TONJA MYLES
CERTIFIED PEERS SUPPORT SPECIALIST & COMMUNITY LIAISON
RI INTERNATIONAL, BRIDGE CENTER FOR HOPE, BATON ROUGE, LA

STATEMENT OF TONJA MYLES BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES APPROPRIATIONS COMMITTEE, SUBCOMMITTEE HEALTH AND HUMAN SERVICES

MAY 13, 2021

Chairman DeLauro, Ranking Member Cole, and Members of the Committee — thank you for the opportunity today to speak with you at this congressional hearing on Mental Health Emergencies: Building a Robust Crisis Response System Also, thank you to this Committee and its members, and other members of Congress in the Senate and the House, for your leadership to build a crisis response system capable of addressing mental health emergencies.

I am Tonja Myles, Peer Support Specialist, Veteran, ordained minister, Mental Health and Substance Abuse Consultant, wife, and Community Liaison for RI International, Bridge Center for Hope, Baton Rouge, Louisiana. RI International is a non-profit mental health crisis provider based in Arizona with crisis services in nine states including Baton Rouge, Louisiana. We were one of the primary authors on the Crisis Now model, the National Guidelines for Behavioral Health Crisis: Best Practice Toolkit by SAMHSA, and active in the work to implement 988 and the required crisis continuum of care across the nation. I have been in recovery for over 35 years and was properly diagnosed with PTSD five years ago. I am a three-time suicide attempt survivor. For over 28 years, I have been blessed to wake up every day on a mission to push hope to those who suffer from addiction, mental illness individuals incarnated and formerly incarcerated. I also work with individuals and families who find themselves in crisis for a

number of reasons. I help them navigate the behavioral health system to ensure that they receive the best quality of treatment and resources available.

I am a dedicated advocate for appropriate and effective mental health and crisis care for communities of color. To ensure health systems and policy makers put in place better systems that will eliminate disparities in access to adequate treatment services.

Throughout my career and calling, I have worked with some of the best organizations nationally and locally such as Louisiana Office of Behavioral Health, Nami Louisiana, Office of Mayor-President Sharon Weston Broome mental health advisory council and Equal Justice USA, just to name a few.

In my hometown of Baton Rouge, I work with local law enforcement as part of their CIT training, a first-responder model of police-based crisis intervention training. I share my expertise and living experience story so that they can see that mental illness does not decimate and it can happen to anyone. I am the primary caregiver to my uncle who is 76 years old and who has schizophrenia, bipolar, and HIV. He has lived in group homes for over 50 years. Since there is no continuum of care available for elderly with serious mental illness, in 2019 I had to have a PEC issued ten times in which his physician issued a Physicians' Emergency Certificate (PEC) to detain him involuntarily for up to 72 hours due to legally needing treatment. Each incident involved 911 and law enforcement.

Five years ago, I became the one in crisis. During a challenging time in my marriage of 27 years, my husband and I separated, and I felt like a failure. I felt hopeless, alone, and that my life was over with no way out. I also felt ashamed because my husband and I are leaders in our

community, and we seemed to have a picture-perfect life. One dark night I wrote a four-page letter saying my goodbyes to my family and friends as I wanted them to know this was my decision and I was tired. Tired of fighting for others while I am the one that is wounded from all the past years of trauma. I took my pills and got in my car to find a place where I could die in peace, easily be found, and laid to rest quickly. I called my cousin to ask him to please let my family know that I loved them and that there was nothing they could have done because I spent most of my life living to die. I hung up the phone and five minutes later the phone began to ring off the hook. Right before I was about to turn off my phone, I got a call from a friend and my mind became a little clearer. She encouraged me to come to her house, but I decided to go back to the house I was staying at the past 5 months. I told her I would go back to the house to get some clothes and then come to her house. I asked her not to call the police. As I turned the corner, I saw the police car in the street along with my nephew, Trei, who spotted my car immediately. I could not turn around and flee the scene. I knew I could talk my way out of what I knew could happen because I have walked family members though this process so many times. When I got out of the car, I began to address the officer. He was nice and professional, and the dialogue was going well. I even asked him if he was CIT trained and he said yes. I began to "name drop" and ensure him I was just having a bad day. He recognized who I was and then his supervisor came on the scene. He got out of his unit and began to interrupt the other officer. When I started to answer his questions, he became rude and confrontational. He treated me like a criminal and not someone in crisis. For a brief moment, I could feel myself becoming angry and thought I could easily provoke him. This could be a perfect way to die in honor, suicide by cop. However, I looked over to see my nephew standing there - sad and scared. I did not want him to have to live with seeing me getting shot in the middle of the street. The first officer could

see I was struggling and redirected me back to him to deescalate the situation. He told me I had to go to the hospital to make sure I was okay. I was taken to the local ER and then to a psychiatrist hospital for 7 days.

