



RE-ROUTING BEHAVIORAL HEALTH CRISIS CALLS FROM LAW ENFORCEMENT TO THE HEALTH SYSTEM

White paper on D.C.'s crisis response system, current challenges, and opportunities to increase health and reduce harm

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Executive Summary

The past year has called for our community to re-imagine our health and human service systems to provide more equitable and appropriate care for District of Columbia residents, including those experiencing mental health conditions and substance use disorders.¹ In 2020, the DC Health Matters Collaborative established the goal to research the crisis response system in the District, educate stakeholders, and advocate for policy improvements.

The DC Health Matters Collaborative is a coalition of hospitals and health centers that combine efforts to assess and address community needs in the District of Columbia. One of the Collaborative's central projects is completing a Community Health Needs Assessment (CHNA) every three years. Based on our 2016 and 2019 needs assessment findings, the Collaborative's work is organized around four key priority needs: mental health, care coordination, health literacy, and access to place-based care. The Collaborative's mental health work has focused on strategies to improve access to and equity within behavioral health care in D.C.

An estimated 19% of Americans have a mental health condition.² Indicators of adverse mental health in the District are on the rise, such as death rate by suicide, prevalence of depression, and frequent mental distress.³ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) notes that only 42% of District residents with a mental health condition currently receive treatment.⁴ If not attended to, mental health challenges can inhibit our ability to care for others, succeed in school or employment, or maintain our physical health.

In some cases, mental health concerns catalyze a crisis, potentially resulting in risk of harm to self or others. In 2020, we began researching what happens when someone calls 911 in the District for a mental health crisis. A review of Metropolitan Police Department (MPD) data and media reports showed that 41% of instances of police contact with those with mental illness resulted directly from a call to 911 from a family member or friend, while an additional 7% of police contacts with persons with mental illness resulted from the individual's own call to 911.⁵ We then considered whether the care persons received during interactions with the

¹ For the purpose of this report, mental health will be used interchangeably with behavioral health.

² “The State of Mental Health in America, 2020,” *Mental Health America*, 2021, <https://mhanational.org/sites/default/files/State%20of%20Mental%20Health%20in%20America%20-%202020.pdf>.

³ “Community Data Dashboard,” DC Health Matters, 2021. <https://www.dchealthmatters.org/indicators/index/dashboard?alias=alldata>.

⁴ “Behavioral Health Barometer: District of Columbia, 2015,” HHS Publication No. SMA-16-Baro-2015-DC. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA), 2015 (page 11), https://www.samhsa.gov/data/sites/default/files/2015_District-of-Columbia_BHBarometer.pdf.

⁵ Emma Frankham, “Mental Illness Affects Police Fatal Shootings,” *Contexts*, July 17, 2018, <https://contexts.org/articles/mental-illness-affects-police-fatal-shootings/>.

District's first responders, including police, was appropriate by the standards of public health and best practices.

This work is both important and timely. Mental health issues can often hasten unwanted interaction with the police, which we have seen with the in-custody death of Daniel Prude in Rochester, NY, among too many others.⁶ The Journal of the American Academy of Psychiatry and the Law notes that between 2015-2018, roughly a quarter of all people fatally shot by police in the U.S. were people with mental illness.⁷ Worse, the Treatment Advocacy Center notes that people with severe mental illness, characterized by intense symptom severity and severe functional impairment if left untreated, are sixteen times more likely to be killed during an encounter with police.⁸

To contribute to conversations already underway in the District related to both health system improvements and law enforcement reforms, the Collaborative convened behavioral health professionals to discuss their experiences with the crisis response system in 2020-2021. The Collaborative spoke with psychiatrists, social workers, nurses, peer support workers, community-based providers, and advocates, in primary and specialty care, emergency departments, and publicly funded services on how the system could be improved. The Collaborative also researched models tested in other U.S. jurisdictions that de-escalate and minimize harm and trauma in crisis situations.

Within the District's crisis response system, there are a several programs funded through the Department of Behavioral Health (DBH): the ACCESS Helpline, which can activate a crisis response team for emergency psychiatric care; Community Response Teams (CRT) to support homeless outreach, mobile crisis, and pre-arrest diversion; and the Comprehensive Psychiatric Emergency Program (CPEP) which offers mental health and addiction counseling, crisis response, event response, domestic violence follow-up, and links to providers, referrals, and well checks. The District also funds the Child and Adolescent Mobile Psychiatric Service (ChAMPS) for crisis response to youth. However, systems, including community-based and preventive services, continue to have too little capacity to meet the need.

Further, DBH conducts a special, 40-hour elective training program for MPD officers – Crisis Intervention Officers, or CIOs – to increase understanding about mental health in the community and provide training in de-escalation techniques. CIO Trend Reports covering 2011-2017 note the most common reasons for CIO dispatch, including disorderly behavior,

⁶ Eric Westervelt, “Mental Health and Police Violence: How Crisis Intervention Is Failing” NPR, September 18, 2020, <https://www.npr.org/2020/09/18/913229469/mental-health-and-police-violence-how-crisis-intervention-teams-are-failing>.

⁷ Michael S. Rogers, Dale E. McNiel, Renée L. Binder, “Effectiveness of Police Crisis Intervention Training Programs” *Journal of the American Academy of Psychiatry and the Law Online*, September 2019, DOI: 10.29158/JAAPL.003863-19, <http://jaapl.org/content/early/2019/09/24/JAAPL.003863-19>.

⁸ Jennifer Mascia, “The Growing Movement to Send Counselors — Not Cops — to Mental Health Crises,” *The Trace*, September 28, 2020, <https://www.thetrace.org/2020/09/alternatives-to-police-defund-public-safety-mental-health/>.

threats of suicide or violence, neglect of self-care, and public intoxication.⁹ Once on site, the most exhibited behaviors CIOs noted included hostility, depression, fear and anxiety, auditory or visual hallucinations, and medical neglect.⁹ With the exception of threats of or actual violence, these common dispatch reasons and behaviors could likely be better handled by a proactive effort of unarmed social workers and other behavioral health professionals, in coordination with services, resources, and providers throughout the District.

There are several model approaches to better support persons with mental health needs in crisis: the National Alliance on Mental Illness (NAMI) notes an effective crisis response system is available 24 hours a day, with walk-in and mobile crisis services.¹⁰ Similarly, the Justice Collaborative Institute notes that a model crisis response system is separate from law enforcement and includes on-site, on-demand and preventative services.¹¹ SAMHSA observes that crisis services must be available to anyone, anywhere, and anytime (and best practices for a child and adolescent crisis system should be available 24 hours a day to all children, regardless of payer). Overall, a comprehensive crisis response system should include screening and assessment, mobile crisis response and stabilization, residential crisis services, psychiatric consultation, referrals and warm hand-offs to home- and community-based services, and ongoing care coordination.¹²

The District provides aspects of a comprehensive system; D.C. nominally meets NAMI's definition given available services, but not the Justice Collaborative Institute's definition, primarily due to the continued presence of police as first responders to behavioral health and crisis calls. The District also lacks sufficient residential crisis beds and services, and experiences gaps in warm hand-offs and connections to ongoing services and treatment.

Models limiting harm and trauma already exist across the U.S. The CAHOOTS program (or "Crisis Assistance Helping Out on The Streets") in Eugene, Oregon, is the oldest program of its type in the U.S. The program diverts mental health cases from law enforcement by responding to mental health calls through the 911 and 311 systems with a medic and an experienced crisis worker.¹³ We also note examples in Colorado, Florida, California, New Mexico, and Washington State, a mere sampling of jurisdictions beginning to reimagine their

⁹ "District of Columbia Crisis Intervention Officer (CIO) Program Annual Trend Report: FY11 through FY16," *D.C. Department of Behavioral Health*, December 19, 2016, https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/CIO_FY11-FY16_Trend%20Report_12-19-16Final.pdf.

¹⁰ "Getting Treatment During a Crisis," *National Alliance on Mental Illness (NAMI)*, Accessed May 3, 2021, <https://www.nami.org/Learn-More/Treatment/Getting-Treatment-During-a-Crisis>.

¹¹ Patrisse Cullors, Tim Black, "Community-Based Emergency First Responders: Explained," *The Appeal*, June 25, 2020, <https://theappeal.org/community-based-emergency-first-responders-explained/>.

¹² "Assessment #9: Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm," *National Association of State Mental Health Program Directors*, August 2020, <https://www.nasmhpd.org/sites/default/files/2020paper9.pdf>.

¹³ "What is CAHOOTS?" White Bird Clinic, October 29, 2020, <https://whitebirdclinic.org/what-is-cahoots/>.

policing and crisis response systems. Providers are eager to explore the implementation of these non-law enforcement crisis assistance programs.

After reviewing the District's current crisis assistance approach and services, speaking with providers, and researching alternative models across the country, the Collaborative identified the following recommendations. These respond to feedback from providers and align with the models recommended above:

1. Establish a practice of dispatching trained behavioral health providers instead of law enforcement to 911 crisis calls. This should be at all hours and in all neighborhoods, and may be either through a new initiative (similar to CAHOOTS) or by enhancing capacity in CRT.
2. Deliver more robust and on-going training for MPD and 911 dispatchers (and other first responders) related to behavioral health, de-escalation, and mental health first aid. Such additional training should support dispatch of non-law enforcement and/or CIOs to mental health crisis calls and incidents, as well as advanced training for 911 dispatchers on routing mental health calls to appropriately-trained first responders.
3. Organize a roster of all active CIO-trained officers and institute staffing practices to provide CIO coverage throughout the District during all shifts.
4. Reform rules related to completing an FD-12 (*i.e.* an admission record/transport request for emergency mental health observation and diagnosis) to expand the types of providers who can execute such orders.
5. Expand the infrastructure to appropriately care for people in crisis in D.C., including increased capacity within health care settings and in the health care and human services workforce.
6. Improve health, justice, workforce, and educational system coordination by establishing an Interagency Council on Behavioral Health.
7. Establish better processes for collection and sharing of information, communication, and coordination between and among providers and families.
8. Increase and improve communication with – and education for – the community about crisis response, to ensure better outcomes when calling 911 or DBH for services.
9. Adequately fund community-based organizations and school programs that provide mental health care¹⁴ and substance use treatment services.

Working together, health care and human services providers, community members, and the District can re-imagine crisis response with the goal of a safer, more compassionate, health-centered, and coordinated response to people with mental illness, addiction, trauma, distress, or crisis.

