Testimony of

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On Behalf of the

American Psychiatric Association

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Committee on Appropriations

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Mental Health Emergencies: Building a Robust Crisis Response System

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Chair DeLauro, Ranking Member Cole and members of the Subcommittee, my name is Doctor Charles Dike. I am Associate Professor of Psychiatry and Associate Program Director of the Law and Psychiatry Fellowship Program at Yale University; Medical Director, in the Office of the Commissioner of the Connecticut Department of Mental Health and Addiction Services (CT DHMAS); and Chair of the American Psychiatric Association Committee on Ethics. As Medical Director for CT DHMAS, my roles include efforts to implement seamless coordination of quality, evidence-based care at all levels across our system, including coordination between hospitals, emergency departments, community agencies that provide respite beds and residential homes, as well as coordination of Assertive Community Treatment teams and Mobile Crisis Teams.

Thank you for this opportunity to testify on behalf of the over 37,400 members of the American Psychiatric Association. The APA is dedicated to providing our physician members with education and training on the most modern evidence-based treatments to diagnose and treat patients with mental health (MH) conditions and substance use disorders (SUD). The APA and our members are focused on ensuring humane care and effective treatment for all persons with MH conditions and SUD and are actively engaged in pursuing policies that affect our patients' access to quality care.

I want to begin by thanking you, Chair DeLauro and Ranking Member Cole, as well as Representative Bustos and all subcommittee members who supported creation of the 5% set-aside for crisis services in the Community Mental Health Services Block Grant beginning in fiscal year 2021. As you all know, MH conditions and SUDs do not discriminate based on age, sex, race, political party or where patients reside. Addressing MH/SUD care, specifically via the implementation of crisis services at state and local levels has been a bipartisan, bicameral effort

with support from both the Trump and Biden Administrations. As Congress, states and local

governments work together to implement 988 by July 2022, it is essential that Congress

support community infrastructure for responding to 988 calls, like the EMS, police and fire

response infrastructure that supports 911.

In managing patients in MH and/or SUD crisis, most communities do their best to patch

together various types and levels of response. This patchwork typically relies too much on

emergency departments (EDs) and police departments and results in patients languishing in

emergency rooms, criminalization of persons with MH conditions and/or SUDs, and at times the

unnecessary loss of life. Rather than continue to divert vital ED and law enforcement resources

towards patients in crisis, we must strengthen the mental health infrastructure by treating

evidence-based community crisis systems as essential community services, analogous to the

EMS, fire and police response systems.

SUPPORTING AND COORDINATING WITH LAW ENFORCEMENT

Today an estimated 10% of 911 calls are for mental health crises. If alternatives like

mobile crisis and stabilization facilities are not available, the chance of unnecessary criminal

justice system involvement is high. The National Alliance on Mental Illness (NAMI) estimates

that nearly 15% of men and 30% of women booked into jails have a serious mental illness. An

estimated 25-50% of fatal encounters with law enforcement involve a person with a mental

illness, with "victims majority white (52%) but disproportionately black (32%) with a fatality rate

2.8 times higher among blacks than whites.[1]   Many high-profile tragedies result when crisis first

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[1] Deaths Due to Use of Lethal Force by Law Enforcement, Am J Prev Med. 2016 Nov; 51(5 Suppl 3): S173–S187.doi: 10.1016/j.amepre.2016.08.027

responders—typically police--are ill-equipped with the de-escalation skills, disposition and knowledge necessary to diffuse a MH crisis.

Over the years, three basic forms of mobile crisis response in coordination with the police have been implemented in communities. These include: (1) police-based response where police are the primary responders; (2) police-based MH response where a MH professional accompanies police; and (3) MH-based MH response where behavioral health mobile crisis teams respond, either with or without police.

Law enforcement officers play a critical role responding to MH crises and need appropriate training, including basic information about mental disorders and symptom presentations, specific de-escalation techniques, and increased awareness of the impact of personal biases related to the stigma surrounding mental disorders, race, and other factors, including the trauma experienced by individuals and communities involved in these encounters.

In addition, strong partnerships between local behavioral health and law enforcement systems are vital. Such policies should prioritize treatment over arrest of persons experiencing a MH crisis where appropriate and safe, avoid unnecessary arrests and encourage the proper clinical assessment and treatment of persons in crisis. Robust, well designed and appropriately funded crisis systems will triage encounters to minimize unnecessary police intervention, criminal justice system involvement, and emergency department boarding.

EMERGENCY ROOM BOARDING OF PSYCHIATRIC PATIENTS

Multiple factors contribute to the ED boarding of psychiatric patients, ranging from large societal challenges and hospital-system issues to individual patient characteristics. Although

the most frequently cited cause of ED boarding is the shortage of inpatient beds, the problem

starts much farther upstream. Insufficient funding for lower levels of care from community

clinics to intensive outpatient programs, community crisis stabilization units, and respite

services fuels the crisis and leads patients to seek care in emergency settings. Average

boarding times of psychiatric patients in EDs range from 6.8 hours to 34 hours. A 2008 survey

of 1,400 ED directors conducted by the American College of Emergency Physicians found that

79% of the 328 respondents reported having psychiatric patients boarding in their EDs; 55% of

ED directors reported boarders on a daily or at least multiple days per week basis; and 62%

reported that there are no psychiatric services involved with the patient's care while they are

being boarded prior to their admission or transfer.

