CRISIS RESPONSE IMPROVEMENT STRATEGY COMMITTEE
2024 MEETINGS: SUMMARY OF PANEL DISCUSSIONS

This document includes a compilation of the CRIS meeting panel discussions through July 2024.

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Substance Use Disorders and Crisis Response

Thursday, March 28 2024

Dr. Mandy Owens, PhD (assistant professor with the Addictions, Drug & Alcohol Institute at the University of Washington School of Medicine) presented on how SUD intersects with mental health crisis.

CRIS Committee member Aleesia Morales, Tacoma Fire Department, moderated the panel discussion. Panelists included Dr. Charissa Fotinos (HCA), Dr. Lauren Whiteside (emergency medicine physician at the University of Washington), Dr. Owens, Michael Robertson (certified peer counselor), and Representative Lauren Davis (32nd Legislative District). Panelist and presenter bios can be found at the end of the meeting summary.

Presentation:

Dr. Mandy Owens, PhD (assistant professor with the Addictions, Drug & Alcohol Institute at the University of Washington School of Medicine) presented on how SUD intersects with mental health crisis. She emphasized that mental health and SUD are often seen together among those in crisis, and separating the two is harmful to the individuals who live it as well as the community. She added that staff in the behavioral health crisis response system need training/support in both to be effective and save lives. Dr. Owens also shared the following data points:

- Among King County Medicaid beneficiaries, 41.2% have a mental health condition, 14.2% have an SUD condition, and 11.9% have co-occurring mental health conditions and SUD conditions.
- Among 23,000 individuals arrested in 2016 in Indianapolis, Indiana, between 20 and 25% of individuals experienced co-occurring mental health conditions and SUD conditions, while smaller proportions experienced these conditions on their own.

Dr. Owens also detailed her project taking place across seven counties in Washington state to determine solutions to crisis response to drug use. A current challenge identified by first responders and law enforcement is the strong connection between drugs and mental health; they expressed frustration about the disconnect in services separating mental health and drug use. For example, the first responders and law enforcement discussed referring individuals to mental health services, after which they are discharged they are seen as having a drug problem rather than a mental health problem. The responders also shared performance measures for mental health and SUD, including detection of SUD needs, referral to any SUD services, and engagement in SUD services. Dr. Owens highlighted unique needs and implications for SUD populations, including the following:

- The issue of stigma due to substance use harms outcomes, including health and service retention, indicates the need for additional training to reduce SUD stigma among behavioral health response system staff.
- Substance use can mask and/or mimic mental health symptoms, as well as exacerbate and medicate mental health symptoms. The current standard of care is to treat both at the same time, which requires a knowledge of the array of services for both mental health and substance use to make appropriate referrals.
- Use of illicit drugs inherently brings more extensive criminal histories, barriers, and stigma. Involuntary Treatment Act (ITA) laws differ for mental health only versus SUD. First responders therefore must also know these nuances for proper referrals.

- Increasing rates of drug overdose related to opioid and/or methamphetamine use represent an opportunity to provide naloxone and overdose education for individuals with both mental health and SUDs.

Dr. Owens then shared a graph on prior year system engagement types for King County overdose decedents between 2019 and 2021. She noted that the graph indicates the opportunities that could have prevented the overdoses, including Naloxone and buprenorphine provisions, or overdose education.

Dr. Charissa Fotinos (Medicaid Director and Behavioral Health Medical Director with HCA) presented on the current state efforts to address SUD. She discussed the need for a trauma-informed approach in responding to people with mental health and substance use disorder issues, particularly in the context of Fentanyl use. Dr. Fotinos also highlighted the efforts of the state government in addressing substance use disorders, including the opening of 23-hour crisis response centers and the establishment of model programs such as health engagement hubs and street medicine teams.

Panel Discussion:

- *What are the unique needs of people experiencing crisis related to SUD and/or co-occurring SUD and mental health conditions? How are these needs different from mental health specific crises?*
    - Dr. Owens highlighted stigma, the complex intersection between mental health and substance use, the legality of substances, and the lethality of substances.
    - Dr. Fotinos noted inpatient psychiatric hospitals often find it difficult to determine underlying concerns for patients experiencing psychosis and placed on an involuntary treatment hold.
    - Michael shared his experience working in Medication-Assisted Treatment (MAT) support, noting treatment and care should occur as quickly as possible.
        - Dr. Fotinos noted the scientific community is now attempting to determine the best way to treat fentanyl. She is currently working on pilots to get individuals stable as quickly as possible.
    - Dr. Whiteside noted that emergency medicine providers often do not have the appropriate tools to identify and treat underlying disorders after a substance-related crisis, including mental health comorbidities.
    - Rep. Davis discussed common factors leading to SUD, including loss of relationships, employment, and/or housing, as well as system interactions (e.g., arrest). There is often a baseline level of despair, resulting in substance use which amplifies those emotions. Additionally, the overlap between SUD and suicide is notable. She added that SUD can be stabilized using medications quicker than mental health needs can be addressing.
- *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 address SUD?*
    - Michael emphasized the need for immediate and convenient SUD treatment opportunities following the stabilization of a crisis.
    - Dr. Owens highlighted the current disconnect and separation between current systems, including medical, behavioral health, and SUD treatments. She encouraged the need to either transform or rebuild a system that addresses all needs at once.

- Dr. Whiteside noted individuals with SUD in the emergency department often are not seeking treatment. Emergency departments need to be able to handle comorbid SUD, specifically opioid use disorder, from the beginning (e.g., identifying patients, triage). The emergency department is an important healthcare location; it's always available with a warm bed and food. However, it can be difficult for patients to navigate. Echoing others, Dr. Whiteside noted healthcare providers must get comfortable outside the walls of healthcare locations, i.e. bringing care to the community.
- Dr. Fotinos highlighted initiatives in King County, Everett, and Tacoma with directed funding to five sites to either build or develop street medicine teams. Going to the community is important; they won't feel like they have permission to ask for help. The downtown emergency services center in Seattle is doing important outreach, providers across the state are going to people in encampments under bridges and trying to re-establish trust. We need to build on these efforts. From the HCA Medicaid system side, we are thinking about training everyone to be able to respond to both basic mental health conditions and SUDs. We can't continue to separate these out as two separate things. Need to consider how to move the system to really be co-occurring and patient centered. This will take training for basic intervention skills.
- Rep. Davis shared that crisis for individuals with SUD is often the window of opportunity into intervention due to the interruption of the daily use cycle. However, the window of willingness to engage in treatment is brief and fleeting. She noted that the workforce is key, as the vast majority of mental health professionals are underprepared to treat SUD due to lack of training. Certain therapeutic modalities are especially effective for SUD, including motivational interviewing and peer support, as well as recognizing and addressing drug seeking behavior. Rep. Davis also highlighted Ricky's Law, which is a Washington state law that allows the involuntary commitment of adults and minors who pose a danger to themselves or others due to SUD. She noted it is both highly effective and heavily under-utilized; emergency departments must bring in designated crisis responders to engage patients. SB-6228 being signed tomorrow will require training every three years for emergency department social workers in civil commitment statutes on the clinical criteria for detention.

