Preamble

It is estimated by the American Psychological Association that conservatively, 20% of all 911 calls are related to mental health and substance use issues[1], otherwise known as behavioral health issues. In 2022, in Washington (WA) state, there were nearly 5.5 million calls to 911; therefore, it is estimated that over one million calls to 911 for behavioral health issues are being responded to by first responders including law enforcement, fire/EMS, and paramedics. These are calls that, in many cases, benefit from having behavioral health professionals integrated into the response. WA law relating to the police use of force makes it clear that de-escalation and alternatives to force are high values of the legislature. Co-response teams have the potential of slowing things down at crisis events while introducing behavioral health expertise. Behavioral health professionals embedded in first responder agencies bring critical assessment and communication skills to crisis situations that can, in many cases, de-escalate volatile events.

Responding appropriately to 911 calls for behavioral health crises is critical but not sufficient. These complex situations often require significant follow-up and coordination with other human and social service agencies to reduce the overutilization of 911 and to help connect vulnerable individuals with much-needed services. Co-response teams are frequently a bridge to these human and social services through follow-up visits, calls, and telehealth. Sometimes these services fall short or individuals fall through the cracks. In these instances, co-response programs provide ongoing assistance through the use of brief non-clinical interventions, medications, transportation, and case management services.

Table 1. 911 Calls in WA State

Year	911 calls	Estimated behavioral health calls*
2018	6,802,791	1,360,558
2019	5,317,793	1,063,559
2020	5,057,065	1,011,413
2021	5,461,365	1,092,273
2022	5,414,835	1,082,967

*Calculated as 20% of all 911 calls in any given year.

Definition of Co-Response

Co-response programs are embedded within the emergency response system in some counties and cities. They are partnerships between **first responders** and behavioral health and other **human services professionals** to respond to calls for service involving clients with behavioral health issues and complex medical needs. First responders include law enforcement, firefighters/ emergency medical technicians (EMTs), and paramedics. Behavioral health and

[1] Abramson, A. (2021, July 1). *Building Mental Health into emergency responses*. American Psychological Association. https://www.apa.org/monitor/2021/07/emergency-responses

other health and human services professionals often referred to as "co-responders" include social workers, behavioral health clinicians, nurses, community health workers, and/or peer support workers. These partnerships provide in-the-moment crisis response, follow-up, and in some instances, case management, to connect individuals with behavioral health needs to appropriate community resources. The goal is to divert people with behavioral health challenges from the criminal justice and emergency medical systems. In addition, with these diverse disciplines working in communities together, there is also future untapped potential for co-response to bring medical and behavioral health care to vulnerable populations where they live, removing barriers to care that currently exist when accessing health and behavioral healthcare in more traditional settings.

The term "co-response" is often misunderstood to mean only a 911 response by law enforcement with an accompanying behavioral health professional. While this is one form of co-response, these programs are diverse and flexible. As discussed, co-response programs often provide follow-up, case management, and prevention services. They are increasingly embedded within fire departments as part of mobile integrated health programs and utilize a wide range of human and social service professionals including social workers, paramedics, and nurses.

In short, co-response is a multidisciplinary field-based approach to behavioral health and medical needs that provides preventive services, crisis response, follow-up response, hospital and agency coordination, care planning, and transportation within the emergency response system.

According to the U.S. Fire Administration, only 4 percent of all reported fire department runs are fire-related. The remainder are calls involving health and behavioral health.[2]

All firefighters in WA State are certified emergency medical technicians (EMTs) and are responding to these calls today with little to no training in behavioral health. Co-response programs bring behavioral health expertise to fire departments and help equip firefighters and EMTs to respond to these kinds of calls.

Co-Response is an Essential Crisis and Follow-Up Service

Calls to 911 for behavioral health will always occur, even with the potential for a robust, 988-driven alternative behavioral health crisis response system. It is important to realize that co-response services proliferated organically in WA state to respond to growing unmet and acute behavioral health needs, fueled most recently by the COVID-19 pandemic and the opioid epidemic. It is well known that WA's current behavioral health system, including its crisis

[2] [2] *Fire department overall run profile (2020)*. U.S. Fire Administration. (2022, September 20). https://www.usfa.fema.gov/statistics/reports/firefighters-departments/fire-department-run-profile v22i1.html#:~:text=incident%20runs%20or%20calls&text=Nearly%20two%2Dthirds%20(64%25),department%20runs%20were%20fire%20related

system, is inadequate to meet the needs of the state's population. The system is underfunded, understaffed, and disorganized. [3,4,5,6,7,8,9]

Calls to the emergency response system for behavioral health will always occur because these calls sometimes have a public safety or criminal component, are medically complex, require care coordination for health issues that fall outside the scope of the behavioral health crisis system, are time-sensitive, or require transportation. Any one of these factors can make a call inappropriate for a mobile crisis team response, and professionals on mobile crisis teams will often not respond to these calls. Furthermore, behavioral health calls to 911 are, oftentimes, better responded to by co-response programs rather than by first responders alone.

With co-response, there is the opportunity to improve first responder response to behavioral health calls by adding an additional skill set to what are inherently complex, unpredictable, and dynamic

Behavioral Health Calls to 911 or 988 that Benefit from Co-response:

1) Calls that are imminent, requiring an immediate response that is faster than a mobile crisis team can provide
2) Calls and other referrals that involve a complicated medical issue (e.g., drug overdose) or encompass a traumatic event (e.g., violent death on the scene)
3) Calls that have a public safety or criminal component. It is important to note that people with behavioral health challenges are far more likely to be victims of crime than they are perpetrators of it.[10] Domestic disputes often have a behavioral health component.[11]
4) Circumstances involving transportation to emergency services or to crisis stabilization centers that are often not available from mobile crisis teams

[3] Baruchman, M. (2021, November 8). How to fix Washington's mental and behavioral health care system? 4 experts weigh in. *The Seattle Times*. https://www.seattletimes.com/seattle-news/mental-health/how-to-fix-washingtons-mental-and-behavioral-health-care-system-4-experts-weigh-in/

[4] Beecher, B., Reedy, A. R., Loke, V., Walker, J., & Raske, M. (2016). An exploration of social work needs of select rural behavioral health agencies in Washington state. *Social Work in Mental Health*, 14(6), 714–732. https://doi.org/10.1080/15332985.2016.1146647

[5] Behavioral Health Workforce Advisory Committee. (2022). *2022 Behavioral Health Workforce Assessment: A report of the Behavioral Health Workforce Advisory Committee*. Washington Training and Education Coordinating Board. https://www.wtb.wa.gov/wp-content/uploads/2022/12/BHWAC-2022-report_FINAL.pdf

