Senate Judiciary Committee Hearing
"Behavioral Health and Policing: Interactions and Solutions"
Questions for the Record
for Keris Myrick, Vice President of Partnerships, Inseparable
(former Director, JED Foundation)
Submitted April 29, 2021

QUESTIONS FROM SENATOR WHITEHOUSE

RESPONSES KERIS MYRICK:

QUESTION 1:

1. This hearing highlighted the difficulties that arise when police officers are called upon to respond to mental health, substance use, and other behavioral health crises, and alternative approaches to these situations.
    a. Based on your experience, what are the most promising models to handle these situations?
    b. What are the biggest obstacles these programs face?
    c. How can the federal government encourage and support these programs?
    d. How have cities and states created sustainable funding for these programs? What can the federal government do to help other jurisdictions do the same?

RESPONSES:

a. The most promising models for response to people experiencing behavioral health crisis are ones in which law enforcement is not involved. Rather than law enforcement, people with lived experience of behavioral health conditions who have experienced crisis and navigating their way to recovery along with training to support others can and do serve as 'first responders' either as a team of Peers (Peer Support Specialist/ Peer Recovery Coaches) and or alongside other licensed professionals such as nurses, social workers and psychiatrists – this can be either as mobile crisis teams or street outreach teams. Other models included Peer Respite for those in crisis who are not in need of emergent medical services and imbedding Peers supports in sobering centers as well.

b. The first obstacle is that of stigma – the belief that Peers in settings such as ERs, Psychiatric units of hospitals and on mobile teams will get hurt, not be well enough to tolerate the work (type of work) or do not have a medicalized understanding of behavioral health conditions therefore will be more of a burden than help. This is not what the research has shown and these stigmatizing beliefs deter the use and or

expansion of a well-trained, needed and for the person receiving crisis services – desired workforce. The other barrier is funding – how to maximize the use of federal, state, block grant dollars as well as how commercial insurance will pay for the use of peer services in mobile teams, peer respite and peers in hospital or ER settings. Further, financing is usually based on the person served (do they have insurance what kind and what does it pay for) which can restrict the crisis continuum of care services and options to build out alternative and effective responsive services that do not include law enforcement.

c. SAMHSA released an advisory in June 2022 – Peer Support in Crisis Care that lays provides excellent guidance on the need , best practices for implementation and the evidence for the use of peers in behavioral crisis along the continuum of care[1]. This is an example of what the federal government can do as a start to provide guidance and technical assistance to field about the role of peer supports in crisis response to reduce or eliminate the use of law enforcement as default responders. To support funding crisis continuum of services to reduce the use of law enforcement – the federal government can provide guidance to states about the following:

   a. the need and importance of requiring all funder participation from private to public behavioral health funders to contribute to crisis systems services that serves people who are covered or affected by their funding.
   b. CMS can provide clear guidance and definitions of what Medicaid and other funders can reimburse within a crisis continuum of care such as urgent care centers, crisis centers, residential crisis services, mobile crisis, intensive community crisis intervention and to ensure that rates adequately cover those services.

The goal is to make sure that at any point within the crisis continuum – when a person needs help and after a crisis subsides – they do not fall through the cracks or have to rely on 911 law enforcement response because there is “no there, there” to support them due to regulatory and or financing barriers.

d. / e.

[1] Substance Abuse and Mental Health Services Administration (SAMHSA). *Peer Support Services in Crisis Care*. Advisory. SAMHSA Publication No. PEP22-06-04-001 Published June 2022

Noting that financing is not my area of expertise, I want to refer to the GAP Report[2]: As a participant in the Group for the Advancement of Psychiatry in developing the report "the ideal crisis system", I learned more about financing and the examples of states with sustainable funding programs and roles of the government from the report are two examples extracted from the report and listed below

Federal Example: "CCBHC Expansion Legislation Introduced"