- *The CRIS is developing recommendations for performance metrics to measure crisis system improvement. As they continue developing these, what is one key takeaway about SUD that you'd like the CRIS to consider?*
  - Dr. Owens encouraged the CRIS Committee to consider the array of services available, including harm reduction services.
  - Dr. Fotinos suggested incorporating safe and respectful questions to determine whether persons calling in crisis may also be using substances.
  - Dr. Whiteside agreed that identification is an important first step. She also emphasized the importance of supporting the workforce to engage patients in crisis, including incorporating navigators and peer support specialists to support the work. Having sufficient workforce and ensuring that the work is being measured is key.
  - Rep. Davis recommended focusing on data capture on priority populations, including people who identify or are diagnosed with primary SUD. It's also important to track the care centers

from which the referrals derive, e.g., emergency departments, law enforcement interactions, etc. Ideally there would be a mechanism for continual feedback loops from system users; individuals with SUD will provide suggestions for improvements.

    - Michael suggested looking at the initial interruption or point of support, and how safe and supportive the interruption was. Crisis centers can't appear similar to carceral settings, and professionals must be fully trained, prepared, and schooled to engage with the affected population. An important metric is also peer support, which must be included at the onset of services. Data collection must happen in the right way and be shared.

- Rep. Orwall thanked the panelists and asked them how the 23-hour crisis relief centers might be configured to be a no-wrong-door opportunity for people with SUD, and whether there is a way to fast track people into the system.
    - Dr. Fotinos offered to share ideas with Rep. Orwall as HCA is working on funding these efforts.
    - Rep. Davis recommended incorporating peers and training clinicians. She also emphasized the role of medications, ideally an opioid treatment program to dispense onsite or becoming a fixed medication site, in addition to having buprenorphine and medications for alcohol use disorder. A more innovative option would be ambulatory detox, allowing individuals to leave the centers and continue withdrawal management at home with supervision. Rep. Davis also highlighted referral pathways that are well worn and established for opioid treatment programs, Methadone, withdrawal management, residential SUD, buprenorphine, etc.
    - Michael suggested revamping and creating an auxiliary training for peers and auxiliary staff that works directly with newfound approach to crises.

Jamie thanked Aleesia for moderating and the panelists for their preparation and presentations.

CRIS Discussion:

Jamie facilitated a discussion in which CRIS members were asked the following questions:

- What was your biggest takeaway from the panel discussion?
- Reflecting on the guiding principles and proposals for metrics that we developed at our last CRIS meeting, based on what you learned about SUD, what else should we add to better address SUD?

CRIS Committee Member Discussion:

- Dillon Nishimoto, Asian Counseling and Referral Service, agreed with statements around the need for additional training for mental health professionals, as well as folks across the board engaging with individuals in crisis. Mental health first aid training is widely available, but it may not include sufficient training around SUD; there may be some room to expand or improve on that.
    - Kristen Wells, Valley Cities Behavioral Health Care, noted the mental health first aid training does not cover SUD, and agreed with either incorporating it or making a substance use first aid training widely available.
- Kristen also reflected on the lack of training for SUD for mental health professionals. As a licensed social worker she completes ITA assessments, and she noted wanting to be more knowledgeable about Ricky's Law and the differences between detainment for mental health and detainment for SUD.
- Anna Nepomuceno, National Alliance on Mental Illness (NAMI) Washington, shared the panel reconfirmed stories from individuals with co-occurring SUD and mental health treatment being forced

to choose between substance use treatment and mental health treatment. This clarifies the need to acknowledge co-occurring conditions and identify opportunity to reduce barriers to treatment.

- Rep. Orwall echoed the need to bring these various components together in the 23-hour crisis relief centers to provide support for co-occurring needs.
- Aleesia highlighted hearing from the panelists about the need for collaboration. Her team supports folks after 911 has been called, so they may have an interaction with a traditional first responder, but it could be an issue related to substance use. Aleesia coordinates with the traditional first responders within the 911 system as well as the hospital, and she contemplated how all aspects can work together in supporting each other and understanding available resources. Workforce development, training, and education should be at all levels, including any folks that could interact with an individual in crisis.
- Darcy Jaffe, Washington State Hospital Association, emphasized Dr. Owen's data around co-occurring mental health and SUD, adding that individuals often have a co-occurring health condition as well. While the current structural systems make it difficult to address the whole person, practitioners should make the shift to view it from that lens.
- Ron Harding, City of Poulsbo, highlighted the discussion around Fentanyl withdrawal, providing personal anecdotes of law enforcement interacting with individuals going through similar experiences. Providing quick treatment and medication to reduce anxiety and fear is important.
- Bipasha thanked the panelists for their presentations, particularly their use of plain language. She echoed the workforce development issue and professionals being trained in SUD along with mental health. As a crisis counselor, she emphasized the need for a holistic approach to address both the individual and their family's needs.
- Dillon added via chat that the panel didn't touch on family-initiated treatment allows a parent or guardian to bring their child that's above the age of consent for minors for behavioral health services (13) but below the age of adulthood (18).
    - Bipasha also noted the lack of discussion around youth and youth issues.
- Puck Franta, Access & Inclusion Consultant, highlighted substance use as a barrier to most places folks access care and housing. The idea that an individual must attain a certain level of sober to access most services is a key challenge. Puck also flagged the perceived lack of cultural competence between some mental health providers and some substance use situations.
- Dr. Snowden, Harborview Medical Center, agreed with Darcy on the importance of recognizing that mental health and substance use issues do not live in a vacuum separate from overall health and physical health conditions. The panel also spurred thoughts the connection between the lack of use of secure withdrawal beds and time to DCR responding to emergency departments, and therefore emergency departments decide not to refer to involuntary treatment. Additionally, the amount of time required to resolve symptoms that come from substance use problems indicates that the system is still designed more on mental health ITA needs than substance use needs. Dr. Snowden suggested identifying a way to have DCRs either in the emergency departments or more rapidly able to respond to emergency departments if time is the barrier to the valuable resource in terms of beds for people to go to.
- Kristen highlighted looking at whether services are divided in places providing crisis services. She has seen mental health facilities turn away folks because they cannot medically support their detoxification process. On the other hand, substance use treatment facilities are not equipped to support an individual that is at risk of harming themselves. This prevents individuals with co-occurring needs from accessing care. When looking at system oversight, she suggested looking at whether facilities can help individuals all at once rather than with one concern at a time.

