MEETING SUMMARY

CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE MEETING SUMMARY

Tuesday, September 24, 2024; 1:00 pm to 4:00 pm
In Person: DoubleTree by Hilton Seattle Airport, Seattle, Washington
Zoom

Meeting Agenda, Slides and Recording are available on the CRIS webpage:
https://www.hca.wa.gov/about-hca/behavioral-health-recovery/crisis-response-improvement-strategy-cris-committees

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ATTENDEES

Committee Members

Adam Wasserman, State 911 Coordinator
Aleesia Morales, Tacoma Fire Department
Anna Nepomuceno, National Alliance on Mental Illness (NAMI) Washington
Amber Leaders, Office of Governor Jay Inslee
Bipasha Mukherjee, Crisis Line Volunteer
Claudia D'Allegri, Sea Mar Community Health Centers
Darcy Jaffe, Washington State Hospital Association
Dillon Nishimoto, Asian Counseling and Referral Service
Jane Beyer, Washington State Office of the Insurance Commissioner
Jan Tokumoto, Frontier Behavioral Health
Joan Miller, Washington Council for Behavioral Health
Kashi Arora, Community Health and Benefit, Seattle Children's
Kristen Wells, Valley Cities Behavioral Health Care
Laura Pippin, Washington Association of Designated Crisis Responders
Levi Van Dyke, Volunteers of America Western Washington
Mark Snowden, Harborview Medical Center
Michael Reading, Behavioral Health and Recovery Division, King County
Michele Roberts, Washington State Department of Health (DOH)
Michelle McDaniel, Crisis Connections
Puck Kalve Franta, Access & Inclusion Consultant
Robert Small, Premera Blue Cross
Senator Judy Warnick, Washington State Senate
Senator Manka Dhingra, Washington State Senate
Teesha Kirschbaum, Washington State Health Care Authority (HCA)

Committee Members Absent

Fennec Oak, Fennec Oak Counseling
Justin Johnson, Spokane County Regional Behavioral Health Division
Kelly Waibel, Tulalip Health System

Larry Wright, University of Washington School of Social Work
Representative Tina Orwall, Washington State House
Representative Tom Dent, Washington State House

American Sign language (ASL) interpreters

Abby Bergman
Caryl Williams Love

Committee Staff

Betsy Jones, Health Management Associates
Kristine Malana, Health Management Associates
Chloe Chipman, Health Management Associates
Jared Staheli, Health Management Associates
Jamie Strausz-Clark, Third Sector Intelligence (3Si)
Michael Anderson-Nathe (Anderson-Nathe Consulting)

WELCOME, INTRODUCTIONS, AND TECHNOLOGY REVIEW

Jamie Strausz-Clark, 3Si, convened the meeting, which was held in-person at the DoubleTree by Hilton Hotel in Seattle. Jamie also reviewed use of Zoom features to ensure understanding among meeting participants regarding use of Zoom meeting technology and expectations for committee members and public observers joining virtually.

Jamie then introduced three new CRIS Committee members: Blaise Geddry (Vancouver Police Department) representing law enforcement, Chloe Merino (Disability Rights Washington) representing a social justice organization addressing police accountability and the use of deadly force, and Tory Gildred (Molina Healthcare of WA) representing a Medicaid Managed Care Organization. Jamie also recognized Jennifer Chancellor, the new 988 coordinator for the Governor's Office.

MEETING OBJECTIVES AND AGENDA

Jamie reviewed the meeting agenda and objectives for each agenda item. This meeting of the Crisis Response Improvement Strategy Committee had seven objectives:

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

7. Hear public comment. (Note: Due to lower sign-up numbers, the comment period was shortened. Public comments are welcome in written form at any point throughout the process and may be submitted to HCAprogram1477@hca.wa.gov.)

DISCUSSION: Legislative Session and State Agency Updates

Jane Byer, OIC, discussed OIC rulemaking updates. In 2022, the legislature passed a bill requiring commercial health plans to cover emergency crisis services. OIC is working to integrate language by the end of 2024 to ensure health insurers contract with behavioral health agencies.

Teesha Kirschbaum, HCA, provided updates on the regional crisis lines and the recent 988 joint policy statement. The statement addresses the future state roles of 988 and regional crisis lines. HCA is committed to carrying out a robust stakeholder process to continue to inform further detail and implementation of the policy statement.

- Claudia D'Allegri, Sea Mar Community Health Centers, asked to confirm the timeline for these changes.
  - Teesha noted that changes will take time to implement and they are committed to working with partners to implement.
- Adam Wasserman, State 911 Coordinator, asked if 911 will be connecting with regional crisis lines to provide in-person response.
  - Teesha confirmed that 911 would connect more with regional crisis lines with regard to in-person, local responses and regional expertise.

Maddy Cope, HCA, provided an update on the HCA Bed Registry and Referral Project, including an overview of the project, work to date, and key findings. Teesha added that the bed registry is important as it connects to A Safe Place to Go—these efforts are an attempt to create a better solution to existing challenges across the system when trying to access resources on places to go.

- Claudia asked whether these efforts would include all mental health and SUD beds or just mental health beds.
  - Teesha noted HCA is looking into this, but it will likely include SUD to support the whole person needs.
- Kashi Arora, Seattle Children's, asked whether the efforts would include pediatric beds.
  - Teesha noted that HCA will confirm this.
- Michelle McDaniel, Crisis Connections, noted one of the challenges is adoption of the solution, and ensuring providers prioritize it and keep resources up to date. Will HCA be leading the adoption as well?
  - Teesha noted HCA will most likely carry out the adoption of the registry.
  - Maddy added that HCA's interested parties included providers and EHR users of various types, who discussed considerations for incentivizing and/or requiring adoption.

