Health Impact Review of SHB 1816
Concerning civilian-staffed crisis response teams
(2025 Legislative Session)

August 14, 2025

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WASHINGTON STATE BOARD OF HEALTH

HEALTH EQUITY
Governor's Interagency Council on Health Disparities

Full review
The full Health Impact Review report is available at:
https://sboh.wa.gov/sites/default/files/2025-08/HIR-2025-08-SHB1816.pdf

Acknowledgements
We would like to thank the key informants who provided consultation and technical support during this Health Impact Review.

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SHB 1816, Concerning civilian-staffed crisis response teams
(2025 Legislative Session)

Evidence indicates that SHB 1816 may increase lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems. It is unclear how provisions may impact certain political subdivisions' actions. Based on these findings, the pathway to health impacts could not be completed.

BILL INFORMATION

Sponsors: House Technology, Economic Development, & Veterans (originally sponsored by Representatives Scott, Parshley, Farivar, Dufault, Fitzgibbon, Davis, Goodman, Obras, Taylor, Pollet, Nance, Ryu, Hill, and Cortes)

Summary of Bill:

- Allows a political subdivision with a population larger than 200,000 to establish and maintain a civilian-staffed crisis response team (CRT)[a] operating outside of a general authority Washington State law enforcement agency.
- Requires the executive head of eligible political subdivisions to 1) set minimum qualifications for the CRT and 2) develop the CRT's operations protocols in consultation with certain entities.
- Allows the executive head of the political subdivision to determine characteristics of the crisis response team.
- Establishes CRT minimum training qualifications.
- Establishes CRT as a third 911 first responder whose scope of responsibilities is separate from law enforcement and fire response, and whose wages, hours, and other working conditions shall be subject to public employees' collective bargaining (Chapter 41.56 RCW).
- Creates a public records exemption for personal information regarding people receiving public safety or health services from a non-law enforcement agency.

HEALTH IMPACT REVIEW

Summary of Findings:
This Health Impact Review found the following evidence for SHB 1816:

[a] Key informants stated, "crisis response" and "alternative response" are used to describe similar bodies of work (personal communication, BHCORE, July 2025). In the field, "crisis response" often indicates work being completed by a behavioral health organization, and "alternative response" often indicates work being completed by government or a non-profit organization (personal communication, BHCORE, July 2025). For this HIR, "crisis response team (CRT)" is used to describe teams which may be authorized under SHB 1816. "Alternative response" and "alternative response models" are used to describe existing models of crisis response efforts currently underway in Washington State which may or may not be subject to the provisions of SHB 1816.

- **Informed assumption** that 1) allowing certain political subdivisions to establish and maintain a CRT operating outside of general authority Washington State law enforcement, 2) authorizing a CRT to serve as a primary response to 911 calls or initiate a field response under certain circumstances, and 3) establishing CRTs as a third 911 first responder with certain scope of responsibilities and public employee collective bargaining rights may lead to increased lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems.
- **Unclear evidence** how increased lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems may impact certain political subdivisions' actions.

Introduction and Methods

A Health Impact Review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington State (RCW 43.20.285). For the purpose of this review "health disparities" have been defined as differences in disease, death, and other adverse health conditions that exist between populations (RCW 43.20.025). Differences in health conditions are not intrinsic to a population; rather, inequities are related to social drivers or determinants (access to healthcare, economic stability, racism, etc.). This document provides summaries of the evidence analyzed by State Board of Health's Health Impact Review staff during the Health Impact Review of Substitute House Bill 1816 (SHB 1816).

Health Impact Review staff analyzed the content of SHB 1816 and created a logic model visually depicting the pathway between bill provisions, social determinants, and health outcomes and equity. The logic model reflects the pathway with the greatest amount and strongest quality of evidence. The logic model is presented both in text and through a flowchart (Figure 1).

We conducted an objective review of published literature for each step in the logic model pathway using databases including PubMed, Google Scholar, and University of Washington Libraries. The annotated references are only a representation of the evidence and provide examples of current research. In some cases, only a few review articles or meta-analyses are referenced. One article may cite or provide analysis of dozens of other articles. Therefore, the number of references included in the bibliography does not necessarily reflect the strength-of-evidence. In addition, some articles provide evidence for more than one research question and are referenced multiple times.

We consulted with people who have content and context expertise about the provisions and potential impacts of the bill. The primary intent of key informant interviews is to ensure staff interpret the bill correctly, accurately portray the pathway to health and equity, and understand different viewpoints, challenges, and impacts of the bill. For this Health Impact Review, we spoke with 31 key informant interviewees, including: 16 state agency staff with expertise in emergency and crisis response systems and health coverage; 8 people who currently implement alternative response models; 4 staff from labor and first responder advocacy organizations; 2 people who conduct research and provide technical assistance on alternative response models; and 1 medical program director. More information about key informants and detailed methods is available upon request.

We evaluated evidence using set criteria and determined a strength-of-evidence for each step in the pathway. The logic model includes information on the strength-of-evidence. The strength-of-evidence ratings are summarized as:

- **Very strong evidence:** There is a very large body of robust, published evidence and some qualitative primary research with all or almost all evidence supporting the association. There is consensus between all data sources and types, indicating that the premise is well accepted by the scientific community.
- **Strong evidence:** There is a large body of published evidence and some qualitative primary research with the majority of evidence supporting the association, though some sources may

have less robust study design or execution. There is consensus between data sources and types.

- **A fair amount of evidence:** There is some published evidence and some qualitative primary research with the majority of evidence supporting the association. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.
- **Expert opinion:** There is limited or no published evidence; however, rigorous qualitative primary research is available supporting the association, with an attempt to include viewpoints from multiple types of informants. There is consensus among the majority of informants.
- **Informed assumption:** There is limited or no published evidence; however, some qualitative primary research is available. Rigorous qualitative primary research was not possible due to time or other constraints. There is consensus among the majority of informants.
- **No association:** There is some published evidence and some qualitative primary research with the majority of evidence supporting no association or no relationship. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.
- **Not well researched:** There is limited or no published evidence and limited or no qualitative primary research and the body of evidence was primarily descriptive in nature and unable to assess association or has inconsistent or mixed findings, with some supporting the association, some disagreeing, and some finding no connection. There is a lack of consensus between data sources and types.
- **Unclear:** There is a lack of consensus between data sources and types, and the directionality of the association is ambiguous due to potential unintended consequences or other variables.

This review was requested when the Legislature was not in session and was therefore not subject to the 10-day turnaround required by law. This review was subject to time constraints, which influenced the scope of work for this review.

Analysis of SHB 1816 and the Scientific Evidence

Summary of relevant background information

Crisis response

- Structural and systemic determinants of health such as access to housing and preventive and behavioral healthcare are at the root of many emergency calls for service.[1] Living without housing or access to healthcare puts people at risk of worsening behavioral health conditions, which can lead to 911 calls, visits to the emergency room, or pathways to incarceration.[1]
- In an analysis of 911 data across 9 U.S. cities, including Seattle, WA, less than 3% of 911 calls were for a situation involving a violent crime.[2] The most common 911 call types were business checks, disturbances, suspicious persons, and complaints.[2]
- Once a 911 call is made, there are many possible responses that may occur. For example, depending on the situation, law enforcement, fire, emergency medical services (EMS), or other first responders may be directed (i.e., dispatched) to a location to respond to a 911 call.
    - Key informants shared concerns related to law enforcement response to 911 calls that involve communities of color and people with mental and behavioral health needs (personal communications, June 2025).
        - There is a large body of research showing equity concerns related to the ways law enforcement interacts with people of color.[3-5] For example, "multiple studies have consistently shown that racial/ethnic minorities, particularly Black people and Hispanic people, are more likely to be subjected to more intense law enforcement practices than [w]hite people."[3] Further, Black people are more than 3 times more likely and Indigenous people are twice as likely to be killed by law enforcement than white people.[6]
        - The involvement of law enforcement in behavioral health calls for service can result in law enforcement use of force and leads to the over-representation of people with mental illness in the U.S. criminal legal system.[7] Data from 2014-2015 showed that 20% of fatal law enforcement shooting victims may have been experiencing a mental health crisis at the time of their death.[8] Data also show people with untreated mental health needs are 16 times more likely to be killed by law enforcement than those without.[6]
        - In a study of shootings by law enforcement that resulted in injury, "injuries associated with physically threatening or threat-making behaviors, behavioral health needs, and well-being checks were most frequently fatal."[9]

- The overall goal of alternative response models[b] is to divert people in crisis away from the criminal legal system and emergency system and into services and programs that will better address the root causes of their needs.[1] A wide range of alternative response programs have been implemented across the U.S. since at least 1988.[10]
- Some community-based prevention program models begin at early intervention points and may include outreach, referral, logistical assistance, direct transport, etc.[1] Other models may include interactions with law enforcement and first response systems and may include dispatchers trained in crisis intervention, de-escalation, clinician assessments, referral, direct transport, case management, etc.[1]
- Key informants stated the creation and expansion of alternative response models increased across the U.S. following changes in public opinion on the appropriateness of law enforcement response, particularly following the murder of George Floyd and the Black Lives Matter movement (personal communications, June 2025).
- Washington State has a wide range of types and availability of alternative response models (i.e., co-response, Mobile Rapid Response Crisis Teams [MRRCT], Community-based Crisis Teams [CBCT], Alternative Response Teams [ART], Designated Crisis Responders [DCRs], mobile integrated health, and community paramedicine).
    - RCW 71.24.025 establishes that in Washington State, MRRCTs provide professional, on-site, community-based intervention such as outreach, de-escalation, stabilization, resource connection, and follow-up support for people experiencing a behavioral health crisis. These teams include certified peer counselors and must meet standards for response times established by the Washington State Health Care Authority (HCA). CBCTs provide the same level of care and intervention strategies as MRRCTs, but personnel may also be part of an EMS agency, a fire service agency, a public health agency, a medical facility, a nonprofit crisis response provider, or a city or county government entity, other than a law enforcement agency.[11] MRRCT staff are credentialed staff who provide services under a licensed behavioral health agency (personal communication, HCA, June 2025). MRRCTs and CBCTs are coordinated under the authority of behavioral health administrative services organizations (BH-ASOs) (RCW 71.24.025) and HCA (personal communications, HCA, June 2025).
        - In 2025, SHB 1811 (Chapter 346, Laws of 2025) amended RCW 71.24.025 to add:
            - The definition of "co-response" as follows: a multidisciplinary partnership between first responders and human services professionals that responds to emergency situations involving

[b] Key informants stated, "crisis response" and "alternative response" are used to describe similar bodies of work (personal communication, BHCORE, July 2025). In the field, "crisis response" often indicates work being completed by a behavioral health organization, and "alternative response" often indicates work being completed by government or a non-profit organization (personal communication, BHCORE, July 2025). For this HIR, "crisis response team (CRT)" is used to describe teams which may be authorized under SHB 1816. "Alternative response" and "alternative response models" are used to describe existing models of crisis response efforts currently underway in Washington State which may or may not be subject to the provisions of SHB 1816.

behavioral health crises and people experiencing complex medical needs. Participants in co-response respond to in-progress 911 calls, 988 calls (i.e., Suicide and Crisis Lifeline), and requests for service from dispatch and other first responders. Co-response teams include first responders such as public safety telecommunicators, law enforcement officers, firefighters, emergency medical technicians (EMTs), paramedics, and human services professionals such as social workers, behavioral health clinicians, advanced practice registered nurses, registered nurses, community health workers, and peer support specialists.[12]

- That people engaged in co-response services are considered a "first responder."[12]
- That a Regional Crisis Line (RCL) (i.e., a local county behavioral health call line operated by a BH-ASO) may not dispatch law enforcement.[12]

▪ RCW 71.24.903 requires HCA to establish standards and outlines certain requirements for issuing an endorsement (voluntary credential that signifies capacity to respond to people who are experiencing a significant behavioral health emergency requiring an urgent, in-person response) to any MRRCT or CBCT. It also establishes an endorsed MRRCT and CBCT performance program.

- Endorsed teams meet standards for staffing, training, and transportation as outlined in WAC 182-140 (personal communication, HCA, July 2025).
- An endorsed CBCT is required to have behavioral health staff and must either be a licensed behavioral health agency or contract with a licensed behavioral health agency for the behavioral health staff on the team (personal communication, HCA, July 2025). Only teams that meet the legal definition of a CBCT and are endorsed by HCA are considered to be part of Washington State's behavioral health crisis response system (personal communication, July 2025).

o RCW 35.21.930 allows any fire department to develop a Community Assistance Referral and Education Services (CARES)[c] program to improve population health and advance injury and illness prevention within its community. CARES is an example of co-response. State law directs CARES programs to identify members of the community who use the 911 system or emergency department (ED) for nonemergency or nonurgent assistance calls and connect them to their primary

[c] Washington State law authorizes any fire department to develop a Community Assistance Referral and Education Services (CARES) program. These programs differ from the City of Seattle's Community Assisted Response and Engagement (Seattle CARE) Department. For clarity, this Health Impact Review will use CARES when referring to co-response programs embedded in a fire department and Seattle CARE when discussing the City of Seattle's program.

care provider, other healthcare professionals, low-cost medication programs, and other social services. Many fire departments within Washington State operate a CARES program (personal communications, June 2025).

- ART builds co-responder models into existing first response and diversion programs.[13] HCA contracts with the Association of Washington Cities and Whatcom County to implement the ART model through contract subrecipients.[13] ART staff include behavioral health providers, medical professionals, and social service specialists, in addition to or instead of first responders, who provide support to connect people to behavioral health services and other needed resources.[13]
- RCW 71.05.020 defines a DCR as a mental health professional appointed by the county, by an entity appointed by the county, or by HCA in consultation with a Tribe or after meeting and conferring with an Indian healthcare provider, to perform certain behavioral health duties. DCRs determine if people present a harm to self/others/property, or are gravely disabled and at imminent risk, or if there is a nonemergent risk due to a substance use disorder or mental disorder, or is in need of assisted outpatient behavioral health treatment.[14]
- RCW 71.24.432 requires that BH-ASOs (RCW 71.24.025), contracted with HCA, establish coordination within the behavioral health crisis response system in each regional service area including, but not limited to, establishing comprehensive protocols for dispatching MRRCTs and CBCTs. Approved regional protocols are required to be in writing and provided to the Washington State Department of Health (DOH), HCA, and the state 911 coordination office.
- Some fire departments and districts in Washington State provide Mobile Integrated Health, which works with social workers and nurses to provide additional care to patients who call 911 (personal communication, Washington State Council of Fire Fighters [WSCFF], June 2025).
- Community paramedicine is "a healthcare model that allows paramedics and EMTs to operate in expanded roles by assisting with public health and primary healthcare and preventive services to underserved populations in the community.[15] The goals are to improve access to care and to avoid duplicating existing services."[15] Key informants stated most counties in Washington State with at least one professional fire department have a community paramedicine program (personal communication, WSCFF, July 2025). Some programs provide county-wide services, while rural area programs may have less comprehensive coverage (personal communication, WSCFF, July 2025).
    - The Office of the Washington State Auditor (SAO) is working on a performance audit related to "Reducing Nonemergency Use of Emergency Systems."[16] The audit will examine actions taken by local governments in Washington State to establish and maintain community paramedicine and mobile integrated health programs.[16] The audit findings will be available in late September 2025 (personal communication, SAO, July 2025).

