Washington State Health Care Authority
Report to the Legislature

Crisis Workforce and Resilience Training Collaborative recommendations

Recommendations for implementing regional training collaboratives

Engrossed Second Substitute House Bill 1134; Section 11(4); Chapter 454; Laws of 2023

December 31, 2024

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Table of contents

Executive summary ... 4

HCA’s partner conversations ... 4

Training needs assessment ... 5

Findings and recommendations ... 5

Serving certain populations ... 5

Partners ... 6

988/911 considerations ... 6

Wider behavioral health landscape integration ... 7

Best practices ... 7

Agricultural community considerations ... 7

Community and public buy-in ... 7

Sustaining the collaboratives ... 8

Funding needs ... 9

Timeline ... 9

Budget considerations ... 9

Table 1: Annual costs per region ... 10

Conclusion ... 11

Appendix A: List of questions for BH-ASOs ... 12

Appendix B: Training needs assessment ... 13

Executive summary

House Bill (HB) 1134 (2023) focuses on crisis response efforts and regional collaboration between partners. Specifically, this bill directs the Health Care Authority (HCA) and others to develop recommendations on how to establish regional training collaboratives (collaboratives) to better serve those in crisis across the state. Legislative language states:

> The authority and behavioral health services organizations, in collaboration with the partners specified in subsection (1) of this section, shall develop recommendations for establishing crisis workforce and resilience training collaboratives that would offer voluntary regional trainings for behavioral health providers, peers, first responders, co-responders, 988 contact center personnel, designated 988 contact hub personnel, 911 operators, regional leaders, and interested members of the public, specific to a geographic region and the population they serve as informed by the needs assessment. The collaboratives shall encourage the development of foundational and advanced skills and practices in crisis response as well as foster regional collaboration.

The recommendations in this report address how the collaboratives will operate, the resources needed, and how collaboratives will address the identified gaps in the training needs assessment (assessment). This report also builds on that assessment, completed by Health Management Associates (HMA), available in Appendix B.

HCA's partner conversations

Prior to HMA completing their assessment, HCA hosted initial meetings with each Behavioral Health – Administrative Service Organization (BH-ASO) in the state. Our goal was to understand BH-ASOs' current infrastructure and what they needed to support the collaboratives.

After HMA completed their assessment, HCA held additional meetings with key partners to discuss how to address the gaps identified in the assessment. We consulted with Frontier Behavioral Health, the State 911 Coordinator, Washington Council for Behavioral Health, and Crisis Connections.

Key findings from these conversations indicate:

- Many BH-ASOs estimate that establishing the collaboratives could take from three to 12 months, depending on the readiness of existing structures and partner engagement.
- Some BH-ASOs already host collaborative meetings, which could be adapted based on assessment guidance and other partner considerations.
- Including clinical providers in the collaboratives allows for integration of 988 (Suicide & Crisis Lifeline) into the wider behavioral health system.
- BH-ASOs could focus on the cross-system collaboration elements of their collaboratives to develop training across systems and communities. They could also develop more comprehensive best practices.
- Agricultural communities currently have a gap in resources and funding; however, they could utilize already-established workgroups and recommendations from partner agencies.
- 988-911 partnerships can leverage work from the Mental Health Crisis Call Diversion Initiative (MHCCDI).

- The collaboratives could employ a wide variety of strategies and methods to market to the public, including education on crisis response procedures and available resources.
- If collaboratives are implemented with our recommendations, the annual cost per region is $173,103.75.

In HCA's discussions, BH-ASOs recommended **they run their own regional collaboratives independently, with HCA supporting when needed.** If implemented properly, collaboratives can improve cross-training among providers, streamline system delivery, and ultimately enhance community support for individuals in crisis.

Training needs assessment

The Washington Behavioral Health Crisis Workforce and Resilience Training Collaboratives: Training Needs Assessment (**Appendix B**) outlines the current behavioral health crisis workforce, training requirements, existing gaps, crisis system provider mapping, and recommended next steps.

Findings and recommendations

Serving certain populations

BH-ASO feedback highlighted the need to evaluate knowledge and skill gaps among service providers on a regional basis. HMA found that some BH-ASOs lack best practices in serving specific populations, including:

- Veterans
- Intellectually and developmentally disabled populations (I/DD)
- Youth
- LGBTQ+ and BIPOC communities
- Agricultural populations
- American Indian and Alaska Native communities

Collaboratives should prioritize training for these populations, especially for service providers who are not mandated to take such training under current regulations.

BH-ASOs should also consider topics like implicit bias, working with interpreters, supporting unhoused individuals, and addressing cognitive impairments like dementia. Cross-system collaboration can enhance training efforts and involve partners like 911 and police departments to learn from consumer organizations and experts.

