Crisis Response Improvement Strategy (CRIS) Committee

Recommendations Summary (DRAFT)

September 17, 2024

During the September 24th meeting, CRIS members will review and refine recommendations for the Committee's Final Report to the Governor and Legislature, due January 1, 2025. To support this discussion, this document includes a summary of CRIS recommendations made through the course of the last several years. During the meeting on September 24th, CRIS members will reflect on what they have 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.

This document provides 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.

I. Vision

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

Guiding Principles

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

II. Services

Systemwide

1. Strengthen **support for consumers to navigate the system** and simplify access to services. Establish a centralized **database of available services and providers**.
2. Establish requirements for **translation and interpretation** for crisis response services across the continuum.
3. Ensure the system has capacity to support people with **substance use disorders.**

Someone to Call:

4. **Minimize time delays** created by 988 dial-pad options (note this action would require Federal action to address).

Somone 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

7. Prioritize **crisis stabilization in the home**.
8. Expand **peer respite services** as a key strategy for expanding access.
9. Develop partnerships and engage local communities to support **expansion of crisis stabilization** facilities across the state.
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.

For youth populations:

11. Expand **juvenile justice programs that provide wrap-around services** to youth with behavioral health needs and diagnoses.
12. Pursue policy changes that provide **behavioral health-focused care for justice-involved youth** with behavioral health needs.

Follow Up Care

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.
14. Develop **system capacity to follow up** with people who have experienced crisis.

III. Prevention

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

IV. System Oversight and Performance

1. In partnership with consumers, develop a **Caller Bill of Rights** that provides information to consumers about what they should expect when they contact 988.
2. 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.
3. Convene and support a **mechanism for diverse communities and individuals with lived experience** in ongoing efforts to develop and monitor the crisis response system.
4. 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).

V. Cross-System Collaboration and Community Partnerships

1. **Encourage and foster regional collaborations** that convene system partners to create regional plans and protocols for crises.
2. 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.
3. 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.
    c. Expand programs that address the needs of justice-involved youth who are experiencing a behavioral health crisis.
4. 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.
5. 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.

VI. Crisis System Workforce and Training

1. 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.
2. **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.
3. 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.
4. 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.

5. Expand **mental health first aid training and education for laypeople** and consider mandating age-appropriate mental health first aid training in schools.

VII. Technology

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 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.

VIII. Funding

1. 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**, recognizing that many Tribal members are enrolled in Medicaid fee-for-service rather than managed care.