
FFS	Fee-for-Service	RT	Round table
HB	House Bill	SAMHSA	Substance Abuse and Mental Health Services Administration
HCA	Health Care Authority	SB	Senate Bill
ITA	Involuntary Treatment Act	SME	Subject Matter Expert
HMA	Health Management Associates	SUD	Substance Use Disorder
IHCP	Indian Health Care Provider	TCBHAB	Tribal Centric Behavioral Health Advisory Board
LE	Lived Experience	UIHO	Urban Indian Health Organization
LGBTQIA2S+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, Two-Spirit	UIHP	Urban Indian Health Program
MH	Mental Health		

Executive Summary

Background

In 2021, the Washington legislature passed House Bill 1477 to establish 988 Lifeline Call Centers and improve Washington's behavioral health crisis response and suicide prevention system. HB 1477 directed the State to convene a Steering Committee to develop recommendations for an improved behavioral health crisis response system, as well as a Crisis Response Improvement Strategy (CRIS) Committee comprised of representatives from key partners and constituencies of the behavioral health crisis response system to advise the Steering Committee.

For the past three years, the Steering Committee, CRIS, and Subcommittees focused on engaging cross-system partners to develop recommendations for a unified and robust behavioral health crisis response system in Washington. Throughout this work, people with lived experience have provided a powerful lens for understanding where the system works and doesn't work and informing the changes necessary to meet the needs of Washington's communities.

The CRIS recognizes that implementation of this change will take time and requires continued work to build trust with Washington's communities and across system partners. This report summarizes the CRIS recommendations and progress to date with the aim of establishing a resource will continue to guide Washington's work to build an integrated and comprehensive behavioral health crisis response system.

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 the 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."*

~ Lived Experience Stories Project Participant

Vision

The CRIS Committee developed a vision for Washington's Behavioral Health Crisis Response and Suicide Prevention System that serves as a foundation for the recommendations.

Vision: 988, Washington's Crisis Response: building understanding, hope, and a path forward for those in need, where and when they need it.

Guiding Principles

People in Crisis Experience:	*The Crisis System is Intentionally:*
1. Timely access to high-quality, coordinated care without barriers	**5. Grounded in equity and anti-racism**
2. A welcoming response that is healing, trauma-informed, provides hope, and ensures people are safe	**6. Centered in and informed by lived experience**
3. Person and family centered care	**7. Coordinated and collaborative across system and community partners**
4. Care that is responsive to age, culture, gender, sexual orientation, people with disabilities, geographic location, language, and other needs	**8. Operated in a manner that honors Tribal government-to-government processes**
	9. Empowered by technology that is accessible by all
	10. Financed sustainably and equitably

Progress to Date

Since 2021, the Legislature, Health Care Authority (HCA), Washington Department of Health (DOH), Tribes, system partners, and the 988 Lifeline crisis centers have made progress on meeting the requirements of HB 1477 and advancing the CRIS Committee's vision for the crisis response system. The 988 Lifeline launched in 2022 and has been meeting or exceeding the national performance benchmark since inception. The first of its kind in the nation—the Native and Strong Lifeline—also launched in 2022 and has become an exemplar for other crisis response systems across the U.S. The state fielded a multi-lingual communications campaign to promote awareness of the 988 Lifeline and help reduce the stigma associated with asking for help and expanded mobile crisis response teams for youth and adults. New legislation passed to expand the crisis response workforce, including rules that clear a major hurdle for peer support specialists—a critical component of the crisis response workforce—to participate in all aspects of the crisis response system. The state has also made progress on minimizing law enforcement involvement in a behavioral health crisis, with new Crisis Response Dispatch Protocols and a pilot program to divert behavioral health calls from 911 to 988.

The progress over the last three years has been important and meaningful, and there is still much work to be done to improve the crisis response system. Below are the CRIS recommendations to guide the continued work to build upon and strengthen Washington's crisis response system.

Committee Recommendations – At a Glance

Promoting Equity

1. In partnership with consumers, develop a **Caller Bill of Rights** that provides information to consumers about what they should expect when they contact 988, and holds the system accountable.
2. Ensure **equity** in behavioral health crisis and suicide prevention services across the state. Establish a **988 Diversity, Equity, and Inclusion Director** to bring a statewide perspective and work with Tribal liaison.
3. **Engage consumer voice** in informing system design and changes needed.
4. Build upon Tribal Behavioral Health Crisis System improvements and **ensure Tribal partners are recognized and connected in the state and local crisis response systems**
5. Establish requirements for **translation and interpretation**.

Services

6. **Ensure there are crisis response services available in all regions so that people have access to care wherever and whenever needed.** *See recommendations outlined across the crisis services continuum (A Place to Call, Someone to Come, A Safe Place to Be, Follow Up)*

Prevention

7. Strengthen **overarching system capacity around behavioral health and suicide prevention** services to prevent behavioral health crises from happening in the first place. Include **community outreach and public education** to address stigma around behavioral health needs and raise awareness around 988; **invest in basic social services**; Increase use of **telehealth services** to enable access to behavioral health services; **Partner with Tribes to ensure Tribal perspectives and priorities** are incorporated into prevention strategies; Expand coverage for **Tribal traditional healing practices** to be included in prevention, behavioral health, and crisis response services.
8. Increase **prevention services for youth**, such as implementing social-emotional learning in schools, mental healthcare on school campuses, etc.

System Quality and Oversight

9. Create a **transparent system of oversight and accountability**, including: **System standards, performance targets, and metrics**; Create a **dashboard; track who the system service and who it misses; Work with Tribes** to incorporate Tribal-specific performance metrics; Ensure system recognition of **Tribal data sovereignty**.
10. Convene and support a **mechanism to engage diverse communities and individuals with lived experience** in ongoing efforts to develop and monitor the crisis response system.
11. Conduct **qualitative research and outreach to understand why some populations are not accessing** the crisis response system.

Cross System Collaboration

12. **Encourage and foster regional collaborations** that convene system partners to create regional plans and protocols for crises. System partners include 911, 988, Native and Strong Lifeline, BH-ASOs, RCLS, Tribal crisis lines, behavioral health providers, hospitals, Indian Health Care Providers, Native Resources Hub, mobile response teams, designated crisis responders, co-responder teams, first responders, Tribal public safety and first responders, 211, and other partners.
13. Encourage and provide **support for ongoing collaboration between first responders and behavioral health providers** to support a safe, effective, appropriate, and unified behavioral health crisis response that minimizes law enforcement involvement.
14. Develop **cross-system coordination protocols** that can be adapted regionally to establish warm handoffs, referrals, and common decision criteria and definitions across a range of system partners. This work should include support to implement **Tribal Crisis Coordination Plans** established by individual Tribes.

15. Pursue **youth-specific crisis system coordination**: Ensure youth 988 callers/chatters are connected with youth-specific resources such as Mobile Response and Stabilization Services (MRSS); Explore data-sharing agreements with schools, with appropriate confidentiality safeguards, to provide students with better follow-up care.

Staffing and Workforce

16. Establish a workgroup and engage consumer voice to develop strategies to expand and sustain a **diverse behavioral health workforce** that shares language, culture, and experience with the populations being served.
17. **Integrate peers**—an essential component of the crisis response workforce—into all parts of the system.
18. Engage providers and first responders across the crisis care continuum in **cross-system training** to ensure a unified crisis response across the state. Engage Tribal partners to tailor trainings to the needs of Tribal communities. Engage people with lived experience in the development of training curriculum.
19. Develop diverse approaches for **supporting caregivers** as a critical source of care for people in crisis.
20. Expand **mental health first aid training and education for laypeople** and consider mandating age-appropriate mental health first aid training in schools.

Technology

21. From 2021-2024, the CRIS Committee and several Subcommittees (Technology, Tribal 988, Rural & Agricultural, Geo-routing, and Lived Experience) informed DOH and HCA's work on the 988-crisis response system technology platform. This input will continue to inform the agencies' work to engage an RFP process to select a technology vendor and begin implementation of the system.

Funding

22. Provide **additional funding to behavioral health crisis systems** across regions and evaluate distribution of resources to identify and address disparities. Develop a payment structure that incentivizes providers to meet performance metrics. Pursue **consistent funding for mobile crisis response;** Provide additional funding in **rural communities**. Consider enabling **"payer blind"** crisis services across the crisis response continuum. Ensure crisis service funding to the **Medicaid fee-for-service system**, recognizing that many Tribal members are enrolled in Medicaid fee-for-service rather than managed care.

Background

The Charge

House Bill 1477 (HB 1477), which passed during the 2021 Washington State legislative session, establishes 988 Contact Hubs and seeks to improve Washington State's behavioral health crisis response system. Goals identified by the bill include:

- Implement and expand 988, the new three-digit national Lifeline number.
- Develop 988 Contact Hubs to provide crisis intervention services and streamline access to services.
- Expand crisis services across the service continuum.
- Collaborate and coordinate across diverse system partners.
- Implement workforce training and development.
- Implement a new technology platform to support system coordination.
- Expand funding through the 988 Behavioral Health Crisis Response and Suicide Prevention Line Account.

Legislative Requirements

House Bill (HB) 1477 created a Crisis Response Improvement Strategy (CRIS) Committee, a Steering Committee of the CRIS, and Subcommittees to develop recommendations to fund and deliver an integrated behavioral health crisis response and suicide prevention system in Washington.[1] In 2023, HB 1134 extended the work of the Steering Committee, CRIS Committee, and Subcommittees by an additional year.[2]

The Steering Committee—with input from the CRIS Committee and Subcommittees—is charged with delivering the following to the Governor and Legislature:

- **JANUARY 1, 2022**: a progress report, including results of the comprehensive assessment of the behavioral health crisis response and suicide prevention services systems and preliminary recommendations related to funding of crisis response services.
- **JANUARY 1, 2023**: a second progress report, including a summary of activities completed by the CRIS and Subcommittees during calendar year 2022 and final recommendations related to funding of crisis response services from the 988 Account created by the line tax.
- **JANUARY 1, 2024**: a third progress report regarding activities completed by the CRIS and subcommittees in 2023, and recommendations of the Steering Committee.
- **JANUARY 1, 2025**: a final report by the Steering Committee—informed by the CRIS and Subcommittees—with final recommendations for the funding and delivery of an integrated behavioral health crisis response and suicide prevention system in Washington.

[1] House Bill 1477 (2021). Retrieved from https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1477-S2.SL.pdf?q=20231104180909; *See:* Revised Code of Washington 71.24.892.
[2] House Bill 1134 (2023). Retrieved from https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/1134-S2.SL.pdf?q=20231104180729

CRIS Committee, Steering Committee, and Subcommittee Structure

HB 1477 charges the Steering Committee to make recommendations to improve Washington's behavioral health crisis response and suicide prevention system. Steering Committee members include:

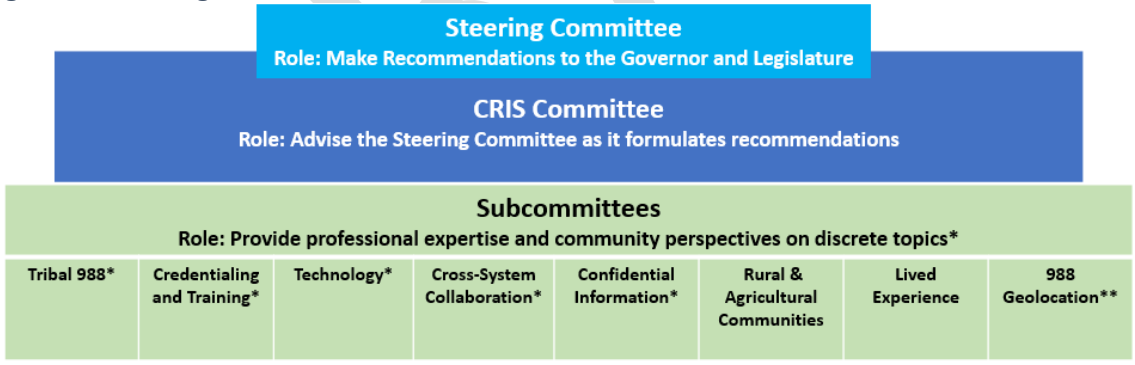
- A member of the Washington State House of Representatives
- A member of the Washington State Senate
- A representative from the Governor's Office
- A representative from the Health Care Authority
- A representative from the Washington State Department of Health
- A person with lived experience.[3]

The CRIS Committee is comprised of 36 members representing a range of crisis response system partners and constituents, as specified in HB 1477. This representation includes people with lived experience, state agencies, service providers, first responders, Medicaid and commercial health plan representatives, Tribal representatives, consumer organizations, state legislators, and other partners across the crisis response system.[4]

Eight subcommittees provide professional expertise and community perspectives in the development of crisis system recommendations.[5] The Subcommittees are made up of CRIS members, state agency representatives, tribal partners, and other partners and constituents offering community perspectives and/or professional expertise in the subcommittee areas of focus.[6]

Recognizing the sovereign authorities of Tribal governments and the existing processes and governing bodies in place to address Tribal behavioral health and crisis system needs and gaps, the Steering Committee also engages in Tribal Consultation. Figure A shows the committee structure.

Figure A: Steering Committee, CRIS Committee, Subcommittee Structure



* Six of the eight subcommittees are established by legislation . The Steering Committee established two additional subcommittees: Lived Experience and Rural & Agricultural Communities
** The Geolocation Subcommittee is expected to be convened in 2024.

