501 3rd Street, NW · 8th Floor
Washington, DC 20001
T 202.467.4900 · F 202.467.4949
childrenslawcenter.org

Testimony Before the District of Columbia Council
Committee on Health and Committee on the Judiciary and Public Safety
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Roundtable:
Sense of the Council on Supporting Humane and Trauma-Informed Responses to Behavioral Health Crises Resolution of 2025

Chris Gamble
Behavioral Health Policy Analyst
Children's Law Center

Introduction

Good afternoon, Chairperson Henderson, Chairperson Pinto, and members of the Committee on Health and Committee on the Judiciary and Public Safety. My name is Chris Gamble, and I am a Behavioral Health Policy Analyst at Children's Law Center. I am also a Licensed Professional Counselor who has previously worked with and responded to children experiencing behavioral health crises and was at one time trained and certified by the Department of Behavioral Health (DBH) as an Officer-Agent, able to initiate the FD-12 process for involuntary hospitalization. I am testifying today on behalf of Children's Law Center. Our more than 100 staff work with DC children and families, community partners and pro bono attorneys toward a future where every child can grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism and other forms of oppression.

Thank you for the opportunity to testify today in support of PR26-0108 - Sense of the Council on Supporting Humane and Trauma-Informed Responses to Behavioral Health Crises Resolution of 2025. Children's Law Center's clients include children who are in foster care, students with special education needs or health conditions, and caregivers who need legal support. Our team of guardians ad litem (GAL) represents over half the kids in DC's foster care system. The abuse and neglect children may experience before being removed from their homes, the harm of removal itself, and the experience of being in foster care can all contribute to traumatization and the

development of behavioral health conditions.[1,2] Over a quarter of the children our GAL team represented last year were diagnosed with behavioral health conditions.[3] As we have testified before, ineffective crisis response at times affects foster parents' willingness to be a placement for a youth, thus destabilizing the youth's living situation and behavioral health.[4] We support the Council's resolution, agreeing that DC needs a more coordinated and effective behavioral health crisis response system to ensure people receive care that is timely and does not further traumatize them in the process. In particular, we support youth receiving crisis response services that are tailored to their developmental stage.

It is poignant that the Substance Abuse and Mental Health Services Administration (SAMHSA), the agency that provides national guidance on behavioral health crisis response and oversees the Suicide and Crisis Lifeline (988), is currently suffering at the mercy of federal cuts and layoffs.[5] Adding DC's local budget pressures to the picture, we must acknowledge that many of the improvements needed in our crisis response system will be hindered by the reality of unavailable funds and federal administrative support. As a result, in today's testimony, I will distinguish between recommendations that can be acted on in the short-term within our budget reality and those that due to funding needs will have to be long-term goals. I will follow the structure of the well-known SAMHSA framework for crisis response—"someone to

contact, someone to respond, and a safe place for help"[6]—to address issues within each component of DC's crisis response system, including:

- The need to streamline crisis call system protocols and increase investment in 988.
- Concerns related to an increase in involuntary hospitalizations of children and the transportation protocols in these situations.
- The lack of crisis stabilization facilities that offer alternatives to hospitalization.

When People Call For Help In A Behavioral Health Crisis, They Need To Be Connected To The Appropriate Service Regardless Of What Number Is Initially Called

In DC, the options for who to call when experiencing or witnessing a behavioral health crisis include 911, 988, the Access HelpLine (AHL), the Community Response Team (CRT), and the Child and Adolescent Mobile Psychiatric Service (ChAMPS). With such an array of options, each with a different phone number and distinct function, it may be difficult for someone to know exactly which number to call, especially when in the midst of or witnessing someone else in a behavioral health crisis. Regardless of which number someone decides to call, the staff members receiving the call should be able to triage and divert as needed to connect the caller to the crisis service that best fits the situation. Achieving this goal requires a coordinated crisis call system.

Our current system is a tangled web of calling options, and we need to work to untangle it. In DBH's 2025 Performance Oversight hearing of government witnesses, Dr.

