D.C. Crisis Response Coalition

D.C. CRISIS RESPONSE COALITION POLICY PLATFORM

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When someone in D.C. experiences a physical health emergency, like a fall or an asthma attack, calling 911 results in EMTs or paramedics promptly providing emergency aid. But when someone in D.C. experiences a mental health emergency, like thoughts of suicide or hallucinations, calling 911 usually results in a response from Metropolitan Police Department (MPD) officers, rather than trained mental health specialists. Local mental health practitioners and MPD officers themselves report that when officers arrive, they generally either do nothing or handcuff the person in crisis and take them to a mental health emergency room in a squad car.

Whether or not someone calls 911, mental health emergency rooms are the primary places in D.C. for individuals to receive care for a mental health crisis. Yet those facilities have long waits and provide invasive interventions that may in fact exacerbate individuals' trauma. Many mental health emergencies could be resolved at a community-based facility where folks could talk with a peer support specialist or a counselor, but few places in D.C. offer such services.

These deficiencies illustrate some of the ways that D.C.'s crisis response system fails to provide the level of care recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency responsible for research and public health initiatives related to behavioral health. According to SAMHSA, the minimum components of an effective crisis response system are:

- *Someone To Talk To*: A crisis call center staffed with mental health professionals who respond to and triage mental health emergency calls;
- *Someone To Respond*: Mental health professionals who can respond to emergencies without police and address crises that the call center cannot resolve telephonically; and
- *A Place To Go*: Crisis receiving centers that provide medically appropriate care to people experiencing different levels of mental health emergencies and, crucially, connect consumers to ongoing care.[1]

The D.C. Police Reform Commission recommended that the District take swift, bold action to develop these types of services.[2] While D.C. has taken some positive steps, much work remains. This policy proposal builds on the Police Reform Commission's recommendations and outlines a path toward providing the 129,000 D.C. residents with a mental illness the care they deserve.[3]

I. SOMEONE TO TALK TO

The D.C. Department of Behavioral Health (DBH) has created two mental health call centers separate from 911: the Access HelpLine/988, which primarily serves adults, and Child and Adolescent Mobile Psychiatric Services (ChAMPS), which serves youth. Both can dispatch mental

[1] SAMHSA, Nat'l Guidelines for Behavioral Health Crisis Care Best Practice Toolkit 13-23 (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf, ("SAMHSA Guidelines").
[2] D.C. Police Reform Commission, De-Centering Policing To Improve Public Safety: A Report of the D.C. Police Reform Commission 36 (April 2021), https://dccouncil.gov/wp-content/uploads/2021/04/Police-Reform-Commission-Full-Report.pdf ("D.C. Police Reform Commission Report").
[3] Mental Health America, The State of Mental Health in America 20, 21 (2022), https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf.

health specialists to emergencies, with 988/the Access HelpLine's responders called Community Response Teams (CRTs).

Nonetheless, the vast majority of people seeking assistance with a mental health emergency in D.C. still call 911. When they do, the D.C. Office of Unified Communications (OUC), which manages the District's 911 program, generally dispatches MPD to the scene. Analyzing OUC data, the Coalition found that in FY2022, OUC staff dispatched MPD to over 36,000 of the 911 calls it received that exclusively or primarily involved mental health emergencies.[4] By contrast, the Coalition's analysis of DBH data shows that in FY2022, DBH's mental health crisis call centers received a *total* of approximately 11,800 emergency calls.[5] In June 2021, the District launched a pilot program aimed at routing behavioral health calls from OUC to 988, but the initiative diverted only approximately 657 mental health calls in FY2021 and FY2022, a fraction of the total.[6]

A. Bolster and Promote the Services Provided by the 988 /the Access HelpLine

Background

District residents' reliance on 911 over 988 may reflect their lack of awareness about 988's services, which D.C. can address by better promoting them. The issue may also arise from the limitations in 988's services. Although 988 exists to connect people with outpatient mental healthcare, 988 staff merely give out phone numbers, expecting individuals to navigate the mental health bureaucracy on their own. That task, which is intimidating to many, can be particularly daunting to people from marginalized backgrounds who may have been turned away from services before. In addition, 988 expects service providers to review 988's call database and contact the people 988 referred to them, which many providers lack the resources to do.