¹⁴ “What is MTSS? A Multi-Tiered System of Supports,” PBIS Rewards, Accessed May 3, 2021, <https://www.pbisrewards.com/blog/what-is-mtss/>.

Introduction

About DC Health Matters

Formed in 2012, the DC Health Matters Collaborative is a partnership of hospitals and health centers that combine efforts and resources to assess and address community needs in the District of Columbia. We work together to achieve our vision: one healthy and thriving capital city that holds the same promise for all residents regardless of where they live.

Collaborative membership includes four non-profit hospitals (Children's National Hospital, The HSC Health Care System, Howard University Hospital, and Sibley Memorial Hospital); four federally qualified health centers (FQHCs) (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care); and three associations (DC Behavioral Health Association, DC Hospital Association and DC Primary Care Association).

Two of the main projects of the Collaborative are completing a Community Health Needs Assessment (CHNA) every three years and implementing a three-year Community Health Improvement Plan (CHIP) that responds to the identified needs. Our work is organized around four key priority needs based on the findings of our past CHNAs: mental health, care coordination, health literacy, and access to place-based care.

For our 2016 and 2019 CHNAs, DC Health Matters Collaborative conducted town halls, focus groups, key informant interviews, and qualitative and quantitative analyses. Stakeholders identified significant impediments to care related to mental health, emotional wellness, and substance use in the District – issues for both patients and health providers – from stigma to waitlists for treatment, as well as reductions of services at community hospitals which have traditionally served Black and brown communities, and opioid abuse within the community. Participants expressed a need for more resources, education, and engagement around behavioral health. The community also wants the pieces of the health system to work better together (*i.e.* care coordination), and for policymakers and providers to show more understanding of the social context in which patients live, work, and seek care.

Existing community health issues have been exacerbated in the COVID-19 pandemic and economic crisis spanning from 2020-2021, while the mental health of communities and individuals has worsened, disproportionately impacting people of color and low-income residents.

About This Project

Like other jurisdictions large and small, D.C. is reassessing how to safely and effectively provide public safety services to residents, which includes reconsidering by whom and how those services should be provided. As discussed below, cities are experimenting with deploying mental health clinicians, emergency medical technicians (EMTs), social workers, and peer support workers rather than police for incident calls where mental health may be the contributing factor. In D.C.'s current system, most people seeking assistance default to calling 911 for help, which often results in police being dispatched to incident calls. However, an armed response may be the antithesis of what and who is needed to address the issue. Too often, a call to 911 from a worried family member, neighbor, or care provider results in harm to people who are simply experiencing a crisis and need support, understanding, and treatment.

The National Conference on State Legislatures (NCSL) notes that people with mental illness are no more likely to commit violent acts than those who do not experience mental illness, yet they are ten times more likely to be the victim of a violent crime.¹⁵ There is an unfortunate parallel between people experiencing mental health issues in the United States and receiving unwanted or overzealous levels of policing.

In 2020, the nation witnessed the in-custody death of a naked Daniel Prude, outside in winter, in Rochester, NY; the shooting of a 13-year-old with autism in Salt Lake City, UT; and the shooting death of a person with schizophrenia who had just been released from a psychiatric hospital in Detroit, MI. In fact, incidents of mishandling persons experiencing a mental health crisis by police in Rochester, NY, continue to be in the news – in January 2021, police were called to a home for a “family disturbance” and after admonishing a 9-year-old girl for “acting like a child”, police pepper sprayed her even though she was *already* handcuffed and in the back of a patrol car.¹⁶ Just outside the District, in January 2020, a 5-year-old was handcuffed by police after leaving school grounds, while officers mocked the child and threatened him with physical harm. (A statement from the Montgomery County Fraternal Order of Police (Lodge 35) noted, “[U]nless an officer is assigned to a specialized unit, Montgomery County police officers do not receive training on how to effectively communicate with a young child in distress.”)¹⁷

¹⁵ “Police-Mental Health Collaboration,” *National Conference of State Legislatures*, July 1, 2020, <https://www.ncsl.org/research/civil-and-criminal-justice/mental-health-needs-of-criminal-justice.aspx#:~:text=CITs%20are%20composed%20of%20experienced,who%20are%20not%20CIT%2Dtrained.>

¹⁶ “Rochester police pepper-spray distraught 9-year-old — ‘you’re acting like a child’” *Mercury News*, February 1, 2021, <https://www.mercurynews.com/2021/02/01/rochester-police-pepper-spray-distraught-9-year-old-youre-acting-like-a-child/>.

¹⁷ Marlene Lenthang, “5-year-old boy allegedly detained, handcuffed and threatened by Maryland police,” *ABC News*, March 27, 2021, <https://abcnews.go.com/US/year-boy-allegedly-detained-handcuffed-threatened-maryland-police/story?id=76721492>.

It is clear that many police officers do not receive sufficient training to successfully communicate with a public that they are sworn to serve, which includes when to de-escalate, apply handcuffs, or use force. The stories above were just a few of the incidents surrounding protests for racial justice that erupted across the U.S. following the videotaped death of George Floyd at the hands of Minneapolis police in May 2020. Clarion calls to “Defund the Police” rang out and urged policymakers to redirect funding from police department budgets to other community support programs that contribute to public safety. The Defund the Police movement is critical of how many services law enforcement is tasked with beyond criminal investigation and enforcing laws, activities for which they are not only insufficiently trained, but for which other community actors and providers would be better suited.¹⁸ For example, people who are experiencing a mental health crisis, and the people (family, friends, coworkers, strangers) around them, should be able to quickly and easily connect with professionals specifically trained in mental illness as well as de-escalation techniques.

As noted above, while most police encounters with persons experiencing a mental health crisis do not result in a death, between 2015-2018, roughly a quarter of all people fatally shot by police in the U.S. were people with mental illness.⁷ Worse, people with severe mental illness are sixteen times more likely to be killed during an encounter with police than persons who do *not* suffer a mental illness.⁸ Even if physical harm does not occur, the resulting encounters – and potential arrests or incarceration – are harmful and traumatizing to individuals, families, and neighborhoods. It is clear that new approaches are necessary to address escalating mental health needs, nationally and locally.

As part of a system-change project to educate stakeholders about mental health, the DC Health Matters Collaborative circulated an informal survey in the summer of 2020 among local decisionmakers, including D.C. Council members and staff, and Advisory Neighborhood Commissioners, about their interest in learning more about the District's Behavioral Health System. The Collaborative hosted a webinar series on requested topics, including an October 2020 webinar about the District's crisis response system. This event – featuring providers and mental health advocates – focused on resources for and experiences of people who may have mental health conditions and/or are experiencing a mental health crisis. This conversation included the nature and frequency of their interactions with police.

Our research for this webinar extended to comparisons of the District's crisis response system with other jurisdictions. (Examples of other models will be noted below.) In summary, we found that the District has a variety of direct and supportive programs – both in government and in the community – but their internal and external system gaps remain. Further, there was

¹⁸ “Defund the police” means reallocating money from policing to other agencies funded by local municipalities.

general dissatisfaction with the level and nature of police involvement with people experiencing mental health crisis. [The recording of the webinar can be viewed on YouTube.]¹⁹

Scope

This white paper is the result of conversations on the mental health crisis response system with health care providers and stakeholders representing more than a dozen organizations, and primary research conducted from September 2020 to April 2021. It is a preliminary attempt to compile qualitative and quantitative data, with best practices and policy recommendations, for improving our current crisis response system. We focus on the District of Columbia, specifically on the practices of and experiences with the Metropolitan Police Department (MPD), while noting that approximately 38 local, federal, and regional law enforcement agencies also have a footprint in the District. Our goal is to contribute to conversations in the landscape from public health and clinical perspectives.

Our foundational questions are: what happens when someone calls 911 for intervention in a mental health crisis in the District? Is it appropriate? What could be improved?

This paper explores the efficacy of the use of the 911 system and MPD intervention in crisis calls because MPD data, cross-referenced with media reports, determined that the most common cause of police contact for those with mental illness (41%) was a call to 911 from a family member or friend, while an additional 7% of police contacts with persons with mental illness resulted from the individual's own call to 911.⁵ We also look at what available health programs and interventions currently exist in the District and how to better integrate these programs and services to support residents in crisis.

So, what is working, what is missing, and what, in an ideal world, should our crisis response system should look like? There are many aspects to such a system, including determining when someone is having a mental health crisis, what systemic response is available, and further, what diversionary options are available to re-route someone *from* the justice system and *into* the health care system. We discuss below many parties and stakeholders in the "system." For example, the District's 911 dispatchers in the Office of Unified Communications (OUC) play a key role, as do the District's Department of Behavioral Health (DBH) programs and private health providers.

¹⁹ "Responding to Mental Health Crises in D.C. Through in a Trauma-Informed Lens," DC Health Matters Collaborative, October 21, 2020, webinar, https://youtu.be/P_4-su3aRTE.

Background

Definitions: what is a mental health crisis and “crisis response”?

The World Health Organization's definition of **mental health** sets a helpful baseline when we talk about the experience in communities:

“Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. Mental health is fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. [...] Multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time. For example, violence and persistent socio-economic pressures are recognized risks to mental health. The clearest evidence is associated with sexual violence. Poor mental health is also associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, physical ill-health and human rights violations.”²⁰

The overarching term **behavioral health**, often used by the District government, refers to emotional and mental health, as well as substance use and addiction, and encompasses a continuum of promotion, prevention, early intervention, treatment, and recovery support services.

According to the National Association on Mental Illness (NAMI), a person has a **mental health crisis** in any situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function.²¹ In these cases, a response should be fast and minimize any harm to the person in crisis or others.

NAMI notes that an effective **mental health crisis response system** is available 24 hours a day, with walk-in and mobile crisis services.²² Similarly, the Justice Collaborative Institute notes that a **model crisis response system** is separate from law enforcement and includes on-site, on-demand and preventative services.¹¹ The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Guidelines for Behavioral Health Crisis Care (2020) notes

²⁰ “Mental health: strengthening our response,” *World Health Organization*, March 30, 2018, <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>.

²¹ “Navigating a Mental Health Crisis,” National Alliance on Mental Illness (NAMI), 2018 (page 8), <https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis/Navigating-A-Mental-Health-Crisis>.