- In October 2023, Seattle's Mayor established the Community Assisted Response and Engagement (Seattle CARE) Department as the city's third branch of public safety to complement the Seattle Fire Department (SFD) and Seattle Police Department (SPD).[17] Seattle CARE's goals are to: 1) improve public safety, 2) unify and align services, and 3) diversify responses to 911 calls.[10] Seattle CARE employs nonlaw enforcement civilian community crisis responders who provide a fully non-policing response to behavioral health crises.[10]

911 System

- The Washington State Military Department (MIL) provides coordination, training, and fiscal support "to ensure the seamless operation of the statewide 911 communications system" in Washington State (personal communications, MIL, June 2025).[18]
    - All Washington State counties are required to have a 911 coordinator responsible for coordinating 911 response in their county (personal communications, MIL, June 2025).
    - MIL organizes the Washington State Enhanced 911 Advisory Committee (911 Advisory Committee) (RCW 38.52.531). The 911 Advisory Committee is responsible for advising and assisting the state 911 coordinator in coordinating and facilitating the implementation and operation of 911 throughout the state.[19,20] The 911 Advisory Committee also sets the strategic direction for the 911 system.[19]
- Responding to 911 calls and dispatching resources is managed by 78 Public Safety Answering Points (PSAPs), also referred to as 911 Centers or Emergency Communication Centers,[d] that serve Washington State's 39 counties and the Washington State Patrol (personal communications, MIL, June 2025).[18,21] All PSAPs are responsible for collecting information received on 911 calls and appropriately dispatching law enforcement, fire response, and EMS to the field (personal communications, MIL, June 2025). Each PSAP operates independently, with varied operations and access to technology (personal communication, MIL, June 2025).
    - There are typically 3 call lines that connect directly to a PSAP: 911, a 10-digit nonemergency line, and an administrative line used by staff and first responders (personal communications, MIL, June 2025).
- Public Safety Telecommunicators work for a PSAP and may be responsible for: 1) answering 911 calls and collecting information; 2) dispatching responders to the field; or 3) both (personal communication, MIL, June 2025).[22] Public Safety Telecommunicators have a "critical role and responsibility […] in the delivery of life safety services as a first responder."[20]
    - MIL is responsible for operating the 911 Telecommunicator Training Program, which offers training and continuing education related to a range of topics, including: "effective crisis communications, Next Generation 911 and location

[d] Public Safety Answering Points (PSAPs) are also referred to as 911 Centers, Emergency Communication Centers, or Dispatch Centers (personal communication, MIL, June 2025).[42] This Health Impact Review will use "PSAPs" to refer to the 78 centers in Washington State.

technologies, call processing and dispatching procedures, stress management, overcoming communication barriers" and additional topics.[22]
    - Effective January 1, 2025, in response to SB 5555 (Chapter 286, Laws of 2022) which established telecommunicators as first responders, MIL launched a statewide certification training program (personal communications, MIL, June 2025). All new telecommunicators are required to complete an approved training program, which includes certain basic training courses and at least training in 1 of the following: 1) receiving and processing 911 calls or 2) dispatching first responders (personal communications, MIL, June 2025). The program includes a legacy certification for staff who were telecommunicators prior to January 2025 (personal communications, MIL, June 2025). All telecommunicators are required to recertify their certification (personal communications, MIL, June 2025). Key informants stated staff are generally certified in both options, and many PSAPs require training in all areas (personal communications, MIL, June 2025). Training is conducted by MIL or by some larger response agencies that have been approved by the state to conduct their own training (personal communication, MIL, June 2025).

Other crisis call lines

- Outside of 911, there are multiple crisis line numbers across Washington State. Implementation of a more centralized approach to the crisis call system is underway (personal communications, June 2025).
- In 2020, the Federal Communications Commission (FCC) adopted the National Suicide Hotline Designation Act, which made 988 the new, nationwide number for anyone experiencing a mental health crisis.[23]
    - In 2021, the Washington State Legislature passed the Crisis Call Center Hubs and Crisis Services Act to support the state's implementation of the 988 Suicide & Crisis Lifeline (988) and enhance and expand behavioral health crisis response and suicide prevention services for Washingtonians.[23] Subsequent legislation passed in 2023-2025 has expanded implementation.[24]

- Washington's 988 Suicide & Crisis Lifeline launched in July 2022.
    - Washington State has three 988 Lifeline crisis centers (Crisis Connection, Frontier Behavioral Health, and Volunteer America) that answer calls, texts, and chats from around the state.[23]
    - Calls made from phones serviced by 3 wireless carriers (T-Mobile, Verizon, and AT&T) are georouted to a 988 Lifeline crisis center based on the caller's general geographic location.[23] Smaller carriers are currently routed by area code.[23]
    - The 988 Lifeline has 3 specialized lines. Each specialized line can be reached by calling, texting, or chatting 988 and selecting the identified option:
        - Veterans Crisis Line serving Veterans, service members, and those who support them.
        - Spanish Language Line
        - Native and Strong Lifeline serving American Indian and Alaska Native people. Calls are answered by Native crisis counselors who are Tribal members and descendants closely tied to their communities.[23]

    - The 988 Lifeline historically had 4 specialized lines, with a LGBTQI+ Youth Subnetwork Line serving lesbian gay, bisexual, transgender, queer or questioning, intersex, asexual, and two-spirit (LGBTQIA2S+) teens and young adults ages 13 through 24 years.[23] Beginning July 17, 2025, the line for LGBTQI+ youth is no longer available due to federal policy and budget decisions.[25]
    - In addition to specialized lines, 988 Lifeline offers interpretation services in more than 240 languages and dialects by calling and saying the name of the language needed.[23] Support in American Sign Language (ASL) can be accessed by visiting the 988 Lifeline website (www.988lifeline.org) and clicking the "For Deaf & Hard of Hearing" link and choosing "ASL Now." [23]
    - RCLs dispatch MRRCTs and CBCTs directly to behavioral health crises (personal communication, HCA, June 2025). Washington's 988 call system also supports dispatch by providing a warm transfer to the appropriate RCL (personal communication, August 2025).
    - The 988 Lifeline crisis centers connect with 911 services and regional crisis services.[26]
    - Guidelines established by Substance Abuse and Mental Health Services Administration (SAMHSA) dictate which types of 988 calls should be transferred to 911.[27]
    - Washington State has ongoing pilot projects where a 988 line is directly connected to a PSAP, and 911 dispatch can transfer certain calls to a 988 clinician (personal communication, MIL, June 2025).
- DOH collaborated with the 988 Lifeline crisis centers and 3 PSAPs to pilot the Mental Health Crisis Call Diversion Initiative.[23]
    - The Initiative's main goals were to: 1) help people in crisis to connect quickly and easily to trained crisis counselors and 2) divert crisis calls made to 911 to help improve the caller's experience and reduce the strain on emergency services.[23]
    - One component of the Initiative is the development of protocols to transfer mental health-related calls received by 911 to 988 when emergency services are not needed.[28] The protocols will be adapted regionally for use by all PSAPs.[28]
    - DOH expects to release its report on 911 to 988 diversion efforts in September 2025 (personal communication, DOH, June 2025).
- There are also 10 RCLs in Washington State available to request assistance for behavioral health crises.[29]
- Some jurisdictions also have a nurse navigation line, where calls to 911 deemed a nonemergency are transferred to a nurse navigator who determines the best treatment path and access to care (personal communications, June 2025).

Additional Washington State laws

- A general authority law enforcement agency is any agency, department, or division of local or state government whose primary function is to detect and apprehend persons committing infractions, violating traffic laws, or violating criminal laws.[30] The Washington State Patrol and the Washington Department of Fish and Wildlife are general

authority law enforcement agencies.[30] General authority peace officers who meet certification requirements may enforce traffic or criminal laws under certain circumstances.[30]

- RCW 38.52.010 defines:
  - "Political subdivision" as any county, city, or town.
  - "Executive head" as the county executive in those charter counties with an elective office of county executive, however designated, and, in the case of other counties, the county legislative authority. In the case of cities and towns, it means the mayor in those cities and towns with mayor-council or commission forms of government, where the mayor is directly elected, and it means the city manager in those cities and towns with council manager forms of government. Cities and towns may also designate an executive head for the purposes of this chapter by ordinance.
- Under the Public Employees' Collective Bargaining Act (RCW 41.56), local governments and certain other public employees, including uniformed personnel and the Washington State Patrol, have the right to organize and designate collective bargaining representatives to bargain their wages, hours, and working conditions.[30]
- In 2024, the Washington State Legislature directed the Washington State Institute for Public Policy (WSIPP) to study EMS trends over time and by county in the state, including the number and types of EMS available, the volume of 911 responses, and the volume of interfacility transports provided by EMS organizations.[31] The report is due to the legislature and DOH by June 1, 2026.[31]

Other jurisdictions

- In 1988, the Memphis Police Department in Tennessee partnered with the City's Chapter of the National Alliance on Mental Illness (NAMI), mental health providers, and 2 local universities to organize, train, and implement the first Crisis Intervention Team (CIT) program.[32] The specialized team was developed to offer "a more intelligent, understandable, and safe approach to mental crisis events."[32] CIT officers participate in "specialized training under the instructional supervision of mental health providers, family advocates, and mental health consumer groups."[32]
- In 1989, one of the earliest Mobile Crisis Response (MCR) programs was established in Eugene, Oregon.[33] The Crisis Assistance Helping Out On The Streets (CAHOOTS) community responder program is a police-contracted provider.[34] Services are provided through the White Bird Clinic, a Federally-Qualified Health Center as a nonprofit mental health and crisis services partner.[34] Since 2020, the White Bird Clinic's consultant team has assisted multiple jurisdictions across the U.S. interested in developing their own MCR models.[33]
  - CAHOOTS' services are dispatched through a local non-emergency contact number.[35] Services include trauma-informed de-escalation, welfare checks, crisis counseling, suicide prevention and intervention, housing crisis assistance, and first aid and non-emergency medical care.[35]
  - CAHOOTS previously served both the cities of Eugene and Springfield, Oregon. As of April 7, 2025, CAHOOTS services are no longer available in Eugene.[35]

- The Council of State Governments' Justice Center published "Expanding First Response: A Toolkit for Community Responder Programs" which serves as a central hub for local communities and states looking to establish or strengthen community responder programs.[36] The toolkit provides an overview of the issue, considerations for implementation, and essential resources (e.g., strategies, field-based examples, instructive videos).[37]
- Other cities that have established MCR programs include, but are not limited to, Albuquerque, NM; Atlanta, GA; Austin, TX; Baltimore, MD; Corvalis and Portland, OR; Dayton, OH; Denver, CO; Durham, NC; New York, NY; San Francisco, CA; and Olympia[38] and Seattle, WA.[39]
- On February 5, 2024, an individual person and Disability Rights Oregon filed a lawsuit, *Disability Rights Oregon v. Washington County et al.,* No. 3:24-cv-00235, which challenges Washington County, Oregon's practice of dispatching armed law enforcement officers, rather than qualified mental health professionals, as first responders to mental health emergencies.[40]

Summary of SHB 1816

- Allows a political subdivision with a population larger than 200,000 to establish and maintain a civilian-staffed crisis response team (CRT) operating outside of a general authority Washington State law enforcement agency.
    - Authorizes a CRT to serve as a primary response to 911 calls or initiate a field response when there is no report or observation of active or imminent violence or possession of weapons and when:
        - A person in crisis does not request law enforcement;
        - A person appears to need or is reported to need a safety and welfare check; or,
        - A person requests resources including, but not limited to, shelter, food, or transportation.
    - Allows a CRT to serve as a secondary response in support of a law enforcement response as determined by the executive head of the political subdivision for all additional 911 calls.
- Requires the executive head of eligible political subdivisions to 1) set minimum qualifications for the CRT, and 2) develop the CRT's services provided, qualifications, training, types of calls where primary 911 dispatch is appropriate, deployable areas, and hours of operation in consultation with any of the following that are active within that particular jurisdiction: HCA, the BH-ASO serving the political subdivision's jurisdiction, the operators of mobile crisis teams administered by the BH-ASO, or the 988 call center hub for the region.
- Allows the executive head of the political subdivision to determine characteristics of the crisis response team, including the department in which the CRT is situated and the number of staff assigned to the CRT.
- Establishes CRT minimum training qualifications.

- Establishes CRT as a third 911 first responder whose scope of responsibilities is separate from law enforcement and fire response, and whose wages, hours, and other working conditions shall be subject to public employees' collective bargaining (Chapter 41.56 RCW).
- Creates a public records exemption for personal information regarding people receiving public safety or health services from a non-law enforcement agency.

Health impact of SHB 1816
Evidence indicates that SHB 1816 may increase lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems. It is unclear how provisions may impact certain political subdivisions' actions. Based on these findings, the pathway to health impacts could not be completed.

Pathway to health impacts
The potential pathway leading from provisions of SHB 1816 to health and equity are depicted in Figure 1. We have made the informed assumption that 1) allowing certain political subdivisions to establish and maintain a CRT operating outside of general authority Washington State law enforcement, 2) authorizing a CRT to serve as a primary response to 911 calls or initiate a field response under certain circumstances, and 3) establishing CRTs as a third 911 first responder with certain scope of responsibilities and public employee collective bargaining rights may lead to increased lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems. This informed assumption is based on information from key informants. It is unclear how increased lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems may impact certain political subdivisions' actions. Based on these findings, the pathway to health impacts could not be completed.