- Aleesia emphasized Michael's point of having all levels of professionals on a crisis response team, including peers, clinicians, healthcare professionals, and nurses to support a person regardless of what the crisis is. It is also important for crisis response teams to understand resources for all types of crises.
- Darcy and Anna noted that one of the insurance exclusions including Medicaid Managed Care Organizations (MCOs) to admission to an inpatient psychiatric unit is primary SUD. This may be an item to explore.
- Anna emphasized Rep. Davis' point around data collection, suggesting the need to document when people are turned away from crisis facilities, particularly those with co-occurring substance use and mental health conditions.
    - Puck added documenting honestly and on-self protectively when we can't meet a person's needs when they show up for treatment.
    - Dr. Snowden noted that Harborview tracks data on number of patients detained by designated crisis responders, but declined psychiatric admission, and why. He suggested doing the same by mental health and SUD ITA mechanisms.
    - Dillon noted tools available through Point Click Care, which provides notification around emergency department visits and other items.
- Michelle McDaniel, Crisis Connections, suggested considering how to reduce barriers for workforce receiving training. Crisis Connections is working to ensure the community is aware of its Washington Recovery Helpline. It's also partnered with DOH to launch a bridge program for individuals to access medically-assisted treatment in the emergency room and then signed up with a provider in their community to continue that work. She also asked about how to elevate peers, including relieving financial and time barriers. Michelle suggested that the workforce is running out of folks to do this important work.
- Lonnie Peterson, DOH, added to the workforce discussion, specifically noting 988 day lifeline crisis counselors. As individuals can contact 988 for substance use concerns, Lonnie wondered whether crisis counselors could become overburdened due to the nuance related to and complexity of the work. She wants to ensure the crisis counselors have the support, training, and resources needed to help people contacting 988 with substance use concerns.
- Dillon also discussed improving follow-up after discharge; ideally outreach happens prior to discharge.
- Darcy discussed potential process measures to address substance use disorder; one of the potential measures could be reassurance that there's collaboration or pathways that are clear between the emergency departments and the 23-hour facilities.
- Michael raised concerns about entities claiming to offer harm reduction without proper execution and the potential blocking of access to actual treatment.

Rural Community Behavioral Health Crisis Response

Thursday, April 18, 2024

Dr. Kirchoff, PhD (clinical track faculty with the Washington State University Psychology Department and associate director with the WSU Psychology Clinic) presented on the WSU Farm Stress Program and the unique behavioral health stressors experienced agricultural communities.

CRIS Committee member Representative Tom Dent moderated the panel discussion. Panelists included Dr. Kirchoff, Don McMoran, Rob Bates (counseling services provider), Cassidy Brewin (suicide and opioid prevention coordinator), Levi Van Dyke (chief behavioral health officer for Volunteers of America Western Washington), and Representative Joe Schmick (9th District, house agriculture and natural resources committee).

Presentation:

Dr. Kirchoff also highlighted the following points:

- In 2020, the National Suicide Rates was 14.1 deaths per 100,000. In 2020, the National Suicide Rates for Farmers, Ranchers and Ag Population was 43.7 deaths per 100,000 population.
    - This is the 6th highest rate among occupational groups.
- In Washington State:
    - 17.5 deaths per 100,000, Suicide is 8th leading cause.
    - 21 counties are higher than state average, of which 17 identified as rural area.
- Common characteristics for farmers who died by suicide include:
    - Average age of 61 for male and 53 for female farmers.
    - The most prevalent circumstances were physical health problems, which was higher in the 65 and older category (54%).
    - Often felt financial stress.
    - Self blame is a risk factor for suicide among farmers. They tend to internalize their struggles, feel hopeless, which influences self-esteem and leads shame. There is reluctance to seek help, mental health stigma.
    - More than 70% of the suicides occurred by firearms (Miller DM, Rudolphi JM, 2022)

Dr. Kirchoff also provided an overview of sources of farm stress:

- Community and social level:
    - Changes in climate, weather patterns,
    - Market fluctuations,
    - Lack of government investment.
    - Limited resources (i.e. child-care, schools, grocery shopping, health services, veterinarian services)
- Individual level:
    - Physical health (i.e. injuries, tractor accidents)
    - Mental health (i.e. divorce, death of partner/ solitude, alcohol use)
    - Financial costs (i.e. rising input costs, thin margins, loans)
    - Social Network
- Identification and values:
    - Reliance on self or on family and community

- Identification with profession, land and livestock
    - Farms often in family hand for generations, livelihood
    - Having to give up a farm is experienced as personal failure
    - Lack of alternate pathways

Dr. Kirchoff highlighted the Farm Stress Voucher Program set up through the funding from WSU and Don McMoran's office. Through the program, WSU offers six flexible telehealth therapy sessions free of charge to the agriculture community. The therapy is anonymous to protect the farmers' privacy. The aim of the program is to decrease obstacles to receiving mental health services as well as meet farmers and family members where they are at. After grant funding runs out, WSU plans to leverage students in the Ph.D. program in Clinical Psychology to provide therapy and assessment services under close supervision.

Dr. Kirchoff shared that Don McMoran was the recipient of the annual Joe D. Shelton Memorial Award from the Broetje Family Trust. Joe D. Shelton was a gifted farmer and leader that devoted his life to serving others at Broetje Orchards. He held a deep respect for the land and all those who worked there. He loved his family, being out in nature, and farming. He believed that everyone deserved an opportunity to work so that children could be raised in healthy, thriving communities. The award goes to organizations that focus on the health and wellbeing of agricultural and Native communities, and those who live close to the land.

Don McMoran (WSU's agriculture and natural resources extension educator and director) presented on the 988 AgriSafe helpline. When WSU started on FarmStress suicide prevention work, the U.S. Department of Agriculture (USDA) mandated the development of a call center for the western region (13 states and 4 territories in the west). WSU initially partnered with Farm Aid to provide agricultural operators with resources and support. However, Farm Aid's east coast hours prevented full support for the west coast. In the third round of USDA funding, WSU suggested Farm Aid provide an additional 8 hours of support per day, 5 days per week, as well as host operators located in Washington state. Farm Aid agreed; there are now two operators located in Washington state working for farm aid on their resource line, and they are successful in connecting farmers with resources including attorneys, accountants, and USDA programs. However, the operators do not work with crisis. WSU pivoted to partner with AgriSafe crisis call center, which operates a 24/7 AgriSafe Stress Hotline and has operators in Washington, Oregon, Montana, Wyoming, and Colorado (available at: 833-897-2474). Don added that senators are pushing for this service to be available nationwide. One downside is that AgriSafe does not mandate its operators to have an agricultural background, and ideally callers can engage with individuals of similar backgrounds. There may be potential to design a new system that works well for Washington state.

Panel Discussion:

- *What are the unique needs of people in rural areas and in the agricultural industry who are experiencing a behavioral health crisis?*
    - Levi recognized the unique needs of rural areas and the agriculture industry, and emphasized the importance of addressing these needs. These include, for example, weather, markets, and added stigma. 988 can expand on agricultural-based training. For example, farming can be isolating due to time spent alone working; farmers may need a number to call or text to feel less alone. Additionally, in rural areas, first response may not be a mobile team, but volunteer firefighters or law enforcement. These responders could also benefit from additional training and resources.