In general, ED boarding contributes to reduced capacity, decreased availability of

emergency staff, longer wait times for all patients in waiting rooms, increased patient

frustration, and increased pressure on ED staff. ED boarding also carries a high-cost burden,

with the average cost to an emergency department to board a psychiatric patient estimated to

be around $2,264[2]. Further, psychiatric patients may require increased use of ancillary support

(such as security officers or safety attendants), especially if they are agitated and because they

have a statistically increased elopement risk.

Boarding results in ED inefficiency, increased rates of patients who leave without being

seen, longer inpatient stays for those admitted, as well as lost hospital revenue and

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[2] Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. *Emerg Med Int*. 2012;2012:306-8.

consumption of resources.[3] Additionally, ED providers experience a higher degree of stress

related to boarding of patients, resulting in a greater risk of adverse events, and lower levels of

reported patient satisfaction.[4] Emergency physicians and nurses may also carry negative

attitudes toward psychiatric patients that in turn can affect the treatment they provide and

may lead to adverse outcomes.[5]

BUILDING A ROBUST MENTAL HEALTH CRISIS RESPONSE SYSTEM

The ideal crisis response system consists of coordinated elements -- crisis call centers,

mobile crisis units and medically staffed crisis stabilization units. These entities reduce

unnecessary emergency department utilization, reduce the time, extent and costs

associated with police response, avoid unnecessary contacts with the criminal justice system,

and save lives. Evidence based mental health crisis response systems are designed to swiftly

transfer patients into the appropriate care setting while avoiding diversion to EDs or the justice

system. They require sustained investments in the set of core evidence based services and best

practices identified by the Substance Abuse and Mental Health Services Administration and the

Crisis Now model developed by the National Alliance on Suicide Prevention. Those components

include:

1. *Regional Crisis Call Centers:* centers that meet National Suicide Prevention Lifeline standards

for risk assessment and engagement of individuals at imminent risk of suicide and offer quality

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[3] Nolan JM, Fee C, Cooper BA, et al. Psychiatric boarding incidence, duration, and associated factors in the United States emergency departments. *J Emerg Nurs*. 2015;41(1):57-64.
[4] Weiss AP, Chang G, Rauch SL, et al. Patient and practice-related determinants of emergency department length of stay for patients with psychiatric illness. *Ann Emerg Med*. 2012;60(2):162-71.
[5] Zun LS. Pitfalls in the care of the psychiatric patient in the emergency department. *J Emerg Med*. 2012;43(5):829-35.

"air traffic control" coordination of crisis care in real-time. These should be regional 24/7 clinically staffed hubs providing intervention capabilities through telephone, text and chat.

2. *Crisis Mobile Team Response*: these mobile teams should be available to reach any person experiencing a crisis throughout a defined service area, in his or her home, workplace, or any other community-based location in a timely manner.

3. *Crisis Receiving and Stabilization Facilities:* these facilities should provide short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment. Options should be available for patients who would benefit from short-term residential care.

Although many communities have used these elements to some extent, very few are effectively using all three on the scale needed for 988 implementation. Further, most communities lack the "care traffic control" that knits the three-pronged system together. Care traffic control systems give communities a real-time communications ability with GPS-guided dispatch and real-time information on where crisis stabilization beds may be available.

MATURE CRISIS SYSTEM (Arizona) - Individuals in psychiatric crisis are often taken directly to a hospital ED by law enforcement. Many are held for days, and in some cases involuntarily confined; others are charged and held in jail without access to MH professionals or psychiatric medicines. In Arizona, such instances have become a rarity thanks in part to a holistic model for crisis care, in which suicide hotlines, mobile crisis units, and crisis facilities that are electronically linked, along with an effective partnership with law enforcement. This relatively mature crisis response system is well positioned to quickly deliver on the promise of 988. It includes all three core elements, including Crisis Intervention Team (CIT)-trained police.

Although many MH crisis calls still land with 911, in Maricopa County, Arizona law enforcement has directed individuals to crisis system providers over 22,000 times per year for each of the last five years. The county's crisis line resolves 90% of its 20,000 monthly calls by phone, without law enforcement involvement. Two thousand mobile crisis team dispatches occur each month and only 3% involve law enforcement. Ultimately law enforcement is only involved in one out of every 300 calls that come into the crisis line. In addition, the "no wrong door" crisis receiving centers accept over 1,800 direct law enforcement drop-offs monthly in less than 10 minutes, offering an effective alternative to incarceration and EDs for law enforcement partners. According to RI International, data from an Aetna/Mercy Maricopa 2017 report indicate that this system has saved $260 million in potential inpatient spending and freed up the equivalent of 37 full-time law enforcement officials to focus on public safety.

