SCHOOL OF SOCIAL WORK
UNIVERSITY of WASHINGTON

CO-RESPONSE: AN ESSENTIAL CRISIS SERVICE

A Landscape Analysis for the Washington State Legislature

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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.

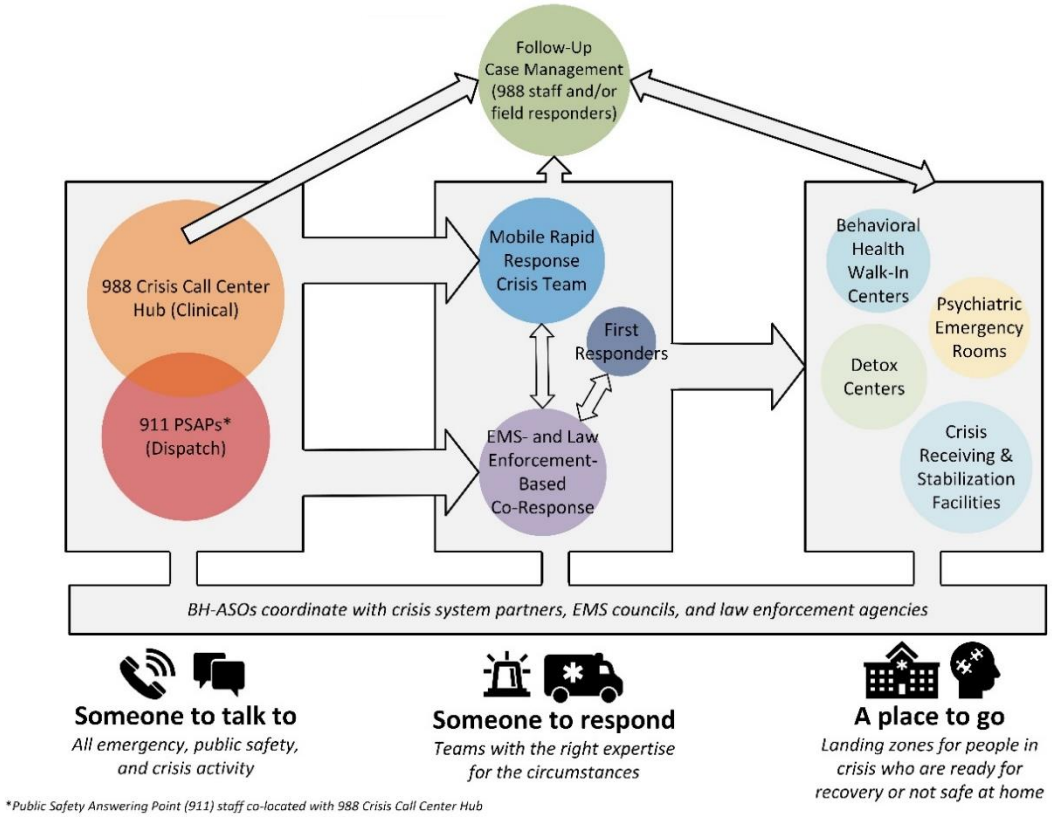
situations. Behavioral health professionals, nurses, and peers can bring expertise, support, and accountability to crisis response and can provide critical follow-up support. Co-response also affects the culture of police and fire departments. Having multi-disciplinary professionals in first responder 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.

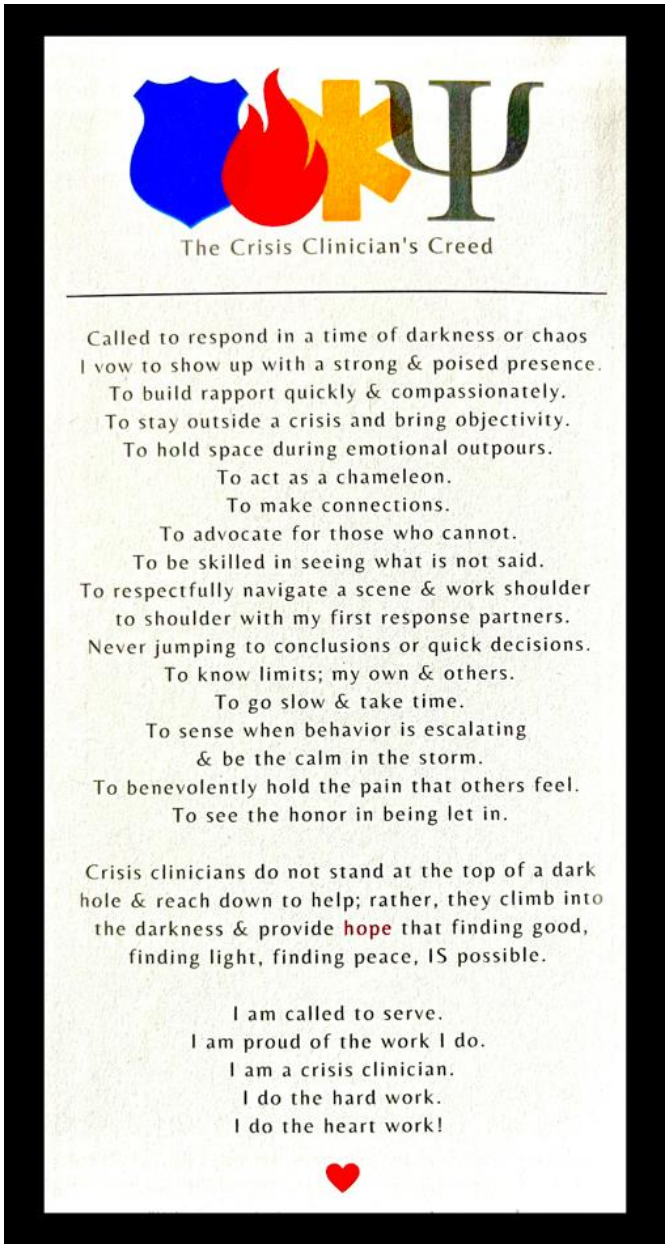
Going forward, this analysis makes the case for robust investments across the behavioral health crisis care continuum that are inclusive of the emergency response system and co-response. It will take a concerted effort to develop a sustainable funding plan that consists of federal, state, county, and 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.

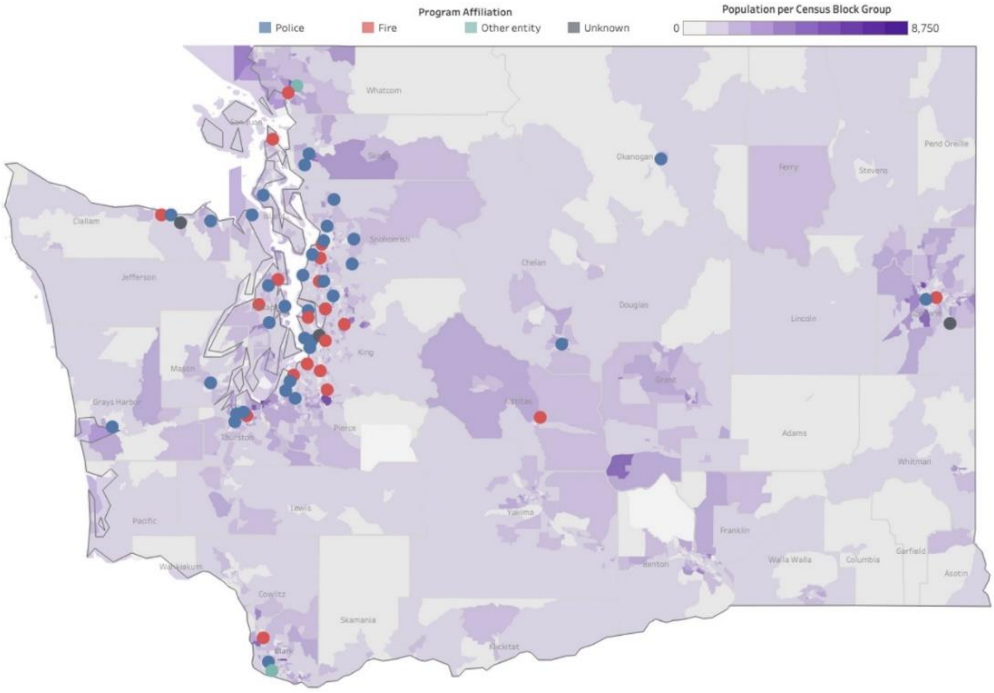
Q&A from 5644

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."

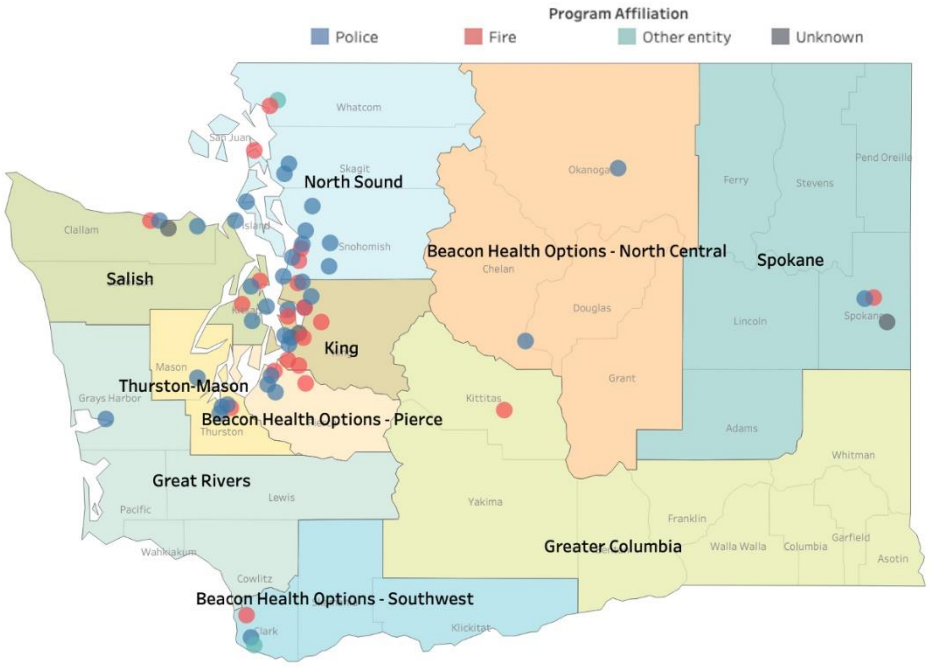
"A barrier has been I only work 40 hours a week and 911 is a 24/7 service. So the chances of me being at work when a crisis call comes in are pretty minimal."

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;

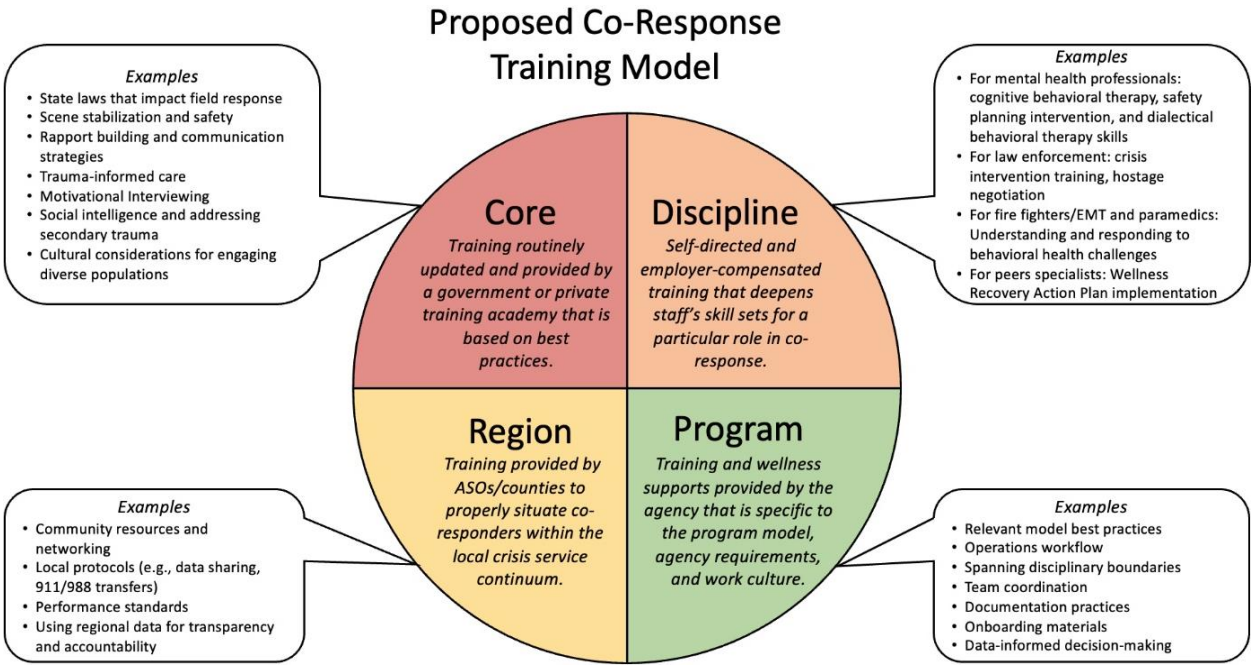
(5) For advanced, discipline-specific training and wellness-related activities to be offered at an annual conference that is led jointly by CROA and a University-based entity

(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]

Chapter 1: What and Where is Co-Response in Washington State?

Co-Response Programs and Services

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 behavioral health issues and complex medical needs. First responders include law enforcement, firefighters, and emergency medical service providers. Behavioral health and other human services professionals include social workers, behavioral health clinicians, community health workers, and/or peer support workers. These partnerships provide in-the-moment crisis response, follow-up, and in some instances, case management, where individuals are connected to appropriate community resources. The goal is to divert people with behavioral health challenges from the criminal justice and emergency medical systems.

The term "co-response" is often misunderstood to mean only a 911 response by law enforcement alongside a behavioral health professional. While this is one form of co-response, these programs are diverse and flexible. Co-response programs can provide follow-up, case management, and prevention services in addition to 911 response. 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.

Co-response programs function at the nexus of the hospital and emergency response, public health and housing, behavioral health, and public safety systems. Co-response programs are an essential component of the behavioral health crisis system because they offer a broad range of services, due to their multidisciplinary team composition, responding to complex needs that no other entity will respond to. Co-response programs are a complement to mobile crisis teams and vice versa; the former tends to take more acute calls where there are public safety or complex health needs also involved.

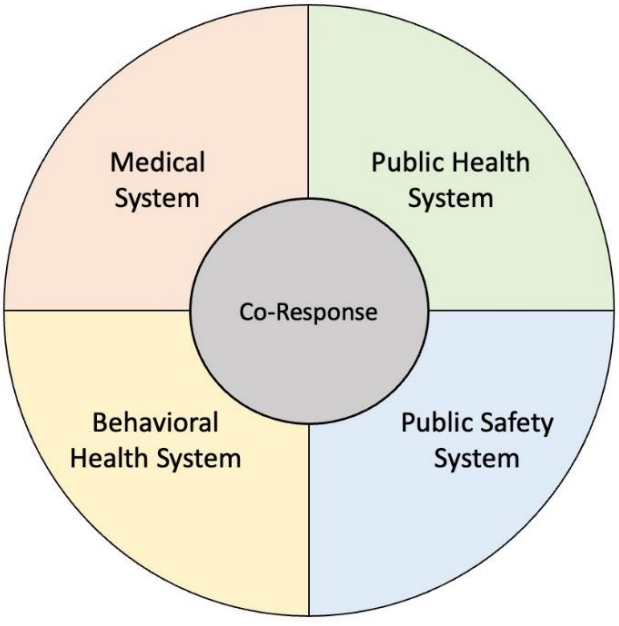


Figure 5. Co-response as a cross-system approach to serving people in crisis

The landscape analysis identified **61 co-response programs operating across 44 cities and 14 counties in Washington**, with a handful of new programs planned to start in the coming months. Co-response programs vary in the breadth of offered services and in the types of situations to which they respond. **Ninety-five percent of programs report offering crisis *prevention* services** (e.g., transportation, outreach to unsheltered individuals, wound care, etc.). **Ninety percent of programs report offering crisis *intervention* services** (e.g., crisis de-escalation, safety planning, medical reconciliation, etc.). **Seventy-four percent of programs report offering crisis *follow-up* services** (e.g., case management, hospital discharge transition, assistance with durable medical equipment, etc.). Some programs (26%) also offer services via telehealth, such as for crisis follow-up or medication consult. Co-response programs responded to **approximately 60,000 unique in-person client encounters across WA state** (87% of programs reporting) in 2022.

Table 2 shows the number of programs by the co-response model type. Models are differentiated by the manner in which the co-responder works with the first responder: alongside a first responder, in coordination with a first responder, or in response to a referral from a first-responder, and without a first responder present at all. The main substantive difference between co-response that is alongside versus in coordination with a first responder is that, in the former, the co-responder is entering into an emergent situation at the same time as the first responder is entering it, and thus there is a higher level of acuity with the situation Note that different models may be utilized within the same program. For example, a program may have staff who respond to emergent situations alongside a first responder while also having staff who provide ongoing case management to someone after receiving a referral from a first responder.

Table 2. Co-response Programs by Model (N = 58)

Co-Response Models	# Police-Based Programs	# Fire Department/ EMS-Based Programs	Both Police- and Fire Department/EMS-Based Programs
Behavioral health or human service professional responding to emergent situations alongside a first responder (i.e., same vehicle)	29	9	2
Behavioral health or human service professional responding to emergent situations in coordination with a first responder (i.e., different vehicle)	21	9	1
Behavioral health or human service professional providing services after receiving a referral from a first responder (i.e., no first responder present)	20	12	1

** The total N is greater than the number of programs responding as some co-response programs deploy more than one type of model.*

The following are examples of the breadth of situations that co-response teams are suited to address better than law enforcement or fire departments/EMS responding alone. These examples also highlight situations where co-response is a better solution than a response by a mobile crisis team (MCT). MCTs are not integrated into the 911 system.

A 42-year-old woman living with psychosis calls 911 repeatedly because she experiences delusions about her house being burglarized and neighbors plotting against her. First responders are frustrated with the repeated calls, neighbors and landlords are frustrated about ongoing accusations, and the individual has no interest in crisis services. Co-responders work with the individual, after each call, to ensure she is safe, offer support, and do non-clinical assessments. Over time, co-responders gain enough trust with individuals to talk about underlying needs and connect to behavioral health services.

A 78-year-old man with major depressive disorder and dementia lives in a motel that he will need to vacate because he's unable to care for himself. He has COPD and range of other chronic health issues and the hotel manager frequently calls 911 out of concern. Crisis services advise that the individual should be taken to the hospital for medical clearance; the individual is not willing to go. A fire department co-response team visits frequently with this individual, as a preventative measure, to provide basic medical care and explore housing options. With their encouragement, after many visits, he is transported to a crisis triage center, where he is screened for suicide risk and assisted with the management of his medications while temporary housing options are explored.

A 54-year-old mom calls the police because her son living with schizophrenia is breaking into her home for shelter, and in doing so, is violating a restraining order put in place because he has been violent in the past. Mom feels threatened and unsafe. A co-response team responds and de-escalates the situation; once de-escalated, the team works with a Designated Crisis Responder to evaluate the son in the field and explore options for crisis stabilization. No charges are filed. Co-responders stay with mom, for hours after the event, explaining the ITA process, talking about support groups in the area, and providing information about assertive outpatient teams and supportive housing.

An 82-year-old man living alone falls frequently and is starting to have memory issues. After calling 911 several times, a co-response team from the fire department is able to offer fall prevention services and install a ramp and rails in the home. The team is able to connect with out of state family that has no idea about this individuals' deteriorating condition, and educate the individual and his family about home care services.

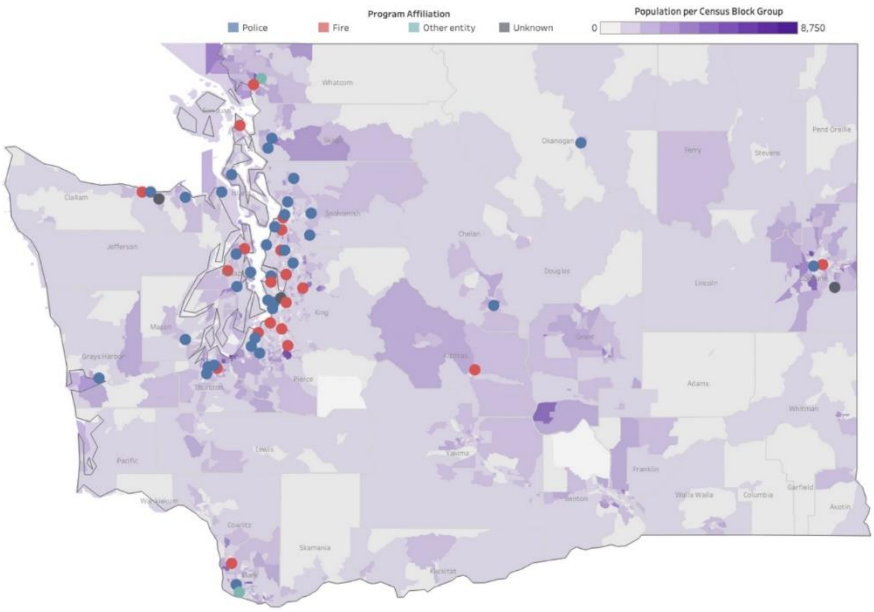
A 65-year-old male transitioning to female seeks help with alcohol addiction, but cannot find a residential treatment center that will house her with women or accept her insurance. Co-responders work, for weeks, to add Medicaid to her Medicare plan and find a facility that accommodates her gender identity. They then take a 6-hour drive—to the facility and back—to ensure that she arrives safely to the facility with the support that she needs.

These are the types of situations that co-response programs respond to and, in some programs, case manage until the appropriate long-term service providers can be engaged. In some instances, this can take months or years. Co-response is uniquely positioned to fill a previously unmet need in service provision for people with behavioral and other unmet health needs. Often, they are the only service available (other than the jail or emergency room) for people living with behavioral health disorders and chronic health conditions. Because of the breadth and flexibility of their services, co-response programs meet a community need that traditional MCTs cannot address, such as in situations involving safety risks, medical complexity, and the need for transportation.

Where are Co-Response Programs Located?

Figure 6 shows an excerpt from an interactive map of co-response programs in Washington State compiled from survey responses. Each dot on the map represents a program. The color of the dot signifies which type of entity has primary oversight of the program: blue for law enforcement, red for fire department/EMS, turquoise for other entities, and gray for unknown. Over half of the 61 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/EMS. Programs based in fire/EMS departments offer the community an opportunity to receive a quick health response without having to engage law enforcement. The other 10% of programs receive oversight from some other entity (e.g., a local government department) or did not provide a valid response. Only a very small fraction of law enforcement and fire/EMS departments report having co-response programs at the time this landscape analysis was completed. According to the Washington Association of Police Chiefs, there are 240 law enforcement agencies in the state (this does not include tribal entities). According to the Washington State Patrol's Active Fire Fighter Department ID list, there are 480 fire/EMS departments (this does not include tribal entities).

Figure 6. Excerpt from interactive WA state co-response map



Also shown in Figure 6 is the location of programs relative to population density, which can be a proxy measure for potential demand. The darker the purple area of the map, the larger the population residing in the area. Many co-response programs are in the population-dense Puget Sound corridor. More rural parts of the state, on the other hand, have no programs. Several high-density population areas such as in the Tri-Cities or in Kittitas and Yakima counties also lack a program.

Co-Response Programs Are Not Equitably Distributed Across WA State

Washington's crisis system is organized by ten regions called Behavioral Health Administrative Service Organizations (BH-ASOs) which are contracted with the Health Care Authority to provide regional coordination, cross-system and cross-jurisdiction coordination with tribal governments, and capacity-building efforts (RCW 71.24.045). Table 3 shows the county/counties comprising each BH-ASO region, as well as the total population and number of full-time equivalent (FTE) co-response staff for that region. The number of co-response FTEs varies disproportionately across BH-ASOs. For example, Greater Columbia BH-ASO is the fourth most-populous region (749,167 people) in the state, yet has the least amount of co-response FTE (4.0 FTE co-responders) among all regions. It is important to note that most co-response programs are not funded by their BHASOs; this chart is simply intended to show the extent of regional crisis system coverage.

Table 3. Co-response Program Full-Time Equivalent (FTE) Positions and Population by Behavioral Health Administrative Service Organization (BH-ASO)

BH-ASO	County	Total population*	Total co-response FTE**
Beacon Health Options (North Central)	Chelan, Douglas, Grant, Okanogan	266, 273	18
Beacon Health Options (Pierce)	Pierce	925,708	25.2
Beacon Health Options (Southwest)	Clark, Klickitat, Skamania	535,792	42
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, Wahkiakum	301,293	40
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima	749,167	4
King	King	2,252,305	115
North Sound	Island, San Juan, Snohomish, Skagit, Whatcom	1,299,056	120
Salish	Clallam, Jefferson, Kitsap	386,128	35.9
Spokane	Spokane	646,478	16.8
Thurston-Mason	Thurston, Mason	365,592	29

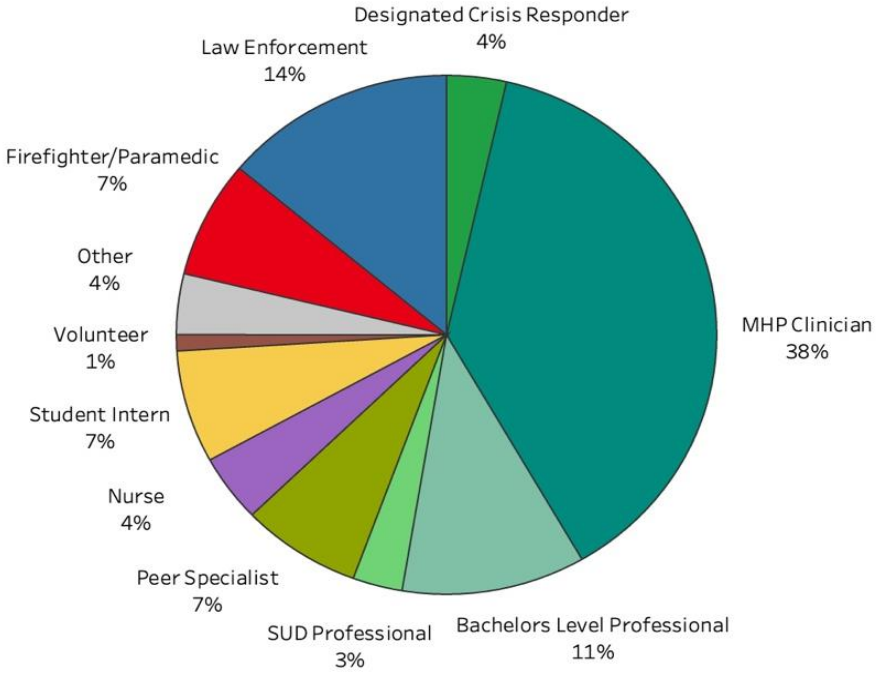
** From most recently available US Census Bureau data.*

*** No co-response program was reported to serve an entire BH-ASO region.*

Program Staff

Figure 7 shows all co-response program staff (95% of programs reporting). Programs are primarily staffed with human service professionals such as behavioral health clinicians at the master's (38%) or bachelor's levels (11%). First responders such as law enforcement officers, fire fighters, or paramedics comprise less than a quarter (21%) of co-response staff. **In total, programs report over 445 full-time equivalent (FTE) positions in co-response programs across Washington**.