Scope
Due to time limitations, we only researched the most linear connections between provisions of the proposal and health and equity and did not explore the evidence for all possible pathways. For example, we did not evaluate potential impacts related to:

- The effectiveness of alternative response models. There are many models of alternative response in operation across the U.S. and across Washington State. Key informants stated research on alternative response models may not be generalizable to all models in operation in Washington State (personal communications, June-July 2025). This Health Impact Review did not analyze research evaluating outcomes of various alternative response models. See Summaries of Findings for additional discussion.
- Cost to local governments to create and maintain a CRT. In the local government fiscal note for SHB 1816, Washington State Department of Commerce (Commerce) stated that it is not possible to estimate the number of people who may be hired for each CRT or the staff positions that would make-up the CRT.[21] The Association of Washington Cities estimated:

> [G]eneral costs are around $100,000 to $125,000 (including salary and benefits) to hire a mental health professional or social worker to serve as a co-responder or

> crisis responder. However, because the number and type of responders that a local government may hire are unknown, the potential cost impacts to local governments that choose to establish CRTs are indeterminate.[21]

This Health Impact Review did not evaluate potential costs or budget impacts to cities and counties that choose to create and maintain a CRT.

- Political subdivisions with populations up to 200,000. It is unclear whether SHB 1816 may be interpreted to mean that political subdivisions with populations up to 200,000 may be prohibited from establishing and/or maintaining a CRT. Key informants did not offer information on this interpretation, and it is not possible to predict how this interpretation may affect bill implementation. Therefore, this Health Impact Review did not analyze how political subdivisions with populations up to 200,000 may be impacted by the bill.
- Public records exemption rights. SHB 1816 creates a public records exemption for personal information for people receiving public safety or health services from a non-law enforcement agency. Key informants stated this provision is particularly important, since alternative response models may operate under government entities that cannot guarantee privacy (personal communication, Behavioral Health Crisis Outreach Response and Education [BHCORE], July 2025). This Health Impact Review did not analyze how provisions related to public records exemptions may impact people receiving services from a non-law enforcement agency.
- State agency rulemaking, policy, or guidance. Key informants from multiple Washington State agencies stated that SHB 1816 would not require any state agency to change current operations, alter policy or guidance, or conduct rulemaking (personal communications, June 2025). Therefore, this Health Impact Review did not evaluate how implementation of SHB 1816 may impact Washington State agency rules or policies.

Magnitude of impact

SHB 1816 has the potential to impact political subdivisions with a population larger than 200,000 as well as the 911 system, existing alternative response models, first responders, and people who may use 911 response services within these political subdivisions.

Political subdivisions

SHB 1816 would allow a political subdivision with a population larger than 200,000 to establish and maintain a CRT. RCW 38.52.010 defines "political subdivision" as any county, city, or town. Based on April 2025 population data from the Office of Financial Management (OFM), 4 cities (Seattle, Spokane, Tacoma, and Vancouver) and 10 counties (Benton, Clark, King, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima counties) have populations larger than 200,000 and would be eligible to create and maintain a CRT based on provisions of SHB 1816.[21,41] RCW 35.02.010 establishes that towns have a population of less than 1,500 at the time of its organization. No towns meet the population threshold detailed in SHB 1816. Since the bill would not require cities and counties to create and maintain a CRT, it is not possible to predict which cities and counties may choose to establish a CRT if SHB 1816 were to pass.[21]

911 System

Responding to 911 calls and dispatching resources is managed by 78 PSAPs, also referred to as 911 Centers or Emergency Communication Centers, that serve Washington State's 39 counties (personal communications, MIL, June 2025).[18,21] All PSAPs are responsible for collecting information received on 911 calls and appropriately dispatching law enforcement, fire response, and EMS to the field (personal communications, MIL, June 2025).

The majority (49) of PSAPs are considered primary PSAPs and directly receive calls when someone in Washington State dials 911 (personal communications, MIL, June 2025). Primary PSAPs may serve more than 1 law enforcement or fire agency (personal communication, MIL, June 2025). When a primary PSAP receives a 911 call, staff may either directly dispatch responders to the field or route calls to a secondary PSAP (personal communications, MIL, June 2025). The remaining 29 PSAPs are secondary PSAPs and typically serve 1 law enforcement or fire agency. Secondary PSAPs receive calls routed from primary PSAPs and dispatch resources to the field (personal communication, MIL, June 2025). There are 40 PSAPs that serve the 4 cities and 10 counties that have populations larger than 200,000 and would be eligible to create and maintain a CRT based on provisions of SHB 1816 (personal communication, MIL, August 2025).

Each law enforcement and fire agency must use a designated 911 call center (personal communications, MIL, June 2025). Most counties in Washington State have 1 large PSAP that provides call and dispatch services to several law enforcement and fire agencies (personal communications, MIL, June 2025). Some agencies have their own call center, with in-house telecommunicator staff and technology (personal communications, MIL, June 2025). For example, King County has a 911 Coordinating Office that serves as a coordination point for 10 primary and 1 secondary PSAPs.[42] Among PSAPs serving King County, the Seattle CARE PSAP serves the City of Seattle and is responsible for dispatching SPD and the Community Crisis Responder Team.[17] The SFD Fire Alarm Center operates as a secondary PSAP and handles all requests for fire response and EMS in Seattle.[17] In contrast, for example, Adams County has 1 PSAP that routes calls to secondary PSAPs (e.g., Othello Police Department) (personal communication, MIL, June 2025).

All Washington State counties are also required to have a 911 coordinator responsible for coordinating 911 response in their county (personal communications, MIL, June 2025). Washington State Patrol also has a 911 coordinator, resulting in 40 coordinators statewide (personal communications, MIL, June 2025). In most counties, the 911 coordinator works at and may be the executive or deputy director of a PSAP (personal communications, MIL, June 2025).

Public Safety Telecommunicators work for a PSAP and may be responsible for: 1) answering 911 calls and collecting information; 2) dispatching responders to the field; or 3) both (personal communication, MIL, June 2025).[22] U.S. Bureau of Labor Statistics data from 2024 show there were approximately 2,580 telecommunicators working in Washington State.[43]

988 System

Washington State data from the month of March 2025 showed that there were 9,700 calls connected to a counselor at a local 988 center, where the average time to answer the call was

20.2 seconds, and the average talk time was 13.5 minutes.[28] Data from the same time period show there were 2,992 texts/chats connected to a 988 counselor with an average time to answer of 7 seconds, and an average talk time of 37.9 minutes.[28] The 988 Lifeline crisis centers can connect with 911 services and regional crisis services.[26] Data show that 98% of 988 calls are handled without involving emergency services.[28]

There are 8 BH-ASOs in Washington State across 10 regions: Greater Columbia, King, North Sound, Carelon Behavioral Health – Pierce, Spokane, Thurston-Mason, Salish, Great Rivers, Carelon Behavioral Health – Southwest, and Carelon Behavioral Health – North Central.[44] There are 57 MRRCTs in Washington State, where 18 teams serve only youth (personal communication, HCA, July 2025). MRRCT team sizes vary greatly (i.e., 112 FTE in King County, 47 FTE in Spokane County, and 1 FTE in Garfield County) (personal communication, HCA, July 2025). All 10 regions have at least 1 youth team and 1 adult team (personal communication, HCA, July 2025). HCA is in the process of endorsing their first CBCT, and there are no known teams identifying themselves as CBCTs outside of the endorsement program (personal communication, July 2025).

First Responders

First responders who may be impacted by the passage of SHB 1816 are law enforcement, fire, and EMS personnel. U.S. Bureau of Labor Statistics data from 2024 show there were approximately 11,070 commissioned law enforcement officers; 18,611 EMS personnel; and 2,580 public safety telecommunicators working in Washington State[43,45,46] (unpublished data, DOH, February 2025). Data from Washington State Department of Retirement Services show there were 9,478 firefighters in Washington State in 2021 (personal communications, WSCFF, July 2025). Many fire personnel are also certified EMTs or paramedics in Washington State (personal communications, WSCFF, June 2025). Washington State has 405 fire departments registered with the U.S. Fire Administration.[46]

First response calls

Data from the U.S. Fire Administration states only 4% of fire department calls are fire related; the remainder involve health and behavioral health.[47] Statewide data are not collected on the details of 911 calls (i.e., overall number of calls, call types [e.g., calls involving active or imminent violence or possession of weapons]) (personal communication, MIL, June 2025). It is not possible to determine how many 911 calls are sent to police departments, fire agencies and EMS,[48] nor is it possible to determine how many 911 calls might currently involve an alternative response model (personal communication, MIL, 2025). Further, individual PSAPs exercise discretion in how each 911 call is coded in their computer-aided dispatch system, and data across PSAPs may not be comparable (personal communication, MIL, June 2025). Lastly, it is not possible to determine information on people who initiate emergency calls for service.

Alternative response

A 2022 national survey of mobile crisis teams (MCTs) across 45 states (including Washington State) found many teams "lack both the capacity and technological infrastructure to collect or report metrics."[49] For example, "45% of MCTs reported not using any metrics to inform incentives or payments. As it relates to critical incidents, 71% of MCTs track staff injuries, 65% of MCTs track suicide deaths during and after MCT services, and 56% of MCTs track suicide

attempts during and after MCT services. For point-of service outcomes, 44% of MCTs measure diversion rates and 23% of MCTs track when they are unable to locate clients."[49] Results also show over 50% of MCTs lack the scale and reach to provide 24/7 availability and on-demand capacity.[49] Among other findings, the survey found MCT geographic distribution, areas served, and contexts are diverse; and clinical best practices and partnerships are unevenly adopted across MCTs.[49] For example, only 32% of MCT respondents from SAMHSA Region 10 (contains Washington State) reported implementing 7 or more of the 10 best practices for MCTs.[49]

Washington State has a wide range of types and availability of alternative response models (i.e., co-response, MRRCTs, CBCTs, ARTs, DCRs). Statewide data on alternative response models is not currently centrally collected (personal communications, June 2025). There is no statewide database or information about which alternative response models currently exist, what services they provide, deployable areas, hours of operation, etc. (personal communications, June 2025). A descriptive evaluation of Seattle CARE, released in March 2025, showed that from October 26, 2023, through December 31, 2024, Seattle CARE responders logged 1,585 calls.[10]

Since reporting to the Washington EMS Information System (WEMSIS) became mandatory in October 2024, over 1.1 million EMS responses have been reported (personal communication, DOH, July 2025). EMS patient care related to community paramedicine is not required to be reported to WEMSIS (personal communication, DOH, July 2025). Only 427 EMS patient care records have been submitted related to community paramedicine or mobile integrated health programs (personal communication, DOH, July 2025). These records came from 17 EMS agencies, and 14 of the 17 agencies have reported less than 10 records (personal communication, DOH, July 2025). Additionally, nearly 90% of these records came from a single, rural EMS agency (personal communication, DOH, July 2025).

Co-response

The University of Washington conducted a 2023 statewide survey of 64 co-response programs and key informant interviews with 45 co-response staff and program managers.[50] Survey data showed 54% of programs serve a law enforcement department, 38% serve a fire department, and 8% serve both a law enforcement and a fire department.[50] Survey results found uneven distribution of programs across BH-ASO regions, with program concentration in the northwest Puget Sound region of the state.[50] Results also showed that 59% of programs responded alongside a first responder, 59% responded in coordination with a first responder, 48% provided follow-up care with no first responder present, and 54% of programs used 2 or more program models.[50] Survey results also showed that community need exceeds available services, where 68% of programs reported being unable to meet community demand in their service area, 58% reported needing additional staff, and 87% operated less than 24 hours a day, 7 days a week.[50]

Research on Washington State co-response programs found that co-response is "not located in many regions or counties and [is] usually not available 24/7 when [it does] 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."[47] In addition, "rural residents of [Washington State] are far less likely to receive mobile crisis or co-response services."[47]

Overall, SHB 1816 has the potential to impact political subdivisions with a population larger than 200,000 as well as the 911 system, existing alternative response models, first responders, and people who may use 911 response services in these political subdivisions.

Logic Model

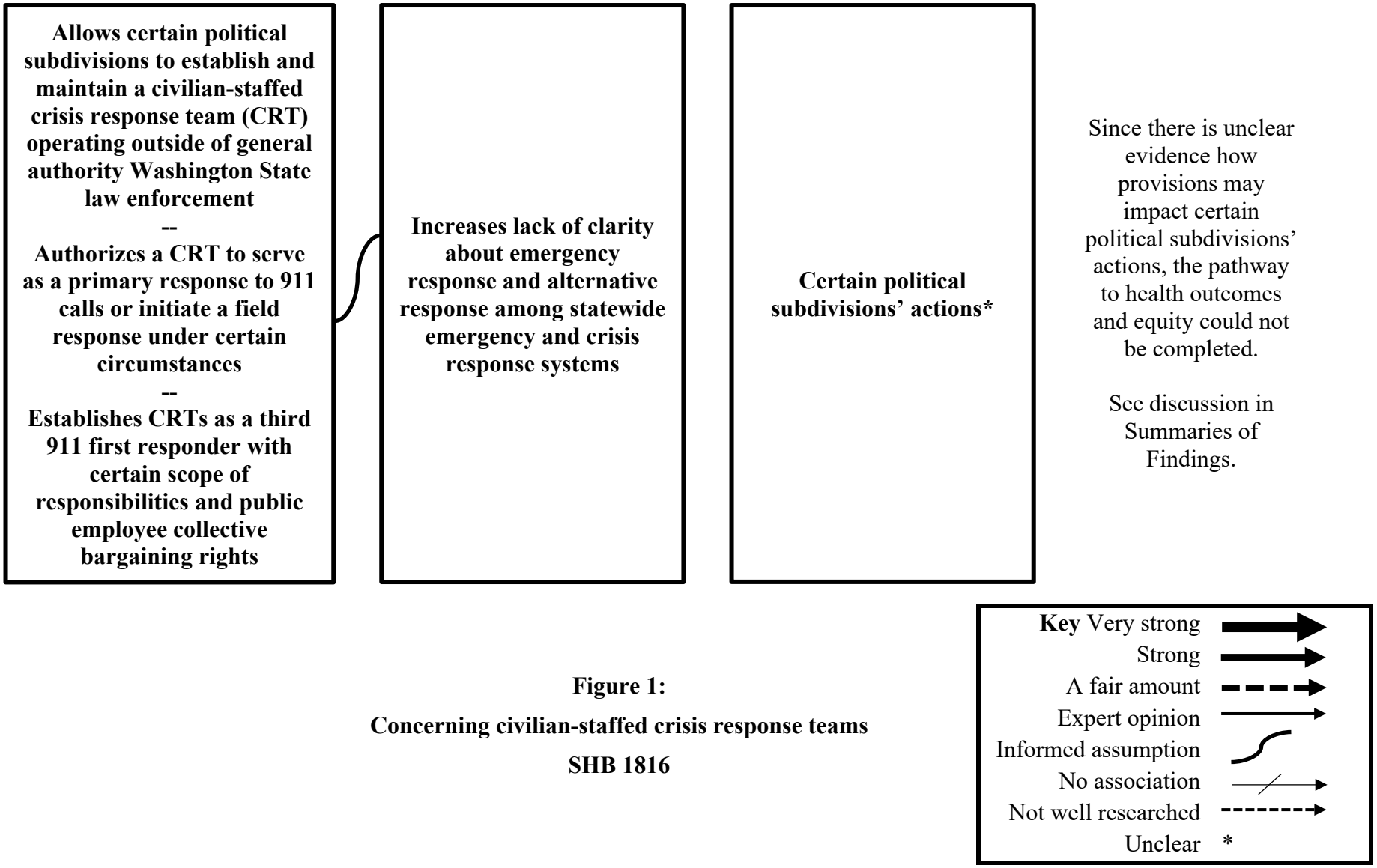

Figure 1:

Concerning civilian-staffed crisis response teams

SHB 1816

Summaries of Findings

Would 1) allowing certain political subdivisions to establish and maintain a civilian-staffed crisis response team (CRT) operating outside of general authority Washington State law enforcement, 2) authorizing a CRT to serve as a primary response to 911 calls or initiate a field response under certain circumstances, and 3) establishing CRTs as a third 911 first responder with certain scope of responsibilities and public employee collective bargaining rights lead to increased lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems?