"In light of the program's success, as of January 2021, Congress has extended the original 8-state Medicaid demonstration to two additional states and allocated yearly funds for CCBHC expansion grants since 2018. Thirty-three states now have at least one CCBHC. The bipartisan Excellence in Mental Health and Addiction Treatment Act (S. 824/H.R. 1767) would renew the CCBHC Medicaid demonstration program and expand it to new states. By renewing and expanding the demonstration, Congress could expand behavioral health capacity and alleviate the pressure on our nation's jails and emergency rooms. This legislation will also ensure sustainability for CCBHC grantees beyond their 2-year grant terms by supporting more states in implementing the model as part of Medicaid." (page 45)

State Example: "All-Payer Example - Kent County, Michigan"

"The Kent County crisis collaborative under the auspice of the population health consortium has developed a business plan for a crisis center, call center, behavioral health urgent care, and mobile crisis that includes all Medicaid Health Plans and commercial plans (including Medicare Advantage) as potential partners. The three largest health plans have been invited to the table and have agreed to participate in the funding collaboration. In Michigan, the Medicaid health plans are responsible for mild to moderate behavioral health but not crisis, even though 60% of Medicaid recipients who have behavioral health crisis are in the mild to moderate group. However, the Medicaid health plans can benefit directly from supporting ED diversion and are interested in partnering with community leaders because of the high-level collaboration that has been created.**" (page 46)**

QUESTION 2:

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[2] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. (2021). *Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response.* https://www. thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system/

2. Even when jurisdictions have alternate responder programs, police may still respond to situations where people are experiencing mental health or substance use crises or have disabilities (whether because of inaccurate dispatching, to support behavioral health professionals, or because a serious crime is in progress).
    a. What should police departments do to better prepare their officers to respond safely and effectively to these situations?
    b. How can the federal government support these efforts—i.e., by providing funding, developing best practices, etc.?

RESPONSES FOR 2 A and B:

Though ideally under any circumstance when some one calls 911 for mental health crisis response, law enforcement should not be the default and or only responder but rather there is a connection to 988 and or other community mobile and or crisis services. There are instances when safety of the person or others are at risk and law enforcement may need to be present to support a safe resolution. There also may be times when calls are dispatched incorrectly from the call centers (or there are no other available responders available in time sensitive crisis situations) when law enforcement are the only available. Also, there may be bias that may occur for example if it is stated that a black male in mental health distress needs crisis support. Evidence shows that police may be called to respond more often than other crisis responses services for similar circumstances that do not involve Black men and disproportionately those calls in the harm or death to Black men.

Training for law enforcement exists such as Crisis Intervention Training and other community-based trainings from the National Alliance on Mental Illness (NAMI), Mental Health First Aid and Psychological First Aid trainings to name a few that may be available to police officers, first responders and 911 call center operators. However, there are no standards, oversight and research that support mandating such training and or providing evidence that such training can reduce harmful outcomes or increase better outcomes when law enforcement is involved. There are mixed outcomes for co-responder models (such as CIT trained officers with Social worker or licensed behavioral health professionals) , yet there is continued use of such models.

At a minimum ensuring all officers, police departments and 91 call centers are aware of 988 can be a short term first step. Creating an easy way to transfer between 911 and 988 can also reduce time lags which may be what drives law enforcement swift response (they operate in seconds not minutes or hours) and reluctance perhaps to call 988. Currently there is no easy way to transfer from one system to another (911 to 988) however, with interagency collaboration this is something that can and should be explored

I also think the best place to start is for an independent body with funding do a landscape analysis of the various training available, the costs, barriers to implementing training and how many officers and call agents have been trained alongside their outcomes. It is hard to understand the complexity and develop a strategic way forward without a deep dive from an independent body to inform a strategy. The landscape analysis can include recommendations for core competency in training, funding needed

to implement the training and oversight to monitor outcomes and hold officers and call agents accountable with incentives and or sanctions for expected outcomes.