Figure 7. Staff across all co-response programs with a valid response (n = 58)



Most human services professionals in co-response programs are employed by the first-responder agency or local government (62%), while less than a third are employed by a behavioral health agency (29%). Most professionals also arrive at emergencies in the same vehicle as a law enforcement officer or firefighter/paramedic (67%). Only about 10% of programs operate 7 days per week and 24 hours per day. Seventeen percent operate 7 days per week but less than 24 hours per day, while 72% operate less than 7 days per week and less than 24 hours per day.

Conclusion

Co-response programs are a unique and essential aspect of the state's crisis response system and behavioral health system of care. By partnering with first responders, the human service professionals in these programs can serve people across the spectrum of a crisis—from prevention to intervention to follow-up. Currently, many Washington communities have an active co-response program, though large portions of the state still do not. Even where programs do operate, the population need appears to greatly exceed co-response capacity.

Chapter 2: The Impact of Co-Response

It's important to measure the efficacy, effectiveness, and perceptions of users of publicly funded programs; otherwise, why are you funding the service? There are several different ways to measure programmatic impact with varying levels of objectivity and scientific rigor. However, evaluation activities require funding and expertise that is typically not available to programs. This chapter summarizes how co-response programs are currently measuring impact and describes their impacts based on rich descriptive first-person accounts of those who provide the services. This chapter also describes how co-response programs are starting to use existing data to measure programmatic impact, which a handful of programs are doing.

Future work should provide first-person accounts of impact based on the perspective of those who use the service.

What Data are Co-Response Programs Currently Collecting?

The collection of operational and outcome data empowers programs to coordinate with other providers in the crisis continuum—which is a crisis system best practice—as well as to tailor responses to individual clients.[13] It also allows the program to be consistent, transparent, and accountable to the funders and the communities that they serve. The landscape analysis found that 98% of programs reported utilizing some type of system to manage data. However, only 43% of programs reported using any kind of data-sharing software. Julota, Netsmart, and HealthCall are all examples of platforms that allow for data management and sharing across teams or agencies. Even fewer programs (21%) reported using an electronic health record (EHO) that is integrated with 911. Though the landscape analysis did not investigate barriers to data sharing and integrated EHOs of which limited funding is probably one of them, the lack of these technologies among co-response programs suggests a significant gap in programmatic needs and missed opportunities to improve care for clients across the crisis continuum.

Data collection should be guided by programmatic inputs, outputs, and the desired outcomes of the program. These features can be captured in a logic model, which is a representation of the essential features of a program that leads to the desired results. Broadly speaking, program data will fall into three categories in the logic model: inputs (the essential components of the program), outputs (the immediate products of these activities), and outcomes (the short-, medium-, and long-term changes that result from the program). The distinction between outputs and outcomes is sometimes blurred because a program may consider a certain output to be a desirable change from the status quo (e.g., achieving a certain number of people served every month). Figure 8 shows an example logic model of a co-response program, while Tables 4-6 show the percentage of programs that collect different data points related to their inputs, outputs, and outcomes. Relevant data points were adapted from a national survey of mobile crisis teams (including co-responders) conducted in 2022.[14]

[13] SAMHSA. National Guidelines for Behavioral Health Crisis Care. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

[14] Odes, R., Manjanatha, D., Looper, P., McDaniel, M., & Goldman, M. L. (2023). How to Reach a Mobile Crisis Team: Results From a National Survey. *Psychiatric Services (Washington, D.C.)*. https://doi.org/10.1176/appi.ps.20220449

Figure 8. Example co-response logic model

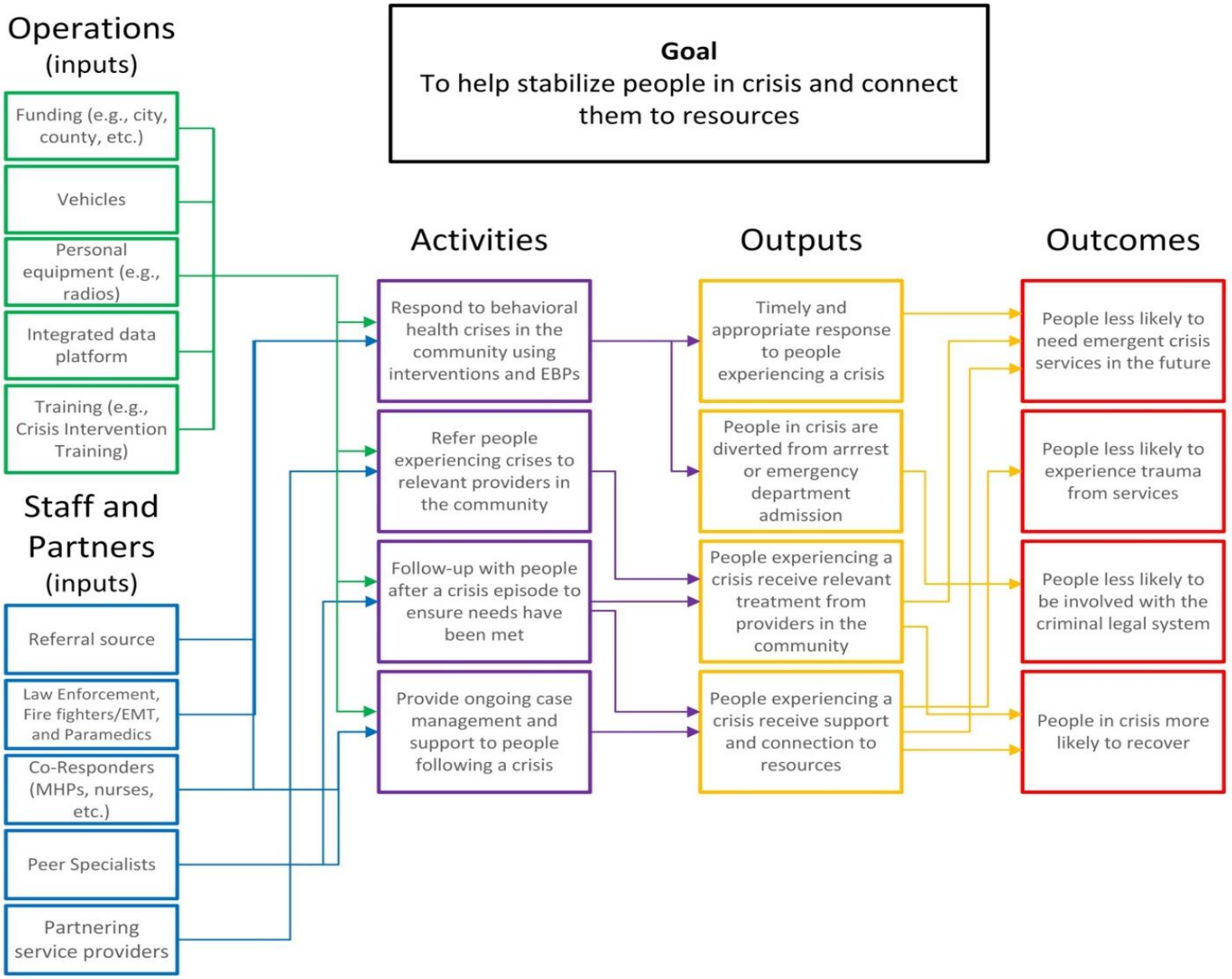


Table 4. Data Inputs Tracked by Co-Response Programs

Input Data	% of Programs That Collect This Data
Referrals	84%
Face-to-face encounters	74%
Follow-up calls	57%
Co-response dispatches	54%
Unique clients served	52%
Care coordination calls	48%
Client race/ethnicity	41%
Inbound calls (if applicable)	34%
Video-based encounters	10%
Other activity not listed here	13%
None	2%
Unknown or no response	11%

Table 5. Data Outputs Tracked by Co-Response Programs

Output Data	% of Programs That Collect This Data
Referral and transport	49%
Detainment for involuntary hold	25%
Followed-up in 24 hours	20%
Completion of suicide risk assessment	15%
Removed/reduced access to means of self-harm	15%
Completion of violence risk assessment	10%
Other data not listed here	26%
None	15%
Unknown or no response	23%

Table 6. Data Outcomes Tracked by Co-response Programs

Outcome Data	% of Programs That Collect This Data
# of referrals to behavioral health and social services	54%
# of enrollments in behavioral health and social services	44%
Reductions in 911 calls	31%
# of arrests or jail bookings avoided	25%
# of emergency rooms avoided	25%
Average response time	20%
Average time to dispatch co-responder	15%
# of incidents where first responder was relieved in the field	15%
% unable to locate	13%
Satisfaction survey of first responders	13%
Average speed of answer for inbound calls (if applicable)	8%
Average abandon rate for inbound calls (if applicable)	2%
Another outcome not listed here	11%
None	8%
Unknown or no response	23%

Reported data inputs did not correspond closely with any one co-response model type, since programs often deploy two or more different models within a single program (e.g., some staff may respond by vehicle to an emergent situation, while others may follow-up with a client after a crisis episode to provide case management). Only 52% of programs, however, reported collecting data on unique clients served. Collecting client-level data is essential for sharing data across the crisis continuum and is considered a best practice in crisis services. Standardization of essential data inputs, outputs, and outcomes is greatly needed among similar co-response program types across the state.

Outcome data helps reveal the impact of co-response programs. To date, there have been at least three evaluations of co-response programs in WA state that have evaluated different outcomes.[15] All three have investigated outcomes like those found in Table 3.[16,17,18] In the landscape analysis, 90% of programs that provided a valid response reported collecting at least one data outcome.[19] While each program may track different outcomes based on the program model deployed, outcomes related to public service utilization were expected to be the most common because reducing the utilization of 911 is a universal purpose of co-response. Only 31% of programs, however, reported tracking reductions in 911 calls, and only 25% reported tracking the number of arrests or emergency room visits avoided. In other words, less than a third of programs that provided a valid response indicated that they were tracking an outcome critical to measuring the impact of co-response. This is likely because meaningful analysis of service utilization changes typically requires cross-system collaboration and assistance from professional researchers. More work is still needed to understand the barriers that programs experience in measuring their program outcomes.

Positive Impact of Co-Response

In the remainder of this chapter, the impact and funding for WA state co-response programs are discussed based on key informant interviews and the brief survey.

Despite major differences in the ways different co-response teams work within communities, there was consistency around the perceived positive impact of co-response programs. Based on the key informant interviews with 48 individuals in co-response programs and a thematic analysis of these interviews, we were able to surmise that co-response has a positive impact on individuals with behavioral health needs who are served in communities in at least 4 ways:

1) By effectively addressing the needs of specific vulnerable populations

[15] Note that all three evaluations were primarily formative or process-oriented (i.e., the primary intention of the evaluation was to investigate how the program is implemented), so included significant qualitative data collection. The landscape analysis did not ask explicitly about qualitative data that programs collect.

[16] Gill, C., Jensen, R., & Vovak, H. (2019). *RADAR: Response Awareness, De-Escalation, and Referral: Final Evaluation Report*. Center for Evidence-Based Crime Policy, George Mason University. https://cebcp.org/wp-content/uploads/2021/11/RADARReport.pdf

[17] Harper, C. J. (2021). *CCAT: Community Crisis Assistance Team*. Social Visions.

[18] Knaphus-Soran, E. (2022). *ART Formative Evaluation Brief: Fall 2022 Stakeholder Interviews*. EKS Evaluation.

[19] Note that the analysis did not examine the actual outcome numbers produced by any one program but, rather, the types of outcomes that programs utilize.

2) By diverting people in crisis from ERs and the criminal justice system to more appropriate services
3) By interrupting harmful situations by providing immediate services
4) By acting as a bridge to close systemic gaps in care.

These themes are elaborated on in more detail below.

Addressing the needs of specific vulnerable populations

Interviewees identified specific groups of people who received crisis response services most frequently, including people who use drugs and alcohol, people facing homelessness, elders, and youth; as well as groups of people with specific issues, including suicidality, psychosis, hoarding disorder, and dementia. Co-responders' unique positioning/ability to address the needs of people facing these circumstances emerged as a theme of the key informant interviews, with many interviewees describing themselves as the "last resort" or last remaining social safety net for individuals in these groups who had burned bridges with other service providers by not meeting behavioral standards, who were unreachable by in-house services, who had difficulty navigating complex health systems, or who needed ongoing intensive support.

The interviews showed that most co-response programs interfaced heavily with these populations, but there were marked differences in the groups of people that different teams felt they were able to have a positive impact on. Some interviewees felt that their biggest positive impact was assisting people who need housing or have substance use disorders, and felt well-resourced to address the needs of those groups. Other interviewees did not feel as though they were able to make an impact with these groups, citing unwillingness on the part of the participant, a lack of resources geared towards these populations in their area, or the chronic nature of some conditions.

Whether or not the interviewees felt impactful also seemed to depend on their definition of success in addressing a problem. Some interviewees felt that simply providing struggling individuals with compassionate support was impactful, while others defined success by more measurable metrics, including abstinence from drugs or alcohol or obtainment of permanent housing. More consistent examples of positive impact on these groups across the dataset included: making effective referrals, interrupting ongoing harmful situations, contributing to individuals feeling more comfortable seeking care, and connection to primary care and housing.

"I think that we also do a really good job with our elderly folks in the community, who have really fallen behind in terms of medical care, are isolated and often really failing at home and getting behind in terms of the volume that's in their home. We're seeing more and more…high-volume situations, whether they started out as hoarding or whether they started out as just getting behind, and then it became that, it doesn't really matter at this point. We are able to get in, in a non-threatening way and help them kind of achieve some basic goals in their home to keep things more stable."

"From my perspective, I would say that although it is not the majority of people who make immediate changes in all of the choices surrounding their life and everything gets fixed, I think that the opportunity, the doors are opened and they may understand the services that are available in the community a little bit better."

"We don't believe in doing sweeps of camps here in Lacey. And so we basically sent out our co-response team and our community response unit. And we just started contacting the people in the camp daily. At the end of nine months, there is no more camp. Everybody had moved on voluntarily, had accepted services, had moved back in with family. We basically eliminated a camp without doing any sweep whatsoever within a year's time."

"Another call our team went on the other day is a teenager stuck scissors to his neck, and everybody thought that perhaps he was trying to end his life. And our care coordinator went. And the mother and the teenager, they don't speak English. And so our care coordinator used an interpreter line 'cause they were using Google Translate to interpret. So the school didn't even know. What we found out was he's autistic, and the boundaries the school was setting were putting him into a crisis. And the school didn't even know he was autistic because no one knew how to tell him. So, we ended up following him up to the school and explaining to the school what we found. And we show up and everybody thinks that he's just a kid trying to kill himself, and he's actually a kid who's autistic, who doesn't understand what's been asked of him. And I feel like without our care coordination, he would have been kicked out of school without any resources."

Diverting people in crisis from ERs and the criminal justice system to more appropriate services

One of the strongest themes in the interviews was co-response programs' positive impact in diverting people in crisis from inappropriate, ineffective, or overburdened ERs and the criminal justice system. Interviewees described ERs 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.

According to interviewees, diversion happens at many points in the cycle: co-response prevented people actively in crisis from needing emergency medical services or getting arrested by de-escalating tense situations by applying simple solutions, replacing police presence at the scene, by providing police with an alternate option to arrest, and providing more appropriate referrals along with transportation. Often, co-responders were able to prevent future crises as well, by working to resolve ongoing circumstances that would often rise to the level of a crisis.

Co-responders were able to pinpoint root causes that were contributing to a crisis and address them so individuals wouldn't have to be continuously "recycled" through what they described as broken systems. There was little disagreement in the dataset about whether diversion was a primary objective or primary impact, although interviewees often mentioned a desire for better resources to refer people to. The diversion was also seen as a measurable outcome.

"What we were also seeing was that for folks that were having law enforcement being that first intercept, they really had, unfortunately, two places to go, and that was either to jail or to the emergency room. And neither one of those are holding locations and places where people are really going to get the services that they desperately need from a competency and from a care perspective. So, the Sheriff's Department started doing some studies with the county where we were doing analysis of what was the behavioral health resources in our county, what were jurisdictions, not only regionally, but also nationally, what were some of the best practices that they were seeing in how to respond to these types of calls, and then what do we do with folks once the call itself has been handled, but where do they go? Because jail and an emergency room are not the solutions for that. It is more of a revolving door for people who desperately needed services."

"They called us and asked, 'Hey, can you come provide this individual with some support?' We were able to show up, just talk with him, we were able to get him out of there in like 15 minutes and instead of having him possibly trespassed or have the police show up or all of the more negative things, even though he was totally pushing boundaries, we were able to get him to understand that the expectations was that we gotta get you moving along. It was a positive experience and he was really appreciative that we showed up and that we were able to get him help. And even just checking in with him and giving him some food and some water really helped him be ready for the day and go out and do what he need to do."

"We see a lot more crisis calls. I think it's probably a nation or worldwide. We still have a lot of police responding to these calls. That's just the way it's dispatched. Police go out, respond to the crisis call, somebody's throwing a fit in the street, in an alley, or in a parking lot, or something like that. They dispatch police and fire/ EMS and the police have the initial contact. Since the change in legislation in Washington, that's changed a little bit. Police have kind of backed off and it's allowed us to spend a little bit more time with the patient. And it also allows us to respond with a behavioral health professional, where we can try and go and de-escalate the situation and find an alternative disposition or alternative facility to take them to, somewhere better to take them to than the emergency department, which might cause trauma."

Interrupting Harmful Situations and Stabilizing with Immediate Services

Interviewees described that some co-response programs are able to provide mediation and de-escalation during crises and stabilize crisis situations at the moment through the use of interpersonal skills. The provision of anti-psychotic injections came up many times in interviews as a way to immediately address behaviors that have escalated to the point where the person may possibly harm themselves or others. They described co-responders as neutral parties who use listening and rapport-building skills to calm tense situations. Co-responders can provide services that can effectively stabilize a person in crisis so they are in a better place to receive more substantial care.

"We have a pretty unique system in the sense that we're able to connect with individuals who no other agency will connect with and provide them with any resource that they might need and get them there. So, we will track 'em down, give 'em a ride to their primary care physician, get 'em established with primary care, mental healthcare, behavioral healthcare, get 'em into any recovery or treatment facility and transport them to wherever that facility might be. We also help with giving injections or starting individuals on antipsychotic injections. We found that a lot of third-party agencies won't do the injections on some of our individuals 'cause they can be 'scary, big mean people who not very predictable' where we can build a rapport pretty quickly and are able to start them on those antipsychotic injections. Right now, it's only Abilify and Invega that we're using and we hope to add more soon because it seems like those two medications aren't as effective in some individuals as some others have been... Our biggest thing is being able to find people, get them connected with resources to prescribe them with a medication to help 'em stabilize, and then provide them that medication for a time period to get them stabilized so they can actually start making their appointments."

"We'll go out and see patients and we'll give them their antipsychotic medications, or we'll go pick up their medications, administer the medication, make sure that they're taking the right medications, they've stopped taking certain medications according to what the physician wants and then if they can't go in to participate in person for their behavioral healthcare, then we do telemedicine visits. So we go out, we'll do a set of vitals and whatever the doctor wants. Sometimes that's a blood draw prior to their appointment. And then we'll go out there and set up video so that they can have a one-on-one with their mental health provider and just kind of using us as a way to make that happen."

"Probably the biggest effect that we have, in the behavioral health sphere is giving antipsychotics injections to people who were separated from their behavioral health providers. There's a lot of barriers when it comes to getting into the clinic... Having monthly injections and so we're able to go meet people where they are and keep them on their behavioral health medications when normally they would fall through the cracks on that. So that's probably our biggest impact, behavioral health wise."

Acting as a Bridge to Close Systemic Gaps in Care

Many interviewees felt that co-response programs have a positive impact by bridging people who normally "fall through the cracks" to connections and resources. Co-response programs have the unique ability to identify and find people who do not have adequate social support and fill in, almost in a way a family member might, to address issues of loneliness and isolation and to connect people to services that they could rely on in the long term. Interviewees highlighted major gaps in the health care system where co-response programs were filling in gaps.

"I would say our biggest impact lies in those gaps. So, up in our area, we have a lot of programs that have very specific responses and things that they do to help their patients, but if they don't fit within that very specific box, then they fall through these cracks. And so there are gaps all over the system, and so when we can do outreach and follow up in treatment where other agencies can't respond or communicate with those patients, that's where we shine. And a lot of our patients have either never had medical care or because they don't know how to, because they don't know... They're scared of the whole system, and so kind of enrolling people back into their own care plans is kind of a big part of the impact we have."

"I would say the ones where we make the most impact… I just think about the people for whom we keep their case open for years and years and years. And they're older women who are living alone with mental illness who are never gonna ever ever get help. Who we're probably the only people who actually have regular contact with them, and we're the only person who brings them a cupcake and a birthday card on their birthday. And we're the ones who go help them build their bookcase when they need a new bookcase. And we're the ones who help them communicate with their payee 'cause their payee won't answer their phone calls anymore because they've been fired. Is that... How do you measure that? But nobody else does that. That impacts this person's life significantly."

Where Co-Response Has Less Impact

By contrast, interviewees also identified circumstances where they are being called in to respond to behavioral health crisis needs, but they are not able to make an impact. When asked about where they felt they were not able to make as much of a positive impact with their work, respondents mentioned various specific populations that included individuals with mental health needs, individuals with substance use disorder (SUD), individuals with co-occurring SUD and mental health needs, the aging population and individuals with hoarding behaviors.

One of the specific populations mentioned by co-responders where it was stated they weren't making as much of an impact as they would like was with people experiencing significant mental health challenges such as active psychosis and paranoia. These illnesses make it more likely that individuals will refuse help by the co-responders. It is also mentioned that the resources for this group are limited.

"I'll just tell you about one of my last unsuccessful outreaches. We had a male who was having a schizophrenic episode but wasn't willing or able to want to get treatment because he was very focused on his devices being hacked. And so, typically, that's a call that would... I don't wanna say easy, but it's a call that we would typically handle frequently. But I could not get him to move in any sort of positive direction."

"There's a woman we've been serving... since I've been here. So six years since I've been here, and the team knew her before I was here. And has pretty significant mental health challenges, can't really care for herself, meaning would go to the bathroom on herself and things like that. But she's a young woman, she's no more than 30. And with a lot of help from family, a lot of help from the community, we finally got her into housing. The housing wasn't what was actually gonna help her because what happened in housing is she completely deteriorated and her behavior was so unsafe inside of her own place. The agency removed her because they couldn't handle her. And so now she goes back to the street. So we thought, oh yeah, we got her housing, it's a housing first model, but she never got the mental healthcare on top of that housing. So she basically bombed out of housing and went right back to the streets. But she didn't understand she bombed out of housing. So she still shows up to her old home almost every day. They call 911, and say she's trespassing and ask for her to be removed from the property every day, 'cause she doesn't have the capacity to understand that she's not allowed back in her apartment."

Another specific population mentioned by interviewees where it was stated they weren't making as much of an impact as they would like was with people living with substance use disorders (SUD). Interviewees mentioned that they frequently see individuals with SUD refuse treatment or any referral services. It was also stated multiple times that the SUD resources often seem not to help people, which caused them to consider whether these services were effective enough for people with these illnesses.

"Man, our hardest cases are people with severe addiction to alcohol. We've got a handful of people that are addicted to alcohol, and the reason we don't make a big difference is 'cause their lack of willing to participate. And we go back to them again and again and again, and eventually we make... So it's weird. Eventually, we make an impact, but they're very, very difficult to work with. It takes us going back again and again and again to finally get them into detox, but they're never... The handful that have don't actually get... We don't fix it."

"I would say the majority of our referrals for substance use people tend to not wanna go to treatment. I have a client, he's younger and he has... He's OD'ed, I don't know, several times. He's been on Narcan in the past few weeks, maybe a month. And it's like we just, for whatever reason, it's like the resources aren't working for him. And he's not engaging with services. And when people don't engage, I usually think maybe especially for substance abuse, it's like they're not ready in the moment to get clean. But I also think it means that we don't have the right programs for people."

"Substance use can be the same way. Alcoholism is really difficult when people... I mean, there is some resources, but we don't find a lot of success there."

"It's very common for somebody to be passed out, need Narcan and we'll roll up on the call and tell the people, you know, they'll have drugs there and we'll be like, 'Hey, you can't have the drugs. That's technically illegal, but obviously we can't arrest you. Would you like a referral to go into treatment?' 'Nope. I don't wanna go into treatment. I don't want your help. Leave me alone.' And that's normal."

Another specific population mentioned by interviewees where it was stated co-response is not able to make as much of an impact, was with people experiencing co-occurring substance use disorders (SUD) and mental health challenges. If individuals with co-occurring SUD and mental health needs do accept help, resources are limited for this population because of the complexities of both sides. It can take a long time and numerous interactions with someone before they accept help, which they cannot force due to the voluntary nature of entering a detox center.

"I think because of the nature of what we're seeing, oftentimes we don't know initially that there is a severe mental illness on board. And so we'll see someone, they're using fentanyl, they wanna stop using fentanyl, and so we'll help get them to our diversion center. And after two or three or four days of either not using any longer or being on medication-assisted treatment, the substance use disorder symptoms sort of take a backseat to mental illness symptoms that start to become more pronounced. And at that time, we definitely have people who don't stay at the DC, it's a voluntary program, and so they'll leave, they'll walk 'cause they don't have the support they need. But also those symptoms can really become disruptive and make it difficult to stay in that location long term."

"It's a tough one to answer because we don't get an immediate result that we obviously like with people using substances in mental health. So sometimes it takes a very long time to work. We've had people that we worked with two or three years that finally came to the decision to work with us and move forward. So, it's difficult working with people with extreme mental health conditions that aren't receptive to any services. I guess that would be something we struggle with. Probably everybody does."

The aging population was another specific population mentioned by interviewees where it was stated that co-response is not able to make as much of an impact as they would like. They described that the aging population generates a lot of calls, but they are unable to do much if they are not a danger to themselves or others outside of calling Adult Protective Services (APS). It was mentioned that APS does not do much so the calls persist to help the aging population with daily activities and with falls.

"There is a handful of clients that we have been trying to work with for quite some time, and by quite some time, I mean, a few weeks to a few months, that want to age in place but aren't necessarily doing it in a healthy or a safe way."

