DC Health Matters Collaborative

Bread for the City | Children's National | Community of Hope
Howard University Hospital | HSC Health Care System
Mary's Center | Sibley Memorial Hospital | Unity Health Care
DC Behavioral Health Association
DC Hospital Association | DC Primary Care Association

Testimony of the DC Health Matters Collaborative
to the Committee on the Judiciary and Public Safety
and the Committee of the Whole on
the Recommendations of the D.C. Police Reform Commission

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My name is Amber Rieke. I am the Director of External Affairs for the DC Health Matters Collaborative. Thank you for the opportunity to testify today, with special thanks to the members of the Police Reform Commission for their important work. I want to speak specifically today to their first recommendation related to behavioral health crisis response, and the evolution of the system at hand.

About DC Health Matters Collaborative
Launched in 2012, the DC Health Matters Collaborative is a partnership of hospitals and federally qualified health centers (FQHCs) that combine efforts to assess and address community needs in the District of Columbia. We work together to achieve our stated 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 DC hospitals (Children's National Hospital, The HSC Health Care System, Howard University Hospital, and Sibley Memorial Hospital); four community health centers (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).

Based on our 2016 and 2019 needs assessment findings, the Collaborative is organized around four key priorities: Mental Health, Care Coordination, Health Literacy, and Place-Based Care.

One of the Collaborative's central projects is working together to improve access to and equity within behavioral health care in D.C. Over the past year we have been looking at the crisis response system in the District. We conducted interviews with our behavioral health professionals - psychiatrists, social workers, nurses, peer support workers – and asked whether what we get now as a first response, is working**.** And what we found is that the status quo is not keeping everyone safe, was in many cases creating *more* trauma and chaos. We released a white

paper summarizing our findings and recommendations this month: "Re-Routing Behavioral Health Crisis Calls from Law Enforcement to the Health System."

Mental Health Crises in the Community

About 20% Americans have a mental health condition, generally less than half of people are receiving treatment. Only 42% of District residents with these conditions are receiving treatment, and we know mental health indicators have worsened amidst the pandemic. In some cases, mental health concerns become an emergency or a crisis. That may look like erratic behavior, threats of suicide, public intoxication, hallucinations. Currently, calls to 911 for urgent help will dispatch MPD.

This is extremely dangerous – not to mention costly and disruptive. Some research suggests that people with severe mental illness are 16 times more likely to be killed during an encounter with police. As we know, this compounds with real disparities in policing and arrest by race. In Washington, D.C. Black people are more policed; they are arrested by MPD at a per-capita rate seven times higher – and killed at a rate 13 times higher – than white people. This makes crisis calls inherently more dangerous for Black individuals and contributing to fear in calling for police help.

Fundamentally, with the exception of instances of violence, these calls could be better handled by an unarmed social workers or other behavioral health professionals, to de-escalate in the moment and then work to connect the people to services and resources for the long run.

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. 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. U.S. Substance Abuse and Mental Health Services Administration (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.

Instead, what we have now, as one D.C. social worker described, is "hit or miss." 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."

Dispatching Behavioral Health Professionals Rather than Police Through 911

As the Police Reform Commission Report states in the first recommendation: "Crises should be met with specialized intervention and skillful de-escalation rather than forced compliance and arrest."

Models limiting harm and trauma already exist across the U.S. to answer calls through the 911 with trained medics, social workers, or experienced crisis workers. We summarized examples in our white paper from Oregon, Colorado, Florida, California, New Mexico, and Washington State, who are beginning to reimagine their policing and crisis response systems.

We are glad to learn of the pilot through Office of Unified Communications and Department of Behavioral Health (DBH) to dispatch professionals instead of police. Within the District's crisis response system, there are a several important public programs: the ACCESS Helpline and Community Response Teams (CRT), and Child and Adolescent Mobile Psychiatric Service (ChAMPS) for crisis response to youth. It is a great improvement if calls to 911 can call on these essential resources, and deploy skilled professionals with health care tools. However, it is not

clear from the pilot whether dispatchers would connect to CRT directly, or create an intermediary step through the ACCESS Helpline.

I also would like to hear whether the kinds of events imagined for alternatives to police will include substance use issues - for example, someone actively using drugs in public, someone displaying disorientation or intoxicated behaviors, etc. We know substance abuse often co-occurs with a mental health issue.

We agree with the Commission co-chairs from their testimony that this pilot should not foreclose the implementation of their recommendations for legislative action. There are several reasons for this, from capacity to evaluation.

Build Workforce and Infrastructure Capacity to Meet Demand

Simply changing the first responder is not the end of the story. There is a lot of infrastructure and practice that will need to improve: we need more mental health professionals in our workforce to meet the demand, we need more kinds of settings to escort people to – for respite, or detox, or a bridge between crisis and ongoing treatment.

We are concerned that a pilot without this capacity dooms it to fail, which would leave us back where we started. This pilot might be a good opportunity to include additional agencies, such as DC Health and the Health Licensing Boards, and even Department of Employment Services. After the year that the health system has had, it would be a good opportunity for some general health care workforce strategic assessment and planning.

As Anthony Hall, director of the Department of Behavioral Health's Community Response Team (CRT), told the Commission - his team is usually successful in responding on the scene without MPD support with individual counseling and de-escalation techniques. Most of our interviews with mental health professionals truly appreciated CRT's model and skills.