[6] Conrick, K. M., Davis, A., Rooney, L., Bellenger, M. A., Rivara, F. P., Rowhani-Rahbar, A., & Moore, M. (2023). Extreme Risk Protection Orders in Washington State: Understanding the Role of Health Professionals. *Journal of the Society for Social Work and Research*. https://doi.org/10.1086/714635

[7] Division of Behavioral Health and Recovery. (2019). *Crisis Stabilization Services*. Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/crisis-stabilization-services-20191201.pdf

[8] Jimenez, E. (2023, April 9). How WA's plan to transform its mental health system has faltered. *The Seattle Times*. https://www.seattletimes.com/seattle-news/mental-health/how-was-plan-to-transform-its-mental-health-system-has-faltered/

[9] Jimenez, E. (2022, August 11). Washington's designated crisis responders, a 'last resort' in mental health care, face overwhelming demand. *The Seattle Times*. https://www.seattletimes.com/seattle-news/designated-crisis-responders-a-last-resort-in-mental-health-care-face-overwhelming-demand/

[10] Ghasi N, Azhar, Y and Singh, J. Psychiatric illness and Criminality, StatPearls Publishing, NIH, 2023.

[11] Huecker, MR. King, KC, Jordan GA, Smock W. Domestic Violence, StatPearls Publishing, NIH, 2023.

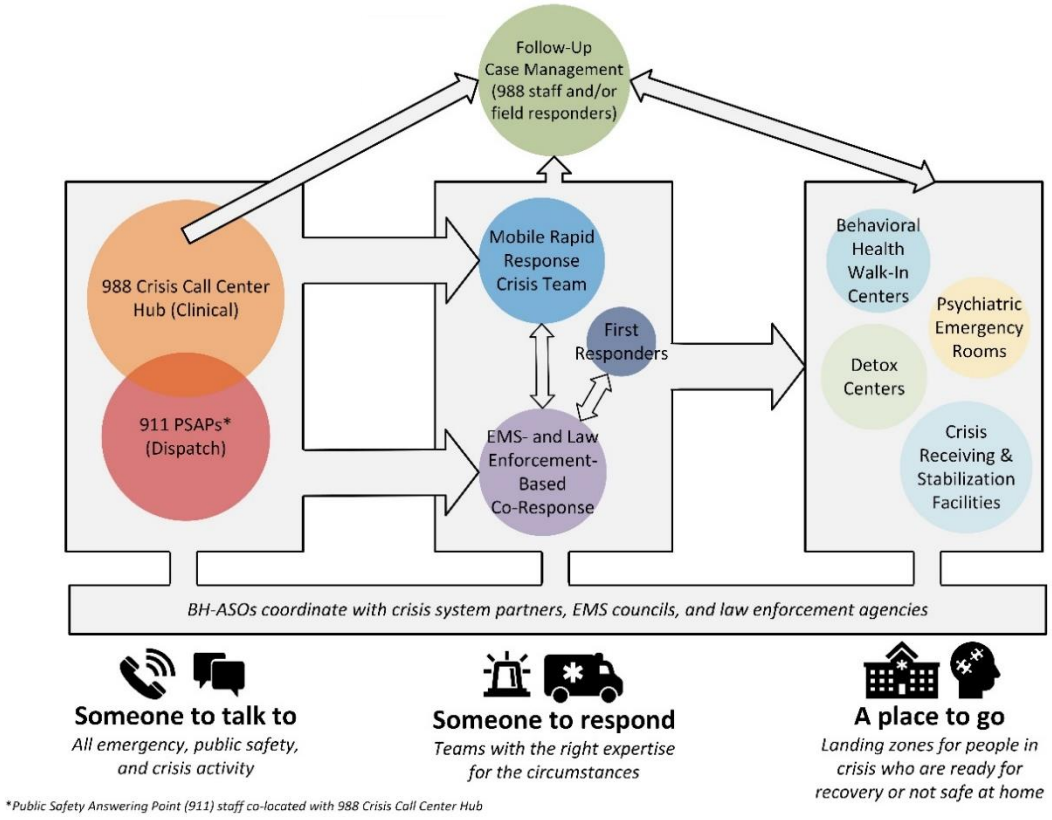
situations. Behavioral health professionals, nurses, and peers can bring expertise, support, and accountability to crisis response and can provide critical follow-up support. Co-response also affects the culture of police and fire departments. Having multi-disciplinary professionals in first responder agencies creates a continual training environment for people within these departments.

WA State Proposed Behavioral Health Crisis Care Continuum

For these reasons, it's important to recognize co-response as an essential service within WA's behavioral health crisis care continuum and to fund the service in a sustainable way. Figure 1 contains a proposed vision and visual aid for planning for WA State's Behavioral Health Crisis Care Continuum. It builds off of the Substance Abuse and Mental Health Service Administration's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit that speaks to the need for having services in place for people in behavioral health crises inclusive of *"someone to talk to, someone to respond, and a place to go"*.

Figure 1 integrates WA's proposed 988-led behavioral health response system and its proposed 911-initiated emergency response system. These two systems must work together, in one continuum, if they are to be successful in meeting the needs of WA residents with behavioral health needs. This landscape analysis is focused on the purple circle and the follow-up and case management services that emanate from co-response and first-response, but this report will show that a focus on one service, without fully supporting the crisis care continuum, cannot be truly effective. The full ecosystem must be coordinated and funded.

Figure 1. Proposed Washington State Behavioral Health Crisis Care Continuum



Below are definitions of these services. Some are defined in WA state statute; others are not.

988 Crisis Contact Center Hub (RCW 71.24.025): A state-designated center participating in the national suicide prevention lifeline network to respond to statewide or regional 988 calls that meets the requirements of RCW 71.24.890.

Behavioral Health Administrative Services Organization (RCW 71.24.025): An entity contracted with the authority to administer behavioral health services and programs under RCW 71.24.381, including crisis services and administration of chapter RCW 71.05, the involuntary treatment act, for all individuals in a defined regional service area.

Behavioral Health Walk-In Clinic: A facility that provides same-day behavioral health assessment and outpatient treatment.

Community Health Worker: A person who facilitates access to healthcare services through a variety of means including outreach, education, and advocacy.

Crisis Stabilization Facilities (RCW 71.24.025): Facilities that offer services such as 23-hour crisis stabilization units based on the living room model, crisis stabilization units as provided in RCW 71.05.020, triage facilities as provided in RCW 71.05.020, short-term respite facilities, peer-run respite services, and same-day walk-in behavioral health services, including within the overall crisis system components that operate like hospital emergency departments that accept all walk-ins, and ambulance, fire, and police drop-offs.

