ACLU District of Columbia

529 14th Street NW
Ste 722
Washington, DC 20045
(202) 457-0800
www.acludc.org

Statement on behalf of the American Civil Liberties Union of the District of Columbia
before the
D.C. Council Committee on Health Budget Oversight Hearing
by
Michael Perloff
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Chairperson Henderson:

If last year's estimates are any guide, tens of thousands of mental health crises will occur in the District this fiscal year, including PTSD episodes, suicide attempts, and hallucinations.[1] How will our community respond? We fear not well enough.

The problems start when someone calls the District for help. Most D.C. residents seek assistance with a mental health crisis by dialing 911, and 911 staff respond to most mental health calls by dispatching the Metropolitan Police Department (MPD).[2] The District continues to limit the number of 911 calls diverted from police to the Access Helpline, a call center staffed with mental health professionals who can de-escalate crises over the phone or deploy Community Response Teams (CRTs) or Child Adolescent Mobile Psychiatric Services (ChAMPS) to do so at the scene. In FY23, Office of Unified Communications (OUC) routed only 644 mental health emergency calls to that service[3]—less than 2% of the total number of mental health emergency calls 911 ordinarily receives[4] and a small increase over the 470 calls diverted from 911 in FY22.[5]

The District's heavy reliance on MPD makes it unlikely that people with mental health disabilities will receive effective care and exposes them to serious risks of harm. "People with mental illnesses are not more likely to be violent than the general public,"[6] and yet, nationally,

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[1] D.C. Crisis Response Coalition Policy Platform 2 (April 2023) (stating that the District received over 36,000 911 calls primarily or exclusively involving mental health emergencies in FY2022), https://static1.squarespace.com/static/63ff8a6ed33bd4177c2715e6/t/6448e019a4f03d04b9b80cdb/1682497563516/D.C.+CRISIS+RESPONSE+COALITION+POLICY+PLATFORM+Cover+and+back.pdf

[2] *Id.*

[3] D.C. Dep't of Behavioral Health FY 2023 Performance Oversight Pre-Hearing Questions 112.

[4] *See* D.C. Crisis Response Coalition Policy Platform, *supra* n.1

[5] D.C. Dep't of Behavioral Health Responses to FY 2023 Performance Oversight Pre-Hearing Questions 112.

[6] Council for State Governments, Addressing Misconceptions about Mental Health and Violence 1 (Aug. 2021), https://csgjusticecenter.org/wp-content/uploads/2021/08/CSGJC_Field-Notes_Addressing-Misconceptions-about-Mental-Health-and-Violence_2019-MO-BX-K001_508.pdf; *see also* John S. Rozel & Edward P. Mulvey, The Link Between Mental Illness and Firearm Violence: Implications for Social Policy and Clinical Practice, 13 Annual Rev. of

police use force against people with serious mental health disabilities 11.6 times more often than against other individuals,[7] and kill people with serious, untreated mental health disabilities at 16 times the rate they kill others.[8] Black people suffer the most from these disparities. For instance, nationwide, the *majority* of Black people with disabilities have been arrested by age 28, double the rate of the white disabled population.[9] Even when police do not use force or make arrests, D.C. mental health professionals tell us that they rarely see police provide appropriate or effective care. Thus, it is unsurprising that the D.C. Police Reform Commission, the D.C. Crisis Response Coalition, the Substance Abuse and Mental Health Services Administration, and even the Department of Justice have all called for relying on mental health professionals, rather than police, as the default first responders for mental health crises.[10]

Achieving this goal will require the District to employ more mental health professionals capable of responding to crises in person or over the phone. Workforce issues may not entirely explain the limited number of diversions to the Access Helpline (and therefore away from MPD), Other factors, such as restrictions on calls that are eligible for diversion and the need to improve training for OUC staff may contribute too. In the long run, though, staff capacity will be crucial.

Despite the great need for mental health professionals, the District has many unfilled positions. As of this past January, Access Helpline had 10 vacancies and CRT had 18, meaning that CRT operated at only 60% capacity.[11] The shortages help explain DBH's report that CRT took, on average, 91 minutes to arrive at the scene of Priority 1 mental health calls, despite a target response time of 30 minutes.[12] These delays result in concrete harm: According to local mental health

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Clinical Psych. 445, 448 (2017), https://www.annualreviews.org/doi/pdf/10.1146/annurev-clinpsy-021815-093459

[7] Ayobami Laniyonu & Phillip A. Goff, *Measuring disparities in police use of force and injury among persons with serious mental illness*, 21 BMC Psychiatry 1, 6 (2021), https://doi.org/10.1186/s12888-021-03510-w.

[8] Doris Fuller et al., *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters*, Treatment Advocacy Center 1 (Dec. 2015), https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf.