²² “Crisis Services Fact Sheet,” *NAMI*, March 2015, <https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/Crisis-Service-FS.pdf>.

that crisis services are for anyone, anywhere, at any time, but that in too many communities, the “crisis system” has been unofficially handed over to law enforcement, sometimes with devastating outcomes. The current national approach to crisis care is patchwork and delivers minimal treatment for some people who fall through the cracks, resulting in multiple hospital readmissions, life in the criminal justice system, homelessness, early death, and suicide.²³

The RAND Corporation states in Transforming Mental Health Care in the United States: “Many communities lack an adequate mental health crisis response system. Poor crisis care results in missed opportunities to direct individuals into treatment and sometimes ends in suicide that might have been prevented. Building an evidence-based response system that swiftly identifies individual mental health needs and efficiently triages individuals into appropriate care should reduce unnecessary suffering.”²⁴

While the District strives to have a comprehensive and functional mental health crisis response system, it only nominally meets NAMI's definition above, and fails to meet the Justice Collaborative Institute's definition due to the lack of separation from law enforcement. The District does meet portions of SAMHSA's model for crisis services, including mobile crisis and 24-hour-a-day services; however, the availability of residential crisis services, timely psychiatric consultation, effective referrals and warm hand-offs to home- and community-based services, and ongoing care coordination, all need strengthening.

There is still a wide gap between what currently happens and what experts, health professionals, and community members would like to see. Now, police are the primary source of support contacted by others observing a person in a mental health crisis, and people experiencing a mental health condition have a higher likelihood of death at the hands of police.

National and D.C. Data

Mental Health

Local and national data help us understand the magnitude of mental health crises. Nationally, 19% of adults (about 47 million people) experience mental illness, with about 5%

²³ “National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit,” Substance Abuse and Mental Health Services Administration (SAMHSA), 2020, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

²⁴ Ryan K. McBain, Nicole K. Eberhart, Joshua Breslau, Lori Frank, M. Audrey Burnam, Vishnupriya Karedy, Molly M. Simmons, “Transforming Mental Health Care in the United States,” *RAND Corporation*, 2021, https://www.rand.org/pubs/research_briefs/RBA889-1.html.

experiencing severe mental illness. Mental Health America, in “2021 State of Mental Health in America” notes:

- The mental health of U.S. youth is worsening;
- Suicide ideation and the prevalence of mental illness among adults is increasing;
- High, unmet need for mental health services for youth and adults:
 - For youth with severe depression, only 27.3% received consistent treatment;
 - 57% of adults with mental illness (over 26 million people) don't get treatment;
 - Even in states with robust access to mental health care, 38% of residents still have unmet treatment needs.²

When compared to states, Mental Health America ranked the District last (51st) for having the largest increase in prevalence of substance use disorder (SUD) in adults (13.1% of residents), and 50th for youth with SUD (5.4%). On the positive side, Mental Health America noted that the District's rate of suicides is low (11th, or 4.2%) compared to states, as are measures of major depressive episodes in youth. The District also has the lowest rate of uninsured residents at 2.5%.²

SAMHSA has separately noted that in the time prior to the COVID pandemic, only 42% of D.C. residents with a mental health condition were receiving treatment.⁴ Temporary allowances within both Medicaid and private insurance for telehealth services may help close that gap, but consistently, residents have not received the mental health treatment that they need.

Data from DC Health Matters notes that the District scores lower than the U.S. at-large on a variety of mental health metrics, although many of those metrics are ticking up, including:

- Prevalence of depression – 14.3% (lower than the U.S. and trending down pre-COVID)
- Frequent mental distress – 10.8% (lower than U.S. but trending up)
- Poor mental health days (average number of days) – 3.6 (lower than U.S. but trending up)
- Death rate by suicide – 6.5% (lower than U.S. but trending up)
- Depression amongst Medicare population – 14.3% (lower than U.S. but trending up)
- Teens who felt sad or hopeless – 25.2% (lower but trending up)
- Teens who considered attempting suicide – 14.8% (lower than U.S. but trending up)³

On other metrics, the District exceeded the U.S. average:

- Teens who have attempted suicide – 14.9% (about double U.S. rates)
- Teens injured by suicide attempt – 5.3% (higher than U.S. and trending up)
- Inadequate social support – 22.8% (very high as compared to U.S. and counties)
- Poor mental health for 14+ days – 13.2% (higher than U.S. and D.C.-past)³

The District is seeing predictable COVID-related impacts on the population's mental health, reflecting global trends, including increases in people seeking help with anxiety and depression, screening as having moderate to severe depression, increases in reports of thoughts of suicide and self-harm (particularly for LGBTQ+ youth), and general difficulty with isolation/loneliness. Data also show increases in Asian and Pacific Islander population seeking mental health services; and screeners for Black populations showing the highest percent changes over time for anxiety and depression symptoms.²

Access to Care

The District, like many U.S. jurisdictions, struggles with an insufficient behavioral health workforce, from the paraprofessional to doctoral level. While professional licensing may create the impression of higher availability than some jurisdictions, the numbers of licensed professionals who do not practice, who do not accept Medicaid, and/or do not accept any insurance all reduce the availability of sources of care. Furthermore, having insurance coverage may create the impression that providers are easily accessible; however, even for people who have adequate insurance coverage, they may find limited provider operating hours, and long waits for intake, treatment, and psychiatric medication services. Stakeholders also identify barriers to care due to transportation issues, stigma, language difference, and negative history with the health system.

Policing

Law enforcement is most often the first responder dispatched to mental health or substance abuse crises, and the volume of these calls is high.⁶ Nationally, it is reported to comprise 20% of calls to 911.

An analysis of almost 940,000 calls to 911 in the District from 2019-2020 by WUSA9 showed that mental health crises were a top reason for calls. Of 258,647 “noncriminal calls,” police dispatched to 36,000 calls for assistance in D.C. in response to a mental health issue over 18 months. Separate of the response dispatched through 911, the government-administered Community Response Team (described below) responded to an additional 10,347 unique individuals with possible mental health issues in 2020.²⁵

In March 2021, the Director of the Office of Unified Communications (OUC) in the District reported that over 8,000 calls for mental or behavioral health crises were noted in a six-month period in 2020. As these statistics show, residents need mental health assistance and intervention frequently, which all too often means coming into contact with law

²⁵ “Fiscal Year 2020-21 Department of Behavioral Health Performance Oversight hearing,” *DC Council Committee on Health*, February 12, 2021, video, http://dc.granicus.com/MediaPlayer.php?view_id=9&clip_id=6112.

enforcement. As history has shown, a person experiencing a mental health crisis may not fare well during police encounters.

There are also real disparities in policing and arrest by race in Washington, D.C. Black people are policed and arrested at higher rates than white people; they are also killed at higher rates. A *FiveThirtyEight* analysis found that Black people were arrested by MPD at a per-capita rate seven times higher – and killed at a rate 13 times higher – than white people.²⁶ From 2015-2020, more than two dozen Black Washingtonians have been killed by police, making crisis calls inherently more dangerous for Black individuals and contributing to fear in calling for police help.²⁷

During their training, MPD officers receive limited education in mental health, and DBH, on behalf of MPD, provides 40 hours of Crisis Intervention Officer (CIO) training to interested officers, going more in depth on mental health and de-escalation techniques.²⁸ According to testimony from Acting MPD Chief Robert Contee at the D.C. Council's Fiscal Year 2020 Performance Oversight hearing for the Department, only 800 officers are currently trained as CIOs out of a force of over 3,500.²⁹ While the Department offers the training up to five times a year, officers only need to take the training once, and there are no continuing education requirements.⁹ Attempts to embed behavioral health staff to support officers in their work or assist in connecting residents to treatment or other services have been delayed. Likewise, initiatives to develop diversion programs have been limited in practice.

Perspectives on Law Enforcement Responses

Many stakeholders envision a better response from qualified behavioral health professionals and/or community-based crisis response teams. In conversations to inform this white paper, current health providers (including physicians, psychiatrists, peer support workers, nurses, administrators, and social workers) shared their impressions of the way the crisis response system currently works. All described persistent challenges and expressed a desire for changes in protocol and capacity.

²⁶ Samuel Sinyangwe, “The Police Departments with The Biggest Racial Disparities In Arrests And Killings,” *FiveThirtyEight*, February 4, 2021, <https://fivethirtyeight.com/features/the-biden-administration-wants-to-address-racial-bias-in-policing-what-cities-should-it-investigate/>.

²⁷ Marisa M. Kashino, “Police Killed These Seven Washingtonians. Here Are Their Stories, and the Family Left Behind,” *Washingtonian*, September 6, 2020, <https://www.washingtonian.com/2020/09/06/police-killed-these-seven-washingtonians-here-are-their-stories-and-the-family-left-behind/>.

²⁸ Benjamin Moser, Emily Tatro, Toya Harris, Yvonne Jones, “ODCA Improving Mental Health Services and Outcomes for All: The D.C. Department of Behavioral Health and the Justice System,” *The Office of the District of Columbia Auditor*, February 26, 2018, http://www.courtexcellence.org/uploads/publications/ODCA_Report_Audit_of_DBH_2.pdf.

²⁹ “Fiscal Year 2020-21 Metropolitan Police Department Performance Oversight hearing,” *DC Council Committee on the Judiciary & Public Safety*, March 11, 2021, video, http://dc.granicus.com/MediaPlayer.php?view_id=44&clip_id=6233.

One health center social worker said that the current system is “hit or miss,” and of the police responding to emergency mental health calls: “sometimes they are respectful and helpful, but even the fact of their presence can be traumatizing or inappropriate.” The decision to call 911 is based on how quickly they need someone related to risk of violence to self or others, but, they added: “We feel conflicted, especially when someone may be dangerous, [if the person in crisis] is a Black man who is more likely to be injured by police. We know they need help, but we know that our decision to call MPD could lead to him being harmed.”

Several providers described experiences of calling 911 for urgent intervention – when someone is trying to walk into traffic, for example – with FEMS and MPD vehicles responding to the same scene in short succession. Multiple police, fire truck and/or ambulances all come at the same time with sirens activated, which may escalate matters when the opposite approach is needed. “That’s a lot of lights and uniforms and can be overwhelming.” One provider noted that “sirens and badges – in the context of systemic oppression – are symbolic in themselves and can be traumatizing.”

First-hand accounts also revealed chaotic or unhelpful communication between entities. Lines of authority or responsibility may exist – for example, which team should transport or call the hospital – but such guidance often appears to be unknown or ignored. The person in crisis is often handcuffed, which seems unnecessary and harmful to many clinicians.