While resources for trauma-informed care, suicide protocols, and violence prevention are available, gaps persist in care for individuals with serious mental illness (SMI) and substance use disorders. Collaboratives should emphasize skill development in these areas, particularly for the 988 and 911 systems, as these populations frequently utilize crisis services.

BH-ASOs aim to identify overlaps in training requirements to reduce redundancy and training fatigue. The collaboratives provide a platform for integrating service providers in shared training sessions, even when not statutorily required.

Partners

BH-ASOs are currently collaborating with a range of partners, including community organizations, first responders, health care providers, and educational institutions. Looking forward, BH-ASOs can expand their partner networks to include correctional facilities, social services, and cultural organizations. The partners we consulted with for this report agree that infrastructure for existing BH-ASO collaborative meetings can be adapted to assessment guidance and other partner considerations.

Recommendations include:

- Creating a comprehensive inventory of current partners to identify gaps and opportunities for new collaborations.
- Reaching out to new partners with active engagement to broaden training reach and effectiveness.
- Engaging systems of care in the community by leveraging system partners with public trainings or to help identify other partners who are not currently known (i.e., social services or people who might encounter a person in crisis and benefit from training).
- Bringing in new partners to show them that they are being listened to, and that trainings provide value to their work. There is a large amount of interest to learn and collaborate across the behavioral health ecosystem. These collaboratives create an opportunity to carry this momentum and interest forward with careful, intentional planning. New relationships should be a focus.

988/911 considerations

BH-ASOs established initial connections with 911 systems to enhance crisis response. These interactions focus on providing crisis intervention training for emergency personnel and enhancing information sharing.

Opportunities for improvement include:

- Establishing protocols for resource sharing, such as training materials and access to crisis services.
- Implementing joint training initiatives that provide regular training sessions and include 911 personnel and BH-ASO/behavioral health agency staff.
- Establishing clear communication for feedback and further needs.

911 system partners note that mental health and suicide trainings have been provided for many years, and these trainings are currently sufficient for their staff. 911 staff need support with helping callers access behavioral health resources, such as differentiating between resources (e.g., purpose of a co-response team vs. Designated Crisis Responder) and understanding what organizations exist.

It is noted that calls to 211 can result in a dead-end to 911 because 211 operators aren't aware of those resources. Additionally, having updated region-specific outlines of resources, spearheaded by BH-ASOs, would be helpful.

MHCCDI aims to help people in crisis connect quickly and easily to trained 988 Lifeline counselors. To do this, 911 dispatchers will divert crisis calls made to 911 to 988 Lifeline crisis counselors. An MHCCDI pilot runs from January to December 2024, and includes warm transfer protocols for 911 telecommunicators. These protocols will help divert crisis calls made to 911 to helps improve the caller's experience and reduce the strain on emergency services, as well as help people in crisis connect quickly and easily to trained crisis counselors. The work from MHCCDI will shift toward a regional approach in 2025, providing an opportunity to leverage cross-system training.

Wider behavioral health landscape integration

Integrating clinical providers into collaboratives is vital for ensuring comprehensive care. This includes:

- Understanding clinical practice by engaging local psychiatrists, psychologists, and social workers and have them provide insights into effective crisis intervention strategies.
- Utilizing research-backed trainings that reflect best practices in clinical care. Hosting collaborative workshops allows clinical providers to share their expertise and experiences related to crisis interventions.

Clinical advisory groups made up of clinical providers may guide the development of some training content. Additionally, regional crisis system training for 988 Lifeline counselors could be provided and contracted to local behavioral health agencies and providers.

Best practices

BH-ASOs can strategize on best practice guidelines and tailor to specific populations, depending on their region's needs and what guidelines are lacking. Resource toolkits could be tailored for serving diverse populations. Additionally, focus groups could gather insights. HCA can also assist with creating these guides through the development of high risk guidelines. HCA's future high-risk guidelines may be utilized to inform these best practices.

Partners note that BH-ASOs carry out clinical trainings and licensing requirements effectively, but training across systems and communities is lacking. So, BH-ASOs could focus on the cross-system collaboration elements of their collaboratives. For example, one of the partners noted a BH-ASO coordinates well with lived-experience groups, whereas another BH-ASO may be lacking in engaging community members. This approach builds rapport and builds solutions that can be streamlined and make the behavioral health ecosystem more efficient.

One suggestion provided by a BH-ASO is to have an already-existing diversity, equity, and inclusion (DEI) officer engage partners in regions where DEI best practices are needed.

Agricultural community considerations

Rural agricultural communities face unique mental health challenges, including isolation and stress. BH-ASOs could focus on outreach programs and collaboration with agricultural organizations.