That traumatic event five years ago changed by life for the better! After I was released from the hospital, I went to counseling for the first time in my life for years of untreated trauma. I am proud to say, that for the first time in my life, I have not had a thought of suicide. I contribute it to therapy, being open with my family and friends about my mental wellness, and having a good crisis care continuum.

Good crisis care prevents suicide and provides help for those in distress. It cuts the cost of care, reduces the need for psychiatric acute care, hospital ER visits, and police overuse. Implementing 988 will also make it easier for individuals and family members in crisis to access the help they need and decrease the stigma surrounding suicide and mental health issues. It will also reduce the traumatic encounters of those in mental health crisis when it comes to law enforcement, and jail diversion, where no one with a mental health crisis should be. The time is now to transform our approach to crisis mental health. Together, we can, and must do this, it will save lives. I am living proof.

Crisis Continuum of Care Is Needed for Effective Care and Support:

Mental health crisis can strike unexpectedly and have catastrophic impacts on the individual as well as their family and the community. All too often, those in crisis do not receive the care they so desperately need due to a lack of available care or care that does not truly fit the need of the person. Communities often have no choice but to absorb the high costs from unneeded hospital

emergency department visits, inpatient treatment, and detainment. These services may be unnecessary and only lead to a worsening of symptoms and the added trauma invoked by detainment or hospitalization. We must devise a crisis system of care that fits the need of the individual, when and where they need it.

Crisis Now Model:

In 2016, the National Action Alliance for Suicide Prevention: Crisis Services Taskforce published Crisis now: Transforming services is within our reach. The taskforce convened to tackle the problems caused by a mental health system that simply does not work for patients. Sheree Kruckenberg, Vice President of Behavioral Health for the California Hospital Association, which represents 400 hospitals and health systems, stated in her April 2015 open letter: The increasing dependence on…hospital EDs to provide behavioral evaluation and treatment is not appropriate, not safe, and not an efficient use of dwindling community emergency resources. This includes not only hospitals, but emergency transportation providers and law enforcement. More importantly, it impacts the patient, the patient's family, other patients and their families, and of course the hospital staff.

Crisis care, in many cases, is either not adequate or does not exist. This unfortunate fact causes increases in costs in many communities as the only option is frequent hospital admission, overuse of law enforcement with tragic results as many fall through the cracks of a broken system. A transformation of the mental health crisis care system is a necessity. In short, the Action Alliance Crisis Services Taskforce made the following recommendations.

Recommendation One: Effective crisis care must be comprehensive and include the core elements of crisis care. (1) regional or statewide crisis call center coordinating in real time, (2)

centrally deployed, 24/7 mobile crisis, (3) short-term sub-acute residential crisis stabilization programs, (4) essential crisis care principles and practices, and (5) recovery orientation that includes trauma-informed care, significant use of peer staff, commitment to Zero Suicide/Suicide Safer Care, strong commitment to safety of consumers and staff, and collaboration with law enforcement.

Recommendation Two: Crisis call services should participate and meet the standards of the National Suicide Prevention Lifeline, and crisis intervention systems should adopt and implement Zero Suicide/Suicide Safer Care across all program elements.

Recommendation Three: State and national authorities should review the core elements of Air Traffic Control qualified crisis systems, apply them to crisis care in their jurisdictions, and commit to achieving these capabilities within five years, so that each regional of the United States has a qualified hub for crisis care.

Table 1: Modern Crisis Care Changes the Paradigm

FROM	TO
Absence of data and coordination on ED wait times, access, crisis bed availability, and outcomes	Publicly available data in real-time dashboards
"Cold" referrals to mental health care are rarely followed up, and people slip through the cracks	Direct connections and 24/7 real-time scheduling
EDs are the default mental health crisis center	Mobile crisis provides a response that often avoids ED visits and institutionalization

Crisis service settings have more in common with jails; police transportation to distant hospitals takes law enforcement off the beat and is unpleasant and stigmatizing for people in crisis	Crisis service settings – the urgent care units for mental health – look more like home settings and also provide a reliable partner for law enforcement
Despair and isolation worsened by trying to navigate the mental health system maze	Crisis care with support and trust: what the person wants and needs, where the person wants and needs it

National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit by SAMHSA

The National Guidelines provide a best practice toolkit for program design, development, implementation, and continuous improvement efforts. It includes the definition of national guidelines for crisis care, tips for implementation services that in accordance with the national guidelines, and the assessment tools to ensure crisis care systems are in alignment.