We have made the informed assumption that 1) allowing certain political subdivisions to establish and maintain a CRT[e] operating outside of general authority Washington State law enforcement, 2) authorizing a CRT to serve as a primary response to 911 calls or initiate a field response under certain circumstances, and 3) establishing CRTs as a third 911 first responder with certain scope of responsibilities and public employee collective bargaining rights may lead to increased lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems. This informed assumption is based on information from key informants.

Key informants stated that entities potentially impacted by SHB 1816 share concerns related to public safety (personal communications, June 2025). For example, some local jurisdictions perceive an unmet need in 911 response and view alternative response models as a way to help more people receive response and resources (personal communication, Teamsters Local 117, June 2025). Law enforcement and fire agencies perceive a potential for any 911 call to become dangerous or an emergency, which may put a first responder, alternative responder, or person at risk (personal communications, June 2025). Alternatively, there are community perceptions that having law enforcement respond to a mental or behavioral health concern escalates the call and introduces unfavorable interactions between people in crisis and law enforcement (personal communications, June 2025). Some key informants stated mental and behavioral health calls could be better handled by civilian mental health providers (personal communications, June 2025). However, key informants also stated there is lack of clarity across current emergency response and alternative response systems, and some provisions of SHB 1816 may increase this lack of clarity, if the bill were to pass (personal communications, June 2025).

Lack of clarity among current emergency response and alternative response

Key informants agreed there is lack of clarity among current statewide emergency response and crisis response systems (personal communications, June 2025). Key informants provided detail on the lack of data on existing alternative response models, current law, regional variability, and dispatching procedures. Key informants stated that better coordination of crisis response as well as additional alternative or crisis response would positively affect overall emergency response in Washington State (personal communications, June 2025). However, key informants expressed

[e] Key informants stated, "crisis response" and "alternative response" are used to describe similar bodies of work (personal communication, BHCORE, July 2025). In the field, "crisis response" often indicates work being completed by a behavioral health organization, and "alternative response" often indicates work being completed by government or a non-profit organization (personal communication, BHCORE, July 2025). For this HIR, "crisis response team (CRT)" is used to describe teams which may be authorized under SHB 1816. "Alternative response" and "alternative response models" are used to describe existing models of crisis response efforts currently underway in Washington State which may or may not be subject to the provisions of SHB 1816.

doubt that SHB 1816 would change current practices or improve crisis response and coordination (personal communications, June 2025).

Data

Overall, there is lack of clarity about what alternative response models currently operate across Washington State and how existing models may work with or alongside emergency and first response (personal communications, June 2025). Currently, statewide data on alternative response models are not centrally collected, and there is no statewide database or information about which alternative response models exist, services provided, deployable areas, hours of operation, etc. (personal communications, June 2025). There is also no reporting requirement for alternative response in the state (personal communication, Washington State Military Department [MIL], June 2025).

Current law

Key informants stated there may be lack of clarity regarding current law in establishing and maintaining a CRT. SHB 1816 would allow a political subdivision with a population larger than 200,000 to establish and maintain a civilian-staffed CRT operating outside of a general authority Washington State law enforcement agency. Key informants stated that no law currently prohibits political subdivisions or organizations from creating and maintaining CRTs (personal communications, June 2025). Key informants stated, if SHB 1816 were to pass, the decision regarding whether to establish and maintain CRTs among certain eligible political subdivisions would remain with each jurisdiction (personal communications, MIL, June 2025). Overall, key informants stated they would not expect this provision to change the way alternative response models currently operate across the state (personal communications, June 2025).

Regional variability

Many cities and counties in Washington State implement a variety of alternative response models including co-response teams (RCW 71.24.905), Mobile Rapid Response Crisis Teams (MRRCT) (RCW 71.24.025), Community-based Crisis Teams (CBCT) (RCW 71.24.025), designated crisis responders (DCRs) (RCW 71.05.020), Alternative Response Teams (ART), community paramedics, and mobile integrated health teams (personal communications, June 2025). Key informants stated there is limited understanding among both crisis and emergency response systems and among community members about what types of alternative response models currently operate in specific jurisdictions in Washington State (personal communications, June 2025). In addition, researchers who study alternative response in Washington State stated in a 2023 report to the legislature, "[c]urrently, there is mixed messaging and confusion in WA state about what number to call in a crisis situation."[47]

Further, it varies statewide whether alternative response models are available, how alternative response models work with law enforcement and fire agencies, and how alternative response models may respond to calls for service (personal communications, June 2025). For example, some law enforcement and fire agencies in Washington State have dedicated units or staff who specialize in mental and behavioral health and substance use disorder and can be directly dispatched to respond to emergency calls (personal communications, June 2025). However, there is regional variability in whether alternative response staff operate in a jurisdiction, whether they are dispatched directly through the 911 system, whether law enforcement or fire agencies request

crisis response services based on information about the call, whether community members may request these services, and whether staff respond to calls through a mechanism outside of the 911 system (e.g., field response, co-responder volunteers respond to calls) (personal communications, June 2025). Key informants from MIL stated alternative response models in Washington State are not currently required to share information with MIL, and sharing program information with MIL would initiate a first step in a coordinated statewide crisis response effort (personal communications, MIL, June 2025).

Dispatching procedures

Key informants stated that dispatch of resources through the 911 system is at the discretion of public safety telecommunicators (personal communication, MIL, June 2025). Key informants also stated there is no statewide dispatching infrastructure (e.g., training of telecommunicators on CRTs, tracking of CRT availability, ability to directly connect CRTs to crisis calls) in place that allows 911 to systematically dispatch alternative response models (personal communication, Teamsters Local 117, June 2025). SHB 1816 would authorize CRTs to serve as primary response to 911 calls; however, some Public Safety Answering Points (PSAPs)[f] already dispatch alternative response models (personal communications, June 2025). Therefore, agencies may already create and maintain alternative response models and work with law enforcement and fire response to authorize these teams to serve as primary response to 911 calls (personal communications, June 2025).

In addition, telecommunicators use emergency medical system (EMS) dispatch protocols set by medical program directors (as defined in WAC 246-976-920) to determine which resources to direct to which type of call, including for mental health emergencies and people in crisis (personal communication, Washington State Council of Fire Fighters [WSCFF], June 2025). Staff from Washington State Department of Health (DOH) and Washington State Health Care Authority (HCA) collaborate to develop and provide education and EMS protocol guidance to medical program directors (personal communication, DOH, August 2025). DOH staff stated additional staff and resources are needed for this work (personal communication, DOH, August 2025). Researchers have noted that more research is needed to understand the ability of medical dispatching systems to accurately dispatch EMS resources according to level of acuity and in recognition of specific health conditions.[51]

Key informants stated 2 alternative response models in Washington State can currently be dispatched directly from 911 where the process is initiated and resources are sent by staff at the PSAP, the Seattle Community Assisted Response and Engagement (Seattle CARE) Department and the Bellingham Alternative Response Team (ART). The Seattle CARE PSAP serves the City of Seattle and is responsible for dispatching Seattle Police Department (SPD) and the Community Crisis Responder Team.[17] The Seattle CARE PSAP also answers the City's non-emergency line.[17] The Seattle Fire Department (SFD) Fire Alarm Center operates as a secondary PSAP and handles all requests for fire response and EMS in Seattle.[17] According to the December 2023 Memorandum of Understanding (MOU) between the City of Seattle and Seattle Police Officers' Guild (SPOG), Seattle CARE's Community Crisis Responder Team can be

[f] Public Safety Answering Points (PSAPs) are also referred to as 911 Centers, Emergency Communication Centers, or Dispatch Centers (personal communication, MIL, June 2025).[42] This Health Impact Review will use "PSAPs" to refer to the 78 centers in Washington State.

dispatched as part of a dual response (i.e., with SPD law enforcement officers) for 2 types of nonviolent 911 calls: 1) 'person down'; and 2) 'welfare checks' on adults when minors are not present and the adult is not in the driver's seat of a vehicle.[52] Some key informants stated the MOU requires law enforcement officers to be dispatched at the same time as Seattle CARE staff so that officers can ensure the scene is safe before handing over the response to Seattle CARE's Community Crisis Responder Team (personal communications, June 2025).

The Bellingham ART began in January 2023 and is housed within Whatcom County Health Department, a licensed behavioral health agency, and consists of behavioral health specialists who respond to non-violent mental health 911 calls (personal communication, Bellingham ART, July 2025). Community connectors are employees of the ART and divide work hours assisting telecommunicators with dispatch at What-Comm 911 (the PSAP serving this region) and responding to certain 911 calls and conducting street outreach (personal communication, Bellingham ART, July 2025). Calls to 911 in this area are screened by community connector and telecommunicator staff, and calls requiring medical or fire response are referred to a different PSAP (personal communication, Bellingham ART, July 2025). During initial program implementation, the Bellingham ART responded to social welfare calls and has since expanded to include many additional types of calls, including disorderly conduct (personal communication, Bellingham ART, July 2025). If a call is deemed non-violent and appropriate for law enforcement diversion, the ART responds by sending a pair of behavioral health specialists (personal communication, Bellingham ART, July 2025). ART staff then provide referrals to appropriate care and services (e.g., crisis stabilization center, emergency room, MRRCT, social services, etc.) and do not provide long-term case management support (personal communication, Bellingham ART, July 2025).

Key informants from Bellingham ART stated cross-training with law enforcement, ART staff, telecommunicators, and information technology staff results in resources being dispatched accurately to various types of calls (personal communication, Bellingham ART, July 2025). In addition, while there is not a formal body of work outlined in contract for Bellingham ART staff, key informants stated there are clear delineations of work across the ART, law enforcement, and additional alternative response models that operate in the area (e.g., MRRCT, additional co-response programs, etc.) (personal communication, Bellingham ART, July 2025). Key informants also stated there have not been any injuries to ART staff in the program's 2.5 years of operation (personal communication, Bellingham ART, July 2025). Key informants from the Bellingham ART stated the program's emphasis on relationship building, particularly with law enforcement, as well as after-incident debrief and "ride-alongs" with law enforcement and ART staff contribute to program successes and expansion (personal communication, Bellingham ART, July 2025).

Washington State's 988 call system can also dispatch resources directly to specific types of crises (personal communication, HCA, June 2025). MRRCTs and CBCTs are dispatched directly from the state's 988 system through RCLs (personal communications, HCA, June 2025). MRRCTs and CBCTs respond to all calls they receive regardless of the source of the call (e.g., calls from the person in crisis, friends and family, the community, first responders) (personal communication, HCA, July 2025). MRRCTs only involve law enforcement if there is a safety risk identified (e.g., a weapon or medical concern) (personal communication, HCA, July 2025).

In contrast, other alternative response models, such as co-responders and DCRs, may be activated by field responders (i.e., law enforcement, fire fighters, EMS), 911 or 988 calls, or some other mechanism (personal communications, June 2025). Lastly, DOH staff stated additional staff and resources are needed (particularly within the Emergency Medical Services and Trauma Care System) to support 988 system implementation and agency collaboration (personal communication, DOH, August 2025).

Lack of clarity in some provisions of SHB 1816

Key informants stated some provisions of SHB 1816 may increase the lack of clarity among current statewide emergency response and crisis response systems and affect how SHB 1816 may be implemented. Key informants raised questions and expressed concerns about bill provisions related to the definition of CRT, the role of state and local agencies, the role of the executive head of the political subdivision, training and procedures, the first responder designation, and labor relations.

Definition of CRT

SHB 1816 does not define CRT, nor is there an existing definition of CRT in Washington State law (personal communications, June-July 2025). Key informants stated national researchers and experts are currently working to form a definition of community and alternative response (personal communication, Council of State Governments, June 2025). Key informants highlighted benefits of a shared definition including developing a common language; establishing clear, consistent expectations for teams (i.e., what community members and other emergency personnel can expect from alternative response models); holding governments, agencies, and organizations accountable for actions; and enhancing program comparability to test validity through evaluation (personal communications, June 2025). Key informants also stated that Washington State's crisis response landscape is unique, and a state-specific definition would be beneficial (personal communications, June 2025). Without a clear definition of CRT, key informants questioned what criteria would make up a newly formed CRT under SHB 1816 (personal communications, June 2025).

In addition, key informants raised questions and offered differing perspectives on how the lack of definition may affect existing alternative response models in Washington State (i.e., co-response, MRRCTs and CBCTs, DCRs, ARTs, community paramedics, mobile integrated health teams) (personal communications, June 2025). While some people may understand alternative response models as teams that provide an alternative to law enforcement response, key informants stated the lack of definition of CRT would likely create confusion about which existing models, if any, the bill may apply to (personal communications, June 2025). For example, while HCA stated the bill would not directly affect MRRCTs and CBCTs, additional key informants were unclear about potential bill impacts on these entities (personal communications, June 2025).

Role of state and local agencies

SHB 1816 does not require or direct MIL, another state agency, PSAPs, or law enforcement and fire agencies to change how they currently operate (personal communications, MIL, June 2025). For example, the bill does not require any state agency to conduct rulemaking, change policies or guidance, or complete specific bill implementation steps (personal communications, June 2025).

Some key informants also pointed out that SHB 1816 does not require MIL to maintain a list of CRTs and does not require an agency to define CRT scope of work or create a designated profession or certification process for civilian-staffed CRTs (personal communications, June 2025). Some key informants who operate existing alternative response models questioned whether bill implementation would require changes to their program operations (personal communication, Bellingham ART, July 2025). Key informants stated that without clear agency implementation directives, SHB 1816 may not change current operations (personal communications, June 2025).