Detox Center (Withdrawal Management Services) (RCW 71.24.618): 24-hour medically-managed or medically-monitored detoxification and assessment, as well as treatment referral, for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery.

EMS- and Law Enforcement-Based Co-Response: Behavioral health and other human service professionals embedded within the emergency response system. Typically, field-based teams that respond to calls for service involving clients with behavioral health issues and complex medical needs with the goal of diverting people from the criminal justice and emergency medical systems.

Follow-Up Case Management: Recovery and treatment support from a human service professional to a person who recently experienced an emergent behavioral health or complex medical crisis.

Mobile Rapid Response Crisis Team (RCW 71.24.025): A team that provides professional on-site community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for individuals who are experiencing a behavioral health crisis, that shall include certified peer counselors as a best practice to the extent practicable based on workforce availability, and that meets standards for response times established by the authority. May be based in a fire department or EMS agency.

Peer Counselor: A person with life experiences in common with the people being served and certified under WAC 182-115-0200 to provide behavioral health services authorized under RCW 71.24.385.

Psychiatric Emergency Department: A 24-hour facility providing emergent assessment and expert care to people experiencing behavioral health crises in the community, including suicide and psychosis, and that accepts all walk-ins, ambulance, fire, and police drop-offs.

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

Today, there is an unfortunate sense in WA state that the existence of mobile crisis response makes co-response unnecessary. Mobile crisis response does not, and cannot, meet the needs of all individuals in crisis who need someone to respond in person. Currently, there is mixed messaging, and confusion, in WA state about what number to call in a crisis situation. When 988 is called, they may not have the capacity to dispatch mobile crisis teams at all without getting a regional crisis line involved. When regional crisis lines are called, they may not have mobile crisis teams available that can respond in a timely fashion.

Many calls for crisis services can be met without an in-person response especially when there are well-trained crisis responders answering the call. However, if an in-person response is needed, WA doesn't currently have enough capacity in all areas of the state for mobile crisis teams to respond. Co-response programs are not located in many regions or counties and are usually not available 24/7 when they do exist. Thus, days, if not weeks, can pass before people in a behavioral health crisis receive any in-person contact from a behavioral health professional if they ever meet anyone at all. Rural residents of WA are far less likely to receive mobile crisis or co-response services. When co-responders do engage, they are sometimes left providing case management to individuals because no other services will take them or will meet them where they live.

As a result, far too often, people in behavioral health crises interact with first responders alone in these situations after a 911 call is made and, far too often, end up in emergency rooms or in jails or they are left to further deteriorate in place. An inadequately funded and coordinated behavioral health crisis care continuum feeds this vicious cycle. Health insurers are not fully financially accountable for not preventing crises from happening to begin with.

A recent case involving an elderly woman in WA state who is aging in place is illustrative of this vicious cycle. The names of the agencies and programs involved have been de-identified to preserve anonymity.

A co-response program has been working with a WA state resident since 2021. The behavioral health professional on the team determined that this individual may meet the gravely disabled threshold. She isn't eating or bathing, and is not ambulatory, staying in bed all day. Mental health issues are suspected as persistent delusions are expressed. The situation is worsening because the caregiver is away.

The co-responder calls the regional crisis line at approximately 4pm on June 27 to request a mobile crisis team response. The regional crisis line relays the information to the mobile crisis team at the provider agency. The mobile crisis team then requests a 911 response from the 911 PSAP, which resulted in a co-response request for service followed by a police request for service when the co-response program was out of service. Police communicate with the behavioral health professional at the co-response program for several hours to determine the appropriate response, and ultimately persuades the mobile crisis team to send a DCR to the home, with a police escort, the following day (6/28).

This issue was discussed with supervisors of the mobile crisis team who recognize the problematic nature of co-response requesting a mobile crisis team response that results in a co-response / police call for service.

This case illustrates the capacity limits of mobile crisis response in this region, and the important role co-response (and police) play in connecting people to assistance. It also illustrates the fact that one of the reasons police are involved in so many crisis calls is because mobile crisis teams request their time and assistance.

This landscape analysis makes the case for co-response as an essential crisis service based on first-person accounts of individuals who are providing co-response services and city, county, behavioral health, and first responder staff who fund and operate these programs. It's one very important, on-the-ground perspective from individuals who are working on the front lines, day to day within the current behavioral health crisis care continuum.

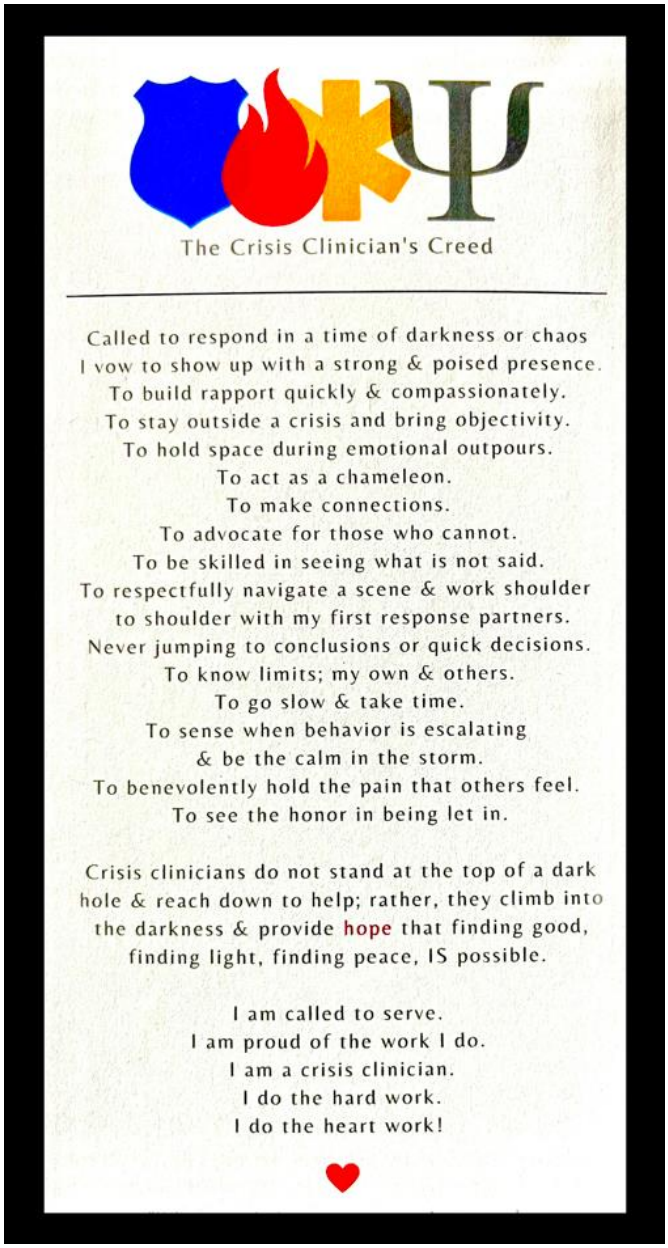
Going forward, this analysis makes the case for robust investments across the behavioral health crisis care continuum that are inclusive of the emergency response system and co-response. It will take a concerted effort to develop a sustainable funding plan that consists of federal, state, county, and city resources, along with robust planning efforts that engage all payors and partners. A robust behavioral health crisis continuum is achievable if we think outside of the tendency to plan within already siloed systems and have the core values of a growth mindset, a sense of urgency for this work, and prioritize regional coordination, transparency, and accountability.