QUESTION 3

3. Reforming how law enforcement responds to mental and behavioral health crises also requires working with other stakeholders at the state and local levels, such as health departments and behavioral health providers.
    a. Are there any jurisdictions successfully coordinating various state and local stakeholders? If so, which ones?
    b. What suggestions do you have to better coordinate funding, training, and resources among stakeholders?

RESPONSES to QUESTION 3:

a. I will refer to the GAP *Ideal Crisis System* report[3] again for examples of states and localities that have coordinated state and local stakeholders:

    The Tucson Model: A Collaborative Approach to Behavioral Health Crisis and Public Safety: Margaret Balfour, MD (Page 184)

    "Pima County also plays an important role as a leader and convener. As the operator of the jail and a primary funder of
    the safety net hospital emergency department, the County has long had an interest in improving care for individuals with behavioral health needs. The County created a dedicated Behavioral Health Department in 2010 to oversee its role in civil commitment evaluations and jail programs. As part of the MacArthur Foundation Safety + Justice Challenge, Pima County has developed data sharing agreements which it uses to identify opportunities for community-based alternatives to incarceration and collaborates closely with the RBHA, law enforcement and various service providers on a variety of self and grant funded programs."

    A community case study: Building a crisis center from the ground up. Johnson County (Iowa City), Iowa: Michael Flaum, MD (page 187)

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[3] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. (2021). *Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response.* https://www. thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system/

"Iowa has a long history of local control for its mental health services. Indeed, up until a recent legislative change, each of Iowa's 99 counties had its own funding streams, and many decisions about services were made at the county level. In the county in which Iowa City is located - Johnson County - a "System of Care" (SOC) group had been established in the early 2000s at the suggestion of a consultant who had been brought in to advise about how our community could improve behavioral health services. This proved to be a critical step in much of what would happen since. The group consisted of representatives from a variety of agencies and entities that share a common population – including each of the hospitals (in addition to UICH, there is a VA hospital and one small private hospital), the primary substance use service provider, the local homeless shelter (which provides a variety of housing services), multiple law enforcement agencies (county sheriff and the police of several surrounding municipalities as well as University police), community support service providers, family and consumer advocacy groups and others. The group met monthly. All those who came did so voluntarily on their own time and expense."

High Level Collaboration to Establish a Crisis Continuum for Adults: The Healthy Minds Policy Initiative Tulsa, Oklahoma (page 192-193)

"Between 2016-2018, careful strategic planning and consensus building resulted in a report by the Urban Institute. The funder of this work, The Anne and Henry Zarrow Foundation, obtained consultation to help establish an ongoing infrastructure to develop and oversee initiatives to advance the plan. What emerged is the Healthy Minds Policy Initiative (HMPI), a dedicated team of mental health policy experts who work with state and local leadership to build capacity and develop policies to improve mental health services in Tulsa and the state. A key focus for Tulsa has been building on the work of multiple collaborations to further develop existing crisis services in the Tulsa area and identifying strategies to address gaps that limit capacity for effective crisis response for all.

After years of careful strategic planning, consensus building and implementation planning, local and state mental health professionals and community leaders from the Mayor's office, Tulsa Police Department, universities, philanthropy and non-profits are well-underway to developing a robust and comprehensive crisis response system for behavioral health disorders"

These examples I think miss only the meaningful inclusion of people with lived experience throughout the process. Further without getting more information it is not clear how the collaborations and or results have changed or improved outcomes for underserved or un-served minoritized populations where the greatest disparities occur especially as it pertains to law enforcement involvement and poor outcomes in crisis care. When creating stakeholder groups that are national, state or local, there must be attention paid to the intentional, meaningful involvement throughout the stakeholder process of people (service recipients) that are directly impacted. Using guidance such as Harts Ladder of Consumer

Engagement[4] (see attached adaptation) can support participation and inclusion of people with lived experience and people of color throughout the process. Federal, State and local bodies can require such involvement within grant or contract requirements to incentive the inclusion of consumers, peers and people of color.

