



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

Testimony of the DC Healthy Communities Collaborative before the Committee on Judiciary & Public Safety

Oversight Roundtable:

Exploring Non-Law Enforcement Alternatives to Meeting Community Needs

Thursday, December 17, 2020

Thank you for the opportunity to testify on behalf of the DC Health Matters Collaborative (DCHMC) about an important issue related to policing: the system that responds to people experiencing mental health crises. We are grateful to be here to amplify the community voice and health provider experiences in this conversation.

We are invested in this issue because we have learned through conducting a city-wide Community Health Needs Assessment that quality mental health services are an urgent need and necessary investment. It may not be common to hear from the health system in these meetings, but our Collaborative sees a meaningful opportunity. Surveys have shown that almost a quarter of fatal police encounters result from calls about disruptive behavior, directly tied to a person's mental health or substance use.

The District has an opportunity to look at how and who is dispatched to respond to a 911 call for a mental health crisis. What models de-escalate, minimize harm and trauma, and keep everyone safe? What models connect a person to care and connect resources to each other? Ultimately, if we can answer these questions in a productive, community-centered, equitable way, we may also be able to improve long-term health outcomes for individuals, families, and communities.

About the DC Healthy Communities Collaborative

The DC Health Matters Collaborative is a coalition of hospitals and health centers that combine efforts and resources to assess and address community needs in the District of Columbia. This work is undertaken in partnership, is data-driven, and engages the community. The ultimate pursuit is an equitable and sustainable state of health for District of Columbia residents.

One of the Collaborative's central projects is completing a Community Health Needs Assessment (CHNA) and an associated Community Health Improvement Plan (CHIP) every three years. Our CHNAs from [2013](#), [2016](#) and [2019](#) are available on DCHealthMatters.org. Collaborative membership includes four non-profit DC hospitals (Children's National Health System, 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 priority needs: mental health, health literacy, place-based care, and care coordination. Our mental health work has focused on strategies to improve access to and equity within mental health care in DC. We have been at the Council many times in recent years to advocate for investment in school behavioral health services, to expand the mental health workforce, to coordinate services in the system through an Interagency Council on Behavioral Health, and to bring providers to share the stories of their patients.

Mental Health Needs in DC

According to data on DCHealthMatters.org, poor mental health is common across many indicators in the District:

- 11.4% of DC residents reported 14 days or more of poor mental health - stress, depression, and problems with emotions - in 2017.
- 14.3% of adults have ever been told by a doctor, nurse or other health professional that they have a depressive disorder, including depression, major depression, dysthymia, or minor depression.
- 14.3% of the Medicare population in DC have been treated for depression.
- 25.5% of high school students who felt sad or hopeless almost every day for 2 or more weeks in a row.
- 23.5% of high school females and 14.3% of high school males reported seriously considering suicide in 2019.
- Between 2016-2018, the suicide rate in DC was 6.5 deaths per 100,000 population, an uptick that reversed the previous downward trend of the rate.

Of emergency department visits attributable to a mental health condition in 2017, 39% were charted as alcohol-related disorder, 27% substance-related disorder, 16% mood or anxiety disorders, and smaller percentages psychotic disorders (6.6%) and self-inflicted injury (4.4%).

The District has one of the highest rates of opioid abuse in the country. The number of deaths from opioid-related overdoses in the District has more than tripled over three years.

A large percentage of adults and children seen DC clinics have experienced trauma and Adverse Childhood Experiences (ACEs). Trauma left untreated can lead to poor outcomes – fear, depression, anxiety, panic attacks, and relationship problems.

The burden of poor mental health is not distributed equally across the city. Nearly every neighborhood in Wards 7 and 8 experience poorer mental health compared to the rest of the city.

In the neighborhood that includes Barry Farm, nearly 24% of adults struggle with poor mental health--the highest rate in the District.

SAHMSA notes that only 42% of DC residents with a mental health condition currently receive treatment. As one resident of Columbia Heights told us, “when mental health is off it is hard to balance any other part of your life.” 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 it reaches points of crisis.

The Community Needs Quality, Accessible Mental Health Services

Community members, health providers, advocates, and system leaders, have identified the following challenges which could lead to difficulty treating mental illness or preventing acute crisis:

- substance abuse,
- high levels of trauma, which can be misdiagnosed or unaddressed,
- persistent mental health stigma,
- disconnection of mental health from primary care encounters,
- difficulty maintaining engagement between providers and patients, including issues of distrust and alienation from health care and social services,
- unstable housing or precarious relationship situations, and
- a shortage of psychiatrists (particularly pediatric psychiatrists), child psychologists, drug and alcohol abuse counselors, and fully licensed therapists.