Bazron explained that the Office of United Communications (OUC), which manages DC's 911 call center, uses a protocol that diverts mental health-related 911 calls to AHL rather than directly to 988 or the CRT.[7] 988 call takers work at the same location as AHL staff, but no clarity was given regarding why AHL is the chosen diversion target.[8] This protocol does not appear to be working, as only 28 calls were diverted from 911 to AHL in FY23 and 12 were diverted in FY24.[9] We support the continuation of collaborative training between OUC and DBH to improve call diversion and recommend considering new diversion paths so there are not unnecessary additional steps when someone is calling for help.

DC should invest in 988 to make it the entry point to the behavioral health crisis system that it is intended to be

When 988 was launched in July 2022, it was envisioned as an easier to remember number that would get people access to help in a crisis. It would be a "front door" of sorts to a crisis response ecosystem that includes mobile crisis response and crisis stabilization facilities. As with establishing 911, lawmakers knew it would take time to develop robust crisis response systems in communities across the country, but key concerns regarding sustainable growth of the system raised by federal, state, and local governments at the time have yet to be fully addressed.[10]

The lack of awareness about 988 was raised multiple times by public witnesses and also by Councilmember Zachary Parker at the DBH oversight hearings, pointing

out that people were unfamiliar with the resource despite DBH's efforts to publicize the number using physical materials and social media posts.[11,12,13]

We can look to our neighbors over in central Maryland[14] for an example of how DC can close the gap in awareness through well-designed community engagement. A year before 988 launched, local grant funding was utilized by stakeholders in the region to hire a marketing firm to assist in conducting surveys, focus groups, and community sessions with residents to inform marketing decisions so that people could build trust and comfort in calling 988. This deep community engagement led to creation of a website to explain in detail what to expect when calling, inclusive language changes in marketing materials, and even recommended color schemes to use in these materials that connected with people in the region.[15] Ongoing local grant funding allows continued market research and the use of ambassadors to spread the message about 988 throughout their communities. Comparatively, DBH worked with an advisory committee to plan for 988 implementation,[16] but there does not seem to be any publicly available information on the process or results of this work. We ask that DBH implement stronger, transparent community engagement strategies in order to increase awareness and utilization of 988.

As the above example demonstrates, sustained funding is critical for the successful implementation of 988. Aside from funding for awareness campaigns, the uncertainty of federal funding for 988 means a larger share of ongoing funding will

likely fall on local state-level funding. We ask that DBH maintain current funding to fill 988 call taker vacancies,[17] and recommend the Council explore sustainable, local funding pathways to maintain the development of 988's crucial services over time.

Non-Behavioral Health Professionals Are Becoming Increasingly Involved In Child Crisis Response, Warranting Considerations Around The Protocols Guiding The Practice Of These Services

Once someone has called for help in a behavioral health crisis, the subsequent response can influence the progression of the crisis. For children in DC, the teams that arrive on the scene in a crisis and what roles they fulfill vary to the point of obscuring what the standard response is supposed to be. We are now about two years into the main children's crisis response team, ChAMPS, having their hours reduced to 8:00am-8:00pm on weekdays, with the CRT, typically dedicated to adults, receiving the calls outside those weekday hours and on weekends.[18] DBH's oversight pre-hearing responses show that ChAMPS received 1093 calls in FY24, 262 of which were re-routed to the CRT during the weekday and weekend hours they cover.[19,20] Of these calls, the CRT was deployed 77 times, resulting in 53 psychiatric hospitalizations of children, 48 of which were done via the FD-12 process.[21] That means 62% of the time the CRT is deployed to respond to a child in crisis, the child is involuntarily hospitalized. In the same fiscal year, ChAMPS deployments resulted in 76 involuntary hospitalizations through FD-12, though the data do not state the total number of ChAMPS deployments.[22] Still, comparing the available data to last year's pre-hearing responses,

there has been a jump in the number of ChAMPS and CRT deployments resulting in involuntary hospitalizations of children from 50 in FY23 to 124 in FY24.[23,24] We ask the Committee on Health to work with DBH on assessing the quality of the training its crisis response teams, particularly the CRT, are receiving on managing children's crises to avoid involuntary hospitalization.