[3] In 2023, the Legislature added the sixth voting member of the Steering Committee to represent Lived Experience.
[4] A CRIS Committee member list is available on the CRIS webpage at https://www.hca.wa.gov/assets/program/cris-committee-member-list.pdf
[5] The charge of each subcommittee is described in the *2023 Subcommittee Report* available on the CRIS webpage at: *https://www.hca.wa.gov/assets/program/cris-subcommittee-report-2023.pdf*
[6] A HB 1477 Subcommittee member list is available on the CRIS webpage *at: https://www.hca.wa.gov/assets/program/cris-subcommittee-member-list.pdf*

Lead Agencies

The Washington State Health Care Authority (HCA) and Washington State Department of Health (DOH) are the lead authorities for administering Washington's behavioral health crisis response system. Figure B shows the roles of each of these agencies in the crisis care continuum. HCA and DOH participate on the CRIS Committee, Steering Committee, and Subcommittees.

Figure B: Overview of HCA and DOH Roles in the Crisis Response Continuum

Tribal Consultation

Washington State is home to 29 federally-recognized Tribes that have sovereignty over Tribal lands. There are existing systems, processes, and governing bodies to address Tribal behavioral health. Tribes and Urban Indian Health Organizations in Washington have worked for decades to address the inequities in access to behavioral health crisis services experienced by American Indians in the state. It is important that the CRIS Committee's recommendations align with and build upon the ongoing work led by Tribes to address behavioral health crisis needs in Tribal communities.

While many Tribes have their own behavioral health crisis response, health care, and/or first responder systems, Tribal members may also interact with non-Tribal affiliated systems. Consequently, the CRIS has considered how these systems support Tribal members and the importance of cross-system coordination to ensure a cultural and trauma-informed response. The Tribal 988 Subcommittee, through the Tribal Centric Behavioral Health Advisory Board, has collaborated with the CRIS and Steering Committee to help ensure Tribal perspectives are brought forward into CRIS recommendations to improve Washington's behavioral health crisis response system.

In carrying out the work of HB 1477, the Steering Committee recognizes the sovereign authorities of Tribal governments. The Steering Committee's relationship with Tribes is distinct from the State's relationship with other system partners. The Steering Committee, with HCA and DOH, initiated a formal Tribal consultation process in 2022 and 2023. Appendix C provides a summary of Tribal recommendations through the Tribal 988 Subcommittee as well as Tribal Consultation.

Centering Lived Experience

HB 1477 states lived experience must be a key foundation of the crisis response improvement strategy. The CRIS and Steering Committees have taken the following actions to center lived experience:

1. Implemented a Lived Experience Subcommittee, planned and facilitated by people with lived experience.
2. Added a person with lived experience to the Steering Committee and supported legislation to make the lived experience representative an official voting member.
3. Featured a story from a person with lived experience at every CRIS Committee meeting to ground the CRIS Committee in the experiences of people encountering the crisis response system.
4. Launched a *Lived Experience Stories Project* that gathered stories from people across Washington State who engaged with the crisis response system. The purpose was to garner insights from these stories that could inform improvements to the crisis response system. This project is summarized in Appendix D (*Lived Experience Project Summary*), and the overall findings can be found by reviewing the Lived Experience Stories Project presentation to the CRIS committee at their September 24, 2024 meeting, or watching the video presentation. In addition, quotes from people with Lived Experience engaged in this project or participating in Lived Experience Subcommittee and broader CRIS efforts are woven throughout the report.
5. Compensated CRIS Committee members representing lived experience for their participation.

Lived Experience quote(s) to be inserted.

Vision for the Crisis Response System

In 2022, the CRIS Committee developed a vision for Washington's Behavioral Health Crisis Response and Suicide Prevention System. This vision and guiding principles establish the foundation of the Steering Committee, CRIS Committee, and Subcommittees work to develop recommendations.

Vision: 988, Washington's Crisis Response: building understanding, hope, and a path forward for those in need, where and when they need it.

Guiding Principles

People in Crisis Experience:	*The Crisis System is Intentionally:*
1. Timely access to high-quality, coordinated care without barriers	**5. Grounded in equity and anti-racism**
2. A welcoming response that is healing, trauma-informed, provides hope, and ensures people are safe	**6. Centered in and informed by lived experience**
3. Person and family centered care	**7. Coordinated and collaborative across system and community partners**
4. Care that is responsive to age, culture, gender, sexual orientation, people with disabilities, geographic location, language, and other needs	**8. Operated in a manner that honors Tribal government-to-government processes**
	9. Empowered by technology that is accessible by all
	10. Financed sustainably and equitably

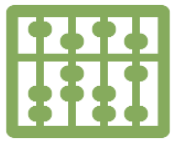
Recommendations, Progress to Date, and Remaining Gaps

Since 2021, the Legislature, state agencies, and the CRIS and Subcommittees have made progress on addressing the recommendations of the CRIS Committee and improving Washington's behavioral health crisis response system.

This section summarizes agency and legislative progress since HB 1477 was enacted in July 2021. It also outlines **22 recommendations** from the CRIS Committee to build on this work and continue improving the crisis response system, and shares CRIS perspectives on remaining gaps that still need to be addressed.

Many of the following recommendations would require an investment of resources—including time and funding—to implement. Therefore, the CRIS recommends that the Legislature **provide adequate funding to the Washington State Department of Health (WA DOH) and Health Care Authority (HCA) to implement these recommendations,** building on progress to date and ensuring the behavioral health crisis response system can provide all Washingtonians with culturally responsive, linguistically appropriate, trauma informed, effective, and confidential services.

Promoting Equity



Throughout its work, the Committee emphasized the importance of a crisis response system that is consumer-driven, responsive to diverse cultural and community needs, and designed by people who are using or have used the system directly. The perspectives of people with lived experience in the CRIS's work has offered a powerful lens for understanding where the system works and doesn't work and informing changes necessary to meet the needs of Washington's communities. Among the highest priorities for many on the CRIS Committee is implementing an ongoing mechanism for engaging system users and people with behavioral health crises—especially those who are the hardest to reach—in ongoing efforts to develop and monitor the crisis response system.

Lived Experience Stories Project Insight: The criminal justice system and EDs are functioning as primary access points to behavioral health care.

"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."
– Lived Experience Stories Project participant

Strategies to promote equity are woven throughout the Committee's recommendations in this report. In addition, several key recommendations focused on equity are summarized below.

Recommendations	Agency and Legislative Progress
1. In partnership with consumers, develop a **Caller Bill of Rights** that provides information to consumers about what they should expect when they contact 988, and holds the system accountable to providing services. *"just because some one is houseless, or addicted they have the same rights, and deserve the same respect as anyone else!"* *– Lived Experience Stories Project Participant*	

Recommendations	Agency and Legislative Progress
2. Ensure **equity** in behavioral health crisis and suicide prevention services across the state. Establish a **988 Diversity, Equity, and Inclusion Director** to bring a statewide perspective, as well as include appropriate Tribal government-to-government relations and work with Tribal liaison across the state. *"[they] dismissed her because of her race or apparent drug use. She needed more workers familiar with trafficking."* *– Lived Experience Stories Project Participant*	✓ DOH distributed increased **funding for 988 Lifeline crisis centers** to support 988 diversity, equity, and inclusion work. ✓ DOH hired a **new 988 Equity Implementation Specialist** focused on providing subject matter expertise around mental health equity, including intentional community engagement efforts focused on equity for 988 implementation. ✓ HCA continues to ensure equity in access through the **Substance Abuse and Mental Health Services Administration (SAMHSA) and National Association of State Mental health Program Directors (NASMHPD) best practices** across the lifespan.
3. **Engage consumer voice** in informing system design and changes needed.	✓ The **CRIS has centered lived experience** throughout its work. See summary of efforts on page 10. ✓ The Lived Experience Subcommittee engaged the **Lived Experience Stories Project** in 2024 to further broaden efforts to engage people with lived experience to share their stories to inform CRIS recommendations to improve the Washington's crisis response system. See summary and outcomes from this work in Appendix D. ✓ A new state law went into effect allowing HCA to offer **stipends to Committee members representing lived experience**. The purpose of the stipends is to further principles of equity in and removing financial barriers to workgroup participation. ✓ Lived Experience representative was added as **voting member of the Steering Committee,** as directed by HB 1134.

Recommendations	Agency and Legislative Progress
4. Build upon Tribal Behavioral Health Crisis System improvements and **ensure Tribal partners are recognized and connected in the state and local crisis response systems**	✓ The **Tribal 988 Subcommittee, through the Tribal Centric Behavioral Health Advisory Board**, has collaborated with the CRIS and Steering Committee to help ensure Tribal perspectives are brought forward into CRIS recommendations to improve Washington's behavioral health crisis response system. In addition, the Steering Committee engaged a formal **Tribal Consultation** process in 2022 and 2023 on Committee recommendations. Progress on Tribal behavioral health crisis response priorities and progress is **highlighted throughout the Committee's recommendations** outlined in the sections to follow.
5. Establish requirements for **translation and interpretation**. *"Language access is a huge barrier. If you talk another language or have an accent then when seeking help, people do not take you seriously."* *– Lived Experience Stories Project Participant*	✓ 988 Suicide and Crisis Lifeline offers **phone, chat, and text in both English and Spanish**, along with **ASL video** via the 988 Lifeline website. **Translation services are available in over 240 languages** when calling 988. ✓ Crisis response services contracted by HCA are also required to provide individuals with access to an interpreter line at the minimum.

Additional Lived Experience quote(s) to be inserted

Services

The CRIS has emphasized the need to expand crisis response services to create equitable access across the state. This expansion must address gaps across the crisis services continuum – A Place to Call, Someone to Come, A Safe Place to Be – and should both build on what is working and explore the creation of new models needed to support people in crisis. CRIS members recognized that many people currently access the system via emergency department or through encounters with the criminal just system and underscored the importance of expansion of behavioral health crisis services to provide a more equitable and trauma-informed response to people in crisis.

> *"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."*
>
> *– Lived Experience Stories Project participant*

In 2024, the CRIS heard about crisis response needs among several focused populations, including individuals with substance use and co-occurring disorders, rural and agricultural communities, people with intellectual and developmental disabilities, children and youth, and Tribal communities. As efforts continue to improve the system, the Committee emphasized the critical work needed to address the gaps identified, and the continued work needed to understand and ensure that Washington's crisis response system meets the diverse needs of individuals and families in crisis.

Recommendations	Agency and Legislative Progress
6. Ensure there are crisis response services available in all regions so that people have access to care wherever and whenever needed. *"no other teams or services for our remote area in Gold Bar " – Lived Experience Stories Project Participant* *See below for summary of recommendations systemwide and across the crisis services continuum below (A Place to Call, Someone to Come, A Safe Place to Be, Follow Up)*	*See areas of progress outlined below across the crisis response continuum.*

Recommendations	Agency and Legislative Progress
Systemwide A. Expand **programs to support specific youth populations**, such as justice-involved youth with behavioral health needs, youth with intellectual and/or developmental disabilities, children under 12, and youth who have been the victims of trafficking. a. Support **recommendations from Children and Youth Behavioral Health Work Group** to expand behavioral health services for children and youth. *"[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." – Lived Experience Stories Project Participant*	✓ The **Children and Youth Behavioral Health Workgroup** is focused on developing recommendations to the Governor and Legislature improve behavioral health services for children, youth, and young adults (prenatal to age 25) and their families. See the CYBHWG's 2024 Recommendations. As part of this work, HCA and agency partners are working with the CYBHWG Strategic Plan Advisory Group to develop a statewide **Prenatal through 25 Behavioral Health Strategic Plan** for equitable behavioral health for children, youth, young adults and their families. In 2024, this work was renamed the Washington Thriving project, and is collaborating with people with lived experience, families, caregivers, and key system partners to develop a Strategic Plan for submission to the Governor and Legislature by November 1, 2025.
B. Ensure the system has capacity to support people with **substance use and co-occurring disorders** across the crisis response continuum.	✓ HCA is **working to strengthen the ability of mobile crisis to respond to people with SUD** in crisis. The MRSS youth teams also conduct a standardized screening for SUD risk and refer to appropriate resources as needed. ✓ HCA is also working with the Recovery Navigator Program and Law Enforcement Assisted Diversion (LEAD) programs **to better integrate crisis response with programs addressing the needs of individuals with SUD.** These programs are also focused on serving **individuals who intersect with law enforcement and the criminal legal system** and providing behavioral health and social supports to address their underlying needs.