"If we keep moving 'em from their chair to their bed, they're gonna keep calling back 'cause we'll keep doing it. And so we have to put up that hard wall so they will be uncomfortable. And that's the thing, I've been doing this since 2019 and it seems like people won't participate in their own healthcare or get what's truly good for them until they're uncomfortable. And discomfort at rock bottom is different for every individual and we just have to find that it sucks. It's terrible to watch but it seems like that's the only way we can be effective and get people to participate in their healthcare is to not bridge that simple thing and make them rely on actual resources that are built for caretaking and mental healthcare".

"There's a lot of situations where it's just really intractable. They're either seniors who are not safe at home, but refuse to change the situation, they refuse to go to any kind of care facility. And then, the calls just keep happening and falls just keep happening. And there's not much anyone can do. Adult Protective Services can't do anything, nobody can do anything. So that gets pretty frustrating."

Finally, another specific population mentioned by co-responders where it was stated they are not making as much of an impact as they would like was with people living with hoarding disorders. There is little training on how to help individuals with hoarding disorders and where to refer these residents who need additional support.

"We're not able to really make a big difference in terms of folks who truly have hoarding behaviors. We can work with them for long periods of time, but it's usually kind of small changes that oftentimes revert back to previous behaviors. So, we have a person right now who it's at least 4 to 5 feet of belongings throughout the home that you have to crawl over or walk on top of. And there's trying to focus on pathways and safety. It's met with, this is my house, this is what I have."

"One of the things that we see more and more often is hoarding and training for that just feels non-existent. And the resources there are, they also feel almost non-existent. They're impossible to access."

Conclusion

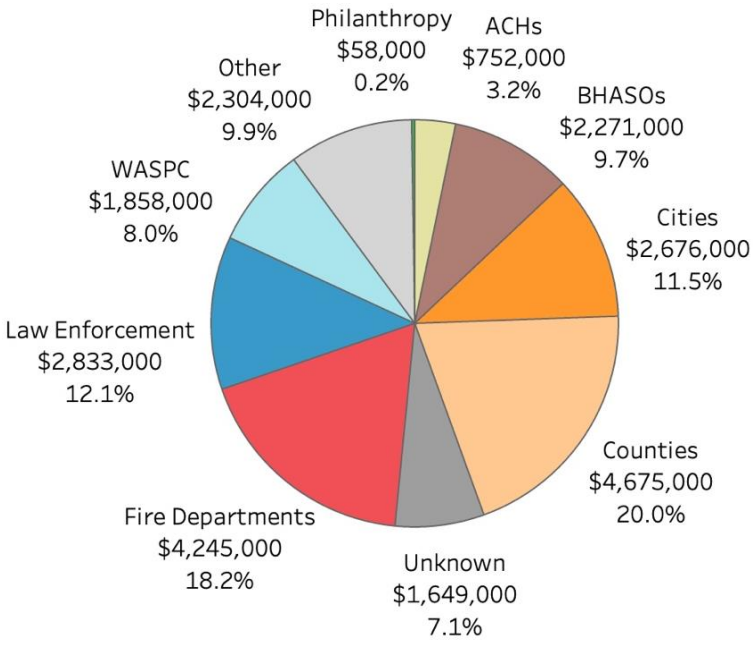
Co-response programs are at the beginning of trying to figure out how they are having an impact on their communities. It is clear from the interviews that co-response programs have both tangible positive impacts and specific populations/ circumstances that they have challenges serving as any entity would. CROA and a University-based entity can greatly help to standardize how programs are measuring impacts. There also needs to be an investment in a flexible, interoperable, and compliant cloud-based platforms that can enable co-response programs to work collaboratively with other partners across the behavioral health crisis care continuum.

Chapter 3: Funding for Co-Response and Future Funding Sources

Co-response operating budgets vary across programs. There were 61 co-response programs identified in the survey and, among the 45 programs that provided valid responses, eight programs (18%) indicated they have an operating budget of $100,000 or less per year. At the other end of the spectrum, six programs (13%) reported operating budgets of more than $1 million per year. Both police-based and fire department-based programs were equally represented across the budget spectrum. Budgets were also generally correlated with average number of people served per year. Programs with higher budgets were more likely to report offering crisis follow-up services, such as following up with clients after discharge from a hospital.

Figure 9 shows co-response program funding sources and amounts among the 47 programs that provided a response to this question. 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%) were the other two largest funding sources—but these are also typically associated with county or city expenditures. Behavioral health administrative service organizations (BHASOs) were another major funding source (10%).[20] Programs were given the option in the survey to indicate Washington state general fund dollars or Department of Justice grant funding, but no programs indicated these options as current funding sources. However, the Washington Association of Sheriffs and Police Chiefs (WASPC) does use state

Figure 9. *Co-response program funding sources and amounts (n = 47). Amounts rounded to the nearest thousand.*
ACH = Accountable Community of Health
BHASO = Behavioral Health Administrative Service Organization
WASPC = Washington Association of Sheriffs and Police Chiefs. [12]



[20] **Behavioral Health Administrative Service Organizations** (BHASOs) are county- or multi-county-level governmental bodies that contract with the Washington State Health Care Authority to provide regional coordination of publicly-funded behavioral health programming, including crisis services. **Accountable Communities of Health** (ACHs) are regional organizations focused on improving the local healthcare delivery system.

allocations to fund its Mental Health Field Response grant program, which comprised 8% of reported co-response funding.

Most programs (66%) regularly submit performance reports to their funders. In all, the 47 programs reported approximately $23 million in annual funding. Note that because 14 programs did not provide a response, the total funding for these programs is likely much higher.

During key informant interviews, interviewees reported that inadequate funding for their co-response program is a barrier to assisting people in crisis. Indeed, only 10% of programs indicated in the survey that they operate 24 hours per day and 7 days per week. Inadequate funding limits the ability of programs to staff crisis responses with human service professionals, as well as the ability of teams to do short and long-term follow-up after a crisis episode. Additionally, county-wide co-response coverage is not available in 25 of the state's 39 counties.[21] As such, access to this essential component of the crisis service continuum is not equitable across Washington.

"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."

[21] County-wide co-response coverage is *not* available in the following counties: Adams, Asotin, Benton, Columbia, Cowlitz, Ferry, Franklin, Garfield, Grant, Grays Harbor, Jefferson, King, Klickitat, Lewis, Lincoln, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skamania, Stevens, Wahkiakum, Walla Walla, Whitman, and Yakima.

For additional context, Washington State Legislature appropriated approximately $38.5m for mobile crisis teams (MCT) in FY2021-2023 or about $19m in annual funding. Importantly, this appropriation does not represent the full amount of MCT funding given the ability of MCT programs to utilize insurance reimbursement (discussed below) or other sources of funding.[22] The number of MCT programs funded by this appropriation is unclear at the time of this writing. MCTs have the ability to operate 24/7, which is a distinct difference from co-response programs whose operations are limited due to funding constraints.

Funding Opportunities

Co-response operates within WA's crisis care continuum. Last year, co-responders responded to a conservative estimate of over 60,000 behavioral health crisis calls. It is important that the state ensures that crisis response services are funded fairly and equitably and that standards for operations and opportunities for training exist. As noted in previous sections, there are many kinds of calls that mobile crisis teams cannot, or will not, respond to (calls involving medical needs, calls involving safety, calls requiring an immediate response when staffing is not available). Sufficient and sustainable funding for co-response is critical to ensuring that every person in WA can receive crisis services when they need them at the nexus of behavioral health, public health, and public safety. Counties and cities, as well as the local law enforcement and fire departments associated with them, currently represent the largest sources of funding for co-response – but other major funding sources need additional exploration that could help co-response programs sustain and expand operations to meet the community needs.

Federal Funding

One funding source for co-response, at least in the short term, is funds from the American Rescue Plan Act. Legislation passed in 2021 (section 9813) authorizes the Center for Medicaid and CHIP Services to provide implementation and planning grants to states for community based mobile crisis intervention services. While police and co-responder pair teams are ineligible for funding under this program, this funding could – and should – be used to support EMS-based co-response teams and civilian teams that work in first response agencies. Twenty states were awarded planning grants in 2021 and Washington is not one of them. The Washington State HCA has expressed interest in applying for these funds but it is not clear, as of this writing, if an application has been submitted or planning funds awarded. More generally, ARPA funds remain an important source of funding for community responder programs, nationwide, that incorporate the skills of fire/EMS into co-response teams.

On December 28, 2021, the Centers for Medicare & Medicaid Services (CMS) released a State Health Official letter (SHO) providing guidance on the scope of and enhanced payments for qualifying community-based mobile crisis intervention services for Medicaid enrollees experiencing mental health or substance use disorder (SUD) crisis as established by Section 9813 of the American Rescue Plan Act of 2021 (ARP). As an incentive to state adoption, the law

[22] Mobile crisis teams (MCTs) are behavioral health professionals dispatched by crisis lines to provide short-term emergent behavioral health care and support to people experiencing crisis in the community.

provides an 85 percent enhanced federal matching assistance percentage (FMAP) for qualifying services for the first three years of the five-year period of state coverage. In 2021, CMS issued 20 planning grants totaling $15 million to states to implement the qualifying community-based mobile crisis intervention service in their Medicaid programs. WA State did not receive one of these planning grants. The CMS guidance came as a response to the staggering need for mental health and SUD services that has grown as a result of the COVID-19 pandemic.

Other states such as Arizona have had significant success in maximizing Medicaid to pay for crisis services. Even if Medicaid will not pay for co-response programs in similar ways as mobile crisis teams, general fund state dollars and other sources of funding should be preserved for co-response programs, with the state taking maximum advantage of federal Medicaid dollars to fund other components of the behavioral health crisis care continuum where it's feasible. WA state should consider hiring an outside expert and have a point person at the Health Care Authority whose specialization is the maximization of Medicaid reimbursement across the crisis care continuum.

Insurance

In general, Medicaid-managed care and commercial insurers should pay something when crisis services are used beyond the first call for help where telecom fees are largely covering the costs. When services are used where clients are identified and served in communities with field-based mobile and co-response services or landing zones, it is theoretically possible to receive directed payments from insurers. Only if insurers are made to bare financial risk for crisis encounters will they be incentivized to fully fund prevention and treatment services that can keep people from going into crisis to begin with. Insurers could make directed payments to BH-ASOs for members who receive crisis services to assist with funding the behavioral health crisis care continuum.

Medicare was also identified in the landscape analysis as challenging when it comes to reimbursing for crisis care services such as co-response. Given the large number of elderly individuals being served in community-based settings not only for behavioral health issues but for medical issues and for fall prevention by co-response programs, there should be greater consideration for funding co-response at the federal level under Medicare reimbursement.

An underutilized funding source for co-response is to expand opportunities for – or remove barriers to – billing insurance. Currently, if an insured person in WA state experiences a medical crisis and 911 is called, that person's public or private insurance can reimburse the costs associated with many needed medical services (e.g., emergent care and transportation to an emergency department). If the same person experiences a behavioral health crisis, however, billing insurance for essential crisis services is not as straightforward. The co-response program must first be licensed by the Washington State Department of Health as a behavioral health facility and then have the infrastructure in place (e.g., an electronic health record) to properly bill an insurance carrier. For billing Medicaid, additional paperwork requirements must be met—and reimbursement is often nominal. Under the state's Ground Emergency Medical Transportation (GEMT) and Treat and Refer Programs, fire-department-based co-response programs can utilize Medicaid reimbursement for a few specific services—*if* they are enrolled as Medicaid providers. However, reimbursements for Treat and Refer are nominal and do not

cover all the costs incurred. Note that GEMT and Treat and Refer cannot be utilized by law enforcement-based programs, which comprise at least 57% of co-response programs identified in the landscape analysis.

In all, only six co-response programs in the landscape analysis (or about 13% of programs that provided a valid response) indicated utilizing Medicaid—and only one of those six programs indicated utilization of additional insurance sources like Medicare or a private insurance carrier. Policymakers can take several steps to support insurance utilization among co-response programs, including minimizing licensure and paperwork burdens, providing support for billing infrastructure like electronic health records, matching Treat and Refer reimbursement rates to GEMT rates, and building upon programs like Treat and Refer to expand the number of services (and agencies) eligible for Medicaid reimbursement.

County Sales Tax for Behavioral Health Services

Under Washington State's Omnibus Mental Health and Substance Abuse Act of 2005, counties may impose a one-tenth of one percent sales-and-use tax to fund local behavioral health services—including crisis and co-response services.[23] Fund allocation can vary from county to county, but typically has been guided by sub-council or committee recommendations to policymakers. Several counties currently utilize this tax, including King and Pierce, which both use the revenue to fund a portion of co-response services. Policymakers in counties that do not utilize this tax should consider implementing the tax to start or sustain co-response operations in their communities. Policymakers in counties that already utilize this tax should consider extending or expanding upon funding to their local co-response programs to ensure services are sufficient to meet community needs. WA state should consider matching county sales tax contributions for behavioral health crisis services using a formula that helps to reduce regional disparities.

Mental Health Field Response Grant Program

The Washington Association of Sheriffs and Police Chiefs (WASPC) currently administers the Mental Health Field Response grant program (MHFR) in accordance with RCW 36.28a.445. The purpose of MHFR is to assist local law enforcement agencies in providing co-response services to their communities.[24] For the 2021-2023 biennium, WASPC awarded approximately 15 grants to unique law enforcement agencies (all or nearly all of which partnered with other agencies), totaling at least $7.8m in funding. As noted above, MHFR grant recipients and funding awards represent only a fraction of the co-response program need in the state. WASPC's annual report recommended the legislature expand MHFR grant funding to $10m for the 2023-2025 biennium. State policymakers did not meet that recommendation, however, and funded MHFR in 2024-2025 to the amount of $8m ($7m of which must be disbursed in grants). Policymakers should consider meeting WASPC's recommended funding level, as well as explore opportunities

[23] Sales and use tax for chemical dependency or mental health treatment services or therapeutic courts. RCW 82.14.460. https://apps.leg.wa.gov/rcw/default.aspx?cite=82.14.460.

[24] Mental health field response grant program. RCW 36.28A.440. https://app.leg.wa.gov/RCW/default.aspx?cite=36.28A.440.

to expand MHFR to meet the larger demand for police-based co-response programs in the state. MHFR funding could also be expanded to cover fire-based programs, or at least fire programs that partner with police agencies. Under current law, WASPC cannot fund fire/EMS co-response programs.

Telecommunications Tax Revenue

Taxes on telecommunications represent another possible source of funding for co-response programs. Currently, Washingtonians pay 95 cents per month in their telecommunication (i.e., cellphones, landlines, etc.) bills that go towards the local 911 emergency communication system, and another 40 cents per month in their bill that goes toward the 988 behavioral health crisis response and suicide prevention contact center HUBS. State and/or local policymakers could instate an additional, nominal tax on top of these telecommunication taxes to adequately fund local co-response programs. In fact, the recently passed HB 1134 from the 2023-2024 legislative session, creates a precedent for this by allowing proceeds from 988 taxes to be used for enhancing mobile crisis service delivery (including among fire department-based co-response programs).

Policymakers could consider implementing a one-time tax on purchases of telecommunication devices that could go towards local co-response programs in the same way. Several states have this one-time tax; WA state does not. As with insurance, revenues from telecommunications fees could provide co-response programs with a steady and predictable funding source to help support operations.

Federal Grants

Co-response programs may also be able to utilize federal grants for funding. Because grant funds are offered on a limited- or one-time basis, they are usually better suited for a startup or to meet the training development needs of existing operations rather than funding current operations at an adequate level. Table 7 summarizes federal grant opportunities that are (or were) active in 2023, totaling nearly $130m in potential funding (at the time of publication, some opportunities were forecasted and not officially posted). Note that grant opportunities frequently change and that some require serving specific populations or partnering with providers in the community that may not be applicable for all co-response programs. Most of these grant opportunities are police-focused.

Table 7. Federal Grant Opportunities Active in 2023 and Applicable to Co-response Programs. HHS = US Department of Health and Human Services; SAMHSA = Substance Abuse and Mental Health Services Administration; DOJ = US Department of Justice; BJA = Bureau of Justice Affairs; COPS = Community Oriented Policing Services.

Opportunity Number and Link	Opportunity Title	Agency	Expected # of Awards	Total Funding
SM-23-002	Mental Health Awareness Training Grants	HHS/SAMHSA	8	$1,111,462
SM-23-005	Promoting Integration of Primary and Behavioral Health Care Program	HHS/SAMHSA	12	$24,920,353
SM-23-006	Treatment for Individuals with Serious Mental Illness, Serious Emotional Disturbance or Co-Occurring Disorders Experiencing Homelessness Program	HHS/SAMHSA	26	$13,103,823
SM-23-012	Law Enforcement and Behavioral Health Partnerships for Early Diversion	HHS/SAMHSA	5	$1,890,177
SP-23-001	Prevention Technology Transfer Centers Cooperative Agreements	HHS/SAMHSA	13	$7,153,318
TI-23-005	Grants for the Benefit of Homeless Individuals	HHS/SAMHSA	33	$13,200,000
TI-23-006	Offender Reentry Program	HHS/SAMHSA	21	$8,925,000
TI-23-009	Addiction Technology Transfer Centers Cooperative Agreement	HHS/SAMHSA	12	$8,600,000
TI-23-011	Rural Emergency Medical Services Training Grant	HHS/SAMHSA	37	$7,400,000
TI-23-012	First Responders-Comprehensive Addiction and Recovery Support Services Act Grant	HHS/SAMHSA	19	$10,900,000
SM-23-021	Tribal Behavioral Health	HHS/SAMHSA	59	$15,055,023
O-BJA-2023-171522	Justice and Mental Health Collaboration Program	DOJ/BJA	Unknown	$550,000
O-BJA-2023-171627	Collaborative Crisis Response and Intervention Training Program	DOJ/BJA	8	$250,000
O-COPS-2023-171554	Implementing Crisis Intervention Teams - Community Policing Development Solicitation	DOJ/COPS	28	$11,500,000
O-COPS-2023-171548	Microgrants - Community Policing Development Solicitation	DOJ/COPS	34	$5,880,000

Conclusion

In summary, insurance, county sales taxes, telecommunication fees, and federal grants are additional possible funding sources for starting, expanding, and sustaining co-response programs across Washington. Given the significant costs to human life and the overutilization of the 911 emergency response system, ERs, and the criminal justice system that results when co-response programs are *not* adequately funded and deployed, it is imperative that co-response programs receive sufficient and ongoing funding for their operations.

Chapter 4: Staff Training and Wellness Needs

The Importance of Training

For co-response programs to be maximally effective, it is vital that they have high-quality training and standards for operation in place. Training is also critical to the safety and well-being of first responders and co-responders who are responding to individuals with complex health and behavioral health needs in the field. Across the 61 programs, there are approximately 445 full-time equivalents (FTE) positions in co-response programs across Washington. And, there are thousands more police (n=25,282), firefighters (n=7200), and paramedics (n=3,000) who are also encountering behavioral health challenges in their day-to-day work independent from co-response programs.

Co-response programs are primarily staffed with behavioral health professionals at the master's (38%) or bachelor's levels (11%). In all, about 56% of co-response staff across the state can be considered some type of behavioral health professional. Behavioral health professionals in co-response programs have the capacity to provide brief non-clinical interventions that are based on best practices typically, developed in clinical settings. They are invaluable in building rapport with clients in the field and, in connecting clients with human and social service resources that can support their recovery. Co-response allows first responders to have peace of mind about the welfare of the clients they respond to. Co-response improves first response, whose primary role is emergent response since it allows first responders to get back into service.

Based on the survey responses, most programs (93%) reported utilizing at least one best practice crisis intervention in their work. Crisis or safety planning in response to suicidality was the most reported (82%), followed by reducing access to means of self-harm (54%) and universal suicide screening (44%). Nearly half of programs (42%), also utilize some form of evidence-based practice for behavioral health, such as recovery-oriented cognitive behavioral therapy (CBT) or motivational interviewing (MI). These practices are typically deployed in programs that provide follow-up or case management services to clients following a crisis—sometimes for weeks or months. Programs also assist people in crisis stabilization and connecting them to support in the community—such as longer-term behavioral health treatment. Using a peer specialist during interventions with people in crisis was reported by about 15% of co-response programs, which suggests there are opportunities for growth in the use of peers.

There are no established training courses or standards for co-responders. As a result, each program conducts training differently. Programs must seek individual trainers when possible or, if relevant, content from other fields to meet training needs. During key informant interviews, some programs reported that they utilize Crisis Intervention Training (CIT) to prepare behavioral health professionals for working in co-response. CIT is a module-based curriculum for intervening with people in crisis—however, it is designed for law enforcement and not

applicable to the full scope of work of a behavioral health professional. As a result, the behavioral health professionals responding to crises alongside firefighters and law enforcement officers are not formally trained for their role because such training does not currently exist in WA state. This is not to say that co-response services are ineffective but, rather, that there is a great need for standardization of practices and the development of relevant training curricula.

Current Training for Co-Response

When interviewees were asked about what kind of existing training their teams had for co-response, they described a wide variety of training experiences and spoke to the timing of training, training content, and training modalities that their teams are exposed to.
Some interviewees noted very established, intentional, strategic approaches to training their teams while others got all of their training through self-study, ad hoc training attendance that they sought out, or described having very little training beyond their educational preparation or credentialing programs. When speaking to the current status of training in co-response, interviewees noted that there was no mandatory training and, at a state level, the system was still figuring out what kind of training was necessary and how it should be offered. The state is "*building the plane while flying it*" with respect to training. The following are some exemplary quotes of the current state of training for co-response.

"There hasn't been really any training so far, so as a social worker, like I have an advanced degree in behavioral health and so I came with that to the job. My past job experience trained me somewhat for this job. And same with the paramedic on our team. He didn't get any specific training outside of being an EMT and firefighter, but he also has experience in community paramedicine before this job started. So, we come with our own experience, our own education. We've talked about doing CCIS, Certified Crisis Intervention Specialist. We've talked about doing that, but haven't done that yet."

"It's really, it's pretty individualized. So all of my staff are licensed in one way or another. And so most licensure requirements include [continuing education units]. And even the ones that don't, like I have agency-affiliated folks too. Every year we put together a training plan, but it's really based on where are the holes and where do we feel like we need more information. I just had three of my staff go to an American Society of Addiction Medicine training 'cause they're all mental health professionals and that was where they felt like they didn't know enough. I've had two SUDPs go to DSM-V training for the same reasons. It's really, we kind of look at where the gaps are. Law enforcement provides a yearly safety training. So from the law enforcement perspective, if we're gonna go out into a camp, this is what it's gonna look like. We're gonna go in first, we're gonna clear the scene. If an officer gets hurt, here's some basic kind of first aid to help your fellow officer. We do first-aid, CPR training, bloodborne pathogens is always required. So that happens. And then ethics, suicide training, kind of the basics, the licensing requirements, but nothing that feels really specific to co-response."

Content of Existing Training

In terms of the content areas that co-responders are currently being trained in, there was again much variety in the type of training exposure. Many interviewees mentioned crisis intervention training and other commonly endorsed topics including, de-escalation training, mental health first-aid, motivational interviewing, and trauma-informed care. A list of the specific topical training by category includes:

- Safety, situational assessment, and tactical training (e.g., crisis negotiation, hostage negotiation, barricaded people, basic defensive topics, using the radio, flashlight training)
- Clinical and medical techniques (e.g., Bloodborne pathogens, tourniquets, wound care, Narcan, basic first aid, catheter insertion, CPR)
- De-escalation and therapeutic skills (e.g., Motivational Interviewing, Conflict resolution, Active listening, Trauma-informed care, Boundaries, suicide intervention, emotional intelligence, harm reduction, Certified Crisis Intervention Specialist, Levels II and III)
- Education and awareness, including cultural awareness (e.g., CIT), mental health first aid, BLEA for law enforcement, Autism, Alzheimer's disease, and co-occurring disorders)
- Administrative, documentation, policy, procedures, knowledge of existing resources and how to make referrals (e.g., training in data platform, layout of the police car, report writing, state statutes)
- Training related to addressing secondary trauma in the team, critical incident stress management, mind-body bridging etc.

Some training was provided to some teams on the co-response model that was structured as a team-based, mission-focused training aimed at understanding the roles of people on the team and spanning the cultural divide between roles. This sometimes included cross-role training (e.g., training on law enforcement topics for behavioral health providers).

Existing Training Modalities

According to the survey, co-response programs train their staff in a variety of ways. Conference attendance was the most reported (69%), followed by video-based content (65%) and some form of job shadowing (65%). Notably, there is only one national conference for co-response-specific training in the United States.[25] Now in WA state due to SB 5644, CROA and the UWSSW will host an annual conference through 2026.

About 13% of co-response programs train students or interns, which can be an effective way for preparing early-career professionals for co-response. Most programs (85%) also offer some form of clinical supervision for their behavioral health professionals, which helps with

[25] International Co-Response Alliance hosts CoRCON. www.coresponderalliance.org.

identifying training needs and maintaining integrity in the delivery of brief non-clinical interventions.

Similarly, interviewees described that many different training modalities and delivery methods are currently used in training co-responder teams. Most commonly, interviewees described experiential learning that happened hands-on while on the job including, case reviews and preparation for common cases, 1:1 shadowing, or ride-along. Didactic or classroom-based training were also commonly referenced and these were administered sometimes through the co-responder program, but more frequently through the employing agency, a conference, or an external education opportunity. Interviewees noted different types of training being offered to people in different roles on the team, as often they were employed by different agencies. Some teams had annual training plans that included multiple modalities and deliveries, but most did not. There was widespread acknowledgment among interviewees that there needs to be on-the-job training that is coupled with more formalized training.

"They get a variety of hands-on and lecture-based training. So we do a variety of things like how to use a computer, how to use a radio, how to write reports, stuff like that. That's kind of boring everyday lecture stuff. We do that, but then we also do some hands-on scenario-based training, including things like contact and cover, de-escalation, barricaded people, law enforcement, casualty care, which is, basic first aid under fire. So we do all of that sort of hands-on scenario-based training for them as well. So all together they do about two months of training before we ever let them out in the car with their partner."

"I've appreciated the opportunities I've had for some training that otherwise I wouldn't have had. Being involved with CROA has been a great experience and a good opportunity for training that I never would've even heard of [chuckle] in the past."

"Social work is like a byzantine maze of a million different services and providers and just learning that is very difficult and it takes time and people can't get it on day one. And I think people have to come to understand that. And what you hear from firefighters all the time, to the extent they, it's a joke among our team. It's like, oh, this person needs services. Okay, well, what does that mean? And then you spend three months on our rig and you learn, oh, that is a very difficult task, and it means very different things to different people. So I would just put that out as sort of a training expectation that like, there is no classroom training that is going to replace that experiential component of this work."