Non-behavioral health professionals are also consistently involved in the process of involuntarily hospitalizing children. Drawing from DBH's performance oversight responses, neither ChAMPS nor the CRT transports children to the hospital even when they are on the scene first. Transportation is instead provided by Fire and Emergency Medical Services (FEMS).[25] For CRT deployments, officers from the Metropolitan Police Department (MPD) were present during all 48 FD-12s in FY24 to assess and maintain safety until FEMS arrived on the scene to transport.[26] On the other hand, we learned from last year's DBH pre-hearing responses that "when a child or youth is aggressive, [ChAMPS] will rely on MPD for support and transportation when FD-12 is required".[27] These conflicting protocols were repeated at the DBH oversight hearing, where the Agency stated that MPD provides transportation for children being involuntarily hospitalized.[28]

Clarity on transportation protocol is even more urgent when we look at MPD's policy on handcuffing minors who are transported to the hospital in their vehicles. A 2015 General Order states that MPD is supposed to first request an ambulance to

provide transportation, but if the ambulance crew refuses, then MPD transports. It also states that if a minor is combative or the ambulance crew requests that an officer ride in the ambulance, the officer shall ensure that the minor is handcuffed.[29] The same Order indicates a policy that, "Members shall use handcuffs on all mental health consumers, regardless of age, who are being transported for mental health services in an MPD vehicle."[30] An updated policy from 2020 states, "Members shall not handcuff juveniles aged 12 and under *unless the juvenile presents a danger to themselves or others* [italics added]."[31] The stipulation of danger to self or others is one of the requirements to initiate an FD-12,[32] so taking all of these policies into consideration, it follows that any minor transported by MPD for an FD-12 must be handcuffed. As for FEMS' EMS manual, there is only one mention of FD-12s that states, "The Metropolitan Police Department should be summoned to the scene to assist with patients that you believe may be mentally incompetent and refusing services," with no statement on handcuffing practices.[33] The Committees should seek clarity about why the CRT and ChAMPS don't provide transportation and determine if there are discrepancies between written policy and what happens in practice when transporting minors for involuntary hospitalization.

The experience of one Children's Law Center client demonstrates the challenges of protocol and practice coming together in crisis response. This young child experienced a behavioral health crisis before heading to school one morning. The child's

caregivers, concerned for their own safety, contacted the CRT for help. It was before 8:00am, but rather than dispatch themselves, CRT left a message with ChAMPS to call the caregivers back when available. The CRT then connected the caregivers to 911 to request a Crisis Intervention Officer (CIO),[34] but there were no CIOs available at the time. Later, a FEMS ambulance arrived. ChAMPS ended up calling the family back at that time and spoke to FEMS staff who had gotten the child to agree to go to the hospital voluntarily, so they provided transportation in the ambulance. As they left, non-CIO MPD officers arrived on the scene and then followed along to the hospital. Once at the hospital, the child did not even receive a psychiatric evaluation because they did not present an immediate danger in that moment and were discharged.

The lack of availability and lack of behavioral health professionals on the scene in this scenario raise concerns about our crisis response system's operations. According to SAMHSA, the best practice for both adult and children mobile crisis teams is the behavioral health practitioner only model.[35] It will take time, money, and dedicated planning for DC to reach that standard, but current protocols need to be clear as far as which teams can or must be on the scene when a child is a danger to themselves or others. Transparent data sharing can also help to provide clarity as to what is happening in crisis response situations. Durham, North Carolina's Holistic Empathetic Assistance Response Teams (HEART) data dashboard is a strong example of what it looks like to openly track and report outcomes like call type,

response time, resolution, need for backup, and other important indicators for how successfully a crisis response system is operating.[36] We recommend that DBH work on developing a similar system of data sharing.

There Are No Options For Care Besides Hospitals For Children To Access When Experiencing A Crisis

In 2023, 502 children were involuntarily admitted to Children's National Hospital's (CNH) emergency department for mental health crises, and in 2024, 472 were involuntarily admitted by mid-October.[37] This represents a continuing increase over the past several years that CNH says has led to a shortage of behavioral health beds and increased emergency room boarding of children.[38] The establishment of a Children's Comprehensive Psychiatric Emergency Program (CCPEP) would provide an option for rapid stabilization of immediate crises, helping to avoid hospitalization and the escalation of needs to the point of needing intermediate or acute levels of care for many children.[39] Reducing the number of admissions would also allow CNH's inpatient unit to operate within its longer-term function by not having to take on the crises that only need short-term stabilization. We appreciate being able to meet with Councilmember Henderson and her team to discuss the importance of a CCPEP and encourage DBH to collaborate with CNH, the Psychiatric Institute of Washington (PIW), and other partners to create a plan for establishing this service in the District.