Role of executive head

SHB 1816 would require the executive head of eligible political subdivisions to 1) set minimum qualifications for the CRT and 2) develop the CRT's services provided, qualifications, training, types of calls where primary 911 dispatch is appropriate, deployable areas, and hours of operation. The bill would also direct the executive head to develop the CRT program in consultation with any active entities within the particular jurisdiction including HCA, the Behavioral Health Administrative Services Organization (BH-ASO) serving the political subdivision's jurisdiction, the operators of mobile crisis teams administered by the BH-ASO, or the 988 call center hub for the region. The bill would allow the executive head to determine characteristics of the CRT, including the department in which to situate the CRT and the number of staff assigned to the CRT. Lastly, the bill would allow a CRT to serve as a secondary response in support of a law enforcement response as determined by the executive head of the political subdivision for certain 911 calls.

Within Washington State counties, the executive head is the county legislative authority or the county executive (in charter counties with an elective office of county executive).[53] Within cities with mayor-council or commission forms of government, where the mayor is directly elected, the executive head is the mayor; and within cities with council manager forms of government the executive head is the city manager.[53]

Under existing first response and crisis response systems, Medical Program Directors, who are medical doctors, provide oversight and guidance to the EMS system, and HCA and BH-ASOs provide oversight and guidance to the 988 system, including MRRCTs and CBCTs (personal communications, June 2025). Key informants stated concern that provisions related to executive head authority would allow a political entity to provide oversight and guidance over certain CRTs (personal communications, June 2025). For example, this bill would give decision-making and program design authority to a political entity who may not have a background in crisis response. Key informants highlighted the importance of sustainable, predictable crisis services that community members and other emergency response personnel can be confident in responding appropriately (personal communications, June 2025). Key informants expressed concerns that authorizing the head of a political subdivision to establish program requirements would not align with current practices for other authorized crisis and emergency teams statewide (personal communications, June 2025). Some key informants stated that the person holding such an office may not have the necessary expertise to set minimum training requirements, which could present safety concerns for CRT personnel and for community members who receive care from CRT staff (personal communications, June 2025). In addition, civilian CRTs would not be bound to EMS protocols or behavioral health professional protocols, which could create

inconsistencies in response resources, timing, and expertise (personal communications, June 2025).

Additional key informants stated that authorizing the head of a political subdivision, an elected position, to create and maintain CRTs, set minimum staff qualifications, and determine CRT characteristics may politicize public safety response (personal communications, June 2025). For example, one key informant questioned how a change in elected city or county leadership would affect CRT implementation (personal communication, Council of State Governments, June 2025). Also, SHB 1816 does not specify whether authority could be delegated within a mayor or county leadership office, which may pose questions about who is responsible for decision-making (personal communications, June-July 2025).

In addition, key informants from HCA raised questions about implementation details of the bill requirement for BH-ASOs to be consulted by the executive head in developing CRT minimum qualifications (personal communication, HCA, June 2025). More specifically, key informants questioned what consultation would look like and how this may interact with the state's 988 system (personal communication, HCA, June 2025). Further, MIL stated that including 911 coordinators in the list of entities who should be consulted would help establish continuity and coordination across the state's 911 system and crisis response efforts (personal communications, MIL, June 2025).

Some key informants also stated that giving authority to political subdivisions to create CRTs, especially without clear definitions of which groups qualify as a CRT, may contribute to inequities (personal communications, June 2025). For example, since there are no standardized evidence-based or best practices for alternative response models, services offered through CRTs may differ by jurisdiction and by resource availability (personal communications, June-July 2025).

Procedures and training

SHB 1816 would authorize a CRT to serve as a primary response to 911 calls or initiate a field response when there is no report or observation of active or imminent violence or possession of weapons and when: 1) a person in crisis[g] does not request law enforcement; 2) a person appears to need or is reported to need a safety and welfare check[h]; or 3) a person requests resources including, but not limited to, shelter, food, or transportation. The bill would also allow a CRT to serve as a secondary response in support of a law enforcement response as determined by the executive head of the political subdivision for all additional 911 calls. Key informants provided varying information on how these provisions may be implemented and expressed ways the bill may increase the lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems.

[g] Neither SHB 1816 nor current Washington State law defines "person in crisis." Key informants stated this can be defined as a person exhibiting abnormal behavior, irrationality and/or unpredictability where using caution is necessary (personal communication, Seattle Police Officers Guild [SPOG], June 20205).

[h] Neither SHB 1816 nor current Washington State law defines "safety and welfare check." Key informants stated this can be defined as action to assure a scene and the people within it are safe, where no serious injury has occurred (personal communication, SPOG, June 20205).

Key informants stated that 911 dispatch is critical to any emergency or crisis response, and key informants were unclear who would dispatch a CRT and how a CRT would be dispatched if SHB 1816 were to pass (personal communications, June 2025). Some key informants noted that if CRTs were to be dispatched by the 911 system, dispatch governing boards and personnel would need to agree to direct calls to a CRT, liability concerns would need to be addressed, and protocols to divert calls would need to be created and embedded into PSAP process manuals (personal communications, June 2025). Processes would need to be specific to each PSAP, since PSAPs operate independently with differing resources, staffing, and operations (personal communications, June 2025). Key informants stated it would be important for 911 telecommunicators to have a clear understanding of what CRTs are and are not, what services these teams can and cannot provide, and in what instances teams should be dispatched (personal communication, Council of State Governments, June 2025). This clarity can support PSAPs in developing protocols and telecommunicators to confidently route calls to the most appropriate entity (personal communication, Council of State Governments, June 2025).

In addition, the bill would establish minimum qualifications for CRTs which would include training in scene safety, de-escalation, and interacting with people in crisis. The bill would require the executive head to consult about CRT training with HCA, the BH-ASO serving that political subdivision, the operators of mobile crisis teams, or the 988 call center hub for the region. In the local government fiscal note for SHB 1816, Washington State Department of Commerce (Commerce) stated that it is not possible to estimate the staff positions that would make-up a CRT.[21] Key informants also stated that it is not possible to predict which types of staff positions or expertise may serve on a CRT (personal communications, June 2025).

Key informants stated that the qualifications outlined in SHB 1816 are not specific or thorough training guidelines for the scenarios CRTs may encounter in the field (personal communications, June 2025). In addition, key informants stated the entities the executive head must consult regarding training may not have specific expertise to provide, because the field of alternative response is new and training standards or best practices have not yet been developed (personal communication, BHCORE, July 2025). While training for alternative response models is not currently standardized, key informants stated SHB 1816 would not create the standardization needed (personal communication, BHCORE, July 2025). Some key informants expressed concern that without specific and thorough qualification requirements, civilian CRTs may have less training and experience than existing first responders, which may affect the safety of all parties involved (personal communications, June 2025). Key informants also stated that SHB 1816 may result in lack of coordination among CRTs with law enforcement, fire response, and EMS, which could result in decreased opportunities for cross-training and learning among first response staff (personal communication, WSCFF, June 2025).

Key informants also expressed concern that the safety of CRT staff could be put at risk since SHB 1816 does not clearly define the body of work for CRTs, which may lead to teams with insufficient training responding to emergency situations (personal communication, DOH, June 2025). Key informants also suggested that, depending on the details of CRTs' body of work, CRTs may need to call 911 or request law enforcement or fire response if they are unable to adequately respond to certain situations, which could delay care for a person in crisis (personal communication, WSCFF, June 2025). Additionally, proposed CRT responsibilities include

elements of other licensed professions, which may lead to instances in which CRT staff inadvertently practice without a license (personal communication, DOH, June 2025). Practicing beyond the scope of training would present safety and liability concerns (personal communication, DOH, June 2025). Although staff in existing alternative response models shared that some staff are required to maintain professional licenses, SHB 1816 does not directly require licensure. Therefore, it is unknown how licensure may or may not be a staffing component for authorized CRTs.

Key informants also raised equity concerns including how to ensure responders recognize and provide the appropriate resources for people with a range of disability statuses, developmental needs, mental health conditions, etc. across various geographies, particularly among communities of color (personal communication, Office of the Insurance Commissioner, June 2025). Key informants shared that insufficient training and lack of requirements for certification or licensure could result in community members who are marginalized receiving inappropriate care (e.g., lack of consent-based and trauma-informed care) (personal communication, HCA, June 2025). Relatedly, some key informants expressed concern that the bill does not include a requirement for equity impact assessments to be conducted within jurisdictions that implement CRTs (personal communication, HCA, June 2025).

First responder designation

SHB 1816 would also establish CRTs as a third 911 first responder, parallel to law enforcement and fire response. Some key informants stated that establishing CRTs as a first responder without directing an agency to take specific implementation actions would not create meaningful change in current operations (personal communications, June 2025). Key informants also stated that the bill language establishing CRTs as a "third" 911 first responder is confusing since there are currently more than 2 types of first responders in Washington State (personal communications, June 2025). In addition, qualifying these staff as "911" responders would be inaccurate as they do not generally work within 911 operations, and confusing since all first responders operate within the 911 system (personal communication, MIL, June 2025).

Some key informants stated that SHB 1816 has the potential to create a parallel responder system outside of existing emergency and crisis response without a direct requirement to collaborate with existing first response systems or the 988 system, which could complicate or delay response and the ability to help people in crisis (personal communications, June 2025). For example, key informants stated it is particularly important to provide alternative response programming alongside fire response, since EMS is situated within fire agencies and provides medical response (personal communication, BHCORE, July 2025). Key informants stated responding to crises without appropriate medical training may introduce harm to people in crisis (personal communication, July 2025). Lastly, key informants stated that a separate system of responders may confuse community members in crisis, who may not know who to call or who might respond to emergencies (personal communications, June 2025).

Labor relations

SHB 1816 would also establish CRTs' scope of responsibilities as separate from law enforcement and fire response, and whose wages, hours, and other working conditions shall be subject to public employees' collective bargaining. Key informants provided mixed information

on how this provision may be implemented. Some key informants stated this provision would allow the Seattle CARE program to change the ways they complete their ongoing contract negotiations and collective bargaining conversations with SPOG; some key informants stated this provision would not change current operations; and other key informants were unsure whether this provision would change current operations (personal communications, June 2025).

Under the Public Employees' Collective Bargaining Act (RCW 41.56), local governments and certain other public employees, including uniformed personnel and the Washington State Patrol, have the right to organize and designate collective bargaining representatives to bargain their wages, hours, and working conditions.[30] Currently, fire personnel and police personnel are each under their own collective bargaining agreements (CBAs) (personal communication, Teamsters Local 117, June 2025). Key informants stated that contract negotiations and collective bargaining determines the body of work for alternative response models (personal communications, June 2025). Key informants stated that people have different ideas about what body of work may be appropriate for these teams, especially related to what work may be performed with and without law enforcement, fire fighters, or EMS (personal communications, June 2025). Key informants also suggested that creating a body of work for civilian CRTs may result in reallocating work that has typically been done by law enforcement and fire agencies (personal communications, June 2025).

Some key informants stated that labor-related provisions of SHB 1816 attempt to work outside of existing current labor negotiation and collective bargaining processes for one alternative response model (personal communications, June 2025). In October 2023, Seattle's Mayor established Seattle CARE as the city's third branch of public safety to complement the SFD and SPD.[17] The program's goals are to: 1) improve public safety, 2) unify and align services, and 3) diversify responses to 911 calls.[10] Seattle CARE employs nonlaw enforcement civilian Community Crisis Responders (CCRs) who provide a fully non-policing response to behavioral health crises.[10]

In December 2023, the City of Seattle and SPOG signed an MOU outlining the City of Seattle's Dual Dispatch Alternate Response Pilot Project.[52,54] It specifies that CCRs will be trained to address mental and behavioral health or social welfare issues and the types of calls for which a dual dispatch can occur, with an option to mutually agree to expand the types of calls covered by the agreement.[52] Although dispatched at the same time, the agreement states that "the Officer [i.e., SPD law enforcement officer] holds the discretion to turn the call over to a CCR, and to reinsert into the call. The Officer is the ultimate authority on the call."[52] Additionally, it requires that "dispatching a CCR will not impact the number of officers that are dispatched to the call."[52] The current MOU places a limit that 24 staff (not including administrative personnel) are permitted to work within Seattle CARE.[52] The current MOU is set to expire January 1, 2026, and contract negotiations with SPOG will likely determine the future of the program (personal communications, June 2025). Some key informants stated concerns that if Seattle CARE continues, it may take on certain components of SPD's body of work (personal communications, June 2025). Key informants stated there is disagreement on language and implementation of the current MOU (personal communications, June 2025). Contract negotiations are ongoing, and key informants were only able to provide limited information on certain contract negotiation details (personal communications, June 2025).

The Public Employees' Collective Bargaining Act (RCW 41.56) requires negotiations on public employee "wages, hours, and working conditions," which are known as "mandatory subjects of bargaining" (personal communication, SPOG, July 2025). The Washington State Public Employment Relations Commission is the state agency that hears cases regarding potential violations of the protections in RCW 41.56 and makes rulings on particular subjects being "mandatory subjects of bargaining" (personal communication, SPOG, July 2025). Under RCW 41.56, an employer has an obligation to refrain from making changes to mandatory subjects of bargaining unless they give notice to a union, provide an opportunity to bargain before making a final decision, and bargain in good faith with the union (upon request) until the parties have reached an agreement or impasse (personal communication, SPOG, July 2025). Key informants stated, in numerous cases, the Washington State Public Employment Relations Commission has found that the decision to move work from one bargaining unit to other employees is a mandatory subject of bargaining (personal communication, SPOG, July 2025). Key informants explained that the ongoing negotiations with Seattle CARE include mandatory subjects of bargaining, and the parties have a duty to bargain over both the decision and the effects of that decision (personal communication, SPOG, July 2025).

Key informants stated that typically, union negotiations include effect bargaining, where parties negotiate the effects of certain decisions (personal communications, June 2025). In decision bargaining, the employer has an obligation to negotiate decisions with the bargaining unit (e.g., whether a CRT operates) in addition to effects (e.g., administrative and economic impacts of a CRT) (personal communications, June 2025). The parties currently engaged in bargaining about Seattle CARE are engaged in decision and effect bargaining regarding the future of the Seattle CARE program (personal communication, SPOG, July 2025). This means current negotiations include whether Seattle CARE may continue to exist outside of law enforcement after the MOU expires (personal communications, June 2025).

Some key informants interpreted the labor provisions in SHB 1816 to mean Seattle CARE could establish a CBA separate from SPOG, and that if SHB 1816 were to pass, negotiations could proceed with effect bargaining (i.e., body of work, working conditions, number of staff) and without negotiating the decision of whether Seattle CARE is permitted to exist outside of law enforcement (personal communications, June 2025). Key informants raised concern that this may be a violation of the Public Employees' Collective Bargaining Act (personal communications, June 2025). Some key informants also stated SHB 1816 could result in protection for Seattle CARE against potential legal challenges stemming from contract negotiations (personal communications, June 2025).