Recommendations/Demands

1. **Publicize 988 and the services it offers widely**, including in public places and medical and mental health facilities.

2. **Provide enough training and staffing so that 988 callers who need a referral to outpatient services receive a 'warm handoff.'** 988 staff should stay on the line with callers while contacting providers and not hang up until the caller begins coordinating an intake appointment. When call volumes preclude this, 988 staff should follow up with callers to ensure that they obtain an intake appointment within 72 hours of the call. Callers should not be told to schedule intakes themselves or to just show up at the provider's office.

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[4] *See* OUC, Response to Fiscal Year 2022 Performance Oversight Questions, Attachments PDF pp. 294-316 (Feb. 2023), https://dccouncil.gov/wp-content/uploads/2023/02/OUCPOHATT-1.pdf.

[5] *See* DBH, Fiscal Year 2022 Performance Oversight Pre-Hearing Questions 30, 31, 88-90 (Feb. 2023) https://dccouncil.gov/wp-content/uploads/2023/03/FY-22-DBH-Oversight-Questions-and-Responses_One-Doc.pdf. The sum includes the deployable calls received by ChAMPS; all referrals to CRT except ones where the basis for call was labeled "missing;" and all calls to 988 (DBH reported them separately from calls to CRT).

[6] *Id.* at 83 (stating that pilot program diverted 327 calls to DBH in FY2022); Sarah Holder, D.C. Extends Program Diverting Mental Health Calls From Police, Bloomberg (Nov. 12, 2021) (reporting 330 calls diverted by pilot program in total between June and Nov. 2021), https://www.bloomberg.com/news/articles/2021-11-12/d-c-will-dispatch-social-workers-to-more-911-calls.

3. **Endorse allowing 988 to geolocate the location of the caller to determine if they are in or out of the District.** (More precise geolocation has privacy and consent concerns.)

B. Divert More 911 Calls to 988

Background

Many factors have stymied the behavioral health crisis call diversion pilot. In particular, D.C. arbitrarily restricts diversion to 988. OUC cannot divert calls involving youth under 18 or calls where the caller is a stranger to the person in crisis, even if the person is unarmed and unthreatening,[7] as most people in crises are. Moreover, OUC has not fully implemented the D.C. Auditor's recommendations for improving supervision, training, and other practices.[8] D.C. states that it is working with the Harvard Kennedy School on some of these issues, which is welcome. But we are unaware of requests for public input, which experts view as crucial to such reforms.[9]

Recommendations/Demands

1. **Create a clear and comprehensive list of the mental health calls routable to 988**

    a. DBH, FEMS, MPD and community representatives should streamline and reduce the 500+ event codes for 911 calls.

    b. Expand the types of calls that can be classified as mental health calls and be referred to 988/the Access HelpLine for a non-police response

2. **Re-train and re-invest in OUC operators to ensure they route calls to appropriate entities**

    a. Train OUC operators to recognize mental health calls. Enlist DBH and community members to train OUC more generally on which calls genuinely require police and which are addressable by CRT, FEMS, or other non-police responders.

    b. Eliminate the blanket prohibitions on routing mental health calls from 911 to 988 when the calls involve people under 18 or individuals not known to the caller.

    c. Train OUC operators on when events such as 'disorderly conduct' or 'trespass' are actually mental health calls and should be routed to non-police responders.