Conclusion

Our current crisis response system contains various entities with poor coordination between them. There is no quick fix to these issues, but committed effort to making improvements is crucial to getting people the right type of help at the right time, with the hope of intervening and preventing future crises. Thank you for the opportunity to testify today and I welcome any questions you may have.

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[1] Johanna K. P. Greeson, et al., *Complex Trauma and Mental Health in Children and Adolescents Placed in Foster Care: Findings from the National Child Traumatic Stress Network*, Child Welfare, (2011) *available at*: https://aztrauma.org/wp-content/uploads/2020/07/Complex-Trauma-and-Mental-Health-in-children.pdf.

[2] Shanta Trivedi, *The Harm of Child Removal*, 43 New York University Review of Law & Social Change 523 (2019). *Available at*: https://scholarworks.law.ubalt.edu/cgi/viewcontent.cgi?article=2087&context=all_fac.

[3] Internal Children's Law Center Data Collection, "GAL Deep Dive," January 2024 through December 2024.

[4] Kim Daulton, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (October 28, 2024), *available at*: https://childrenslawcenter.org/wp-content/uploads/2024/11/K.-Daulton___Childrens-Law-Center-Testimony-before-the-DC-Council-Committee-on-Health___10.28.24.pdf.

[5] Art Levine and Rob Waters, *Inside America's Mental Health Agency: Mass Firings and Work Stoppages Sap Morale, Impede Mission*, (March 2025), *available at*: https://mindsitenews.org/2025/03/14/chaos-at-samhsa/.

[6] Substance Abuse and Mental Health Services Administration, *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care*, (January 2025), *available at:* https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf.

[7] *Performance Oversight of Department of Behavioral Health (Government Witnesses)*, YouTube, (February 2025), *available at*: https://www.youtube.com/watch?v=2k8wdKs4Ba0.

[8] *Id*.

[9] *Id*.

[10] Megan Messerly and Sarah Owermohle, *988 set for quiet launch in light of state, federal concerns about crisis call spike*, (July 2022), *available at:* https://www.politico.com/news/2022/07/12/988-mental-health-line-launch-00045194.

[11] *Performance Oversight of Department of Behavioral Health (Public Witnesses)*, YouTube, (February 2025), *available at*: https://www.youtube.com/watch?v=AwR_eEt5WB0

[12] *Performance Oversight of Department of Behavioral Health (Government Witnesses)*, YouTube, (February 2025), *available at*: https://www.youtube.com/watch?v=2k8wdKs4Ba0.

[13] Putting this disconnect into the national context, it was actually an intentional decision by many states not to publicize 988 at its launch, or keep those efforts to a minimum, due to concerns about increased

calls and call centers' ability to handle the larger volume. See: Megan Messerly and Sarah Owermohle, *988 set for quiet launch in light of state, federal concerns about crisis call spike*, (July 2022), *available at:* https://www.politico.com/news/2022/07/12/988-mental-health-line-launch-00045194. National polling shows that as of mid-2023, only 18% of adults had heard a lot or some about 988. See: Heather Saunders, *988 Suicide & Crisis Lifeline: Two Years After Launch*, (July 2024), *available at*: https://www.kff.org/mental-health/issue-brief/988-suicide-crisis-lifeline-two-years-after-launch/. It is unclear what DC's intended awareness strategy has been.

[14] Baltimore City, Baltimore County, Carroll County and Howard County.

[15] Stephanie Hepburn, *Central Maryland's Data-Driven 988 Marketing Campaigns and Lowering the Stakes of Engagement*, (February 2024), https://talk.crisisnow.com/central-marylands-data-driven-988-marketing/. These efforts were led by the nonprofit organization, Behavioral Health System Baltimore, which manages the behavioral health system in Baltimore City.

