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Testimony of Kristin D. Ewing, Policy Counsel
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Committees on Health & Judiciary and Public Safety:
Sense of the Council on Supporting Humane and Trauma-Informed Responses to Behavioral Health Crises Resolution

Thank you for the opportunity to testify regarding PR26-0108, the "Sense of the Council on Supporting Humane and Trauma-Informed Responses to Behavioral Health Crises Resolution of 2025." My name is Kristin Ewing, and I am Policy Counsel at the DC Appleseed Center for Law and Justice (DC Appleseed).

DC Appleseed is a non-profit, non-partisan organization with a proven track record of tackling some of the District's most challenging problems, developing proposed solutions, and implementing them. Our work has significantly contributed to making the District a better place to live and work.

Much of my work at DC Appleseed focuses on health equity and the health workforce, with the goal of creating an equitable, just, and thriving city for all residents of the District. My testimony today addresses:

1. Why we should prioritize responding to behavioral health crises with a behavioral health team;
2. Why we must invest in behavioral health crisis response the same as other emergency responses;
3. Why we need to enhance existing behavioral health facilities and establish new facilities to ensure a seamless continuum of care for behavioral health in the District, particularly for youth; and
4. Why we must increase awareness around 988 and other behavioral health resources.

It is essential to develop a more coordinated, robust, and effective response to behavioral health crises that prioritizes care over criminalization. Individuals experiencing these crises should receive the same urgency, care options, and quality of care as those facing physical health emergencies. Every person in crisis deserves timely, trauma-informed care delivered by culturally and community-competent behavioral health professionals. This approach not only supports the individual in need but also fosters a healthier, safer, and more supportive community.

1. We should prioritize responding to behavioral health crises with a behavioral health team.

The District needs to increase and enhance the behavioral health provider response to crises. When behavioral health providers respond to crises, several positive things occur:

First, focusing on de-escalation and treatment rather than enforcement, with specialized care that trained mental health professionals can provide, can lead to better health outcomes. It can also reduce the likelihood of unnecessary arrests, criminal charges, or harm. This is especially important since those with untreated mental illness can be up to 16 times more likely to be killed during an encounter with police. A recent incident in DC drove this point home: a man in the middle of a mental health crisis was killed by police, even with a trained crisis intervention officer on the scene. Although we support all first responders in receiving robust crisis intervention and de-escalation training, this isn't a substitute for professional mental health services. Data shows that police agree with this sentiment.

Second, responding with mental health professionals can foster a more supportive environment, helping individuals feel safe and understood during their most vulnerable moments. This can be particularly important for marginalized communities who may have a mistrust of law enforcement due to past negative experiences. Supportive and positive interactions can also lead to successful connections with care and services, which often rely on relationships and trust. While many jurisdictions, including DC, have co-responder programs for behavioral health crises, where police and behavioral health providers respond in tandem, the District should continue to enhance and grow crisis response teams that can react without police, as evidence shows this is a more effective model and is a growing public safety trend across the country with strong public

support, even over hiring more police officers.

Last, involving behavioral health professionals can alleviate the strain on emergency services and law enforcement, allowing them to focus on situations that require their specific skills. This can also potentially reduce costs by lowering hospitalization and incarceration rates as well as reducing the use of law enforcement resources.

Ultimately, this kind of response promotes healing and recovery while reducing the stigma surrounding mental health issues, creating a more compassionate and effective system for all.

2. We must invest in behavioral health crisis response the same as other emergency responses. If the District truly wants a robust, trauma-informed response to behavioral health crises that mirrors the response to medical and other emergencies, then we must invest in the behavioral health workforce and crisis teams.

Currently, the Metropolitan Police Department (MPD) has over 4000 sworn officers and professional staff members, and DC's Fire and Emergency Medical Services (FEMS) has 1600 firefighter EMTs, and 300 paramedics. However, according to the most recent Department of Behavioral Health (DBH) oversight hearing responses, the Community Response Team (CRT) has 44 full-time equivalents (FTEs) with 19 vacancies and an average response time of 52 minutes. Furthermore, according to the hearing responses, ChAMPS, the Child and Adolescent Mobile Psychiatric Service, has even fewer staff members, operates only Monday through Friday from 8:00 AM to 8:00 PM, and has an average response time of 76 minutes.