PRESENTATION AND PANEL DISCUSSION: Crisis Response for People with Intellectual and Developmental Disabilities

David O'Neal (IDD Services Director, Sound Mental Health) served as moderator and opened the presentation and panel discussion of crisis response for people with Intellectual and/or Developmental Disabilities (IDD). He discussed the complexities of intellectual developmental disabilities, emphasizing the need to understand the underlying causes of aggression and the challenges faced by individuals with sensory sensitivities and neurocognitive deficits. David also highlighted the issue of diagnostic overshadowing and the difficulty of accessing primary care for this population. He introduced the concept of caregiver burnout and the high incidence of trauma-related responses and mental health issues among people with IDD.

Crisis Response for People with IDD Panelists

Panelists included DeAnn Adams (Clinical Program Manager, Washington Developmental Disabilities Administration), Debra Hughes (Clinical Supports Director, Hope Human Services), Heather Gethers (Case Manager, Washington Developmental Disabilities Administration), Jermaine and Mikelle Hayes (Parents of a 10-year-old boy with IDD), Jim Ott (Community Information and Outreach Program Manager, Developmental Disabilities and Early Childhood Supports Division of King County), and Katrina Davis (Family Advocate and Case Manager – Profound Autism and IDD, Seattle Children's Emergency Department; Parent Advocate and Resource Specialist, ECHO Autism and IDD Washington, Institute on Human Development and Disability, University of Washington). Panelist bios can be found at the end of the meeting summary.

Panel Discussion

- *What are the unique needs of adults and/or youth with IDD who are experiencing a behavioral health crisis?*
  - Katrina shared that in her role working in the emergency department, she sees many people with IDD. She clarified that the needs are unique in the level 3 autism (profound, limited or no communication) category. This population is unethically underserved. Contracting providers for the Developmental Disabilities Administration (DDA) are not mandated to serve this population (i.e., you don't get paid any more to serve the higher needs population). Schools have to serve this population, but they struggle, and often just refer youth to DDA.
  - Jim indicated that there is a need for timely access to care, including calling a crisis line and getting mobile response from programs skilled in crisis intervention and stabilization. He added there is a lack of skilled staff in the workforce; staff should ideally have lived experience and professional experience working with individuals with IDD.
  - Debra emphasized there are unique needs and challenges for each person with IDD. There is a need for education on these shared challenges (e.g., communication challenges, social interaction barriers, emotional dysregulation, limited empowerment, trauma, etc.). Students with IDD are three times more likely to experience trauma (e.g., abuse, neglect). Adults with IDD are five times more likely to need mental health crisis supports.
  - Heather added there are a lot of things we need to do that we can't do (e.g., address problems with waitlists, funding, etc.). Hospitals often don't understand the IDD population. Our clientele are encountering barriers at hospitals, which aggravates the crisis.
  - Jermaine shared his personal experience as a parent of a child with intellectual disabilities, emphasizing the importance of providing adequate support and resources for individuals with

intellectual disabilities. He shared that the timing can be a challenge—whether that's the amount of time it takes to be accepted into a program, or the length of time programs are available. For example, with a recent program, Jermaine's son did well while there but regressed when reintegrating into home. His providers are encouraging longer-term treatment, but the family is not able to access this care.

- *Given these differences, what are the implications for the behavioral health crisis response system? In other words, how do we need to approach crisis response system improvement to support adults or young people with IDD?*
    - Deanne answered that DDA is not funded to provide the level of individualized support needed, especially in the crisis services area. Frankly, the system isn't robust or tailored enough, particularly in crisis response settings. Need to have system able to respond in tandem with services DDA can support.
    - Heather added they often hear DDA has programs and resources, etc. While it's true to an extent, it's often not recognized that services are provided by contracted providers who can pick and choose who to serve. DDA can't force contracted providers to take on individuals.
    - Katrina noted that the profound Autism population is systematically excluded. Services and programs exist, however, this population is often told "their needs exceed the model of care". 988 is a great concept, but they will often refer to DDA. People with IDD often have to leave their family and community and leave the state to receive services. Systems of care need to be able to provide services they currently can't. HB 1580 will help with solutions. People who require institutional level of care require longer-term solutions so they can return to their community.
    - Debra emphasized that while there are huge system gaps for youth, it is ten times worse for adults. Students that age out of school and try to access services experience greater challenges. If they don't have right clinical diagnosis documentation, it is a challenge to get them re-diagnosed. Debra is often the one getting called in when these crisis situations occur; she noted needing quicker response times. While everyone is doing the best they can, the process itself is too cumbersome. In Pierce county, individuals have to call the crisis line, the initial screening takes 5 to 15 minutes, they are then transferred to provider line, then another screening, then wait 20 minutes for callback which doesn't always occur, then finally speak to a clinician then to be told it can take up to 2 hours or more for an in-person response. As soon as aggression is mentioned, the staff say they can't help, you have to call 911, who doesn't always turn up. Phone calls and telecommunication are not the best way to communicate with this population; in person is better. Sound is the only mental health agency in region that services the IDD population.
    - Jermaine added that his son has therapists and specialists he's had for years, and he builds relationships with these providers. However, as soon as the relationship is built, that provider has to leave. There is no consistency as far as care goes. When you have a kid who has problems dealing with transitions and change, makes this more difficult and does harm.