Recommendations	Agency and Legislative Progress
Someone to Call: C. **Support capacity of 988 Lifeline crisis centers** to respond to call, text, and chat. a. Establish a way to **identify youth help seekers** while respecting the privacy of the health seeker. b. Support continued capacity of the **Native and Strong Lifeline** to serve Washington's Tribal communities, including call, text and chat. c. **Minimize time delays** created by 988 dial-pad options (note this action would require Federal action to address). *"I called 988 to ask what I should do to help her and they suggested I call the mobile crisis team or take her to Wellfound because we're located in Tacoma." – Lived Experience Stories Project Participant*	✓ DOH **expanded the capacity of 988 Lifeline crisis centers** to respond to increasing call, text, and chat volume. Since the launch of 988 in 2022, Lifeline crisis centers have seen increases in calls by 52%, texts by 923% and chat by 238%. Similarly, the Native and Strong Lifeline and Native Resource Hub increased capacity to respond to increasing call volume for Tribal populations, with the call volume increasing by approximately 182% since the launch of the Native and Strong Lifeline in 2022. ✓ DOH is working with Tribal Partners and Vibrant to add the **text and chat option to the Native and Strong Lifeline.** ✓ DOH engaged a rulemaking process to develop **rules for designation of 988 Contact Hubs**, informed by the CRIS and input from community and Tribal listening sessions and workshops. Final rules will be effective January 1, 2025. ✓ DOH has prepared a **2025 policy decision package budget request for funding for the 988 Lifeline crisis centers** to manage projected call rates, retain sufficient staff, expand services, and maintain funding for the Native and Strong Lifeline. ✓ Each of the 988 Lifeline centers receives training for serving youth in crisis, including **strategies for building rapport and gathering age and other demographic information** while maintaining 988 policies of not requiring callers to share this information.
Somone to Come: D. **Continue expansion of adult and youth mobile crisis response services**. E. Support Tribal Partners in work to develop **Tribal mobile rapid response crisis teams and Tribal Designated Crisis Responders.**	✓ **HCA has expanded youth and adult mobile response teams** throughout the state, and created map of youth and adult teams and projected needs to identify system gaps. **Continued expansion is planned with funding authorized** by the Legislature. ✓ Dedicated youth-focused **Mobile Response and Stabilization Services (MRSS) teams have expanded** from four to 15 teams, increasing coverage from five to 21 Washington counties. There are 9 counties West of the Cascades and 12 counties East of the Cascades with youth teams. These teams provide

Recommendations	Agency and Legislative Progress
"I wish that the mobile crisis team had been more responsive to us and had actually came out to see her." – Lived Experience Stories Project Participant	developmentally appropriate services from initial crisis response through stabilization. ✓ HCA is working to support Tribes to establish **Tribal Designated Crisis Responders** and **Tribal Mobile Crisis Teams**. There are two Tribal Mobile Crisis Teams and one Tribal DCR operating in Washington, with several additional Tribes evaluating the feasibility of establishing these teams. ✓ HCA adopted rules to establish the **mobile crisis response endorsement standards** for Community-Based Crisis Teams and Mobile Rapid Response Teams, as required under HB 1134 (2023). The agency has also worked with Tribes to establish Mobile Rapid Response Team **endorsement standards and resources specific to Tribal teams,** as well as **training requirements for all endorsed teams for working with Tribal populations.** ✓ In 2023, a legislative budget proviso authorized $4 million to support the development of **fire-based co-response programs**, as well as to pilot crisis response training for firefighters and emergency medical service personnel that could be expanded statewide. During the Spring 2024, these grants were awarded to nine (9) fire departments to engage work in key innovation areas.
A Safe Place to Be F. Prioritize **crisis stabilization in the home** and expand outpatient services and resources to support this. G. Expand **peer respite services,** including working with Tribes to support development of these services. H. Develop partnerships and engage local communities to support **expansion of crisis stabilization** facilities across the state. I. Ensure that the range of state and local crisis stabilization services (e.g., peer respite, crisis receiving centers, in-patient care) are **culturally tailored for Tribal members**. In addition, Tribal partners identified opportunities to support expansion of Tribal in-patient	✓ DOH engaged process to develop **23-hour Crisis Relief Center licensure rules** by January 1, 2024, as required by SB 5120 (2023). This creates a new model for providing short-term stabilization services for adults in crisis. ✓ The Legislature passed SB 5853 (2024) to **expand Crisis Relief Center model to serve youth populations.** DOH has engaged rulemaking to support this expansion. ✓ HCA engaged **cost modeling for in-home stabilization** across the lifespan

Recommendations	Agency and Legislative Progress
facilities through strategies including additional state funding, transfer of public lands to Tribes to build a facility, and removal of licensing and certification barriers. J. **Review capacity of crisis stabilization facilities to serve people who need support for**: *a.* Co-occurring mental health and substance use disorder *b.* Intellectual and developmental disabilities *c.* Activities of daily living *d.* Minimize the use of gendered spaces that create further anxiety for non-binary and transgender people. *"I wish we had 'drop in' centers/clinics where people could access mental health counselors to talk to" – Lived Experience Stories Project Participant*	✓ HCA obtained federal approval for Medicaid coverage for up to **eight weeks of in-home stabilization for youth as part of the MRSS model,** effective January 1, 2024. This coverage **includes Tribal youth covered under Medicaid FFS**. HCA and the Office of the Insurance Commissioner are currently **working to expand coverage for commercially-insured youth from care during the initial 72-hour crisis response to the full 8 weeks of in-home stabilization services aligned with Medicaid.** ✓ The Department of Commerce has **awarded capital funds for the development of peer-respite organizations,** as authorized by HB 1394 (2019). DOH has developed rules for licensed behavioral health agencies to add peer respite to their scope. ✓ The Tribal Centric Behavioral Health Advisory Board continues to support work to build one to two **Tribally-operated Evaluation and Treatment Facilities.**
Follow Up Care K. Review current requirements for **discharge planning** to prevent people from being discharged from inpatient settings into a repeated cycle of crisis. Work with Tribal Partners to support hospital discharge planning for Tribal members that coordinates with Tribes and Indian Health Care Providers, including the development of **Tribal Care Coordination Agreements**. L. Develop **system capacity to follow up** with people who have experienced crisis, including and especially community-based	✓ Washington's 988 Centers and the Native & Strong Lifeline **received SAMHSA funding to conduct follow-up calls** for appropriate callers/texters/chatters who consent to the service within 24-72 hours of initial contact with 988. Staff must make at least 2 attempts to reach the person to provide this service and use the time to assess the person's well-being and safety, review and update risk assessment and safety plan as needed, and support coordination of care or connection to additional referrals as needed.

Recommendations	Agency and Legislative Progress
systems. Develop **standardized protocols and processes** for follow up care.	✓ HCA worked with OIC to develop the **Next-Day Appointment (NDA) referral directory** and **improved process to connect people to NDAs.**
M. Provide continued support for the **Native Resource Hub** as a centralized resource of services and supports for American Indian and Alaska Native people and Tribal communities.	✓ The **Native Resource Hub** has been established to provide a centralized resource for services and supports American Indian and Alaska Native people and Tribal communities.

"[Would like to see] ensuring seamless transition to ongoing care and support beyond the initial crisis. I hope they integrate substance use crisis response with long-term recovery resources"– Lived Experience Stories Project Participant

Prevention

In addition to the expansion of services for people in crisis, the CRIS emphasized the need to focus on system investments needed to prevent behavioral health crisis from happening in the first place. These investments in prevention are equally critical to the investments to expand and strengthen Washington's crisis response services.

> *"I couldn't find a prescriber to see me quickly, and i was truly in crisis. But I didn't want to go to the ER so went to urgent care. They told me they don't deal with behavioral health issues, so I had literally no choice other than the ER. It was devastating. I was a mess, couldn't stop crying, and was so embarrassed."*
>
> *– Lived Experience Stories project participant*

CRIS Committee members have also cited lack of basic social services, such as safe and affordable housing and health care as a key driver of behavioral health crisis. A crisis event may often be a window into basic needs that are not being addressed. While they acknowledge that investing in basic social services is outside of the scope of HB 1477, CRIS Committee members believe that doing so would be one of the most effective strategies for reducing demand for crisis response services.

Recommendations	Agency and Legislative Progress
7. Strengthen **overarching system capacity around behavioral health and suicide prevention** services to prevent behavioral health crises from happening in the first place. a. Leverage broad **community outreach and public education** to address stigma around behavioral health needs and raise awareness around 988. b. Include **investments in basic social services** and services to meet people where they are (e.g., schools, hospitals, community centers). c. Increase use of **telehealth services** to enable access to behavioral health services. d. **Partner with Tribes to ensure Tribal perspectives and priorities** are incorporated into prevention strategies.	✓ DOH **planned and launched a 988 Communications Campaign** authorized by HB 1134 (2023) to promote awareness of 988, address the stigma associated with seeking help for a behavioral health crisis, and provide culturally-attuned messages among diverse communities. To inform development of the campaign, DOH sought input from people with lived experience and representatives of rural, veteran, and agricultural communities. In addition, Tribes and DOH partnered to develop and disseminate communication materials to promote awareness of the Native and Strong Lifeline and Native Resource Hub among Tribal members. ✓ DOH is working to update the **Washington State Suicide Prevention Plan,** with an anticipated release in December 2024. As part of this process, DOH engaged a series of listening sessions

Recommendations	Agency and Legislative Progress
e. Expand coverage for **Tribal traditional healing practices** to be included in prevention, behavioral health, and crisis response services across the continuum. *"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." – Lived Experience Stories Project Participant*	in 2024 to gather input from diverse populations including Tribes, people with lived experience, agricultural workers, LGBTQIA2S+, youth ages 18-24, Veterans, and first responders. ✓ DOH has prepared a **policy decision package budget request for the 2025 legislative session to enhance DOH's suicide prevention infrastructure** for community-based coalitions and Tribes. DOH aims to establish a behavioral health prevention infrastructure statewide, focusing on perinatal infant, early childhood, and school-aged periods. The main goals include investing in suicide prevention, promoting social connectedness, preventing mental health and substance use issues, reducing stigma, improving access to behavioral health services, and easing the burden on workforce development.
8. Increase **prevention services for youth**, such as implementing social-emotional learning in schools, mental healthcare on school campuses, etc.	✓ See above for work of the **Children and Youth Behavioral Health Workgroup** to develop recommendations to the Governor and Legislature improve behavioral health services for children, youth, and young adults (prenatal to age 25) and their families. As part of this work, the **School-based Behavioral Health Subgroup** is focused on efforts to increase access to behavioral health services and supports for students and their families.

Additional Lived Experience quote(s) to be inserted

Quality and Oversight

> *"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."*
>
> *– Lived Experience Stories Project participant*

The CRIS has underscored system oversight and performance measurement as foundational for holding the system accountable to achieving Washington's goals, ensuring system transparency, and building trust with communities. In 2024, the Committee considered crisis response system performance measures currently in use in Washington and identified key priorities for performance measurement aligned with the CRIS Vision and Guiding Principles. This work underscored a common theme around the importance of engaging user input to support system accountability and ongoing quality improvement efforts. These recommendations can inform continued efforts needed to develop Washington's system performance measures and oversight.

Recommendations	Agency and Legislative Progress
9. Create a **transparent system of oversight and accountability**, including: a. System standards, performance targets, and metrics to hold the system—including 988, 911, and Regional Crisis Lines—accountable to desired outcomes and with specific attention to disparities across populations. b. Create a dashboard to display system performance metrics publicly, with the ability to break data down by age, race/ethnicity, language of care, etc. c. The system should track not just who it serves, but who it misses. d. Work with Tribes to incorporate Tribal-specific considerations to system performance and oversight and to ensure system recognition of Tribal data sovereignty.	✓ HCA and DOH developed a **Best Practice Guide** for 988 Lifeline Call Centers and Regional Crisis Lines to support common standards and best practices across crisis contact centers. Similarly, HCA developed a Best Practice Guide for Mobile Crisis Response to support common standards and adoption of SAMHSA best practices. ✓ DOH and HCA published the first **annual 988 Usage Report** in 2023, and the 2024 report will be released by the end of the year. The 2023 report provides data from July 2022 through June 2023 on the usage of the 988 Lifeline, call outcomes, and the provision of the crisis services inclusive of mobile rapid response crisis teams and crisis stabilization services. ✓ HCA and DOH developed an **inventory of crisis system metrics** currently in use in Washington across the crisis services continuum (Somone to Call, Someone to Come, A Safe Place to Be). This inventory established a baseline understanding of current and best practice measures that informed CRIS Committee and Tribal partner discussions of system quality

Recommendations	Agency and Legislative Progress
	oversight and accountability in 2024. Appendix E includes a summary of CRIS and Tribal input on **key priorities for performance measurement** aligned with the CRIS Vision and Guiding Principles. A common theme across this input centered on the **importance of engaging user** input to support system accountability and ongoing quality improvement efforts.
10. Convene and support a **mechanism to engage diverse communities and individuals with lived experience** in ongoing efforts to develop and monitor the crisis response system.	✓ The Lived Experience Subcommittee planned and implemented a **Lived Experience Stories Project** that collected stories from people across Washington state who encountered the crisis response system. Volunteers from the Lived Experience CRIS representatives read every story and developed an analysis that included key insights from the stories to inform crisis system improvement. While they acknowledged in their analysis that there were limitations to the methodology and the stories are not a representative sample of crisis system users, their hope is that the state can use the lessons learned from this project to improve the crisis system and develop an ongoing mechanism for gathering and responding to system user input.
11. Conduct **qualitative research and outreach to understand why some populations are not accessing** the crisis response system, with a focus on using creative approaches (e.g., census model) for harder to reach populations (e.g., unhoused people).	

Additional Lived Experience quote(s) to be inserted

Cross System Collaboration

Committee recommendations emphasize the need to create a unified crisis system response that offers people in crisis a true "No Wrong Door" access to care. This work involves coordination and collaboration across many system partners—988, 911, Behavioral Health Administrative Service Organizations (BH-ASOs), Regional Crisis Lines, the Native and Strong Lifeline, the Native Resource Hub, Indian Health Care Providers, Tribal crisis lines, Tribal public safety and first responders, mobile response teams, designated crisis responders, co-responder teams, and first responders (fire, emergency medical services, and law enforcement), hospitals, emergency departments, 211, and other partners. To support effective collaboration, the CRIS has underscored the importance of building trust, both with diverse communities accessing crisis services as well as across system partners. This work highlights the importance of cross-system training and other mechanisms to support collaborative relationships across the crisis response workforce.