Timing of Existing Training

When interviewees described the training their teams went through, there were three distinct time periods when the training occurred: 1) the training people get before they are hired into the co-responder role, 2) on-boarding immediately after joining, and 3) continuous training throughout the role. Many interviewees said that the formal education, licensing, or credentialing program that they did before getting hired gave them training in the skills they

needed for the job. Others commented on the way that their program required a minimum number of years in a first responder role before doing co-response and felt that picking people who are more experienced ensures that they come in with some amount of experiential readiness that serves as pre-job training. A small number of interviewees noted that hiring people with existing expertise in populations, languages, etc. can help to build out areas of specialization within a program without needing to train specifically. Onboarding was a formal process on some teams, and informal on others, but it was generally described by interviewees as an initial training process that lasted from several days to several months. Onboarding training often included orientation to the program's mission and vision, team roles, familiarization with protocols, etc.

Regardless of the type of training offered, several interviewees said it can take several months before people are fully trained and comfortable with their jobs. Many interviewees spoke about training that happened throughout their time in the role, which would occur in a continuous way for some and an ad-hoc way for others. This type of training was diverse and often optional or self-directed where people had continuing education funds to use at their own discretion. Ad-hoc training included community resource fairs, community agency-led training, in-service training on various topics, continuing education workshops, and conference attendance.

"You have to be a paramedic level to work as a community paramedic, and you have to be a paramedic for three years before you can apply, and that just gives you enough experience out in the field to talk with individuals, make those cold contacts and help deescalate situations."

"For onboarding for us... We bring them on, we get them used to our facilities, provide them a workspace. There's a lot of criminal justice things that they have to go through to be in the vehicle with an officer. Requirements that they have to meet, they have to meet our background checks. They have to be cleared to just to even be in the car where they could see some of the data that we have access to. I know there are a lot of HIPAA things when you're talking about medical and crossover and whatnot. So, they're sitting in a car, next to an officer. So part of that onboarding is familiarization with police tactics and response, basic safety. Our social workers are invited to attend our defensive tactics training that the officers do on a regular basis too, we call it skills refreshers. But our social workers are invited to attend that. And then there's other onboarding."

"What's nice about the programs in Pierce County, all of them, they all have budgeted for continued education. So last year all the co-responders went to Colorado and went to a conference and received education credits."

"We are very lucky to be able to pick our own trainings, pursue those. There is funding for conferences both locally and nationally. We have a lot of autonomy in being able to choose the trainings that we'd like to do that are relative to what we're seeing in our communities."

Effectiveness of Current Training

Informants were mixed in their views on the effectiveness of the current on-the-job training that they are receiving. A theme emerged that small programs have a harder time providing effective training. Co-responders were all over the map in terms of how well they thought the training the program was giving/ receiving was helpful. Some desired more guidance as they felt like they were shouldering it alone.

"I think it was really effective. If you read the program evaluation, our teams are very effective. We had specific goals in terms of just not connecting people with services, but reducing unnecessary bookings, unnecessary ER visits, and decreased use of force, and I think when you start looking at the benchmarks against that which is in the training, we reach those, and we did those things."

"I think that the training and onboarding of new CARES team members is something that I continue to wrestle with a little bit, like how to have it structured enough that people get the support and education they need. And then how do I, you know, continue to provide that support? So, it's something I still wrestle with."

"Training [is] pretty limited. So, I would say training itself is not particularly effective, we have... With a passion, a drive, a desire, compassion, and some basic skill sets that are kind of improvising if they do and they do it well with that, but yeah. There's certainly a need for some more focused training."

There was also strong consensus among interviewees that training is best delivered by people who are crisis responders themselves as opposed to deploying people to train who aren't working in crisis situations

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"I think that the thing I'd like to see changed or enhanced is more crisis responders picking up the training versus agencies if that makes sense. Agency-informed crisis training is very different than an actual crisis. So when I bring somebody to a crisis center, they're already better. All the work in the field, they're already better, if that makes any sense. They're still in crisis and that crisis still looks terrible, but they're already better 'cause we convinced them to get in the car and get there. So taught by more people who have to deal with the crisis on a regular basis versus the person who doesn't see that crisis is the field."

"What we found is once we've been doing the crisis intervention when you go to a suicide intervention training, it no longer really applies to you, and it doesn't really feel like it fits. It might have fit when I worked in an agency working around youth or when I worked in the hospital, this training would be great. But what we found is, you're sitting in a training and you wanna argue with the training, 'cause it doesn't work like that."

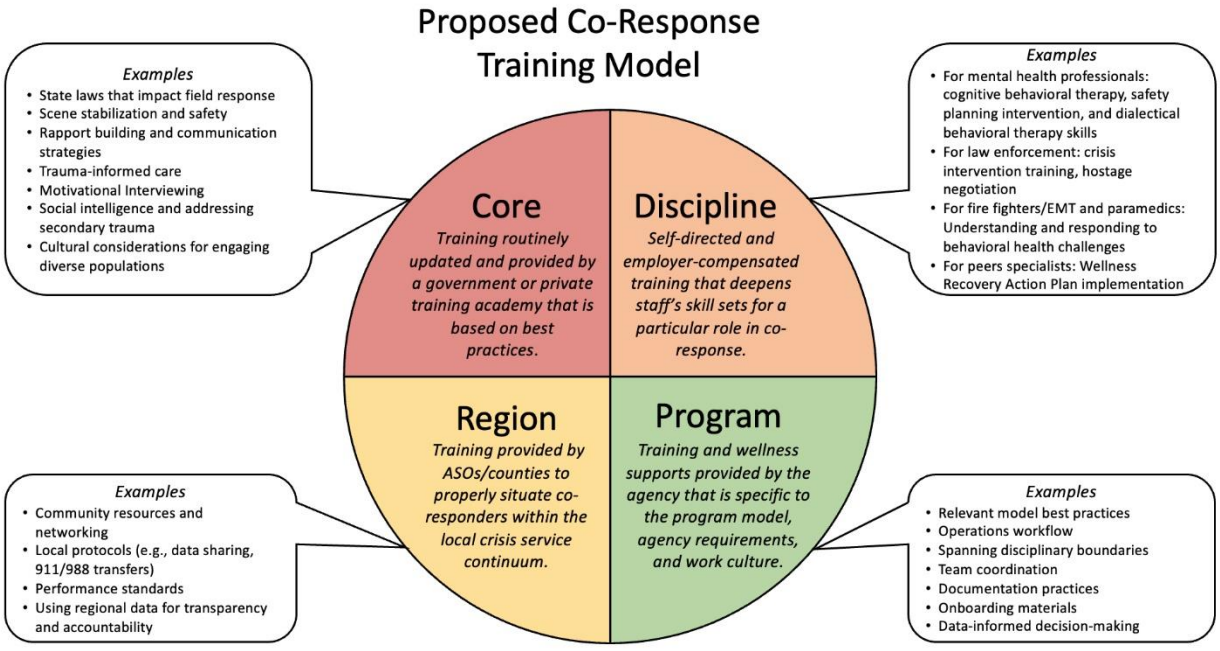
A final theme that consistently emerged from interviewees was that the emphasis in current training needs to be on skills development-- ON DOING RATHER THAN RECEIVING-- in training.

"It's very didactic or focused on knowledge or at least the beginning of knowledge, not nearly enough focus on skills. Now, again, it's different in different places and I have no doubt that when you get CIT training in some parts of the state, there's some excellent like scenario-based training and you come out with skills. So, I don't wanna say that I know everything that happens everywhere, but in the CIT classes I've been through, and I've been through a lot of them, woefully insufficient on that skills-based piece. And again, I want to emphasize that it's got a law enforcement focus and that's just becoming very outdated."

"For me, I feel like training's great, and as long as there's a way to like role play and kind of like practice, that really helps for me 'cause I'm a visual learner or just kind of have to like to do it."

Training Recommendations

Interviewees in co-response programs across the state spoke of the need for additional training, and the need for consistent approaches to training. Responses were so consistent during the thematic analysis that it allowed for a proposed statewide training strategy for co-response programs to emerge. Interviewees discussed the need for training across the following domains: *CORE training, regional/ resource-oriented training, program-specific training, and discipline-specific training*. Quotations in this section from interviewees are illustrative of the overarching approach and of each individual training component.



CORE training is routinely provided by a government or a private contracting entity that is based on current best practices. A key component of CORE training is that program supervisors are trained and remain up-to-date with CORE training modules so that they can coach co-responders in the skills they learned until they are fully engrained in practice. It's also vital that CORE training modules provide ample opportunities for people to study and practice the skill, ideally practicing until they achieve competency in the skills so that they can retain the new practice.

Regional training, ideally provided by the ASOs, was seen as essential to collaboration and to ending the fractured, siloed systems of care delivery that are currently serving people with behavioral health and other social service needs. Regional training was identified as key to learning about available local resources in the human and social service fields, developing collaborations across the 911 and 988 crisis delivery systems, arranging for MOUs with organizations, streamlining referrals for clients, for information-sharing purposes, and as a way for programs to learn from each other. Regional training can also lead to greater system accountability.

Program-specific training, provided by the agency where the co-response program is based, is specific to the program model, policies and procedures, agency requirements, and work cultures. It is necessary to: onboard employees, support first-response and co-response collaboration, teach program technology, documentation, and evaluation needs, and to monitor progress to increase program performance. The support provided by the interviewees for these training domains comprises the remainder of the chapter.

Discipline-specific training is self-directed and compensated, allowing staff to develop their skill sets in ways that are consistent with their professional orientation and bring added value to their role on their co-response team.

CORE Training

CORE training that is routinely updated and provided by a government or private contracting entity in collaboration with CROA that is based on current best practices. A consistent range of topics that would comprise the core was routinely called for, leading to the development of CORE competencies.

Most law enforcement on co-response teams come into this work with a base of training in behavioral health crisis response from Crisis Intervention Training or CIT. This is a 40-hour course that many law enforcement officers take. MHPs have the foundational background attained from their graduate programs. By contrast, fire/EMS, paramedics, and peers receive little to no foundational training in behavioral health crisis response. The ability to fully benefit from the CORE training assumes there are some prerequisites already met in terms of a basic understanding of behavioral health disorders and how these conditions manifest themselves in crisis situations.

The most common topics listed as CORE by interviewees that MHPs on co-response programs should be trained in include: verbal de-escalation, safety tactics, suicide intervention in acute situations, how to support people in crisis who are having active delusions, hoarding disorders

(which is not covered in any foundational training), how to handle secondary/ vicarious trauma, and state-laws and eligibility for state programs/ resources. Below are quotes from interviewees describing the need for CORE training.

"… my preference would be that we have a robust state-wide training program for MHPs in co-response, so that we can put our clinicians, train them to work with the police officers."

"One of our partner agencies has an 18-point training when it comes to even personal like situational awareness and crisis response. I think implementing those trainings on a wide scale, would be really beneficial."

"I'd like to see some like core curriculum developed for co-response. You know, things that involve the things that we know just because we've been doing the work long enough. But I think it's very important because we have other agencies trying to emulate what we do and they don't have the core training. The core curriculum needs to include: trauma-informed de-escalation, motivational interviewing, progressive engagement, and, harm reduction."

"There's probably eight or 10 foundational topics or pieces of training that we all should have and we all should get trained on regularly. And so having that in place is really exciting to me. So I'm looking forward to the day when that happens."

"I think increased training is always great. I think specific co-response training would be great. The training we get is from either a law enforcement perspective or mental health professionals in the field perspective, and neither of those quite hit the mark."

"I would like to see more on crisis intervention, on de-escalation, on behavioral health disorders, on substance use disorders, there's a ton that... I think sort of the didactic and the conceptual framework that you don't necessarily get through the hands-on component, I would like to see more there but I think... And this is where kind of our work with CROA comes in. It really has to be first responders specific, because we have seen a lot of classes that are just not tailored to people who are out there in the field."

"One is a sort of standardization of approaches and best practices. I mean, every program is going to be different in the particulars based on where they are and where they're based. But I think that there's a lot of sort of shared there, there's a lot of shared approaches and techniques that are really universal. And I think sort of really focusing on those for things like, de-escalation and approaching patients in crisis and understanding things like personality disorders and opioid use disorders or whatever it may be. I think that getting some level of standardization there and then just from a basic competency thing, basically saying, we've put all our people through this, we can generally assure that at the very least, they have received training and instruction in X, Y, and Z."

"You can't replace the three years of experience on a front-line unit, but I definitely think we could have a more structured approach to mental health training, behavioral health training, trauma-informed care, all of that. It's just difficult to pay for."

Related to specific topics to be offered in CORE training, below are survey responses to requested training topics as well as representative quotes from interviewees supporting the rationale for content surrounding specific topics.

When survey respondents asked about which training topics programs would like to see offered to co-responders, most programs reported topics about keeping staff safe and managing high-risk calls. As shown in Table 8, safety in the field was the most requested training topic (77%), followed by de-escalation (74%) and team member well-being (66%).

Table 8. Requested Training Topics for Co-Response Programs

Training Topic	% of Programs Requesting
Safety in the field	77%
De-escalation	74%
Team member well-being	66%
Trauma-informed care	66%
Violence risk assessment and Intervention	64%
Suicide risk assessment and Intervention	62%
Harm reduction practices	59%
Involuntary Treatment Act and other state laws that affect crisis response	56%
Structured brief interventions (e.g., SBIRT)	54%
Level-of-care decision making[26]	44%
None	5%
Unknown or missing answer	7%

Key Topics within CORE Training

WA laws relating to the police use of force make 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 a non-law enforcement perspective. As importantly, behavioral health professionals in first responder agencies teach first responders and practice critical communication skills that can, in some cases, de-escalate volatile events. (RCW 9A.16.020). It is vital that all first responders and co-responders are well-trained in multiple strategies for verbal de-escalation to help mitigate the need to use force.

[26] "Level-of-care decision making" is the process of deciding the level of behavioral health service intensity that a client needs.

"We just did de-escalation and safety training last week here, hired somebody to come in because it's happening with increasing frequency that we're having people that react negatively to our presence. And they're not necessarily treating us like the good guys. And the police, like the bad guys, they're becoming very antagonistic to our people too. And I'm not sure that, we're not very far away from having to put hands on somebody and I just don't wanna do that, but I think it's probably gonna happen."

"I'm sure you're hearing this from everybody, but there is a lot available for the basic clinical skills. There's a little less available around crisis intervention and de-escalation, and there's very little available right now for the very specific situation of somebody that's in highly acute crisis, has called 911, and is in that level of acuity and of escalation that requires a law enforcement response. There is not a lot of training to that level of need and acuity."

"I think comprehensive training around safety is important. I think it's needed."

"I've been noticing there is certainly a change in our unhoused population. I mean, just on our low-income population too, people are just a lot angrier. And being able to navigate such intense emotions that can drive people to do things that maybe they wouldn't typically do, I think is something that we could all benefit from of how to protect ourselves and keep ourselves safe, but while also not being fearful of our job."

"I also worked at a psychiatric hospital and we had [training] called Handle With Care, and it was specific de-escalation training but then also on how to do holds. And I know that doesn't apply in this role, but we did that every six months. It was very structured. And we had to practice over and over and over again. And so it was this thing that when we were in those situations it just was second nature to practice those protocols because we have learned it so many times over and over again. And although there were a lot of different situations that could happen that were unsafe, that we needed to do X, Y, and Z, we had all that training and all that knowledge for those situations. It's a little bit harder 'cause that's a more confined space and we're in a community so there's a lot more, but something like that would be really helpful to just have something as second nature to do when we're out on scene and something goes wrong."

"Most of the time, but I think that's different for my program because we do respond with police, and we have the option to bring them on follow-up appointments if we feel it's necessary. So usually if there's a situation where I might feel unsafe, they're there with me. I don't know if I would feel differently if they weren't there with me. And sometimes that doesn't necessarily feel like enough because like they have all of their training and I'm like choosing to trust that they can protect me, which they're very good at and they do very often. But in the scenario that something just goes completely awry, I don't know, like I feel like it would be nice for me to have my own training on like what to do."

"Co-Response is a lot different than seeing people in a controlled setting. A lot of our people are under the influence of some sort of substance and/or in crisis. And a lot of these people are known to carry weapons and so, I think clinicians who are used to seeing people who are sitting in front of you that it's a whole different game than when you have someone who is physically escalated saying... Like, I had one client saying, 'I'm gonna kill everyone in sight. I'm going to kill everyone.' Just a matter of when, essentially. And so, I have this man in front of me who's posturing and is within reach of me, right? I have my law enforcement officer. But there are times when even my officers turn away and chat with the other officer to communicate something. But basic defensive tactics are appropriate for our job because the likelihood that we're gonna get hit or that we're going to be in a position where someone is very escalated, like I said, posturing and sometimes violent. It's not a clinical setting. It's not a setting where someone's sitting in front of you and yes, agitated, but it's a whole other ballgame when someone's spun up on meth and thinks that the government is after them or that someone's trying to kill them. It just puts people in a fight or flight sort of state. And because of that state, in my opinion, it's better to be prepared than to not be prepared."

Suicide Intervention

Suicide prevention training is typically designed with the clinician who is treating someone in a 50-minute appointment slot. This is not at all the context that first responders and co-responders are in when they are responding to calls related to suicide. The situations encountered typically have a very high range of acuity and complexity such as, suicide attempts that are imminent or in progress that may have competing factors at play; welfare checks where you don't really know what is happening behind a person's front door; responding to suicide deaths and providing suicide death notifications to grieving family members, needing to secure lethal means in a person's home, and working with family and collateral to ensure they know how to provide on-going support in a compassionate manner as well as assistance in navigating resources. Interviewees discussed the need for training that is specific to these types of situations that feels applicable to the real-life obstacles to addressing suicidality in the field that they encounter. Without improved training they will continue to perpetuate the harmful cycle of: taking people to emergency rooms, dropping them off, only for the emergency room to release them without proper treatment, ultimately, increasing the likelihood that they will refuse care in the future. Interviewees also discussed that the limited community resources in the form of next-day appointments that actually result in any treatment in the near term, inpatient beds, and stabilization centers poses significant challenges for managing suicide risk in the field.

"I think that I really need to build up more around the suicide assessment when people are saying yes. And it's not necessarily that they need to go to a hospital. Like there's some steps we need to take in between that."

“One thing I've been talking to [Redacted] about is high acuity suicidality that we don't really... That is not available right now that I would like to see available and accessible.”

“What I would love to see change is that if crews are on scene with somebody making suicidal comments, that they are at least a little bit trained in doing risk assessments so that they can confidently say like, "I'm not transporting this person because they don't have intent and they don't have a plan. And so their risk level is low, I'm gonna leave them home and refer them to CARES and CARES will follow up with them the next day."

“What we found is once we've been doing the crisis intervention when you go to a suicide intervention training, it no longer really applies to you, and it doesn't really feel like it fits. It might have fit when I worked in an agency working around youth or when I worked in the hospital, this training would be great. But what we found is, you're sitting in a training and you wanna argue with the training, 'cause it doesn't work like that, if that makes any sense.”

“… just going back to suicide prevention and intervention and HIPAA. I feel like those are two pieces of training that most agencies checkbox, but if you ask staff if they feel really confident, then they don't. And so I just feel like those are two areas kind of, whether it's every six months or monthly, and team meetings that teams are able to continue to feel like they're thinking and applying what they learn from those basic training.”

Secondary Trauma & State Laws that Affect Crisis Response

Two other topics that interviewees provided a lot of context around are the need for additional training related to secondary trauma and state laws that affect crisis response and navigation of existing human and social service systems.

“The work is traumatic, the work is bad hours. The work is very soul-crushing, just like police work is, and if you're not going into it with an understanding of resiliency. And so that's one of the huge gaps that I see is we don't have a great training state-wide and we don't have great expectations.”

“Relevant training that I think would be good everywhere are like DSHS related training about Medicaid eligibility, medical long-term care and the financial qualifications and that, because... I think that's a generally applicable thing and not... That's not easily accessible information.”

“I think we should probably have some good legal training to come up constantly in the field about what is Joel's law. How long does an ITA process hold last? Where can I go if my son was evaluated and was not treated properly? Where can I go if my mental health provider isn't giving me the care I need? I think having a primer and basic law around crisis and working with people that are part of our emergency behavioral health system would be really helpful.”

The Need for a Training Pipeline

Some interviewees described their desire for CORE training in more precise terms calling for a new certificate program for MHPs in co-response programs that agencies could send their staff to. Others indicated that the current collaboration between CROA and the UW was on the right path to developing and implementing the CORE training.

A couple of interviewees also pointed to the need for a training pipeline that begins prior to graduation, an area of specialization in co-response within graduate programs, that could be inclusive of some bachelor's level programs, as well. Eleven percent of co-response MHPs are bachelor's level according to the survey. The inclusion of Bachelor's level MHPs would increase the workforce however, it is vital that these individuals be deeply trained in crisis response strategies and have a strong foundation to build off of with relevant training in the human services or social service realms. In Massachusetts and in Illinois there is precedent already established for creating a training pipeline to develop the workforce more quickly and effectively.

Furthermore, interviewees expressed excitement about CROA and a University entity collaborating on building the training components. The idea of offering conditional scholarships to lessen the debt-to-salary burden for Master's level students who enter this work was also recognized as an important need. The people who go into this work endure long hours, high stress, and absorb secondary trauma, they must be well supported in this work through training, compensation, and reduction of the debt-to-salary ratio or, you will not have a robust workforce.

"It would be quite interesting to see if at the state level, they could come up with some sort of training or certification course for co-responder teams of law enforcement and mental health, yeah, especially since it's growing a lot across the state and programs are building the plane as they're flying."

"I think CROA and UW are the right entities to be developing this type of training. Because it's kind of CROA are the experts and UW is the educational institution. I think CEs are always helpful and, just with a focus. I would say with a focus on the special needs and requirements of high acuity co-response. And the audience, a focus on the audience as well. Something that CROA is really attentive to is that first responders can tend to receive things differently. So it's like a, important that it's tailored to the audience."

"I'm super excited about this partnership with the University of Washington and CROA and this notion of comprehensive training for co-response teams. I think that, we started this program in 2016, and some days I'm like, I think I know what I'm doing. But we don't have any sort of training curriculum. We don't have any sort of like, like there isn't a roadmap, right? So we've just always sort of figured it out as we went along. But I do wonder sometimes like, could I be better? Could I be better equipping my social workers and social services staff to be out doing what they're doing?"

"Maybe UW can make a co-responder Master's degree? That would be awesome. I think there's a lot of buy-in in terms of just what we do, having an education focused more on what we do than community mental health in an agency at a clinic."

"I would like to hire more staff, I'd like to have a better pipeline of applicants. So I don't have any good school programs churning out people who are keyed up for co-response. They don't teach it, and so we've got to do a lot of on-the-job training. This is good in that we get someone who's custom-tailored for us, but it's bad also, that I want someone who comes in with some stable ideas and can help us innovate as well too. I'd like more."

"I think financial assistance is huge when you're looking at that educational component and especially that master's level. I know my sister was blessed when she went to get her master's degree that she had 100% paid for through a program in the state where she got it at. If we could have something like that for students to really get them over that additional barrier, that is of course, there's a lot of time for investment in getting a master's, but the financial component is huge. I think that that would be a great investment to help us really bolster that workforce."

Regional Training and Collaboration

Interviewees recognized the importance of co-response programs having strong relationships in place with regional behavioral health crisis providers such as mobile crisis teams and other human, and social service agencies to put stabilization, housing, and treatment resources into place for people following a crisis response. It's a lot of work for individual programs to create a landscape of their local resources, maintain them, and periodically reach out to develop relationships with each resource, one by one especially, under conditions of high turnover. Several interviewees called for a regional entity to take the lead on collaboration and coordination efforts to ensure there are shared goals and accountability within the regional ecosystem serving people with behavioral health needs.

The ten regional ASOs are a logical entity to lead this regional effort as they are the entity named in WA statute to provide coordination of the crisis system RCW 71.24.045]. Few ASOs have contracts with co-response programs and, as a result, this is not an entity that was well-known to interviewees thus, they were not named by interviewees often as the logical leader of regional training efforts. Counties and the eight EMS trauma-informed authorities were other potential candidates mentioned by interviewees to play this coordinating role. However, organizing regional training on a county-by-county basis could be difficult to sustain. There should be a dedicated funding source for whatever entity does play this role. Support should be provided to the regional entity that takes up this charge to build a consistent model across regions to help stakeholders visualize how people in crisis flow through the behavioral health crisis system and connect to additional resources in the community.

Support for these ideas is contained in the representative quotes below:

“Most of our communities are very small, a regional approach to both crisis response, care coordination, like cares and training, I think it's all a piece and all very important, the more we stay in our corners and try to re-create systems and programs and training and just do it ourselves the least effective we are. This kind of goes back to those earlier comments about the regional entity, whether it's a BH-ASOs or the county. Let's get together and not only train together, but learn from each other's practices."

“With the MCTs, we refer to them and hopefully try to mitigate or stop the situation from escalating again. But now that I'm thinking about that, that would be useful training to understand their process and where they're going to be referring to, 'cause I don't know, I make the referral and then it goes into oblivion and I hear back from the families, but never from the mobile crisis team themselves.”

“I would like to see some more training amongst agencies and information sharing amongst agencies about services and maybe expanding how to access or share services, maybe even between counties. They try to keep that kinda siloed for obvious reasons, for costs and management. But sometimes there might be some other services in another county that might meet the needs better than we can, so we should know about that.”

“I don't know obviously what exactly that would look like, but I think regionally, for any services including co-responders or behavioral type of stuff or even law enforcement, I think regional training is important to try to have folks on the same page. So we're all working towards the same goals.”

“I don't really know where my boundaries are with activating the DCRs, generally they get called from the ER.”

“I think just bringing the heads of those organizations together. So at a law enforcement level, our leaders have monthly meetings but is coordinating that I think with our mental health community. And again, I mentioned there's so many different entities that are all trying to get a piece of that mental health piece. And all have very, very good intentions on helping people, but I think a lot of times they all end up competing for the same types of funding sources. And so sometimes it kinda becomes fractured I think.”

“With any kind of work, especially this kind of work, when you're trying to learn all the different resources in the community and build those bridges, it takes about a year to know the job and then you have to constantly keep up with the changing landscape because turnover is high.”

Program-specific training

Interviewees spoke to the need for program-specific training to meet the needs of co-responders serving the community who often bear witness to the trauma of others vicariously. They discussed the need for evidence-informed methods to debrief traumatic events with the team and the need for high-quality training provided to programs to implement best practices and peer support to combat the effects of secondary trauma. The need for critical incident debriefing as part of what programs routinely do to support co-responders, is in addition to having a range of other supports to promote wellness that are discussed in more detail later in this chapter.