- *The CRIS is developing recommendations for crisis system improvement. As they continue developing these, what is one key takeaway about adults or young people with IDD you'd like the CRIS to consider?*
    - Jim suggested expanding funding and the capacity of programs that are working in the community to prevent use of the emergency room or long-term out of home placement. Currently serving 40 – 50 families a year, but could be serving double to triple with more adequate funding.
    - Jermaine shared that more people are realizing their kids have issues, more so than in the past. He encouraged the CRIS Committee to act upon the panel discussion topics.
    - Debra noted the IDD population is just as deserving and even more in need of mental health support. There is a need for education for first responders and clinicians to encourage understanding that the IDD population often can't participate in traditional crisis response.
    - Katrina noted the profound needs of this population and the cycles of crisis. The emergency department is not a solution and should never be a solution. Parents need immediate placement with a highly supportive environment. Current inpatient facilities don't work for this population. Those with profound IDD need to be acknowledged. She recommended involving parents of this population in CRIS efforts and building unique services for the IDD population.
    - Deanne emphasized we have an ethical responsibility as a community to come together. Every region across the state has a clinical team created to try and partner with other resources.
    - Heather indicated there is a need to expand on existing work. Families are suffering and being told to get a caregiver. However, available caregivers are often not qualified to support the IDD population.

CRIS Committee Member Discussion:

- Anna Nepomuceno, National Alliance on Mental Illness (NAMI) Washington, asked for information about how often people with IDD end up in the criminal justice system.
    - David suggested the criminal justice system has a large population with fetal alcohol syndrome. Different etiologies make it challenging to answer. It is likely drastically underrepresented.
    - Debra shared that law enforcement can be understanding of profound populations. With higher functioning individuals, there are maladaptive cycles where high functioning individuals engage in illegal behaviors with a level of intention. This can lead to agencies terminating services for that individual, who often end up homeless.
    - Heather gets 2 – 5 calls a month about their patients going to jail. Their clients are vulnerable, but also manipulatable (e.g., "a friend asked me to"). That is likely underestimated, and they are facing charges.
- Michele Roberts, DOH, noted DOH supports the three 988 call centers. She noted the likelihood of having a 988 call line specifically for the IDD population is very slim. She is interested in the gaps, and what would it take for DDA to be able to partner and offer services needed so that 988 can refer to them. Happy to look with DDA at how staff are being trained and improving knowledge of resources.
- Claudia noted providers are often getting claims denied. IDD is separated from mental health coverage.

- Aleesia Morales, Tacoma Fire Department, asked if you're calling for an in-person crisis response, with a hope of detaining, how often are you actually seeing this as a potential outcome? Our team often finds this population can't be detained.
    - David noted it would be great to have resources to put stats together, however, no one is gathering this information (e.g., no checkbox to see if someone has IDD). No one wants to detain someone with IDD. We have had people assaulted in psychiatric hospitals due to vulnerabilities. Those aren't great options for this population. But if there is an acute mental health need, that's the place we have to treat it. Sometimes it takes education and understanding of acute presentation, and the etiology of the aggression.
    - Heather added when people get to a certain point in detainment, sometimes providers will lift detainment and discharge to homeless shelters.
    - David added that just because someone has an IDD doesn't mean they can't recover. It just may take longer to build relationships, understand communications, etc. Our crisis systems aren't designed for that slower process.
    - Puck noted this is something they have suggested studying before; looking at the desired response that doesn't happen solely because we don't have the capacity for it.
- In response to Jermaine and Mikelle's remarks, Bipasha Mukherjee, Crisis Line Volunteer, noted hearing parents needing to provide institutional level care for their children with disabilities at home with no support. Bipasha noted that this experience is echoed in the Lived Experience Story Project presentation.
- Bipasha added that on the crisis line, she has heard this often about people bonding with their counselor and after a while that counselor leaving. It is deeply impactful for people to be able to trust care. It would be a lot harder for folks with IDD. However, high caseloads can cause burnout. We need to do better with paying people well, and lowering burnout so they can stay longer term which in turn will benefit clients which is the ultimate goal.
- Puck Kalve Franta, Access & Inclusion Consultant, noted research found that being matched with mentors who were there less than a year was actually detrimental to mentees. The logic of this transfers pretty well to the supports of therapy with this community. Puck lost their entire autism care team with a health insurance change and it's indescribably difficult.

Jamie thanked David for moderating and the panelists for their preparation and discussion.

Presentation and Discussion: Lived Experience Stories Project Outcomes

Bipasha Mukherjee, Crisis Line Volunteer, and Kristen Wells, Valley Cities Behavioral Health Care, provided an overview of emerging insights from the Lived Experience Stories Project. A recording of this presentation is available on the CRIS webpage.

