TESTIMONY FOR PUBLIC HEARING ON THE ENHANCING MENTAL
HEALTH CRISIS SUPPORT AND HOSPITALIZATION AMENDMENT ACT
OF 2024

COMMITTEE ON HEALTH

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Disability Rights DC at University Legal Services (DRDC) appreciates
the opportunity to submit written testimony regarding the proposed
Enhancing Mental Health Crisis Support and Hospitalization Amendment Act
of 2024. DRDC is the designated protection and advocacy program for
people with disabilities in DC. Pursuant to our federal mandate, DRDC
advocates on behalf of hundreds of DC residents with mental illness each
year. We work to ensure that, in accordance with the Americans with
Disabilities Act (ADA) and other civil rights laws, District residents living with
mental illness and other disabilities receive treatment in the most integrated
setting appropriate to their needs.

DRDC has serious concerns about this bill. While we appreciate this
committee’s work to attempt to address significant issues with the District’s
behavioral health system, we do not agree that many of these amendments
will result in DC residents receiving better access to quality treatment, nor
that these amendments will “contribute to the overall well-being of the
community by addressing mental health concerns.”¹ Instead, many of these
changes will likely do nothing more than cause individuals to be involuntarily
detained for a longer period of time than necessary with little to no supportive
treatment, will subject individuals with disabilities to an increased likelihood
of abuse and neglect, will cause further destabilization in their lives, and will

¹ Council of the District of Columbia, Statement of Introduction, Enhancing Mental
Health Crisis Support and Hospitalization Amendment Act of 2024, February 5, 2024, at
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most greatly negatively impact low-income Black and brown residents living with disabilities.²

DRDC supports the amendment that would require DBH to create online training modules on the involuntary commitment process, including “alternatives to voluntary or involuntary commitment” and the “legal rights of individuals receiving mental health services,” for both laypersons and healthcare professionals.³

**Extending the detention time for emergency observation is inherently harmful and will have devastating consequences for District residents living with psychiatric disabilities and for the District’s behavioral health system.**

This bill proposes to extend the emergency detention period for assessment and observation from seven to 15 days.⁴ In addition, this bill proposes to extend the timeframe during which a probable cause hearing must be held to “the hearing shall be held within 72 hours after receipt of the request and in no event earlier than 24 hours after the hospital or facility where the person is detained receives written notification of the request except that any request received on a Friday shall be heard no earlier than

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² DRDC is disappointed that the Council did not seem to engage in a local community input process prior to introducing this bill, which is an overhaul of the Ervin Act. To DRDC’s knowledge, individuals who will be directly impacted themselves by this bill, nor their advocates, were consulted during its formulation. Further, at a time when the District is actively fighting for Statehood in part to prevent national interests from infringing upon our local autonomy and rights, DRDC is concerned that local advocacy organizations, who actually represent the individuals impacted, who are much more intimately familiar with the District’s unique service landscape, and who can much more greatly speak to the needs of our own residents, were not consulted.

³ Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024 at 6.

⁴ Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024 at 2.

⁵ No explanation is offered in the introduction of the bill nor in the proposed bill itself why 15 days was chosen. DRDC notes that since 2016, 15 days is also the number of days in a month that Congress has allowed Institutions for Mental Disease (IMDs) to receive federal financial reimbursement for admitted individuals age 21-64 who are enrolled in managed care plans. While the District currently has permission from CMS to waive the IMD exclusion through 2024, enabling federal financial reimbursement for longer than 15 days per month in IMDs if necessary, this permission is currently only temporary. Thus, DRDC questions whether this may be an additional motive from provider entities to extend the detention period to exactly 15 days.
the following Tuesday.” Overall, these changes together could result in an individual being detained for at least 21 days without having the ability to challenge this involuntary detention at a probable cause hearing.

First, this implicates serious constitutional due process and liberty interest concerns. When the Ervin Act was passed in 1964 and amendments were later made in 2002, Congress and the District acknowledged then the importance of regular court review of involuntary commitment, the importance of patient choice, and intended for there to be a strong preference for voluntary treatment. These proposed changes are not in line with the historical intent of this Act.