In a 2019 focus group, a participants summarized the need for attention to mental health on a systemic level in DC – before crises:

“Behavioral health is like a forest fire – it’s running rampant, it’s growing, we’re fighting against it but it’s still growing. If we were able to implement strategies to be more pro-active to where we’re actually putting the smoke out before it even gets to a fire – early detections, early evaluations, more concrete assessments, especially for children.”

A common theme in our assessment was a need to build trust and relationships with the community, as well as between agencies and institutions. Community members’ distrust of the health care system contributes to reluctance to seek treatment for psychological, emotional, behavioral, and substance abuse disorders, particularly among racial and ethnic minorities and immigrants. As we know, distrust is something the health system and public safety must both repair to effectively serve our communities. These systems, though, only make distrust worse, when they make the act of seeking help complicated, inaccessible, or dangerous.

Responding to Mental Health Needs and Times of Crisis

Conversations this year have painfully clarified the need to both improve trust with the community and be more attentive to mental health needs. This year our Collaborative began researching the District's crisis response system, particularly how it responds to people who may have undiagnosed or untreated mental health conditions. We began by talking with our health providers, from Emergency Department psychiatrists to social workers, and comparing it against other jurisdictions.

As the U.S. continues to reckon with its systemic issues in policing, we must ensure that mental health conditions are not triggers resulting in tragedy. There is an unfortunate correlation between mental health issues and unwanted attention from and interaction with police, as we've seen quite recently with the in-custody death of Daniel Prude in Rochester, NY, the shooting of a 13-year-old with autism in Salt Lake City, Utah, and the shooting death of a person with schizophrenia who had just been released from a psychiatric hospital in Detroit, Michigan.

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. Worse, the Treatment Advocacy Center notes that people with severe mental illness are 16 times more likely to be killed during an encounter with police.

MPD's Trend Reports also noted some of the most common reasons for CIO dispatch and the behaviors officers encountered on site. From reports covering both 2011-2016 and 2014-2017, disorderly behavior and threats of suicide were the most common reasons for dispatch, with CIOs also noting threats of or violence, neglect of self-care, and public intoxication as reasons for dispatch. Once on site, CIOs noted hostility and depression were the most common behaviors exhibited, while also noting fear and anxiety, audio or visual hallucinations, or medical neglect as common. With the exception of threats of or actual violence, these common dispatch reasons and behaviors encountered 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 more appropriate instances for the use of police resources, even police who have been trained in mental health conditions and de-escalation techniques, than responding to calls for people who, for example, are experiencing anxiety, are disoriented, or are inappropriately dressed.

District of Columbia Behavioral Health Crisis Response System Overview

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, and harm reduction.

- Community-based and primary care providers, which serve a critical need for therapy services and improved co-location of services for people of all income levels and payor types.
- Residential and acute care supports provided by our hospitals.
- Recovery support services such as supported employment and peer clubhouse services.
- Mental health clinicians to students in schools in both the school mental health program and the community-based provider school-based behavioral health program.
- And the justice-related portion of the system, (Metropolitan Police Department [MPD] and the Department of Corrections), including health care to incarcerated persons and reentry support.

Within the District's crisis response system, there are a variety of programs and acronyms. On the government side, the Department of Behavioral Health (DBH) runs:

- The Access Help Line, which is available 24 hours a day/7 days a week and can activate a crisis response team for emergency psychiatric care;
- Community Response Teams (CRT), a 24 hour a day/7 day a week service to support homeless outreach, mobile crisis, and pre-arrest diversion.
- The Comprehensive Psychiatric Emergency Program (CPEP) offers mental health counselors, peers, and certified addiction counselors to provide crisis response, event response, grief and loss response, domestic violence follow-up with DC SAFE, as well as links to providers, referrals, and well checks.

On the community-based provider side, the District funds:

- Core Service Agencies (CSAs), DBH-certified mental health providers offering services including diagnostic assessment, medication, counseling and community support.
- Assertive Community Treatment (ACT), which is a community-based provider program funded by DBH and run by DBH-certified mental health providers, providing team-based, integrated, multidisciplinary, flexible treatment and support to people with severe mental illness who are more at-risk of psychiatric crisis and hospitalization and involvement in the criminal justice system.
- CSAs may employ Peer Specialists and Community Support Workers to assist with their outreach and treatment efforts.
- Peer Specialists are self-identified current or former consumers of behavioral health services with the ability to support other individuals diagnosed with a mental illness and/or substance use disorder.
- The Child and Adolescent Mobile Psychiatric Service (ChAMPS), is a community-based, mobile crisis response for children and adolescents to help manage extreme emotional behavior and assist families in arranging a temporary placement or other emergency care.