> *"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 …"*
>
> *– Lived Experience Stories Project participant*

Recommendations	Agency and Legislative Progress
12. Encourage and foster regional collaborations that convene system partners to create regional plans and protocols for crises. a. System partners include 911, 988, Native and Strong Lifeline, BH-ASOs, RCLS, Tribal crisis lines, behavioral health providers, hospitals, Indian Health Care Providers, Native Resources Hub, mobile response teams, designated crisis responders, co-responder teams, first responders, Tribal public safety and first responders, 211, and other partners.	✓ **Regional Crisis Coordination Plans:** HCA is leading work with BH-ASOs to develop regional crisis coordination plans, as required by SB 6251 (2023). These plans will outline crisis response partner roles, responsibilities, cross-system coordination, and warm-transfer protocols. This work will build upon many regional efforts already underway to support cross-system collaboration across first responders, behavioral health and Tribal partners. ✓ In 2024, the Legislature passed **HB 1877 to improve coordination with Tribes, IHCPs, and Tribal entities in Involuntary Treatment Act processes and requirements**. These requirements are being

> *"The counselor at the crisis line also provided valuable information about local mental health services and support groups. They helped me create a safety plan and encouraged me to seek ongoing therapy."*
> *– Lived Experience Stories Project Participant*

Recommendations	Agency and Legislative Progress
	incorporated into contract requirements and ITA system forms, protocols and guidance.
13. Encourage and provide **support for ongoing collaboration between first responders and behavioral health providers** to support a safe, effective, appropriate, and unified behavioral health crisis response that minimizes law enforcement involvement. Include opportunities developed by the Behavioral Health and First Responder Collaboration Workgroup (See Appendix F). *"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."* *– Lived Experience Stories Project Participant*	✓ **Regional Crisis Workforce Resilience and Training Collaboratives:** As set forth by HB 1134 (2023), HCA is leading work with BH-ASOs to develop recommendations for regional training collaboratives that would support cross-system collaboration and the development of basic and advance skills across the first responder and behavioral health crisis system workforce. ✓ **Annual Crisis Continuum of Care Forums for Regional Partners: As directed by** HB 1134 (2023), BH-ASOs in partnership with HCA will be working to convene regional partners annually to identify and develop collaborative, regional solutions to address crisis system needs.
14. Develop **cross-system coordination protocols** that can be adapted regionally to establish warm handoffs, referrals, and common decision criteria and definitions across a range of system partners. b. This work should include support to implement **Tribal Crisis Coordination Plans** established by individual Tribes.	✓ **911-988 Diversion Initiative and Warm Transfer Protocols:** DOH is engaging the Mental Health Crisis Call Diversion Initiative, a one-year pilot focused on diverting behavioral health crisis calls that do not involve a life-threatening emergency from 911 to 988. In addition, DOH is supporting the development of standard 911-988 warm transfer protocols that may be expanded statewide and adapted regionally. These efforts include work Tribal partners to develop warm hand offs with the Native and Strong Line Lifeline and incorporate key considerations for crisis response to Tribal communities.

Recommendations	Agency and Legislative Progress
	✓ **988/RCL Policy Statement:** HCA and DOH released a RCL-988 Joint Policy Statement, developed in partnership with BH-ASOs and 988 Lifeline crisis centers, outlining recommendations to address the shift in roles of Regional Crisis Lines (RCLs) and the establishment of 988 Contact Hubs. The recommendations align with the vision of HB 1477 by establishing 988 as the primary contact number for people in crisis. HCA and DOH will continue work in partnership with BH-ASOs and 988 Lifeline crisis center to develop regional implementation plans. ✓ **988 Dispatch Protocols:** HCA and DOH worked with system partners to develop crisis response dispatch protocols that provide standard guidelines to dispatch an in-person response based on a person's level of crisis. These protocols will be incorporated and adapted to the Regional Crisis Coordination Plans (see above). ✓ **Tribal Crisis Coordination Protocols:** HCA and DOH have worked with Tribes to update the Tribal Crisis Coordination Protocol template. These protocols establish processes between individual Tribes and state, county, and local agencies, for voluntary and involuntary crisis services for Tribal members. HCA is working with Tribes to establish these protocols, as supported by HB 1877, SB 6251. In 2024, these protocols were expanded to include 988 Lifeline crisis centers. Future priorities include incorporation of 911, hospitals, and behavioral health facilities in crisis coordination agreements for Tribal members.

Recommendations	Agency and Legislative Progress
15. Pursue **youth-specific crisis system coordination**: a. Ensure youth 988 callers/chatters are connected with youth-specific resources such as Mobile Response and Stabilization Services (MRSS). b. Explore data-sharing agreements across school systems and crisis systems (with appropriate confidentiality safeguards) to provide students with better follow-up care. *"In the end he [youth] was discharged with a PRN [pro re nata (meaning as needed)] 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."* *– Lived Experience Stories Project Participant*	✓ **988 Center Youth Dispatch Protocols:** Each of the 988 centers has established protocols for connecting youth callers to youth-specific resources, including youth mobile response as well as other state and local resources. DOH, HCA, and 988 Lifeline centers are continuing to work with youth partners to strengthen protocols for serving youth.

Potential additional Lived Experience quote(s) to be inserted

Staffing and Workforce

> *"nobody is currently offering new appointments for Medicaid patients"*
> *– Lived Experience Stories Project participant*

CRIS Committee members—particularly the service providers—have raised the alarms about a workforce shortage of crisis proportions. Throughout Washington State—especially rural and remote areas—there is a critical shortage of licensed and trained professionals in the behavioral health field. This impacts both prevention and crisis response. CRIS Committee members have emphasized that this is one of the most urgent priorities for improving the crisis response system.

CRIS Committee members emphasize that Washington State needs more population-specific workforce development to ensure that people with unique needs—such as people with intellectual and/or developmental disabilities, substance use disorder, youth, Tribes, and people in rural communities—receive the care they need. Workforce strategies should also recognize the essential role of natural supports as an essential and integral part of supporting loved ones in crisis.

Recommendations	Agency and Legislative Progress
16. Establish a workgroup and engage consumer voice to develop strategies to expand and sustain a **diverse behavioral health workforce** that shares language, culture, and experience with the populations being served. Include strategies to expand the size and diversity of the workforce pipeline and address parity in salaries and burnout prevention for behavioral health workers, including peers.	✓ Several legislative **bills passed in 2023 to support expansion of the crisis system workforce** (HB 1069 Mental Health Counselor compact for out of state counselors; SB 5189 certification for behavioral health support specialists; HB 1724 helps get qualified behavioral health providers into the field as quickly and safely as possible.)

> *"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."*
> *– Lived Experience Stories Project participant*

Recommendations	Agency and Legislative Progress
17. **Integrate peers**—an essential component of the crisis response workforce—into all parts of the system. Conduct outreach to system partners to educate them on how to integrate peers and the important role that peers play in client care. Partner with Tribes to support efforts to increase the Tribal peer and behavioral health aide workforce. *"Where are the peer support counselors? Where are the people that link my ability to stay stable and well?"* *– Lived Experience Stories Project participant*	✓ SB 5555, passed during the 2023 session, **established Certified Peer Specialists and Certified Peer Specialist Trainees** as new health professions that may engage in the practice of peer support services. These voluntary credentials must be available by July 1, 2025, and DOH is currently engaged in rulemaking.
18. Engage providers and first responders across the crisis care continuum in **cross-system training** to ensure a unified crisis response across the state. a. Develop a standardized training curriculum across a core set of topic areas that may be tailored to local conditions. b. Develop evaluation to measure training outcomes and results. c. Engage Tribal partners to tailor trainings to the needs of Tribal communities. d. Engage people with lived experience in the development of training curriculum.	✓ **Regional Crisis Workforce Resilience and Training Collaboratives:** HCA is leading work with BH-ASOs to support the development of recommendations for regional training collaboratives that would support cross-system collaboration and the development of basic and advance skills across the first responder and behavioral health crisis system workforce, including training to support services for Tribal populations. ✓ **Behavioral Health Crisis Response Training Needs Assessment:** This assessment synthesizes current crisis workforce training requirements, best practices and other resources in Washington, and key gaps identified by system and Tribal partners. ✓ **Co-Responder Training Academy:** With support of legislative budget proviso funding in 2023 and 2024, the UW School of Social Work is developing Co-Responder training resources based on training gaps identified in the 2023 legislative report, *Co-Response: An Essential Crisis Service – A Landscape Analysis for the Washington State Legislature*.

Recommendations	Agency and Legislative Progress
	✓ HCA invested SAMHSA funding in a **Certified Crisis Intervention Specialist-II (CCIS-II)** statewide training for mobile response teams and other crisis responders. To date, nearly 1,000 crisis responders earned the CCIS-II credential. HCA plans to continue offering this training while expanding it to more crisis providers across the continuum. ✓ **988 Training Community of Practice:** To ensure high quality and consistent care for people in crisis reaching 988, DOH staff and 988 center trainers in Washington are working collaboratively to set statewide 988 counselor curricula.
19. Develop diverse approaches for **supporting caregivers** as a critical source of care for people in crisis. Develop systems to support families of a person in crisis, including respite care, resources to help with loss of income, and skills training to support a loved one in crisis. *"I was hoping to get connected with support for myself who was pouring into an ex from an empty cup. … 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."* *– Lived Experience Stories Project participant*	✓ HCA developed a mobile crisis response toolkit that highlights how to support caregivers for older adults. ✓ MRSS centers the caregiver and the youth and supports caregivers to keep youth safe at home whenever possible. MRSS teams can work with caregivers to connect them to supports as well as family- and youth-led peer organizations.

Recommendations	Agency and Legislative Progress
20. Expand **mental health first aid training and education for laypeople** and consider mandating age-appropriate mental health first aid training in schools.	✓ The legislature made several investments during the 2023 legislative session (SB 5187) to **expand the mental health first aid training,** including incorporating as part of a pilot program in Island County to expand behavioral health resources for youth in rural communities.

Additional Lived Experience quotes to be inserted

Technology

CRIS Committee members frequently discussed the importance of sharing data across the crisis response system, both to improve service to help seekers and track how well the system is serving (or not serving) people experiencing a behavioral health crisis. They have emphasized the importance of interoperability across systems, supporting cross-system collaboration and coordination, maintaining privacy of people seeking help, and engaging people with Lived Experience to ensure the system is designed around the people it is intended to serve. Some CRIS Committee members—including those representing rural communities—raised the need for more reliable and affordable access to internet and cell phone service.

> *"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."*
>
> *– Lived Experience Stories Project participant*

Recommendations	Agency and Legislative Progress
21. From 2021-2024, the CRIS Committee and several Subcommittees (Technology, Tribal 988, Rural & Agricultural, Geo-routing, and Lived Experience) informed DOH and HCA's work on the 988-crisis response system technology platform. Committee members emphasized the following in their feedback: A. The **user experience** needs to be simple, easy to follow, and allow people to engage in the way that is best for them (i.e., text, chat). It should also be **clearly distinct from 911**, so as not to cause confusion or concern for help seekers that calling 988 would automatically trigger a law enforcement response. B. The technology platform needs to allow for safe and secure **sharing of information** about the help seeker across the crisis response system, to **minimize the need for a help seeker to repeat their story over and over,** while maintaining and complying with privacy and consent laws.	✓ DOH and HCA have been working on a 988-crisis response system technology platform, as charged in HB 1477, with input from the CRIS Committee, Subcommittees, Tribes, 988 Lifeline crisis centers and a broad range of system partners. In 2024, the Washington State Legislature passed SB 6308 that extended the date by which funding would be made available for the technology platform from July 1, 2024, to January 1, 2026. An RFP is expected to be released by July 2025, a vendor selected by December 2025, and platform implementation by April 2027. The agencies will continue to provide updates and gather CRIS Committee and Tribal input to inform this work. ○ HCA and DOH have initiated a comprehensive feasibility study to evaluate the current vendor landscape, assess existing technologies that could be re-used and to assess the capabilities of the Vibrant 988 Unified Platform in meeting the requirements of Washington's 988 system. The results of the feasibility study will inform the Request for Proposal (RFP)

Recommendations	Agency and Legislative Progress
C. The system should set up a **central source where information about the person in crisis** can be accessed and updated by the person in crisis, authorized caregivers, and all members of their care team. This could include a **Mental Health Advanced Directive.** D. The system should simplify access to services and strengthen **support for consumers to navigate the system**. Establish a centralized **database of services and providers**. E. The technology platform should support data collection, which is important for **oversight, performance, workforce** forecasting, etc. Any data collection needs to be balanced with privacy and security, as well as an understanding that a person in crisis may not be willing or able to respond to demographic or user experience questions in the moment of crisis. Data collection must also recognize principles of **Tribal Data Sovereignty.** F. A **Tribal Consultation** government-to-government process was engaged to review the 988 Technical and Operation Plan and ensure Tribal considerations are incorporated into the 988 crisis response technology platform development. A summary of this feedback can be found in the Final Technical and Operational Plan, Appendix G (2022). G. It is critical that people contacting the 988 Lifeline crisis centers can **be assured privacy**, particularly with the implementation of **988 geo-routing capabilities** to route people to the closest 988 Lifeline crisis center based on their location rather than area code.	approach for the project, ensuring that the most effective and reliable technological solutions are selected. ○ The agencies sought input from people with lived experience, Tribes, and diverse groups to inform the 988-technology user experience and work to ensure a human-centered platform design. ✓ **Mental Health Advanced Directives:** As directed by SB 5660 (2024), HCA is working to convene a workgroup comprised of broad system partners, people with lived experience and diverse perspectives to develop recommendations for the effective implementation of MHADs in Washington. These recommendations will address storage, information sharing across partners, and training on MHAD creation and utilization. ✓ **Behavioral Health Bed Registry and Electronic Referral:** As part of the Behavioral Health Integrated Client Referral platform envision by HB 1477, HCA is working to develop and implement a behavioral health bed registry and electronic referral tools, with input behavioral health providers, people with lived experience, Tribes, and a range of system partners. ✓ **988 Geo-routing:** In 2024, the 988 Lifeline national network activated geo-routing for major wireless carriers. DOH and HCA, with input from the CRIS and Geo-routing Subcommittee, submitted comments on federal rules relating to 988 Geo-routing and supported state implementation of this federal change, including clear communications around protection of caller privacy. The agencies are also working with Tribes to ensure geo-routing supports access for Native communities to the Native and Strong Lifeline.