6 Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024 at 2-3.
7 An individual who is FD-12ed can initially be detained for up to 48 hours without any court involvement. D.C. Code § 21-523. That period is automatically extended if it ends on a weekend or holiday, in which case that 48 hours can turn into up to 5 days. D.C. Code § 21-526(a). The proposed bill then allows for the individual to be involuntarily detained for assessment and observation for another 15 days. Lastly, the proposed bill would extend the probable cause hearing timeframe to having to be held within 72 hours, if not more, depending on which day the request is made. Thus, each of these parts added together can result in involuntary detention without the ability to challenge it for at least 21 days, if not more.
8 Together, the Fifth and Fourteenth amendments to the United States Constitution protect individuals from the deprivation of “life, liberty, and property without due process of law” by states and the federal government.
9 At each step of the process, “the entire statutory scheme postulates independent judicial review as the cornerstone of the protections against erroneous deprivations of liberty . . . such review is at the heart of due process.” In re Herman, 619 A.2d 958, 966 (D.C. 1993) (citing Senate Comm. On the Judiciary, Protecting the Constitutional Rights of the Mentally Ill, 88 S. Rpt. 925 at 1078 (1964)).
10 In re Blair, 510 A2d 1048, 1050 (D.C. 1986) (“When Congress [drafted the Ervin Act], it recognized that voluntary hospitalization was preferable to emergency, involuntary detention . . . [and] that the forced detention of those seeking voluntary hospitalization would defeat the Act’s purpose of encouraging voluntary admissions.”); See also New Legislation Passes to Protect the Rights of People with Mental Illness, Department of Behavioral Health (December 17, 2002), https://dbh.dc.gov/release/new-legislation-passes-protect-rights-people-mental-illness; See also Testimony of Martha B. Kinsley, Director D.C. Department of Mental Health on the “Mental Health Commitment Amendment Act of 2002” Bill No. 14-605 Before the Committee on Human Services (June 26, 2002) (“At the core of these amendments is the commitment to ensuring that persons with mental illness are treated in the most integrated setting that can be accommodated, consistent with consumers’ needs and society’s best interests, including public safety.”) (“The amendments make clear that a person may seek voluntary outpatient services, and requires the Department or a private mental health
Second, this change to the law is unnecessary in that the law already allows for the extension of the detention time for further observation and diagnosis. Specifically, § 21-526 of the Act as currently written already allows the court to extend the period of detention if a doctor who has examined the person opines that the person “remains mentally ill and is likely to injure himself or others as a result of the illness unless the emergency detention is continued.”

Third, and with great emphasis, there is a lack of data that supports that forced treatment is effective. In general, nationally, there is a dearth of publicly available data that shows that civil commitment improves treatment outcomes and reduces re-hospitalization rates. When looking to international studies, there is data to support that, to the contrary, forced treatment does not reduce the rate of readmission of individuals experiencing psychosis, nor does forced treatment improve service use, mental state, or quality of life. The publicly available data simply does not support that the District should be increasing the length of time of forced treatment, and instead, the District should be focusing on investing in and creating better quality, accessible, voluntary, community-based treatment options that people want to seek for assistance. Unlike forced treatment, we know that these community-based interventions, such as Assertive Community Treatment (ACT) and supportive housing (Housing First) have proven success.

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11 D.C. Code § 21-526(c).
12 Tom Burns, et al., Community treatment orders for patients with psychosis (OCTET): a randomised control trial. The Lancet (2013) (“We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients’ personal liberty.”), https://www.thelancet.com/action/showPdf?pii=S0140-6736%2813%2960107-5.
13 Kisely S, et al., Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Cochrane Database Syst Rev 2017; 3: CD004408 (Results from the trials showed overall forced community treatment was no more likely to result in better service use, social functioning, mental state or quality of life compared with standard voluntary care.), https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004408.pub5/pdf/full.
Extending the emergency detention period is not going to result in individuals receiving the treatment and support that they need. Through our clients’ experiences and our observations when we monitor facilities, we know that individuals in crisis receive little to no treatment and programming while admitted to acute inpatient psychiatric units. If the District fails to improve discharge planning services, care coordination practices, community-based behavioral health services, and fails to provide adequate housing support to individuals living with mental illness and other disabilities, extending this period will likely do nothing more than cause people to sit in the hospital for longer, continuing to not receive the help that they need, and they will continue to cycle in and out of these facilities.