It is vital to provide high-quality training to all professionals working across this crisis care continuum. Training needs will vary to some extent based on whether the setting is phone, field, or place-based. This analysis focuses on the specific training needs of co-responders who

need training in scene stabilization and safety during crises. It also highlights the training needs of Fire/EMS who currently receive little to no training in behavioral health identification based on behaviors that manifest in the field, or training in scene stabilization. This report highlights the need to support the wellness of all first responders and co-responders due to the secondary trauma they encounter in their day-to-day work. Their wellness affects their ability to support people with behavioral health needs in the field.

Furthermore, there is a need to establish best practice standards for co-response programs in their various forms. With high-quality training and standards in place, there will be more effective and efficient responses to people who call 911 for behavioral health issues utilizing the emergency response system. There is also the potential to reduce premature deaths, decrease emergency department use, use of the criminal justice system, and to decrease 911 utilization.

WA state is in the process of developing its 988-led behavioral health crisis response system. The hope is that some (currently unknown) percentage of calls will be able to be transferred from 911 to 988. While this is an important goal, the future growth of this alternative behavioral health crisis response system will never supplant 911 calls involving behavioral health needs and the need for co-response as an essential crisis service. The 988-led behavioral health crisis response system is not functioning anywhere near capacity in terms of providing, someone to respond, or a place to go. It is not known what capacity currently exists, which impacts the emergency response system. As a result, the 911 emergency response system has to step-up even more than is necessary to provide support to people with behavioral health needs.



The Crisis Clinician's Creed

Called to respond in a time of darkness or chaos
I vow to show up with a strong & poised presence.
To build rapport quickly & compassionately.
To stay outside a crisis and bring objectivity.
To hold space during emotional outpours.
To act as a chameleon.
To make connections.
To advocate for those who cannot.
To be skilled in seeing what is not said.
To respectfully navigate a scene & work shoulder
to shoulder with my first response partners.
Never jumping to conclusions or quick decisions.
To know limits; my own & others.
To go slow & take time.
To sense when behavior is escalating
& be the calm in the storm.
To benevolently hold the pain that others feel.
To see the honor in being let in.

Crisis clinicians do not stand at the top of a dark hole & reach down to help; rather, they climb into the darkness & provide hope that finding good, finding light, finding peace, IS possible.

I am called to serve.
I am proud of the work I do.
I am a crisis clinician.
I do the hard work.
I do the heart work!

The Crisis Clinician's Creed encapsulates the profound responsibility borne by crisis responders in WA State inclusive of co-response and mobile crisis teams.

They must be fully trained and their wellness supported in doing this life-saving work that can cause secondary trauma.

Permission to reprint granted by Michelle Muething, Frontline Crisis Academy

Executive Summary

In 2022, Washington State Senate Bill 5644 called for a landscape analysis of Washington co-response programs by the Co-Responder Outreach Alliance (CROA) and the University of Washington School of Social Work (UWSSW). The purpose of the analysis was to describe the field of co-response as it exists in Washington state today; its impacts and barriers faced in doing crisis response and follow-up work; funding, training, and technology needs; and to make recommendations to policymakers about the ways in which they can improve co-response for individuals living with behavioral health issues. The analysis also provides insights about the current state of WA's behavioral health crisis care continuum, supporting recommendations that come from an on-the-ground perspective of how things are working.

To complete the landscape analysis, CROA and UWSSW partnered with the Washington Association of Sheriffs and Police Chiefs and the Washington Association of Fire Chiefs to conduct a mixed-method study. This study was comprised of a brief survey of all co-response programs across Washington state and 48 key informant interviews with co-response program managers and front-line workers responding to calls in the field. Interviews were de-identified so that interviewees felt that they could be frank about the current state of WA's behavioral health crisis response system.

There was nearly 100% participation among identified programs in response to the brief survey. The survey was analyzed using R software-(4.2.3), and a map of co-response programs with population and administrative overlays was created in Tableau. The 48 key informant interviews were conducted using a semi-structured interview guide. Interviews were approximately 1 hour in length. Interviews were coded, and a reflexive thematic analysis was completed resulting in summaries of findings that comprise the qualitative findings contained in the chapters that follow in this report. This data set contains many organized, first-person accounts that are utilized throughout this analysis.

In the remainder of this Executive Summary, information requested by the legislature in SB 5644 is responded to in a concise format with references to later sections of the report where additional information can be found. The statute posed several questions the state needs answers to in order to develop recommendations for how co-response programs fits within a well-functioning emergency response and behavioral health crisis care continuum. Policy recommendations are also provided based on the analysis.

