

There are, instead, many pieces and touchpoints – public, private, and non-profit – for prevention, harm reduction, treatment, and recovery support services, which do not necessarily function with any coordination. This is not a problem unique to the District, it is the nature of American healthcare. Most providers are like islands. And while most of these healthcare islands in DC are delivering dynamic, high-quality, person-centered care, patients need more bridges, more maps, and better intercontinental communication.

Our 2019 assessment identified four actions required by the health sector and government to improve health in DC:

1. **Foster Community Dialogue:** facilitate communication and collaboration among residents, health professionals, community organizations, policymakers, and other stakeholders.
2. **Build Relationships:** strengthen trust and genuine relationships as a foundation for collaboration to improve health and well-being.
3. **Develop Workforce Capacity:** cultivate health and social care providers through approaches that are responsive to the communities and persons they serve.
4. **Simplify the Path to Wellness:** make it easier to engage with the health system by removing complexity, redundancy, and/or inefficiency within health and social service organizations.

Based on our findings, we have advocated for the establishment of an Interagency Council on Behavioral Health since the original bill was introduced in 2019. We believe the proposed legislation set the table to facilitate the relationships, integration, and trust-building that is so necessary to achieve systemic improvements.

Support for the Interagency Council Model

This new body is modeled on the successful structure of the District’s Interagency Council on Homelessness (ICH). Fully understanding the needs of clients of the homelessness assistance system is necessary to both serve the individual and make meaningful systemic change.

Coordination is crucial across a broad spectrum of government agencies, community-based providers, managed care organizations, consumers, advocates, businesses, philanthropy, and academics, in order to understand the complex network of behavioral health delivery, and to correct gaps in care, access, and payment/funding.

The Time is Right for Bright Spotlight on Behavioral Health

DC 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 with moderate to severe depression, increases in reports of thoughts of suicide and self-harm (particularly for LGBTQ+ youth), and general difficulty with isolation and loneliness. Data also

shows increases in Asian and Pacific Islander population seeking mental health services; and screeners for Black populations showing the highest percent changes over time regarding anxiety and depression. There is fear about increased rates of abuse with decreased access to points of connection for help due to service closures and reduced capacity.

Even before the pandemic, there were myriad reasons for a city-wide spotlight on behavioral health. When we first testified in 2019, there are concerns about the closure of multiple Core Service Agencies (CSA), the impacts of those closures on consumers, and whether consumers are successfully transferred and receiving quality services from new providers. The opioid crisis continues to take the lives of hundreds of District residents as overdose numbers continue to rise. Increased violence in the community may arise from and result in trauma to individuals, families, and neighborhoods.

There is a significant workforce shortage of behavioral health providers, especially for children, and persistent stigma and barriers that prevent people from connecting to care. In fact, about 60% of adults and youth with mental illness are not receiving treatment. This may inhibit their ability to work, go to school, care for themselves or others, or result in a mental health crisis. The Office of Unified Communications (OUC) noted at its 2021 oversight hearing that 911 logged over 8,000 calls for such a crisis in a six-month period in 2020.

Elevating the Department of Behavioral Health's Mission and Work

In 2019, it was our understanding that the Interagency Council bill was shelved to give the incoming Director of the Department of Behavioral Health (DBH) Dr. Barbara Bazron a chance to implement her vision for the agency before creating a new initiative. Dr. Bazron and her staff deserve credit for important expansions to DBH's School Behavioral Health Expansion Program, ACCESS Helpline, Community Response Teams (CRT), and Comprehensive Psychiatric Emergency Program (CPEP) over the last two years. We believe the proposal would increase the ability of Dr. Bazron and the staff of the agency to meet their highest goals for the system.

The responsibility and challenges of the behavioral health eco-system stretch far beyond one agency. The delivery of behavioral health care - and associated services - in the District is not the sole responsibility of DBH, and the shortcomings and gaps in the program are likewise not its sole responsibility. Private practitioners, primary care providers, hospitals, and federally qualified health centers hold a significant share of responsibility, and are outside of DBH's oversight.

To better incorporate all relevant entities, and to ensure behavioral health impacts and services are understood within and outside of the DBH context, an Interagency Council on Behavioral Health will allow all parties in the system to see all aspects of the system, how the multiple entities interrelate, and how to work better.