[16] *Mayor Bowser Announces Launch of 988 Suicide and Crisis Lifeline*, (July 2022), https://mayor.dc.gov/release/mayor-bowser-announces-launch-988-suicide-and-crisis-lifeline#:~:text=In%20Fiscal%20Year%202022%2C%20Mayor,be%20even%20easier%20to%20reach.

[17] Dr. Bazron noted 7 staff vacancies. See: *Performance Oversight of Department of Behavioral Health (Government Witnesses)*, YouTube, (February 2025), *available at*: https://www.youtube.com/watch?v=2k8wdKs4Ba0.

[18] Department of Behavioral Health, Community Response Team, *available at*: https://dbh.dc.gov/service/community-response-team.

[19] DBH FY2024 Performance Oversight Responses, response to Q54, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.

[20] *Id*, response to Q112g.

[21] *Id*, response to Q54,55.

[22] *Id*, response to Q55.

[23] DBH FY2023 Performance Oversight Responses, response to Q45, *available at*: https://dccouncil.gov/wp-content/uploads/2024/08/FY-23-Oversight-Pre-Hearing-Responses.- DBH_UPDATED.pdf.

[24] DBH FY2024 Performance Oversight Responses, response to Q54,55 *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.

[25] *Id*, response to Q54.

[26] *Id*, response to Q54.

[27] DBH FY2023 Performance Oversight Responses, response to Q44, *available at*: https://dccouncil.gov/wp-content/uploads/2024/08/FY-23-Oversight-Pre-Hearing-Responses.- DBH_UPDATED.pdf.

[28] *Performance Oversight of Department of Behavioral Health (Government Witnesses)*, YouTube, (February 2025), *available at*: https://www.youtube.com/watch?v=2k8wdKs4Ba0.

[29] MPD General Order 308.04: Interacting with Menal Health Consumers, (February 2015), *available at*: https://go.mpdconline.com/GO/GO_308_04.pdf.

[30] MPD General Order 308.04: Interacting with Menal Health Consumers, (February 2015), *available at*: https://go.mpdconline.com/GO/GO_308_04.pdf.

[31] MPD General Order 305.01: Interacting with Juveniles, (September 2023), *available at*: https://go.mpdconline.com/GO/GO_305_01.pdf.

[32] D.C. Code § 21-521, Detention of persons believed to be mentally ill; transportation and application to hospital, *available at*: https://code.dccouncil.gov/us/dc/council/code/sections/21-521.

[33] District of Columbia Fire and EMS Department Emergency Medical Services Manual and Pre-hospital Treatment Protocols, (August 2024), *available at:* https://fems.dc.gov/sites/default/files/dc/sites/fems/page_content/attachments/DC_Fire_%26_EMS_Protocols_August_2024.pdf.

[34] The Crisis Intervention Officer (CIO) program in the District of Columbia was established in collaboration with the Washington Metropolitan Police Department (MPD), the Department of Behavioral Health and the National Alliance of Mental Illness (NAMI DC). The 40-hour training program teaches patrol officers the signs and symptoms of mental illnesses and the best de-escalation techniques. Since the program was established in 2009, about 100 officers are trained each year. The two primary goals of the CIO program are safety and the diversion of nonviolent individuals with mental illnesses away from the criminal justice system to more appropriate mental health services. See: https://dbh.dc.gov/node/610092.
[35] Substance Abuse and Mental Health Services Administration, *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care*, (January 2025), *available at:* https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf.
[36] HEART Data Dashboard, *available at*: https://www.durhamnc.gov/4576/Community-Safety.
[37] Elizabeth Davis, Children's National Hospital, Email Communication to Chris Gamble and Marcia Huff, December 2024.
[38] Adelaide Robb, MD, Children's National Hospital, Testimony Before the District of Columbia Council Committee on Health, (October 28, 2024), *available at*: https://lims.dccouncil.gov/Hearings/hearings/537.
[39] *A Path Forward: Transforming the Public Behavioral Health System for Children and their Families in the District*, p. 93, (December 2021), *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BH.System.Transformation.2023.Update.Rou nd4_.pdf.