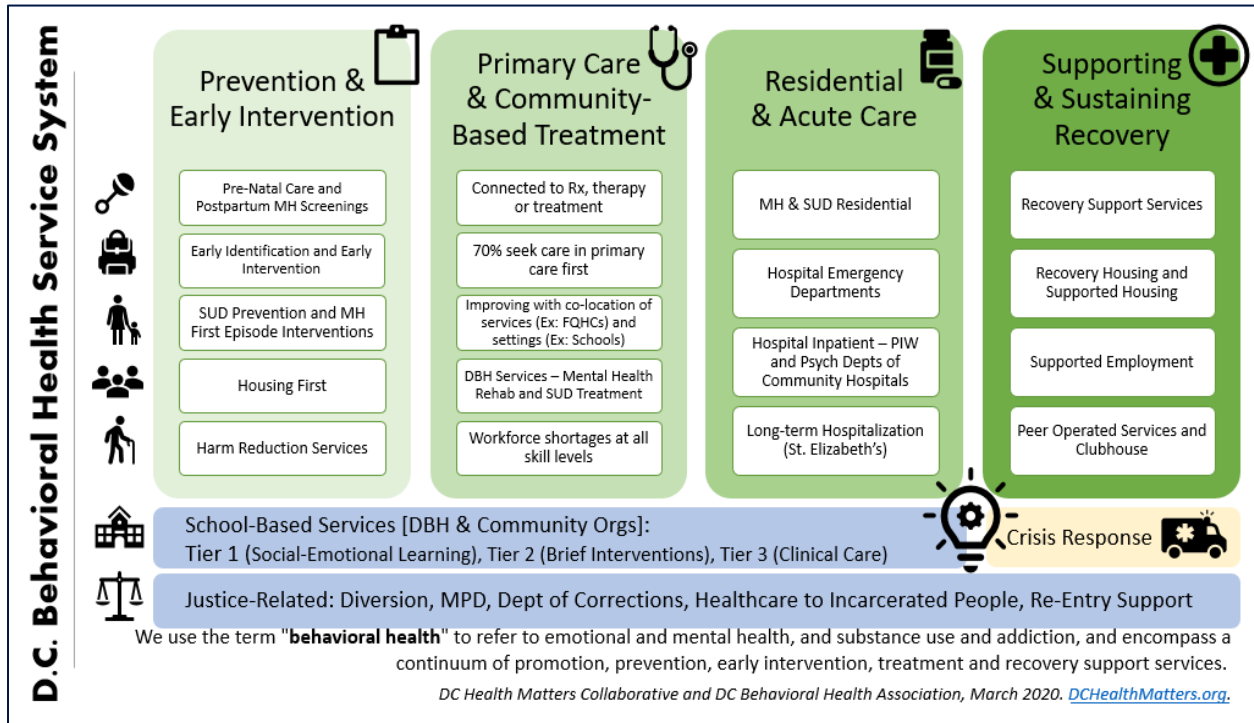
One experienced clinician summarized: “In general, police are called to respond to many kinds of situations that they don’t have training, knowledge or background to handle – they don’t *infuse health* into situations that are already escalated and in crisis.” She described MPD as “not super empathetic or sympathetic.” She recalled times she would have to call 911 to get transport to a hospital for a patient with her at the clinic, only to have MPD or FEMS “try to barge into the exam room.” Clinicians feel like it is out of their hands, even in their own facility. “It’s a circus. Meanwhile you’re trying to create a safe environment for the patient.”

“Sometimes you really do need a first responder,” said another social worker, “but ideally they would be separate from MPD.” Many named other cities using models that deploy social workers or counselors (described below) and wanted access to something similar.

A community-based behavioral health services provider described difficult household scenes and family conflict. “A crisis does not affect just the individual, but it affects the whole family. Parents often try their best to understand and support their children, but when they see behavior that they don’t understand, they don’t know what to do.” If they call 911 for help, it may escalate a situation that required mediation, or isolate a family member who needs support.

A community outreach professional noted that certain groups may be actively disrespected, harassed or even abused by police officers, (such as people who use recreational drugs, live in encampments, or sex workers), and this attitude carries over when those individuals are in crisis. They report law enforcement ignoring calls or reports of violence, refusing to provide protection, taking a crisis less seriously, or even laughing off reports of violence. A psychiatrist recalled police officers making light of sexual assault claims in front of the victim experiencing symptoms of post-traumatic stress disorder (PTSD). These experiences are a perceived deterrent to people engaging with CRT teams or other service providers because they do not know whether law enforcement will ultimately become involved.

District of Columbia Behavioral Health System Landscape



The District's behavioral health system includes services provided by government and community-based providers through:

- **Early intervention**, including prenatal and postpartum care, housing as health care, prevention, and harm reduction.
- **Community-based treatment and primary care providers**, which serve a critical need for therapy services, improved co-location of services, and delivery in people's homes and other community settings.

- **Residential and acute care supports** provided by residential treatment providers, community hospitals, and the DBH-operated St. Elizabeth's State psychiatric hospital.
- **Recovery support services** such as recovery housing, supported employment, and peer clubhouse services.
- **Mental health clinicians to students** in schools in both the DBH school mental health program and the community-based provider school-based behavioral health expansion program.
- And the **Justice-involved** portion of the system, (MPD and the Department of Corrections), including diversion, specialty courts, health care to incarcerated persons, and reentry support.

There are a variety of agencies and programs within the District's crisis response system. On the government side, DBH funds and operates several significant behavioral health crisis response functions.

The **ACCESS Helpline** is available 24 hours a day, seven days a week, and can activate a crisis response team. It carries out four functions: 1) acts as the District's Suicide Lifeline, 2) connects District residents to enroll in behavioral health treatment services, 3) authorizes rehabilitative care that requires District review before delivery, and 4) during COVID, acts as a warm line for callers experiencing general emotional distress or trying to decide if they should seek treatment services. The hotline is available at 888-793-4357 (or 888-7WE-HELP).

In interviews, health providers reflected that the ACCESS Helpline has expanded its reach during the pandemic, and serves as an effective steppingstone to make connections to care. They noted challenges for callers, however, getting from the enrollment process over the hotline to getting an appointment for treatment. This is, in part, a universal issue of limited behavioral health care workforce capacity.

DBH also runs **Community Response Teams (CRT)**, "the 24/7, 365 direct care arm of the Department" to support homeless outreach, mobile crisis, and pre-arrest diversion. Teams of behavioral health specialists are available to assess and offer referrals, encourage treatment, connect residents to services, offer harm-reduction options, and support diversion from the criminal justice system.

CRT Director Anthony Hall described services as available both to individuals seeking assistance as well as individuals "that may be observed in engaging in behaviors that are concerning to the community." Additionally, CRT supports cold weather outreach, substance use disorder outreach, and partnerships with Department of Human Services (DHS), MPD and community providers to ensure that people are connecting with appropriate services. CRT also oversees the District's new diversion program, wherein MPD can call CRT to engage in co-responses on a scene, for case consultation, or general guidance on processing a

situation and making decisions regarding the most appropriate modality of treatment “with the least harm caused.” CRT aims for a non-punitive approach to care.

Director Hall has observed more justice partners calling for co-response and evaluations over the last year, as well as a general increase of about 35% in call volume to CRT directly from 2019 to 2020 during the COVID pandemic.

Behavioral health professionals we spoke with generally praised CRT's multi-disciplinary, health-centered approach, and its staff. However, the reality is that CRT is not dispatched through 911 and therefore not a seamlessly integrated first responder. A direct call to CRT is required (which requires experience or ‘insider’ knowledge). Fundamentally, CRT does not seem to have the capacity in its current form to respond to all time-sensitive calls for which they may be the most appropriate responder.

The **Comprehensive Psychiatric Emergency Program (CPEP)** program, also run by DBH, provides crisis and event response, grief and loss response, certified addiction counselors, domestic violence follow-up with D.C. SAFE, as well as links to providers, referrals, and well checks. CPEP operates out of St. Elizabeth's campus, is open for walk-ins 24 hours a day, seven days a week, and responds to calls from 9 am-1 am. Like CRT, CPEP utilizes a trauma-informed, multi-disciplinary team model, with social workers, psychiatrists, counselors, internists, and others to address mental health crises, substance use issues, or issues of structural barriers to maintaining their mental health.

CPEP's Director of Crisis and Emergency Services Dr. Morgan Medlock, MD, MDiv, MPH considers CPEP “often the first door to care within the larger DBH system.” She estimated in October 2020 that CPEP fielded about 3,800 encounters per year; 75% of those with individuals who are initially engaged by police.

A psychiatrist we interviewed said that he loved the programs offered and is impressed by range of services from CPEP. He qualified that, like CRT and other programs, they do not have the staffing to meet the true level of need in the District.

The **Child and Adolescent Mobile Psychiatric Service (ChAMPS)**, is a community-based support for children and adolescents aged 6-17 years. ChAMPS will also respond for individuals aged 18-21 years in the custody of the Child and Family Services Agency (CFSA). The program provides a mobile crisis response to help manage extreme emotional behavior and assist families in arranging a temporary placement or other emergency care. In Fiscal Year 2020, ChAMPS received 1,443 calls (nearly half were new to the program), logged 594 deployments (plus 105 where they not needed once on site), and provided clinical consultations for 407 calls by a provider or parent.

Providers we spoke with praised ChAMPS for their responsiveness, communication, and coordination efforts. They were especially noted for their follow-up with other parties post-call, which is less common in other programs or the adult system. Providers lamented that there was no alternative to hospitalization for a child or adolescent determined to need time away from the home or community to stabilize from acute psychiatric distress.