The goal of the Project is to broaden our ongoing work of elevating lived experience (LE) stories to inform the Washington Behavioral Health Crisis Response System. Sixty-five valid stories were collected between June 1 and July 31, 2024. Demographics captured included age, race, disability, veteran status, gender identity, LGBTQIA2S+, housing instability, accessing the behavioral health system for self/others, and engagement with

corrections, foster care, immigration, mental health, and substance use. Bipasha and Kristen identified the following insights:

- What's working:
    - People are receiving help they need across the crisis continuum and beyond.
- What could be better:
    - CRIMINAL JUSTICE SYSTEM (CJS) & EMERGENCY DEPARTMENTS (Eds) functioning as primary access points to behavioral health care
        - People are ending up in the CJS rather than getting the BH help they need
        - The CJS can be/is traumatizing
        - Rehabilitation programs within CJS are helpful
        - Transitions between CJS-BH and community-based behavioral health are problematic
        - Emergency departments are not a good place for BH crisis care
        - Suggestion: Allow BH intervention to take precedence over criminal justice especially when there is an arrest warrant for non-violent crimes
    - BARRIERS TO ACCESS include insurance, cost of care, lack of providers, & transportation
    - PROTOCOLS are unaligned, inconsistent, and often do not meet the needs of the community
        - There are protocol issues across the system, around the Involuntary Treatment Act (ITA), and Designated Crisis Responders (DCRs).
        - Suggestions:
            - Educate community and be transparent on what people can expect
            - Standardize education for all service providers on how the system works, in their domain, and other related/relevant domains
            - Consider changing/improving protocols to better support the community
    - QUALITY of SUPPORT is inconsistent
        - Quality of support is inconsistent across the system, including Someone to Call, Someone to Come, and a Safe Place to Be/Go.
        - Bias might be impacting quality of support
        - Suggestions:
            - Agencies adequately staffed to minimize burnout
            - Adequate pay & personal time off for staff
            - TRAINING for STAFF on
                - Secondary Trauma education and support
                - Unconscious Bias
                - Special needs/Minority/Underserved population care
                - Trauma Informed Care
            - Enable consumers to rate quality of care
    - CROSS-SYSTEM GAPS lead to people falling through
        - Follow up not given or if promised does not come through
        - Parts of the system don't talk well to each other. There are big gaps.
        - Suggestions:
            - 988 hubs need to be the repository of knowledge on all aspects of the BH crisis response system so they can act as a one stop shop to connect people to other parts of the system as needed. They should warm transfer clients to programs like WISe, CLIP, MRSS, MCT, DCRs, BeST, PACT etc. They can also inform people about options like Joel's law or Ricky's law.

        - The 988 Tech Platform should house standardized information so both the community and service providers can access it as needed
    - FOLLOW-UP and PREVENTION pillar needs to be added to, integrated, and aligned with the crisis response system
        - Without it people are cycling in and out of the behavioral health crisis response system
        - Lack of basic needs triggers behavioral health crises
    - NATURAL SUPPORTS need to be an integral part of the design and delivery of crisis response system
        - The balance between personal agency and family engagement
        - Natural supports are also in crisis and need support

CRIS Committee Member Discussion:

- Amber Leaders, Office of Governor Jay Inslee, noted having a safe place to go had a number of negative comments. Did you see anything about what safe places were available?
    - Kristen noted that for a safe place to go or be, there were responses about emergency departments, inpatient facilities, and a few about crisis diversion services. There were some positive responses, but more were negative for this category specifically. People are having trouble figuring out where to go when experiencing a crisis.
    - Bipasha added that the team could further review the data to see what people mentioned to get a better picture of what's happening under that pillar.
- Sen. Dhingra thanked the team for the presentation and recommendations. Regarding insurance as a barrier, she asked if this was related to a lack of the insurance or the type of insurance. She noted efforts around ensuring parity in insurance coverage with covering mental health the way that physical health is covered. Regarding filling prescriptions as a barrier, she noted bills she sponsored to remove barriers and ensure medications are covered. Lastly, Sen. Dhingra noted Washington jails are now required to fulfill mental health prescriptions in the manner they're prescribed, without substitutions. She wondered whether that should be done in prisons as well.
    - Kristen confirmed that most respondents had insurance, suggesting the issue might be with the type of insurance and provider availability. She added that for some medications that are controlled substances, there can be a lot of additional requirements.
    - Bipasha shared an article about ghost systems in private insurance, where people have coverage but are able to access adequate care due to outdated provider lists (link to article here: How a one patient got trapped in a health insurance ghost network : Shots - Health News : NPR). In terms of the criminal justice system, Bipasha noted stories where people went in and out of the system and didn't receive help when they called. When they are in the criminal justice system, the medication management is different, and it's not very consistent. There are certain classes of drugs that they will not prescribe.
    - Dr Snowden noted certain newer medications, particularly long-acting antipsychotics, require a repeat authorization in different settings (e.g., hospital, outpatient).
    - Sen. Dhingra noted she worked on a bill two years ago where the intent was that prescribers don't have to get authorization for severe mental illness prescriptions once they have been prescribed.
    - Jane noted SB 5300 goes into effect January 1, 2025. Health insurers are asking how they know that a drug has been prescribed for a serious mental illness because of how much off-label prescribing there is. Their teams should be working on how they will review those

prescriptions. There is rulemaking on the bill right now. If folks encounter challenges and their plan is trying to switch them to another drug, OIC needs to know. While the OIC will be enforcing SB 5300, we need to hear from people when they encounter issues. The issue is health insurers contract with pharmacy benefit managers to manage their prescription drug benefits, and those formularies change too often. We need to keep people stable on medications that are working. Regarding ghost networks, Congress has done hearings about them for Medicare Advantage plans, and we have extensive network adequacy requirements. The issue that comes up is not only the accuracy of an insurer's provider directory, but also the fact that an insurer can contract with providers but there's nothing that obligates the provider to see every enrollee for that health plan.