To support stakeholder groups that may not normally come together, have difference of opinions and or professions with cultures of practice that differ from one another, I think this is where the field of organizational psychology and or human centered design can play a pivotal role. The organizational psychology practitioners train in systems design, group development, facilitation and change management. Human Centered Design practitioners are expert in systems design work from all users' perspectives. Using funding from philanthropy matched with federal, state and local dollars can help support the work needed in bringing diverse experienced stakeholders together using expert facilitation and trainers in the work of system design theories (and pragmatic evidence-based practices) to reform our old way of using law enforcement to a new way of creating a humanistic, safe and recovery practiced crisis response continuum of care.

[4] Hart, R. (1992). *Children's Participation from Tokenism to Citizenship.* Florence: UNICEF Innocenti Research Centre

The Lived Experience-Engaged Ladder

Keris Jän Myrick, MBA MS

A lived experience engaged organization and or project is one where people with lived experience contribute to the success of the organization/project in meaningful ways. A fully lived experience organization and or project has a vibrant partnership between clinicians, administrators, peers and people with lived experience (service recipients) in order to identify and meet the needs of people they serve, innovate to meet emerging needs, and reduce barriers to success.

The Lived Experience-Engaged Ladder is built on the concepts first outlined in Hart's Ladder of Participation (1992) where UNICEF sought to better define how they were involving the people they were seeking to serve in the design, implementation, and evaluation of all of its programs.[1]

This tool is intended to encourage organizations and or projects to go through a self-assessment and act intentionally to more fully integrate people with the experience of living with their own behavioral health condition or as a parent of a child under the age of 18 living with a behavioral health condition as well as people of color and other historically marginalized groups into the development, implementation, and evaluation of their organization's or project's program policies and procedures.

By involving people with the lived experience in all aspects of the organization's life, the system is better able to offer high quality and effective programs, policies, and procedures that meet the needs of those they are seeking to serve.

While it may help point the way, the Lived Experience-Engaged Organization Ladder is not intended to define a career ladder for peer support staff or those with lived experience receiving services. It is designed as a self-assessment tool for organizations, programs and or projects to rethink how they include consumers in all aspects of the organization so that the organization can be effective in meetings its mission.

The Lived Experience Engaged Ladder:

[1] adapted from Hart, R. (1992). *Children's Participation from Tokenism to Citizenship.* Florence: UNICEF Innocenti Research Centre

The Lived Experience-Engaged Assessment

Every organization/project will have a mixture of things they do that might be best described by different rungs on the ladder. For example, an organization/project may be able to describe themselves on rung eight and still be doing things at rung one. There is nothing wrong with having a mixture of ways people with lived experience are engaged in the organization/project. Not every person with lived experience or peer will have the experience to contribute at rung seven and may be more comfortable developing those skills through volunteer activities at rung two. However, a review of where your organization or project primarily and consistently lands on the ladder can point out areas for growth and lead to strategically improving your success as a lived experience engagement.

Step One: Take a moment think about your project and project partners, work together and place check marks next to the corresponding rung on the ladder as follows as it pertains to your Learning Lab Project:

✓✓✓ We do this consistently
✓✓ We can point to a few instances where we have done this
✓ We have done this on a rare occasion
No check mark means we have never done this

Step Two: Jot down an example that illustrates your check marks in each area

Levels	**Check Marks**	**Illustration**
Lived Experience Contributing at all Levels		
Lived Experience in Leadership		
Lived Experience Initiated Partnerships		
Lived Experience Input and Influence, No Leadership		
Separate but Equal		
Input, No Influence		
Job Tokenism		
Tokenism		
Marketing Capital and Entertainment		

Step Three: Now take a moment and consider where most of your check marks are placed. Do you see any patterns? Are most of your check marks in the green, yellow or orange zones? What does it mean?

Step Four: What specific strategies could you implement to improve the lived experience engagement orientation of your organization/project?