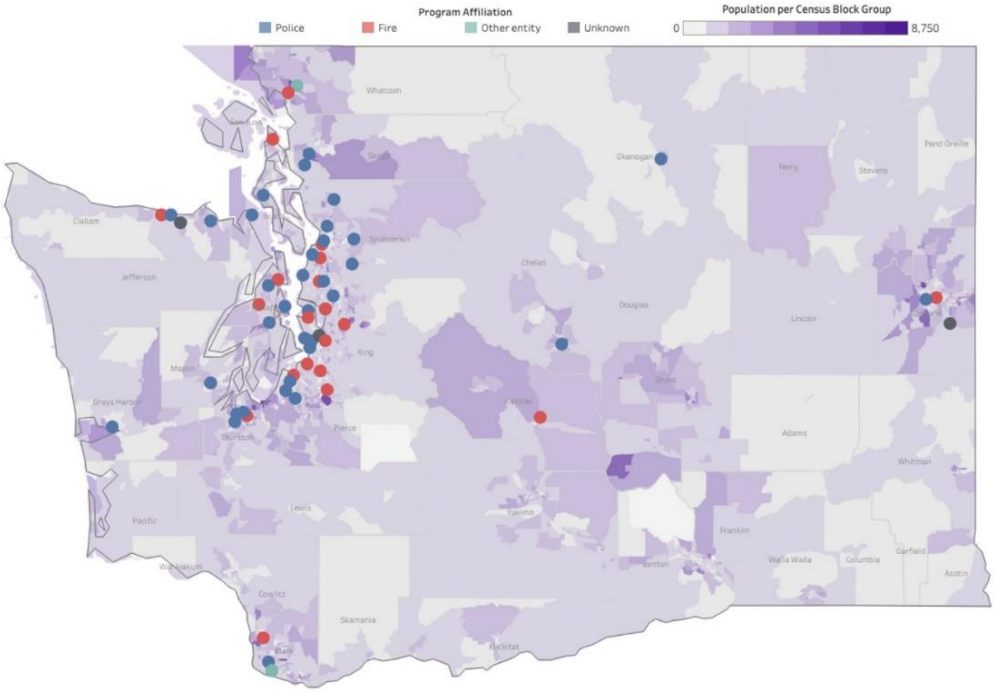
Q&A from 5644

What are the existing capacity and shortfalls across the state in co-response teams and the co-response workforce?

The landscape analysis identified 61 co-response programs in Washington state in 2022 operating across 44 cities and 14 counties in Washington. Most counties in WA state do not have a co-response program. These programs comprise more than 445 full-time equivalent staff who provided upwards of 60,000 in-person encounters in 2022 with individuals who have

behavioral health needs. Key informant interviews indicate the demand for co-response program capacity greatly exceeds the current supply. Only about 10% of programs operate 7 days per week and 24 hours per day. Most co-response programs predominately serve population-dense areas within the Puget Sound corridor, while several high-density population areas—such as the Tri-Cities or Kittitas and Yakima counties—lack programs. Many rural parts of the state also are not served by co-response.

Figure 2. Co-response program distribution by population



There were multiple references throughout the key informant interviews to workforce shortfalls in co-response staffing capacity, which restricted programming to certain times of day and to less than 7 days per week. Key informants felt they could serve more people in crisis, and provide more follow-up support if they could extend their hours of operation and increase their staffing. [See Chapters 1 and 5]

"At this point, since there's only two of us in the office, we have not been able to respond as a second tier responder to 911 calls... Last year we managed over 700 patients, and that means that we just don't have the capacity to leave what we're doing and respond to 911 calls like a first responder would, and that's definitely a place [where] a co-response unit would be really helpful in the future, and we're trying to build to that, but staffing wise, it's not possible at this point."

"I'd love for us to have additional FTEs for social workers. Right now we are beyond our capacity for just the referral follow-ups; we have some folks waiting after a referral for three or four weeks before we're able to make contact due to capacity issues."

"I think we're limited by our capacity because we are only two people. So right now that's our biggest hurdle of the program."

"The calls for service are definitely there, the number of suicide threats and then our state law application as officers to respond to that, that's the burden that we have to meet, and we only have an MHP 36 hours a week and people are threatening suicide a lot more than 36 hours a week."

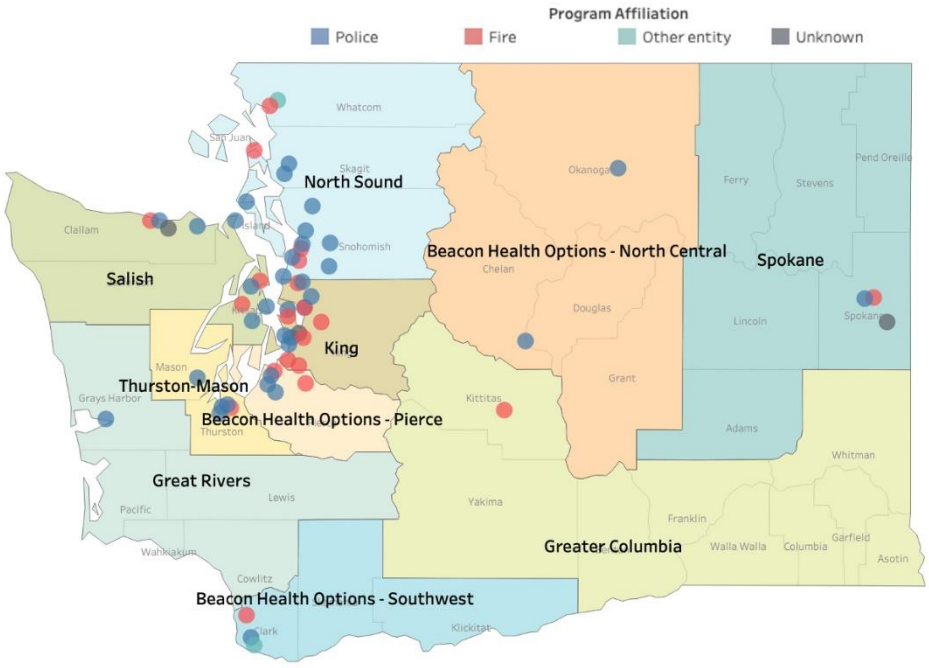
"A barrier has been I only work 40 hours a week and 911 is a 24/7 service. So the chances of me being at work when a crisis call comes in are pretty minimal."

These concerns are not dissimilar to behavioral health workforce shortages described in other behavioral health settings such as in community mental health agencies and in schools. While salary data was not collected systematically in the landscape analysis, several program managers and mental health professionals on co-response teams did mention in the interviews that first responder agencies generally pay better than community mental health agencies and that the wage differential is significant. This may make recruitment and retention for social workers and other mental health professionals in first-response agencies somewhat easier as compared to community mental health. However, there were still significant workforce challenges discussed by co-response program managers. [See Chapters 1 and 5].

What is the current alignment of co-response teams with cities, counties, behavioral health administrative services organizations, and call centers; distribution among police, fire, and EMS-based co-response models; and desired alignment?