The Case for Cross-Sector Collaboration and Coordination

Many sectors have a stake in the mental wellbeing of DC residents and workers, whether they recognize it or not:

- DC Child and Family Services Agency (CFSA) while working with youth under their supervision;
- Corrections officers and jail administrators within the Department of Corrections (DOC) related to inmates and their needs;
- 911 dispatchers answering when someone calls for help in a mental health crisis and Metropolitan Police Department (MPD) dispatched to respond;
- Healthcare, MPD or FEMS workforce experiencing PTSD or extreme stress on while on the job;
- The Department of Human Services managing cases for clients in public benefits programs;
- The many groups involved in workforce development to respond to the current workforce shortage,
- Private businesses employing hundreds of thousands of District residents;
- Housing providers and landlords with tenants who need services for mental health or substance use to remain stably housed;
- Teachers and school employees seeking to reach and educate students suffering trauma.

Case Example: Interagency Coordination for Crisis Response

We especially want to highlight the need for cross-sector collaboration related to the crisis response system. Currently, when someone needs help because a family member is threatening self-harm, a neighbor is disoriented, or a friend appears to have overdosed on substances, the most common response is to call 911. The dispatcher triages to respond with an ambulance or an officer. The individual may be transported to a hospital for psychiatric evaluation or stabilization. Ideally, that individual would then be connected to ongoing support or treatment in the community. Here we see how many parties are involved: OUC, MPD, FEMS, hospitals and health providers, as well as DBH. And at the center of this experience is a person, part of a family and neighborhood, for whom this may be a deeply significant, critical, even traumatic time. As we have seen many times – and typified in the story of [Daniel Prude in Rochester](#) – this scenario does not always end well, sometimes horrifically.

In his March 25 confirmation hearing, Acting MPD Chief Robert Contee was asked what the hardest part of his job has been in his 30-year police career. He immediately named the inability to get stakeholders to work together to improve outcomes. He also talked about his desire to be able to serve people in crisis with one phone call, getting help and resources rather than using his handcuffs or firearm. But, he said, when he asks who he should call, “there is silence in the room.” If we can create a table for these conversations, perhaps we could break the silence.

Recommendations for Representation and Participation

The creation of work groups will be essential to carry out the strategic actions of the interagency council – as with the ICH. In 2019, we suggested the following potential work groups for an Interagency Council on Behavioral Health:

- Assessment of CSAs
- Rates, payments, and claims
- Children’s providers/services
- Crisis services
- Substance Use Disorder and Adult Substance Abuse Rehabilitative Services providers/services
- MHRS providers/services
- Housing DBH consumers and coordination with the Coordinated Assessment and Housing Placement/Family Coordinated Assessment and Housing Placement process (with ICH)
- Information sharing across providers
- Behavioral health issues and homelessness (with ICH)

We are glad to see the requirement for consumer representation; community engagement will be the key to success. While advocates and professionals offer important expertise, people with the lived experience of behavioral health challenges or mental illness can best speak to the context, barriers, cultural and social factors, triggers, aftermath, and opportunities for improvement.

These consumer voices, with their lived experiences, are invaluable to the ICH. We would suggest that all consumer members of the Interagency Council be offered stipends to compensate ICH consumer members for their time, effort, and travel expenses. There is precedent for this in the ICH to provide a stipend of \$50 per meeting of the Council, meeting of a committee of the Council, or meeting of a formal working group.

We appreciate the broad range of representation required in the legislation. We suggest a few more considerations in the design of the Interagency Council:

- Add representation from the primary care sector on the Interagency Council. This integration is key in medical practice – as many people first bring mental health concerns to their primary care provider (*i.e.*, physicians, nurses). The field is continuing to try to advance the work of integration and coordination across service types.
- Likewise, leaders of faith communities are a key and distinctive stakeholder in these conversations. They are very influential for their congregants and recovery groups, and often sought for counseling by individuals with family strife, mental health conditions, or substance use issues. We also hear that some religious cultures may perpetuate stigma or treatment avoidance, which necessitates more outreach to this constituency.