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[7] *See* OUC, Response to Fiscal Year 2022 Performance Oversight Questions, *supra* n.2 at PDF p.65

[8] Office of the D.C. Auditor, 911 Reform Status Report 2: Progress Made But Transparency Needed 7-18 (Mar. 2023), https://dcauditor.wpenginepowered.com/wp-content/uploads/2023/03/OUC.911.Reform.Status.Report.3.23.23.pdf.

[9] *See, e.g.*, Council of State Governments, *Expanding First Response: Community Engagement and Collaborations with Key Stakeholders*, https://csgjusticecenter.org/publications/expanding-first-response/the-toolkit/stakeholder-collaboration/ (last accessed Apr. 17, 2023).

d. Ensure OUC operators have resources they need to perform their jobs, including sufficient staffing, fair wages, and access to mental health services to help them process the daily trauma they hear.

3. Increase integration between OUC and 988

a. Ensure interoperability between 988 and OUC's Computer Aided Dispatch (CAD) system. Ensure 988 dispatchers can alert the nearest CRT responder and design efficient travel routes.

b. Create a secure digital registry with real-time availability of all mental health crisis and respite beds in the District, accessible by both 911 and 988 operators.

4. Set clear progress goals and collect data to track them

a. Ensure OUC routes a significant share of 911 calls to 988, specifically:
   i. By 2024, OUC should refer at least 25% of all mental health calls to 988.
   ii. By 2025, OUC should refer at least 50% of all mental health calls to 988.
   iii. By 2026, OUC should refer at least 75% of all mental health calls to 988.

b. Engage the D.C. Auditor and community representatives to review random samples of OUC calls to identify any systemic problems in routing decisions.

c. Collect, and regularly publish in anonymized form, data on mental health calls, including:
   i. The time and location of the call;
   ii. The facts that led the OUC staffer to treat the call as a mental health call;
   iii. Where the call was referred (e.g. FEMS, MPD, or 988) and why;
   iv. Whether any personnel were dispatched to the scene; and
   v. Whether a voluntary or involuntary transport to higher level care occurred

II. SOMEONE TO RESPOND

According to SAMHSA, relying on "local law enforcement as the de facto mental health mobile crisis system" is "unacceptable and unsafe."[10] Yet, as discussed previously, D.C. relies on MPD to address the vast majority of mental health emergencies in the city. The District can do much more to provide appropriate care.

A. Make Mental Health Specialists The Default Front Line Responders to Mental Health Crises.

Background

[10] SAMHSA Guidelines, *supra* n. 1 at 33.

Local mental health practitioners told us that they want to call CRT in a crisis but slow CRT response times cause them to call 911 (and receive a police response) instead. The District has struggled to hire more CRT members, which it attributes to a nationwide shortage of licensed providers.[11] But D.C. can surmount that challenge with more aggressive recruitment and by relying more on trained peers supports, individuals with relevant life experience certified by DBH to provide care after completing a course or passing a test.

The Police Reform Commission recommended making mental health specialists the default front line responders for mental health crises.[12] The District can more aggressively pursue that goal.

Recommendations/Demands

1. **Give CRTs and ChAMPS the resources needed to act as the default front line responders for mental health crises.**

    a. CRT and ChAMPS should serve as the default, initial front line responders for mental health emergencies, responding to (1) all welfare checks and (2) all requests for assistance for a person's mental health where (a) the person in crisis does not possess a firearm and (b) the caller has either (i) stated that the individual does not pose a threat to other persons' physical safety or (ii) has failed to provide a concrete basis for concluding that the individual poses such a threat. The vast majority of mental health emergency calls likely meet this standard. For instance, in its most recent analysis, DBH found that between FY2019 and FY2022, a person had a firearm in less than 1% of reported mental health crises calls to which crisis intervention officers (MPD's officers with the most mental health training) responded.[13]

    b. Provide CRTs and ChAMPS the funds needed to respond to high priority mental health emergencies within 5 to 9 minutes, the same goal D.C. sets for EMTs and paramedics to respond to high priority physical health emergencies.[14] Ensure that CRTs and ChAMPS have the resources needed to respond promptly to lower priority calls too.

    c. Oppose the Mayor's proposed FY2023 reduction of funds to CRTs and ChAMPS.

    d. Increase skills training for CRTs and ChAMPS members so that they can respond quickly to mental health emergencies using a trauma-informed approach.