- Sen. Warnick raised a concern about young people being released from emergency rooms or care without a parent or guardian, potentially leading to homelessness and vulnerability.
    - Kristen acknowledged this issue, suggesting increasing youth services to provide a safe alternative after emergency room discharge. She added that one of the insights related to emergency departments is that people often feel they go to an emergency department and then are discharged without any real behavioral health intervention taking place. The hope is that the 23-hour centers will be a better alternative once open. For youth, once they turn 13, they have a right to access and use services without consent of their parents, while the parent is still responsible for the youth and generally want to be involved. A solid family foundation can be a good natural support for youth, but in some cases families are not positive natural supports.
    - Bipasha proposed the continuation of a project that allows people to provide direct feedback to the state about their experiences in the system.
- Puck thanked Kristen and Bipasha for their efforts and spoke to the limitations of the project. The team was able to receive a fair number of stories by providing some financial compensation. Puck emphasized the need for a more comprehensive approach to gather feedback and improve the system.
- Dillon Nishimoto, Asian Counseling and Referral Service, shared a notification system for providers to talk about the transition of care following hospitalization and other types of care. Getting the lived experience feedback is important as well. It would be helpful if there was a way to get multiple angles of the story and see failures in the process and protocol.
- Kashi thanked Kristen and Bipasha for this work - the themes are incredibly resonant. It is really important and powerful to hear these stories and to be accountable as a system to doing better.

Discussion: CRIS Committee Recommendations

CRIS members reviewed and refined recommendations for the Committee's Final Report to the Governor and Legislature, due January 1, 2025. CRIS members reflected on what they learned from the panel discussions throughout 2024 meetings, as well as the key insights identified through the Lived Experience Stories Project, to inform where there are gaps or areas of emphasis needed for the Committee's recommendations in the Final Report. See Appendix A for details on comments made during the meeting.

ACTION ITEMS AND NEXT STEPS

Next steps and action items for the meeting:

- HMA to incorporate input from the discussion into the Committee's recommendations in the Final Report.
- HCA and DOH to develop plans for ongoing lived experience engagement after CRIS sunsets.

PUBLIC COMMENT PERIOD

Jamie reviewed the public comment process and opened the public comment period; two members of the public commented. For individuals with additional comments or time needed, Jamie highlighted the opportunity to submit public comment via email to: HCAprogram1477@hca.wa.gov.

MEETING ADJOURNED

Panelist Bios: Crisis Response for People with Intellectual and Developmental Disabilities

CRIS Meeting – September 24, 2024

Panelists:

Moderator: David ONeal, IDD Services Director, Sound Mental Health

David currently manages a 45-person, interdisciplinary staff team involved in the provision of mental health, vocational, chemical dependency, crisis stabilization, solution based systemic problem solving, and case management for individuals with intellectual and developmental disabilities. My role is to build community and system capacity to better understand the strength and vulnerabilities of this unique population. As a lifelong learner, I always strive to improve and have created many new programs and projects, including an award-winning program for chemical dependency services targeted to this population. Follow us at: https://www.facebook.com/SoundIDD. In addition to that fun, I also work with the Center for START Services at the Institute on Disability/UCED at the University of New Hampshire. http://www.centerforstartservices.org as a project instructor and trainer and as a Clinical Director for Special Olympics Strong Minds Healthy Athletes Initiative!

DeAnn Adams, Clinical Program Manager, Washington Developmental Disabilities Administration

DeAnn Adams holds a Master's Degree from University of Washington School of Social Work and has over 25 years' experience working in the fields of youth and young adult homelessness, transitional housing, foster care, residential treatment, behavioral health management and crisis intervention. This work has been done both within the public and non-profit sector and joining DDA in 2022 as the Clinical Supports Program Manager for Northwest region of Washington state.

Debra Hughes, Clinical Supports Director, Hope Human Services

Debra Hughes is the Clinical Supports Director for Hope Human Services in Pierce County. She has over 14 years of experience in providing social, behavioral and clinical supports in Australia, Scotland and the United States. In her role with Hope Human Services, she works with multiple programs to provide overarching behavioral health focused clinical supports. This includes coordinating services for individuals with developmental disabilities and complex support needs. Central to Debra's role is providing clinical support to the HHS bed-based Diversion program. The program focuses on supporting individuals in crisis situations referred through DDA. It provides short-term placement, structured habilitative and positive behavior supports, and focuses on addressing key needs so individuals can stabilize and are set up to succeed in a residential long-term placement. Debra is one of the agency's certified trainers for the Green Zone Energy Focused Personal Support curriculum as well as Ukeru "Least Resistance" Approach to Crisis Management framework curriculum. She also provides direct and indirect crisis intervention support for all of Hope Human Services' programs, especially when supported individuals are in need of emergency services intervention or the need for a Designated Crisis Responder. Debra is passionate about advocating for equity of individuals with complex challenges and dual diagnosis, as they often are unable to access the services they need to be successful. Throughout her career Debra has been part of the journey of supporting dozens of individuals through intense challenges and barriers, some of whom were believed to be unable to be supported in a community setting and who have then flourished and exceeded expectations.

Heather Gethers, Case Manager, Washington Developmental Disabilities Administration

Heather Gethers has worked in the social services Industry for nearly 20 years. She has worked from direct care staff into management, which has been beneficial to build strong teams and carry out the mission of an organization with great success. Heather is currently a case manager with the Washington Developmental Disabilities Administration. She previously worked as the staffing manager with SKILS'KIN where she successfully restructured a Prevocational program and placed clients in community-based employment.