- Cassidy emphasized stigma as a specific barrier. In her experience, people don't want to visit their suicide prevention booths at community events because of the association to mental health. Individuals don't want to be seen as weak or needing behavioral services. She has also seen a breakdown of the crisis care continuum in her community, specifically someone to respond and somewhere to go. In her community, it can take hours for mobile crisis teams to respond; that person may no longer be in acute crisis and may not qualify for support such as respite beds in the Crisis Center.
- Rob emphasized the barriers that come with responding across farther distances in rural areas. The lack of mental health providers in hospitals can also pose a challenge.
- Rep Schmick noted that when he speaks with farm groups about the agricultural suicide situation, and financial and other stressors that cause this, he is hearing that they want to talk to someone as close to home as possible. Encouraged to hear AgriStress have staff in five western states. He added the need for operators that are trained in and speak agriculture. Rep. Schmick personally experienced challenges as a farmer looking for financing. It would be helpful to get more farmers and folks associated with the farming industry that understand triggers and stressors to support crisis work. He wondered about what happens to individuals that move beyond an acute crisis; what might that follow-up look like.
- Don highlighted the Agrarian Imperative created by Michael Grossman (available at: https://www.lsuagcenter.com/~/media/system/b/8/4/3/b8435231cbb318bac67b4f0f552ba93a/the%20agrarian%20imperativepdf.pdfhttps://www.lsuagcenter.com/~/media/system/b/8/4/3/b8435231cbb318bac67b4f0f552ba93a/the agrarian imperativepdf.pdf). Generational pressures can be a unique challenge for the agricultural community. However, the landscape has changed. Commodity prices, with the exception of beef, are trending lower, and input costs are higher. Farmers are under tremendous stress to make ends meet, specifically with high interest rates. Don also emphasized the need for education and resources, and the idea of a dedicated resource line for farmers.
- Dr. Kirchoff noted the need for a more sustainable and comprehensive system for farmers, highlighting the importance of having specific language and knowledge of issues. She suggested the establishment of a specific hotline for farmers, which would provide immediate access to resources, including mental health services and short-term labor assistance. Beyond that, there is a need for people on the ground who are aware of what's going on and can follow-up and reach out. If someone is in crisis and reaches out, could have a lot of resources available to them. Our program for example can quickly help someone that is suicidal that needs mental health services.

- *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 people living in rural and agricultural communities?*
  - Cassidy touched on the appropriateness of existing contract deliverables for crisis services in rural and agricultural communities, suggesting a need for improved systems tailored to these communities' specific needs.
  - Levi emphasized the need for creativity, collaboration, and layering in specific expertise to improve the current systems. He also highlighted the importance of follow-up services and

using various communication modalities to reach out to individuals. Levi also suggested involving more people from the communities they serve in decision-making roles.
  - Rep. Schmick agreed with Levi's ideas and added that they need to find the right people to help their communities, particularly those experiencing specific stressors. He expressed a shared commitment to preventing suicide among farmers.
  - Dr. Kirchoff proposed that the hotlines could recommend key people that could be trained to recognize and respond to signs of distress. A farm response team could also contact farmers, either as a mobile response team or at least virtual response.
  - Don highlighted the importance of accessible and affordable mental health support for farmers.
  - Rob proposed that recruiting staff and providers from local communities could help the behavioral health system, especially in areas with unique cultural needs.
- Representative Tina Orwall asked if there are specific regional farming issues that would not be well addressed on a national line.
  - Rep Schmick shared that differences in crop cultivation can create unique needs among agricultural communities. These can be impacted by market and market access.
  - Levi added that the impact of weather patterns, such as wildfires, can create additional unique needs.
  - Rep. Dent noted different locations will have unique social dynamics within agricultural communities.
- Kashi Arora, Seattle Children's, asked if the panel could share insights on the unique needs of children and youth in agricultural farming families.
  - Rep Schmick noted it is difficult for families in agricultural settings to hide stress. Parent stress will fall to the family; they can feel when something is wrong. These children and youth can internalize a lot.
  - Cassidy added that school districts in agricultural and rural communities can play a role in supporting behavioral health services. However, many school districts do not have access to behavioral health services onsite.
  - Rob highlighted the need to support parents in order to support their children. Otherwise, the same cycle and negative coping skills will be transferred to children, and nothing will change.
  - Levi noted that youth today have more stress than ever. Physical ailment or difficulties among parents can result in youth feeling they need to pick up slack on farm or ranch and do more. There is also a concern around access to lethal means for children and youth on farms.
  - Dr. Kirchoff shared that family legacy is very important. If a farm is affected, it usually will affect whole family. This is a huge burden on youth to feel responsible and help the farm, and may have limited access to resources compared to urban counterparts.
  - Rep Dent shared an example of a large agricultural family in North Central Washington facing significant financial challenges, leading to family tragedies.

- Claudia D’Allegri, Sea Mar Community Health Centers, noted that a large portion of farm workers are Latinx. What kind of mental health and culturally competent services are available to them and their families?
  - Cassidy emphasized that there are not enough culturally competent resources provided to Latinx communities. Walla Walla is trying to increase the number of trainings offered by bi-cultural folks who can offering those sorts of resources to folks. She added the need to compensate folks to come to those things. They will have lost wages if they are not offered at appropriate times. There is a need for space to share resources while making sure they don’t lose wages to get to those resources.
  - Levi noted VOA is constantly trying to make services more culturally relevant, but this is an area where we can all do more.
  - Dr. Kirchoff emphasized the presence of stigma around mental health and suicide prevention.
- Kashi also asked about effective strategies to reduce stigma around mental health conversations and/or asking for help when an individual is suicidal.
  - Rob highlighted the importance of open conversations.
  - Dr. Kirchoff agreed with drawing attention to stigma, noting the younger generation may be a key entry point, and working to normalize mental health issues. It can be powerful when people in the community share about their own mental health issues to other farmers.
  - Cassidy noted efforts in her community to build a foundation of everyone speaking the same language around suicide prevention. She emphasized the need for community-based solutions, such as offering mental health first aid and QPR trainings, to promote awareness and reduce stigma.
- The CRIS is developing recommendations for performance metrics to measure crisis system improvement. As they continue developing these, what is one key takeaway about rural and agricultural communities you’d like the CRIS to consider?
  - Rob emphasized the importance of workforce development and encouraging more people into the mental health care system in these areas.
  - Rep Schmick stressed the need for people who can speak the language of farming and ranching.
  - Cassidy: Noted that improving crisis systems in rural areas will require continuous effort and improvement. She encouraged the CRIS Committee not to give up on rural areas, adding they are just as important as the urban areas.
  - Dr. Kirchoff agreed with Cassidy, noting farmers are our food source. A metric for success would be a decline in death by suicide, as well as an increase in utilization of suicide health lines by farmers from the communities. She recommended asking farmers about their experience receiving services, including what was helpful and what could be improved.
  - Levi noted that trust and engagement are key.