CARE TRAFFIC CONTROL (Georgia) - Like Arizona, Georgia continues to enhance a statewide live system to complement their integrated statewide crisis response structure and divert individuals away from emergency departments or incarceration. The principal hub of this system, available to Georgians in all 139 counties, 24 hours a day, is the Georgia Crisis and Access Line (GCAL). GCAL staff, who can be reached via audio or text, may resolve the crisis by phone, schedule an appointment in a local clinic, or dispatch a locally established mobile crisis team to conduct face-to-face assessments and determine treatment needs. The GCAL works like an air traffic controller, guiding individuals through the state crisis system to facilities best equipped to serve them. Mobile crisis response teams, stabilization centers and all other actors in the system know their role, and the public knows where to call for help, resulting in timely

referrals, better utilization of capacity, and reduced reliance on public resources from EDs and law enforcement.

MENTAL HEALTH BASED MENTAL HEALTH RESPONSE (Oregon) - The Crisis Assistance Helping Out On The Streets (CAHOOTS) model initiated in Eugene and Springfield, Oregon, utilizes a mobile response team to respond to crises with a behavioral health component. CAHOOTS' unarmed two-person teams composed of an EMT and crisis worker, utilizes verbal de-escalation to respond to those in crisis. CAHOOTS may be dispatched rather than law enforcement when someone calls 9-1-1 or the non-emergency police number for help with a non-violent and non-criminal situation. In 2019, CAHOOTS had some level of involvement in 20% (20,746) of the incoming public safety calls in Eugene, suggesting significant needs in the community that do not require a law enforcement response. CAHOOTS was not designed to replace, reform, or repair policing, but to augment the structure of public safety, ostensibly filling gaps that law enforcement was never designed to handle.

THE CONNECTICUT EXPERIENCE - In my home state of Connecticut, we have been building out our own Crisis Intervention Team (CIT) model for quite some time now. CIT programs have used a community-based approach to improve the outcomes of these encounters through collaborative partnerships and intensive training to help ensure both officer and community safety, and also to reduce the need for arrest in favor of referrals to appropriate treatment resources and support. CIT programs exist in over 2,700 communities nationwide.

Since 2003, DMHAS has contracted with the Connecticut Alliance to Benefit Law Enforcement, Inc. (CABLE), to provide training on the CIT model to local, state and campus/

university police. To-date, DMHAS has funded over 80 CIT trainings attended by approximately

4,200 people including state, municipal, hospital, and university police officers, mental health

professionals, correctional officers, probation officers, and EMS. At this time, 116 law

enforcement agencies including police departments, campus police, Mohegan Tribal Police, US

Marshall Services and others have CIT trained officers and 43 have established a CIT policy.

In 2020, CT DMHAS, in partnership with United Way of CT, launched a centralized crisis

call center for adults in the community experiencing an emotional crisis for which an immediate

response may be required. This service is called the Adult Crisis Telephone Interventions and

Options Network (ACTION Line). The ACTION line is available 24 hours a day, 7 days a week.

Services include, telephonic support, referral to the Mobile Crisis Team (MCT) of the area,

information about resources/services, afterhours telephonic coverage for some mobile crisis

teams and if needed, direct connection to 911.

Demonstrating the strain put on these resources by the pandemic, the CT Department

of Health and Addiction Services calculates that the ACTION Line alone handled nearly 15,000

calls between August 12 and November 30, 2020, 260 of which were subsequently referred

to a MCT. MCTs are multidisciplinary teams which may include licensed master's level social

workers, licensed clinical social workers, licensed professional counselors, peer support

specialists, nurses, mental health workers and psychologists. They have a great working

relationship with our state police. There are 18 MTCs in our state, 8 DMHAS operated and 10

DMHAS funded. All MCTs offer persons in distress (crisis) immediate access to a continuum of

crisis response services of their choice (person-centered) including, mobile clinical services,

family, peer and community supports and/or mental health and addiction treatment. In

Connecticut, we also have a robust Young Adult Services Team tasked with handling the most

challenging individuals aged 18-25. The United Way of CT (UWC) is also the single provider of

the National Suicide Prevention Lifeline (NSPL) in CT. DMHAS is leading the planning and

implementation of 988 and working with UWC and other stakeholders to ensure the new three-

digit number is implemented by July 16th, 2022.

ONGOING SUSTAINABLE INVESTMENT

Ultimately, the financing of crisis systems will depend on a combination of funding

streams, including Medicaid, private insurance and ongoing, annual appropriations.

APA supports the Biden Administration's proposal to more than double funding for the

Community Mental Health Services Block Grant (CMHSBG) to $1.6 billion, to enable states to

implement evidence-based MH promotion, prevention and treatment practices for early

intervention with individuals with serious mental illness and children with serious emotional

disturbances. As the subcommittee works through its FY22 funding legislation, the APA also

requests that you increase the set-aside you enacted last year for evidence-based crisis services

to 10%. This would amount to a set-aside of $160 million based on the Administration's

proposed total funding amount for the CMHSBG.

Thank you for your attention to the mental health needs of our patients across the

country. We are encouraged by the bipartisan, bicameral support that this issue and funding to

support crisis services and 988 have received from members and both the current and previous

Administrations. Finally, I thank you for extending me the opportunity of testifying before you

here today and look forward to answering each of your questions.