Co-response programs across the state vary significantly in their alignment with local authorities and the geographies that they serve. Most teams limit services to a specific area within a county—usually one or more cities. County-wide co-response service is found in only 14 of the state's 39 counties. The analysis found at least one co-response program in each of the state's 10 Behavioral Health Administrative Service Organization (BH-ASO) areas. BH-ASOs are made up in most cases of contiguous counties. They are contracted with the Heath Care Authority to provide accountability and oversight for the state's providers working within the 988-led behavioral health crisis response system. However, BH-ASO involvement in co-response varies, with 39 programs reporting some form of collaboration with BH-ASO mobile crisis teams and only 14 programs reporting a formal agreement with local BH-ASO crisis facilities. Most co-response programs (70%), however, are connected to their local emergency response system by working with 911 dispatch to respond to emergent situations or receive referrals from dispatch to join a case in progress. [See Chapter 1]

Figure 3. Co-response program distribution by BH-ASO region



Over half of the programs (57%) report that a law enforcement agency has primary oversight of their day-to-day operations, while a third (33%) report the same of fire departments or emergency medical services (EMS). The remaining 10% of programs receive oversight from some other entity (e.g., a local government department) or did not provide a valid response.

There are important and different functions for law enforcement versus fire-based co-response. The former is more focused on calls and referrals that involve some form of criminal activity or have a public safety element, involve an imminent risk, or may present a potential need for involuntary detention and transport. Fire-based co-response typically focus on situations where there are chronic health, social service, and behavioral health issues involved. These programs are well-known for the follow-up supports they can provide and for the integration of nurses and paramedics into their response.

It is recommended that every region of the state have both police and fire-based co-response programs available as an essential crisis service. It is further recommended that these programs, which are embedded within the emergency response system, share information and closely collaborate with the 988-led behavioral health response system, inclusive of its call centers, mobile crisis teams, and crisis stabilization facilities.

There are several ways in which the employment of behavioral health professionals on co-response teams can work. Generally, the behavioral health professionals on these teams described they prefer to be employed by the first-responder agency so that they are employees working on the same team as their first-responder colleagues, with consistent policies and procedures, and with comparable benefits. First-responder agencies seem to prefer this as well due to their ability to build comradery and supervise co-responder employees.

However, there are several co-response programs in the state where behavioral health professionals are employed by the city, or by another social service agency, including, a community mental health agency. These employment arrangements are also workable and have some upsides in maintaining clear boundaries for professional culture and opportunities for enhanced information sharing with the behavioral health system. It is recommended that local regions decide on the most advantageous employment configurations of their co-response programs, but that any state-funded co-response program be required to collaborate with the behavioral health crisis response system through MOUs with the BH-ASOs and, through information sharing to the greatest extent possible to improve client care.

What are current funding strategies for co-response teams and identification of federal funding opportunities?

Co-response programs are funded by a variety of funding sources. Counties (20% of total funding), as well as cities (12%), comprise two of the largest sources. Fire departments (18%) and law enforcement agencies (12%) are the other two largest funding sources—these funding sources are also typically associated with county or city expenditures. BH-ASOs are another funding source (10%). The Washington Association of Sheriffs and Police Chiefs (WASPC), which uses state allocations to fund its Mental Health Field Response grant program, comprises 8% of reported co-response funding. While no program reported receiving federal funding, the landscape analysis identified more than $130m in federal grants (representing 15 grant opportunities) active in 2023 that could potentially fund a portion of a program's operations for a time-limited period. These federal programs are focused on law enforcement co-response. However, the use of grant programs to fund co-response programs raised many concerns because of the challenges in recruiting and retaining staff to work in challenging positions in conditions of high uncertainty. Sustainable funding sources are needed to develop the landscape of co-response programs.

Recommendations for potential ways to raise additional funding for new co-response programs or to expand co-response programs regionally to address the stark geographic inequities in the availability of this essential service are provided in Chapter 3. Several potential funding sources are discussed in Chapter 3, including: insurance, telecom fees, the county sales tax, and general fund state dollars. Other states, such as Colorado, Massachusetts, Connecticut, and Illinois, have legislation to formally recognize and create standards for co-response, in addition to identifying stable state funding sources for these programs.

What are the current data systems utilized and an assessment of their effectiveness for use by co-responders, program planners, and policymakers?

Most programs (98%) reported utilizing some type of system to manage data. However, no single data system is used by a majority of programs. Only 43% reported using some kind of data-sharing software. Even fewer programs (21%) reported using an electronic health record (EHO) integrated with 911. The landscape analysis found that data-sharing software and integrated EHOs are the most effective systems for tracking data and coordinating crisis care along the crisis continuum, which is a best practice for crisis response. The lack of these technologies among co-response programs suggests a significant gap in programmatic needs

and missed opportunities to improve care coordination for clients across the crisis continuum. [See Chapter 2]

What are current training practices and identification of future state training practices?

There is a great need for an entity like the Co-Responder Outreach Alliance or CROA (croawa.org) in collaboration with a University based entity to disseminate best practices through training and protocols for various situations, such as supporting clients in the field who are at high risk for suicide, or de-escalating individuals who are experiencing acute psychosis. Interviewees commonly identified the need for a Training Academy – perhaps a certificate in co-response, to teach CORE curriculum modules that are a necessity to work safely in the field to address behavioral health needs. Interviewees identified a dozen or so CORE curriculum modules (e.g., verbal de-escalation, safety in the field, suicide risk assessment, and cultural humility to work with diverse populations in the field).

Research examining other states models of training co-responders and first responders has identified some promising best practices. WA's investment in Crisis Intervention Training or CIT has been important for law enforcement, but it is not appropriate as the sole training for fire/EMS responders and for co-responders. It is vital that individuals in these roles on teams play a role in training to bring to life scenarios and to offer credibility.

Interviewees did not think it was sufficient for behavioral health professionals working on co-response teams to attend CIT, which is largely focused on building awareness for common presentations of mental health conditions and destigmatization of mental illness and substance use disorder based on presentations by people with lived experiences. This would be duplicative and more superficial in some ways than the training that most behavioral health professionals receive. In addition, CIT is focused on the role of law enforcement in responding to individuals with behavioral health needs in the field. It is not preparation for behavioral health professionals or for fire/EMS for these roles. Behavioral health professionals working on co-response teams don't typically receive training in field-based competencies in areas such as de-escalation and scene safety, brief crisis interventions, and working with first responders before entering the field; these competencies are highly needed.

The LA County Sheriff's Department has developed a training program called "ROAR", which stands for: Respond, Observe, Assess, React, which has several important elements to consider emulating. ROAR provides a grounded theoretical approach for how first responders and co-responders can approach every crisis call. The framework can help to organize training around a unifying set of constructs and to measure skill development through competency-based assessment.[12] The state of MA offers a law enforcement-focused co-response training program at William James College (williamjames.edu).