Interviewees also discussed program-specific training in terms of the importance of onboarding new staff, familiarization with program-specific policies, procedures, and documentation requirements, the use of technology and equipment, and the need to span the cultural divide across the varying disciplines working together to support people in behavioral health crises. Finally, a very important role of program-specific training is the application of CORE training. Interviewees expressed skepticism that didactic training alone can have an impact without a concerted effort to integrate what's being learned through debriefing and coaching around the new competencies that are being built through CORE training.

Programs will need to tailor their materials to their individual programs, however, CROA would be a good entity to vet and provide sample materials for program-specific training, as well as, provide guidelines and an outline for what forms program-specific training should take for newer programs that are just starting up.

The quotes below speak to the need for training in debriefing, for spanning the cultural divide, and for the application of CORE training as essential elements of program-specific training.

Debriefing

> *"I think a lot more... Like about six months ago we did a vicarious trauma workshop. Honestly, just being able to see that other people struggle. You know, I've encountered a lot of suicide. I've been on calls where people have killed themselves. I've been on calls trying to help with, without getting too descriptive and giving things away, where a kid drowned. And I'm trying to now work with these teenagers that tried to save this kid, and it didn't happen. Those are things that are really hard, even being licensed, to disconnect with. I think there needs to be a debriefing requirement in place for programs. Who is the debriefing group that you're gonna go to? Is it a state-wide group, a county-wide group? But I feel like that almost needs to be a requirement for these types of programs."*

Spanning the Cultural Divide

"On a flip side, I want the MHPs to be trained on how police response, what it looks like, so they're not working on myths and rumors, they understand what a call response actually looks like. So if we could have a more holistic training on both ends."

"I think the cross-training for us, if we had the time and the funding for that, I think would be a good thing."

"I would like to see more time and funding for our team to be able to cross-train with our deputies. Certainly, our day shifts and swing shift folks that work at the same time as our team interact with them much more than our graveyard shifts do. And so, yeah, I think that would be something that would be definitely nice to see more of, is the ability to cross-training with our teams so that all of our folks are familiar with that. And again, though, we're a fairly new team, so just getting up and running on that."

"It's incumbent on any agency that decides to bring on a co-response program to determine the parameters of how they want their MHP to function, and if they determine that they're going to calls and not just doing follow-up, then those extra cultural pieces, law enforcement pieces, crisis intervention pieces, knowing what the cops are taught really, really comes into play with that, spanning that cultural divide and doing the work right and keeping themselves out of the way and as safe as they possibly can."

Discipline-specific training

A strength of co-response, as stated by interviewees, is its interdisciplinarity, providing the opportunity to respond to behavioral health crisis situations that are acute, time-sensitive, and complex. Interviewees seemed to deeply appreciate this strength and the potential it affords to help people in increasingly sophisticated ways in the moment of crisis and to provide follow-up support in its aftermath. It was often stated that co-response programming has a vicarious benefit in helping first responders feel less helpless in their line of work. Not only do they have much-needed assistance in resolving behavioral health crisis situations that they were not until recently being trained to, but they now have the sense that there will be help in picking up the pieces for people in crisis after their work is done. The first responder's "fix-it mentality" was regularly noted by interviewees. Quite simply, more complex situations have a greater chance of being fixed if more tools can be brought to the situation. First responders, may internalize less trauma from being a part of a more solution-oriented approach.

The interdisciplinary nature of co-response programs also means that staff are each coming to the program with different cultural orientations, skills, and goals for interactions with clients in the community (e.g. safety, connection to resources, safe transport, first aid). This complementarity can be molded into a distinctive strength with focused time and attention and, with a frame of equity where all team members feel that their respective roles and

perspectives have equal weight. Staff in co-response programs each have different training that enables them to sit in the roles they are in now. Thus, it only makes sense that each member of the team would have the flexibility to continue to grow in that role and to integrate new training that will benefit the team.

One program manager said it best, "I always think it's helpful when people self-identify areas like personal areas of growth and focus on those. So we kind of go through this model where, during their performance for the year, they self-identify an area that they wanna grow and then the supervisor also self-identifies an area that they wanna grow."

There was a lot of gratitude for the 40-hour CIT training and for the booster components that it offers, which are largely geared toward law enforcement officers. However, it's important to note that CIT training looks different and is of varying quality depending on what region of the state you reside in. Co-responders and fire/EMS will occasionally make use of CJTC training as a way to supplement their own training, but it was stated by interviewees multiple times that CIT is mainly designed for law enforcement and their role in responding to behavioral health needs in the field. This matters in terms of its effectiveness for other personnel.

Where there is the most prominent gap in training for first responders in the behavioral health space is for fire/EMS and for paramedics. There is very little formal training offered to these personnel who are increasing in their relevance and utilization in terms of behavioral health response. Below are quotes that are illustrative of how staff in co-response programs could benefit from deepening their training depending on their disciplinary orientation.

Law Enforcement

> *"I would like to see the investment in law enforcement training, that if we do get specialized officers that they, there's a program through CIT that they would maybe go get credentialed in, particularly in small towns where you might not have an officer that has a psychology degree or some background, but being able to take a general officer and give them the skillset to be a co-responder. So similar to, not every officer knows how to investigate a fatal traffic collision, there's schools and programs and to build that repertoire."*

Behavioral Health Professionals

> *"I'd like to see more training in some sort of suicide risk assessment and how to use risk instruments I think that's pretty key. I think, again, we're kind of restricted because we're not allowed to do clinical services, it would be odd for us to lean into things like cognitive behavioral therapy in general, or for psychosis because we don't provide those services, but I think the information in those trainings is just so meaningful when we're working with somebody that needs a brief intervention, even if we don't say we're doing it, I think those trainings would be super useful."*

"My supervisor knows this, but I would like to work into more higher risk crisis negotiations. Just because for me, sometimes I provide almost too much space for people. Kind of in a clinical setting where sometimes our clients need to be directed better. And so, like a hostage negotiation training, which I don't wanna be negotiating with hostage things. That's a swap thing. So, that's a hard to sell because it'll give me the tools that I need to work with specific clients, but also it's outside of the scope of my job, and so, that training will be hard for me to get. But it would provide the directive skills that I would want to add to my toolkit. 'Cause like I said, my approach is sometimes too therapeutic. And sometimes we need to really move our client in a specific direction for the benefit of the client."

Need for Training for Fire/EMS and for Paramedics

"I think mental health and crisis training should be mandatory for all of our EMTs and paramedics in the state. 'Cause you know, police officers get it and we think that only police officers deal with mental health because they've had co-response longer than us. And I think that they get it mandatory... They get it mandatory because they're the ones around the media and when they do something wrong. But your next-up person or the person that's going to go in and manage and take that person to wherever they gotta go is your fire EMS and there's... So yeah, I think that that's... I think that should be mandatory past the state."

"I think that behavior identification in response connected to particular behaviors that is part of CIT and that's very valuable. I think it could be done much better, at least much better than I'm exposed to. So thinking through that a little bit more, but rolling that out would be great. The interesting thing about fire-EMS programs as they are medical and orientation. So I think in addition to behavior identification and behavior responses, using a medical lens to talk about some kinds of behaviors that are being presented in front of you, be hugely important. Like how does this limbic system relate to what you're seeing, how would a UTI be an interesting first approach to this older individual that's starting to not make sense when they talk, medication assisted treatment for addiction. I am not a medical person, but you get the idea. "

"I don't want there to be any type of required training to become a community paramedic or EMT, because that would be a barrier for smaller departments that have no money because they can't afford that type of training. But I would like there to be an option available for departments that can't afford it, to be able to find behavioral health, substance use and geriatric care training that could help us navigate questions to ask how to approach individuals and how to stay safe in those scenes."

"We don't get real professional training in behavioral health, like de-escalation techniques and... I would say what we would really need is advanced, things like that, because my partner and I have been doing this for 10 years as paramedics and EMTs and firefighters and everything, and we get used to these types of calls over the years and we understand how to manage these patients, but it's all by on the job training. There's no professional stuff. So we kind of reach out to try and find some training, but they don't really offer training to specifically paramedics or community paramedics to deal with this."

Wellness Needs for Co-Response Programs

Being a first responder or a co-responder who is assisting people with behavioral health needs is a very physically and emotionally demanding job. It requires inserting oneself into uncertain, stressful, occasionally dangerous, and traumatic situations to serve people in dire need in whatever setting they are in during their crisis. Because of these work hazards, experiences of secondary trauma, alternatively called vicarious stress, are common. They lead to these first responders some of the highest rates of anxiety, depression, post-traumatic stress, substance use disorder, and suicide. It is estimated that 30 percent of first responders develop behavioral health conditions including, but not limited to, depression and posttraumatic stress disorder (PTSD), as compared with 20 percent in the general population[27]. According to the Help for our Heroes program, 14.6% of paramedics face PTSD at least once in their lifetime, with firefighters having a 7.3% rate, and police experiencing a 4.7% rate. Rates of alcohol and drug abuse are also far higher than in the general population.

Secondary trauma can also result in compassion fatigue, which is an overwhelming mental and physical exhaustion brought on by feeling pain, stress, and other emotions of the people you are helping. It's a survival mechanism that can adversely impact the clientele that is being served if there aren't mitigation strategies in place for burnout.

There is growing recognition internationally that first responders need multiple forms of support at their jobs, a proactive self-care routine in their personal lives, and that there are multiple evidence-based strategies developing that can help to mitigate the adverse outcomes that accompany secondary trauma. There is also variation among individuals in terms of stress reactions and what works to maintain wellness in the face of adversity. While this voluminous literature is beyond the scope of this landscape analysis to review, the key informant interviewees documented several things that are happening in the wellness space for first response, that are very helpful in reducing secondary trauma and promoting wellness.

Interviewees discussed that these things are not happening consistently in all first-response agencies and, that they are much less likely to occur for behavioral health professionals who are part of co-response programs because these individuals are sometimes not fully immersed in the benefit structures of their first-responder counterparts. First responders often have

[27] Abbott, C. Barber, E. Burke, B. Harvey, J. Newland, C. Rose, M. and Young A. (2015. What's killing our medics? Ambulance Service Manager Program. Conifer CO.

generous benefits and are unionized employees, which is not always true of behavioral health professionals working on co-response teams. When the behavioral health professional on the co-response team is employed by a community mental health agency, and not by the first responder agency, there can be discrepancies in benefits and wellness supports vary depending on the team member's employer. This challenge was noted by interviewees.

"That becomes challenging because we are not city employees. We are contracted employees. So as contracted employees, we don't get access to any of the wellness, resilience, peer support, anything that the police officers do, and [X agency] that we're contracted from really isn't equipped to understand the work that we're doing. Because that's not their... They're largely an agency that's community mental health and based on homelessness, which we deal with, but doesn't really take into account like, how do I deal with the fact that someone just jumped off a bridge in front of me? Like that is not an active thing that they ever plan for. So we see a lot of things that need... The [first responder] side can't support us with because we're not their employees and [X agency] isn't equipped for it. So a lot of it comes down to us having conversations with each other and supporting each other as best we can in an informal sense, just to see what we can do to like, be kind to one another and whatever each other need. So we kind of got screwed out of both sides of things. We don't really get any sort of wellness support, peer support, resilience stuff."

From analyzing the interviews, several themes emerged that make it clear there isn't only one thing that needs to be done to support first responders and co-responders in the role of responding to people with behavioral health needs in the field. The metaphor of needing to fill one's bucket with multiple forms of support from various sources emerged.

"CROA is the closest thing that we've had to support and it's not enough. So yeah, anything that we could get from any side would be helpful. And it's gotta be definitely self-care, wellness, peer support, that type stuff would make a huge difference for my team."

Filling One's Bucket to Protect Against the Adverse Effects of Secondary Trauma

"The first big area is the resources that are available as a whole to anyone in our department. And that includes our co-responder team and our first responders. We offer a critical incident stress management team. That's generally more for like specific high trauma, high impact incidents. We have a peer support team which is very active. We have, now, as of last year, our department sort of behavioral health coordinator who does a ton amount, a ton of this sort of coordination. So there's a lot of peer resources. And then we also have a mental health professional essentially, on retainer specific to our team who can do things like group debriefing and then one-on-one debriefing as well."

Below is a list of strategies that were mentioned multiple times across the interviews with representative quotes. Most of these strategies are not available in all first responder agencies. It is likely that an agency that takes input from employees on their preferred strategies and then robustly implements them is going to be more effective at reducing the harmful effects that can come along with doing this type of work.

Self-care practices

Self-care practices should not be viewed as placing the onus of wellness solely on the individual first responder or co-responder. Rather, wellness was part of a mosaic of practices that individuals have more control of in their day-to-day lives that needs to be supported, and supplemented, by the employer alongside other wellness strategies.

"Well-being is all about your behaviors and habits. What are you doing every day? Like, you would just go to the club to work out once and expect results. You know, if you're gonna do something, you need to do it over and over and create a habit, that's where you have a life change. So, I make sure that our CARES units also are receiving the same health and wellness, so that's sleep, hygiene and self-care. That's meditation, yoga, and breathing. I want them... They're getting relationship classes just like our firefighters. We're bringing them into this whole family night to make sure that... Even financial health. If they're healthy away from work, you're gonna have a healthy worker. We're investing in our people…"

Debriefing expertise available as needed

Interviewees spoke about the need to debrief critical incidents after they happen in the field using evidence-based approaches. They talked about supervisors and/ or a contractor being available to offer Critical Incident Stress Management interventions after large-scale traumatic events occur. CISM is a comprehensive, integrative, multicomponent Intervention system used in a wide variety of community and occupational settings that involve trauma exposure. Developed in response to the reactions of fire and police personnel following critical incidents, CISM is an umbrella concept of critical incident response. CISM encompasses a wide range of programs and intervention strategies designed to help manage stress. The tactical tools under the CISM umbrella are interventions such as Critical Incident Stress Debriefings, Crisis Management Briefings, defusing, and individual crisis interventions. In total, there are seven core components of CISM. The importance of using multiple interventions within the CISM framework is vital.

Interviewees discussed that it can be complex to debrief first responders and co-responders in the same debriefing if they are involved in the same traumatic scene -- that care should be taken surrounding these dynamics. First responders are often the stakeholders for co-responders as the former can make referrals for the latter, which can create complex dynamics after an event that goes sideways. It was emphasized that everyone needs to feel safe and supported in a critical incident stress debriefing.

"We do have a program called CISM here, Critical Incident Stress Management. So, when there is a critical incident like one of our officers pulled a dead child out of the river, which happens frequently enough, we would have a critical incident like a debrief and support for those officers and those first responders."

"They did a debriefing on that that we were invited to. But we, I didn't feel comfortable going to that just because of that specific call, our team had had a referral for that guy earlier in the week and we hadn't gone to see him. And that was part of the reason why I was upset is because there was maybe something we could have done differently to like fix the situation. He was okay. But it was really stressful to think that like we may be dropped the ball on that and going into a debrief with the firefighters who made a referral for this guy to say like, we kind of dropped the ball. This is why I'm upset. Just doesn't seem appropriate. Like, because again, there are stakeholders and then there might be like, well, why are we even making referrals to you if you're not really doing your job?"

Having mental health professionals available on-call who are well-versed in crisis care

A common theme that emerged from the key informant interviews is that first responders need access to behavioral health professionals who have specific expertise and experience in treating this population of professionals. Without training, mental health professionals can find themselves experiencing vicarious trauma from the people whom they are treating and, they are not likely to gain the trust that is needed to be effective. Behavioral health professionals need to be educated about what it is that first responders face on the job so if they choose to go into the line of work to support them, they understand what that means exactly.

Stigma looms large for first responders in terms of help-seeking. First responders are usually the last ones to show up for counseling. They need to be met where they are at. It means visiting the places they work and seeking them out rather than waiting for them to come in for counseling. They also want to know therapists are on their side and understand their needs. First responders are less likely to seek help if they don't believe the therapist understands their unique needs. Concerns about confidentiality were also mentioned by first responders as a reason why these professionals sometimes won't seek treatment for behavioral health challenges. Suggestions for how to mitigate this concern are also contained in representative quotes below.

Ideally, mental health professionals that treat first responders would be on contract and on call to address needs as they arise rather than being put on a waiting list for treatment. Employee Assistance Programs (EAPs) were also mentioned as a potential resource for mental health counseling, but limited sessions, long wait times, and a lack of experience among those providers were challenges that were commonly mentioned.

"I called our EAP about a month ago. It takes them two and a half weeks to find somebody. And that's not anyone with expertise in the kinds of situations we are drowning in..."

"We have a contract with a licensed psychotherapist and clinical social worker where if somebody is in crisis, they can call and ask for an individual resilience plan. We call it an IRP that exists of 290 minutes sessions where they're provided with tools and techniques on how they can navigate what's going on. It's somewhat individualized and personalized, but it's not therapy. An important distinction because the city is paying for it and because the city is the client, we want to make sure that there aren't any records that could put the employees' confidentiality at risk. So it's very... It's not therapy."

"We are within that health and wellness program, we have a licensed trauma care psychologist, who's available to any of our department members and is on call basically 24/7 through us. And she provides her services only to law enforcement in Pierce County on call who have expertise in working with first responders."

"More mental health assistance. It's really challenging for first responders to find clinicians that understand the unique pressures that we're under, and so that's challenging enough. But right now, in the current state of things, it's just challenging to find any mental health professional. And so I would love to have an exclusive contract with a mental health professional where they could just completely respond to services for the police department. Right now, in 2024, what we'll be looking at is actually securing a block of office hours with our mental health professionals for our employees, and if those hours... We'll essentially pay the mental health professional for the hours, and the hours that are used will be billed against the employee's insurance, but whatever isn't used, we'll pay for them. But that way our employees have that direct access to a mental health professional."

"We were very fortunate to find our department's psychologist who has worked with first responders for many years, and you can relate to her really well, and you don't have to tell her the story 15 times. She's already heard it from other people, and she can really start targeting in on that. Finding mental healthcare professionals who are very well-versed in first response, I think is huge, because a lot of the things that we see and it's... Yeah, a lot of the things that we see or is just very unique that a lot of people don't understand, and then you sit in front of some psychologists and talk stories and they are more interested in the story than they are in what your mental health is doing, it seems like."

"I would just say that most therapists don't know how to be therapists to this workforce and don't know how to be therapists to first responders or dispatchers. And so I feel like that's kind of another area of growth, is having clinicians and therapists who understand the work and are approaching that therapeutic relationship very different than someone who is not responding to traumatic events when they go to a therapist."

"I know that EAPs traditionally have a limit of a handful of sessions for mental health support, maybe unlimited mental health support or trauma consultants that can come in and do debriefs and, do regular check-ins about chronic secondary trauma."

"I think that we should have access to a therapist perhaps on staff here. We have peer support, which is great because that's like friends supporting friends and then we have EAP, which personally I have seen it not as effective because of the need for first responders to talk with somebody that they know. They don't... EAP is super short-term. They don't know those people. There's no trust there. So I think something that would be really beneficial to first responders is to have a staff therapist of some sort. Somebody that they know who's a familiar name or face around either the specific department or the zone."

"We have a pretty exceptional EAP program within Snohomish County. And our EAP isn't just like there and a number that people can call. They put out regular newsletters. They sponsor on-campus activities, massages and yoga classes, and they stay pretty visible. And then both myself and my supervisor and my department manager, we're all big EAP fans. So we try to talk about it, kind of normalize it, talk about it all the time, but especially when there's an incident, when there's something that happens, we'll sit down and go over the brochure with folks, kind of make sure they understand the full scope of what all is available to them."

Key informant interviews revealed that modeling by first responders in authority the use of professional mental health supports was vitally important to encouraging help-seeking among first responders.

"I think it's starting to become something that's much easier for people to talk about in law enforcement. It was always kind of something that wasn't really in the forefront or discussed. And so I think as it becomes more of a norm, it becomes more comfortable for people. And so those services are available to our co-responder teams as well."

"Honestly, I think that just having a top-down approach to mental health within first response programs and agencies is really the only way to do it. The only way to de-stigmatize seeking help and taking a break and realizing that it's okay to not be okay really needs to come from the top down."

"As [their] boss, I check in with my employees regularly to ensure that they are seeking external care, that is provided for our insurance, and so I will go talk to my employees and go, 'Hey, I'm open about my needs, I'm in therapy, I've been a cop for 19 years, so I've got all kinds of things I carry around with me.'"

Peer support to be made available by CROA for co-response

An additional approach to wellness that was commonly offered up in the key informant interviews as very helpful to addressing the adverse impacts of secondary trauma is peer support. Peer support can happen formally, where there is training and structure, or informally. It was described by interviewees that law enforcement and fire departments tend to have

robust formal peer support programs in place in widespread recognition of how helpful these programs can be. No such programming currently exists for co-responders. CROA had its origin as an informal peer support opportunity for behavioral health professionals working on co-response teams however, that focus has recently shifted as the organization has professionalized. The is a strong desire to form formal peer support programming at a regional level for co-responders with CROA perhaps taking the lead to organize these efforts.

"I think most police departments have pretty good peer support teams for their police to consider how when they have a mental health co-response piece, even in fire or whatever, 'cause fire also has peer support team, how do we get that same type of thing going for our mental health responders on the mental health side of the house who are either contracted from another agency, or like myself, hired by the city, but we don't have union protections, we don't have any of those things in support or some kind of peer support. And in the beginning, before CROA became what it is, that CROA group was actually just a support group for us talking to each other about not feeling supported."

"Peer-to-peer support I think would be the most beneficial, someone who you can really talk to about what you've been through who obviously gets it as opposed to clinical support."

"[Our] program's about two years old almost. Within the last year we've started working on peer support. We're bringing back peer support training. We're providing additional peer support, not just for our agency, but for EMS and fire and other law enforcement agencies. So that's something that our agency is essentially paying for spots for other agencies, and not just in law enforcement, but in fire and in EMS to have that peer support training."

"Additionally, what we offer, and this isn't enough, is we have a program that is a peer support program that we work with a contract agency that comes in and they do wellness training for the whole department. We're trying to expand that right now, but they come in and do wellness training. They come in and do rides with the officers and they're like a counselor to the counselor or to the social worker. They're just available, just a sounding board. They come in with no motives or expectations, but the officers find themselves just unloading everything on this person, this peer support person."

"I think that a peer support program similar to what's available to firefighters for co-responders regionally would be great."

"More of the informal support from groups like CROA and other organizations that I'm part of. It's nice to be able to have other people as sounding boards to help you with the difficult client or difficult situation to be able to bounce ideas off of."

"I mean just space to talk about what they're experiencing, counselors, like a support group of other co-response teams that they can meet on a regular basis and just kind of talk through client cases or talk through debrief on like the stresses of what they're feeling and seeing. Have maybe like a couple wellness workshops conferences focused on that."

Team building & supportive supervision

It's well-known that team building and having supportive supervisory structures are critical to retention efforts for employees regardless of the field. Thus, it's not surprising that this was mentioned as a cornerstone of wellness practices for co-response as well. There is a tension in co-response between team building between behavioral health professionals and first responders while at the same time maintaining the unique disciplinary culture of each contributor. Behavioral health professionals spoke to the need for strong supervision and the ability to do case consultations with like-minded behavioral health professionals while simultaneously, needing to span the cultural divide to improve their working relationships with their first responder counterparts.

"We do once-a-month team meetings, so it's a chance to dream, a chance to vent, a chance to get to know your colleagues that maybe you don't get to see that often, to feel like you matter, if that makes sense, that your work matters beyond just your day-to-day. And then every quarter, which seems like... When we think about it, it seems like a lot of things, we get together with a team that's much bigger than ours, so we belong to the community development department of the city. And so they do a lot of work around housing insecurity and all these other huge planning land use projects that, honestly, I don't understand, not my wheelhouse. But we still get together with them to understand how we're part of a much bigger picture that supports the city as a whole, and then it's kind of... We try to do fun things in that, like a donut day or let's play a game, or try to celebrate people's birthdays, try to make it a celebratory event for getting to know each other and having that moment with everybody as a bigger picture."

"If you want to keep 'em, you bring 'em in, you empower 'em, you train 'em, you treat 'em like the other members of the fire department, then they feel like they're part of something bigger. You gotta feel like you're part of something bigger."

"They all get either weekly or biweekly supervision to help manage all of that stressors. We have supervisors on call to also help them process. We have like a pretty abundance set up on-call staff."

""My supervisor is overseas EMS services and really great. I feel a lot of support from my supervisor when I need things or when I need to vent…"

"Almost all of our programs do one-on-one supervision weekly. A few of our staff that have been around for a while do every two weeks, but at minimum, every other week, you're meeting with your supervisor for at least an hour, and then bi-weekly program team meetings, and then a monthly all-staff division meeting. And so in all of those, trying to build connection and recognizing that people can feel really isolated in this work and feel like it's helpless or hopeless... I had a monthly meeting today and we spent the first 45 minutes just doing pretty fun check-ins. We were all laughing, and sharing..."

"I think we have a fairly liberal, well, as a supervisor I'm able to be pretty liberal around work schedules and time away from work and work-life balance. And so I really try to be aware of how people are, I have regular supervision with all of my staff and really check in about capacity and caseload sizes and do you need a mental health day and when was the last time you had vacation and do you have a vacation scheduled?"

"I have a clinical supervisor that I meet with twice a month that is like my space to meet with another social worker because I'm the only social worker in the fire department. And so to have another social worker that I can do like case consults with and that sees things from the same lens that I do and a space where like I can vent and a space where I can let down my guard a little bit is helpful."

Employee Benefits and Agency Culture

Interviewees stated there is a lot that agencies can do to help individuals in this line of work to feel seen and recognized for the hard work that they do. They talked about the need for flexible schedules, and the ability to go out of service after a difficult call to decompress. They said little things provided by their employer matter, ranging from free massages, to wellness apps, and schedules that allow people to have more concentrated time at work so that they have more time to decompress from the stressors of the job with longer weekends. Generous wellness packages were appreciated and utilized in helping individuals to practice self-care.

"One of the things is we offer 4/10s and a compressed work schedule. So individuals have like a three-day weekend. We also have like a pretty generous PTO package and we encourage people to use it."

"We do have a state app called Cordico that's going to be coming out for... No it's coming out for law enforcement. So I will make a hard push for it to also be made available to our crisis response unit, but that is literally hot off the press."

"If something happens and someone needs to leave mid-shift in order to go decompress about a really intense call, we have that available for them too."

"I think we try to be really flexible with scheduling where we can. I think that's one of the things we try to do. If people need to take a mental health day, if we recognize that someone is struggling, we're gonna do what we can to have them take time."

"An area of improvement is if we could have wellness hours where people are paid to work out or do whatever wellness looks like for them. And I know some agencies have done that. It's still a 40-hour work week, but they've moved to 36 hours of work, and then you get four hours of wellness hours."

“I used to work in this hospital in Florida and once a week they would bring their team of massage therapists down and set up in the lunchroom and give free chair massages. And we all know it goes a long way towards people's mental wellness and first responders and co-responders deserve this kind of thing so much.”