These are all important programs, and we hope the District continues to invest in these services to meet the range of needs. The health system, however, continues to have too little capacity to

offer comprehensive emergency and intermediate-level services to all residents who could benefit. More investments and strategic planning are direly needed in this area. If more people had their mental health needs met early in the lifespan, or early in their course of illness, if we focused on preventing trauma and de-escalation, we may not see so many people in acute stages of crisis in a system with limited capacity to meet their needs.

Crisis Intervention Training

Ideally, persons with mental health conditions are supported with the care and resources they need prior to experiencing a crisis or having an interaction with police or the crisis response system. 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. We will reference only Intercept 0 and Intercept 1 here. The SIM also includes Intercept 2-5, which focus on court hearings, jail, re-entry, and parole/probation.

Intercept 0 occurs before contact with the criminal justice system, enabling diversion into treatment and reducing pressure on local emergency departments and the need for psychiatric beds. Before Intercept 0 are all the upstream social determinates of health, including having safe and stable housing, enough food to eat, access to quality health care, and financial security. 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.

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. 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 the sharing of data to identify persons who come into frequent contact with police but could likely be served better through connections to services.

The District has a Crisis Intervention Officer (CIO) program within MPD, where DBH provides 40 hours of training for MPD officers in de-escalation techniques and mental health education. The intent of the program is to divert non-violent persons with mental health needs from the criminal justice system. Over 1,100 officers have been trained. In agency Trend Reports, we see that the CIO program has resulted in:

- 89% of CIO-responded incidents having no injuries reported at all, and injuries to CIOs are as low as 1-2%;

- Discovery of weapons is low, in 7-11% of incidents, with the most common being a knife;
- Crisis intervention occurred in 63% of incidents, while transportation away from the scene occurred 72-84% of the time;
- The majority of incidents involved those aged 19-29;
- Arrests were few, in only 4-8% of incidents; and
- Responses usually concluded in approximately a half-hour.

What happens in a crisis? Is it appropriate?

It is important to consider what an ideal crisis response should look like and why. Specifically, we should ask ourselves what would *you* want to see happen when you call 911? More specifically, what or whom would you want to see handling mental health-related calls?

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.

In the District, while a portion of MPD's officer have received CIO training, that trained portion represents approximately one-fourth of the active-duty force. Further, the 911 operators within the District's Office of Unified Communications (OUC) have not received mental health de-escalation training and mental health education from DBH. For calls that may require or benefit from a CIO or team of CIO-trained officers, it is currently unclear how a 911 operator would have the ability to assess a call and dispatched appropriately-trained officers. Expanding CIO training to not only all MPD officers, but all 911 operators as well, would greatly increase the awareness of mental health needs and concerns, and ideally improve assessment, response, and outcomes.

The DC Auditor, in conjunction with the Council for Court Excellence, reviewed the CIO program in 2018. They noted pros to the program, including fewer arrests and injuries and low instances of use of force, as noted in MPD's Trend Reports. But the audit also noted some cons – that there are not enough trained CIOs for all community members, 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 are transported, whether children or adults.

Another con for the program relates to the larger structure of crisis response and behavioral health system in the District – the pathways and process flows for people to access and find the best care are challenging and need better connections.

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

NAMI's 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.

In the District, we are nominally meeting NAMI's definition, but not meeting the Justice Collaborative Institute's definition.

As noted above, the District does offer 24/7 services, including information from the Access Help Line, mobile crisis from Community Response Teams, and 24/7 walk-in services at the CPEP office in Southeast, DC. However, these resources are each separate and not available through any singular contact approach (like a 911, 311, or 988 number), requiring those seeking assistance to potentially navigate through various service providers to find what is best in the instant situation.

Further, the Justice Collaborative Institute notes that law enforcement should not be involved in the mental health crisis response system, which is not the norm in the District. The District should also have on-site, on-demand and preventative programs, which exist but are not particularly coordinated. As with much of DC'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.

What models de-escalate, minimize harm and trauma, and keep everyone safe?

Building off the SIM, the National Conference on State Legislatures (NCSL) named models of different response formulations that could help improve interactions with police and persons with mental illness. These include crisis intervention teams, co-responder teams, mobile crisis teams, case management teams, and crisis stabilization centers. NCSL notes that people with mental illness are no more likely to commit violent acts than persons who do not experience mental illness, but they are 10 times more likely to be the victim of a violent crime. This is, in part, due to the propensity for bystanders to call police when someone is experiencing a mental health crisis, versus engaging mental health professionals.

To address this disparity, jurisdictions are experimenting with Crisis Intervention Teams and Co-Responder teams that include trained law enforcement responding to mental health incidents but offering different care approaches. The District has its training program for Crisis Intervention Officers and offers mobile crisis, through both the Department of Behavioral Health and through contracted community-based organizations. The NCSL also notes the need for crisis stabilization centers that are not emergency departments and/or jail. Having, as NCSL notes, "authorized and funded triage centers" to deflect people with mental health needs from the criminal justice system are increasing as lawmakers seek to develop functional alternatives.