Jermaine and Mikelle Hayes, Parents of a 10-year-old boy with IDD

Jim Ott, Community Information and Outreach Program Manager, Developmental Disabilities and Early Childhood Supports Division of King County

Jim Ott has over thirty years of experience implementing and administering innovative, best practice and evidence based early intervention and prevention programs. He has worked in the areas of developmental disabilities, early childhood, home visiting, youth development, family support, juvenile justice, and public health. Jim currently works for the King County Developmental Disabilities and Early Childhood Supports Division where he manages community information and outreach programs, in-home behavioral support programs, and co-staffs the King County Board for Developmental Disabilities. Jim is interested in programming that is responsive to the intersecting needs and identifies of people with intellectual and developmental disabilities and their families. Jim was born and raised in Seattle. He and his wife have five adult children and a growing number of grandchildren.

Katrina Davis, Family Advocate and Case Manager – Profound Autism and IDD, Seattle Children's Emergency Department; Parent Advocate and Resource Specialist, ECHO Autism and IDD Washington, Institute on Human Development and Disability, University of Washington

Katrina Davis is a mother of two children and a career advocate who brings a blend of personal and professional expertise to her role as crisis case manager at Seattle Children's Emergency Department and as Resource Specialist and Parent Advocate HUB team member for several Autism ECHO cohorts at University of Washington's WA INCLUDE Collaborative. Katrina specializes in the unique needs and services for the profound autism and IDD population. She has come to know autism services and resources through advocacy for her own autistic son for the last 25 years and through her sincere interest in helping others navigate the complex maze that accompanies an autism and/or IDD diagnosis and the life-long journey. With a background and extensive experience in disability services, advocacy, and resource navigation, Katrina is skilled at assisting parents, families, and individuals as they seek vital autism and IDD services, supports, and information.

Appendix A: Crisis Response Improvement Strategy (CRIS) Committee

Recommendations Summary

See below for a summary of CRIS recommendations made through the course of the last several years in the following areas:

1. Vision
2. Services
3. Prevention
4. System Oversight & Performance
5. Cross-System Collaboration
6. Workforce and Training
7. Technology
8. Funding

The Washington State Health Care Authority and Department of Health are also engaged in many efforts aligned with these recommendations. These efforts will be highlighted in the draft Final Report (for the Committee's consideration in November) to highlight progress being made on recommendations as well as remaining areas of work needed.

Recommendation	CRIS Member Comment
II. Services	All of these (many are under way) Services for IDD Population (1 dot) There is a gap in services for people with co-occurring behavioral health and developmental disability and intellectual disabilities. This needs to be addressed! (1 dot) Re-evaluating ITA process in community & hospitals. Also supporting MOUD/MAT services being a part of crisis services. This all seems to be at the heart of the work we are doing - all important. Some programs have already been made, some still have a long way to go, i.e., safe place to go. Still much to do! (2 dots)
Systemwide	988 must serve as over-the-phone support AND as connection to in person (mobile) resources and follow up care Despite the older adult population being the fastest growing demographic there aren't services recommended for dementia crisis calls (2 dots) Accelerating a move toward a co-occurring capable system of care (2 dots)
1. Strengthen support for consumers to navigate the system and simplify access to services. Establish a centralized database of available services and providers.	Need to fund the 211 database to include MH resources & ensure they stay up to date (1 dot) How will this system work with existing resource lists/databases? How can we ensure information is updated? Info on BH related laws like Ricky's law, Joel's law, Info on ITA etc.
2. Establish requirements for translation and interpretation for crisis response services across the continuum.	Requirements for translation and interpretation need to have adequate funding and can't be an unfunded mandate and be successful (2 dots)

Recommendation	CRIS Member Comment
3. Ensure the system has capacity to support people with substance use disorders.	Mental health parity laws need to be updated to include parity for substance use health care 1 dot
Someone to Call	Better coordination with 211 system (2 stars)
4. Minimize time delays created by 988 dial-pad options (note this action would require Federal action to address).	
Someone to Come	
5. Continue expansion of adult and youth mobile crisis response services to address current gaps in the system and ensure a timely response to people in crisis.	
6. Support Tribal Partners in continued work to develop Tribal mobile rapid response crisis teams and Tribal Designated Crisis Responders.	
A Safe Place to Be	Caution around only implementing 23-hr...level of care - very important to have 24/7 urgent care… in model as part of the continuum (1 dot) We can't expand only crisis services at the expense of the outpatient system. 23-hour facilities + urgent care are not going to solve this problem alone. Caution around "more beds will solve problem" the community supports social services and a more targeted approach is where we should invest (2 dots)
7. Prioritize crisis stabilization in the home.	2 dots
8. Expand peer respite services as a key strategy for expanding access.	Ensure peers get a wage to allow peers to live within few miles of where they work. Ensure ample personal time off, are not overworked - so budget for optimal over staffing rather than being understaffed. Help them with secondary trauma and personal care.
9. Develop partnerships and engage local communities to support expansion of crisis stabilization facilities across the state.	We also need to look at the quality of care that exists in current crisis stabilization facilities. (1 thumbs up)