DBH also offers **Crisis Intervention Officer (CIO)** training within MPD, consisting of a one-time, 40-hour training for officers, focusing on de-escalation techniques and mental health education. Over 1,100 officers have been trained over the course of the program's existence; most recent estimates are that 800 active officers have CIO training.^{9,29} A 2020 WUSA9 story notes its Chief Investigative Reporter learned that within MPD, less than one-quarter of officers had taken any course in crisis intervention.³⁰

In agency Trend Reports, we see that CIO-responded incidents generally resulted in low levels of injuries or physical harm, as well as higher percentage of diversion than arrest:

- 89% of incident have no injuries reported, and injuries to CIOs are as low as 1-2%;
- Only 7-11% of incidents involve a weapon, the most common being a knife;
- 64% of incidents receive crisis intervention; 72-84% of incidents involve transportation away from the scene;
- Only 4-8% of incidents result in arrest;
- The majority of incidents involved those aged 19-29;
- Responses usually concluded in approximately a half-hour.⁹

While these trends show the potential of special training, our interviewees widely concluded that the CIO program is not adequate, nor is it a reliable feature of an MPD response to a 911 call. They perceive that the current training only reaches officers who have a personal interest, and only provides them with a surface-level understanding of mental health issues and best practices. They note that it is not system-wide, nor an adequate number of hours for true skill-building. One provider who interacts frequently with MPD summarized: "It seems like the training is just an elective. If we're going to keep the CIO role in any capacity, the training needs to be strengthened, regular and ongoing. There also needs to be systematic way for disbursing officers so one is always near." This was a common complaint, that one could not expect a CIO to respond, even when explicitly requested, since they are not staffed, assigned, or dispatched that way.

³⁰ Eric Flack, Jordan Fischer, "DMV police are called on tens of thousands of mental health runs a year. Most don't get any training on how to handle it," *WUSA9*, November 11, 2020, <https://www.wusa9.com/article/news/911-mentally-ill-crisis-intervention-training-police-mental-health-D.C.-police-secret-service-metro-transit-police-fairfax-montgomery/65-3270ab6a-e15c-4ecb-9605-de5490668ca2>.

What happens when we call 911? Is it appropriate?

As noted above, NAMI holds that an effective crisis response system is available 24 hours a day, with walk-in and mobile crisis services, while the Justice Collaborative Institute finds an ideal model crisis response system is separate from law enforcement and includes on-site, on-demand and preventative services.

Our central guiding questions for this paper were: what happens during and after a 911 call? Specifically, how does OUC, FEMS or MPD respond, refer, stabilize, or bring for medical attention? Is the response appropriate and/or adequate?

Calling 911

As noted above, about 40% of calls to 911 during a mental health crisis come from a family member. The potential situations may range from emotional distress to imminent threat of harm to self or others. There is often ambiguity. An individual's perception of their own state of mind, a family's perception, a professional's perception, and an emergency responder's perception may substantially differ, with enormous potential real-world consequences. The caller may have limited knowledge or experience to help themselves; training in mental health first aid is not widespread in the lay community, nor is awareness of the DBH resources described above.

Professionals will often need to place calls for help, but many will try to call other programs (CRT, ChAMPS) before 911 or MPD. When professionals do call 911, they are careful in their communication, hoping that calm, clear language will prevent an escalated, overly forceful response. For example, they may say "someone needs a transport to get care" and not lead with the context that they may be "threatening violence." They may say "medical emergency" instead of "overdose" which seems more likely to trigger an ambulance than MPD. And they often specifically ask for a CIO. In a November 2020 report from WUSA9, the President of NAMI D.C. advised residents that, if a friend or family calls 911 about someone in a mental health crisis, the caller should specify the mental health crisis and request a trained Crisis Intervention Officer.³⁰ Even with careful communication, the default workflow of dispatching the nearest MPD officer (rather than a CIO) is the default expectation.

Providers explained that while they may want to downplay danger to mitigate the use of force, it is important to give dispatchers context about the history, threats, or related behavior, for example, to show that a threat was not just made in the height of conflict/a provocation. This would include noting any references to self-harm or fear of harm befalling someone else, as well as if the person is currently receiving any mental health treatment and/or medication.

It is unclear whether the District's 911 operators have received mental health de-escalation training or mental health education. According to DBH Director Barbara Bazron, PhD, at the Fiscal Year 2020 Performance Oversight hearing for the agency (held virtually February 2021), DBH does not provide any training or assistance to the OUC, and the OUC does not currently dispatch calls to CRT or other specialized programs, though a pilot to do so is in the works.²⁵ OUC's Director said during a March 2021 oversight hearing that dispatchers do perform "safety assessments" in their triage.³¹ Given a dispatcher's ability to make sophisticated triage decisions, and walk a caller through other life-saving measures, it is an oversight if dispatchers are not provided any mental health or de-escalation training in order to assist a caller or appropriately dispatch services.

One community-based provider summarized: "When someone needs help, there needs to be a better understanding of what that help should look like, what really is the need, and better training for the 911 dispatchers. Dispatchers could be helpful by asking someone two more questions about the behavior of this person: Does this person have a mental health diagnosis? If not, then could you tell me the behaviors this person has been exhibiting recently?"

Generally, there was not clarity, even among those who frequently call 911, about how the system works. They guess that more people would call 911 if they knew a mental health response was possible. Further, if the current system remains intact, they would like to see more general education around resources and who to call other than 911.

Dispatched First Responders

As described above, providers we interviewed agreed that first responders often appeared unprepared to change their approach from routine response for situations that involved behavioral health distress or crisis. They noted that while responding to mental health crisis is a regular occurrence for FEMS and MPD, there is seldom a good sense among parties of who is supposed to perform which roles or responsibilities, including transporting an individual to the hospital for evaluation. There were mixed experiences with the officers themselves, who sometimes "added to the chaos" rather than helped. Providers say they want to be able to take a leadership role in incidents involving their own patients, to ensure good coordination between family, health providers, and/or law enforcement. However, they are often sidelined.

As noted above, MPD's CIO Trend Reports covering both 2011-2016 and 2014-2017 show the most common reasons for CIO dispatch were disorderly behavior, threats of suicide or

³¹ "Fiscal Year 2020-21 Office of Unified Communications Performance Oversight hearing," *DC Council Committee on the Judiciary & Public Safety*, March 18, 2021, video, http://DC.granicus.com/MediaPlayer.php?view_id=44&clip_id=6261.

violence, neglect of self-care, and public. Once on site, CIOs noted hostility and depression, fear and anxiety, audio or visual hallucinations, medical neglect, or inappropriate dress as common exhibited behaviors. Most of these behaviors could likely be well handled by unarmed social workers and other behavioral health professionals.

The D.C. Auditor, in conjunction with the Council for Court Excellence, reviewed the CIO program in 2018.²⁸ They noted benefits to the program, including fewer arrests and injuries and low instances of use of force. But the audit also noted some cons – that there are not enough trained CIOs for all community members (only about 20% of the force is trained), there is a lack of connection to treatment and/or case management, and there is an additional traumatizing element of the use of handcuffs on everyone who is transported, whether children or adults. This was echoed in our interviews: “Officers are very intimidating, and it seems like we just can’t get away from handcuffs. When someone is being paraded out in handcuffs, it attracts attention. ***It criminalizes a mental health concern.***”

While providers often requested a CIO in crisis calls, they did not generally believe the CIO training was comprehensive or sufficient. “Officers who have mental health response training may have some understanding, but don’t necessarily have skills or ability to recognize issues – they aren’t trained like therapists or social workers, still have a law enforcement mindset.” Some experienced that even CIOs were not well-versed in their requirements, resources, or options for treatment. While a group like ChAMPS does have the staff to respond effectively, if medical transport is required, they have to call MPD anyway, as they aren’t empowered to transport themselves unless the individual willingly goes in a private vehicle.

Most providers we interviewed agreed with this statement: “police have more involvement than ideally they would - we’re further traumatizing [people in crisis] by putting them in handcuffs. We’re now punishing them for having a mental health crisis and maybe even stigmatizing them more.”

Transporting and the Role and Process of FD-12s

A crisis response call will often involve an FD-12 – the name of the application form used to effectuate transport for observation and psychiatric evaluation at a hospital. This is executed by an officer, or an “officer agent.” An officer agent is a physician, psychologist, or certain mental health provider type who is trained and certified by DBH. This process was frequently cited in our conversations with providers, including misunderstandings about the purpose of these orders, and major gaps in regulations that lead to poor outcomes.

Providers perceived that “some people do feel like their needs are being met” and have a helpful experience when they are transported to the hospital after a call to 911 or ChAMPS. It is common that they desire the attention, structure, care, or predictability they receive in the

health system, particularly if they have been in residential treatment before and they have trouble reintegrating into family life or community setting.

However, the perception or experience of the FD-12 process is not always positive. A provider who works with adolescents explained that she had seen it used by schools or foster parents as a threat or punishment when they cannot handle the child or adolescent's behavior. An adult provider who works with severely mentally ill people commented that an FD-12 does not always result in a hospitalization after the required evaluation because the involuntary hold requirements are quite strict. In her perception, the execution of the FD-12 may cause trauma or damage to the patient-provider relationship, especially if it does not result in meaningful care.

The restrictive criteria for what kind of professional can write or carry out an FD-12 feels arbitrary or problematic to providers we interviewed. Providers frustrated with current "officer agent" parameters wondered "why can't anyone with a license to give medical care or write prescription be eligible to execute an FD-12?" For example, a psychiatric nurse or social worker has to call MPD or CRT to execute an order for her own patient. Beyond the definitional barriers, DBH trainings to become an officer agent are infrequent and very limited in size. One provider who had gone through the training reflected that the opportunity to receive the training is important, and touches on essential issues of civil liberties, and should be more accessible.

Finally, a major limitation in the current system is that one may not be able to be held or evaluated at the hospital after an FD-12 if they are actively intoxicated on substances. Behavioral health providers point out that when someone has a mental health condition and they are also on substances, it creates a grey area wherein mental dysregulation may be difficult to evaluate. One provider reflected on instances when she has wanted to write an FD-12 for someone, but the fact that they were also intoxicated was a deterrent. They may opt to call CRT instead, with the aforementioned wait times. There is a reported need for alternatives to FD-12s in these instances, such as medically managed withdrawal programs, detox or sobering centers, or protective custody, in D.C.

During and After the Crisis

Transportation to the emergency department (ED), or to CPEP, is generally done in a private vehicle, by police or ambulance. When people in crisis arrive, it can be a harrowing process to be admitted, and undergo medical evaluation, followed by a social work evaluation, and observation. A psychiatrist at Children's National Hospital reported that the whole process can take on average four to six hours (up to eight in busy times). Then, waiting for admission clearance to a psychiatric institution, inpatient facility, or next level of care can take several days from the ED. Another pediatric provider explained that sometimes more trauma awaits after a child is discharged, if their parent or caregiver is ambivalent or unsupportive, or

struggles with their own crisis they are projecting onto the child. “It feels like a dead end. They think, ‘now I’ve tried everything, and nothing is helping.’”