Subcommittee on Criminal Justice and Counterterrorism
Behavioral Health and Policing: Interactions and Solutions
Submitted April 29, 2021

QUESTIONS FROM SENATOR BOOKER

Questions for Keris Myrick

1. In most instances, when people with mental illness need assistance, what is the consequence of a police response?

    a. How would a response from a mental health professional better serve the needs of people with mental illness than a law enforcement officer in moments of crisis?

2. Why is peer support so important in behavioral health care? What function does it serve?

RESPONSE from Keris Myrick-
Question 1 –
Police response is not what one would expect or want when experiencing any kind of health emergency including a mental health emergency. Police are not nor should they be trained primarily as health professionals. Police are trained to enforce the law (hence the name of the use of the name law enforcement as synonymous with Police officer) and to protect the public and themselves. Police response can result in emotional and physical harm including death to people with mental health conditions when they need emergency or crisis assistance. Further these harms result in trauma which can result in people refusing to reach out for assistance, in the future, access treatment or deteriorating trust of the mental health system, providers and or even their loved ones who may have called 911 for help.

The Washington Post Database on Police Officer Shootings indicate that 1 in 5 people with a mental illness are fatally shot by on-duty police. It is important to also point out the disparities of outcomes for people who have a mental illness who are also Black and Brown. A recent study found that when police are responding to a mental health emergency call, unarmed Black men are more likely to be shot and killed (1).

QUESTION 1A-
Mental health professionals such as social workers, psychiatric nurses, psychiatrists, Peer Supporters/Recovery coaches can and do respond to people experiencing mental health crisis. They are trained to work with people and support people during all aspects of their recovery journey. Trained mental health professionals can work in teams such as mobile crisis teams, or in home like settings such as Peer Respites where people who themselves have been through similar mental health crisis are trained to provide a welcoming, safe and trusting environment in which one can heal and move forward toward on their recovery journey.
Mobile crisis teams made up of mental health professionals including Peers can many times resolve a crisis in the field reducing the need to transport to costlier and more intensive

emergency room or psychiatric hospitals. While police may in general only transport to EDs and locked psychiatric wards.
From my personal experience and those of my peers who report similar encounters, what is desired when we are in emotional distress and in need of emergent care is to be met with someone who is caring, can slow things down, meet us where we are, build trust and create a sense of safety as we navigate through these struggles. This type of response is part of providing person centered humanistic care which is technically what mental health professionals as trained to do as opposed to police. The Harm to Health Report: Centering Race Equity and Lived Experience in Mental Health Crisis Response provides a 'north star vision' to move from our now too often used public safety response to a public health response to eliminate trauma, handcuffs, harm and death and advance prevention, earlier intervention, advance use of peer support services and increase access to an array of mental health and other services that help people when they are at their most vulnerable to heal (3).
SAMHSA released an advisory *Peer Support Services in Crisis Care* in June 2022 that also provides information about, the role, evidence and support of Peer Support as an important part of crisis response systems. This advisory can aid legislators, policy makers, systems of care, CBOS (federal, national ,state and local folks) to not only understand the importance of the peer support and service role, but also how to deploy across the continuum of care including crisis services.

Foot notes:

1. Marilyn D. Thomas, Nicholas P. Jewell, Amani M. Allen,
   Black and unarmed: statistical interaction between age, perceived mental illness, and geographic region among males fatally shot by police using case-only design,
   Annals of Epidemiology, Volume 53, 2021, Pages 42-49.e3, ISSN 1047-2797,
   https://doi.org/10.1016/j.annepidem.2020.08.014.

2. Fatal Force: Washington Post Database.
   https://www.washingtonpost.com/graphics/investigations/police-shootings-database/
   Retrieved 8.7.2022

3. From Harm to Health: Centering Race Equity and Lived Experience in Mental Health Crisis Response. https://fountainhouse.org/reports/from-harm-to-health . Retrieved 8.7.2022

4. Substance Abuse and Mental Health Services Administration (SAMHSA). *Peer Support Services in Crisis Care*. Advisory. SAMHSA Publication No. PEP22-06-04-001 Published June 2022