Additional Lived Experience quote(s) to be inserted

Funding

CRIS recommendations continued to emphasize the need for adequate funding to support equitable distribution of crisis response services across Washington. In addition to funding to support Committee recommendations, the CRIS highlighted several specific areas of focus for Washington's approach for crisis system funding summarized below.

> *"nobody is currently offering new appointments for Medicaid patients." – Lived Experience Stories Project participant*
>
> *"my daughter has received a bill for over $5,500 from Capital Medical Center [ED visit]" – Lived experience Stories Project participant*

Recommendations	Agency and Legislative Progress
22. Provide **additional funding to behavioral health crisis systems** across regions and evaluate distribution of resources to identify and address disparities. Develop a payment structure that incentivizes providers to meet performance metrics. A. Pursue **consistent funding for mobile crisis response**, rather than braided local funding to expand workforce and improve response times. B. Provide additional funding to behavioral health crisis response systems in **rural communities**. C. Consider enabling **"payer blind"** crisis services across the crisis response continuum (i.e., services not just for Medicaid clients or commercially-insured clients). D. Ensure crisis service funding to the **Medicaid fee-for-service system**, recognizing that many Tribal members are enrolled in Medicaid fee-for-service rather than managed care.	✓ In 2024, HCA contracted with Milliman to conduct an actuarial analysis of **Mobile Crisis Response Payment Options** for endorsed mobile response teams. The payment model for endorsed teams included three components: grants to support teams to become endorsed, enhanced rates for endorsed teams, and performance payments for endorsed teams that meet the time thresholds specified in the HB 1134 (2023). The report provides a range of cost scenarios for further development of enhanced rates and performance payments for endorsed teams. ✓ HCA convened a workgroup with system partners per a 2023 budget proviso to **assess gaps in the current funding model for crisis services and recommend options** to address these gaps. A preliminary report was submitted to the legislature and Governor in early 2024, with a final report to be completed by December 2024. ✓ HCA and the Washington Office of the Insurance Commissioner (OIC) are implementing recommendations **to support processes to bill commercial insurers for behavioral health emergency**

Recommendations	Agency and Legislative Progress
	response services, as guided by the multi-partner HB 1688 Behavioral Health Crisis Services Workgroup. This includes developing the technical infrastructure to support access to enrollment and eligibility information and information sharing.

"...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 an 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 months 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." – Lived experience Stories Project participant

Additional Lived Experience quote(s) to be inserted.

What's Next

The CRIS Committee and Subcommittees have done extensive work over the past three years to develop recommendations to advance their vision for the statewide crisis response system. Furthermore, state agencies, Tribes, 988 Lifeline crisis centers, 911 and first responder partners, BH-ASOs, providers, and the Legislature have made progress on addressing many of these recommendations and this work will continue into the future.

While recognizing the progress that has been made, there is still more work to be done. This report is intended to inform continuing work by the CRIS, Washington's Legislature, state agencies, Tribes, providers and crisis response system partners, community groups, and others to advance efforts to improve Washington's crisis response system.

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 the 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."*

~ Lived Experience Stories Project Participant

Potential additional Lived Experience quote(s) to be inserted.

Appendices

Appendix A. Definitions for Terms Related to Crisis Delivery

Crisis Relief Center: Also known as **23-hour crisis relief center**. means a community-based facility or portion of a facility serving adults, which is licensed or certified by the department of health and open 24 hours a day, seven days a week, offering access to mental health and substance use care for no more than 23 hours and 59 minutes at a time per patient, and which accepts all behavioral health crisis walk-ins drop-offs from first responders, and individuals referred through the 988 system regardless of behavioral health acuity, and meets the requirements under RCW 71.24.916. *See* RCW 71.24.025(1)

911: The universal emergency number across the US that typically dispatches to local police, fire, or sheriff departments.

988 Contact Hubs: Also known as **Crisis Contact Hubs**. A state-designated contact center that streamlines clinical interventions and access to resources for people experiencing a behavioral health crisis and participates in the national suicide prevention lifeline network to respond to statewide or regional 988 contacts that meets the requirements of RCW 71.24.890

988 Lifeline: Also known as **988 crisis hotline**. The universal telephone number within the United States designated for the purpose of the national suicide prevention and mental health crisis hotline system operating through the national suicide prevention lifeline (RCW 71.24.025). *See* RCW 71.24.025(2)

Behavioral Health Aide: means a counselor, health educator, and advocate who helps address individual and community-based behavioral health needs, including those related to alcohol, drug, and tobacco abuse as well as mental health problems such as grief, depression, suicide, and related issues and is certified by a community health aide program of the Indian health service or one or more tribes or tribal organizations consistent with the provisions of 125 U.S.C. Sec. 1616l and RCW 43.71B.010 (7) and (8). *See* RCW 71.24.025(9)

Behavioral health provider: means a person licensed under chapter **18.57**, 18.71, 18.71A, 18.83, 18.205, 18.225, or **18.79** RCW, as it applies to registered nurses and advanced registered nurse practitioners. *See* RCW 71.24.025(10)

Behavioral health administrative services organization: means an entity contracted with the authority to administer behavioral health services and programs under RCW **71.24.381**, including crisis services and administration of chapter **71.05** RCW, the involuntary treatment act, for all individuals in a defined regional service area. *See* RCW 71.24.025(8)

Community-based Crisis Team: A team that is part of an emergency medical services agency, a fire service agency, a public health agency, a medical facility, a nonprofit crisis response provider, or a city or county government entity, other than a law enforcement agency, that provides the on-site community-based interventions of a mobile rapid response crisis team for individuals who are experiencing a behavioral health crisis. *See* RCW 71.24.025(18)

Crisis Stabilization Facility: Also referred to as **crisis stabilization unit.** A short-term facility or a portion of a facility licensed or certified by the department, such as an evaluation and treatment facility or a hospital, which has been designed to assess, diagnose, and treat individuals experiencing an acute crisis without the use of long-term hospitalization, or to determine the need for involuntary commitment of an individual. *See* RCW 71.05.020(14)

Crisis Stabilization Services: Means services such as 23-hour crisis relief centers, crisis stabilization units, short-term respite facilities, peer-run respite services, and same-day walk-in behavioral health services, including within the overall crisis system components that operate like hospital emergency departments that access all walk-ins, and ambulance, fire, and policy drop-offs, or determine the need for involuntary hospitalization of an individual (RCW 71.24.025).

Designated crisis responder: means a mental health professional appointed by the county, by an entity appointed by the county, or by the authority in consultation with a tribe or after meeting and conferring with an Indian health care provider, to perform the duties specified in this chapter. *See* RCW 71.05.020(17)

EMS- and Law Enforcement-Based Co-Response: Behavioral health and other human service professionals embedded within the emergency response system. Typically, field-based teams that respond to calls for service involving clients with behavioral health issues and complex medical needs with the goal of diverting people from the criminal justice and emergency medical systems. *See* University of Washington, Report to the Legislature: Co-Response An Essential Crisis Service (2023)

Evaluation and Treatment Facility: means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the Department of Health. The Health Care Authority may certify single beds as temporary evaluation and treatment beds under RCW 71.05.745. A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility. *See* RCW 71.05.020(24)

Emergency Medical Services (EMS): Also considered first responder services, EMS are typically ambulance or paramedic services, and operate within a system of coordinated response and emergency medical care that is integrated with other services and systems with the goal to maintain and enhance the community's health and safety.[7]

First responders: includes ambulance, fire, mobile rapid response crisis team, co-responder team, designated crisis responder, fire department mobile integrated health team, community assistance referral and education services program under RCW 35.21.930, and law enforcement personnel. *See* RCW 71.24.025(32)

Historical Trauma: The Washington Community Behavioral Health Services Act defines "historical trauma" as situations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were perpetuated by outsiders with a destructive or genocidal intent.

Hospital Emergency Departments (ED): The department of a hospital responsible for the providing medical and surgical care to patients arriving at the hospital in need of immediate care. The emergency department is also called the emergency room or ER.[8]

[7] Office of EMS, *What is EMS?*, Available at https://www.ems.gov/whatisems.html
[8] MedicineNet, *Medical Definition Of Emergency Department* (2021) available at https://www.medicinenet.com/emergency_department/definition.htm

Indian Health Care Provider: means a health care program operated by the Indian health service or by a tribe, tribal organization, or urban Indian organization as those terms are defined in the Indian health care improvement act (25 U.S.C. Sec. 1603). *See* RCW 71.24.025(34)

Involuntary Treatment Act Investigation: The DCR conducts an evaluation and investigation pursuant to chapters 71.05 and 71.34 RCW. This investigation is conducted to determine if a person presents a harm to self, others, property; needs assisted outpatient behavioral health treatment; is gravely disabled and at imminent risk; or has a nonemergent risk due to a substance use disorder or other behavioral health condition.[9]

Licensed or certified behavioral health agency means:
(a) An entity licensed or certified according to this chapter or chapter **71.05** RCW;
(b) An entity deemed to meet state minimum standards as a result of accreditation by a recognized behavioral health accrediting body recognized and having a current agreement with the department; or
(c) An entity with a tribal attestation that it meets state minimum standards for a licensed or certified behavioral health agency. *See* RCW 71.24.025(36)

Mobile Rapid Response Crisis Team: Also known as **mobile crisis response team** or **mobile crisis team.** Means a team that provides professional on-site community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for individuals who are experiencing a behavioral health crisis, that shall include certified peer counselors as a best practice to the extent practicable based on workforce availability, and that meets standards for response times established by the Health Care Authority. *See* RCW 71.24.025(43)

Mobile Response and Stabilization Services: A Mobile Rapid Response Crisis Team that provides developmentally appropriate crisis outreach when youth and families ask for help. MRSS is screened in, not out, and breaks down barriers to care by allowing the caller to define the crisis. This promotes upstream interventions designed to interrupt the pathways leading to more restrictive, facility-based care and emergency department use for behavioral health needs. Teams can follow up for 8 weeks to stabilize the family and keep youth safe at home.

Native and Strong Lifeline: Is the 988 Lifeline available for American Indian and Alaska Native people and Tribal communities in Washington. For further information, please see Native and Strong Lifeline (nativelifeline.org)

Native Resource Hub: Is a phone line that offers central place for American Indian and Alaska Native people and Tribal communities in Washington to find a range of resources to support physical, behavioral health and social needs. See Native Resource Hub (nativehub.org).

Peer Respite: A peer-run facility to serve people in need of voluntary, short-term, non-crisis services that focus on recovery and wellness. (RCW 71.24.025).

Psychiatric Hospital Beds: Inpatient mental health facilities where people may go voluntarily or involuntarily.

Public Safety Answer Point (PSAP): means the public safety location that receives and answers 911 voice and data originating in a given area as designated by the county. *See* RCW 38.52.010

[9] Washington State Health Care Authority, *Designated Crisis Responders* (2021) available at https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/designated-crisis-responders-dcr

Regional crisis line: means the behavioral health crisis hotline in each regional service area which provides crisis response services 24 hours a day, seven days a week, 365 days a year including but not limited to dispatch of mobile rapid response crisis teams, community-based crisis teams, and designated crisis responders. *See* RCW 71.24.025(45)

Appendix B. History of Tribal Centric Behavioral Health Crisis System Efforts

Tribes have a longstanding history with barriers in accessing needed crisis services for their Tribal members. Washington State's movement towards managed care and crisis services supported through a county and regional system did not provide resources to Tribal governments to fund services to members within their communities. Issues relate to access to timely services, honoring of Tribal court orders and clinical assessments, and funding to support Tribal crisis resources. The Tribes have worked with the state to advocate and develop plans to:

- Improve crisis services for Tribal members and urban Native people across the state
- Address longstanding barriers to access to care and the significant crisis and mental health outcomes for AI/AN people

AI/AN people and families navigating behavioral health crises experience extensive wait times for ITA evaluations and mobile crisis response. At times, the Tribe may not agree with the DCR's ITA evaluation of a Tribal member.