[9] Erin McCauley, The Cumulative Probability of Arrest by Age 28 Years in the United States by Disability Status, Race/Ethnicity, and Gender, 107 Amer. J. of Public Health 1977 (Nov. 8, 2017), at https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304095

[10] *See* 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-ReformCommission-Full-Report.pdf; D.C. Crisis Response Coalition Policy Platform 4; 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; DOJ and Dep't of Health & Human Servs. Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities 3–4 (2023),https://www.justice.gov/d9/202305/Sec.%2014%28a%29%20%20DOJ%20and%20HHS%20Guidance%20on%20Emergency%20Responses%20to%20Individuals%20with%20Behavioral%20Health%20or%20Other%20Disabilities_FINAL.pdf

[11] D.C. Dep't of Behavioral Health Responses to FY 2023 Performance Oversight Pre-Hearing Questions 7, 112.

[12] *Id.* at 7

professionals, when people in crisis wait extended periods for service, they often decompensate, withdrawing or becoming agitated in ways that will ultimately make it more difficult for them to receive care.

We appreciate that the Department of Behavioral Health's (DBH) has made efforts to hire more staff. But there is much more recruitment work to do. For example, as of today, neither DBH's website, nor the District's career page, lists any open jobs specifically for CRT or the Access Helpline. (All the postings on DBH's career page state that the opening closed in 2022.[13] And, on D.C.'s career page, the closest position we could find was Job ID 25753, which conducts assessments for the Community Services Administration/Adult Services and makes referrals to programs such as Supported Employment.[14] The posting made no reference to CRTs.) Filling existing vacancies requires not only making the most of existing resources but also exploring creative strategies to encourage applications. The District must ensure DBH has the budget needed for this crucial promotional work.

Effective mental health crisis services extend beyond telehealth and in-person response, as some mental health crises cannot be resolved on the phone or at the scene. The Roadmap to the Ideal Crisis System, a white paper prepared by national experts on mental health crisis systems, recommends that communities develop three categories of places for people to go when they need additional care. First, behavioral health urgent cares (akin to medical urgent cares) serve individuals seeking voluntary assistance before a crisis becomes acute.[15] These programs offer individuals the opportunity to speak with a mental health professional about their symptoms, receive updated prescriptions, and receive connection to follow up care.[16] Second, crisis centers act as specialized emergency rooms for mental health crises. They serve people experiencing all forms of mental health crises—including people arriving both voluntarily and involuntarily—and provide comfortable environments for people to stabilize, undergo short-term observation, and receive medication and therapeutic interventions.[17] Finally, residential crisis programs provide extended care (usually up to a few weeks) for people who "do not need the full resources of a psychiatric inpatient unit or other secure treatment setting," but still need require supports.[18] Residential crisis programs come in three forms: high-intensity programs serve as "hospital step-downs" that "can shorten the length of [hospital] stay;" low-intensity "respite" programs serve people on the verge of crisis or people who exiting intensive care who still need a bit of support; and intermediate facilities accommodate people whose needs fall between those seeking aid at the other two.[19]

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[13] D.C. Dep't of Behavioral Health, Employment Opportunities, https://dbh.dc.gov/employment-opportunities-0 (last accessed April 24, 2024).

[14] D.C..Gov, Behavioral Health Assessor, https://careers.dc.gov/psc/erecruit/EMPLOYEE/HRMS/c/HRS_HRAM_FL.HRS_CG_SEARCH_FL.GBL?Page=HRS_APP_JBPST_FL&Action=U (last visited April 24, 2024).

[15] Nat'l Council for Mental Wellbeing, Roadmap to the Ideal Crisis System (March 2021) 100, https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system/

[16] *Id.* at 101

[17] *Id.* at 89–90. The Roadmap notes that, in some cases, people in crisis will need to receive care at traditional emergency rooms. *See id.* at 88–90.

[18] *Id.* at 108

[19] *Id.* at 108, 111–12

The ACLU-DC is currently working with a team of experts and community members to assess the extent to which the District provides these services. Our research is not yet complete but based on preliminary findings, we believe that, when it comes to providing people in crisis a place to go, the District has significant gaps. For example: the District's behavioral health urgent cares are open for far fewer hours than experts believe are required; community members dread referrals to the District's primary crisis center, the Comprehensive Psychiatric Emergency Program (CPEP); and the District has no crisis centers or residential crisis programs for children and adolescents. The D.C. Stabilization Center, which opened last year, represents a positive development; however, it focuses largely on substance use crises as opposes to mental health ones.

We look forward to sharing the results of our research on the District's emergency mental health facilities, and, more generally, collaborating with the Council and the administration to bolster the services D.C. provides people in crisis—work that is essential to ensuring the thousands of District residents with mental health disabilities receive the care they need and deserve.