Lack of next-level care is a major challenge in the District. Many models or settings are simply not available beyond inpatient, emergency departments, and CPEP. Other residential levels of care could include “bridge clinics,” children’s Psychiatric Residential Treatment Facilities (PRTFs), Partial Hospitalization Programs (PHPs), Intensive Outpatient Programs (IOPs), respite beds, etc. Even for patients who have an existing relationship with a mental health or SUD provider, days or even weeks may pass before they can see a provider following a crisis event.

SAMHSA notes the need for “crisis receiving and stabilization facilities” or bridge clinics, that are 24/7, open to walk-ins, and cannot turn anyone away (“no reject policy”).³² There is also a baseline historical lack of psychiatric beds locally. Some states have “psychiatric bed registries” so communities can rely less on law enforcement and have increased options for placements for people in crisis.³² There is not a “bed board” in the District, or any system to tell providers where one of these beds are available, though development efforts are underway.

Some jurisdictions are experimenting with a “living room” model in conjunction with emergency departments, which allows law enforcement officers to simply deliver the person into care and leave, versus current trends of officers waiting in an ED for hours until the patient can be seen. Baltimore, MD has city-funded Crisis Centers to reduce the demand on EDs. Patients are able to stay for two weeks while working with a social worker and a psychiatrist, and, if necessary, stabilizing on medication and receiving assistance finding housing.

District providers named some organizations who operated a limited number and duration of “crisis beds” (for example, SOME and Woodley House), but they do not take the place of a formal bridge clinic or place to “step-down.” One provider stated that if funds could be divested from police, the District could reallocate resources into wrap-around resource – such as a 24-hour center with a harm reduction framework.

Information Sharing and Care Coordination

Compounding difficulties, there are major break-downs in communication between patients and providers, and between providers. If a patient is seen somewhere other than their medical home, there may be no way for a provider to become aware that their patient is in

³² “Executive Order Safe Policing for Safe Communities: Addressing Mental Health, Homelessness, and Addiction Report,” SAMHSA, October 17, 2020, <https://www.samhsa.gov/sites/default/files/safe-policing-safe-communities-report.pdf>.

crisis, let alone to provide follow-up treatment and services. There are care coordination and hospitalization notification tools which help, such as CRISP (Chesapeake Regional Information System for our Patients)³³ and certain features in electronic health record products, but there are also rules that limit sharing information across providers. Information gaps are particularly common for persons with a SUD, since addiction treatment records may identify behaviors or activities that may be considered criminal.

In one of our interviews, a provider stated that while better coordination between points of care would “absolutely” lead to better health outcomes, getting notes on encounters from providers with other systems “is a nightmare.” Providers are well-versed in CRISP, but note that the information from hospitals may be limited, delayed, or missing entirely. There are not necessarily notifications when new prescriptions or hospitalizations are logged.

A psychiatric nurse said a small number of patients are referred to her as a primary care referral from the hospital. From her vantage point, the follow-up from the hospital or MPD should be handled better: “they may make a referral for a patient because they need to put a referral on their paperwork, but they don’t do enough follow-up to make sure the real connection is made.” Family members or case managers also encounter roadblocks when trying to get information from hospitals, police, or other parties, making it more difficult for them to support people through next steps in their treatment.

Another large gap is that 911 dispatch or EMS records are not integrated into health information systems. However, some providers have been able to call 911 for a wellness check on a patient by name based on dispatch records. Tracking individuals or families who call emergency services frequently could possibly result in enhanced care coordination. Providers who have practiced elsewhere believed other counties actively use 911 dispatch logs and call data for such purposes.

The District, in fact, does keep surveillance records for people who call 911 for drug overdose. DBH shares the data, then community groups are asked to go to those locations to do follow-up outreach. However, no entity in D.C. is apparently looking at such data on frequent callers from a high-enough level; data is not analyzed jointly or systematically for intervention or continuity of care.

Does “the system” meet the standards for effective crisis response?

NAMI defines an effective crisis response system as one that is available 24 hours a day, with walk-in and mobile crisis services. Similarly, the Justice Collaborative Institute notes that a

³³ CRISP (Chesapeake Regional Information System for our Patients): <https://crisphealth.org>

model crisis response system is separate from law enforcement and includes on-site, on-demand and preventative services. The District nominally meets NAMI's definition, but not the Justice Collaborative Institute's definition.

As noted above, the District does offer 24/7 services, including information from the ACCESS Helpline, mobile crisis from Community Response Teams, and walk-in services at CPEP. However, these resources are not accessed through a singular contact approach (like a 911, 311, or 988 number), requiring those seeking assistance to navigate through various service providers to find what is most appropriate.

Further, the Justice Collaborative Institute notes that law enforcement should not be involved in the mental health crisis response system. This is not the norm in the District. We do have on-site, on-demand and preventative programs, but they are not particularly coordinated. As with much of D.C.'s behavioral health system, stronger connections leading into obvious decision paths are needed to ensure that the help people need is available, easy to contact, timely, and appropriately responsive.

Models to De-Escalate, Minimize Harm, and Keep Everyone Safe

There is a range and spectrum of mental health crises, and we need a range and spectrum of responses at all levels of acuity. Ideally, people with mental health conditions are supported with the care and resources they need before experiencing a crisis or interacting with police.

SAMHSA's Sequential Intercept Model (SIM)

The Sequential Intercept Model (SIM) is a continuum that details how individuals with mental health and substance use disorders come into contact with, and move through, the criminal justice system.³⁴

Intercept 0 occurs *before* contact with the criminal justice system, enabling diversion into treatment. The key elements at Intercept 0 include warm lines and hotlines as alternatives to 911, mobile crisis teams with clinicians, peer supports from persons with lived experience, an SUD-focused strategy for referral and outreach, and community assets and supports for those in crisis, separate from emergency departments.

³⁴ "The Sequential Intercept Model (SIM)," SAMHSA, Accessed May 3, 2021, <https://www.samhsa.gov/criminal-juvenile-justice/sim-overview>

The primary activities at **Intercept 1** are law enforcement and emergency service responses to people with mental health and substance use disorders. This stage assumes collaboration between law enforcement and behavioral health providers to effectively address diversion into treatment instead of arrest and incarceration. The key elements at Intercept 1 include training for dispatchers to help identify instances where mental health crisis expertise could be needed; training for officers in de-escalation techniques and mental health disorders; partnerships with law enforcement, clinicians, and case managers; and sharing data to identify persons who come into frequent contact with police who could need connections to services.

The SIM also includes Intercept 2-5, which focus on court hearings, jail, re-entry, and parole/probation.

Jurisdictional Models

Models can be found across the U.S. that include the three components of crisis services systems' best practices: crisis call centers, mobile crisis teams, and crisis receiving and stabilization facilities (that are not emergency departments and/or jail). The National Conference on State Legislatures (NCSL) notes that having "authorized and funded triage centers" to divert people with mental health needs from the criminal justice system are increasing as lawmakers seek to develop functional alternatives.¹⁵ SAMSHA has compiled multiple other references to alternatives in their Safe Policing: Safe Communities report.³²

Eugene and Portland, Oregon

The CAHOOTS program in Eugene and Springfield, OR, or "Crisis Assistance Helping Out On The Streets," is the oldest program of its type in the U.S. working to divert mental health cases from law enforcement.¹³ CAHOOTS teams a medic and an experienced crisis worker, dispatched to mental health calls through the 911 and 311 systems. The CAHOOTS program is run by the White Bird Clinic in collaboration with the city governments of Eugene and neighboring Springfield, Oregon. The publicly funded program responds to roughly 20% of all mental health-related 911 and 311 calls in the respective jurisdictions. The program saves millions of dollars annually, and of the 24,000 calls they received in 2019, only 150 of those required back-up from police.

Portland, OR is launching its own program, Portland Street Response (PSR) in 2021.³⁵ The program is funded in part by reductions to the police budget, recently increasing from only \$500,000 to \$4.8 million. This funding increase will allow the program to expand by the end of 2021 to having two full-time, four-person teams. One team would include a paramedic, a

³⁵ "Portland Street Response," City of Portland, Oregon, Accessed May 3, 2021, <https://www.portland.gov/streetresponse>

licensed therapist, and two community health workers, while the other team would switch out the paramedic and health workers for an EMT and two peer support workers.

Denver and Boulder, Colorado

Denver and other cities in Colorado have been piloting the STAR Van, or “Support Team Assisted Response,” matching mental health professionals with police to respond to incident calls.³⁶ In Boulder, CO the program cost \$600,000 annually to operate, but saved the city \$3 million in jail costs due to fewer arrests and incarcerations. Looking at data from 2017, only 2.4% of encounters resulted in an arrest. One third of the 1,000 people who saw clinicians were connected with outpatient treatment. People assisted by the team were also connected to walk-in crisis services, protective services, a detox facility, or if necessary, were hospitalized.³⁷

Miami-Dade County, Florida

Miami-Dade County, FL received the dubious honor in 2008 of its jail being named the “largest psychiatric warehouse in the country.” This prompted the formation of a Mental Health Task Force which recommended crisis intervention training for 4,600 officers. The county also provided funding for additional mental health professionals. As a result, the county saw a dramatic decrease in the number of arrests from calls, dropping from approximately 10% of all calls (around 400-500 arrests out of 5,000), to less than 1% of calls resulting in arrest (10-20 arrests out of 5,000 calls.) Recidivism also dropped dramatically for people in either the misdemeanor or felony treatment programs.^{38,39}

San Francisco, California

San Francisco, CA announced in October 2020 that it would remove police from behavioral health calls, and instead seek to deploy teams from both its fire and health departments to respond to the majority of calls the city receives related to psychiatric, behavioral, or substance abuse concerns. Instead of police, these types of crisis calls will mostly be handled

³⁶ David Sachs, “The Denver STAR program that replaces police with mental and behavioral health counselors is working,” *Denverite*, February 2, 2021, <https://denverite.com/2021/02/02/in-the-first-six-months-of-health-care-professionals-replacing-police-officers-no-one-they-encountered-was-arrested/>.

³⁷ Mary Kate McGrath, “The 4 Best Examples of Police and Mental Health Response,” *RAVE Mobile Safety*, November 21, 2019, <https://www.ravemobilesafety.com/blog/best-examples-of-police-and-mental-health-response>.