- Rep. Dent emphasized that the rural community thinks differently, and their lives are different. They will react better to someone that understand them and relates to them. He encouraged the CRIS to think about the uniqueness of the rural and agricultural communities.

Rep. Dent shared that he received proviso in the Washington state budget for $250k to support and finance a panel to look at uniqueness of agriculture, mental health, and suicide, and determine if we need to do things differently.

Jamie thanked Rep. Dent for moderating and the panelists for their preparation and presentations. CRIS members shared that the presentation and panel helped them appreciate behavioral health crisis considerations for farming and agricultural communities at a new level.

Crisis Care Continuum for Youth

Thursday, June 18 2024

CRIS Committee member Kashi Arora (Program Director for the Behavioral Health Service Line at Seattle Children's) served as moderator and opened the presentation and panel discussion of youth crisis needs. Kashi provided an overview of the youth crisis service continuum, which includes someone to talk to, someone to respond, and a safe place to be for youth. Kashi underscored limited options for crisis response for youth, particularly in crisis service continuum of safe places to be. In addition, there is need for connections between all three elements of the system.

Panelists included Starleen Maharaj-Lewis (Systems and Family Tri-chair at North Sound Family Youth System Partner Round Table/FYSPRT), Dianne Boyd (Licensed Mental Health Counselor and Child Mental Health Specialist at YMCA Social Impact Center), Sue Rash (Clinical Supervisor with the CCORS program at YMCA Social Impact Center), and Dr. Alysha Thompson (Clinical Director and attending psychologist at Seattle Children's Hospital).

Presentation:

Presenters from 988 contact centers and HCA provided as overview of current crisis response services and protocols for youth.

Courtney Colwell, MSW, MHP (Director of 988 Services at Volunteers of America Western Washington) and Diane Mayes, MA, LMHC, MHP, CWPC (Clinical Director of 988 Crisis Services at Crisis Connections) shared protocols for responding to calls from youth or third parties calling about youth. Crisis Connections and VOA have expanded their outreach and ability to connect with contacts across the state, starting first with phone services in July 2022, now adding chat/text services statewide and Mental Health Diversion Initiative pilots in which 988 counselors are embedded in three different 911 centers across the state. This has led to an increase in contacts across the spectrum, particularly with youth contacts, as historically 50% of clients accessing chat and text services tend to be under the age of 18. VOA has been working improving barriers to data collection for chat and text as well. 988 Youth Response Protocols include the following:

- Training for call teams and crisis teams includes youth content
    - Lifeline tip sheets from Vibrant
    - Webinars for self-pace learning and informational updates
    - Resources and Guidelines for LGBTQ+ Youth
        - Inclusive language tip sheets
        - Youth Page: https://988lifeline.org/help-yourself/youth/
    - State and local resources used within crisis centers
- All contacts received by youth under 18 require clinical observation
- All contacts are assessed for safety
- Build rapport
- Attempt to gain demographic information, history, other pertinent details

Diane shared that in King County, Crisis Connections offers opportunities to connect youth contacts to Children's Crisis Outreach Responses System (CCORS/CCORS-YA), which is run through the YMCA and connects youth directly to care. Crisis Connections also has a Youth Mobile Crisis Team Dispatch which coordinates with Regional Crisis Lines (RCLs). It also offers follow-up care for youth contacts the same as adult contacts, where they are offered the opportunity to receive a follow-up call or outreach from follow-up specialists. Courtney

highlighted VOA's ability to warm transfer and stay with the client as long as possible through the process should they need services outside of its immediate service region.

Sherry Wylie (HCA) provided a brief refresher on the Youth Mobile Response & Stabilization Services (MRSS) model for youth callers. MRSS has two phases, first offering outreach to all open referrals through an initial response, and second through stabilization in-home services. Youth stabilized in the home and community prevent return to crises. The goals of MRSS are the following:

1. Support and maintain youth in current living environment.
2. Engage youth and families by providing access to care.
3. Promote safe behavior in home, school and community.
4. Reduce use of ED's, Inpatient units and detention centers.
5. Assist families in linking with community and clinical services.

Washington state went from four youth teams covering five counties in 2022 to 14 youth teams covering 18 counties and with plans for continued expansion. These youth MRSS teams reduce reliance on the adult crisis system, the involuntary treatment system, and 911.

Panel Discussion:

- *What are the unique needs of youth and transitional age youth who are experiencing a behavioral health crisis, specifically after 988 implementation?*
    - Sue noted the age of consent issue can cause challenges. For example, since the COVID-19 pandemic, children around 11 or 12 are coming in with significant suicidal ideation and other behaviors that had previously been attributed to older children.
    - Dianne shared key issues they are seeing:
        - Earlier onsets of psychosis from kids, as well as ramifications from the COVID-19 pandemic including anxieties and school issues.
        - Young adults with unstable housing or at risk of losing housing because of behavioral health issues. They often struggle with substance use and finding appropriate housing resources.
        - Programs have seen a lot of staff turnover which creates a lack of trust with other providers.
        - Families also often do not have respite options when they need a break.
    - Starleen shared her recent experience with accessing crisis services for her child, illustrating the difficulties faced by families trying to access help during times of crisis.
    - Alysha emphasized the need for a broader definition of "crisis" beyond suicidal ideation, given the diverse manifestations of crisis among youth. She also expressed concerns about the current system's inability to provide adequate support for youth experiencing aggressive or other dangerous behaviors.
- *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 youth experiencing a crisis?*
    - Alysha highlighted the need for immediate connection to the right resources via 988.
    - Starleen recommended simplified language and scripts to navigate the system.
    - Sue suggested the increased use of parent partners and peers in crisis response.
    - Dianne highlighted the importance of thorough vetting of crisis situations to ensure staff safety.

- *As the state continues to work on improving the crisis response system, what is one key takeaway about youth and transitional age youth you'd like the CRIS to know?*
    - Dianne suggested looking at other gaps in the system that are needed for supporting families, e.g., building up a respite system.
    - Sue highlighted the lack of depth among youth services.
    - Starleen noted the challenges related to accessing services, which promotes distrust with the crisis system for youth.
    - Alysha emphasized that youth are part of systems, and we need to support caregivers. She added the crisis continuum needs to include follow-up and prevention efforts. Alysha also highlighted the issue of youth needing to fail out of systems to access higher levels of care, which needs to be addressed.
- *What kinds of supports exist for the siblings of youth in crises?*
    - Sue noted their crisis teams with CCORS work with the whole family as much as possible.
- *What does a safe place to be look like for youth? What services would be available?*
    - Dianne shared that working with the young person and their family at their home is ideal. Natural supports such as grandparents, uncles, a trusted friend, etc. can also spend time with the youth. This is to keep them in the community with friends and family as a first option.
    - Sue suggested there should be staff at crisis centers that are child mental health specialists or youth peers that are trained to work with youth in spaces that are comfortable and feel safe.
    - Starlene reframed safe places as a space to deregulate, which requires situational awareness to identify.
    - Alysha added more accessible respite options are needed. She emphasized ensuring there are options for youth beyond family and other natural supports.
    - Puck, Lived Experience Subcommittee member, emphasized the importance of individualized supports. They recommended focusing on getting people stabilized first before having conversations with them about what their care might look like to be successful. Puck suggested asking youth what's going well.
- *How do we ensure those places are actually safe and culturally responsive? How can we make this space particularly more comfortable and accessible for youth?*
    - Starlene emphasized the importance of engaging with youth where they are and identifying appropriate avenues for communication. This includes allowing them to express themselves in various ways, such as through art and group sessions.
    - Alysha suggested making it easy for youth to contribute from where they are, both psychologically and physically.
        - Kashi added timing is also important to avoid conflicts related to school, etc.