The national guidelines list core services as (1) Regional Crisis Call Center, (2) Crisis Mobile Team Response, and (3) Crisis Receiving and Stabilization Facilities. Additionally, qualities that must be included are (1) addressing recovery needs, significant use of peers, and trauma-informed care, (2) Suicide safer care, (3) safety and security for staff and those in crisis, and (4) law enforcement and emergency medical services collaboration.

The core services must operate to, at least, minimum expectations as outlined in the guidelines and to be fully effective meet the outlined best practices.

Minimum expectations for a regional crisis call service are (1) operate 24/7/365, (2) be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls,

(3) answer every call or coordinate overflow coverage, (4) assess risk of suicide in a way that meets the standards of the National Suicide Prevention Lifeline, (5) coordinate connections to crisis mobile teams, and (6) connect individuals to facility-based care through warm hand-offs and coordination of transportation. Best practices for the regional crisis call services are to meet the minimum standards and to (1) incorporate caller id functions, (2) implement GPS-enabled technology to collaborate with crisis mobile teams for dispatch, (3) utilize real-time regional bed registry technology, and (4) schedule outpatient follow-up appointments.

Minimum expectations for mobile crisis teams are that they must (1) include a licensed and/or credentialed clinician capable of assessing the need, (2) respond where the person is and not restrict services by locations or day/time, and (3) connect individuals to facility-based care through warm hand-offs and coordinating transportation. Best practices for the mobile crisis teams are to meet the minimum expectations and to (1) incorporate peers within the mobile crisis team, (2) respond without law enforcement accompaniment unless special circumstances warrant it to support true justice system diversions, (3) implement real-time GPS technology to partner with the region's crisis call center hub, and (4) schedule outpatient follow-up appointments to supporting ongoing care. Minimum expectations for crisis receiving and stabilization services state they must (1) accept all referrals, (2) not require medical clearance prior to admission but to support medical stability while in the program, (3) design services to address mental health and substance use crisis issues, (4) employ capacity to assess physical health needs and deliver care for minor physical health challenges along with a pathway to transfer to a more medically staffed service when needed, (5) be staffed 24/7/365 with multidisciplinary team that meets all level of crisis care and includes psychiatrists or psychiatric nurse practitioners, nurses, licensed and/or credentialed clinicians who can complement assessments, and peers with lived experience, (6)

offer walk-in and first responder drop-in options, (7) structures to accept all referrals at least 90% of the time with no rejections to first responders, (8) screen for suicide risk and complete comprehensive suicide risk assessments and planning, and (9) screen for risk of violence and complete comprehensive violence risk assessment and planning. Best practices additionally require that crisis stabilization programs (1) function as a 24-hour or less crisis receiving and stabilization facility, (2) offer a dedicated first responder drop-off area, (3) incorporate some form of intensive support beds to a partner program for persons who need additional support, (4) includes beds within the real-time regional bed registry system operated by the crisis call center, and (5) coordinate connection to ongoing care. To implement a comprehensive system of care, additional services that would be provided include facility-based resources such as short-term residential facility and peer respite programs to provide care after a crisis has occurred.

Crisis care must incorporate core principles in the delivery of crisis care which are (1) addressing recovery needs, (2) significant role for peers, (3) trauma-informed care, (4) Zero Suicide / Suicide Safer Care, (5) safety/security for staff and people in crisis, and (6) crisis response partnerships with law enforcement, dispatch and emergency medical services.

988 Implementation

The National Suicide Hotline Designation Act of 2020 (Public Law 116-172) designates 9-8-8 to be the universal telephone number for national suicide prevention and mental health crisis. It will be operated through the National Suicide Prevention Lifeline and through the Veterans Crisis Line and is due to be implemented on or before July 2022.

The purpose of the 988 line is to provide a universal hotline for peoples across the country to reach out to when they are in the midst of a mental health crisis. In order to ensure calls are answered, a crisis call center that is alignment with the National Suicide Prevention Lifeline standards and connects to NSPL as a regional hub is necessary for coverage in every region, whether it be urban or rural areas. However, it will do little good, to have a fully staffed regional crisis call center to accept 988 calls without a fully functioning comprehensive crisis system. Individuals in crisis must not only have a number to call but also someone to meet them where they are and somewhere to go. Therefore, the establishment of the core services of mobile crisis teams and crisis stabilization programs for each region is needed and must be implemented now. These core services must follow the minimum standards of the National Guidelines for Behavioral Health Crisis Care by SAMHSA at a minimum. For a comprehensive crisis care continuum to be established, all three-core service must, not only follow the minimum standards but also, meet the criteria for best practices.

While the date of 988 implementation is July 2022, crisis has no schedule and persons in crisis are in immediate need of care. The time to establish a crisis care system to meet mental health emergencies is now.