Key informants stated this provision may impact future CRTs that do not already have decision bargaining rights (personal communication, WA State Labor Council, June 2025). However, key informants were not aware of any additional alternative response models across the state that are in similar labor negotiations and may potentially be affected by the labor-related provisions of SHB 1816 (personal communications, June 2025).

Some key informants stated the labor-related provisions in SHB 1816 have the potential to create a change in staffing of current alternative response models. For example, key informants

expressed concern that SHB 1816 may create duplication of services already underway through 988 legislation; yet, without direct oversight by BH-ASOs, responders may be less trained and without certification (personal communication, HCA, August 2025). Further, staff employed by cities and counties may have additional protections, compensation, and benefits, compared to the majority of current alternative responders, which could impact the 988 workforce (personal communication, HCA, June 2025). Key informants stated this may lead to staff leaving current positions (personal communication, HCA, June 2025).

Additional key informants stated the labor-related provisions in SHB 1816 would not create a change or were unsure if provisions would create change in current operations (personal communications, June 2025). For example, some key informants stated that requiring CRTs to be subject to collective bargaining would likely result in the same collective bargaining negotiations that are either currently underway or would need to occur to create a new CRT (personal communications, June 2025).

Overall, there is lack of clarity across current emergency response and alternative response systems, and some provisions of SHB 1816 may increase this lack of clarity, if the bill were to pass (personal communications, June 2025). Key informants stated the potential impact of CRTs would depend on how CRTs are created and implemented and how the teams work within or alongside existing crisis and emergency response systems (personal communications, June 2025). Therefore, based on information from key informants, we have made the informed assumption that 1) allowing certain political subdivisions to establish and maintain a CRT operating outside of general authority Washington State law enforcement, 2) authorizing a CRT to serve as a primary response to 911 calls or initiate a field response under certain circumstances, and 3) establishing CRTs as a third 911 first responder with certain scope of responsibilities and public employee collective bargaining rights may lead to increased lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems.

Would increased lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems impact certain political subdivisions' actions?

There is unclear evidence how increased lack of clarity about emergency response and alternative response among statewide emergency and crisis response systems may impact certain political subdivisions' actions.

SHB 1816 allows a political subdivision with a population larger than 200,000 to establish and maintain a CRT. Based on April 2025 population data from the Office of Financial Management (OFM), 4 cities (Seattle, Spokane, Tacoma, and Vancouver) and 10 counties (Benton, Clark, King, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima counties) have populations larger than 200,000 and would be eligible to create and maintain a CRT based on provisions of SHB 1816.[21,41]

Since SHB 1816 does not require cities and counties to create and maintain a CRT, it is not possible to predict which cities and counties may choose to establish a CRT if SHB 1816 were to pass.[21] Moreover, key informants expressed differing opinions about whether eligible political

subdivisions would change existing alternative response models or would establish and maintain a new CRT (personal communications, June-July 2025).

Some key informants stated that if SHB 1816 were to pass, eligible political subdivisions might not change current operations and that lack of clarity about bill implementation details may discourage jurisdictions from taking action (personal communications, June 2025). However, other key informants stated the current lack of clarity among statewide emergency and crisis response systems and the lack of clarity with SHB 1816 implementation may result in some eligible political subdivisions changing existing alternative response models, or being unsure whether the bill requires them to change existing models (personal communications, June-July 2025). For example, key informants stated that without a clear definition of CRTs, some political subdivisions could interpret SHB 1816 to apply to an existing alternative response model, which could cause changes in existing emergency response and alternative response within a jurisdiction (personal communications, June 2025).

Other key informants stated that only the City of Seattle would be likely to operate differently if SHB 1816 were to pass (personal communications, June 2025). For example, some key informants stated the bill could provide a way for Seattle CARE to operate outside of law enforcement authority (i.e., without an MOU with SPOG) (personal communications, June 2025).

Lastly, some key informants stated the bill might provide legal structure for some jurisdictions to establish a CRT outside of law enforcement authority (personal communications, June 2025). Some key informants stated the bill may provide a starting point for jurisdictions to establish a CRT program (personal communications, June 2025). However, key informants stated that current law does not prohibit jurisdictions from creating CRTs now (personal communications, June 2025).

Overall, SHB 1816 does not require political subdivisions to act, and it is not possible to determine how eligible political subdivisions might proceed, should SHB 1816 pass into law. Therefore, there is unclear evidence how increased lack of clarity regarding emergency response and alternative response among statewide emergency and crisis response systems may impact certain political subdivisions' actions.

Annotated References

1. **Abt Associates Arnold Ventures. A Guidebook to Reimaginine America's Crisis Response Systems: A Decision-Making Framework for Responding to Vulnerable Populations in Crisis.2020.**

This guidebook provides resources and a framework for areas considering how to expand or begin crisis response team services. Houselessness and untreated behavioral health conditions are at the root of many calls for emergency services. Living without a home or not having access to preventative care puts people at risk of worsening behavioral health conditions, which often leads to 911 calls, visits to the emergency room (ER), or a pathway toward incarceration. The goals of crisis response teams are to divert people in crisis away from the criminal legal system and emergency systems and into services and programs that will better address their needs. The types of programs vary in who responds, the nature of the response, and the intended outcomes of the response. This report cites previously collected data that shows people with multiple arrests have serious health needs. For example, among people with 2 or more arrests, 25% had a serious or moderate mental illness, 30% had serious psychological distress, 52% had substance use disorder, and 27% did not have health insurance. The percentage of each of these factors increased with each arrest that led up to 2 arrests. Further, among people who are frequently arrested and put in jail, there were more people with serious or moderate mental illness (27%) and people with substance use disorder (61%) than people without prior arrests in the last 12 months (9% and 7%, respectively). The authors reviewed programs that operate at the community or emergency response levels that operate within the U.S. and found programs that focus on various intervention points, and focus on outreach, specialized dispatch, specialized response, embedded co-response, mobile/virtual co-response, etc. The authors sorted programs into three models: outreach and prevention, intervention at 911 call, and intervention by first responders. Each program type has different features which may include the presence of a clinician, referrals to treatment, dispatchers trained in crisis intervention, community-based crisis hotlines, etc. The guidebook provides visual displays of each program type. The guidebook encourages a focus on which agencies will be involved in the response, what partnerships or coordination will be required, what and how local laws and policies might impact implementation, sources of payment to cover program services, necessary technology to support implementation, the scale of the program, and training when initiating or expanding a program model. The authors described the importance of involving relevant stakeholders as early in the process as possible to ensure contextual factors are considered. The report also includes logic models for each program model and outcomes generated from those models. Specialized response programs have the most published evidence, compared to other program models. This is mainly due to the literature on the CIT and LEAD programs. The report also summarizes literature on these programs, as well as on MCAT, CRT, PERT, and Project ETHAN.

2. **Justice Vera Institute of. 911 Analysis: Call Data Shows We Can Rely Less on Police.2022.**

Vera Institute of Justice published this report of 911 calls across 9 U.S. cities. The researchers used publicly available 911 data from police departments in Baltimore, MD; Burlington, VT; Cincinnati, OH; Detroit, MI; Hartford, CT; New Orleans, LA; New York, NY; Seattle, WA; and Tucson, AZ. The data includes a total of 15.6 million community member-initiated calls to 911

between January 2019 and November 2021. The researchers found that in most of the cities, fewer than 3% of calls were for situations involving a violent crime.

3. **Zare H. Disparities in Policing From Theory to Practice. *Am J Public Health.* 2024;114(4):384–386.**
Zare published this article which describes public health literature on policing and inequities among communities of color. The author categorizes disparities in policing into 3 categories of theories: majority-minority communities, conflict theory of law, and minority threat hypothesis–group threat theory. These categorizations claim that 1) high levels of violent crime in areas with more people of color lead to increased levels of police and increased risk of fatal outcomes, 2) policing enforces social control that benefits those in power, which leads to increased risk of use of force and more intense policing among communities of color, and 3) non-white groups and marginalized communities experience more aggressive policing and lethal outcomes because these groups are perceived as threatening. However, the author states that the following must be considered when evaluating police actions on marginalized communities: size and composition of the population, neighborhood and geographical disparities, characteristics of police officers, and quality of the data. The author encourages framing and exploring research through a structural and systemic lens. The article also cites previous research stating that due to historical and present factors interconnected to systemic racism, people of color are more likely to be subjected to more intense law enforcement than white people. The article states police are more likely to use fatal force in communities of color.

4. **Ghandnoosh N., Barry, C. . One in Five: Disparities in Crime and Policing The Sentencing Project;2023.**
This report summarizes research on policing, particularly among communities of color. The report calls for ending racial inequities in the criminal legal system through specific strategies.

5. **DeAngelis R. T. Systemic Racism in Police Killings: New Evidence from the Mapping Police Violence Database, 2013-2021. *Race Justice.* 2024;14(3):413–422.**
DeAngelis evaluated data from the Mapping Police Violence Database (2013-2021) to examine systemic anti-Black racism in police killings across the U.S. The author calculated race-specific odds and probabilities that victims of police killings exhibited mental illness, were armed with a weapon, or attempted to flee the scene at the time of their killing. The author also used multilevel, multivariable logistic regression techniques to account for the victim's age, gender, year of killing, and geographical clustering. Results showed that white victims were underrepresented, and Black victims overrepresented in the database. Relative to White victims, Black victims also had 60% lower odds of exhibiting signs of mental illness, 23% lower odds of being armed, and 28% higher odds of fleeing. Hispanic victims exhibit 45% lower odds of being armed relative to their white peers but are otherwise comparable. These patterns persist regardless of the victim's age, gender, year of killing, or geographical location (zip code, state, and neighborhood type). Thus, the threshold for being perceived as dangerous, and thereby falling victim to lethal police force, appears to be higher for white civilians relative to their Black or Hispanic peers. Current findings provide empirical support for political initiatives to curb lethal police force, as such efforts could help to reduce racial disparities in deaths by police nationwide.

6. **Mitchell C., Badruzzaman, R. Mental Health First: Evaluating Oakland and Sacramento's Non-Police Crisis Response Program. Health In Partnership;2025.**
This report includes an overview of the Mental Health First program, a project of the Anti Police-Terror Project, which launched in 2020 in Oakland and Sacramento, CA. Mental Health First "is a community-led crisis response hotline outside of the 911 and police system that community members can call when they, or someone in their community, is experiencing a crisis." This report includes data from a mixed-methods process evaluation of 29 interviews with key stakeholders and 167 survey responses. The results examine the program's current structure and operations, perceived impact, and potential for deepening and
increased services to the Oakland and Sacramento communities.

7. **Lowder E. M., Grommon E., Bailey K., et al. Police-mental health co-response versus police-as-usual response to behavioral health emergencies: A pragmatic randomized effectiveness trial. *Soc Sci Med.* 2024;345:116723.**
Lowder et al. conducted a randomized controlled trial of a police-mental health co-response team to determine program effectiveness relative to a police-as-usual response on key outcomes identified by community stakeholders. The researchers randomized behavioral health emergency calls for service in one of six police districts in Indianapolis, Indiana between January 2020 and March 2021. Logistic and negative binomial regression were used to assess group differences in emergency medical services (EMS) events within 12 months of the randomized incident along with jail booking, outpatient encounters, and emergency department visits. The researchers randomized 686 calls for service with co-response completed in 264 cases and police-as-usual response in 267 cases. Results show the overall rate of attrition was similar across conditions and the final sample included 211 co-responses and 224 police-as-usual responses. There were no significant differences in any EMS event or event counts. The researchers also found no differences in secondary outcomes (jail booking, outpatient encounters, and emergency department visits). The authors stated the police-mental health co-response team model was not more effective than traditional police response on key outcomes. The research also shows co-response team models, such as the one reported here, may unintentionally foster emergency services utilization among persons with behavioral health needs. The authors concluded by stating, "without a functioning national mental health system, communities in the US will continue to struggle to identify solutions to meet the needs of community members with complex behavioral health issues."

8. **Khan H., Miller M., Barber C., et al. Fatal Police Shootings of Victims with Mental Health Crises: A Descriptive Analysis of Data from the 2014-2015 National Violent Death Reporting System. *J Urban Health.* 2024;101(2):262–271.**
Khan et al. evaluated data on fatal police shootings from the National Violent Death Reporting System (2014-2015) to (a) identify incidents where the victim is reported to have experienced an mental health crisis (MHC) at the time of their death, (b) describe the characteristics of these incidents, and (c) compare the characteristics of MHC to fatal police shootings where the victim was not experiencing an MHC at the time of their death. Results show 203 of 633 fatal police encounters (32%) involved victims who showed signs of an MHC at the time of their death. The authors provide additional data and discussion, including an appendix of homicide data.