Recommendations include targeted outreach initiatives and incorporating agricultural workers/leaders in collaboratives to identify specific training needs and resources. With current suicide prevention and other initiatives within this population, any existing workgroups and recommendations that already exist from partner agencies could be utilized.

Additionally, there is an existing agricultural-specific stress helpline—AgriStress—and farm aid line that only operates during business hours and is based on resources available. There is also some funding for agri-safe training from the AgriSafe Network. There is a noted gap in resources and funding currently available to assist agricultural communities.

Community and public buy-in

Collaboratives have the potential to increase the public's understanding of how to access the crisis system by training community members; however, engagement relies on the public's understanding the

availability and utility of the collaboratives. Creating understanding of the collaboratives will increase public buy-in, and add to the value of collaboratives through the public's engagement.

We can achieve community and public buy-in by:

- Conducting public awareness campaigns via social media and flyers.
- Advertising at community events about available trainings.
- Offering workshops to educate the public on accessing the crisis system.
- Building new partnerships and integrating into current standing partnerships.
- Showing flexibility to drive engagement and offering training to answer community questions.

Also, ensuring trainings in the collaboratives are meeting their intended goals is paramount for community support. There are a wide variety of strategies and methods available to market to the public.

BH-ASOs indicated a need for educating the public around crisis response procedures (clarifying what to expect during a crisis intervention) and available resources (providing information on the range of services available to individuals in crisis, especially as the crisis system in Washington State evolves).

Partners share that educating the public on the 988 and wider behavioral health system remains a challenge. Efforts needs to continue here, even with the current media campaigns from the Department of Health. Crisis collaborative town halls could be a helpful, additional resource. Public service announcements (PSAs) and social media messaging proves effective, as seen by the increase in 988 calls.

Sustaining the collaboratives

To ensure the long-term sustainability of collaboratives, BH-ASOs need to focus on funding models and staff capacity. They should explore diverse funding sources, including grants and partnerships to support ongoing training, if needed. In addition, assessing staffing needs and capacity to coordinate training initiatives is significant to long-term sustainability.

The Washington Council for Behavioral Health noted gaps in system trainings and areas of duplication, as behavioral health professionals may have overlapping requirements (e.g., any additional training required in Washington Administrative Code (WAC) once starting on a mobile crisis team). With the turnover of staff in behavioral health agencies, there is a constant training cycle happening. This requires more resources and staff time.

Virtual and in-person collaboratives offer their own advantages and drawbacks. A hybrid collaborative could be an option. A traveling, statewide collaborative could also be possible, allowing various groups across the state to attend in person. In-person trainings may likely have more engagement and support more interaction among participants but would cost more and be a challenge for some to attend.

To avoid confusion, we must clarify the difference between collaboratives and regular system of care meetings. BH-ASOs should clearly distinguish their funding uses, what will be covered at such a meeting or collaborative, and meet all contractual requirements. We encourage BH-ASOs to leverage available resources and keep HCA informed about their strategies and needs.

Each BH-ASO should independently develop their collaboratives, incorporating feedback from partners on desired elements. Some partners highlighted the need to attract organizations outside the behavioral health system and support clinicians' self-care. Regions could conduct feedback sessions to effectively establish collaboratives and gather recommendations for engaging communities.

Funding needs

BH-ASOs shared numerous considerations for funding costs. These considerations are available below in the Budget considerations section.

Administrative costs are the most-burdensome resource needed. In-person sessions add costs as well. Several BH-ASOs discussed hiring an additional full-time equivalent (FTE) position to serve as a training coordinator or similar. Funding may be needed to procure trainers and training materials—including training for multiple regions or even statewide training—to lower costs. HCA could help with procurement of statewide trainings and/or the development of materials as well.

In addition to administrative costs, renewal funds are needed (e.g., to continue to receive funding to cover administrative costs). There are also costs associated with offering continuing education (CE) credits. A regular check in with HCA to monitor program progress and funds would be helpful,.

Timeline

The timeline for establishing each region's collaborative varies, based on current resources and partner engagement. Key insights from BH-ASOs include the initial set up and factors influencing the timeline. Many BH-ASOs estimate that it could take three to 12 months to fully establish the collaboratives, depending on the readiness of existing structures and partner engagement.

BH-ASOs may create a phased implementation plan, developing a timeline that outlines key milestones for establishing collaboratives over a 12-month period. BH-ASOs may also schedule regular check-in meetings with HCA to assess progress and adjust the timeline or tasks, based on issues or feedback that arise.

The collaboratives would be easy to establish, based on the structure of current meetings in each region. Timing of implementing the collaboratives depends on ample resources, funding, and partner and community interest. As regions clarify the specifics of what will be needed in their area, timelines can be more easily drawn out.