“I hope my team knows that when they have a rough call, they [can] call me. We had something happen recently where somebody put a hands-on [Redacted] and somebody blocked [Redacted] in a halt stairwell. And when they called me I was like, "Okay, do what you need to do at the hospital." They felt, they wanted to make sure that this person got to the hospital and that they got detained and then it was like, "Okay, go outta service. You're outta service, go outta service. Go do what you need to do. Go eat ice cream, go get coffee, go be quiet. Go do what take a walk. Do whatever you need to do. Take care of yourselves. I'll meet you at Seeley Hall," that is something that we definitely do. If something happens, they're outta service to take care of themselves.”

“I think the ability to have access or space to like a quiet room or like one of those sensory rooms some that are pretty cool that have like either plants or bean bags or different like sensory areas to help staff decompress, that would be great.”

“We bought the Calm app for everyone. So, it's little things like that to say, "We are thinking about you. We're thinking about you and your life."

“We have a fabulous wellness package that the agency offers. One, we have robust PTO, and healthcare, but we also have... We get parks passes, we get a discover pass and a discount gym membership and pool pass. So it's a big deal.”

“Basically a 1040 schedule means that they'll be on for five days, they'll work five days, 10 hour and 40 minutes a day for five days on, then they get four days off. And they do five days on, then they get four days off, then they do five days on and then they get five days off.”

“I think that it takes an entire day to get your cortisol level kind of back down and in check for you to even be able to start to relax. And half days off. And if you only have two days off that you don't really ever get to kind of recalibrate and kind of recover from the shifts. So I'm hoping that that's gonna be really helpful for wellness is for folks to have four or five days between their shifts to really be able to...”

“I would say things that are typically known as self-care, whether it's, you can go get a massage paid for by the company once a quarter or, I don't know, maybe more than that. Having, hey, you can get half off this gym membership or just providing access to those things. Like not necessarily being like, hey, this is what you should do, but just knowing that those are available as benefits in the company.”

Co-response is a wellness tool for first response

A final theme that emerged from the interviews is adding a co-response team to a first-response agency has significant benefits for first responders because now they feel like they can leave a call and know that someone else will be following up. While it's vital that co-responders not become the therapists for the first responders whom they collaborate with day to day, behavioral health professionals on co-response teams can lend invaluable insights into processing traumatic events, encourage help-seeking, and, explain the reasons why challenging clients sometimes behave in the ways that they do. These varied perspectives can be helpful in mitigating secondary trauma among first responders.

"I would just say that the MIH program in general, in any fire department is just... The secondary gain from that is, it's just from a mental health perspective to the firefighters, just given the fact that you are there and available to these families, because when they go in and walk out the door... It's much easier to make that referral and then walk out the door with a clean conscious knowing that help will be given to these families. So instead of carrying it like they did before, it's just a lighter load for the firefighters. And so MIH programs, though we are for the citizens and the communities, the secondary, just value of any MIH program is what it gives to the firefighters to be able to just give them more space to be able to be compassionate for every citizen that they see."

"When we reached out to our on-retainer MHP, it was because that came as a request from our firefighters, which is very unusual. Firefighters are not known for this. But they reached out to me and said, 'We would like some help. We're really struggling.' I think they were really particularly struggling with the fact that, normally fire EMS runs are very short, right? You deal with the situation, however traumatic or catastrophic it may be, and then you're done 15 minutes later, and now they were spending two hours on scene and learning a lot about patients' backstory and their history and their trauma, and then seeing them again, and then often seeing their outcomes, right? Like seeing what ultimately happened with them."

Conclusion

Co-response programs are primarily staffed by behavioral health professionals who deploy a range of interventions and practices to serve people in crisis, such as safety planning and motivational interviewing. There is not yet any training curriculum for co-responders in particular, so programs are often left to their own devices in deciding how to prepare their staff for the field. Besides better serving clients, training is needed to help programs support their own staff given the high physical and emotional demands of co-response. The landscape analysis found that formal curriculum and training for co-responders is therefore greatly needed to help these programs serve people in crisis.

A training plan emerged from the interviews and a clear set of strategies to promote wellness within first responder agencies was suggested.

Chapter 5: Barriers Facing Co-response Programs

According to Forbes Advisor, challenges in WA State regarding its behavioral health system underperforming relative to other similar states including OR, CA, MN, and CO are not new. At some point in their lives, nearly a quarter of Washington residents will struggle with a mental health or addiction problem, but nearly half of the state's 39 counties don't have a single psychiatrist or psychologist to help. According to a recent state-funded study, Washington has just one mental-health provider for every 360 people. People who have less severe or less immediate concerns may have to wait months to see a mental- health specialist. And when WA residents experience crises, ERs are frequently the only place to take people yet these facilities are not adequately equipped for this role. The current state of affairs necessitates that the legislature and Governor's office dig into the reasons underlying these performance deficits and begin to hold its state agencies and the behavioral health system more accountable. The interviewees included in this report are on the front lines, day-to-day, seeing clients with significant behavioral health needs. Their perspective is that WA state's behavioral health system is itself in crisis. This chapter describes some of the barriers that co-response programs are facing. None of what is reported in this chapter is news.

Interviewees described the barriers as:

- Severe shortages in behavioral health services outpatient, inpatient, and crisis services
- Limited resources for housing and other essential needs
- A lack of network adequacy and insurance carriers not stepping up to meet needs or to coordinate care
- A lack of regional coordination and poor communication across providers serving the same clients
- Workforce scarcity due to poor compensation and high stress
- Silos of care, limited accountability and transparency for how dollars are being spent
- Lack of understanding and the politicization of co-response

Severe Shortages in Behavioral Health Services: Outpatient, Inpatient, and Crisis Services

The strongest and most pervasive theme in the dataset of key informant interviews is the lack of resources for behavioral health in WA state. Interviewees described, at length, a desperate lack of mental health and substance use disorder (SUD) treatment facilities. The extreme need for more resources was mentioned by every single person interviewed.

WA state was described as uniquely under-resourced relative to peer states. Interviewees originally from other states described disbelief about the lack of mental health and SUD treatment available in WA state. In some regions, there was more of an extreme need for

services for people with severe mental illness, in other regions the detox and SUD care options were even more dire. Everywhere, in inpatient, outpatient, and crisis services, there were shortages and a lack of options especially, for patients who were medically complex or had co-occurring disorders. Interviewees described it as being hard to find the right "fit" for clients because the few available options had limitations on eligibility and long waiting lists, leading to more care options for clients who are higher functioning.

Interviewees were frustrated with the lack of inpatient beds that were available and used words like "thin" or "non-existent" to describe all available behavioral health services. Most interviewees noted wait times that are too long for beds (3-4 months was a commonly described wait time), which leads to an exacerbation of mental health issues and unnecessary deterioration of the clients that are being served. Many interviewees described there would not be a need for so many crisis services if there were more overall treatment options and non-crisis services available. They similarly felt they wouldn't need to send so many people to the ER if there were more (and better) crisis services available. Extreme service shortfalls also lead to burnout among providers including those on co-response teams who feel like they can't properly help their clients, exacerbating a workforce crisis that further deepens the resource shortfall.

"The biggest barrier is trying to get somewhere to take somebody. Like we just don't have any behavioral health or substance use or co-occurring facilities around that have abilities. Our two or our three local community health providers for mental health haven't taken new patients in two years. Literally it's been two years since they've taken new patients. So, we get somebody stabilized through their primary care physician, which takes three months to get into a primary care half the time. And they'll be willing to write the mental health med. We'll be injecting the mental health med out in the field until we can finally find a care facility or other more intensive mental health support."

"There's just nowhere to take people. Like that's the thing, we have 15 or 16 different providers third party providers, 16 third-party providers that offer outreach services but there's nowhere to take people like... And if there is a place to take people, they're above their need. They're above their skill level. So they won't accept them anyways. So that's the thing like, most of what we do is just try to move people around so there's not causing an incident where a lot of the public can see them. They only cause incidents where a little bit of the public can see them essentially."

"I think that there's just a tremendous dearth of available beds throughout the state for skilled nursing or just generally long-term care, and so the facilities can be frankly somewhat choosy about who they take. And so someone who have just described is never gonna get in. He's on Medicaid, he has not... Has no private insurance that's gonna pay the higher rates, he is extremely behaviorally difficult, he uses substances, he's a sex offender, so no facility is gonna wanna take this client and they don't have to because they have so many people, so many other potential patients to choose from. So yeah, he's not gonna get in anywhere."

"I would love to have it reflected that the community behavioral health system is so overwhelmed that we are frequently seeing people in deep crisis that could have otherwise had their symptoms managed in an outpatient setting, but the system has not met their needs, and then the wait lists are weeks, if not months long to get into treatment. And so the navigators, like us, are very good at creatively cobbling together supports and solutions, but often that means kind of a duct tape band-aid while someone waits for the treatment that they need because the treatment system is so swamped."

"There's some pretty significant barriers, obviously. Of course, the capacity of mental health agencies right now is so severely limited. Like getting people in for intakes, getting people in for regular mental health services, not just medication management. It's manageable sometimes. It's really hard to get people in. And then beds are also limited. So getting inpatient beds can also be pretty limited right now."

"When I talk about behavioral health needs, I talk beyond just mental health. I talk about substance use as well. So access to detox is a huge one. So somebody is suffering and they need detox but they also have a mental health, like a co-occurring disorder on top of that. Finding them a place that... A detox center that will take them, it's like winning the lottery is how I feel. The closest facility right now that will take people for us like that is Ituha, which is on Whidbey Island. So that's at least an hour and a half away for our team to get that person to that place, and they have only 10 beds. So again, if somebody stays in that place for three to five days, how often do they actually have an opening? And you have to kind of call frequently throughout the day to see if somebody didn't show up. And then they'll say, 'Oh yeah, it's an intake at eight tonight, but we don't work till eight tonight.' And how do you get a person to Oak Harbor from here? It just doesn't really work. And then mental health facilities, being willing to take people who are not as huge severe risk, meaning the crisis is acute."

Limited Resources for Housing and other Essential Needs

In addition, to the overall lack of mental health and substance use disorder treatment services for people with behavioral health needs, interviewees described a lack of basic services that exacerbate the behavioral health challenges their team is facing in the field. Interviewees discussed housing as a top need they are seeing: a need for more transitional housing, more affordable housing generally, and for more housing that comes with good mental health support. In addition, they see the need for housing that doesn't have conditions or restrictions so that people are more likely to accept it. Interviewees noted, when shelters do exist, they are often full. Some teams had hotel vouchers they could distribute, but could only use those for a limited time on behalf of their clients. Interviewees also discussed needing money for outreach services, such as food or have bus tickets to be able to give clients (the current supply of bus tickets being too limited). Finally, hygiene services and cell phone access were mentioned as a top unmet need for many of their clients.

"Just more available housing. I mean, knowing that, like not everybody wants housing, but for the people that do, having more options to give somebody and to be able to hook them up with services. 'Cause if they're in a specific housing, then you know where they are and they're easier to find and easier to work with.

"That kind of goes back to the money portion, but not necessarily our program couldn't make a difference, but I do... It is really unfortunate, like right now I have a family with three kids and herself living in a hotel room, and I feel like my program could make a significant more impact if I had funding myself for this program, that is allotted to Housing Services or those outreach style services, even a cup of coffee, things like that."

"We're supposed to be short-term, connect you to the right resources. And then I might find, okay, well you're... You need more support finding long-term housing, right? So I try to connect you with the people that are gonna do that, but they are only working over the phone, right? Or they're only working from their office. And so, then they just completely lose touch with that person. So then I have to kind of be the conduit and be in their house on the phone with that person facilitating that contact."

"Responding to a crisis is one thing, but then what, right? There are resources needed to ensure that the crisis doesn't continue or that the crisis is interrupted. And those resources, if they're behavioral health recess resources or housing resources, there aren't enough. They're not... We don't have enough units of housing for all the people that need housing. We don't have enough assessment appointments for all the people that need assessments. So it would be having to have more robust resources to meet the needs of those folks in crisis. Domestic violence shelters, the list goes on. It's outside of behavioral health."

In addition to the lack of overall services, a specific subtheme emerged related to the lack of immediate treatment options available, having nowhere to send someone in the short term and no immediate options for care. Co-responders noted that even crisis services that are supposed to be "no wrong door" approaches will turn clients down who are not behaviorally well-controlled, too medically complex, or because they are just too full. The wait times for care were described as being connected to the overall resource shortage, but also distinctly as a problem that created its own unique ramifications. For example, interviewees described that expectations of stability are too high for the people who want to get into community mental health services because the wait times are 3-4 months, and require someone to attend 3-6 consecutive appointments that are 1-2 weeks apart just to get medication stabilization. This time lag allows for a deterioration in well-being that makes them no longer well suited to the resource when it finally does become available.

Not having a place to immediately take people for care left co-responders relying on the ER and they described challenges created by using the ER system for behavioral health needs at length. Additionally, interviewees shared that there were not enough resources for lengthy waits for specialized care, for example, not enough services that can be offered to people in their homes or wherever they are living/sheltering: a frequently mentioned need. Finally, there were some

regional differences described in the wait-time problem and no residential beds in smaller geographic locations had bigger implications as transport becomes an issue. For co-responders in small or rural communities, even if they can find a bed in a neighboring county, it might be 45-90 minute drive, and there is no guarantee that they will admit the patient when they arrive, which creates a resource challenge for the co-response program.

"I think more in-home services, more outreach services. We've got all these folks who aren't able to leave their home, won't leave their home. I'm trying to facilitate video visits with their primary care doctors just to keep them in contact, keep their medications and things, but medical services that go into people's homes, behavioral health services, just more services that outreach people where they're at."

"There's a couple that would spring immediately to mind from all of our providers, the first is lack of what our team would call landing zones, places to take people, there's just not enough. There's not enough beds, and this pertains to crisis centers, this pertains to sobering, this pertains to in-patient rehab and detox, just across the board. And then lastly, the other huge area of difficulty we find is places to bring people who are unsheltered and they've significant medical issues or behavioral health issues, so basically shelters that are sufficiently low barrier to take these folks. We often just simply cannot please them, and so we end up taking them to the hospital, which is the entire point of our program, is to avoid doing that. Across the board we just don't have enough..."

"A lot of times they'll just discharge them with a list of phone numbers to call and to get appointments in six weeks when their crisis is a little bit more than that, they need an appointment like soon, or they need to go inpatient soon, or to get connected to an outpatient program. It's also really hard with people on state insurance to get them into places very quickly. It's actually hard with both state and private insurance. There are different barriers to it."

A Lack of Network Adequacy and Insurance Carriers Not Stepping Up to Meet Needs

Interviewees described numerous insurance barriers to treatment that came up frequently, especially for their clients on Medicare or Medicaid. Ongoing therapy or counseling was especially hard to find because of network inadequacies. Insurance barriers that came up included most services being non-reimbursable, people with private insurance getting treatment preferentially because providers can be reimbursed at a higher rate, and the assessment wait times (to see if a service will be covered). Interviewees noted that it would be helpful to have a resource guide that shows what is available and inclusion criteria/insurance eligibility for behavioral health and SUD care. Finally, transportation is difficult, and there are legal requirements on where EMS can transport people. The costs of transport can be extremely high, which is often not covered by insurance.

"One of the most significant issues is that people on Medicare have very limited options for behavioral health treatment. So Medicare services for people experiencing mental health crises is they can be involuntarily detained, but there are just not a lot of follow-up services for regular counseling or mental health services people can engage in. Primary care doctors will give them medications to manage things like anxiety and/or depression, but they have such limited options to work on ongoing coping mechanisms and ongoing services."

"You don't have to have an assessment or wait for Medicaid authorization to go to treatment, you still have to have your assessment and wait because there's not enough treatment beds and there's not enough staff at the treatment centers anyway. So you still have to wait a really long period of time to go to treatment, whether or not you have to get authorization or not. And I don't think people actually understand that there's this great law that says you don't have to wait so people can go. It's not any different since that law came into play."

"It's better when someone has Medicaid because there's... We've got a handful of clinics that will take them, but they're often at capacity and have a wait time. It might be a month or two before I can get someone an assessment and another month after that before they'll actually see their therapist. And then we've got a lot of seniors, a lot of seniors who need behavioral health services, and there just isn't any. We've got like one outpatient clinic that we know of that accepts Medicare. And then we try to connect them to their primary care doctor's office in the hopes that they have a staff person at the primary care clinic that does behavioral health. There are a lot of barriers there. And then even if... We come across folks who have private insurance as well. The insurance directories online are never updated. We often end up sitting here for four hours making phone calls to a list and a provider directory trying to see if a private therapist will call us back."

"We're looking at the crisis stabilization short-term recliner thing. We're just trying to figure out how does this make sense? How do we staff it? And how do we have that capability? Most of it seems to be non-reimbursable. If you're on Medicaid, apparently you can get it, but everybody else has basically done it with no reimbursement possible using state dollars. And that would be a piece, is to figure out, it's healthcare, how do we pay for it? That would help."

A Lack of Regional Coordination Leading to a Silos in Care and Poor Communication across Providers Serving the Same Clients

When asked about barriers to providing care to individuals with behavioral health needs, interviewees spoke frequently to the silos, strained relationships, and a lack of regional coordination and communication. An overall lack of oversight and/or difficulties with accountability or oversight were also frequently mentioned.

Interviewees mentioned not being able to get ahold of designated crisis responders (DCRs) and having to find alternative means of getting people taken to the hospital involuntarily, like the police. There is a general disconnect between DCR's and co-responders where they just won't show up to a call, there is inconsistent communication of what to do on scene, or they won't communicate with co-responders on needs like next-day appointments. There also appears to be a general lack of understanding of the DCR process by police and at the ER. It was also cited that there was a general lack of working with mobile crisis teams as a whole due to lack of response from them when contacted by co-response.

Interviewees described there are often strained relationships between co-responders and the ER due to how many people get taken there versus an alternative due to a lack of resources. It was also mentioned that it is difficult to form relationships between co-response and ER staff due to turnover and general dissatisfaction with ER practices. Clients were noted to oftentimes leave the ER because they were encouraged to voluntarily leave or because they don't think they can be helped. Co-responders also noted ER's discharge people without consulting with the co-response team or listening to DCR assessment. Oftentimes, the lack of a discharge plan also means no family is contacted either. Additionally, similar to the ER, it is noted that triage centers don't typically have a discharge plan and an overall lack of collaboration between triage and co-response.

Interviewees described strained relationships with other crisis service providers due to many factors. They said they often feel they have a lack of urgency and are not carrying their weight. The red tape to vet people into crisis centers is overwhelming. ERs are often the only place to take people, but their individuals in crisis have to wait in the lobby so long that they oftentimes will change their minds about accessing treatment. ERs will discharge people with a list of resources and no direct connection to care. Waiting for medical clearance for detox admission was described as extremely challenging. There were often tensions with partner agencies and regions because of the need to transfer patients to hospitals in other regions.

"We frequently see we are challenged by the DCR system when there's somebody that we believe would benefit from an involuntary hospitalization and they either don't meet criteria or they meet law enforcement criteria and then are quickly released from the hospital because of capacity and that's to the detriment of their own and community safety."

"Someone did call 988 and they met criteria to have a DCR do an investigation and they didn't meet criteria for detention, but what if they could coordinate with us to go out and check with them the next day or that same day and help them look at maybe treatment alternatives or the diversion center or shelter? I think more collaboration is what is needed."

"I call mobile crisis and hope that they're gonna show up in the next 15 minutes and then they are typically busy and don't show up till the next day, but in the beginning, when they weren't as busy, I used them as a resource, they were a pretty good resource and now I use them to cover my butt."

“We don't really talk to other mobile crisis teams unless they've told us of a new training, then we'll try to go to that training. Like that's it. There's not very much communication. Sometimes we'll have XX MIH program reach out to us 'cause they're like, ‘We think this person's in your area.’ But they're like, no. There's a little bit of that communication, but there's not much sharing of data or coordination. We don't really work too much with each other.”

“I think where the tension is in the relationship is that often the facilities that are supposed to care for our most vulnerable are simply not interested in caring for that population, their staff, their leadership. And I know there are many, many factors, but we continually see that the people that are seen by first responders and are in crisis regularly do not receive quality care. So how do we insist on that without burning bridges? So say the relationship is challenged.”

“You have all these great programs, and yet community mental health is overloaded. There aren't any of the behavioral urgent cares. There's only... You know what I mean? There's not crisis diversion facilities, etcetera. And I have to say, you know, we worked in hospital and psychiatric emergency for a long time. We still hear when someone goes into the hospital and/or we take someone to urgent care, and then they get piped over to the emergency room, we will still hear, ‘Why are you here? Like, what are you doing here?’ And that is just sort of a reflection on the care system right now.”

“There's not coordination with family. So the discharge plans are disjointed and you try to work with the hospital to get a clearer plan, and you're met with, ‘That's not my job.’”

“We have a lot of folks who have pretty significant mental health challenges on top of a significant substance use challenge. And they might be frequently detained by our designated crisis responders, but after maybe a few hours XX doctors decide, this isn't actually something that they need to be detained on. So they get discharged into our community and then they're... It's like we could deal with that same person three times in a day without being able to actually help them.”

“I've seen lots of models, but I do think that it's collaboration through, communities and counties and states and I don't think it's a one-size fits-all, but you need overall services. You need overall facilities, you need overall mental health workers, and, you need people that can respond all the time, and that has time to do case management and really have a robust program, to follow these individuals through treatment. I mean, it's not just today or tomorrow or a week or even 90 days or a hundred days. A hundred days is about our average case management for CARES. But we just don't have a robust system to take care of these individuals. In fact, another piece of it is, insurance companies and who's gonna pay for it and all of that.”

"I would love to see hospital systems have the capacity to do a little bit more thoughtful discharge planning, whether that's from the emergency room or an inpatient psychiatry or behavioral health unit. I think... Unfortunately, oftentimes what I see in my role as a social worker with the fire department, the huge gaps in time between connection to service or lack of confirmation of services already being established. And I think in a lot of cases, premature discharge because there are other folks on the front end who also need help. Which is where our program comes into to be able to mitigate that. But, if we all had the opportunity to do a little bit more thoughtful transition of care planning would be huge."

"XX hospital is not equipped to have a behavioral health section in the ER. They've told us that their staff is not trained to deal with those individuals. And so a lot of times we take them to the hospital and voluntarily commit them and they're back out on the street in two hours. So we need facilities that will actually treat that individual versus just putting them back out on the streets."

"The second part is, sometimes there's too many cooks in the kitchen. You have 25 people working with this person, and they're literally falling through the cracks, every direction. That does happen sometimes here too, where I encounter somebody and they're like, 'Okay, well, I was involved in housing. Well, I was involved in a treatment program. I was involved in this outreach program. I was involved...' All these things that if people just talk to each other, they would have made the biggest impact.

Workforce Deficits Due to Poor Compensation and High Stress Due to Resource Scarcity

Interviewees mentioned that their team capacity, which is described as being limited by both the number of people on the team and the hours of operation, were barriers to helping people with behavioral health needs. Many interviewees expressed being willing to work off hours and the desire to both grow their teams and to expand the hours their team covered as a whole. They also expressed this to be a barrier because often more calls will come in while they are in the office, but not enough people to answer them or, calls come in when they are off hours where no one is able to respond.

"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."

"We only have 40-hour week MHP coverage, and now with our contract with Duvall, we have 36 hours a week. And 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 is pretty minimal."

Inadequate Compensation

Interviewees mentioned compensation that is too low for the high-stress nature of work of providing crisis services in the community. Low compensation is a barrier for both hiring and retaining talented employees. Too little compensation was also cited to be a barrier to the sustainability of programs as a whole. It was expressed that it is really hard to find program funding. A lot of the funding that is present comes from grants that are not guaranteed year over year which means no consistent funding and a lack of job security for team members. Compensation was expressed to be used as a means to incentivize behavioral health professionals to work with law enforcement, to mitigate turnover and increase retention.

"I think the challenge that we have right now is simply going to be about funding. I look at our RCR program, which is actually being funded by these five cities to create this agency, but these are five cities that are pulling money out of their own resources and not receiving assistance from either the county or the state. So that limits to what they can do. So ideally, as with all things like this, it's gonna be a matter of money and finding personnel who are willing to step in and work in the programs."

"There's a shortage on mental health professionals. And not only just being a mental health professional but a mental health professional that wants to work with law enforcement. That's a huge struggle. I am a huge advocate. I've done the work. I know what's needed. And so I'm constantly looking for funding. I'm always advocating for my team to... So they're competitive."

"I think sometimes there's a struggle for compensation, I wish we got paid more for what we do, but that's above what... That's not part of the program. That's just me about pay."

"Even when we're talking to folks from transit who are looking at potentially bringing on co-responder type teams or units... It's a job that requires a high level of experience and education and skills, but is not very high on compensation, and it's very, very hard work. It's work that is challenging for people to do year after year after year, in any type of crisis field. So right now for us, just our number one challenge by far or barrier is... It's staffing. We are so blessed by our dedicated staff that we have... We have just a tremendous team which we are so thankful for. And we wish we had more of them."

Interviewees described recruitment, and hiring practices specifically, for behavioral health professionals as a large workforce barrier. Strict licensure practices for mental health professionals in the state have contributed to the shortage. The overall shortage of behavioral health professionals and licensed social workers makes it hard to recruit for them, especially given the nature of co-response work in terms of safety. Requirements by the individual co-response programs that require licensed behavioral health professionals also limit whom they can hire.

"I think one of the reasons that we have such a shortage of available MHPs is the licensure requirements can't typically be met by working in a co-response program. To become a licensed mental health professional in this state, you have to have direct client hours, office administration time, and clinical supervision time, and those office hours are measured in actual hours of providing services."

"Another piece of it is, is that we do hire individuals with Master's of Social Work, and the field, there's not enough individuals to fill those spots or that might be interested in it, and so the hiring is a little bit difficult, so if we could change that, that would be wonderful."

"Another area we struggle with is hiring. We cannot... There's a shortage of mental health professionals. And not only just being a mental health professional but a mental health professional that wants to work with law enforcement. That's a huge struggle."

Silos of Care with Limited Accountability and Transparency for the Dollar that are Being Spent

Interviewees described a lack of oversight over the emergency response and behavioral health crisis systems and that the siloing of these system is a barrier to care that has led to insufficient communication among co-response and mobile crisis teams and an ultimate lack of client care coordination. There is a general siloing of the systems that is felt across state, county, regional,

and city lines. There is also an overall feeling of a lack of accountability for who is responsible for a client due to a lack of any meaningful oversight. It was also cited that the inability to share information across systems limits overall care coordination among teams and within regions.

"I think trying to eliminate silos and coordinate the response and service efforts that are out there would probably be the biggest thing. And it seems like there's a lot of energy and a lot of efforts, but some of it, whether it be from 988 initiatives and some of those efforts along with other things. I'm not sure that we're getting away from the silos or we might just be creating bigger silos. I think finding a way to communicate and streamline those resources across different platforms would be most helpful."