Recommendation	CRIS Member Comment
10. Review capacity of crisis stabilization facilities to serve people who need support for: **a. Activities of daily living** **b. Co-occurring mental health and substance use disorders** **c. Intellectual and developmental disabilities** **d. Minimize use of gendered spaces that create further anxiety for non-binary and transgender people.**	Crisis providers equipped + trained to provide medication first as needed i.e. medication for (?) or alcohol use disorder Include up-to-date daily capacity ...on in person
For Youth Populations	...Specific resources in each region. Esp for youth exiting systems...psych hospice There is a lot more needed in terms of youth services. Right now this only mentions justice-involved youth but more services are needed across the continuum
11. Expand juvenile justice programs that provide wrap-around services to youth with behavioral health needs and diagnoses.	Honestly, we need these for adult populations too, not just youth. Justice involvement, and lack of follow up care were insights for adults as well as youth in the stories project.
12. Pursue policy changes that provide behavioral health-focused care for justice-involved youth with behavioral health needs.	
Follow Up Care	Standardize follow-up protocols + processes F/U with providers involved with crisis
13. Review current requirements for discharge planning and identify gaps to prevent people from being discharged from inpatient psychiatric or hospital settings into circumstances that create a repeated cycle of crisis.	The story project recommendation is that it is vital to talk of presentation if you want to avert crisis and keep costs down.
14. Develop system capacity to follow up with people who have experienced crisis.	Increasing community based services, especially for specialized populations of people requiring crisis services, is essential to preventing crisis in the first place and effectively responding to it (2 stars) 1 dot

Recommendation	CRIS Member Comment
III. PREVENTION	Prevention is THE place where we can have the most impact! It costs less but most importantly it's less trauma for both people who need services and their providers (2 dots) Still have room in this space for improvement but much has been accomplished/impacted (1 dot) Provide more consistent prevention funding Support recommendations from children and youth BH workgroup about how to increase capacity for BH supporters Fund & support services embedded already where people are (schools, community, etc.) (3 dots) Additional prevention suggestion: allow BH intervention to take precedence over criminal justice especially when there is an arrest warrant for non-violent crimes (1 thumbs up)
15. Strengthen overarching system capacity around behavioral health and suicide prevention services to prevent behavioral health crises from happening in the first place. **a. Include investments in basic social services** **b. Ensure equity in behavioral health crisis and suicide prevention services across the state. Establish a 988 Diversity, Equity, and Inclusion Director.** **c. Leverage broad community outreach and public education to address stigma around behavioral health needs and raising awareness around 988.** **d. Increase use of telehealth services to enable access to behavioral health services**	Prevention services for youth need to be increased and expanded such as implementing SEL in schools, mental healthcare on campuses, etc. (1 dot) As we said in our presentation, a lack of basic social services is a precursor to crisis. Focusing on prevention and basic needs will reduce strain on the crisis system. (1 star, 1 dot) We talked in our story project presentation how basic needs can create or exacerbate BH crises Rebuilding community fabric: -School as community resource hub -Community events to bring families/community members together in a low barrier way Bolster community family supports: -In home parenting support skill building -Basic social needs in the home Low cost/free mobile data/internet service needed

Recommendation	CRIS Member Comment
IV. SYSTEM OVERSIGHT AND PERFORMANCE	Could be the core of public education, provide info and decrease stigma In order to shift our system away from the criminal justice system, we have to bolster our civil commitment system as an alternative while continuing to work on early intervention and education. (1 star)
16. In partnership with consumers, develop a Caller Bill of Rights that provides information to consumers about what they should expect when they contact 988.	Our LE SC Story Project presentation talked about being clear about what 988 is and what it is not. But how do you connect people to the next steps?
17. Create a transparent system of oversight and accountability, including: **a. Set system standards, performance targets, and metrics to hold the system accountable to desired outcomes and with specific attention to disparities across populations.** **b. Create a dashboard to display system performance metrics publicly.** **c. Work with Tribes to incorporate Tribal-specific considerations to system performance and oversight and to ensure system recognition of Tribal data sovereignty.**	2 dots Adequately fund thru Medicaid + commercial rates incentives to create transparency + be motivated by metrics Develop system oversight mechanisms not just for who we serve, but for who we miss. (1 dot) Oversight and accountability including standards of care that are consistent across 988/RCL/911 and the behavioral health provider agencies providing services so providers & community understands roles/expectations This can fit within the role of the ASO. Assume accountability, plan for consistency... Ensure metrics are viewable by age, race/ethnicity, and language of care (2 dots)
18. Convene and support a mechanism for diverse communities and individuals with lived experience in ongoing efforts to develop and monitor the crisis response system.	This is something we very much want. With the lived experience subcommittee ending and our project not having both phases we are worried about how (1 heart) LE SC is working w HCA & DOH to figure out the future of voices heard via the LE SC. How can we tap into that after this year in an ongoing fashion

Recommendation	CRIS Member Comment
19. 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).	4 dots People who don't feel safe with the possibility of law enforcement response still deserve crisis supports. (2 dots)
V. CROSS-SYSTEM COLLABORATION AND COMMUNITY PARTNERSHIPS	
20. Encourage and foster regional collaborations that convene system partners to create regional plans and protocols for crises.	Mental health advance directives need to be utilized by all system partners! This has been brought up but not explored enough (1 dot)
21. 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. **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, and other crisis system partners.** **b. Implement Tribal Crisis Coordination Plans established by individual Tribes.**	Need to include 211 as a major partner - it provides post-partum (?) and prevention services Create pathways for social se (?) referrals (2 dots)
22. 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.**	Solutions need to be established on how to identify youth callers while still respecting caller privacy. (2 dots) Youth should be connected to youth peers Youth with IDD, youth with challenging behaviors, young children under 12, and youth victims of trafficking. (1 dot)