³⁸ “How to Transform the Response to Those Having a Mental Health Crisis,” *Pew Charitable Trusts*, December 8, 2020, <https://www.pewtrusts.org/en/research-and-analysis/articles/2020/12/08/how-to-transform-the-response-to-those-having-a-mental-health-crisis>

³⁹ Ted Roelofs, “Mentally ill suspects get help in Miami, jail in Michigan. Guess which works,” *Bridge Michigan*, May 1, 2019, <https://www.bridgemi.com/michigan-health-watch/mentally-ill-suspects-get-help-miami-jail-michigan-guess-which-works>.

by new, unarmed mobile teams comprised of paramedics, mental health professionals, and peer support counselors.⁴⁰

Albuquerque, New Mexico

Bernalillo County, NM has six Mobile Crisis Teams (MCTs) providing a specialized response to 911 calls related to behavioral health.⁴¹ The two-person teams consist of one MCT-trained law enforcement officer and an MCT-trained master's level behavioral health clinician. New Mexico's Institute for Social Justice reported that almost half of the more than 5,000 calls received since the program's inception have been suicide or behavioral health incidents.

In response to racial justice protests in the summer of 2020, Albuquerque's mayor announced a plan to restructure the MCTs into a new cabinet-level department of first responders for mental health crises.⁴² Albuquerque Community Safety (ACS) will serve alongside the Albuquerque Police Department and Albuquerque Fire Rescue to deliver a "civilian-staffed, public health approach" by working with trained professionals such as social workers, housing and homelessness specialists, and violence prevention and diversion program experts. ACS will allow trained 911 dispatchers the option to send ACS personnel when a community safety response is more appropriate than an armed police officer, paramedic, or firefighter.

Olympia, Washington

In Olympia, WA a CAHOOTS-style program has operated for two years, seeing remarkable results.⁴³ The Crisis Response Unit (CRU) is an extension of the Olympia Police Department and handles a majority of calls related to homelessness, domestic violence, and substance use. Here, like in Oregon, the CRU operates on a 911 dispatch triage model, based on the potential for violence or crime in the immediate instance. Washington state law requires a paramedic to be accompanied by the fire department; the CRU is not currently a co-responder with other emergency services, and therefore cannot have a paramedic on their team.

⁴⁰ Eric Westervelt, "Cities Aim To Remove Police From Most Psychiatric, Substance Abuse Calls," *NPR*, October 15, 2020, <https://www.npr.org/2020/10/15/923885799/cities-aim-to-remove-police-from-most-psychiatric-substance-abuse-calls>.

⁴¹ Ted Alcorn, "Albuquerque's vision for non-police first responders comes down to earth," *New Mexico In Depth* By Ted Alcorn, *New Mexico In Depth*, January 17, 2021, <https://nmindepth.com/2021/01/17/albuquerques-vision-for-non-police-first-responders-comes-down-to-earth/>.

⁴² News Release: Mayor Tim Keller to Refocus Millions in Public Safety Resources with First-of-Its-Kind Civilian Response Department, The City of Albuquerque, June 15, 2020, <https://www.cabq.gov/mayor/news/mayor-tim-keller-to-refocus-millions-in-public-safety-resources-with-first-of-its-kind-civilian-response-department>.

⁴³ Christie Thompson, "This City Stopped Sending Police to Every 911 Call," *The Marshall Project*, July 24, 2020, <https://www.themarshallproject.org/2020/07/24/crisisresponders>.

Issues of Force or Physical Restraint

Providers who participated in our interviews enthusiastically agreed that an emergency, non-police response would be ideal. They also acknowledged a minority of cases that pose a risk to the physical safety of the individual in crisis, others on the scene, or to responders. This issue would have to be worked through in development of a new route for crisis response: would a social worker, health provider, or peer support worker responding to a crisis be trained or required to use force or restraint? How do we ensure that the first responder is the best equipped, most appropriate, and safest responder?

Providers wanted to participate in further conversations between professionals, community members, and/or police – and consult with experts like CAHOOTS – about how to triage when someone is unpredictable or violent, and/or when force is necessary. Policies and procedures in these cases should be spelled out. For example, ChAMPS currently provides staff with additional training about holds to break up a fight, to prevent immediate harm, or to defend themselves.

Recommendations to Improve Response, in Time of Crisis and Beyond

The Council for Court Excellence (CCE) has shared a variety of recommendations to transform the District's criminal justice system, including recommendations regarding the mental health crisis response system.⁴⁴ The CCE noted the need to increase CRT response in instances where a mental health professional is needed, specifically noting that: 1) the OUC should develop a better screening system for 911, 311, and mental health hotline calls, 2) additional funding should be allocated to the CRT, 3) in Fiscal Year 2022, the OUC should develop and test a screening system to dispatch CRT, either alone or in concert with FEMS/MPD, and 4) that in Fiscal Year 2023, the District should contract with community based organizations to fulfill CRT services and add peer support specialists.

Alongside these and other recommendations and proposals being discussed in the District, we suggest the following actions to re-route and improve responses to mental health crises based on our conversations with providers, assessment of jurisdictional models, and review of best practices:

- 1. Establishment of a practice of dispatching trained behavioral health providers to mental health crisis calls through 911 instead of law enforcement (like CAHOOTS).**

⁴⁴ “Jails & Justice: Our Transformation Starts Today; Phase II Findings and Implementation Plan,” *District Task Force on Jails and Justice*, February 2021, <http://www.courtexcellence.org/uploads/publications/TransformationStartsToday.pdf>

Our primary recommendation is to establish a practice of dispatching trained behavioral health providers instead of law enforcement to 911 crisis calls. This approach responds to our conversations with providers and aligns with the models recommended by professional organizations NAMI, Justice Collaborative Institute, and SAMHSA. We asked providers from more than a dozen organizations for their top recommendations to policymakers, and in nearly every case, they named that a model like CAHOOTS (or the others named above) would make the biggest positive impact. Trained behavioral health providers should be available at all hours, and in all neighborhoods.

This approach would require either a new initiative or program (possibly conducted through a community-based organization, as CAHOOTS is), or building more capacity for a fast response from DBH's CRT. Providers we interviewed generally appreciated CRT's multi-disciplinary, health-centered approach, but a larger team with more availability would make it more effective and widely used.

Providers noted that dispatch through 911 would be preferable to asking community members to know a separate number (including 311, 988, or ACCESS Helpline). They also wanted to be able to track data, and have access to follow-up information, which would likely require some changes in the way 911 dispatch records are analyzed and/or relate to health records or public health data. They wanted to be a part of conversations about how to staff or structure low-acuity calls, as well as those that may pose safety risks. Lastly, they wanted a response that would center on the patient or individual, and involve their current or past clinicians in a response, follow-up and execution of protocols.

2. Deliver more robust and on-going training for MPD, FEMS, 911 dispatchers related to behavioral health, de-escalation, and mental health first aid.

Even with new programs, first responders of all kinds will still frequently be involved in situations related to behavioral health concerns. All parties, including 911 dispatchers, should have consistent training and robust understanding of mental health conditions. Training on de-escalation techniques and mental health first aid for agencies across the system could greatly improve assessment, response, and outcomes, as well as community relationships.

This might mean expanding CIO training to a larger proportion of (if not all) MPD officers; given COVID, one provider suggested MPD begin more virtual training so officers can continue to get the training they need. Second, providing specialized training, such as mental health first aid to ensure skills and knowledge are up-to-date and in use, modify training requirements to be on-going. Further, instituting more connections between various programs and actors within the crisis response system would strengthen the system and address care gaps. One possibility is to leverage existing training options offered by organizations within the District, such as trauma-informed training offered by Children's National Hospital, or the D.C. Office of the State Superintendent of Education (OSSE).

3. Organize a report or roster of CIO-trained officers and institute staffing practices.

In addition to increasing training offerings, providers wanted more reliable access to CIOs when needed, especially in volatile situations. While they often requested CIOs directly in a 911 call, they knew it was not a reliable expectation. Providers suggested that MPD should update the crisis intervention officer roster so that dispatchers could see who is active for dispatch. Until MPD provides CIO training to every officer, the agency should look at staffing and scheduling practices to ensure that CIOs are appropriately distributed across shifts and neighborhoods. It would also be helpful to assess the way CIOs are dispatched to crisis calls.

We note that CCE, in its February 2021 report, Jails and Justice: Our Transformation Starts Today, sets a goal to increase the number of trained CIOs from 21% to 50%, as well as increasing the police referrals to CRT from 1% to 20%.⁴⁴

4. Reform FD-12 rules to expand the types of providers who can execute transport orders.

As described above, the process for transporting a person in mental health crisis to a hospital for evaluation is problematic because only a limited kind and number of providers can order an FD-12, therefore relying on police to intervene. This could be remedied by changing the definition or criteria of eligibility for “officer agents” to write FD-12s, for example to include any provider who is licensed to treat or prescribe medication. Because the training for “officer agents” by DBH is incredibly important, DBH should increase the frequency and capacity of these trainings. Both of these steps would increase the pool of qualified mental health professionals who could initiate this process without involvement of law enforcement.

5. Expand the infrastructure (including types of health care settings and increases to non-clinical and clinical workforce) to appropriately care for people in crisis in D.C.

No matter how a crisis response call is handled, the District also needs an infrastructure in the health system to appropriately meet the demand in the community. This includes both physical facilities and spaces (*i.e.* intermediate crisis recovery spaces, bridge clinics, etc.), as well as the human capital of a qualified workforce.

Suggestions to increase this health system capacity include: more mid- and long-term psychiatric beds in hospital settings, more temporary “crisis beds” in and outside of hospitals, low-acuity inpatient stabilization centers and short-term respite centers, bridge clinics to support patients as they await long-term treatment, “living room” models for law enforcement in emergency departments, sobering centers, harm reduction facilities, and more substance use disorder treatment facilities.

The District must also address its ongoing, persistent mental health provider shortage, especially if CRT or another crisis response team model is to be adequately staffed. There are

especially low numbers of licensed and independent clinical social workers; psychiatrists, particularly for children; and specialized workers for specific populations and subpopulations of residents, such as non-English language speakers or persons who are blind or hard-of-hearing. This means recruiting and training more professional psychologists, psychiatrists, and social workers, as well as creating and financing peer support and Community Health Worker (CHW) models.

A city-wide strategic effort is necessary to look at current regulations and legislation barriers, such as First Source requirements, general salary limits, conditions for background checks, and other professional requirements. For example, a group of providers is currently asking the Board of Social Work reconsider its supervised practice rules to ensure that recent social work graduates can work in the field while also receiving supervision and preparing for their licensing exam.