Models that limit harm and trauma exist across the U.S. The Justice Collaborative Institute's model for crisis response includes on-demand services and dedicated public funding for mental health and alternatives to policing. There is such promise in collaborative programs, in terms of saving lives and saving dollars, as surveys have shown that almost a quarter of fatal police encounters result from calls about disruptive behavior, directly tied to a person's mental health or substance use.

The CAHOOTS program in Eugene, Oregon, 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 by responding to mental health calls through the 911 and 311 systems with a medic and an experienced crisis worker. The CAHOOTS program is run by the White Bird Clinic in collaboration with the city governments of Eugene and neighboring Springfield. 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.

Denver, Colorado, as well as other cities in Colorado, have also been experimenting with pilot programs matching mental health professionals with police to respond to incident calls. In Boulder alone, the program cost \$600,000 annually to operate, but saved the city \$3 million in costs due to fewer arrests and incarcerations. Looking at just data from 2017, only 2.4% of encounters resulted in an arrest, while a third of the 1,000 people the clinicians saw 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.

Similarly, Miami-Dade County in Florida received the dubious distinction of its jail being named the "largest psychiatric warehouse in the country" in 2008. 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 program saw a dramatic decrease in the number of arrests from calls, dropping from approximately 10% of all calls, or around 400-500 arrests out of 5,000, to just a fraction of 1% of calls resulting in arrest, or 10-20 arrests out of 5,000 calls. Recidivism also dropped dramatically for people in either the misdemeanor or felony treatment programs.

San Francisco announced in October 2020 that it would remove police from behavioral health calls and instead seek to deploy teams of professionals 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 by new unarmed mobile teams comprised of paramedics, mental health professionals, and peer support counselors.

How do we connect people to resources, and resources to each other?

The District's crisis response system has multiple parts, involving several government agencies and community-based providers. We must ensure this system understands itself, communicates effectively amongst its partners, and provides sufficient connections and supports to not only the patients and clients, but the providers and professionals.

During Council Period 23, the DC Council held a hearing on Bill 23-178: the Interagency Council on Behavioral Health Establishment Act of 2019, but unfortunately the Committee on Health has declined to take the bill to mark-up as of November 2020. This bill would construct an interagency council, modeled after the successful Interagency Council on Homelessness (ICH), bring together representatives from several relevant government agencies ; organizations providing behavioral health care; persons experiencing behavioral health care needs; managed care organizations; academic, philanthropic, advocacy and business organizations with expertise regarding behavioral health; professional associations; and representatives from the DC Council. 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.

The health system is attempting to build electronic systems of coordination and connection, such as the Health Information Exchange through CRISP, based on a common understanding in the need for better coordination and resource directories. In the crisis response realm, we may also consider a singular contact number for mental health crisis response, rather than separate lines for each program. Better advertising, awareness work, and training for providers, agencies, and community organizations could also be beneficial.

Recommendation

As jurisdictions continue to study and pilot diversion approaches and assess integrating and funding additional mental health supports both within and outside of law enforcement, we hope to continue to see progress in the District in its approaches to working with residents and visitors with mental health conditions in need of crisis supports. Our research here is just beginning, and we hope to share with you more findings and recommendations with you in the new year.

Today, we summarize with these recommendations for the Committee:

1. Adopt a goal for the District to achieve a crisis response framework that meets the criteria of NAMI's and the Justice Collaborative Institute: a crisis response system that is available 24 hours a day, that is separate from law enforcement and includes on-site, on-demand and preventative services and mobile crisis services.
2. Look to programs across the country – including the examples in Oregon, Colorado and Florida – for models to respond to crisis with de-escalation and health care rather than force, as safer, more cost-effective alternatives.

3. Better understand and improve the capacity and workflow of 911 dispatchers when calls relate to mental health and substance use.
4. Determine whether the CIO training for MPD officers is sufficient and appropriate to meet the needs, and ensure that officers with CIO training are available where and when they are needed.
5. Create opportunities for better coordination between agencies, programs, services and stakeholders – centering experts and people with lived experience – to improve support across the system and across the lifespan.

There are significant tasks for the health system as well, including workforce shortages, treatment capacity in hospitals and community settings, better coordinating services within and across sectors, and community work around trust and stigma.

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 response to people with mental illness, addiction, trauma, distress, or crisis.

Conclusion

In our testimony, we have shared some of our initial research and recommendations. We will be continuing 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.

Thank you for the opportunity to testify on behalf of the DC Health Matters Collaborative. We are happy to answer any questions and continue the dialogue on this important issue. I can be reached at arieke@dchealthmatters.org.