However, while they may need the skills CRT can bring to an incident, if they need response sooner than 30-45 minutes, they call 911 for the police. CRT themselves told the Commission that at its current operational capacity, the CRT cannot provide a timely emergency response.

We also need more robust training for first responders and 911 dispatchers related to behavioral health, de-escalation, and mental health first aid. Will a dispatcher to be equipped to stay on the phone with me and help stabilize a situation until help arrives, in the same way as a medical emergency?

From the Commission report: "Because patrol officers are likely to encounter individuals in crisis and may need to engage the person until a specialized responder arrives, every MPD officer must complete 40 hours of crisis intervention training (CIT). To supplement this, the Council should provide special funding to DBH to lead additional crisis intervention training that is open to the public and required for all MPD members."

Reform of the FD-12 Authority and Implementation

Further, about 20% of CRT's calls require involuntary treatment or execution of an FD-12 for transport to hospital for evaluation and involuntary commitment. If we use this number only to extrapolate the volume a pilot might show, there should be urgent attention to another issue the Commission report raises: the legal authority and implementation of FD-12s.

As the report states: "The Council should amend DC Code Sec. 21-521 which governs involuntary commitment (FD-12), making it truly a last resort undertaken only by behavioral healthcare professionals and in ways that avoid further traumatizing people… Initiation of the FD-12 process to hospitalize an individual against their will is a treatment option that should only be pursued under limited circumstances and when there is not a viable, safe, less restrictive alternative. When circumstances require involuntary commitment of a person, steps must be taken to protect that person from further physical or psychological trauma. Tasking agents of the criminal justice system—MPD officers—with enforcing involuntary commitment unnecessarily exacerbates the trauma of this experience for individuals in crisis, and misuses MPD time and resources. This is especially true when the officers facilitating involuntary hospitalization do not have crisis intervention training or real-time guidance from behavioral healthcare professionals."

Currently, an FD-12 is executed by an officer, or an "officer agent," 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 major gaps in regulations that lead to poor outcomes. They perceived that the execution of the FD-12 can causes trauma or damage to the patient-provider relationship, especially if it does not ultimately 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 practicing at a federally qualified health center – arguably the exact kind of provider you'd want to walk someone through this life event – has to call MPD or CRT to execute an order for her own patient sitting in her own exam room.

Beyond the definitional barriers, DBH trainings to become an officer agent are infrequent and very limited in size. I want to emphasize that the training is essential, as it involves essential issues of civil liberties. The training should be more inclusive and accessible. We might have the right professionals responding to 911 calls, but they need to be able to perform the full spectrum of care if the goal is to keep MPD out of these interactions.

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.

Assessment and Evaluation of System Changes

Further, we vigorously affirm their recommendation for an assessment of the views of the community and professionals in the first of several methodical steps to scaling up current programs. "The Council must ensure that the voices of DC's most impacted residents are invited, elevated, and honored in this assessment." We also agree that there should be feedback from or consultation with the individuals and community served, and all professionals involved in the process, to determine the future course of the system.

Whether through the pilot or future legislation, we see the need for a public hearing, or a community advisory group to be consulted from start to finish. The Commission calls on the Council "to establish a task force or coalition of community-based providers and public officials to assess the adequacy of preventative community behavioral health and wellness programs on an annual basis."

The report suggests an evaluation of very important data to assess success, including average response time; resolution of crisis teams' interventions; any refusals from either program to respond and the reasons; incidence of injury to the person in need or crisis team members; and incidents that required MPD support, and source of referral (911, MPD, person in crisis, family member, or observer).

We might add to the pieces for oversight and evaluation:

- "Average wait times" ***plus*** details related to contributing factors, for example whether the wait times were because of staffing, traffic or parking issues, geographic distance, etc;

- Ward and/or Zip code of call location, which would be informative for staging and staffing decisions for future work.

Meeting Mental Health Needs with Care and Treatment, Before and After Crisis

What is really essential – for this issue and for preventing people from being in crisis to begin with – is expanding the infrastructure to appropriately care for people in crisis in D.C., including more beds in health care settings and more people in the workforce. To this end, we agree with the Commission's second recommendation: With funding from the Council, and support of the Mayor, the Department of Behavioral Health (DBH) must increase investments in evidence-based, culturally competent behavioral health and wellness services to meet the current and anticipated needs of all District residents.

On the topic of treatment options, we also affirm the Commission's suggestion that "The District must simultaneously expand voluntary inpatient treatment options... The District must build a campaign around future efforts to expand community mental health services in order for these efforts to prevail."

Finally, the proposed changes "require a robust campaign to educate the DC public on recognizing the signs of a behavioral health crisis; recognizing behaviors related to a developmental disability; and the appropriate agencies and numbers to secure help for people with developmental disabilities and people experiencing behavioral health crises… The more we can empower DC residents to correctly use 911, the sooner appropriate crisis responses can be dispatched to the scene."

Conclusion

Working together, health providers, community members, and the District can re-imagine crisis response with the goal of a safer, more health-centered, and better coordinated care for people with mental illness, addiction, trauma, distress, or crisis. We appreciate and support the discussion and recommendations of the Police Reform Commission for these reforms.

In our white paper, we detail more of our own research and recommendations. We will continue to look at what is working, what is missing, and what, in an ideal world, our crisis response system should look like. We are eager for the opportunity to create this dialogue with policymakers and partners in the health system.

I'm available to answer any questions you may have. I can be reached at arieke@dchealthmatters.org. Thank you.