Despite the expectation that fire responds to calls involving mental health, mental illness, suicidality, drug use, and cognitive decline, firefighters/ EMTs receive virtually no training on

[12] D'Ingillo, P., Ehrhorn, E., & Satterfield, J. (2021, July 9). *ROAR: A roadmap to de-escalation, Field Dynamics and decision making*. Sheriffs' Relief Association. https://sheriffsrelief.org/2021/07/roar-a-roadmap-to-de-escalation-field-dynamics-and-decision-making/

behavioral health issues and nothing comparable to CIT training available to police officers. While not the main subject of this report, firefighters are de facto providers within the behavioral health crisis system and as such, need additional training to be effective and safe on the job. The state of Arizona has a training academy for fire/EMS training called Crisis Support Intervention Training or CST that provides a 32-hour equivalent to CIT except designed with a firefighter in mind.

A few interviewees also identified the need for a training pipeline to bring more people into the field from universities across WA State from bachelor's level programs in the human and social services field. Well-trained Bachelor's level students who have the right temperament for crisis work and orientation to working in the human and social service fields can play roles in co-response programs, particularly if they are engaged in follow-up work.

In sum, training practices across co-response programs currently are inconsistent and unique to each program. Recommendations based on interviews are:

(1) For a University entity and CROA to build a CORE competency-based certificate program and/ or a training academy, in close collaboration with subject matter experts in co-response and brief crisis interventions, to disseminate, and evaluate it

(2) Training needs to be skills focused and competency-based (not Zoom, and largely didactic) to the maximum extent possible and supervisors need to coach co-responders to competencies following training opportunities

(3) For CROA to offer outlines/ models for program-specific curricula through quarterly meetings and to support wellness activities such as peer support for behavioral health professionals working on co-response teams

(4) For the BH-ASOs to lead regional collaboration and training on 911 and 988 collaboration, resources, and other practicalities that are regionally specific;

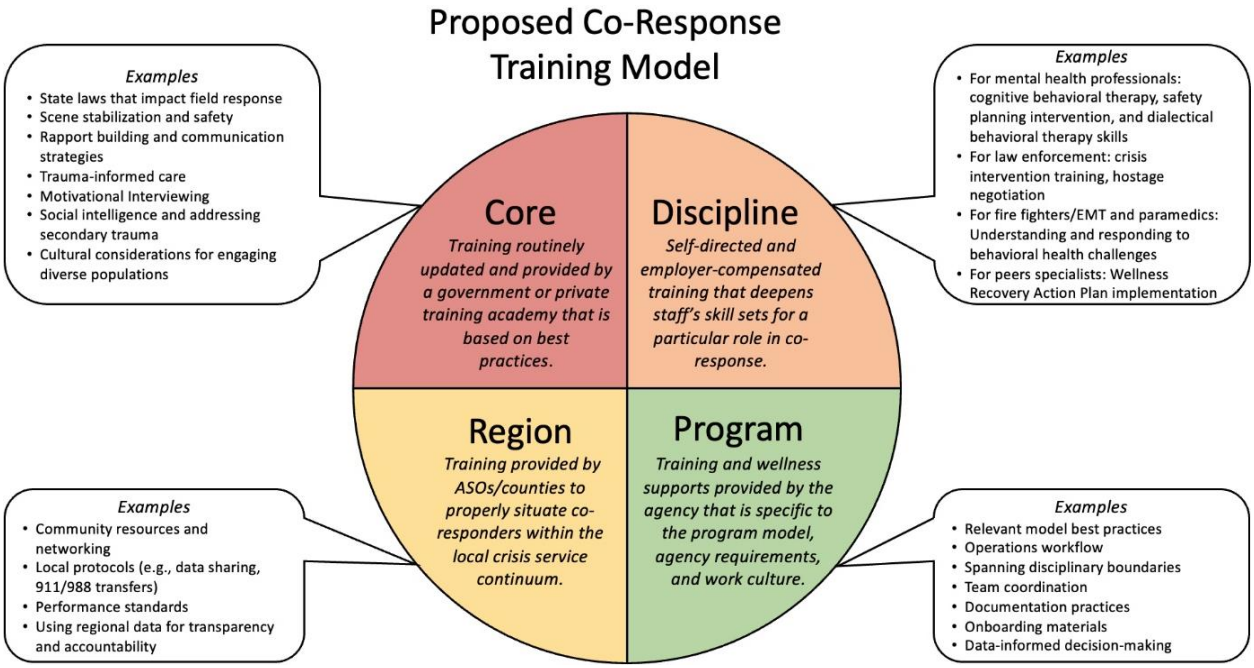
(5) For advanced, discipline-specific training and wellness-related activities to be offered at an annual conference that is led jointly by CROA and a University-based entity

(6) Firefighters need additional training in behavioral health and scene stabilization to be effective and safe on the job

(7) The development of a training pipeline for Bachelor's level and Master's level crisis responders who are working to staff an integrated behavioral health crisis care continuum should be considered

It is a public investment to develop a highly-skilled workforce in crisis care. In many counties, law enforcement agencies are paid for officers to attend CIT. Consideration for how co-responders and how Fire/ EMS agencies are compensated for staff to attend training needs to be given. Training needs to be available, funds to pay trainers need to be available, and reimbursement for training hours needs to be given. This should not be the state's sole responsibility. Training is an important shared responsibility at the state, county, and local levels. [See Chapter 4]

Figure 4. Recommendation for future state training



What is the alignment of co-response with designated crisis responder (DCR) activities?

Typically, Designated Crisis Responders typically work separately from co-response programs. There are five co-response programs that reported at least some amount of FTE from a DCR. A common scenario is that DCRs will do investigations for involuntary treatment in emergency rooms (ER) after individuals have been detained there by police.

Interviewees described that a lack of resources for people across the behavioral health crisis continuum leads to poor outcomes and frustrating experiences for those who are involuntarily transferred to the ER. They described a cyclic process amounting "*to moving individuals in behavioral health crises around without providing proper care"*, while potentially causing harm because individuals in crisis are being boarded in ERs, receiving bills for services they didn't want, and are not receiving trauma-informed care. Each time this cycle occurs, it makes it even more difficult to engage people in care in the future.

A strong recurring theme in the interviews related to the need for "landing zones" that are not ERs, but rather short-term crisis stabilization facilities that can provide a safe and secure environment that is less restrictive than a hospital or jail. The main goal of a crisis stabilization unit is to stabilize the person in crisis and to get them back into the community quickly while simultaneously ensuring ongoing connections to resources.

Interviewees repeatedly described crisis stabilization centers as a much-needed resource where people could stabilize and ultimately, avoid needing to engage with the DCRs in the behavioral health crisis system. A scarcity of involuntary treatment beds was also discussed as a major challenge, which crisis stabilization facilities can help to mitigate. Increasing the number of DCRs will not lead to more stabilization and treatment. Having more voluntary treatment beds

available was also viewed as a way to divert individuals with behavioral health needs from the DCRs.