2. **Empower trained peer supports and increase incentives to work in D.C.**

    a. Establish protocols allowing trained peer supports to fill key positions in the crisis response system.

[11] DBH, Fiscal Year 2022 Performance Oversight Pre-Hearing Questions, *supra* n. 5 at 31, 87.
[12] D.C. Police Reform Commission Report, *supra* n. 2 at 36.
[13] DBH, Crisis Intervention Officer Incident Data (FY19-FY22) 8 (on file with coalition) (hereinafter DBH Crisis Intervention Officer Report).
[14] D.C. Fire and Emergency Medical Services, Fiscal Year 2022 Performance Oversight Questions: Part 2, 18 (Feb. 2023), https://dccouncil.gov/wp-content/uploads/2023/02/FEMSPOH.pdf

b. Pay peer supports fair wages, create pathways to advancement, train managers on best practices to retain employees, and evaluate hiring protocols for trained peer supports to remove any unnecessary barriers.

c. Recruit more licensed behavioral health professionals by passing Bill 25-0055, the Pathways to Behavioral Health Degrees Act of 2023.[15]

B. Reduce the Trauma and Indignity of Crisis Care

Background

The District vests every MPD officers with authority to decide if a person in crisis needs to be transported to a mental hospital for evaluation, a power not even given to many clinicians.[16] Further, MPD policy generally requires officers to handcuff individuals in crisis during transports, even if clinicians on site advise against it.[17] D.C. should rely on mental health professionals, not police, to decide how to resolve crises. It should also rely on the insights of people with mental health disabilities themselves by creating a system for them to prepare psychiatric advanced directives specifying in advance the support they want and need if a crisis occurs.

Recommendations/Demands

1. **Allow people with mental health disabilities to specify how front line responders should treat them in a crisis, as the Police Reform Commission recommended.[18]**

   Encourage local mental health providers to talk with patients about writing psychiatric advanced directives—i.e. instructions on how to approach them during a mental health crisis, including what de-escalation tactics to use and what loved ones or medical providers to call. Ensure CRTs and ChAMPS have access to psychiatric advanced directives.

2. **Minimize the hardship involved in involuntary transports for psychiatric evaluations.**

   a. Provide Mental Health ambulances, as other countries do, equipped with comfortable seats, that CRT and ChAMPS can use to meet with people in crisis and, when needed, transport them to respite centers and stabilization beds.[19]

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[15] https://lims.dccouncil.gov/downloads/LIMS/52128/Introduction/B25-0055-Introduction.pdf
[16] MPD General Order 308.04, Interacting with Mental Health Consumers § V.C.2, V.I.1.c (Feb. 9, 2015), https://go.mpdconline.com/GO/GO_308_04.pdf; 22 DCMR §§ 7601, 7603.2, 7604.
[17] MPD General Order 308.04 §§ IV.C, V.C.5.a, V.I.2.
[18] D.C. Police Reform Commission Report, *supra* n. 2 at 56–57.
[19] *See* de Jong, et al., *Responding to Persons in Mental Health Crisis: A Cross-Country Comparative Study of Professionals' Perspectives on Psychiatric Ambulance and Street Triage Models*, 7 J. of Comm. Safety & Well-Being S36, S37, S41 (Jul. 2022), https://www.journalcswb.ca/index.php/cswb/article/view/250/688.

b. Require CRT and ChAMPS to publish protocols for the circumstances under which they contact MPD so that the public can evaluate those protocols and individuals can make informed decisions about calling for assistance.
c. Amend MPD General Order 308.04 to require MPD officers to receive approval from a CRT clinician (for adults) or ChAMPS clinician (for young people) before initiating an involuntary transport or handcuffing an individual involuntarily transported. The District should ensure that a CRT and ChAMPS clinician is available to provide advice via video call 24/7 and require those clinicians to confer with the individual's mental health provider, if such a provider is identified in the CRISP database and is available.