- We would like to see explicit inclusion of representatives of groups who experience worse health outcomes in the District, have less health access or opportunity, and/or experience more social or medical precarity. Unfortunately, this is not spelled out in the bill. These groups could include low wage workers, people who are under- or unemployed, people in caregiving professions, people experiencing homelessness, people living with HIV, immigrant residents, pregnant and parenting people, members of the LGBTQIA+ community, and Black residents, and people of color in the District.
- We recommend equitable representation of child, family, pre-natal, and adult providers across the stakeholder groups that form the Interagency Council to ensure a multitude of perspectives across the life span, and input across the behavioral health continuum.

Recommendations for Oversight

For the Interagency Council to meet its highest potential, oversight, accountability, and a clear, measurable strategic plan are essential. We celebrate the accomplishments of the Interagency Council on Homelessness, as well as the high esteem it enjoys in the District. We hope this proposed body would operate on that high level of efficacy and impact. This would require committed participation from all government representatives and serious oversight over its work.

The Director’s mandates in the legislation include providing “a single point of accountability for the improvement of the behavioral health system of care efforts in the District.” Therefore, great care must be invested in selecting the right individual for this position, who can oversee, coordinate, and execute all duties of the director. We would like to see someone who will set ambitious goals for system transformation, be organized and intentional about data and metrics, enjoy a high level of trust from all community stakeholders, and be empowered to act independently, yet accountable to the strong oversight we expect from this Committee.

One of the first issues for a new Interagency Council to tackle must be a strategic plan for workforce development of behavioral health professionals across the spectrum of certifications, levels of education, languages, and life experience. The workforce shortage has been considered urgent for many years now. We need professionals and public officials from the health, education, labor sectors to work together to remedy this major gap as demand for services continues to increase. We would especially like to see a racial equity lens applied to this plan, and strategies that draw on young and long-time District residents of color to gain the training, experience, and credentials to serve.

Recommendations About Assessments and Report Requirements

While we are glad to see such a focus on assessments, engagement, and strategic planning, the sheer number of deliverables and the frequency of some of the reporting is notable. As a group formed specifically to conduct needs assessments and implementation plans, one of the powers and responsibilities in Section 5120e - (b)(1) *annual community-wide needs assessment* - jumped

out to us: “Coordinate an annual community-wide needs assessment and planning process to identify, prioritize, and target behavioral health needs with the aim of improving the behavioral health system of care of. The needs-assessment shall take into account and integrate existing data, including previous plans, recommendations, and assessments.”

We propose exploring whether this needs assessment requirement could be combined or aligned with the responsibility in Section 5120e (b) to conduct an evaluation of the behavioral health service needs of the District’s children and transition-age youth every five years. For example, instead of doing an annual CHNA, five-year plan, *and* five-year review of youth service needs, could the group be responsible for one comprehensive needs assessment on the five-year cycle (including both youth and adult service needs), to which the five-year plan can respond?

A five-year cycle of assessment and system transformation efforts seems like a significant workload, and adding another full-scale annual CHNA on top of it gives rise to concerns about when the actual system transformation work could be done. We started our CHNA related work on mental health in 2016. It revealed *many* large-scale issues that we still see now five years later – including this very legislation.

Further, there are numerous agencies and groups in DC doing assessments and similar work that could serve this new Interagency Council. For example, non-profit hospitals, FQHCs, and our health department all have legal requirements on different cycles to conduct needs assessments. DC Health, MedStar Health, our DC Health Matters Collaborative, DC Primary Care Association, advocates including Children’s Law Center, DC Behavioral Health Association and Children’s National, have all conducted various needs assessments in the last several years. We hope the Interagency Council would incorporate and leverage the work that has been undertaken and will continue to be done. Continuing to move toward greater coordination in these efforts could reduce redundancy and break silos, and lead to more impactful, inclusive data and action.

Conclusion

In conclusion, the DC Health Matters is hopeful that the Interagency Council model could serve to better integrate stakeholders to respond to community needs in behavioral health. With robust community engagement, thoughtful oversight, and focused strategic planning, we believe an Interagency Council on Behavioral Health could build trust and relationships with the community, productively address long-entrenched issues, remedy workforce shortages, improve referrals and services, and correct gaps in access. This is exactly the moment for the District to rise to the many challenges that residents face.

We encourage this Committee and DC Council to consider this legislation, and break ground on the infrastructure required for a coordinated, organized system of behavioral health care in the District of Columbia.