Recommendation	CRIS Member Comment
c. Expand programs that address the needs of justice-involved youth who are experiencing a behavioral health crisis.	
23. 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.	Collaboration should include all first responder types to ensure education around who the behavioral health providers are and the resources they provide is known so alternative services can be used. Can someone remind me about this workgroup?
24. 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.	Reground crisis center (within each ASO) as a crisis center hub to be the expert of crisis services and resources on the … with 988 centers We need to ensure we are in close collaboration with the Youth MH group and can agree to actionable items for the 2025 session that are consistent. Youth MH access to services is woefully inadequate. (1 heart)
VI. Crisis System Workforce and Training	We are in a workforce crisis - very important
25. 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.**	Need to ensure 988 RCL staff have training in supporting youth and adults with IDD especially if it is a parents' loved one making the call. (3 dots) What IDD system? How we create a continuum of care if the system doesn't exist Ensure training isn't duplicative or overly burdensome so providers still have adequate time to deliver care to their patients/clients Help 988/RCL call takers appreciate that connection to MRSS/resource isn't "dispatch" it's the clinically appropriate next step! How do we help see that as success? Developing training for 988/RCL/911 call takers to understand different call types and caller

Recommendation	CRIS Member Comment
	demographics. Also what responders are available outside of the traditional first responders? More definitive as to an ideal state crisis continuum...
26. Integrate peers into all parts of the crisis system workforce. 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.	Peers are essential as part of the workforce (2 dots)
27. 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 for behavioral health workers, including peers.	LE story project talks about how diversity can change an outcome e.g. person who was scared of law enforcement but connected with officer because they were both veterans (1 star) We heard a quote from our story project that how you pay makes a difference in the quality of staff you get.
28. 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.	2 dots LE story project covers this in natural supports insight. Caregivers need care too. (1 star)
29. Expand mental health first aid training and education for laypeople and consider mandating age-appropriate mental health first aid training in schools.	2 dots More pop-health specific workforce development. IDD - esp. those with more profound autism or “aggressive” behaviors. MH First Aid grants were given out through the legislature - we should get an update on where all these trainings have been done and by whom - I know NAMI did many of them. We should build on that work to ensure access across the state and to all individuals. (1 thumbs up)

Recommendation	CRIS Member Comment
	Very important for Agricultural folks (1 star) We need to treat staff well and support them so we don't burn out, otherwise we will continue to have too few staff across the board. (1 heart)
VII. TECHNOLOGY	1 star Make sure that the people doing the work (VOA, CC, FBH) are driving the process What can we learn from other states and technology solutions that streamline + create more transparency (1 dot) This portion of our work has the potential to drastically alter the counsel... (1 dot) This is key to efficiency. Complex work that still seems to be a future vision + plan Data collaboration between 988/RCL/911 and alternative/crisis programs (3 dots)
In 2022 and 2023, CRIS Committee and Technology Subcommittee focused on informing DOH and HCA efforts to develop 988 crisis response system technology platform as envisioned by HB 1477. In 2022, this included a focus on development of the Technical and Operational Plan: Crisis Call Center and Behavioral Health Integrated Referral System. This report described the technical tools currently used in Washington, technical functional requirements needed to achieve the vision of HB 1477, initial research of the vendor landscape, and technical considerations for the platform. A Tribal consultation process also informed the development of the Technical and Operational Plan. **In 2023, the Committee focused on work informing the technology vendor Request for Information (RFI) and Request for Proposals (RFP) process led by HCA and DOH. In addition, DOH and HCA gathered input from diverse groups, including the Lived Experience and Tribal Subcommittees, to inform**	There is no continuing input into the tech platform development from the LE perspective. This needs to be figured out.

Recommendation	CRIS Member Comment
the 988 technology user experience and work to ensure a human-centered design for the technology platform. **In 2024, the Washington State Legislature passed SB 6308 that extended the date by which funding would be made available for the Crisis Call Center Platform from July 1, 2024, to January 1, 2026. This extended timeline allowed the agency to update the project timeline to the approximate dates:** • **Completion of feasibility study by December 2024** • **Release of the RFP by July 2025** • **Selection of the successful bidder by December 2025, vendor development of platform in 2026** • **Phased roll out of the platform being in April 2027.** **The CRIS Committee will continue to inform the agency work to develop the technology platform in these continued efforts. In 2024, the Geo-Routing Subcommittee was also convened to advise on 988 implementation of geo-routing in Washington as directed by federal policy.**	

Recommendation	CRIS Member Comment
VIII. Funding	Regional discrepancies in service availability contribute to … and confusion of the system (3 dots) Provide realistic funding in the "somewhere to go" category to support complex care needs Still recommend a 24/7 "firehouse" model approach to funding our mobile crisis system (1 dot) Fund a strong 211 system as a post … (211 call centers & robust database) (1 dot) Ongoing resources for qualitative lived experiences input (like the stories project) Ensure stable & adequate funding for 988 contact centers (DOH DP) Need a payment methodology statewide to sustain the crisis services. Fee for Service + firehouse model w/… metrics for incentive payment (1 dot) Open/support processes to increase alternative providers to receive funding by becoming MRRCTs/CBCTs CRE: Endorsement Reqs Housing - critical to funding a crisis continuum (1 dot)
30. Provide additional funding to behavioral health crisis systems across regions and evaluate distribution of resources to identify and address disparities. **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 (i.e., services not just for Medicaid clients or commercially-insured clients).** **d. Ensure crisis service funding to the Medicaid fee-for-service system,**	4 dots Recognition that the funding will have to be braided + account for regional + population differences Incentivize providers to locate in rural areas through tuition payments etc. (1 thumbs up) This recommendation is confusing to me. The crisis system is payer blind. What is being described is the connection to outpatient

Recommendation	CRIS Member Comment
recognizing that many Tribal members are enrolled in Medicaid fee-for-service rather than managed care.	