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

CRIS Discussion

Jamie facilitated a discussion in which CRIS members were asked the following questions:

- What are your reflections on what you heard today? What – if anything – surprised you?
- Based on what you heard today, what is a gap that we need to address as a committee to create a crisis response system that better serves youth?

CRIS Committee Member Discussion:

- Bipasha suggested that 988 can act as a gatekeeper to the next level access within the system when certain crises don't seem to "qualify" for care. She noted there is a scarcity mentality in the system right now, where potentially MRSS offerings are not what is being screened for. Bipasha added there is a deep need for education between real crises and what is being screened.
- Kristen highlighted the need for a more connected and comprehensive crisis line system. She added there is no easy way for people taking calls to know where to refer to.
- Aleesia Morales, Tacoma Fire Department, highlighted the need to better integrate the 911 and 988 systems to better serve people experiencing behavioral health issues.
    - Bipasha agreed that people with behavioral health issues should get help regardless of whether they call 911 or 988.
- Leah raised concerns about the need for cultural competency training as well as ensuring that people are not referred to unlicensed facilities.
- Dr. Snowden, Harborview Medical Center, emphasized the gap between how the system is supposed to work and the experience of people in the system. The recent emphasis about monitoring and oversight will likely make a difference. It's not currently clear what actually happens in these systems to respond from a quality improvement standpoint. He recommended developing that oversight system and a way to instill quality improvement rather than just counting on building the system out and assuming it will work the way we want it to work.
- Kashi highlighted the need to improve data collection processes.
- Puck suggested that the system needs to be responsive; it should be able to accept feedback and adapt based on that feedback. This will require hearing from people who have poor experiences within the system that may not have an advocate supporting them.
- Bipasha asked whether it is possible to track why a call wasn't connected to MRSS rather than just when it was.

Tribal Behavioral Health Crisis Response

Tuesday, July 16, 2024

Vicki Lowe (Executive Director for the American Indian Health Commission, AIHC) served as moderator and opened the presentation and panel discussion of Tribal behavioral health crisis response.

Panelists included Councilwoman Rosalee Revey-Jacobs (Council Member at Lummi Nation), Emily Arneson (Suicide Prevention Coordinator at Port Gamble S'Klallam Tribe), and Kelly Waibel (Licensed Mental Health Counselor at Tulalip Tribe Behavioral Health).

Presentation:

Vicki provided an overview of Tribal efforts in Washington to improve access to behavioral health services and crisis response for Tribal members. The behavioral health crisis response system in Washington was not developed with the inclusion of Tribes as Tribal Health Jurisdictions or Indian Health Care Providers (IHCPs). Examples of key gaps include:

- Behavioral Health Administrative Service Organizations (BH-ASOs) are not clear on how to work with FFS Medicaid patients and Indian Health Care Providers.
- Non-Tribal Providers often consider the FFS program as "not having coverage" which has a significant impact on Tribal populations given that 60% of the AI/AN population is enrolled in Medicaid FFS.
- Lack of access to voluntary in-patient treatment impacts the ability to help those in crisis.
- Tribes and Indian Health Care Providers are not directly funded to provide crisis care.

Vicki highlighted the impacts and poor outcomes for Tribal populations, including disproportionate suicide rates, emergency room visits, adverse childhood effects, and historical and intergenerational trauma in the AI/AN community. Vicki also provided an overview of Tribal Authority and Sovereignty and the inherent power that Tribes have to govern their people, and as well as work to develop Tribal-specific crisis response resources such as Tribal Designated Crisis Responders, Tribal Mobile Crisis Teams. Further detail regarding these efforts is available in the meeting slides and recording on the CRIS webpage. For those interested in learning more about Tribal behavioral health and crisis response efforts, email Vicki Lowe vicki.lowe.aihc@outlook.com.

Panel Discussion:

- *What are some innovative and cultural solutions your Tribe/community are incorporating into your programs to address crisis and suicide prevention efforts?*
  - Councilwoman Revey-Jacobs highlighted Lummi Nation's crisis team, which consists of a manager and four peer supporters. They are available to go on scene and help individuals as needed. They can also bring in cultural support from elders, referred to as cultural coordinators. The whole team does everything in-house. A drug task force is also underway, with plans to hire a coordinator soon.
  - Kelly noted Tulalip's newer Designated Crisis Responder (DCR). There is also a crisis team, which consists of one mental health professional, one peer, and Kelly. Tulalip is hoping to double that number if they can find the staff. One option is to utilize behavioral health aides more in the behavioral health system, with substance use disorder (SUD), and mental health crisis to try to grow a workforce who are a part of and serve their own community. Tulalip is also working on drug task force to address opioid issues.
  - Emily shared that Port Gamble has an integrated health facility with medical, behavioral/mental health, SUD counselors, peer support, health aid, and dental all in one

facility. The integrated facility supports people where they're at; they use a no wrong door approach. Port Gamble is a small community and relies heavily relies on outside crisis response systems given their population size. Port Gamble has cross-training in the facility and provides holistic care to best support the culture and community. For example, there was an individual in crisis, and Port Gamble provided a psych nurse that also had a good rapport with their medical provider, who gave support and de-escalated the crisis. Beyond that, Port Gamble coordinates with external partners, including its BH-ASO, which contracts out mobile crisis and crisis triage services. Port Gamble has been working to outline coordination with system partners through the Tribal crisis coordination protocols.