9. **Ward J. A., Cepeda J., Jackson D. B., et al. National Burden of Injury and Deaths From Shootings by Police in the United States, 2015–2020. *Am J Public Health.* 2024;114(4):387–397.**

Ward et al. conducted this study to describe all-outcome injurious shootings by police and compare characteristics of fatal versus nonfatal injurious shootings nationally. The researchers reviewed publicly available records on all 2015–2020 injurious shootings by US police, identified from Gun Violence Archive. Study results showed a total of 1769 people were injured annually in shootings by police, 55% fatally. The study also found that when a shooting injury occurred, odds of fatality were 46% higher following dispatched responses than police-initiated responses. Injuries associated with physically threatening or threat-making behaviors, behavioral health needs, and well-being checks were most frequently fatal. Relative to White victims, Black victims were overrepresented but had 35% lower odds of fatal injury when shot. The authors concluded with a call for enhanced reporting systems, comprehensive evaluation of emerging reforms, and targeted investment in social services for equitable injury prevention

10. **Helfgott J.B. , Hickman M.J. , Svedin S. , et al. Descriptive Evaluation of the Seattle Community Assisted Response And Engagement (CARE) Community Crisis Responder (CCR) Implementation.Seattle, WA: Seattle U Crime & Justice Research Center; 3/31/2025 2025.**

Helfgott et al. conducted a descriptive evaluation of the Seattle Community Assisted Response and Engagement (CARE) Community Crisis Responder (CCR) Initiative. The evaluation sought to "understand the program's evolution and potential impact on holistic and diversified first response, crisis response efficiency, interagency collaboration, and public safety outcomes." Authors provided an overview of the CARE program and how it interacts with other crisis response teams. Established in 2023, CARE is the third branch of public safety, a complement to the city's Fire Department (SFD) and Police Department (SPD). The agency's goals are to: 1) improve public safety, 2) unify and align services, and 3) diversify responses to 9-1-1 calls. CARE employs non-law enforcement civilian CCRs who provide a fully non-policing response to behavioral health crises. Seattle CARE operates the 911 Communications Center that screens incoming 9-1-1 calls and oversees public safety radio dispatch of Seattle PD and CARE CCR Team. Prior to implementation of CARE, the city used a dual response to calls for service through SPD and SFD. Seattle's history of co-response began in 1998 and includes its Crisis Response Unit (CRU) in 1998, co-responder Crisis Response Team (CRT) in 2010, and Crisis Intervention Committee in 2013. The CRT model consists of mental health professionals and specially trained SPD officers trained in crisis intervention. As of 2025, there are 5 CRTs serving Seattle's 5 precincts. Additionally, SPD also employs civilian personnel as Community Service Officers (CSOs), or non-commissioned outreach specialists who are trained and work as liaisons between community members and SPD. CSOs connect people to essential resources including housing, healthcare, and treatment through outreach and response to non-emergent service calls. In 2019, SFD launched Health One, a Mobile Integrated Health Response Unit designed to help navigate medical care, mental healthcare, shelter, and social services. King County's Let Everyone Advance with Dignity (LEAD) program is a law enforcement-initiated diversion program for people experiencing unmet behavioral needs and extreme poverty. In conducting the evaluation, authors used a Mixed Methods-Grounded Theory (MMGT) research design to collect and analyze both qualitative and quantitative data and received Institutional Review Board (IRB) approval. Data were collected from October 26, 2023, through December 31, 2024. To

understand CARE's evolution and effects, the evaluation used Calls-for-Service data; incident reports; CARE CCR weekly reports; Seattle Police Crisis Template data; interviews with CARE administrators and CCRs, SPD and SFD personnel, and collaborative partners; and field observations during CARE CCR ride-alongs and 9-1-1 Call Center observations. A total of 18 key stakeholder interviews were conducted, with each semi-structured interview designed to assess how CARE functioned within Seattle's emergency response system, how well it integrated with traditional first responders, and what challenges or successes had been observed since implementation. Participants included CARE administrative personnel and CCRs (n=8), SPD command staff, CSOs and CRTs (n=8), SFD/Health One (n=1), and social service providers and other collaborative agencies (n=4). Researchers also documented observations as part of 22 ride-alongs with CARE responders, and 6 observations were conducted at the 9-1-1 Call Center to analyze how emergency calls involving behavioral health crises were triaged and dispatched. From October 26, 2023, through December 31, 2024, CARE responders logged 1,585 calls. Over the course of the study period, CARE evolved from a dual or co-response model (SPD/CARE) to a diversified response model in which CARE CCRs could serve as primary responders. Additionally, CARE expanded into Seattle's East Precinct July 2, 2024, and on October 8, 2024, the CCR scope of work was expanded to include on-view calls. This expansion authorized, CARE responders present in the community and engaging with members of the public to "on-view" a client in need of assistance and then call dispatch to log the call. During the initial study period (October 2023 through July 1, 2024), CARE responders logged an average of 2 calls per day (range: 0-6 calls). After CARE responders were authorized to proactively on-view calls through the end of the study period (October 8, 2024, through December 31, 2024), CARE responders logged an average of 9 calls per day (range: 3-22 calls). The analysis showed that "after October 8, 2024, there was a substantial shift from SPD/CARE co-response to primarily CARE responses. SPD/CARE co-response dropped from 85.1% of calls logged to 21.9%, while CARE only responses increased from 13.3% of calls logged to 77.2%." At the same time, CCR response to Priority 1 and 2 calls decreased and response shifted to a majority of premise checks/on-view activity (from 3.7% to 48.8%) and Priority 3 calls (from 52.6% to 38%). Over the full study period, "about three-quarters (76.1%) of final call types are in four categories: Assist Public (35.8% of calls, with median time on scene of 16 minutes), Directed Patrol Activity (22.3% of calls, with median time on scene of 25 minutes), Crisis Complaint – General (13.3% of calls, with median time on scene of 34 minutes), and Crisis Complaint – Pickup or Transport (4.7% of calls, with median time on scene of 54 minutes)." During the post-period (10/8/2024-12/31/2024), "87.2% of final call types were in: Assist Public (36.1% of calls, with median time on scene of 8 minutes, Directed Patrol Activity (43.7% of calls, with median time on scene of 25 minutes), Crisis Complaint – General (4.5% of calls, with median time on scene of 36 minutes), and Crisis Complaint – Pickup or Transport (2.9% of calls, with median time on scene of 54 minutes)." Qualitative data analyzed indicate, "[t]he nature and experience of the CARE CCR calls for service is characterized by a focus on behavioral crisis/mental health, resource referral/connections, provision of basic need items, and provision of shelter/housing resources." Interview data indicate that CARE CCRs fill a need in Seattle valued by other first and secondary responders and social service providers. Some of the identified program strengths included: empathy/compassion/active listening; community collaboration and relationship building; subject matter expertise; community response without a uniform, badge, or gun; problem solving and street level triage skills. Examples of challenges identified included: underutilization; bureaucratic/operational/organizational obstacles largely associated with body

of work issues; community responder mission confusion (e.g., overlap between CARE CCR and SPD CSO roles); view of CARE as associated with 2020 protests and movement to defund the police; the view of some SPD personnel that police are skilled in de-escalation and CARE CCRs are not needed. Authors concluded that CARE's approach and "the administrative separation of CARE CCRs from [SPD] while fully organizationally integrated as a third public safety department […] offers a unique approach to emergency response, calls for service, and public safety that fills a distinct community need and complements" the roles of SPD, SFD, social service providers and other community responders. Authors recommended a quasi-experimental investigation examining matched calls for service with and without CARE response as well as data to evaluate changing community perceptions of CARE as a community diversified response model.

11. **Authority Washington State Health Care. Community-Based Crisis Team (CBCT).**
The Washington State Health Care Authority published this fact sheet outlining Community-Based Crisis Teams. This resource includes information on E2SHB 1134, passed in 2023, which created the endorsed mobile rapid response crisis team (MRRCT) and established a new type of team, community-based crisis teams (CBCT).

12. **State 69th Legislature of Washington. Substitute House Bill 1811. 2025.**
In SHB 1811, a formal definition of co-response was added to RCW 71.24.025, and established that a regional crisis line may not dispatch law enforcement. This law outlines these changes.

13. **Authority Washington State Health Care. Alternative Response Teams Program. 2024.**
This information sheet was published by the Washington State Health Care Authority and provides information about Alternative Response Teams.

14. **Designated crisis responders (DCR). Available at: https://www.hca.wa.gov/billers-providers-partners/program-information-providers/designated-crisis-responders-dcr. Accessed.**
The Washington State Health Care Authority published this webpage that provides a definition of Designated Crisis Responders (DCRs) and resources relevant in their implementation of the Involuntary Treatment Act (ITA) (RCW 71.05 and RCW 71.34).

15. **Community Paramedicine. 2025; Available at: https://www.ruralhealthinfo.org/topics/community-paramedicine. Accessed.**
The Rural Health Information Hub published this webpage about Community Paramedicine. The page includes a definition of the practice, and outlines challenges faced in rural areas. It also discusses community paramedicine models and existing programs, and provides resources for starting a rural community paramedicine program, such as education and curriculum requirements.

16. **Performance Audit, Work in Progress: Audit Description; Reducing Non-Emergency Use of Emergency Systems. 2025; Available at: https://sao.wa.gov/sites/default/files/2024-12/PA_overview_Nonemergency_Use_Emergency_Systems.pdf#:~:text=This%20audit%20**

will%20examine%20actions%20taken%20by%20local,including%20the%20barriers%20they%20have%20encountered%20and%20overcome. Accessed.
This document provides an overview of an Office of the Washington State Auditor (SAO) performance audit related to "Reducing Nonemergency Use of Emergency Systems."

17. **CARE Department. Available at: https://www.seattle.gov/care/about-the-care-department. Accessed 6/10/2025.**
This City of Seattle webpage provides an overview of the Seattle Community Assisted Response and Engagement Department.

18. **Washington State 911 Program. 2025; Available at: https://mil.wa.gov/e911. Accessed.**
This Washington State Military Department (MIL) webpage provides an overview of the Washington State 911 Program. MIL, Emergency Management Division, 911 Unit "works to ensure the seamless operation of the statewide 911 communications system." They work with 78 Public Safety Answering Points (911 Centers) serving all of Washington's 39 counties.

19. **Legislature Washington State. RCW 38.52.531, 911 Advisory Committee. 2022.**
RCW 38.52.531 outlines the responsiblities and membership of the Washington State Enhanced 911 Advisory Committee.

20. **Department Washington State Military. Washington State Emergency Management: Enhanced 911 Advisory Committee 2019-2025 Strategic Plan.2019.**
The Washington State Enhanced 911 Advisory Committee published the 2019-2025 Washington State Emergency Management Strategic Plan. Membership on the Washington State Enhanced 911 Advisory Committee is outlined in statute and members are appointed by the director of the Washington Military Department (the adjutant general). The Strategic Plan outlines 14 objectives in 4 areas of work: People; Systems, Policies & Procedures; Finance; and Outreach. For example, the plan includes an objective to create a State Classification for Public Safety Telecommunicators. Currently, 911 public safety telecommunicators hold Washington State job classifications of Administrative or Secretarial staff. However, public safety telecommunicators have a "critical role and responsibility […] in the delivery of life safety services as a first responder." Establishing a new classification would also help establish and develop initial certification, recertification, and testing procedures for public safety telecommunicators.

21. **Management Washington State Office of Financial. Multiple Agency Fiscal Note Summary: SHB 1816 (Civilian crisis response teams). 2025.**
The Multiple Agency Fiscal Note for SHB 1816 includes cost estimates from Washington State Health Care Authority (HCA), Washington State Military Department, and local governments. HCA stated that SHB 1816 would require the executive heads of political subdivisions that choose to create and maintain a civilian crisis response team (CRT) to coordinate with staff in HCA's Division of Behavioral Health and Recovery. The Washington State Military Department "manages the state's 911 program, but dispatch and response is managed by local public safety access points". Therefore, "[a]uthorizing a new resource to respond to 911 calls has no fiscal impacts to the Military Department." The local government fiscal note stated that, were SHB 1816 to pass, cities and counties with populations greater than 200,000 could choose to establish

a CRT; however, it would be a local option whether a jurisdiction would establish a CRT. The fiscal note stated that it is not possible to estimate which jurisdictions would choose to establish a CRT, the number of people that may be hired for each CRT, or the staff positions that would make-up the CRT. Based on April 2024 population data from the Office of Financial Management, 4 cities (Seattle, Spokane, Tacoma, and Vancouver) and 10 counties (Benton, Clark, King, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima counties) have populations greater than 200,000 and would be eligible to create and maintain a CRT. The local government fiscal note specifies that CRTs would be subject to existing collective bargaining agreements (CBAs).

22. **911 Training: Telecommunicator Training Program. 2025; Available at: https://mil.wa.gov/enhanced-911-training. Accessed.**
This Washington State Military Department (MIL) webpage provides an overview of the 911 Telecommunicator Training Program, which serves Public Safety Telecommunicators employed in a Public Safety Answering Point (911 Center). Training and continuing education courses include topics such as, "effective crisis communications, Next Generation 911 and location technologies, call processing and dispatching procedures, stress management, overcoming communication barriers" and additional topics. Additional training is provided by the Washington Chapter of APCO-NENA (Association of Public Safety Communications Officials-National Emergency Number Association).

23. **Washington State Department of Health. 988 Suicide & Crisis Lifeline. Available at: https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/suicide-prevention/988-suicide-crisis-lifeline. Accessed 6/11/2025.**
This Washington State Department of Health webpage provides an overview of the 988 Suicide & Crisis Lifeline, its creation, diversion initiative, and other frequently asked questions.

24. **Authority Washington State Health Care. Update on 988 & Access to Behavioral Health Crisis Services. In: Health WSDo, ed. Olympia, WA2025.**
This joint presentation from the Washington State Health Care Authority (HCA) and Department of Health (DOH) was presented to the Senate Health & Long-Term Care Committee on January 21, 2025. Agency staff discussed the authorizing legislation (2021-2024) and the roles of HCA and DOH in implementing Washington State's vision of the Behavioral Health Crisis Care Continuum: someone to contact through DOH's 988 contact hubs, someone to respond through HCA's mobile rapid response crisis teams, and a safe place for help through HCA's crisis stabilization services. Staff presented data on the number of calls, texts, and chats by year (e.g., 988 received 113,357 calls in 2024), discussed the mental health crisis call diversion initiative pilot program (in which over 5,000 calls were diverted from 911 to 988), mobile rapid response crisis teams (MRRCTs) and endorsements, and regional crisis lines and how they fit into the futue of the 988 system.

25. **SAMHSA Statement on 988 Press 3 Option. 2025; Available at: https://www.samhsa.gov/about/news-announcements/statements/2025/samhsa-statement-988-press-3-option. Accessed July 10, 2025.**
The Substance Abuse and Mental Health Services Administration issued this statement on the 988 Press 3 Option, which is specialized for LGBTQIA youth. The statement reads, "On July 17,

the 988 Suicide & Crisis Lifeline will no longer silo LGB+ youth services, also known as the "Press 3 option," to focus on serving all help seekers, including those previously served through the Press 3 option. The Press 3 option was established as a pilot program in Fiscal Year 2022 under a government agreement with a third party. The Fiscal Year 2023 Omnibus included a Congressional directive for $29.7 million to fund the specialized services. Federal funding in FY24 for the Press 3 services increased to $33 million. As of June 2025, more than $33 million in funds have been spent to support the subnetworks, fully expending the monies allocated for 988 Lifeline LGB+ subnetwork services. Everyone who contacts the 988 Lifeline will continue to receive access to skilled, caring, culturally competent crisis counselors who can help with suicidal, substance misuse, or mental health crises, or any other kind of emotional distress. Anyone who calls the Lifeline will continue to receive compassion and help."

26. **Washington State Health Care Authority. 988 crisis line implementation (HB 1477). Available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/988-crisis-line-implementation-hb-1477. Accessed 6/11/2025.**
This Washington State Health Care Authority webpage provides and overview of 988, crisis contact centers, mobile crisis response, best practices guidelines, additional resources, and news.

27. **Administration Substance Abuse and Mental Health Services. Advising People on Using 988 Versus 911: Practical Approaches for Healthcare Providers. Substance Abuse and Mental Health Services Administration;2024. PEP24-06-009.**
The Substance Abuse and Mental Health Services Administration published this guide to share practical strategies for healthcare providers to help people understand when to use the 988 Suicide & Crisis Lifeline for behavioral health support and 911 for physical emergencies.