"I think that you're speaking my language here. It's pretty incredible... As an advocate in Olympia, I constantly am kind of advocating for like, 'Okay, what's the regional approach and how are we all working together?' Right? Like this doesn't make any sense, where we're creating these silos really, but… if there was to be kind of a more of a regional focus there, everyone's getting on the same page, crossing over the traditional behavioral health system into the behavioral health system with the 988 and the regional crisis line, and then you guys with the emergency medical response, who do you think would be the most natural coordinator of these different entities to get everyone on the same page?"

"We have the County Health Department where we host a meeting every week with all of the care providers in our community, there's 28-50 people that will show up on these calls and just make sure everybody's on the same page. And then once a quarter, we meet with all the supervisors to see what's going on and what improvements can be made, what gaps there are, but nothing changes. So we do have a few oversight committees and the county health department is typically spear-heading it now, but you can't enforce anything."

"Usually when somebody is detained by designated crisis responders there's a whole fit of stuff going along with that, and the system is silo-y and choppy. So I spend lots of time educating on the crisis system, all the way from initial police contact to discharge from an inpatient treatment facility."

Interviewees mentioned a lack of communication among resources like detox centers, shelters, triage centers presenting a barrier to client care coordination. They also mentioned that due to resource provider turnover, gaps in available resources are created and creates an overall gap in the network. Some resources like detox centers will not recognize certain members of co-response so they will not coordinate client care like, if they are paramedics. There are certain regions where there are no immediate options so co-responders go to other regions which, both strains relationships in their home region and in the region where they had to take the client to. It is also mentioned that co-occurring issues with SUD and mental illness create a disconnect with treatment since many facilities don't want to take someone with both, siloing and limiting the available treatment options. Interviewees cited lack of case management,

especially in places like detox centers. There are also issues with coordinating care with resources when crisis occurs after hours.

"We're just very, very far behind and gets out county on cross-agency collaboration and care coordination, and we're making progress, but we still have a long way to go. There's a lot of fear, as I mentioned before, about communications, sharing some very bad misunderstanding of what HIPAA means, what CFR 42.2 does and doesn't permit, how to use multi-party release of information forms. A lot of the approaches that are adopted around me are based on liability concerns, not based on what individuals need, and that sort of like risk management approach to care coordination is a huge obstacle to getting people surrounded with the care they need."

"In infrastructure, so like I talked about earlier, we don't have a, like mental health facility in the hospital similar to what Spokane has somewhere of. And so finding a bed space or a place for them to detox is a huge barrier. Because these, even though the log indicates co-occurring is a priority, we still have programs that are very much siloed."

"Lack of shelter, obviously upstream from shelters, housing and we don't have any direct connections with housing, we can get people on the path, but that's a long... That's a long road. It's difficult and sometimes we can be sort of the catalyst for them to ultimately get housing, but again, it's very difficult. And then I think, again, siloing, figuring out who is serving folks, it takes a lot of leg-work to be like, alright, are you served by XX agency, is reach out reaching you, are you a lead person, where is your mental health provider? It takes a lot of time and in-person resources, which obviously decreases the total number of cases that we can take because each one becomes that much more time consuming. Yeah, I think those are definitely big barriers."

"The bulk of what we do, is really care coordination. So let me talk about the many barriers to care coordination. While we do have partners in the area that provide some of the services that the people we're trying to help need, they're overwhelmed, they're short-staffed, they have very serious limits on what they can do. And there's an overriding fear, I think, of open communication and too much collaboration, because of liability risks and taking on the responsibility of individuals and the complications that that brings on."

Lack of Knowledge and Politicization of Co-Response

Interviewees also cited that a barrier to providing care in the community is the resistance or lack of knowledge about co-response and a general misunderstanding of the difference between what police and co-response programs based in police departments can and should do. They also mentioned this was likely a barrier due to the laws in place for what paramedics can do specifically, in terms of where they can transport. The overall lack of understanding by the community, facilities, and providers of what the different types of co-response teams can

do for people with behavioral health needs and what types of people can/should make up a co-response team is a barrier to care.

"Legislators at the local level or at the state level or the federal level, I've just adequately understood how much behavioral health response fire-EMS does anyway, and how much better they could be at that part of their job if they were given funding and incentives and the power to do more. I just think it's a lack of knowledge. Whenever we talk about a crisis response, we talk about law enforcement, and it's either like, Yes or No, it's very binary. "Law enforcement should be doing it, law enforcement shouldn't be doing it," and that's the end of the first responder conversation. I think that we've leapfrog right over, the incredibly valuable work that some fire-EMS agencies are doing in this area and how much more could be done with funding and incentives."

"I think there is a very unfortunate prejudice against first responders in crisis in Washington state. It's become trendy and very popular to talk about moving 911, moving first responders out of the way to let the mobile crisis teams do its excellent work. That is short-sighted and counterproductive. I would like to say, as my overall point about crisis systems, we will be better as a state. We will help the people that need these systems the most when we figure out how to improve the 911 system, create a better police response, create a better fire response, create a better 911 response that is coordinated and supported by the 988 system. We continue to look at these things as either/or, and that's not gonna benefit the people that need the help the most. My overall point here is, we're at an opportunity moment to talk about the improvement of 911, and 911/988 integration, and we're not having that conversation."

"Certain expectations that the community thinks that mental [health] co-responders can do. That's another barrier. I think there's expectations that responders should... respond to calls without law enforcement. I don't think that's appropriate that all those calls that are coming in, there's firearms or there's some kind of weapon involved sometimes... A lot of times there's a history of aggression that needs help from mental health staff. Mental health professionals are not law enforcement and we don't go hands on, it will blur the lines of us as mental health professionals. Of course, we'll bend ourselves, but we don't transport, we don't go hands on, we're not gonna force someone onto the gurney, or force them to therapy. There's a misconception amongst the community and law enforcement. So there needs to be an education that no, it's not appropriate for mental health professionals as well too. Co-responders should not be going out without law enforcement. And law enforcement needs to basically clear the scene for co-responders or mental health professionals before they interact with a client."

“I will say there's just a brief thing in terms of like politics. People talk about the politics of having co-response and really a lot of people want the alternative response teams, like I mentioned, but don't know that co-response teams exist and are doing a lot of the work that alternative response teams are sort of ideally meant for. So we've had a lot of barriers in terms of getting acknowledgement that we exist and because people don't know we exist when we show up on calls, people are very either resistant or very surprised by our mere existence which isn't exactly a barrier, but it is like a challenge just to have to describe who we are or what we do, and why we're there over and over and over again, versus having people know, oh yeah, this is who we are, and this is what to expect.”

“The other barrier definitely is the Diversion Center. The Diversion Center, mental health facilities, they don't recognize that a paramedic is a professional that can bring a lot of information. And some other contracts work with police or with social workers, but fire is not listed. The whole 988 number, we're eventually gonna go to those calls, but even the state doesn't recognize that like, "Hey, EMTs and firefighters, we're gonna be the ones that are responding, and the only thing we're allowed to do is take people to the ER." There's a broken system that prevents us, the state legislation, the understanding of what kind of calls fire goes to. And I think the professionalism, they don't understand our education. We do things doctors aren't allowed to do. I don't think people get that.”

Conclusion

WA state faces numerous barriers in providing behavioral healthcare to its residents. The perspectives of co-response teams that are frequently showing up to the crisis and follow-up calls are vital to truly understanding what is happening on the ground. To make better policy decisions at the state, county and city levels it’s important to take these perspectives into account. Regional coordination, accountability, oversight is severely lacking.

Chapter 6: Co-Response and the Involuntary Treatment Act

WA state's civil commitment law is known as the Involuntary Treatment Act (ITA) and is codified in the Revised Code of Washington. WA's legislature enacted the ITA in 1973 and has since revised it a number of times. The legislative intent of the ITA is to protect the health and safety of people in behavioral health crises and to protect the public. The Washington state legislature reaffirmed the ITA's intent in 1998, stating: "[i]t is the intent of the legislature to: provide additional opportunities for mental health treatment for persons whose conduct threatens himself or herself or threatens public safety and has led to contact with the criminal justice system."

The civil commitment process includes four stages: evaluation, initial detention, hearing, and commitment. In WA, a Designated Crisis Responder (DCR) evaluates people who are undergoing a behavioral health crisis. A DCR can provide an evaluation in an emergency room or non-emergency room setting although in practice these evaluations typically happen in ERs. Through evaluation and a brief investigation—which frequently includes speaking to law enforcement, family, friends, or other witnesses present for the evaluation—the DCR decides whether the individual meets the legal threshold for initial involuntary detention. This legal threshold requires the individual to be gravely disabled, meaning they cannot care for their own basic needs, or at risk of harming themselves, others, or property.

If the DCR decides that initial detention is appropriate, they prepare and file a petition for initial detention and attempt to find the individual an available inpatient bed at an evaluation and treatment facility. If placement at an E&T is not available within the county the individual is in, they may be transferred to an E&T in another county. If a placement in an E&T bed is not available at all, the DCR can apply for a single bed certification (SBC), where the individual will be held until an E&T bed becomes available. These placements are often in non-psychiatric emergency room beds. If neither an E&T nor an SBC is available, the DCR will file a No Bed Report, and the individual can no longer be legally held under Washington's civil commitment laws.

There is no court hearing involved in the initial evaluation process. After the DCR files an initial petition for detention, an individual can be held at an E&T or on an SBC for up to 120 hours, excluding weekends and holidays. If the detaining facility believes the individual warrants detention beyond the initial 120 hours, they must file a petition with the court for fourteen days of involuntary treatment.

The judge then determines whether a person is gravely disabled and/or presents a likelihood of serious harm, utilizing "all available evidence concerning the respondent's historical behavior." If the judge finds the legal threshold for involuntary treatment is met, the individual will remain in the treatment facility for up to fourteen days from the date of the hearing. The evidentiary standard for this stage of the hearing is also preponderance of the evidence. Detainment facilities can discharge individuals at any point, even after a judge decides they meet the legal threshold for detention. If an individual remains in the treating facility at the end of the

fourteen days, and the facility believes they require further involuntary care, the petition and hearing process repeats. The individual then faces civil commitment for ninety days. The evidentiary standard is raised to clear and convincing for this longer detention and any hearing that occurs thereafter.

The ITA also allows for involuntary outpatient treatment, often court ordered through a less-restrictive order (sometimes referred to as a "less restrictive alternative"). This procedure closely mirrors that of involuntary inpatient treatment. As discussed above, an individual may be ordered a less-restrictive alternative at the time of the fourteen-day.

While there have been analyses of WA's ITA statute by legal professionals, to date, there hasn't been an analysis provided by first responders and co-responders of how the ITA process works in practice. The only professionals who have the legal authority to detain someone are law enforcement and the DCRs. Because there is such a widespread shortage of DCRs statewide, this means that law enforcement is most frequently the professional doing the initial detainment and transport (or arranging for transport by ambulance) of individuals who need evaluation to ERs where ITA evaluations most frequently occur.

On average there are approximately 1000 ITA evaluations across WA state; and according to data from the HCA, half do not result in initial detention. This suggests there is a lot to time and energy being spent on ITA investigations with scarce resources when it's not clear what help people who do not qualify for ITA are receiving. Even people who meet the legal threshold for involuntary treatment may be unable to get a bed due to widespread psychiatric bed shortages across WA state.[28] This raises the important question of whether there is more that can be done in community-based setting by behavioral health professionals other than DCRs both to evaluate individuals and to mitigate the need to take people to ERs by stabilizing people in the community. This is an important potential role for co-response. Thus, the perspectives of law enforcement and co-response on ITA are vital to understanding what is actually happening in practice and how the ITA statute might be improved.

The thematic analysis revealed that a lack of behavioral health resources is contributing to an ineffective, wasteful and potentially traumatic ITA process for people experiencing behavioral health crises. Participants described the way the lack of resources for people in the crisis system leads to poor outcomes and frustrating experiences for those who are involuntarily transferred to the emergency room (ER). Because there is no other place to take people, and the ERs are frequently overburdened, patients end up waiting for extended periods of time in the ER with little support and usually subsequently get released without any help either due to capacity issues at the ER or the receiving clinical team determining there are no grounds to continue to detain the patient. Interviewees expressed frustration with this process that was seen as cyclic and leading to moving people around without providing proper care. They view this unresolved treatment cycle and the ER being the only option for care as a recipe for

[28] WA has continued to experience a regular shortage of beds (https://www.hca.wa.gov/assets/program/single-bed-certification-quarter-1.pdf). A 2021 study suggests that WA appears to have about 25 psychiatric beds per 100,000 people, but that's less than the 31-33 psychiatric beds (per 100,000 people) predicted to be needed (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8625568/). This is radically different than the Treatment Advocacy Center's 2016 estimate of about 10 beds per 100,000 people.

creating extreme outcomes. For example, a patient who may have had a previous traumatic experience with hospitals gets forced to wait in the ER against their will, only to be released with no actual mental health care received, now may be more likely to refuse services in the future and is almost immediately returned to the situation in which they were in danger to themselves or others.

"Our community, I think like every community in the nation really lacks enough treatment facilities, and whether that be mental health or substance use disorder we... Until we have those facilities where we can really help people towards wellness there's a lot of repeat contacts."

"King County is bereft of crisis diversion facilities. And I know that there's gonna be a new one that will be opening a Kirkland, and it sounds like a different model, certainly, than crisis solution centers, but it... We need many, many more and we also need more behavioral health urgent care centers."

"Joel's law does not work when your hospital does not cooperate. We have officers that round kids up on Joel's law, but when you have no place to take them, you cannot provide care, it doesn't work."

While having access to a DCR was described by co-responders as sometimes the only option to actually get someone access to behavioral health treatment, and not just taken to the ER, participants identified many challenges with the DCR process. Many participants viewed the DCR system as broken due to there not being enough DCRs available to meet the needs, extreme wait times, the separation between DCRs and co-responder systems, DCRs declining to evaluate patients unless there was a bed available, and DCRs not using consistent standards.

Notably, because crisis response times are very slow (e.g., 2-3 weeks, as reported by participants) and DCRs sometimes don't respond to requests at all, some co-responders described instead having police detain patients until they get to the hospital, activating an emergency response system that doesn't need to be activated and leading to an unnecessary use of police and ER resources. Finally, several participants described frustration when the DCRs, who are mental health professionals but usually not co-responders, do not agree that the person needs to be detained based on the situation or scene that they encounter, which may be different than the one co-responder encountered, by the time they arrive to evaluate the patient.

"Our system with designated crisis responders is a system that really needs to change. In general, we need to be able to assist people and get them containment from that perspective earlier before they are so far into crisis that they're at a danger to themselves or others."

"I just think that the wait times are dangerous for people with the wait times for DCRs to come out, wait times for mobile crisis team, wait times in the emergency department and then we've exhausted our resource."

A strong recurring theme in this dataset, and in discussions of involuntary treatment related to the need for "landing zones" that are not ERs, wraparound and holistic treatment facilities, and places where people can go to stabilize. The creation or establishment of these resources could, as co-responders described, hugely help to address the needs of people in crisis who do not need DCR services as distinct from the needs of people who are in crisis and who do need the services of a DCR. Participants described crisis stabilization facilities as a needed resource where people could stabilize and ultimately avoid needing to engage with the DCR system. Having more voluntary options available was viewed as a way to divert resources from the DCR system, which was described as severely challenged. Notably, one participant described a historical shift in available services, where there used to be many more voluntary treatment options which were largely switched to involuntary treatment options, connecting this shift to an increased need for DCRs because voluntary options were simply not available.

Additionally, participants described the ways involuntary treatment does not work when the only option for treatment is the ER, as it is not actually a means of ensuring treatment or care. For this reason, having alternative destinations that offer better care for people in crisis was viewed as highly necessary. For some participants, changing laws related to involuntary treatment was not perceived as politically feasible, however, opening crisis centers was seen as feasible and prosed as a necessary next step.

"Crisis stabilization facility, a 23-hour facility, would be the most impactful thing that we could possibly have. Especially if it had the ability to do blood draws there and medically clear somebody and avoid them actually taking up space in our ERs. That way the person could be calm in a 23-hour facility and wait from that DCR to come and already be medically cleared."

"I would say the most feasible would be getting some kind of 23-hour crisis center, because you have to... People will agree to a crisis center, people will agree to bring people to a place, but detaining people more or having less restrictions around helping people with mental health, there are so many big huge feelings around that. You have the people who really believe they should be allowed to be like that, and who cares. And I used to be over there. So now that I've had to deal and work with these people, I understand my own views were wrong and that these people need a lot more help, so that's a really huge thing for people to grasp, and people really can't grasp that unless they see it. So a crisis center is so much easier. 'cause everybody wants to help people, and I think that's the easiest one to sell, if it's sold right, pitched, right, and you have the right partners to sponsor it."

"What if someone did call 988 and they met criteria to have a DCR do an evaluation and they didn't meet criteria for detention, but what if they could coordinate with us to go out and check with them the next day or that same day and help them look at maybe treatment alternatives or the diversion center or shelter? I think more collaboration is what is needed."

"Several years ago, most of our facilities in the State of WA went from being voluntary mental health to involuntary mental health. I know that likely has to do with insurance reimbursements and making more money, however, it is a real shame to our systems. Because I encounter a lot of people who say, 'I do wanna go to mental health treatment,' but in the State of Washington we have around 100 crisis stabilization beds that could help support voluntary treatment. And that is for an entire state. And that is insane to me, 'cause that includes detox."

Interviewees described not being able to help people as something that was very difficult for them, and many used words like "powerless" and felt that the current system was "inhumane" and not "compassionate" to those who need crisis services. They spoke about how difficult it was to see people in need, and to see the impact of untreated mental health issues on patients and their families, and some felt that in certain cases it would be more compassionate to detain someone than to respect their autonomy and choice. This feeling sometimes led to interviewees stating that the bar for involuntary treatment might be too high, and some connected the high bar for involuntary treatment to a situation where escalation of risk and legal involvement were more likely.

On the other hand, interviewees spoke about the need to protect free will, and talked about any involuntary treatment as being a "delicate balance." Furthermore, participants spoke about the need to have more voluntary options for treatment, so that co-responders could have a better uptake of services without the need for involuntary treatment. One participant described the way their team works around the high bar needed for involuntary treatment by relying on communication and relationships with patients and spending more time talking to people to convince them to seek available treatment.

"Maybe some more focus on the mental health and how... the legal system can help with that, but I don't know what that is because we have to protect everybody's rights. Delicate balance."

"We have a lot of folks who have pretty significant mental health challenges on top of a significant substance use challenge. And they might be frequently detained by our designated crisis responders, but after maybe a few hours hospital doctors decide, this isn't actually something that they need to be detained on. So they get discharged into our community and then they're... It's like we could deal with that same person three times in a day without being able to actually help them."

"The reality is that so long as people are free and independent within our world environment, there is no magic wand. You simply have to hope that people have some moment of clarity or some point where they've hit that bottom where they want or are willing to accept help."

In addition to the many other proposed changes to the crisis system that would help avoid the need for involuntary transfer altogether, two types of changes were discussed related to involuntary transfer.

"I understand that you don't want to force people into things, but this whole idea that it's compassionate to lead people in the states of crisis that they are on the street and say, 'Well, it's not illegal to be that way.' And we have to be thoughtful and compassionate. I think that's... I think it's the wrong direction, and I think it's not serving us."

"We have a significant population that does not do any of those things that we absolutely have no tools to help other than we might try to have them detained and hope that the hospital doesn't let them go, and we might bring them to the jail and the same situation could happen in the jail because they could be deemed what's called not competent to stand trial … we know they're not competent to stand trial, but the wait list for Western State is so long you just release 'em right from the jail, so they never get seen by a mental health professional, they never get medication, and they go right back to having interactions that are really not positive, if that makes sense. So I mean any interaction where they might be acting erratically could end in some form of use of force with police, right. And/or they might damage city property, they might damage public property, they might damage a car that somebody's driving. This happened every day, all day long, and there's nothing we really can do to help them. And that makes me feel powerless because they need help and they don't know they need help."

"It's a fine balance between giving them as much rights as possible and taking away their rights."

First, interviewees spoke about the possibility of expanding the number of clinicians who can authorize involuntary transfer. They suggested that extending these powers to other behavioral health providers working in the co-response system would help address the DCR challenges raised in the interviews. Similarly, a couple of participants mentioned the possibility of having outreach workers, peers, etc. be able to advocate before the court for mandatory treatment (under "Joel's law"). One participant added that recognizing the medical clearance capacities of paramedics which could get people directly into detox would be helpful. While some participants wanted fewer restrictions in place for police-related detainment abilities, others felt that police should not be the profession responsible for involuntary treatment.

The second set of changes that some interviewees felt would be helpful included changing or more specifically describing the criteria for involuntary transfer to make it easier for patients to qualify. Some noted that it is challenging to meet the needed criteria for involuntary transfer, and others noted inconsistency in the interpretation of imminent danger and grave disability. Another minor theme in the dataset expressed by only a couple of participants was co-responders noting the difficulty in using an involuntary treatment process when substance use was involved, and wanting solutions that could help in cases where substance use and mental health issues were intertwined, as current practice is not to detain people due to substance use.

"We got dispatched to a 911 call for a girl that had cut her wrist open. And the way it was dispatched is the police were already on scene and they were requesting us to come evaluate the patient. So when we got on scene, the police approached us and said, 'So she's cut her wrist, it's not bleeding currently. I'm gonna ITA her and we'll just get her down to the hospital and get stitches because she doesn't want to go.' And I was like, 'Well, can I talk to her 'cause I know her?' And, he said, 'Well, it doesn't matter. We're gonna ITA, she needs to get that, it's gonna get infected. She needs to get stitches and stuff.' And I was like, 'Well, you can't. She's answering questions appropriately, you can't just take her down to the hospital, so why don't you let me talk to her?' So, I approached and talked to her, moved her around where she couldn't see the police officer, got her to sit down. She was bawling, looked at her wrist. She allowed me to do that. Saw that it wasn't bleeding. She hadn't cut into anything worse than through the skin. She has cuts all over her arms and legs from doing this. So I know [that, for her], this is normal. She's answering all my questions appropriately. And from previous trauma, psychological trauma and everything, she's very scared to go to the hospital. So I said, 'I'm gonna talk to the police officer. I'll get you some bandages and stuff. I just want you to keep it clean. And if you have any problems, then she can call us and we just give people our cards or we will come pick you up and take you down to the hospital.' And she calmed down a little bit and said okay, I went back and talked to the police officer and he said, 'No, we're gonna ITA her.' He ITA-ed her and forced her to go down to the hospital. And so that could have been managed, I don't know, at least five different ways. And that wasn't the way. I think we would be less likely to transport people under an ITA overall, drastically, compared to police officers. But sometimes they ITA people that just, they don't need to be ITA-ed and then sometimes we can't get them to ITA the ones that we need ITA-ed."

"As a licensed clinical social worker along with a psychiatrist or an MD could involve an individual for a short period of time that we're working with or that we've evaluated so that you can utilize already existing community services to be able to evaluate and detain an individual short term."

"We have some legislation that we could use some assistance with too. And and so until we can move the needle a little bit on our involuntary treatment criteria free will is a very real thing, and I think it should be protected. But there's a number of times where we have very, very ill people in our community who aren't able to get the help that they need because of caveats in the system or facilities to really care for them."

"I feel like in those areas where we're trying to get someone into a mental health facility or detox and they're asking for it, I feel like we don't make a difference because our system is not allowing us to make the difference. They're asking for these medical clearances, and then we have to sit there. And there are some things that we as a paramedic... I'm literally... I could draw their blood. I could do a breathalyzer. I can write a report of what I checked. I could give that to the doctor, and then I could take them straight to detox. But our system isn't recognizing us as a... We're not recognized as providers through some of the system."

"It would be great if there was a middle ground for inpatient and outpatient involuntary treatment, and that if you are a master's level clinician as a co-responder, to have DCR detention powers."

"We're encountering these people that are starving to death, for example. They're literally unable to care for themselves, they're sleeping on the streets, they're not eating, they're not showering, they're not doing all of these things. They're being sexually assaulted, it happens all the time. But they're not a vulnerable adult. They're not considered a vulnerable adult unless the hospitals actually take the time to have them, to have them advocate to be a... To get a guardian ad litem. So all these people that are very, very severely mentally ill, Adult Protective Services cannot help them at all. They don't even generate into their system. Because they are not legally considered a vulnerable adult. Therefore they have zero safeguards."

Conclusion

According to key informants, WA's involuntary treatment system, the way in which it is currently designed, is not serving anyone well. Designed as a well-intentioned layer of accountability for the civil commitment process, has led to onerous barriers to care through the creation of a professional entity, DCRs, that don't exist in most other states. The creation of DCRs who are largely seeing people in ERs and to involuntary treatment investigations exacerbates existing severe workforce shortages in behavioral health. Co-response could play a vital role in addressing workforce shortages in DCRs and in supporting medical clearance processes.

Conclusion

As stated, co-response programs function at the nexus of the hospital and emergency response, public health and housing, behavioral health, and public safety systems.

Quality healthcare, and quality behavioral health care in particular, is not available to many low-income and vulnerable individuals because of regional inequities, financial barriers, and a disconnect between client needs and conventional, office-based care. When community-based services are unavailable, or barriers to access them are too high, 911 becomes a default response for a range of health- and behavioral health-related issues. As more fire and police calls involve unmet health and behavioral health care needs, co-response programs have proliferated. A first responder partnered with a social worker, nurse, or peer is a more effective, trauma-informed response than police or fire alone.

By its very nature, co-response tends to be incredibly varied in both the services it provides and the populations it serves. Co-response teams work actively to engage people who are experiencing some of the worst days of their lives for a multitude of reasons. To be effective, these teams need to be self-reflective and data-driven, in other words, well trained, and gain knowledge that will help them to serve their clientele in the best way possible. Due to the vulnerability of the people co-response serves, it's important for teams to look at and embrace diversity and lived experience in hiring practices, and to implement inclusive practices in their daily work.

Co-response should strive to embrace the human qualities that make people unique, and listen carefully when someone says something that do not understand or have experienced. Co-responders, owe it to the individuals they serve to see them as full individuals with a vast array of experiences that they may not share, but can still validate for how real they are for that person. Co-responders will be better equipped to assist people in crisis when they have open minds, have opportunities to gain knowledge and skills training to better prepare them for their work, and most importantly, when they, and the agencies that employ them, care about their well-being.

Co-responders need to be prepared to treat those who are the most vulnerable in our society and to help improve outcomes, aiding people in their self-defined path to recovery. By leaning into the needs and cultures of the people they serve, co-response can be there for those they serve. This is a deep commitment and conversation as co-response moves out of the shadows of the emergency response system and into the sunlight as an essential service of the behavioral health crisis care continuum.

Are You Affiliated with a Co-Response Program?