In addition to increasing crisis stabilization beds, more involuntary treatment beds, and more voluntary treatment beds, two additional changes were discussed by interviewees related to involuntary treatment. First, interviewees spoke about severe DCR staffing shortages. Interviewees discussed the possibility of expanding the number of clinicians and other professionals who can authorize and assist with involuntary treatment due to these staffing shortages. They suggested extending these powers to other behavioral health professionals, who are trained to conduct DCR investigations and who are working in co-response programs.

Interviewees recognized the potential of paramedics, or event EMTs to provide medical clearance services in the field to get people directly into crisis centers and detox facilities, which could be an important mechanism to divert individuals with behavioral health needs from the ER. In WA state's current crisis system, many individuals must be routed to ERs to be "cleared" before they are allowed to alternative destinations. This practice, in many instances, is expensive and unnecessary and creates a deterrent to care.

Some interviewees felt it would be helpful to provide additional guidance around the criteria for involuntary treatment to make it easier for clients to qualify. First responders and co-responders who lived in other states talked about how onerous and self-defeating WA's current processes for involuntary treatment are relative to other states where they have lived. Some noted it is too challenging to meet the needed criteria for involuntary transfer, and others noted inconsistency in the interpretation of imminent danger and grave disability standards.

Finally, another theme in the dataset was the difficulty in using an involuntary treatment process when substance use was involved despite Ricky's law, due to a shortage of treatment services for withdrawal and addiction. [See Chapter 6]

Additional observations by the authors of this analysis related to the state's ITA statute are as follows:

The terminology of a DCR conducting an "*investigation"* should be reconsidered. The term investigation implies wrongdoing. Individuals in behavioral health crisis are often not committing any crime; they may be a threat to themselves or are facing untreated, life-threatening illnesses. The language we use impacts how we treat people and in turn, how people who use services feel they are being treated. Is the term, crisis assessment, a more appropriate one to use?

WA state statute is unclear about who holds the authority in a county to designate a DCR leading to questions among policymakers about who has that power. Clearer rules need to be created to not only clarify who can serve as a DCR but to give this power to existing co-responders with clinical training given the workforce shortages. It is recommended that the same entity providing the oversight of the crisis care continuum specifically, the BH-ASOs also be allowed to designate who can become a DCR. [Chapter 6]

What are recommendations concerning best practices to prepare co-responders to achieve objectives and to meet future state crisis system needs, including those of the 988 system?

Definition and Recognition

It's significant that we have 61 programs operating across WA State handling challenging, volatile, and potentially high-profile situations without formal recognition, coordination, or sustainable funding from the state. This is especially discordant in light of the state's recognition of both police field response (RCW 36.28A.440) and fire-based mobile integrated health programs (RCW 35.21.930). We recommend additional investment in programs and training, and for CROA, in collaboration with a university-based entity, to play an important role in the professionalization of the field of co-response.

It is vital that the emergency response system and co-response not be segregated from the 988-led behavioral health system, from mobile crisis teams and from landing zones. Rather, there needs to be cross-sector collaboration and accountability at a regional level. Notably, co-responders reported a lack of coordination between the emergency response system and the behavioral health crisis system currently, which is resulting in the fracturing and siloing of care, as well as in care inefficiencies.

State Funding for New Programs to Provide More Equitable Co-Response Services

We recommend additional funding for state co-response programs based in police and fire departments and that grants from the state receive oversight from the Behavioral Health-Administrative Service Organizations, the Association of Washington Cities, and/ or the Washington Association of Counties. To start, we recommend that the state fund in the next biennium at least one fire and one police-based co-response program in each BH-ASO. Funding for these new investments must not supplant existing funding already provided by counties and municipalities for co-response.

Training the Current and Future Co-Response Workforce

We recommend additional investment in training [see above] and for a University entity and CROA to play the lead role, support for CROA for program-specific training, and support for the BH-ASOs to offer regional-specific training to enhance collaboration and accountability, to implement these training recommendations. Additional recommendations for wellness and secondary trauma are provided within Chapter 4 with a recommendation for CROA to play a lead role in the coordination of regional peer support for behavioral health professionals working in co-response programs.

Coordination of the Behavioral Health Crisis System and the Emergency Response System

The BH-ASOs have powers and duties related to the behavioral health crisis system as per RCW 71.24.381. We recommend that these duties extend to regional coordination, cross-system, and cross-jurisdiction coordination with the emergency response system inclusive of co-response programs. WA's current behavioral health crisis system is disorganized. Its lack of clear accountability and transparency is not only apparent to individuals with behavioral health

needs and to their families but to co-responders and, first responders. The ASOs are not adequately funded, or clearly expected, to play the role of the lead coordinator of WA's regional behavioral health crisis care continuum and, as such, they are not recognized to play this role by co-response either.

There must be entities within the behavioral health crisis system that can lead, be transparent, and that can hold system providers and responders accountable or WA will be unable to buck the current trend of user-disjointed crisis care. 911 and the emergency response system must work as seamlessly as possible with the 988-led behavioral health crisis system. There must be strong, collaborative relationships and information sharing across the two systems, which can only happen with regional coordination. The BH-ASOs must engage new partners in the emergency response system including local law enforcement agencies and regional EMS councils.

What are recommendations to align co-responder activities with efforts to reform ways in which persons experiencing a behavioral health crisis interact with the criminal justice system?

One of the strongest themes in the analysis, is co-response programs' positive impact in diverting people in crisis from inappropriate, ineffective, and overburdened ERs and criminal justice systems. Interviewees described emergency rooms and jails as default places to "hold" people experiencing a behavioral health crisis, but emphasized that both systems were heavily overburdened and were not equipped to provide the necessary supports required to stop a crisis and prevent more crises in the future. Many interviewees identified diversion as both their main task/imperative and their biggest impact. Many of their clients were people whom they referred to as "high utilizers" of emergency services; people who called 911 several times a week or were frequently arrested for problems that could be addressed in another way with the right support.

Having more law enforcement-based co-response programs built into our 911 system as an essential crisis service has the potential to transform the way individuals in behavioral health crises interact with the criminal justice system at the earliest intercept point. With the addition of alternative landing zones to the behavioral health crisis care continuum, the first response system will be less likely to criminalize behavioral health crises. In addition, co-response programs have been shown to improve law enforcement officers' understanding of individuals in behavioral health crises and to change the way departments interact with people in crisis, both in policy and in practice. [See Chapter 2]