C. Protect People with Mental Health Disabilities from Needless Arrests

Background

Police frequently have unnecessary interactions with people with mental health disabilities outside the context of a crisis. For instance, a passerby may call 911 about someone yelling to themselves on the street or a businessperson may call about a disoriented person sitting in front of their store. These calls often require neither law enforcement officers nor mental health specialists but rather individuals with conflict resolution skills. The District has several programs specializing in conflict resolution services and should allow 911 dispatchers to rely on them in addressing certain calls. Additionally, D.C. must do more to ensure that one person's minor annoyance does not lead to another person's incarceration—a result that happens all too often, particularly for people with mental health disabilities and people of color.

Recommendations/Demands

1. **Create a pilot to divert non-violent, low-priority 911 calls involving trespass or disorderly conduct to conflict resolution specialists**, such as D.C. Peace Teams, and appropriately fund the community-based program contracted to provide the services.

2. **Follow the D.C. Police Reform Commission's recommendations to increase use of the pre-arrest diversion program**, an initiative permitting police to provide people with behavioral health challenges who committed low-level offenses treatment in lieu of arrest.[20]

III. A PLACE TO GO

SAMHSA predicts that in most communities only 14% of mental health crises need to be resolved via hospitalization and that, in most cases care should be provided at less expensive, less restrictive crisis receiving and stabilization centers.[21] SAMHSA data also suggests that even a high

[20] D.C. Police Reform Commission Report, *supra* n. 2 at 44–45.
[21] Id.

proportion of people in crisis who are evaluated for hospitalization can be safely cared for in a community-based crisis facility with outcomes at least as good as hospital care.[22]

Yet in D.C., when front line responders cannot resolve a crisis on site, individuals' only option for more care is generally a mental health emergency room. One local psychiatrist described these facilities as dark, loud places, with long waits. Multiple practitioners told us that a trip to a mental health emergency room can exacerbate symptoms rather than alleviating them.

The District can reduce the number of people who turn to psychiatric emergency rooms by making it easier for people to obtain care before they experience a crisis, expanding the number of alternative facilities where people can receive care, and ensuring people receive the post-crisis care necessary to prevent similar outcomes in the future. SAMHSA data suggests the cost of crisis care is substantially less than that of inpatient care and its accompanying emergency department "medical clearance" charges.[23] Improving community-based crisis options can better individuals' health outcomes while simultaneously lowering the District's financial expenditures in the long run.

A. Expand Non-Hospitalization Options for People to Receive Care When a Crisis Occurs

Background

D.C. has few community beds for people experiencing mental health emergencies. Instead, most beds are at hospitals, where the costs are higher and the outcomes are similar if not worse.[24] The lack of intermediate services puts unnecessary pressure on the District's hospital system while requiring individuals to choose between a potentially traumatizing hospital visit or receiving no care at all.

Recommendations/Demands

The District should invest in crisis and stabilization options distributed throughout the city. These facilities are not intended as sites for involuntary transports and, in creating and expanding them, the District should make clear to providers, CRTs, ChAMPS and police officers that for many people, receiving support at home is, the best option for resolving a crisis.

In general, crisis stabilization centers fall into three categories and the District should expand the number of beds of each type.

1. **Crisis beds** refer to community-based beds where people can stay for a week or two and receive professional mental health services. Presently, only 16 crisis beds are available to DBH consumers in the District.

    a. By 2024, increase crisis beds to at least 24.
    b. By 2025, increase crisis beds to at least 35.
    c. By 2026, increase crisis beds to at least 50.