In 2013, the Tribes, Indian Policy Advisory Committee, and the Department of Social and Health Services developed a report to the legislature that outlined the following crisis improvement recommendations to improve the Tribal Centric Crisis System:

- Timely and equitable access to crisis services for AI/AN people
- Improved ability to have designated crisis responders (formally DMHPs)
- Notification and coordination by evaluation and treatment facilities when discharging AI/AN people from care
- Legislation to allow Tribal courts to issue ITA commitments for Tribal citizens
- Training for non-Tribal DCRs for evaluations of AI/AN people
- Conduct feasibility study for one or more E&T facilities to serve AI/AN people in need of inpatient psychiatric care

Building on these recommendations, Tribes have led continued efforts to pass legislation in Washington to address inequities experienced by Tribal members in the crisis response system through the Indian Health Improvement Act in 2019 (RCW 43.71B)[10] and the Indian Behavioral Health Actin 2020 (SB 6259).[11]

Since 2016, Tribes have partnered with the State to support planning and work to build one or more E&T facilities per the recommendation of the 2013 report. The Tribes met to establish a workgroup in 2017 and developed a robust plan outlining goals and activities to address crisis services for AI/AN people and create a successful culturally appropriate behavioral health crisis facility. Activities put into action by the workgroup include:

[10] Washington State Senate Bill 5415, 2019. Accessed at: https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Senate%20Passed%20Legislature/5415.PL.pdf
[11] Washington State Senate Bill 6259, 2020. Accessed at https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/6259-S.SL.pdf?q=20211115124634

- Continued planning on the development of a culturally appropriate Tribal inpatient behavioral health facility managed by the TCBHAB.
- Development of Tribal DCRs (T-DCR), appointed by the tribe and appointed by HCA for state jurisdiction processes, that can evaluate anywhere and with anyone in the state.
- Funding support for T-DCR services.
- Legislation to enhance Tribes' ability to provide crisis services to their Tribal and community members, including notification to tribes for ITA investigations of Tribal members and AI/AN people with an Indian Health Care Provider (IHCP) as a medical home.[12]
    - Training and technical assistance to Tribes and IHCPs on enhancing crisis services, including development of T-DCR Tribal Codes, DCR processes and procedures/T-DCR protocols, operationalization of T-DCR, tabletop exercise for tribes.
    - Training and technical assistance to non-Tribal crisis providers and DCRs on working with AI/AN people and Tribal communities, including reviewing and providing feedback on the DCR protocols.
    - Improvements to the Tribal Crisis Coordination Protocols template and processes.
    - The Native and Strong Lifeline and Native Resource Hub.
- Establishment of a formal Tribal Centric Behavioral Health Advisory Board (TCBHAB) to oversee these activities

In addition to the statewide Tribal/state crisis improvement projects, the 29 Tribes are at different stages of implementation of crisis services. Under the self-determination act, Tribes have moved toward implementation of crisis services for their Tribal and community members. Several Tribes have crisis lines available either on a workday basis or 24/7 basis. Several Tribes are working on establishing Tribal designated crisis responders who will conduct ITA evaluation and investigations through the state system as well as through their Tribal court systems. Tribes are also exploring mobile crisis response teams and crisis facilities.

Since 2021, the Tribal 988 Subcommittee, through the Tribal Centric Behavioral Health Advisory Board, has collaborated with the CRIS and Steering Committee to help ensure Tribal perspectives are brought forward into CRIS recommendations to improve Washington's behavioral health crisis response system. In addition, carrying out the work of HB 1477, the CRIS Steering Committee has recognized the sovereign authorities of Tribal governments, and initiated a Tribal Consultation process to ensure Tribal perspectives and priorities are integrated throughout the Committee recommendations.

[12] Senate Bill 6259 (2020, enrolled). Retrieved from https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/6259-S.SL.pdf?q=20221127130523

Appendix C: Summary of Tribal Recommendations

In carrying out the work of HB 1477, the Steering Committee has recognized the sovereign authorities of Tribal governments. In 2022 and 2023, the Steering Committee initiated a formal Tribal consultation process. In addition, the Tribal 988 Subcommittee, through the Tribal Centric Behavioral Health Advisory Board, has collaborated with the CRIS and Steering Committee throughout the committee process to ensure Tribal perspectives are brought forward into CRIS recommendations to improve Washington's behavioral health crisis response system.

This Appendix C provides a summary of Tribal recommendations that are integrated throughout the body of the Committee Final Report. Please note that the summary includes language that is excerpted from the Committee Recommendations.

Summary of Tribal Recommendations Integrated Throughout the HB 1477 Committee Final Report (January 1, 2025)		Page #
Letter from the Steering Committee	*To be inserted*	
Acronyms	○ AI/AN American Indian or Alaska Native people ○ AIHC American Indian Health Commission ○ IHCP Indian Health Care Provider ○ NSLL Native and Strong Lifeline ○ TCBHAB Tribal Centric Behavioral Health Advisory Board ○ UIHO Urban Indian Health Organization (also referred to an Urban Indian Health Program or UIHP)	Page 1
Executive Summary		
Vision	○ CRIS Vision and Guiding Principles include: • Care that is responsive to cultural needs • System that is operated in a manner that honors Tribal government to government process.	Page 2
Progress to Date	○ The Native and Strong Lifeline launched in 2022 and has become an exemplar for other crisis response systems across the U.S.	Page 3
Recommendations	○ Summary of recommendations 'At-a-Glance'	Pages 3-4
Background		
Committee Structure	○ Recognizes sovereign authorities of Tribal governments and the engagement of Tribal Consultation. ○ Visual committee structure inclusion of Tribal 988 Subcommittee to inform Committee throughout the process to develop recommendations on Tribal priorities and considerations.	Pages 5-6
Tribal Consultation	○ Recognizing role of Tribal 988 Subcommittee through the Tribal Centric Behavioral Health Advisory Board to integrate	Pages 6-7

Summary of Tribal Recommendations Integrated Throughout the HB 1477 Committee Final Report (January 1, 2025)			Page #
	Tribal perspectives and priorities throughout CRIS Recommendations. ○ Recognizing the sovereign authorities of Tribal governments and the existing processes and governing bodies in place to address Tribal behavioral health and crisis system needs and gaps, the Steering Committee with HCA and DOH also engages in Tribal Consultation.		
Vision for the Crisis Response System			
Vision and Guiding Principles	○ Vision and guiding principles informed by Tribes during 2022 process to develop. ○ CRIS vision and Guiding Principles include: ▪ Care that is responsive to cultural needs ▪ System that is operated in a manner that honors Tribal government to government process.		Page 8
Recommendations, Process to Date, and Remaining Gaps			
Recommendation Area	**Recommendation**	**Agency and Legislative Progress**	
E. Promoting Equity	*Recommendation #2:* Ensure equity in behavioral health crisis and suicide prevention services across the state. Establish a 988 Diversity, Equity, and Inclusion Director to bring a statewide perspective, as well as **include appropriate Tribal government-to-government relations** and work with Tribal liaison across the state. *Recommendation #4:* Build upon **Tribal Behavioral Health Crisis System improvements** and ensure Tribal partners are recognized and **connected in the state and local crisis response systems**.	✓ The **Tribal 988 Subcommittee, through the Tribal Centric Behavioral Health Advisory Board,** has collaborated with the CRIS and Steering Committee to help ensure Tribal perspectives are brought forward into CRIS recommendations and agency implementation efforts to improve Washington's behavioral health crisis response system. In addition, the Steering Committee engaged a formal **Tribal Consultation** process in 2022 and 2023 on Committee recommendations. Progress on Tribal behavioral health crisis response priorities and progress is **highlighted throughout the Committee's**	Pages 9-10

Summary of Tribal Recommendations Integrated Throughout the HB 1477 Committee Final Report (January 1, 2025)			Page #
		recommendations outlined in the sections to follow.	
F. Services	*Recommendation #6:* Ensure there are crisis response services available in all regions so that people have access to care wherever and whenever needed. ▪ *Someone to Call:* Support continued capacity of the **Native and Strong Lifeline** to serve Washington's Tribal communities, including call, text and chat. ▪ *Somone to Come:* Support Tribal Partners in work to develop **Tribal mobile rapid response crisis teams** and **Tribal Designated Crisis Responders.** ▪ *A Safe Place to Be:* Ensure that the range of **state and local crisis stabilization services (e.g., peer respite, crisis receiving centers, in-patient care) are culturally tailored for Tribal members**. Work with Tribes to **support development of peer respite services.** In addition, Tribal partners identified opportunities to support **expansion of Tribal in-patient facilities** through strategies including additional state funding, transfer of public lands to Tribes to build a facility, and removal of licensing and certification barriers.	*Someone to Call* ✓ **Launch of the Native and Strong Lifeline** in 2022 and continued growth. ✓ Addition of **text and chat option** to the Native and Strong Lifeline in 2024. ✓ DOH engaged a rulemaking process to develop **rules for designation of 988 Contact Hubs**, informed by the CRIS and **input from community and Tribal listening sessions** and workshops. Final rules will be effective January 1, 2025. ✓ DOH **policy decision package for 2025** to request funding for projected increased call rates and support for the Native and Strong Lifeline. *Someone to Come* ✓ HCA is working to support Tribes to establish **Tribal Designated Crisis Responders** and **Tribal Mobile Crisis Teams**. There are two Tribal Mobile Crisis Teams and one Tribal DCR operating in Washington, with several additional Tribes evaluating the feasibility of establishing these teams. ✓ HCA adopted rules to establish establish Mobile Rapid Response Team **endorsement standards and resources specific to Tribal teams**, as well as	Pages 11-15

Summary of Tribal Recommendations Integrated Throughout the HB 1477 Committee Final Report (January 1, 2025)			Page #
	▪ *Follow Up Care:* Work with **Tribal Partners to supports hospital discharge planning for Tribal members** that coordinates with Tribes and Indian Health Care Providers, including the development of **Tribal Care Coordination Agreements**. Provide continued support for the **Native Resource Hub** as a centralized resource of services and supports for Tribal populations.	**training requirements for all endorsed teams for working with Tribal populations.** *A Safe Place to Be* ✓ The Tribal Centric Behavioral Health Advisory Board continues to support work to build one to two **Tribally-operated Evaluation and Treatment Facilities.** *Follow Up Care* ✓ The **Native Resource Hub** has been established to provide a centralized resource for services and supports for Tribal populations.	
G. Prevention	*Recommendation #7:* Strengthen **overarching system capacity around behavioral health and suicide prevention** services to prevent behavioral health crises from happening in the first place. a. Leverage broad community outreach and public education. b. Include investments in basic social services. c. Increase use of telehealth services. d. **Partner with Tribes to ensure Tribal perspectives and priorities** are incorporated into prevention strategies. e. Expand coverage for **Tribal traditional healing practices** to be included in	✓ DOH planned and launched a 988 Communications Campaign. In addition, Tribes and DOH partnered to develop and disseminate **communication materials to promote awareness of the Native and Strong Lifeline and Native Resource Hub** among Tribal members. ✓ DOH is working to update the **Washington State Suicide Prevention Plan.** As part of this process, DOH engaged a series of **listening sessions in 2024 to gather input from Tribes.** ✓ DOH has prepared a **policy decision package budget request for the 2025** legislative session to	Pages 16-17

Summary of Tribal Recommendations Integrated Throughout the HB 1477 Committee Final Report (January 1, 2025)			Page #
	prevention, behavioral health, and crisis response services across the continuum.	**enhance DOH's suicide prevention infrastructure** for community-based coalitions and **Tribes.**	
H. Quality and Oversight	*Recommendations #9:* Create a **transparent system of oversight and accountability**, including: a. System standards, performance targets, and metrics. b. Create a dashboard to display system performance metrics publicly. c. Track not just who the system serves, but who it misses. d. Work with **Tribes to incorporate Tribal-specific considerations to system performance and oversight** and to ensure system recognition of **Tribal data sovereignty**.	✓ See Appendix E for a summary of CRIS and **Tribal input on key priorities for performance measurement** aligned with the CRIS Vision and Guiding Principles.	Pages 18-19
I. Cross-System Collaboration	*Recommendation 12:* **Encourage and foster regional collaborations** that convene system partners to create regional plans and protocols for crises. a. System partners include 911, 988, **Native and Strong Lifeline**, behavioral health providers, **Indian Health Care Providers, Native Resources Hub,** mobile response teams, co-responder teams, **Tribal public safety and first responders,** first responders, **local Tribal crisis lines,** Regional Crisis Lines, BH-ASOs, hospitals, 211, and other crisis system partners.	✓ **Regional Crisis Coordination Plans:** HCA is leading work with BH-ASOs to develop regional crisis coordination plans. This work will build upon many regional efforts already underway to support cross-system collaboration across first responders, behavioral health and **Tribal partners.** ✓ In 2024, the Legislature passed **HB 1877 to improve coordination with Tribes, IHCPs, and Tribal entities in Involuntary Treatment Act processes and requirements**. These requirements are being incorporated into contract requirements and ITA	Pages 20-22

Summary of Tribal Recommendations Integrated Throughout the HB 1477 Committee Final Report (January 1, 2025)			Page #
	Recommendation 14: Develop **cross-system coordination protocols** that can be adapted regionally to establish warm handoffs, referrals, and common decision criteria and definitions across a range of system partners. This work should include support to implement **Tribal Crisis Coordination Plans** established by individual Tribes.	system forms, protocols and guidance. ✓ DOH is supporting the development of standard **911-988 Warm Transfer Protocols, including work with Tribal partners** to develop warm hand offs with the Native and Strong Line Lifeline and incorporate key considerations for crisis response to Tribal communities. ✓ **Tribal Crisis Coordination Plans:** HCA and DOH have worked with Tribes to update the Tribal Crisis Coordination Plan template, and to establish these plans. In 2024, these plans were expanded to include 988 Lifeline crisis centers. Future priorities include incorporation of 911, hospitals, and behavioral health facilities in crisis coordination agreements for Tribal members.	
J. Staffing and Workforce	*Recommendation #17:* **Integrate peers**—an essential component of the crisis response workforce—into all parts of the system. Partner with Tribes to support efforts to **increase the Tribal peer and behavioral health aide workforce.** *Recommendation #18:* Engage providers and first responders across the crisis care continuum in **cross-system training** to ensure a unified crisis response across the state.	✓ **Regional Crisis Workforce Resilience and Training Collaboratives:** HCA is leading work with BH-ASOs to support the development of recommendations for regional training collaboratives that would support cross-system collaboration and the development of basic and advance skills across the first responder and behavioral health crisis	Pages 23-25