- *What are system barriers that you are working to address crisis in your Tribe/community?*
    - Emily touched on their system, which includes someone to call, someone to come, and a place to go. Port Gamble has been partnering with the Native and Strong Lifeline, which has been helpful. While they don't have control over who is calling and who is not, it has been a great resource to continue to build that partnership and give services for referral. However, Someone to Come and a Place to Go are inconsistent and not always available. The county has one facility for crisis triage. The requirements for eligibility are lengthy and aren't necessarily "no wrong door approach," so folks are often diverted to emergency rooms. With hospitals, communication with the Tribe is lacking and inconsistent. Port Gamble has been working on different ways to address crisis coordination protocols. They're working on an approach involving individual agreements with hospital and inpatient facilities to increase communication. We know our people and what they need, so that communication is important and is a big barrier for us if we don't know where our people are.
        - Vicki noted HB 1877 recently passed, requiring all parts of crisis system to coordinate with IHCPs and Tribal governments on whether individuals are receiving care.
    - Kelly shared barriers revolve around knowing if folks are in the hospital, where they are going, where they are released to. Tulalip wants to ensure individuals in crisis have the community around them so they are successful when they come back. That coordination is getting better. As the DCR, she has been lucky to have county and BH-ASOs working well with us on training and support. However, it took time to build those relationships and figure out who does what, what is the best for the community, etc. Those are where most of the barriers are – building those relationships. Communication doesn't happen automatically like it should. Folks ask how they know whether someone is Native American – these are part of demographics that are usually gathered in the hospital setting. We are working to coordinate across systems. DCRs can go through the county system, or the Tribal court has codes for involuntary treatment. Tulalip is working with different inpatient facilities to make this work. Most of the time when someone is detained, that county system takes over the court process. That's not what Tulalip wants – they want to maintain people in their Tribal court system, which are often more restorative, with wraparound services. Tulalip is working with hospitals to make that happen, including looking at MOUs, equipment, payment, etc. The communication and relationship building takes time and persistence, which does eventually make a difference and we are grateful for that.
    - Councilwoman Revey-Jacobs noted Lummi Nation has struggled to hire on staff, which has been difficult since the COVID-19 pandemic. This has impacted Lummi Nation's most vulnerable departments, including law enforcement, behavioral health, and medical departments. Lummi Nation recently hired a behavioral health director, and she has been building their capacity, including the crisis response team and additional positions filled. They

are currently letting the community know what services are available 24/7, engaging outreach, and coordinating with internal and external departments.

- *What recommendations do you have for the CRIS committee to ensure the state addresses crisis system barriers?*
    - Kelly recommended encouraging communication; don't be afraid to ask. As a non-Native American, she is here to support the community. Tribes are resilient. Sometimes they just need support in what they want and need to do. Important to support the direction the Tribes would like to follow.
    - Emily echoed Kelly's thoughts, adding that training is important. We need to have training across ask sectors about Tribal sovereignty and crisis response processes. People need to be informed at all levels, including folks on the ground to understand what the Tribes are looking for and be familiar with the process. Prioritizing a no wrong door approach is important as well. Right now people are more familiar with and comfortable with 911, but there is a need to integrate our services to work together in tandem and ensure people receive what they need, no matter where they call or who they ask for help from.
    - Councilwoman Revey-Jacobs also recommended improving care coordination between local, state, and tribal resources, as well as government to government agreements, to ensure alignment and expectations.
- *Share experiences from your community on partnerships with hospitals and inpatient behavioral health facilities.*
    - Kelly noted that historically, relationships have been challenging. Police will take people into the emergency room, they are released after evaluation, and sent back out in two hours, while no one from Tulalip is notified. This is part of the reason the DCR and the crisis team was a priority for this community. Partnerships are getting better, but there are still times where someone is in a hospital and gets listed as a missing person because no one knows where they are. HIPAA regulations also prevent families from calling and asking if an individual is at the hospital or facility. Sometimes detectives will call Kelly about a missing person with a mental health history and ask if she knows where they are. Working with hospitals, Tulalip's DCRs have also started to get calls from the ER and inpatient social workers and about patients they believe are Tribal members. It's a work in progress, specifically coordinating with Tribal court orders to keep Tribal members within the Tribal court system instead of going through the county system.
        - Vicki added that since HB 1877 passed, that coordination between hospitals should be happening. She encouraged the group to think about what is keeping people and organizations from following the law in these circumstances.
    - Emily noted Port Gamble has been working on partnerships and relationships with their BH-ASO, and now coordinating with the hospitals. Port Gamble will need to have agreements in place with the hospitals moving forward. They are beginning to work more on those relationships, and Emily believes their success may vary from facility to facility. One struggle has been medical clearance; Hospitals are asking them to go to the ER before someone can go inpatient, for example. People are being sent home when they should not have been sent home or kept when they should not have been kept. The hospital also gets to decide when the DCR comes in or not, even if Port Gamble calls for a DCR in the county to come into the hospital. Staff turnover can also make relationship building difficult. An overall culture change is needed regarding the importance of communicating with Tribes. While the care

    - coordination agreements will be challenging, that's the avenue that Port Gamble must take right now, because the communication and coordination are not happening for them.
    - Councilwoman Revey-Jacobs echoed Emily's points on culture change and mental health. Lummi Nation does not have a good partnership with the hospitals at this time. She emphasized that it feels there is no follow through with them, and that their people are slipping through the cracks. Inpatient behavioral health facilities have no availability. However, the Councilwoman is hopeful they are heading in a good direction. Lummi Nation has a new Tribal liaison in the hospital to help build that bridge so they can coordinate better.
    - Vicki highlighted these challenges as institutional barriers and institutionalized racism. The Tribal leaders have been working on these for decades, including relationship building. She noted upcoming legislation from AIHC that will focus on addressing the hospital and ER challenges.

CRIS Committee Q&A:

- Kristen Wells asked to hear about "practice-based evidence" in crisis response since that is unique to the way Tribes think about evidence for interventions.
    - Vicki noted that evidence-based practices are created based on evidence that is not typically representative of Tribes. Tribes therefore have practices from their ancestors that have been handed down and have worked for thousands of years.
    - Councilwoman Revey-Jacobs shared that Lummi Nation has brought on two Tribal elders to provide cultural support as cultural coordinators. They are important to the community members and add value to the crisis system.
    - Emily noted their culture is their prevention. Talking about mental health and suicide is becoming easier within the community; there is less stigma, but it's still a challenge. Emily has begun facilitating groups to come together. Events that bring the community together are on the front end of prevention, and do not necessarily target a specific issue. Within the system, Port Gamble's integrated care also looks at the whole person to support treatment.
    - Kelly highlighted services at Tulalip's health clinic, including reiki, massage, and acupuncture. Tulalip also encourages community events, connection, and community. They look at the energy individuals are feeling and consider cultural treatments such as going to the water. This involves looking at what is most helpful to the individual rather than what might be considered a best practice or evidence-based. Evidence-based practices don't always work on a community that it wasn't based on, so adapting to the community is key.
    - Vicki emphasized that treatments may be different in each community. She highlighted efforts to implement behavioral health aides and ensure they are Medicaid billable. These are "grow your own" providers; they have a longer pathway to certification, and fit better with how Tribal people work. There are also projects to support billing for traditional Indian medicine—the Seattle Indian Health Board has developed billing codes. The AIHC is working on a credentialing process through a State Plan Amendment (SPA) with HCA. A few other states have amended their Medicaid State plan to include billing for traditional Indian medicine.
- What is something you wish the CRIS Committee and all state policymakers and lawmakers understood about Tribal sovereignty and how it affects your behavioral health crisis response work?
    - Councilwoman Revey-Jacobs emphasized that Lummi Nation knows how to take care of their people. She recommended more trust in the Tribes and better coordination.