[22] SAMHSA Guidelines, *supra* n. 1 at 22.
[23] *Id.* at 23.
[24] *Id.* at 23

2. **Extended Observation Unit (EOU) beds** refer to beds located in the community where people can voluntarily receive mental health services for shorter periods, usually 23 to 72 hours. The District has only a small number of beds providing care similar to that of EOUs, but they are all located at the Comprehensive Psychiatric Emergency Program. Because of the hospital setting, these beds are more likely to increase trauma and impede stabilization than community-based EOUs.
    a. By 2024, create at least 6 new community-based EOU beds.
    b. By 2025, increase the number of community-based EOU beds to at least 15.
    c. By 2026, increase the number of community-based EOU beds to at least 30.

3. **Respite facilities** are quiet places where people can visit or stay temporarily shortly after a crisis, or when they are at risk of a crisis. People receive informal support, such as meeting with peers and group therapy. Respite facilities can help individuals avoid hospitalization and sustain their recovery. The District has no such facilities.
    a. By 2024, establish a respite facility with at least 10 beds.
    b. By 2025, add another 10 respite facility beds, increasing the total number of beds to 20.
    c. By 2026, add 15 additional respite beds, increasing the total to 35.

4. **Data collection.** The District should collect data on the percentage of mental health crisis calls resolved on-site, the percentage routed to a hospital, and the percentage routed to the community facilities listed above. The District should also create a community feedback mechanism to assess and promote efficacy.

5. **Incorporate considerations for special populations in the implementation of crisis care.**

    a. Reserve a third of the newly created crisis beds, EOUs, and respite beds for young people under 18.

    b. Ensure facilities consult with trans and gender nonconforming people about housing assignments to ensure they feel safe in their placement. Provide all-gender restroom and shower facilities. Require that staff receive training on trans-inclusive care. For facilities that provide overnight housing, create at least one single occupancy room for LGBTQIA+ individuals who feel unsafe in a shared sleeping environment.

    c. Accommodate people who use drugs, including individuals with substance use disorders and related disabilities, in the construction of the facilities discussed above by permitting people to receive treatment even if they aren't sober, creating specific programming for people who use drugs, hiring people trained to care for people with dual mental health and substance use disorder diagnoses, and including separate wards to avoid triggering other individuals in the program who may be in recovery from such disorders. Further, the District must move toward creating facilities for people who use drugs that feature safe consumption components.

    d. Establish protocols, including the provision of childcare services, that allow parents experiencing medium-level mental health emergencies to bring their children with them to crisis beds, EOUs, and respite centers if the children cannot otherwise receive care from a caregiver whom the parent approves.

B. Increase Access to Mental Health Care After the Crisis

Background

After someone experiences a mental health emergency, they should be connected with outpatient mental health services and receive the care needed to make future crises less likely. These services, though, are particularly hard to access for people who, due to their disability or life circumstance, find visiting traditional outpatient mental health facilities prohibitively intimidating. Assertive Community Treatment (ACT) programs are designed to serve such individuals by dispatching teams of clinicians and trained peers to provide outpatient care at an individual's home, whether it is an apartment or an encampment. But practitioners claim that D.C. does not provide ACT sufficient funding to provide adequate care or enough oversight to ensure effectiveness.

Recommendations/Demands

1. **Perform a fidelity audit of existing ACT programs** to assess current compliance and identify areas for improvement.

2. **Increase funding for ACT** so that caseloads are lower.

3. **Increase training and oversight mechanisms for ACT teams** so that new and existing funds result in higher quality care.

CONCLUSION

An effective crisis response system provides people with someone to talk to, someone to respond, and a place to go, including connection to post-crisis care. The District has made some progress toward these goals but considerable work remains. We look forward to working with D.C. to achieve a crisis response system that provides District residents with mental health disabilities the care they deserve.

FOR MORE INFORMATION

www.dccrisisresponse.org