Summary of Tribal Recommendations Integrated Throughout the HB 1477 Committee Final Report (January 1, 2025)			Page #
	a. Develop a standardized training curriculum across a core set of topic areas that may be tailored to local conditions. b. Develop evaluation to measure training outcomes and results. c. Engage **Tribal partners to tailor trainings** to the needs of Tribal communities. d. Engage people with lived experience in the development of training curriculum.	system workforce, including **training to support services for Tribal populations.** ✓ **Behavioral Health Crisis Response Training Needs Assessment:** This assessment synthesizes current crisis workforce training requirements, best practices and other resources in Washington, and key gaps identified by system **and Tribal Partners.**	
K. Technology	*Recommendation #21:* From 2021-2024, the CRIS Committee and several Subcommittees (Technology, **Tribal 988,** Rural & Agricultural, Geo-routing, and Lived Experience) informed DOH and HCA's work on the 988-crisis response system technology platform. Data collection must recognize principles of **Tribal Data Sovereignty.** A **Tribal Consultation** government-to-government process was engaged to review the 988 Technical and Operation Plan and ensure Tribal considerations are incorporated into the 988 crisis response technology platform development. A summary of this feedback can be found in the **Final Technical and Operational Plan, Appendix G (2022).**	✓ DOH and HCA have been working on a 988-crisis response system technology platform, as charged in HB 1477, with input from the CRIS Committee, Subcommittees, Tribes, 988 Lifeline crisis centers and a broad range of system partners. In 2024, the Washington State Legislature passed SB 6308 that extended the date by which funding would be made available for the technology platform from July 1, 2024, to January 1, 2026. An RFP is expected to be released by July 2025, a vendor selected by December 2025, and platform implementation by April 2027. The agencies will continue to provide updates and gather CRIS Committee and **Tribal input** to inform this work. ✓ As part of the **Behavioral Health Integrated Client Referral platform** envision	Pages 26-27

Summary of Tribal Recommendations Integrated Throughout the HB 1477 Committee Final Report (January 1, 2025)			Page #
		by HB 1477, HCA is working to develop and implement a behavioral health bed registry and electronic referral tools, with input behavioral health providers, people with lived experience, **Tribes**, and a range of system partners. ✓ 988 Geo-routing: HCA and DOH are **working with Tribes to ensure geo-routing supports access for Native communities to the Native and Strong Lifeline.**	
L. Funding	*Recommendation #22:* Provide **additional funding to behavioral health crisis systems** across regions and evaluate distribution of resources to identify and address disparities. Develop a payment structure that incentivizes providers to meet performance metrics. Ensure crisis service funding to the **Medicaid fee-for-service system, recognizing that many Tribal members** are enrolled in Medicaid fee-for-service rather than managed care.	✓ See above for progress on resources for the **Native and Strong Lifeline, endorsed Tribal mobile crisis response teams**, and **inpatient Tribal treatment facilities.**	Pages 28-29
What's Next			
What's Next	*Summary to be added based on CRIS and Tribal Input*		Pages 30-31
Appendices			
Appendix A: Definitions	○ Historical Trauma ○ Indian Health Care Provider ○ Native and Strong Lifeline ○ Native Resource Hub		Pages 33-36
Appendix B: History of Tribal Centric Behavioral	○ Brief overview of Tribal efforts to improve behavioral health crisis response for Tribal communities.		Pages 37-38

Summary of Tribal Recommendations Integrated Throughout the HB 1477 Committee Final Report (January 1, 2025)		Page #
Health Crisis System Efforts		
Appendix C: Summary of Tribal Recommendations	○ Summary of Tribal recommendations.	Pages 39-46
Appendix D: Lived Experience Stories Project	○ Overview of the Lived Experience Stories Project	Pages 47-49
Appendix E: Summary of CRIS and Tribal Input on System Performance Metrics	○ See Table for summary of input on Tribal-specific measures.	Pages 50-60
Appendix F: Behavioral Health Crisis Response and First Responder Collaboration Workgroup Recommendations	○ Workgroup included Tribal representatives	Pages 61-64

Appendix D. Lived Experience Stories Project Summary

Purpose:
The Lived Experience Subcommittee of the CRIS committee sought to broaden their work of elevating lived experience (LE) stories to inform the Washington Behavioral Health Crisis Response System. While they have been inviting members of the community with lived experience to attend meeting and share their personal stories, they understood the barriers and limitations that keep some people from sharing their stories. To expand the number and diversity of lived experience stories, the Lived Experience Stories Project was created.

Key Findings:
The overall findings can be found by reviewing the Lived Experience Stories Project presentation to the CRIS committee at their September 24, 2024 meeting, or watching the video presentation of the project findings.

In total, the analysis team elevated 7 key insights:

1. Criminal Justice System and Emergency Departments were functioning as primary access points to behavioral health care
2. Barriers to access include insurance, cost, lack of providers, and 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 the cracks
6. Follow-up and Prevention are pillars that need 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 the crisis response system.

Methods:
Lived experience stories were solicited from anyone who had previous experience interacting with the Washington Behavioral Health Crisis Response system within the last two years. A general call for stories was released through multiple recruitment channels and stories were collected over a two-month period (June 1, 2024 – July 31, 2024). Stories were collected through virtual submissions via Qualtrics along with a standardized participant demographic collection form. Community members also had the option of contacting HMA staff to arrange to share their stories via audio or Zoom recording. Stories submitted through this manner were than transcribed for analysis. Participants also had the option of submitting stories and data in Spanish. Participants were eligible to receive a gift card in recognition of the emotional labor and time involved in submitting their stories.

Once collected, story submissions were reviewed for completeness and to ensure alignment with project purpose. Several submissions were excluded from analysis due to:

- Incomplete submissions (story was missing)
- Falling outside our last two-year time frame
- Did not involve accessing the Behavioral Health Crisis Response System in Washington
- Appeared to be fake submissions to get a gift card

Data analysis was conducted by HMA staff and two members of the Lived Experience Subcommittee. Each story was reviewed by at least two members of the analysis team. Stories were reviewed at a

minimum of four times, one for each analysis element (expectations of the system, experience of the system, barriers to access, and facilitators of access) and quotes pulled and organized by service type and themes. Analysis team members then met multiple times to check for resonance across reviewers and to identify insights to inform CRIS recommendations for the Washington Behavioral Health Crisis Response System.

Data Collected:
In addition to personal stories, each participant completed an accompanying demographic collection form. Demographics collected included:

- Age
- Race
- Disability
- Veteran status
- Gender identity
- Sexual orientation
- Housing status
- Experience accessing the Washington Behavioral Health System
- Engagement with the following systems:
    - Corrections
    - Foster care
    - Immigration
    - Mental health
    - Substance use

While over 148 submissions were received, only 65 were identified as complete or valid submissions and analyzed.

Project Limitations:
The project team established the following project expectations and limitations.

What this project is…	What this project isn't
A way of elevating the stories of people with lived experience	A large research study or evaluation
A small sample of stories from people who were able to submit	A robust or necessarily representative sample
Both/and – this is another way of incorporating voices from people with lived experience, not a replacement for other efforts	A replacement for the voices and stories of people already engaged in the CRIS process

Additional limitations/considerations identified by the project team included:

- The point of this project was to create pathways for lived experience to inform the CRIS project – therefore we talk about insights rather than themes as we are not trying to quantify people's experience or make sweeping conclusions from our findings
- The story collection period was limited for the purposes of this project. Additional outreach efforts and time could have yielded many more stories

- People who had primarily negative experiences accessing the behavioral health system may be more likely to share their experiences with the project. The project still received stories of times when people's needs were being met, and highlighted examples of when the system is working.
- While a diverse sample of individuals participated in the project, the team recognized that the project was unlikely to reach people while actively in crisis.

Appendix E. Summary of CRIS and Tribal Input on System Performance Measurement Aligned with the CRIS Vision and Guiding Principles

The table A below summarizes CRIS and Tribal Partner input on crisis system performance measurement indicators aligned with the CRIS vision and guiding principles for Washington's behavioral health crisis response system. The table summarizes the discussion of the "meaning" of each guiding principles, and potential ways to "measure" the system is meeting these expectations. This input can inform continued efforts needed to develop Washington's system performance measures and oversight.

Table A. Summary of Tribal Input on System Performance Aligned with the CRIS Vision and Guiding Principles

Guiding Principle	Meaning	Measurement
People in crisis experience timely access to high-quality, coordinated care without barriers.	We determine what "timely" means, depending on the service, and people in crisis receive services in a timely manner.	Identify targets for providing 1) initial, live response and 2) trained behavioral health response for each type of service and measure whether system is meeting these targets.
	Responders know the system, know what services a person in crisis has already received, and are able to provide informed referrals.	Track how many transitions a person makes before they get the service they need.
		Gather client/customer/consumer satisfaction surveys to ask whether people who accessed the system received a "high-quality service" (i.e., they felt the service was helpful, met their needs, and met their expectations for timeliness).
	Youth have access to evidence-based intervention (e.g., Mobile Response and Stabilization Services - MRSS)	Percent or number of youth who accessed the system who were connected to MRSS.
	Translation services are available to anyone who needs them.	Track how often people ask for help in a language other than English, which language, and whether or not they are able to receive that language support.
	Crisis response workforce (e.g. 988 centers, regional crisis lines, mobile crisis responders, first responders, hospitals, and others) is trained in how to connect AI/AN populations to the Native & Strong Lifeline, Native Resources Hub, and other Tribal resources.	Monitor number of referrals to the Native & Strong Lifeline and Native Resources Hub.

Guiding Principle	Meaning	Measurement
	Tribal Crisis Coordination Plans are followed and implemented for Tribal members.	Monitor implementation of Tribal Crisis Coordination Plans.
People in crisis experience a welcoming response that is healing, trauma-informed, provides hope, and ensures people are safe.	People who accessed the system feel like it was valuable for them to use the services and that they benefited from the services.	Gather qualitative feedback from users about how they experienced the system, e.g., whether it felt trauma-informed, healing, and hopeful; whether they would use it again if they had another crisis.
	People who accessed the system see themselves reflected in the people providing services, meaning the providers may have shared identities with the people they are serving and/or lived experience.	Monitor demographics of workforce--including whether they have lived experience (recognizing that there are privacy limits to what we can ask)
	Responses are appropriately matched to the need, e.g., use of first responders is avoided when a behavioral health response is sufficient.	Monitor first responder vs. behavioral health deployments for appropriateness.
	Users know what they are consenting to when they ask for help.	
	The physical environment (i.e., the facility) is well kept and demonstrates care for individuals in crisis.	Physical space assessments
	AI/AN populations accessing the system see themselves reflected in the people providing services across the crisis continuum.	Monitor demographics of workforce; number of Tribal DCRs; number of endorsed Tribal mobile response teams; number of Native and Strong Lifeline Native counselors, Native peers
	Crisis Response Workforce is trained in providing culturally-responsive, welcoming, trauma-informed, and healing care.	Monitor trainings received by workforce.
		Workforce development measures, such as hiring of BHAs, or BHA/apprenticeship crossovers. Native student spots in BH related fields.

Guiding Principle	Meaning	Measurement
People in crisis experience person- and family-centered care.	The caller (person in crisis and/or family, when appropriate) defines the crisis, resolution, and whether the crisis has been adequately addressed.	Gather qualitative feedback from users about whether they felt centered (e.g., they felt listened to, they agreed with the documentation of resolution, they offered options for resolution, they did not have to repeat their story multiple times, etc.)
	The caller does not need to tell their story multiple times.	
	The caller is able to explore various options for referrals/resolution and determine which is the right fit.	
	People in crisis are listened to when they have a complaint or grievance about the care they received; they are not dismissed.	
	Responders are trained in motivational interviewing.	
	Mental health advanced directives are followed (e.g., providers have access to mental health advanced directives).	Monitor how often individuals/families are asked about advanced directives, whether they were followed, and why.
	Individuals are asked who they want involved in their care.	
	Families are offered support resources, including respite care.	Quotes from families are included in documentation of resolution.
	Support exists for people who need extra help.	
	For families working to support individuals in crisis, the system should support families to partner with providers.	
People in crisis experience care that is responsive to age, culture, gender, sexual orientation, presence of disabilities, geographic location,	The workforce is trained in provide culturally-responsive, welcoming, trauma-informed, and healing care.	
	Call takers are trained to be responsive to age, gender, sexuality, language needs, and/or presence of an intellectual	Number of trainings provided to call takers on needs related to different identities (e.g., sexuality and gender expression, age, neurodivergence etc.)

Guiding Principle	Meaning	Measurement
language, and other needs.	or developmental disability, including neurodivergence.	
	The system is flexible and adapts to the needs of the user. For example, people in crisis with intellectual or developmental disabilities are able to access the services they need, even if they need support with communication and/or activities of daily living.	Demographic information about people who received crisis services crossed with outcomes data about whether or not the services met their needs.
	People in crisis receive the level of support that meets the needs/acuity of their crisis.	Measure whether individuals in crisis have a clear treatment plan focused on what is effective/appropriate rather than just what NOT to do.
	People in crisis feel heard and supported after their experience with calling 988.	Client/customer/consumer feedback loop, including but not only a survey.
	Staff at call centers are representative of the people they serve.	Demographic information about call takers compared to the populations they serve.
	Callers have access to language supports.	Data on calls that included use of an interpreter, including completed calls, dropped or incomplete calls, and calls where the requested language supports were not available.
	People are able to access support through texting (because not everyone is able to make phone calls)	Measure use of text/chat
	Crisis Response Workforce is trained in providing culturally-responsive care, and is able to connect AI/AN individuals to culturally-specific resources such as the Native & Strong Lifeline and the Native Resources Hub.	Monitor trainings received by workforce.
	AI/AN populations accessing the system see themselves reflected in the people providing services across the crisis continuum.	Monitor demographics of workforce; number of Tribal DCRs; number of endorsed Tribal mobile response teams; number of Native and Strong Lifeline Native counselors

Guiding Principle	Meaning	Measurement
	System accountability for ensuring that native people are referred to places that provide culturally appropriate care.	Monitor complaints received by OBHA, DOH, and HCA's OTA
The crisis response system is grounded in equity and anti-racism	The system is aware of where institutional racism exists and how to mitigate.	Conduct organizational audits to identify and address systemic racism.
	There are embedded and ongoing systems to assess and affect equity and racism.	
	People working in the system routinely and consistently receive training in equity and anti-racism, there are clear expectations about participating, and they are compensated to participate.	Track participation in trainings.
	The system values and treats workers equitably, so they can then show up and treat users equitably.	
	Users are not turned away from receiving help based on their health insurance coverage or lack of carrier pre-authorizations.	Monitor access and outcomes to look for disparities.
	All vested parties in the system pay their share.	Examine funding streams by payer to look for parity/equity.
	System is aware of historical trauma and disparities experienced by AI/AN populations and how to mitigate.	Monitor access and outcomes for disparities experienced by AI/AN populations.
	People working in the system routinely and consistently receive training in equity, anti-racism, and culturally responsive care.	Monitor trainings received by workforce.