- Emily echoed the Councilwoman's thoughts and emphasized that relationships are fundamental to the behavioral health crisis system. Should be a part of the process from start to finish.
    - Kelly noted they aren't trying to build a whole new system, but rather developing a community-based system instead of a state-based system.
    - Vicki added that Tribal sovereignty means that the Tribe has the right to govern their own people and manage their own resources. There's a federal trust and responsibility for the federal government to respect that. When a Tribe does something differently, that doesn't mean they are doing something wrong. It's not anyone else's right to tell Tribes they are wrong when they make decisions. Harm can result for Tribes when Tribal sovereignty is not understood.
- What do you think needs to happen on the state side to improve implementation of the intent of this bill?
    - AIHC is working on implementation plan that includes educating all relevant partners. The Commission will partner with HCA, DOH, and others to get information out statewide to help people understand changes and what they are responsible for.
- Michele Roberts asked if the panelists had any suggestions for the 988 Native and Strong Lifeline.
    - Councilwoman Revey-Jacobs emphasized the importance of coordinating care.
    - Kelly echoed the importance of continuing to coordinate.
    - Emily added communicating services to callers. Callers can also be referred directly to Port Gamble to provide or identify services. Having coordinated many times with 988, Emily is grateful for the relationship. It takes time to see the community trust the line; it will continue to take time. However, she has started to hear success stories, which is exciting.
- Vicki Lowe noted Councilwoman Revey-Jacobs mentioned difficulty in filling positions. She asked if there is anything the state can do to support addressing Tribal workforce needs.
    - Councilwoman Revey-Jacobs noted that Lummi Nation will need to ensure their salaries are adequate and ensure staff are happy to come to work.
    - Kelly noted overall, hiring providers is a challenge nationwide. This is a universal struggle.
    - Emily echoed the idea that workforce is a struggle everywhere. Port Gamble is interacting with county and state systems; any way they can support retention is important. Staff turnover causes issues and prevents progress in the system. If there is turnover, that transition could be smoother to ensure progress isn't completely lost.
    - Vicki noted that AIHC has created a behavioral health attestation process for Tribal behavioral health agencies. In the last legislative session, the Commission passed the bill to have an attestation process Tribally operated. Working on trying to get through backlogs and issues with behavioral health providers; this isn't specific to Tribes. There are a lot of people wanting to become providers, but the process has been difficult. The legislature has worked on this too. There are federal rules about IHCPs that DOH and HCA follow— leadership may follow but education throughout the system is needed and important.

CRIS Committee Member Discussion:

- Dillon Nishimoto, ACRS, emphasized the need to cultivate the habit of communication, not just when it's a crisis, but also normalize reaching out/coordinating even for routine things.
- Bipasha Mukherjee, CRIS and Steering Committee member representing Lived Experience, echoed Dillon's comment and expressed her frustration regarding the issues around coordination and

communication. She added hospital ERs consistently seem to be a place where many groups are not getting the right care in a crisis. She hopes there are broader bills that change that.

- Bipasha added that another example of Practice Based Medicine (PBM) vs Evidence Based practice (EBP) is Acupuncture which for a long time was not considered EBP and covered as a treatment. Now it is but a lot of things known to help are not researched in part due to lack of financial gain, so they never make it into EBP. From India – Neem is known to be highly medicinal and but very little money is put into research because it can't be patented to make money as it's a tree that's been grown for 1000s of years and used as medicine. This is deeply frustrating for people coming from other systems that have used practices for way longer than the term EBP existed. EBP is wonderful and needed but what do we do if there is not enough funding to bring them into the world of EBP because there isn't financial gain to be made.
- Claudia D'Allegri, SeaMar, noted her facilities receive Tribal members seeking care. In some cases, Tribal members prefer services away from their community to avoid judgement. How do you recommend we provide those services while being culturally appropriate?
    - Kelly noted she experiences similar challenges. Tulalip recommends connecting individuals to services in different areas, so they are still within a Tribal community but it's not their community. Additionally, offering virtual appointments, other services where they don't have to go somewhere where people will see them, can be helpful. In a close-knit community, people talk. Tulalip tries to be conscientious of that.
    - Vicki added there is a Native Resources Hub that anyone can call and connect to the Indian healthcare delivery system with more appropriate services.
    - Councilwoman Revey-Jacobs highlighted Lummi Nation's new Tribal health center, noting it has a discreet entrance. At their care offices, the substance use disorder services are tucked away in their own section so people can discreetly use the services.
- Jane Byer, OIC, noted the care model at Port Gamble is probably the care model that everyone should have access to; the ability to effectively work with people before they get into a crisis is impressive. Jane plans to connect with DOH and talk to the hospital licensing folks about not letting the DCR into ER to do an evaluation as that should not be happening.
- Michele, DOH, touched on helping to connect people to services, especially coming out of treatment. What are ways to explore identifying if someone is a Tribal member?
    - Vicki shared that a question would be "Do you receive services from an Indian Health Care Provider?" which is noninvasive. Would need to support the people asking the questions to be comfortable with asking about race and ethnicity.
    - Kelly liked that idea, noting you typically ask someone about their primary care provider, so it's not more invasive. Just getting information that is needed without making people feel they are being discriminated against.
    - Jamie asked if an individual said yes, what would be the next step to connect them to their particular Tribe of citizenship? We have heard it's important for the Tribe to be able to keep track of and serve individuals.
        - Vicki noted the hospitals know how to bill Tribes for people, meaning they should know that the individuals are Tribal. Language in HB1877 says if they have reason to believe someone is a Tribal member or is connected to an IHCP, they should be connecting with that IHCP. Other tips could be if the individual has an address on a Tribal reservation, certain last names, etc.

- Dillon noted an advantage of having co-located services in a community center, health center, behavioral health center, it helps normalize coming together without the fear of getting asked, "What are you doing here?"
- Kristen Wells reflected on the personal story from the last CRIS meeting. Leah shared her story about her son; after he was in a detox facility, he got sent to an unlicensed facility where his hair was cut. Thinking about how that trauma could have been avoided if the detox center had identified this is a Native person and connected him to support from Tribes in the area. This came up when panelists emphasized the importance of communication and coordination with the Tribes, and how that is missed.
- Beyond cultural competency, Emily highlighted the importance of cultural humility. This is what will change our system. Cultural humility involves knowing that you don't have the answer necessarily, and that you should ask, listen, and be present, as well as create empathy and understanding with the community you are working with.

Jamie thanked Vicki for moderating and the panelists for their preparation and discussion. Vicki expressed appreciation for the CRIS Committee and State government, particularly in honoring how to appropriately work with the Tribes in Washington State and the Urban Indian health programs. She highlighted the work of the Tribal Centric Behavioral Health Advisory Board, which hosts the 988 Tribal Subcommittee, has been incorporated into CRIS reports and broader crisis response improvement efforts.