The Department of Health Care Finance and D.C. Health have been considering how to expand CHWs, including what kind of certification and/or training would be required, how experiential hours would be measured and applied, and how to ensure ease of billing and reimbursement for CHWs. Literature shows a significant return on investment for CHW programs – from \$2-11 saved per \$1 spent in some areas. It is also a proven way to get people from lower incomes and lower education levels in the workforce, as well as to increase trust in the community. Therefore, this is a particularly attractive opportunity to grow a new workforce.

6. Improve system coordination through an Interagency Council on Behavioral Health.

The District's crisis response system has multiple parts, involving several government agencies and community-based providers. To ensure this system understands itself, communicates effectively amongst its partners, and provides sufficient connections and supports to patients and clients, as well as providers and professionals, we have advocated that D.C. Council pass *Bill 24-65: The Interagency Council on Behavioral Health Establishment Act of 2021*. Working groups could be created under that Council, including ones for systemic crisis response and workforce development. The bill was co-introduced and/or co-sponsored by eight members of the 13-member D.C. Council; the Committee on Health held a hearing on the bill on March 29, 2021.⁴⁵ The Director of DBH testified that she was not in support, due to concerns that such a Council could dilute the department's authority.

Advocates believe that this bill, modeled after the District's successful Interagency Council on Homelessness (ICH), would bring together representatives from several relevant groups

⁴⁵ “Public Hearing: Bill 24-0065: The Interagency Council on Behavioral Health Establishment Act of 2021,” *DC Council Committee on Health*, March 29, 2021, video, http://dc.granicus.com/MediaPlayer.php?view_id=2&clip_id=6298

and government agencies.⁴⁶ This diverse group would represent the various consumers, providers, payers, and stakeholders and would allow the District to see the gaps in care, payments, and services, and address those issues in a coordinated and collaborative way.⁴⁷ Given the separate nature of most of the District's crisis response services and supports, having an Interagency Council focus on coordination, advertising, messaging, and connections could help save not only time and money, but lives.

7. Establish better collection, communication, and coordination between and among providers and families.

Family members, clinicians, and case managers encounter myriad roadblocks when trying to get information from hospitals, police, or other parties. Most we spoke with cited shortcomings on the availability or actionability of data in a patient's health record and/or information about a crisis call. CRISP and electronic health record products still have limitations on sharing information across providers, not the least of which is delayed or incomplete input from a treating provider. They may not find out that one of her patients has been in custody or seen in a mobile crisis. Information gaps are particularly common for persons with a substance use disorder.

While a family member may be the one to call 911, they are generally excluded from the visit and do not receive updates. Concerns about privacy restrict two-way communication among providers and family members, though these parties could use the information to support a patient post-crisis.

System-wide, 911 dispatch or EMS records are separate from health information in the District, though other counties use 911 dispatch logs and call data more effectively. Better coordination between points of care would lead to better health outcomes (for example, follow-up from the hospital or MPD to a provider with whom the patient has an established relationship.) Not only could better data sharing and integration help with care coordination for individuals, but analysis at the system-wide "bird's eye view" could offer unprecedented insight into trends and gaps.

8. Increase and improve communication with - and education for - the community about crisis response.

⁴⁶ The City Administrator, Deputy Mayor for Health and Human Services, DBH, DHS, CFSA, D.C. Health, DOC, DOES, DDS, OSSE, D.C.PS, D.C.PCS, MPD, CSOSA, DYRS, DHCF, HBX, Aging, ICH, and DISB

⁴⁷ Potential work groups could include: Reviewing health of CSAs; Rates, payments, and reimbursements; Children's providers/services; Crisis services; SUD and ASARS providers/services; MHRS providers/services; Housing DBH consumers and coordination with the CAHP/FCAHP process (with ICH); Improved information/data sharing across providers.

Communication within and about the system is needed, from the ground up. Community education is necessary for families and community members about resources available for treatment and counseling, alternatives to calling law enforcement, and mental health first aid.

A community-based provider we interviewed noted how important it is “for the family to be empowered themselves about information they need” to prevent a crisis, or to better facilitate an appropriate response in a crisis. They recommended tailored outreach to people who do not yet have experience with the system, but may be in a position to call in the future (grandparents, neighbors, etc). Education could be delivered through churches, community centers, schools, bus advertisements, posters and social media infographics.

Clinicians also stressed the importance of educating communities about what to expect – and what to say – when calling 911, or for DBH services. People should trust and understand what will happen. “We need clarity about the system. There are little bits about what to do, when, all over the place. If someone moves into the District or is living in the community, how would they know what to do?” Mental Health first aid is one community-based response to mental health emergencies, and some health clinics are trying to offer this training to a broader group of their providers, such as medical assistants and receptionists.

Many community members are hesitant to call for any help because they do not want to involve law enforcement. Therefore, community engagement will be required to get buy-in and spread information about any reformed crisis response model. As CPEP’s Dr. Medlock explained in our 2020 webinar: “The ideal response is a response that is endorsed and engaged through the community process. I would love to see us not only have policymakers at the table, but to actually have community members at the table and to have a robust community engagement process to figure out what policing looks like.”

Conversations and training with health professionals and community members will be just as important to crisis response reform as new models or CIO training. The input of people with lived experience is essential to making reforms that are trauma-informed, practical, and effective. They can share what they most need, and what is least helpful, when experiencing a mental health crisis. One provider understood the sensitivity and hesitation when talking publicly about mental health topics, but noted that people seem willing to talk about their mental health experience, especially as the COVID-19 pandemic has even further de-stigmatized mental wellness topics. One specific recommendation is for Councilmembers Charles Allen and Vincent Gray to convene a joint roundtable with the Committees on the Judiciary and Public Safety and Health with the public and professionals.

9. Adequately fund community-based organizations and school-based programs that provide mental health care and substance use treatment services.

In addition to expanding the capacity of CRT or a crisis response team (outlined in 1, above), the District should also financially support CPEP and ChAMPS. The Mayor has indicated plans to expand the CPEP model across D.C., particularly into Wards 7 and 8 where there are critical shortages in mental health resources, racial disparities, and other structural barriers to care.

Further, the District must continue to invest in prevention and treatment for mental health and substance use before one reaches the point of crisis. This includes, but is not limited to, adequate levels of funding to community-based organizations through grants and billable services through Medicaid and DBH, the school-based behavioral health expansion program, and pediatric interventions such as HealthySteps⁴⁸ and Healthy Futures.⁴⁹ Further, if data trends on use of telehealth are positive, it will be important to keep and expand telehealth as a permanent means of delivering mental health care, beyond the public health emergency.

Conclusion

The past year has called on our community to critically examine and build capacity within – our health and human services systems to provide more equitable and appropriate care for residents, including those experiencing mental health conditions and substance use disorders. As part of this evaluation, we spoke with service providers across the public and private spectrum, assessed program availability, accessibility, and connectivity, and researched best practices and models across the country that better support people experiencing behavioral health crises. We offer many recommendations to consider, including re-routing 911 calls from law enforcement to trained, unarmed responders (*i.e.* an expanded CRT program), with the ultimate goal of connecting a person to appropriate health care, while keeping everyone safe and minimizing harm.

There is great promise in these programs; in other jurisdictions, we already see the evidence in terms of saved lives and dollars. The DC Health Matters Collaborative and District health providers hope to see additional progress locally in better integrating and funding mental health supports both within and outside of law enforcement. This is worthwhile and urgent work. Nearly a quarter of fatal police encounters result from calls about disruptive behavior are directly tied to a person's mental health or substance use. As one provider told us, after summarizing his impression of the status quo: "other things are certainly worth a try." He continued with this simple challenge: "When we go back to 'normal' [after the pandemic]– can we make all the stops on the spectrum work better?"

⁴⁸ HealthySteps, A Program of Zero to Three, www.healthysteps.org.

⁴⁹ Children, Youth and Family Services, DBH, <https://dbh.dc.gov/service/children-youth-and-family-services>.

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Glossary

- **ACCESS Helpline** – DBH-provided, 24-7 service which can activate a crisis response team for emergency psychiatric care.
- **CAHOOTS (“Crisis Assistance Helping Out on The Streets”)** – oldest community crisis response program of its type in the U.S. in Eugene, Oregon.
- **Child and Adolescent Mobile Psychiatric Service (ChAMPS)** – DBH-contracted service (to Catholic Charities) for crisis response to youth.
- **Community Health Improvement Plan (CHIP)** – mandated requirement of the Affordable Care Act (ACA) for non-profit hospitals and Federally Qualified Health Centers (FQHCs) following completion of a CHNA.
- **Community Health Needs Assessment (CNHA)** – mandated requirement of the Affordable Care Act (ACA) for non-profit hospitals and Federally Qualified Health Centers (FQHCs), to be implemented via a CHIP.
- **Community Response Teams (CRT)** – DBH program to support homeless outreach, mobile crisis, and pre-arrest diversion.
- **Comprehensive Psychiatric Emergency Program (CPEP)** – DBH program which offers mental health and addiction counseling, crisis response, event response, domestic violence follow-up, and links to providers, referrals, and well checks.
- **Council for Court Excellence (CCE)** – local non-profit organization working to enhance the justice system in the District of Columbia to serve the public equitably.
- **Crisis Intervention Officer (CIO)** – specially trained MPD officers who have received 40 hours of training in mental health conditions and de-escalation techniques.
- **CRISP (Chesapeake Regional Information System for our Patients)** – a designated Health Information Exchange (**HIE**) in Maryland and the District of Columbia.
 - An **HIE** is a way of instantly sharing health information among doctors' offices, hospitals, labs, radiology centers, and other healthcare organizations.
- **Department of Behavioral Health (DBH)** – the District's public behavioral health department.
- **FD-12** – an admission record/transport request for emergency mental health observation and diagnosis.
- **Federally Qualified Health Centers (FQHCs)** – federally funded, community health centers.
- **Metropolitan Police Department (MPD)** – the District's police force.
- **National Alliance on Mental Illness (NAMI)** – national association focused on supporting persons with, and providers for, mental illness.
- **Sequential Intercept Model (SIM)** – service continuum that details how individuals with mental health and substance use disorders come into contact with, and move through, the criminal justice system.
- **Substance Abuse and Mental Health Services Administration (SAMHSA)** – federal agency focused on substance use and mental health conditions and service needs.
- **Substance Use Disorder (SUD)** – complex condition in which there is uncontrolled use of a substance despite harmful consequence.