Guiding Principle	Meaning	Measurement
The crisis response system is centered on and informed by lived experience.	The system adapts to user feedback. There are systems in place to collect user feedback and clear expectations for how that feedback is used.	User feedback systems. Create different avenues for sharing experience and feedback on the system (could have something similar to Yelp reviews)
	People with lived experience are involved in refining the system at all stages, including after implementation. For example, there is a continuation of a CRIS Lived Experience Subcommittee through and past implementation.	
	People in crisis have access to help navigating the crisis response system and there are proactive processes in place to get feedback from people who have had negative outcomes.	
	There are people with lived experience working (i.e., employed, not just volunteering) in all parts of the system, including policymakers.	Monitor employment demographics, including % of state employees working in crisis response who report anonymously that they have lived experience. Monitor proportion of policymakers involved in making crisis response policy report having lived experience.
	Staff with lived experience have clear roles that align with their position (i.e., they aren't just "given everything").	Staff surveys that gather feedback, including on respect and support.
	There are peers interacting with system users at every stage of the crisis care continuum, and peers are being used appropriately (i.e., they are trained in the particular area of response they are addressing).	Track presence of peers at each stage of the continuum, as well as % of users who have interactions with peers.

Guiding Principle	Meaning	Measurement
	There are Native peers interacting with AI/AN individuals across the crisis care continuum.	Monitor number of Native peers.
The crisis response system is coordinated and collaborative across systems and community partners.	All aspects of the system communicate with each other in giving care to a person in crisis, and communication is timely.	
	All providers have in-depth knowledge of services and resources and are able to make informed referrals.	
	There are clear criteria for when to deploy 988 or 911.	Monitor adherence to protocols for deploying first responders vs. behavioral health.
	There is strong, consistent collaboration between 988 and 911 that supports the right response.	
	People in crisis are connected with appropriate resources without being transferred (or asked to call themselves) multiple times or falling through the cracks.	
	Someone holds responsibility for ensuring the system is coordinated and collaborative.	
	Cross system protocols are developed to support cross-system coordination protocols between Tribal and state and local systems (including but not limited to, 911, 988, the Native and Strong Lifeline, the Native Resource Hub, local Tribal crisis lines, Hospitals, Indian Health Care Providers, and Tribal Public Safety and Tribal First Responders.	Monitor implementation of cross-system protocols. Data on individuals who are released from emergency rooms without receiving care/connection to follow up care. Data on lack of information about people being discharged and where they are going.
	Tribal Crisis Coordination Plans are followed and implemented for Tribal members.	Monitor implementation of Tribal Crisis Coordination Plans.

Guiding Principle	Meaning	Measurement
	Tribal partners are recognized and included in system information sharing (2024 proposed legislation)	
	System providers should have understanding of IHCP system and how Tribal providers operate in relationship to other systems.	
	Workforce should be trained to be culturally humble. Staff should not act knowledgeable about the IHCP system if they do not actually have this knowledge.	
The crisis response system is operated in a manner that honors Tribal government-to-government processes.	Culturally-driven care is recognized as evidence-based practice throughout the system.	# of referrals for cultural based services
	There is recognition throughout the system of Tribal practices and that there are meaningful differences between Tribes.	
	Staff throughout the workforce are trained in culturally-attuned care, and in government-to-government relationship with Tribes.	# of trainings to crisis system, # of streamlined trainings, # of trainings available to provide this training.
	Tribal Crisis Coordination Plans are in place between Tribes and regional crisis partners, and a forum for discussing improvements in service provision.	# of protocols in place and published each year
	Identification of critical government to government processes that need to occur so the crisis response system can be successful.	
	There is regular review and update of government to government processes.	Include case review of whether these processes have been appropriately implemented. Ask for Tribal feedback on whether this is happening.
The crisis response system is empowered	Crisis response resources are accessible via text, chat, and other modes.	Track completed vs. incomplete/dropped contacts with the system.

Guiding Principle	Meaning	Measurement
by technology that is accessible to all.	Users receive the same level of service, regardless of which mode they use to access the system.	Customer/client/consumer satisfaction surveys and other feedback modes.
	People in crisis can access help in their language, regardless of which mode they use to access the system.	Track completed vs. incomplete/dropped contacts with the system by language.
	People who communicate differently (e.g., hard of hearing, sight impaired, etc.) are able to access the system.	
	The system is easy to use, regardless of the mode of access.	Track trends over time (e.g., decreased interactions with criminal justice system, increases to referrals for social services, etc.)
	Users and providers can quickly and easily see what resources are available.	Confirm that providers have access to these resources.
	Closed-loop referrals (i.e., when a patient enters the system through a health-care setting and ends up in a social services setting) are happening.	Track number of referrals to social services from health care, track episodes of follow up care as needed to reduce higher level of care.
	Native and Strong Lifeline is accessible via text and chat	number of calls via text/chat to NSLL
	Tribal providers have access and are integrated within the crisis response technology platform. (See Tribal consultation and feedback on the integrated crisis response technology platform).	# of Tribal health programs with access to the system. Determine appropriate level of access.
The crisis response system is financed sustainably and equitably.	Users are not turned away for help based on their health insurance coverage or lack of carrier pre-authorizations.	
	Seamless access to behavioral health crisis services regardless of coverage via Medicaid Fee-for-Service or through managed care.	

Guiding Principle	Meaning	Measurement
	System can hire and retain workforce as needed to provide high quality services to all who need it.	Track staffing retention/hiring/turnover.
	System provides competitive salaries in line with other first responders.	Salary comparison
	System has dependable, forecasted long-term funding.	Track funding streams
	Crisis system providers are trained in how to submit claims to private carriers (understanding that when someone is in crisis, asking for insurance information is not optimal.)	Track claims to private insurers.

Appendix F: Behavioral Health Crisis & First Responder Collaboration Recommendations

The CRIS formed a Behavioral Health Crisis & First Responder Collaboration Workgroup in 2023 to further CRIS discussions regarding collaboration between behavioral health and first responders in Washington's behavioral health crisis response system. Workgroup members included a subset of CRIS members as well as additional members representing lived experience and system subject matter experts. The workgroup met approximately five times in May and June 2023, and developed a working vision, guiding principles, current barriers, and set of recommendations summarized below.

Working Vision

Washington has an appropriate, effective, equitable and safe collaboration between behavioral health crisis response and fire, police, and emergency medical services (first responders).

Emerging Guiding Principles

1. Shared goal to move towards a more collaborative approach with aligned and complimentary systems.
2. People with lived experience should be included in every aspect of this work.
3. This is not about *if* first responders and mobile crisis response will collaborate, but rather *how* they will collaborate.
4. This is about systems, not individuals. We can critique a system while still acknowledging that good people work within them.
5. Ensure collaboration and partnership with Tribes in a manner that respects their sovereignty.

Barriers to this Vision

What gets in the way of having appropriate, effective, equitable and safe collaboration between behavioral health crisis response and first responders (fire, police, and emergency medical services)?

1. Lack of adequate or consistent training, integrated systems, and shared understanding of roles, responsibilities, authority, and approaches between BH and First responders including across 988 and 911.
2. Lack of consistent and clear processes for determining when a behavioral health crisis has an existing safety risk component that requires first responders which can lead to an inappropriate response to the level of need.
3. Lack of parity in funding for crisis system (at systems level) which result in 911/emergency room being the default. Additional challenges with livable wages and workforce retention across all systems.
4. Lack of trust and relationships between systems, between systems and communities, etc. (behavioral health, first responder, hospital/ER systems).
5. 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.
6. Lack of a shared vision for Co-Response models in Washington leading to differences in standards, implementation, oversight, and outcomes.
7. Concerns over consumer confidentiality and presence of body cams.
8. Access barriers due to concerns over US Immigration and Customs Enforcement

involvement.

9. Complex social and medical needs combined with lack of resources further exacerbating crisis situations.

Summary of Behavioral Health Crisis Response and First Responder Collaboration Workgroup Recommendations *** Some recommendations span multiple pillars.**	
Pillar 1: Leadership	1. Form a workgroup, in partnership with the Co-Response Outreach Network (CROA), to develop the protocols, best practices, training, and other resources to support co-response in Washington in manner that allows first responders and behavioral health professionals to have co-ownership in system. 2. Create a Washington Behavioral Health and Crisis System workgroup to research and develop recommendations to build and sustain behavioral health workforce including workforce pipeline programs that help to diversify the behavioral health workforce. 3. Encourage regular cross collaboration and partnership. For example, hold annual conferences, engage quarterly workgroup meetings with representatives across systems as part of the co- response workgroup. 4. Invite behavioral health professionals to serve on the Criminal Justice Training Commission.
Pillar 2: Resources	1. 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. 2. Fund more prevention services to avoid need for crisis.
Pillar 3: Policies	1. Convene a workgroup with representatives from first responders, behavioral health staff, people of color, and people with lived experience (and intersections of these identities) to make recommendations about how to determine and define how to assess safety risk in behavioral health crisis and appropriate response. This should include establishing shared understanding or definition of "safety" that acknowledges and takes into account how racism and bias show impact this. Any policy decisions should lead to the development of standardized protocols for implementation. It should include identifying what data and indicators to monitor to assess impact. 2. Advocate for policy changes related to public information requests and body cam footage for when there are patient confidentiality concerns. 3. Include requirements for translation services for crisis response services and invest in culturally specific service providers. 4. Advocate for policy changes that bar immigration status to be used in behavioral health crisis response situations (mostly through requirements for first responders to identify individuals)- likely through removal of the requirement for identifying the person in crisis. 5. Advocate for lessening CJIS (laws that prevent Peers to have access to working within law enforcement).

Summary of Behavioral Health Crisis Response and First Responder Collaboration Workgroup Recommendations *** Some recommendations span multiple pillars.**	
Pillar 4: Procedures, Workflows, Protocols	1. Develop protocols for determining who is "lead" in the field based on safety issues and how and when that shifts. Should start with behavioral health as automatic lead unless safety concerns are present. Also needs to address how implicit bias and racism impact staff of color in the field and interactions/dismissal by first responders. 2. Establish a consensus on the rights of people in crisis and create a "caller bill of rights." Focus on informed consent for community. Develop clear materials for communities on what to expect when they call. Develop monitoring plan to include in system oversight to assess trends. 3. Ask co-response group to tackle developing core standards for embedded co-response programs that are consistent no matter which system they reside in. 4. Build upon current 988 dispatch protocols to include 911 but do this through a collaborative workgroup of people from both systems and then train - scale and spread. 5. Develop and spread best practices for effective handoffs between systems with a goal of being least restrictive response. This should be addressed in the workgroup that is charged with expanding and spreading the 988 dispatch protocols. 6. Look at the Stepping Up initiative with a goal of it being in all counties in Washington 7. Develop and pilot a crisis response and first responder collaboration in a region that is receptive to developing more of a "shared system" and capture best practices and spread. 8. Prioritize SIM and Crisis Intervention Training (CIT), not just the 40-hour training but true collaboration across all systems.
Pillar 5: Training	1. Partner with people with lived experience to create and require participation in a comprehensive training curriculum for behavioral health and first responders that includes: - overview of roles, authority, requirements, training, and approaches for responding to behavioral health crisis for both behavioral health and first responders - implicit bias and recognizing and addressing power and privilege - best practices for engaging with people who are appear erratic or non-compliant - understanding difference between safety issues and behavioral health crisis - person-first and respectful interactions (cultural responsiveness and trauma-informed) 2. Develop and implement cross training and ride alongs across systems. 3. Develop and launch a community outreach and education campaign on 911 and 988 system and co response. 4. Create behavioral health lexicon/glossary and share across systems

Summary of Behavioral Health Crisis Response and First Responder Collaboration Workgroup Recommendations *** Some recommendations span multiple pillars.**	
	and for community education campaigns. 5. Build out training on "client-centered services, systems, and approaches" to start a paradigm shift for workforce. 6. Develop training for first responders and crisis response on confidentiality laws and use of data and body cam footage so everyone understands dos and don'ts. 7. Include more information on medical clearance process, rules, and practices in all training. 8. Include messaging on immigration status and process/policies in community education and training. 9. Expand on the work happening under Mental Health Advanced Directives that can help advise on community education campaigns, and champion things that make the system more client- centered including behavioral health release of information or mental health advanced directive. Incorporate into integrated platform. 10. Standard Dementia crisis intervention and transport for all first responders.
Pillar 6: Monitoring and Accountability	1. Do root cause analysis on lack of trust issue between systems and systems and community (behavioral health and first responders and between both systems and communities) - then acknowledge causes and work to develop solutions. 2. Conduct an audit to ensure alignment with current CIT training standards for co-response programs in Washington. 3. Spread 988 dispatch protocols and monitor for implementation.