The District's investment in behavioral health services and crisis response is disproportionately low compared to its investment in police and medical responses. To swiftly and adequately meet the needs of all District residents in crisis, DC must increase funding for behavioral health crisis response programs and teams, not only to expand overall FTEs but also to raise salaries to a competitive level. This will ensure proper staffing, retention, and recruitment. DC should also invest in developing an adequate pipeline of behavioral health professionals from a workforce development perspective, ensuring that DC residents are informed about these job opportunities and that there are sufficient training and education offerings in the District. Furthermore, it is

crucial to provide these workers with the mental health support they require, given the highly traumatic situations they frequently encounter.

Bread for the City's recent lawsuit against the District underscores the need for a comprehensive behavioral health response to crises. Rather than utilizing District resources to defend and settle lawsuits stemming from insufficient behavioral health investments, DC should proactively invest in a robust behavioral health crisis response infrastructure.

3. We need to enhance existing behavioral health facilities and establish new facilities to ensure a seamless continuum of care for behavioral health in the District, particularly for youth.

The District must continue to invest in, expand, and provide robust oversight of existing behavioral health programs and facilities. Additionally, DC needs to establish new programs and facilities to address all levels of need and ensure a seamless continuum of care. This is vitally important so that crisis response teams and police, if involved, have alternatives for where to take residents in need instead of relying solely on emergency rooms, psychiatric facilities, and jails. This will also ensure that high-quality options are available across the continuum of care when needed, along with strong support and options for patients once they have stabilized.

The DC Stabilization Center plays a critical role in crisis response and the continuum of care for adults facing a substance use crisis. Research indicates that the use of stabilization centers is growing nationwide, the public supports them, and these centers offer an alternative to criminal legal involvement, jail, and emergency rooms, leading to better outcomes for patients and reducing stress on law enforcement and the healthcare system. However, to truly make stabilization centers meet the needs of communities in the District, DC must:

- Expand stabilization center services so centers can also meet the needs of residents experiencing mental health crises in addition to those experiencing substance use crises;
- Increase the number of stabilization centers throughout the District to ensure accessibility for residents in all wards and adequate availability for everyone in need;
- Create a youth stabilization center, and
- Explore the addition of safe consumption sites to the District's stabilization centers.

- Evidence indicates that safe consumption sites, sometimes referred to as overdose prevention centers, can reduce infection and disease transmission, prevent overdose deaths, and increase connection to health services.

Oversight of existing psychiatric facilities is also vital to ensuring high-quality care and outcomes. The Psychiatric Institute of Washington (PIW) and St. Elizabeth's both provide psychiatric care in the District and have faced scrutiny for quality of care, neglect, and abuse, leading to lawsuits against both institutions. The District must ensure that all existing behavioral health facilities provide high-quality, trauma-informed care and are adequately staffed to ensure positive patient experiences and outcomes. When these facilities provide poor, neglectful, or inadequate care, they not only do a disservice to the patients but also create a chilling effect on utilization. This can discourage those facing a mental health crisis, or their friends and family, from seeking care out of fear of poor care and outcomes.

We also need to ensure that the District has ample alternatives to hospitalization. The District should offer accessible, high-quality residential treatment and partial hospitalization program (PHP) options for individuals who require support but do not necessitate complete hospitalization. DC must ensure that there are sufficient facilities and programs for adults in need and develop similar options for youth. Currently, DC has no PHP provider for youth and lacks a local Psychiatric Residential Treatment Facility (PRTF). District youth deserve better, and DC must work to provide the entire continuum of care for its children.

4. We must increase awareness around 988 and other behavioral health resources.

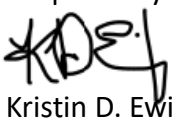
Last, we need to improve awareness of the 988 Suicide and Crisis Lifeline and other behavioral health resources, such as the Access HelpLine, the Stabilization Center, the Comprehensive Psychiatric Emergency Program (CPEP), and the CRT and ChAMPS teams. The information for these resources should be readily available on District websites, in schools, hospitals, community centers, medical offices, public transportation, and other public spaces.

Ideally, 988 will become as ubiquitous as 911, but DC has not effectively launched an education campaign for this crucial service. For instance, 988 is not even mentioned on the DBH or Office of Unified Communications (OUC) website homepages. If DC is going to properly invest in

behavioral health crisis response, this must include ensuring the public is aware of their care options, particularly for those who don't want to call 911 or involve the police in the response.

Thank you for your time and attention to these critical matters. We look forward to continuing to work together to make DC a better place to live and work. I am grateful for the opportunity to share my testimony and would be happy to answer any questions.

Respectfully submitted,



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