Co-response programs are multidisciplinary programs based in first responder agencies including police, fire, EMS, and public health or safety departments. In these programs, first responders partner with healthcare and behavioral healthcare professionals, including peers, to address the social and health needs of individuals. This can involve direct 911 response, proactive outreach, or follow-up depending on agency needs and policies. The combined expertise of the first responder and the health/behavioral health professional is used to de-escalate situations, intervene as appropriate, and connect people to community resources and services. Behavioral health co-response programs focus on behavioral health-related calls and referrals for service.

1 Per the definition above, are you affiliated with a co-response or a behavioral health co-response program?

- ◯ Yes, behavioral health co-response
- ◯ Yes, co-response without a specific focus on behavioral health
- ◯ No, my agency/department does not offer co-response at this time

1a Is your agency/department currently interested in starting a co-response program?

- ◯ Yes
- ◯ No

1b What are your barriers to starting a co-response program? Please select all that apply.

- ☐ Insufficient funding
- ☐ Rules for funding sources are too onerous
- ☐ Cannot find sufficient behavioral health staff
- ☐ First responders are not interested
- ☐ Community is not supportive
- ☐ No need in community
- ☐ Other barrier(s) not listed here
- ☐ I don't know

1c Please list the other barrier(s) not listed above. If applicable, separate multiple barriers with a comma. _____

Contact Information

2 Name of person completing this survey

(First Last)

3 Email of person completing this survey

Please note that the email you provide above will be the recipient of the $25 Tango Card upon completion of this survey. If you prefer not to receive the Tango Card, please check the box below.

_____

4 Phone number of person completing this survey

(e.g., 555-555-5555)

5 Agency/department name

6 Agency/department address

About Your Co-Response Program

7 What is your role in the co-response program? Please select all that apply.

- ☐ Program Director or Manager
- ☐ Behavioral health professional (DCR, MHP, bachelor's level professional, etc.)
- ☐ First responder
- ☐ Chief, CEO, or Executive Director
- ☐ Other role(s) not listed here

Please describe the other role(s) not listed above. If applicable, please separate multiple roles with a comma. _____

8 Name of co-response program

_____

(Write "N/A" if your program does not have a name)

9 Phone number of co-response program

_____

10 Website address of co-response program

_____

(Write "N/A" if your program does not have a website address)

11 What kind of geographic area does your co-response program serve? Please select one.

- ◯ Region
- ◯ County
- ◯ Multiple cities
- ◯ City or smaller

12 In which cities or counties does your co-response program operate? Please separate each city and/or county with a comma. _____

13 Approximately how many people does your co-response program serve per month?

_____

(e.g., "25". If unknown, please enter "I don't know".)

14 Please describe who is eligible to receive your co-response services. Examples include "people in mental health crisis", "elders at risk of injury", etc.

_____

(If unknown, please enter "I don't know".)

15 Which populations does your co-response program serve? Please select one.

- ◯ Children (under 18 years old)
- ◯ Adults (over 18 years old)
- ◯ All ages

16 Which situations does your co-response program respond to? Please select all that apply.

- ☐ Mental illness
- ☐ Suicide risk/attempt
- ☐ Psychosis
- ☐ Substance use
- ☐ Intellectual/developmental disability
- ☐ Medical conditions affecting behavior (e.g., delirium, dementia, traumatic brain injury)
- ☐ Homelessness
- ☐ Social service needs
- ☐ Other situation(s) not listed here
- ☐ I don't know

Please specify the other situation(s) not listed above. If applicable, please separate multiple situations with a comma.

_____

17 Which services are offered by your co-response program? Please select all that apply.

- ☐ Crisis de-escalation
- ☐ Crisis prevention
- ☐ Transportation
- ☐ Community resources (e.g., housing, food access)
- ☐ Case management
- ☐ Brief crisis intervention
- ☐ Behavioral health screening
- ☐ Substance use/addiction treatment
- ☐ Health education and promotion
- ☐ Environmental home safety
- ☐ Assistance with durable medical equipment
- ☐ Medication reconciliation
- ☐ Hospital transition/discharge follow-up
- ☐ Wound care
- ☐ Outreach to homeless and unsheltered individuals
- ☐ Other service(s) not listed here
- ☐ I don't know

Please specify the other service(s) not listed above. If applicable, please separate multiple services with a comma.

_____

18 Are there any individuals that your co-response program will not work with? Please select all that apply.

- ☐ High medical complexity
- ☐ High violence risk (e.g., weapons present and threatening to use)
- ☐ Experiencing homelessness
- ☐ Non-resident of catchment area
- ☐ Undocumented citizenship
- ☐ Other circumstance not listed here
- ☐ I don't know

Please specify the other circumstance not listed above. If applicable, please separate multiple individuals with a comma.

_____

19 On which days does your co-response program currently operate? Please select one.

- ◯ 7 days per week
- ◯ Monday - Friday
- ◯ Other days not listed here

Please specify the other days not listed above.

_____

20 What are the hours of operation for your co-response program? Please select one.

- ◯ 24 hours per day
- ◯ 8 hours per day
- ◯ Other hours not listed here

Please specify the other hours not listed above.

_____

21 In which year did your co-response program begin?

_____
(e.g., "2017". If unknown, please type "I don't know")

22 From which source does your co-response program receive calls and referrals? Please select all that apply.

- ☐ 911 dispatch
- ☐ First response dispatch
- ☐ Through an electronic system (e.g., ESO, Julota)
- ☐ Through emails and phone calls
- ☐ 988
- ☐ Regional crisis line
- ☐ Hospitals
- ☐ Ambulance service
- ☐ Law enforcement
- ☐ Aging and disability service providers
- ☐ Jail
- ☐ Accountable community of health (ACH)
- ☐ Behavioral health providers
- ☐ Community-based organizations
- ☐ Other source(s) not listed here
- ☐ Not applicable
- ☐ I don't know

Please list the other source(s) not listed above. If applicable, please separate multiple sources with a comma.

_____

23 Which agency/department has primary oversight over the operations of your co-response program? Please select all that apply.

- ☐ Police
- ☐ Fire department
- ☐ Emergency medical services (EMS)
- ☐ Behavioral health agency
- ☐ Public health department
- ☐ Public safety department
- ☐ Other entity not listed here
- ☐ I don't know

Please specify the name of the police entity that has oversight.

_____

Please specify the name of the fire department that has oversight.

_____

Please specify the name of the EMS that has oversight.

_____

Please specify the name of the behavioral health agency that has oversight.

_____

Please specify the name of the public health department that has oversight.

_____

Please specify the name of the public safety department that has oversight.	
Please list the other entity that is not listed above. If applicable, please separate multiple entities with a comma.	
Please specify the name of the other entity that has oversight. If applicable, please separate multiple entity names with a comma.	

Staffing

24 Please list the full-time equivalent for each type of team member on your co-response team (e.g., "1.0" or "0.5"). Estimates are OK. If position is not applicable, please type "0".

Mental health professional (MHP) (not including DCR) _____
Substance use disorder professional (SUDP) _____
Bachelor level behavioral health staff _____
Designated crisis responder (DCR) _____
Paramedic _____
EMT _____
Law enforcement officer _____
Peer specialist _____
Psychiatric medical director _
Psychiatric prescriber _____
Nurse _____
Student/intern _____
Volunteer _____
Other team member type not listed here _____
_____ _____
_____ _____

Please specify the other team member type not listed above. _____

Please specify the second other team member type not listed above. _____

Please specify the third other team member type not listed above. _____

25 How do the behavioral health professionals in your co-response program respond to calls? Please select all that apply.

- ☐ In the same vehicle as law enforcement
- ☐ In the same vehicle with fire fighters or other EMS
- ☐ Separately but in coordination with police, fire, or EMS
- ☐ Separately to do case management/provide follow-up services without first responders present but after receiving a referral from police, fire, or EMS
- ☐ Other modality not listed here
- ☐ Not applicable
- ☐ I don't know

Please specify the other modality of responding to calls not listed above. If applicable, please separate multiple responses with a comma. _____

26 Who employs the behavioral health professional(s) in your co-response program? Please select all that apply.

- ☐ Fire department
- ☐ Law enforcement agency
- ☐ Mental health agency
- ☐ Substance use treatment agency
- ☐ Peer agency
- ☐ City government
- ☐ County government
- ☐ Self-employed or contracted
- ☐ Other entity not listed here
- ☐ Not applicable
- ☐ I don't know

	Please specify the other entity not listed above. If applicable, please separate multiple entities with a comma.	_____
27	Does your co-response program train students or interns?	◯ Yes ◯ No ◯ Not applicable ◯ I don't know
27a	How many students per year are trained by your co-response program? Estimates are acceptable.	_____
28	What kind of supervision structure does your co-response program have for clinicians? Please select one.	◯ No supervision structure ◯ Scheduled ◯ On-demand ◯ Other supervision structure not listed here ◯ Not applicable ◯ I don't know
	Please specify the other supervision structure not listed above.	_____
29	Does your co-response program use a vehicle to work in the field? Please select all that apply.	☐ Personal vehicle ☐ Standard vehicle owned by program ☐ Ambulance ☐ Community paramedicine vehicle (aid car, paratransit) ☐ Police cruiser ☐ Other vehicle(s) not listed here ☐ None ☐ I don't know
	Please specify the other vehicle(s) not listed above. If applicable, please separate multiple vehicles with a comma.	_____

Partnerships

30 Does your co-response program currently have a formal agreement with any of the following local services (e.g., for expedited drop-offs or care transitions)? Please select all that apply.

- ☐ None
- ☐ Outpatient behavioral health (e.g., case management, medication support)
- ☐ Behavioral health crisis facility (e.g., residential, respite, stabilization unit)
- ☐ Substance use detox/sobering
- ☐ Psychiatric emergency services
- ☐ Emergency department
- ☐ Urgent care
- ☐ Other service(s) not listed here
- ☐ I don't know

Please list the other service(s) not listed above. If applicable, please separate multiple services with a comma. _____

31 Does your co-response program collaborate with mobile crisis teams (MCT)?

- ◯ Yes
- ◯ No
- ◯ I don't know

31a In what ways do you collaborate with MCTs (e.g., information sharing)? If applicable, please separate multiple responses with a comma. _____

31a What are the reasons your co-response program does not collaborate with MCTs? _____

Training and Staff Wellness

32 Does your co-response program have staff who are trained/qualified to provide specific evidence-based clinical intervention for behavioral health (e.g., cognitive behavioral therapy for psychosis)?

- ◯ Yes
- ◯ No
- ◯ I don't know

Please specify the clinical intervention(s) your team provides. If applicable, please separate multiple interventions with a comma.

_____

33 Which suicide prevention best practices are used by your co-response program? Please select all that apply.

- ☐ Universal suicide screening
- ☐ Crisis or safety planning
- ☐ Reducing access to means of self-harm
- ☐ Other best practice(s) not listed here
- ☐ None
- ☐ I don't know

Please specify the other best practice(s) not listed above. If applicable, please separate multiple practices with a comma.

_____

34 What type of training modalities does your program use to train its co-responders? Please select all that apply.

- ☐ On-demand videos
- ☐ Self-directed reading
- ☐ Classroom, lecture-based
- ☐ Classroom, scenario-based
- ☐ Virtual reality/simulator
- ☐ Shadowing/provisional period < 1 month
- ☐ Shadowing/provisional period 1 - 3 months
- ☐ Shadowing/provisional period > 3 months
- ☐ Conference attendance
- ☐ Other modality not listed here
- ☐ None
- ☐ I don't know

Please specify the other modality not listed above. If applicable, please separate multiple modalities with a comma.

_____

35 What training topics would you like to see offered to co-responders in your program? Please select all that apply.

- ☐ Suicide risk assessment and intervention
- ☐ Violence risk assessment and intervention
- ☐ Management of agitation and verbal de-escalation
- ☐ Structured brief interventions (e.g., SBIRT, CALM, SPI)
- ☐ Level-of-care decision-making
- ☐ Trauma-informed care
- ☐ Harm reduction practices
- ☐ Safety in the field
- ☐ Team member well-being
- ☐ ITA statute
- ☐ Other topic(s) not listed here
- ☐ None

Please specify the other topic(s) not listed above. If applicable, please separate multiple topics with a comma.

_____

36 Does your program have effective mechanisms in place to prevent, detect, and respond to the following experiences among co-responders? Please select all that apply.

- ☐ Fatigue
- ☐ Burnout
- ☐ Traumatic events and vicarious trauma
- ☐ Team dysfunction
- ☐ Stress related to understaffing
- ☐ Other experience(s) not listed here
- ☐ None
- ☐ I don't know

Please specify the other experience(s) not listed above. If applicable, please separate multiple experiences with a comma. _____

Technology

37	Which type of record/data management system does your co-response program use? Please select all that apply.	☐ Software specific to co-response programs (e.g., Julota) ☐ Stand-alone electronic health record (e.g., ESO) ☐ Stand-alone electronic behavioral health record ☐ EHR integrated with 911/EMS dispatch ☐ Microsoft Excel, Microsoft Word, fillable .pdf files ☐ Other system(s) not listed here ☐ None ☐ I don't know
	Please specify the other system not listed above. If applicable, please separate systems with a comma.	_____
38	How is telehealth used in your co-response program? Please select all that apply.	☐ All co-response staff use telehealth ☐ Clinician uses telehealth for supervision/consults ☐ Psychiatrist uses telehealth for medication consults ☐ Other use(s) not listed here ☐ No use of telehealth ☐ I don't know
	Please specify the other uses of telehealth not listed above. If applicable, please separate multiple responses with a comma.	_____

Funding

39 What is the approximate total annual budget for your co-response program (in dollars)? Please enter the number only (no "$" needed).

_____

(e.g., an annual budget of $50,000 is entered as "50,000")

40 From which of the following sources does funding for your co-response program come? Please select all that apply. For each funding source you select, please enter the percentage of co-response funds that come from that source.

_____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please specify the other funding source not listed above. _____

Please specify the second funding source not listed above. _____

Please specify the third funding source not listed above. _____

41 How do you bill for and/or justify funding for services? Please select all that apply.

- ☐ Submit regular performance reports to local/county/state government
- ☐ Medicaid
- ☐ Medicare
- ☐ Veterans Administration/Tricare
- ☐ Private insurance
- ☐ Other billing source(s) not listed here
- ☐ I don't know

Please specify the other billing source(s) not listed above. If applicable, please separate multiple billing sources with a comma. _____

Co-Response Program Data

42 Does your program collect data on any of the following co-response activities? Please select all that apply.

- ☐ Inbound calls (if applicable)
- ☐ Co-response dispatches
- ☐ Referrals/referral types
- ☐ Face-to-face encounters
- ☐ Video-based encounters
- ☐ Care coordination calls
- ☐ Follow-up calls
- ☐ Unique clients served
- ☐ Client race/ethnicity
- ☐ Other activity not listed here
- ☐ None
- ☐ I don't know

Please specify the other co-response activity not listed above. If applicable, please separate multiple activities with a comma. _____

43 Does your program collect data on any of the following outcomes? Please select all that apply.

- ☐ Completion of suicide risk assessment
- ☐ Completion of violence risk assessment
- ☐ Collaborative safety planning
- ☐ Removed/reduced access to means of self-harm
- ☐ Followed-up in 24 hours
- ☐ Detainment for involuntary hold
- ☐ Referral and transport
- ☐ Other outcome(s) not listed here
- ☐ None
- ☐ I don't know

Please specify the other outcome(s) not listed above. If applicable, please separate multiple metrics with a comma. _____

44 Does your program use any of the following program performance metrics? Please select all that apply.

- ☐ Average speed of answer for inbound calls (if applicable)
- ☐ Average abandonment rate for inbound calls (if applicable)
- ☐ Average time to dispatch co-response team
- ☐ Average co-response team response time
- ☐ % unable to locate by co-response
- ☐ Reductions in 911 calls post-referral to team
- ☐ # of referrals to behavioral health and social services
- ☐ # of connections to behavioral health and social services
- ☐ # of arrests/jail bookings avoided
- ☐ # of emergency room visits avoided
- ☐ # of incidents where police/fire crews were relieved in the field
- ☐ Satisfaction survey of first responders
- ☐ Satisfaction survey of individuals served
- ☐ Other performance metric(s) not listed here
- ☐ None
- ☐ I don't know

Please specify the other program performance metrics not listed above. If applicable, please separate multiple metrics with a comma. _____

Survey Completed

Thank you for completing this survey. A statewide summary of results will be available by June 2023. _____

Before you go, we would like to schedule a time for you to participate in Step 2 of the statewide assessment, the key informant interview. That interview will take 60 minutes to complete. We will send you a second $25 Tango Card for your participation.

Please specify your preferred day/time of the week to participate in the key informant interview. Based on your preference, we will send you an invitation to a Zoom interview in the coming months. You will have the option to decline that interview if the date doesn't work for you and we will reach out to reschedule. The invitation will be sent to the email you entered in this survey. The meeting that will show up in your calendar will be called "WA State Behavioral Health Co-Response Assessment - Key Informant Interview. "

Please specify your preferred day and time for a key informant interview or check the box below.

Day of week (e.g., "Mondays", "Friday-Saturday"): _____

Time of day (e.g., "10am", "3pm-4:30pm"): _____

_____

For questions about this survey, please contact Jennifer Stuber at jstuber@uw.edu.

WA State Behavioral Health Co-Response Program

Landscape Analysis and Needs Assessment

Key Informant Interview Guide

PERSON 1 - Preamble

Thank you for your willingness to do this interview today and for contributing to this landscape analysis/ needs assessment for WA State co-response programs for people with behavioral health needs. My name is NAME, and I am at the University of Washington.

PERSON 2 – *And my name is NAME, and I am also at the University of Washington.*

PERSON 1- *The purpose of this interview is to learn about your co-response program and how it meets needs of people in behavioral health crisis and, how it intersects with the current crisis system. We also want to discuss how the impact of your services could be enhanced.*

As we go through the interview, I will be reading questions from a script. Please note that as we go through the questions, I will be asking you to elaborate on many of your answers. This is to ensure we are answering all the questions thoroughly. Please also keep in mind that there are no wrong answers. It is important that you answer as honestly as you can. We rely on your information to help improve emergency, prevention, and follow-up services for people living with behavioral health challenges. If you have any questions or, if there is something you don't understand, please stop us and ask for clarification.

We realize that some of the topics covered in this interview are sensitive. If you do not want to answer a question or discuss a topic, just let us know and we will move on.

If you experience any technical issues or are disconnected for any reason, please do your best to reconnect to this zoom link. If this is unsuccessful, feel free to email us and we will troubleshoot with you.

These interviews will be audio-recorded and transcribed, which means they will be typed out. Your name or other identifying information will be removed from the transcript. All the information you provide will be kept confidential and the audio files will be stored securely. We will never include any information that could identify an individual or a program in any official publications or reports. There may be an occasion, however, when we want to spotlight a program or use a quote from an interview, but would never do so without your permission.

This interview will last approximately 1 hour. If you need a break, let us know and we can stop for a short rest before we finish the interview.

Given everything that I just mentioned, do you consent to be interviewed? [Wait for confirmation] Do you have any questions before we begin? [Wait for any questions]

When you are ready, I will begin the recording of this interview. [Note: remember to start backup recording device too]

[Proceed to Topic Guide]

PERSON 2 - Let's start with some questions about your role and the kinds of calls your co-response program goes out on to serve people in behavioral health crisis.

Role of co-response team and encounters with people in a behavioral health crisis Purpose: get specific examples of calls, get people comfortable talking about their work, understand what success or impact means to different people.	
Question	**Probes**
1. We have a few questions about your agency and role to start. Can you please tell me the name of the co-response program and department/ agency that you work for? *Interviewer note: It's okay if they don't have a formal name, however they classify their team/ name is fine.*	What is the region that your program serves? What is your position at that department/ agency? What kinds of calls is your program responding to? Who is generally giving you referrals? Is your co-response program responding to crisis calls or doing follow-up or both? *Interviewer note: people who are responding to crisis calls are going to have more acute care experiences, people doing follow-up are doing more case management*
2. Now we are done with questions that require short answers, and we are ready to get into our deeper questions. Starting with the big picture, can you tell me in what kinds of calls/ situations you think your program has the most positive impact? *Interviewer note: ask people both the stem question and the probes in this section (unless interviewee answers it without probing)*	Can you please give us a specific example of a call you went on where you had this positive impact? Was that call typical of behavioral health calls that your team responds to?
3. In what kinds of calls do you feel like your program isn't making as much of a difference?	Can you please give us a specific example of a call you went on where you felt like your program wasn't able to make a difference? Was that call typical of behavioral health calls that your team responds to?

Interviewer note: if needed, steer the convo back to behavioral health from physical or medical health issues throughout	
4. Do you have any other examples of how your program impacts behavioral health needs that they wish to share? (Pass the baton to your partner).	

PERSON 1-

Now we want to ask you about some barriers you may face in delivering crisis services to people with behavioral health needs and about your relationship with other crisis service providers in your region.

Purpose of this section: get into the barriers people are facing in their work, understand how regionality affects barriers

Question	**Probes**
Interviewer note: ask about all topics covered in both stem and probes, can also ask additional natural or conversational probes to fully understand the interviewee's context and perspective	
5. What barriers do you face in assisting people with behavioral health needs in your region?	What would help you to address these barriers?
6. If you had a magic wand and could make it easier to help people with behavioral health needs, what would you do?	Is there a specific policy you want to change? Or specific changes in the system you'd like to see? Of the ones that you've said, which ones feel the most feasible with the current resources to change?
7. Are there additional services you think would be useful to implement in your community, either by your program or otherwise?	Why would [service mentioned] be helpful?
8.	

[Ask interviewee if they have any other comments about barriers they face serving people in behavioral health crisis. Pass the baton to your partner.]

PERSON 2 - - *Now we would like to ask you questions about your specific program, how you'd like to see it improve, and about training and support services that are currently in place and could use.*

Perceptions of training and supports to debrief after challenging crisis calls	
Questions	**Probes**
9. Are there any ways in which you would like to see your program change or improve? *Interviewer note: we want to understand both immediately feasible and less immediately feasible recommendations for system change, so probe to determine what they would do with/without resource constraints depending on how they answer*	What would it take to make your program more effective?
10. What training do team members in your co-response program receive to serve individuals with behavioral health needs? *Interviewer note: we want to learn about what kinds of interventions would be helpful to bring into this space, so interviewers can probe on specifics based on what is mentioned in the stem question*	How effective do you feel this training currently is? Is there anything you would like to see changed or enhanced with the current training? What additional training do you think you need?
11. What kind of support services and wellness resources are in place for co-responders in your program to help them to manage the stressors related to this work?	What additional services and wellness supports do you think would be helpful?

[Ask interviewee if they have any other comments about training and support services. Pass the baton to your partner.]

PERSON 1 - As you are likely aware, many changes are happening in crisis response in Washington state right now. We are interested in your thoughts on the changing crisis response landscape and your team's role in it.

Purpose of this section: understand how co-response feels they relate to other services, how they are coordinated, complementary, integrated, etc.

Interviewer note: ask about all topics covered in both stem and probes, also ask additional natural or conversational probes to fully understand the interviewee's perceptions of where they fit in the changing system and how they feel about those changes

Perceptions of changing crisis landscape	
Questions	**Probes**
12. What are your thoughts about "988" as a new way to activate the behavioral health crisis system?	What do you think about your program possibly responding directly to 988 calls?
13. How do you currently work with mobile crisis teams in your region?	Who makes sure all crisis service providers are working well together? What entity (or entities) would be best positioned to make sure crisis service providers and first responders are well-coordinated and accountable?
14. Do you currently have places to take people with behavioral health needs who can no longer remain at home or shelter in place? How is this working in your region?	If yes: what's your program's relationship like with that entity or entities? If no: how do you think it would change your work if there were more places to take people with behavioral health needs? What do you think it will take to get there?
15. Do you think regional organization for training and collaboration for crisis service providers and first responders would be valuable? Why or why not? What would be helpful to get everyone working together?	

[Ask interviewee if they have any other comments about crisis service landscape. Pass the baton to your partner.]

PERSON 2 – There has been a lot of recent discussion about safety in crisis response, and what types of responders are necessary to deliver services in a way that is safe for both the community and the responders. We would now like to ask you your thoughts on how to best ensure calls are safe and effective for everyone involved.

Safety in crisis response and team composition *Purpose of this section: trying to figure out what types of responses are needed to what types of calls and understand co-responders' feelings and perceptions of safety in responses, what are considerations around safety in this space.*	
Question	**Probes**
16. What do you need to feel safe in responding to crisis calls?	What is the current dispatch protocol with behavioral health crisis calls as far as safety is concerned? Should it be changed at all?
17. What would the ideal crisis response team composition be from your perspective?	For each of the team members suggested, ask: What skills and perspective do they bring, how could they be most useful in responding to these calls??
18. What are your thoughts on police responding to behavioral health crisis calls? *Interviewer note: if they already talked about one of the professions below, change the wording and/or only ask the unanswered probes. If you are running low on time in the interview, it's okay to omit questions 19 and 20.*	What types of behavioral health crisis calls are better with police? What types of behavioral health crisis calls are better without police?
19. What are your thoughts on Fire/EMS responding to behavioral health crisis calls?	What types of behavioral health crisis calls are better with Fire/EMS? What types of behavioral health crisis calls are better without Fire/EMS? Do you think paramedics should be a part of co-response programs?
20. What are your thoughts on behavioral health professionals and peers responding to crisis calls?	What types of behavioral health crisis calls are better with behavioral health professionals and peers? What types of behavioral health crisis calls are better without behavioral health professionals and peers?

21. Finally, would you want to include a profile on your co-response program in the future in the CROA newsletter?	If yes, what would you like to see said or highlighted about your program? We would write something up based on your

	response and send it to you for your review.

Demographic Questions

1. What is your gender identity? _____
2. What term would you use to describe your race and/or ethnicity?_____
3. What is your age?_____
4. What is your highest level of educational attainment? _____
5. How long have you been in your role? (# of years)

Great, those are all of the questions we have for you, do you have anything else you want to share with us about behavioral health response?

Those are all of our questions for you. Do you have any questions for us?

If they ask "what are you going to do with this information" – give update on rough number of interviews (ie..,we anticipate doing about 30-40 interviews as part of this work, each co-responder team in WA has been invited to participate). This work is being done in response to funding from the State Legislature to better understand the co-response system in WA, and our project is continuing until the end of June. We will be analyzing the results of these interviews along with a survey we conducted to report back to the State Legislature so that they can continue to improve the emergency response and crisis landscape. We can share the results back with you when we are done, likely over the summer, if you would like?

Thank you so much for your time and input, it has been very valuable for us to hear your perspectives. We will be in touch to send you an e-gift card by email and to share the results of our study with you.

Interviewer note: take notes on meta reflections throughout (pen and paper), then debrief at the end and return to your notes during the interview and type up any thoughts or feelings or reflections on the process