28. **Health Washington State Department of. 988 Suicide and Crisis Lifeline General Awareness.**
The Washington State Department of Health published this presentation on the 988 system. Information includes how the 988 system works and data on 988 calls.

29. **Mental health crisis lines. 2025; Available at: https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/mental-health-crisis-lines. Accessed, 2025.**
This Washington State Health Care Authority webpage includes information about regional and county crisis lines.

30. **House Committee on Technology Economic Development, and Veterans. House Bill Reprt HB 1816. 2025.**
This bill report summarizes the substitute version of HB 1816, includes background on the topic, compares the original to the substitute version, and summarizes public testimony.

31. **Current Projects: Emergency Medical Services. 2025; Available at: https://www.wsipp.wa.gov/CurrentProjects. Accessed.**
This webpage provides an overview of Washington State Institute for Public Policy's (WSIPP) current project related to Emergency Medical Services.

32. **About Memphis Police Crisis Intervention Team. Available at: https://www.memphispolice.org/about/partnerships-initiatives/crisis-intervention-team/. Accessed 6/12/2025.**
This Memphis Police Department webpage provides an overview of the mission, history, and benefits of the City's Crisis Intervention Team (CIT). The CIT program is a "community effort enjoining both the police and the community together for common goals of safety, understanding, and service to the mentally ill and their families." Approximately 268 CIT officers participate in "specialized training under the instructional supervision of mental health providers, family advocates, and mental health consumer groups."

33. **Villafranca Omar. An alternative to police: Mental health team responds to emergencies in Oregon. *CBS News.* 10/23/2019, 2019.**
This news article out of Eugene, Oregon, discusses the Crisis Assistance Helping Out On The Streets (CAHOOTS).

34. **Fleming E. . Developing and Strengthening Partnerships with Police, Fire, and EMS: A Q&A with the CAHOOTS Program. New York, NY: CSG Justice Center; 2022.**
This interview presented on the Council of State Governments Justice Center webpage discusses Eugene, Oregon's CAHOOTS Program as a model to develop and strengthen partnerships among first responders to community members with behavioral and mental needs. CAHOOTS is a police-contracted provider, and as such local law enforcement oversees funding and contracts for service.

35. **White Bird Clinic. CAHOOTS. 2025; Available at: https://whitebirdclinic.org/cahoots/. Accessed 6/3/2025.**
This White Bird Clinic webpage provides and overview of the CAHOOTS (Crisis Assistance Helping Out On The Streets) mobile crisis intervention program currently offered in Springfield, OR. Services provided include, but are not limited to: crisis counseling; suicide prevention, assessment, and intervention; conflict resolution and mediation; grief and loss; substance abuse; housing crisis; first aid and non-emergency medical care; resource connection and referrals; and transportation to services.

36. **Center CGS Justice. Expanding First Response: A Toolkit for Community Responder Programs. New York, NY: The Council of State Governments.**
This Council of State Governments Justice Center webpage presents its "Expanding First Response: A Toolkit for Community Responder Programs." It includes various resources and videos outlining the issue, community responder program highlights from across the U.S., and considerations to implement a community responder program.

37. **Expanding First Response. 2025; Available at: https://csgjusticecenter.org/publications/expanding-first-response/topics/. Accessed 6/3/2025.**
The Council of State Government's Justice Center provides an overview of the topics included in its Expanding First Response toolkit for community responder programs. Topics discussed include community engagement and collaboration, needs assessment, call triage, program

staffing, date-informed decision-making, safety protocols, program financial stability, and legislation to support community responder models.

38. **The Council of State Governments. Program Highlights. Available at: https://csgjusticecenter.org/publications/expanding-first-response/program-highlights/. Accessed 6/3/2025.**
This webpage from the Council of State Governments Justice Center's toolkit provides program highlights for several communities across the U.S. that had implemented various community responder models.

39. **Mayor Harrell Announces Citywide CARE Expansion [press release]. Seattle, WA: City of Seattle, Office of the Mayor, 6/26/2025 2024.**
This announcement from the Seattle Mayor's Office outlined the proposal to expand the Community Assisted Response and Engagement (CARE) Department behavioral health responder team citywide, 7 days a week. The announcement cites the successful dual dispatch pilot launched in October 2023. The Mayor noted, "This plan is informed by 9-1-1 call data, and we will continue to be rigorous in evaluating this work." Federal funds were secured to support the pilot expansion. The phased expansion was planned to be complete by the end of 2024. During the pilot, "the CARE team safely responded to over 500 dispatch calls, with an average response time of less than [10] minutes and an average time on scene of 39 minutes. 88% of calls came primarily from police officers requesting assistance and the remaining 12% were dispatches from the 9-1-1 Center for known high utilizers of emergency services." Additionally, "data for April and May [2024] shows that across 125 total calls, SPD was able to secure the scene, hand off to CARE, and leave for other priorities over half the time. An analysis of 9-1-1 calls from 2023 found approximately 8,000 calls which could be appropriate for the CARE Community Crisis response team under expansion plans."

40. **Disability Rights Oregon v. Washington County et al.; No. 3:24-cv-00235. 2024.**
On February 5, 2024, an individual person and Disability Rights Oregon filed a lawsuit, Disability Rights Oregon v. Washington County et al., No. 3:24-cv-00235, which challenges Washington County, Oregon's practice of dispatching armed law enforcement officers, rather than qualified mental health professionals, as first responders to mental health emergencies.

41. **Management Office of Financial. April 1 official population estimates. 2025.**
The Washington State Office of Financial Management publishes population estimates of all cities, towns, and counties in the state. This estimate includes 2025 data.

42. **Serving King County: Public Safety Answering Points (PSAPs). 2025; Available at: https://kingcounty.gov/en/dept/kcit/data-information-services/911-program-office/psaps. Accessed 6/18/2025.**
This King County webpage provides information about PSAPs serving King County.

43. **Statistics U.S. Bureau of Labor. Occupational Employment and Wage Statistics Query System. 2024.**
The U.S. Bureau of Labor Statistics publishes occupational employment and wage statistics by state. This system allows users to query for specific occupations.

44. **Authority Washington State Health Care. Behavioral Health-Administrative Services Organizations (BH-ASO).**
This map, published by the Washington State Health Care Authority, shows the 10 Behavioral Health-Administrative Services Organizations (BH-ASO) and which counties are in each BH-ASO.

45. **Chiefs Washington Association of Sheriffs and Police. Full Time Law Enforcement Employee Count 2024.**
The Washington Association of Sheriffs and Police Chiefs publish data on numbers of full time law enforcement employees. This data includes 2024 totals.

46. **Administration U.S. Fire. National Fire Department Registry Quick Facts. 2025.**
The U.S. Fire Administration creates a national database for use by the fire protection and prevention communities, allied professions, the general public and the U.S. Fire Administration (USFA). USFA uses the database to conduct special studies, guide program decisionmaking, and to improve direct communication with individual fire departments.

47. **Stuber J., Klein, R., deHaan, B., Kitajo, J. Co-Response: An Essential Crisis Service. A Landscape Analysis for the Washington State Legislature. University of Washington, School of Social Work;2023.**
The University of Washington's Behavioral Health Crisis Outreach Response and Education program published this report to the legislature on co-response in Washington State. The report includes information on what types of co-response are across the state, and where it exists, as well as the impact of co-response, funding mechanisms, staff training and wellness needs, barriers facing co-response programs, and the Involuntary Treatment Act.

48. **Neusteter M. M., Khogali, M., and O'Toole, M. The 911 Call Processing System: A Review of the Literature as it Relates to Policing. Vera Institute of Justice;2019.**
The Vera Institute published this report of the U.S. 911 call processing system. The authors provide an overview of the history of 911, how 911 calls are generally processed, data limitations, findings from literature, and opportunities for alternatives for police departments.

49. **Goldman M. L., Looper, P., Odes, R. National Survey of Mobile Crisis Teams. Vibrant Emotional Health as funded by the Substance Abuse and Mental Health Services Administration (SAMHSA);2023.**
Goldman, Looper, and Odes published this report detailing results from a 2022 national survey of Mobile Crisis Teams (MCT). Results were obtained prior to the launch of the 988 line. A total of 1,290 responses were completed by MCT programs, however, only the responses that provided their state (N=562) were included due to significant missingness of data among respondents who did not provide a state (728 respondents, which answered on average fewer than 3 questions). Respondent roles included MCT Program Director/Manager (43%), Front-Line MCT Clinician (19%), MCT Clinical Supervisor (12%), and Executive Director or CEO of the organization that oversees the MCT program (10%). 45 states included at least one response, except for Rhode Island, Washington DC, Minnesota, North Dakota, Wyoming, and Hawai'i. Survey results show MCT geographic distribution, areas served, and contexts are diverse; MCTs

themselves are diverse operationally and administratively; there is a gap between the vision and reality for MCT scale and reach; operational integration between MCTs and the crisis continuum is limited; MCTs collaborate with law enforcement on multiple key functions; metrics tracked by MCTs are incomplete; and, clinical best practices and partnerships are unevenly adopted across MCTs. The report includes limitations and policy implications. One specific policy implication pertained to a registry of MCTs. The authors wrote, "Respondent contact information gathered in this survey can set the foundation for the creation of a registry of MCTs across the US states and territories to drive the creation of an "MCT Finder" search engine to be used by referring agencies, including the potential for 988 crisis hotlines to "dispatch" MCTs. Such a registry could further enable outreach to MCT programs for participation in convenings, technical assistance opportunities, funding opportunities, and creation of learning communities."

50. **Buettner Jennifer Stuber and Brook. Co-Response in Washington State. University of Washington School of Social Work; Co-Responder Outreach Alliance;2023.**
The University of Washington's School of Social Work published results from a 2023 statewide survey of co-response across the state. Survey data showed 54% of programs serve a law enforcement department, 38% serve a fire department, and 8% serve both a law enforcement and a fire department. The survey found that program oversight was managed by law enforcement (48%), a fire department (35%), a community behavioral health agency (24%), or a public health department (5%). Survey results found uneven distribution of programs across BH-ASO regions, with program concentration in the northwest Puget Sound region of the state. Results also showed that 59% of programs responded alongside a first responder, 59% responded in coordination with a first responder, 48% provided follow-up care with no first responder present, and 54% of programs used 2 or more program models. Survey results also showed that community need exceeds available services, where 68% of programs reported being unable to meet community demand in their service area, 58% reported needing additional staff, and 87% operated less than 24 hours a day, 7 days a week. Co-response programs who participated in the survey receive funding from a range of sources, including first responder agencies, county, city, state, or federal government, Accountable Communities of Health, BH-ASOs, Washington State Association of Sheriffs and Police Chiefs, and Philanthropy. The survey also found that programs reported coordinating with 988 (23% of programs) and receiving calls/referrals from 988 (16% of programs).

51. **Bohm K., Kurland L. The accuracy of medical dispatch-- A systematic review.** ***Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine.*** **2018;26:94.**
Bohm and Kurland conducted a systematic review of 18 articles published from 2012 up to May 16, 2017, that examined the ability of medical dispatching systems to accurately dispatch EMS according to level of acuity and recognition of specific health conditions. The authors used PRISMA and GRADE methodology. The role of "the telecommunicator at the dispatch center is – based on the information obtained during a telephone call – to evaluate whether emergency medical services (EMS) are needed and with which priority the source needs to be dispatched." Moreover, "[t]he challenge is to dispatch EMS appropriately with limited resources and still be safe the patients; this requires accurate dispatching systems." The authors stated that, generally, telecommunicators use either a Medical Priority Dispatch System (i.e., based on codes and scripted questions asked of the caller) or a criteria-based dispatch system (i.e., based on the experience of the telecommunicator to conduct an interview). In both systems, "the

telecommunicator allocates each call to one of the listed chief complaints." The authors state there are also different systems for EMS response ("e.g., advanced and/or basic life support ambulances, first responders or pre-hospital emergency physicians and helicopter emergency services"). The accuracy of EMS systems is based on both the dispatch and the response to the dispatch. Specifically, "[d]ispatching accuracy, or effectiveness, relates to the ability of the dispatching system to discriminate between the required EMS resources and the priority of these." The authors identified studies examining the accuracy of identifying cardiac arrest, stroke, medical priority, and helicopter medical services for major trauma. Overall, the authors found "there is a very low to low overall level of evidence for the accuracy of medical dispatching systems." For example, about half patients with stroke are identified by the medical dispatcher. Of times when helicopter medical services are deployed for major trauma, about half are cancelled by ground EMS. In addition, "[a]lthough more than half of the calls are dispatched as priority 1 – only approximately 5% of these calls are critical, demonstrating the large over-triage in systems, and at the same time, revealing the lack of consensus on what level over-triage level is reasonable." Dispatching systems are typically designed to over-triage so as not to miss any people in need of intervention. The authors also found "scant evidence concerning the necessary skills and competence for the telecommunicator." The authors concluded that, "[m]easures of accuracy for dispatching systems are needed as a step in the direction of getting the right treatment to the right patient at the right time. However, there is an inherent challenge to identify the subset of patients that benefit from a specific intervention (e.g., [helicopter medical services] or acute coronary syndrome])." The authors also noted that there is no common or agreed upon way to measure dispatcher accuracy, especially as there are different dispatch systems and EMS response tiers and organizations. Therefore, there is a need to "create a consensus on common standards for reporting before consensus can be reached for the level of accuracy in medical dispatching systems."

52. **Guild The City of Seattle and Seattle Police Officers'. Special Event Premium, Dual Dispatch Pilot, and Park Rangers Memoradum of Agreement. 2023.**
This Memorandum of Agreement by and between the City of Seattle and Seattle Police Officers' Guild (SPOG) outlined the City of Seattle's Dual Dispatch Alternate Response Pilot Project. Parameters included the maximum number of FTE involved in the pilot project as "Community Crisis Responders" (CCRs), types of calls for which dual dispatch can occur, and describes the meaning of dual response. The language states that "During the course of the pilot project, the parties may evaluate additional call types that may be suitable for dual dispatch and may mutually agree in writing to expand the types of calls covered by this agreement."

53. **RCW 38.52.010(2024).**
RCW 38.52.010 defines "executive head" as well as additional 911 emergency terms.

54. **SPOG Collective Bargaining Agreement. Seattle, WA2024.**
The Collective Bargaining Agreement (CBA) by and between the City of Seattle and Seattle Police Officers' Guild (SPOG) was approved by the Seattle City Council in May 2024 and retroactively applied from January 1, 2021 through December 31, 2023. The CBA incorporated previously signed Memoranda of Understanding (MOUs) and Memoranda of Agreement (MOAs) including the December 2023 Special Event Premium, Dual Dispatch Pilot (or Alternate Response Pilot Project), and Park Rangers MOU.