Budget considerations

HCA requested a cost estimate to determine needed resources for establishing and maintaining the collaboratives. After discussions with BH-ASOs, HCA drafted a preliminary list of expenses.

BH-ASOs proposed a recurring request for a new FTE position **in each region** to support the collaborative. FTEs could be split across various crisis work initiatives and projects (including regional protocols, crisis team endorsement, etc.) These FTEs would allow BH-ASOs to balance multiple initiatives and ease demand on existing staff, allowing them to focus on program operations and meeting mandates.

The following table outlines annual cost estimates **per region:**

Table 1: Annual costs per region

Expense per region	Annual cost per region
One FTE to provide oversight of operations of collaboratives and related crisis work projects within BH-ASOs.	$89,918 *Annual salary/rate estimate using Milliman information for comparison
New training procurement; marketing materials; training operation costs. Includes costs for: 1. A shared website 2. Webinar day-training expenses (hybrid) 3. Webinar day-training expenses (on-site) 4. Corporate training for 360 people annually and buffer costs for custom program materials, created collateral materials, unforeseeable expenses, etc. 5. Outreach and educational materials 6. Stipends and honorariums for meeting participants and volunteers, for anything over seven hours (per the Office of Financial Management (OFM) Lived Experience Compensation guide)	Low range to high range: 1. $5,000 to $6,000 2. $8,400 to $12,600 3. $4,200 to $6,300 4. $16,704 to $39,600 5. $2,000 to $2,400 6. $3,600 to $5,400
Travel expenses, which include costs for lodging, mileage, and meals as needed.	Low range to high range: $5,400 to $9,762
Supplies and materials for staff, which includes costs for program office supplies and consumables	$623.75 *No value range provided
Insurance, facility, and liability to provide facility or off-site liability coverage at 500 FTE per year	$500 *No value range provided
Total	Low range to high range: $136,345.75 to $173,103.75 (+$850 for one-time procurement of a laptop for one FTE)

These suggested per-region amounts help ensure adequate resources. After thoughtful initial calculations, these are the necessary amounts to operate the collaboratives as planned and with assessment recommendations. The total cost for all BH-ASOs and regions in Year 1 is $1,996,035.

Conclusion

There is general excitement over the possibility of collaboratives, with many BH-ASOs already having an infrastructure in place to build from. These collaboratives would be a central designated space for learning and collaboration, run according to the unique needs of each region.

Outside of the statute and rule requirements, there are numerous areas of concern and potential growth to enhance the crisis system. This is an avenue for any system partner to participate in trainings that would benefit them and the community but are not specifically required.

Participation in these voluntary collaboratives increases the confidence and competence of each system partner interacting with a community member in crisis. To incentivize participation, increasing and maintaining value with effective trainings is necessary. It is important to understand the needs and knowledge gaps of system partners before implementing a collaborative.

Establishing collaboratives presents a significant opportunity for BH-ASOs to enhance service delivery and strengthen partnerships across the behavioral health ecosystem. By leveraging existing structures, tailoring training content, and engaging community partners, BH-ASOs can create robust training programs that effectively address the diverse needs of providers and the communities they serve.

Through a collaborative and flexible approach, BH-ASOs can ensure these training initiatives increase the capacity and skills of service providers and foster a more integrated and responsive behavioral health system. Continued dialogue, resource allocation, and commitment to internal BH-ASO assessments will be crucial in this endeavor.

Establishing these collaboratives will directly benefit communities' well-being. Every person facing a crisis deserves a skilled and compassionate response from trained professionals. Collaboratives will ensure our service providers are well-equipped to deliver quality care and promote recovery and support for those in need.

Appendix A: List of questions for BH-ASOs

Below are the list of questions HCA asked each BH-ASO:

1. Who would you like involved in the regional collaboratives?
    a. Behavioral health providers
    b. Crisis workers
    c. Crisis contact centers
    d. First responders
    e. 911
    f. Co-response
    g. Recovery Navigators
    h. System of care partners
    i. Local governments and councils
    j. Others?
2. In your region is there already partnerships or meetings that can be leveraged to develop these collaboratives? Is there cross training in place?
3. How do we develop cross training amongst different providers with the goals of the collaboratives in mind?
4. How do you see the different trainings that will be developed being administered?
5. What resources do you need to get this started?
    a. Do you need Zoom licenses?
    b. Flyers or outreach?
    c. Administrative costs
6. What do you need to keep these going?
7. How do we bring in new partners?
8. How can we develop these to increase community buy in?
9. How long do you think it would take to stand these up and what barriers do you foresee?

Appendix B: Training needs assessment

View the **Washington Behavioral Health Crisis Workforce and Resilience Training Collaboratives: Training Needs Assessment**, prepared by HMA for the University of Washington Behavioral Health Institute.