What is more, interaction with forced treatment often discourages people from wanting to voluntarily seek treatment in the future. The Judge David L. Bazelon Center for Mental Health Law, which “has a long history of opposing forced treatment,” in its position statement on involuntary treatment states that: “Not only is forced treatment a serious rights violation, it is counterproductive. Fear of being deprived of autonomy discourages people from seeking care. Coercion undermines therapeutic relationships and long-term treatment. The reliance on forced treatment may confirm false stereotypes about people with mental illnesses being inherently dangerous. Moreover, the experience of forced treatment is traumatic and humiliating, often exacerbating a person’s mental health condition.”

15 Currently, as part of our mandate as the designated Protection and Advocacy organization for the District, DRDC periodically monitors conditions inside of PIW, St. Elizabeths Hospital, and the acute psychiatric inpatient units at United Medical Center, in addition to other facilities (such as Children’s National Hospital and DYRS facilities).
17 Franke I, et al., Perceived institutional restraint is associated with psychological distress in forensic psychiatric inpatients. Front. Psychiatry 2019; 10: 410 (“Perceived institutional restraint . . . was associated with a higher general level of psychological symptoms. Furthermore, patients who perceived a lack of institutional transparency and respect were more likely to have higher scores for hostility, depression, and suicidal ideation.”), https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsyt.2019.00410/full.
Most individuals who are involuntarily admitted in the District are admitted to PIW. PIW is the only private, for-profit stand-alone psychiatric hospital in Washington, D.C. PIW is one of more than 400 facilities owned by Universal Health Services (“UHS”), a for-profit corporation and one of the largest owners of behavioral healthcare facilities nationally, serving over 3.6 million patients a year. UHS’s revenues increased to over $14 billion in 2023. While reaping enormous profits, UHS-operated behavioral health facilities have been the subject of numerous investigations and lawsuits, which allege incidents of disturbing abuse and neglect, as well as violations of federal and state regulations.

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18 Per data provided by the Public Defender Service for the District of Columbia, 60 percent of individuals who initially present to the District’s Comprehensive Emergency Psychiatric Program (CPEP) and who are determined to require further inpatient hospitalization are transferred to PIW.

19 Psych. Inst. of Washington, About Us, https://psychinstitute.com/about-us/ (last visited April 18, 2024). St. Elizabeths Hospital is also a psychiatric facility located in Washington, D.C. However, in contrast to PIW, it is a nonprofit public facility, not private, and is operated by DC’s Department of Behavioral Health. See Dep’t of Behav. Health, Saint Elizabeths Hospital, https://dbh.dc.gov/page/saint-elizabeths-hospital (last visited April 18, 2024).


22 In 2020, the United States Department of Justice settled with UHS for $122 million resolving 18 actions against UHS which alleged failure to provide adequate staffing, training, and supervision of staff, improper use of restraint and seclusion, failure to discharge patients when hospitalization was no longer necessary, failure to develop and/or update treatment plans, and failure to provide adequate individual and group therapy. U.S. Dep’t of Just. Off. of Pub. Affs., Universal Health Services, Inc. And Related Entities to Pay $122 Million to Settle False Claims Act (July 10, 2020), https://www.justice.gov/opa/pr/universal-health-services-inc-and-related-entities-pay-122-million-settle-false-claims-act. In March 2024, a jury found a UHS behavioral health facility was negligent in the rape of a 13-year-old patient and awarded the family $535 million in damages. (The decision has been appealed.) Samuel Lisec, Jury renders $535 million judgment against The Pavilion in 2020 rape of patient, The News-Gazette (March 29, 2024), https://www.news-gazette.com/news/local/courts-police-fire/jury-renders-535-million-judgment-against-the-pavilion-in-2020-rape-of-patient/article_c36a05f5-e80a-53c6-92ee-9f1f17acafef.html. Also in 2024, a United States Senate Committee Report discussed taxpayer funded child abuse and neglect, including at UHS operated facilities, Chairman's News | Newsroom | The United States Senate Committee on Finance.
If passed, these proposed amendments will certainly increase profits for UHS. But it will have dire consequences for hundreds of DC’s residents with mental health disabilities, forcing them to endure unsafe and non-therapeutic conditions for even longer periods of time than they must do now. Not only do many PIW patients complain about the lack of meaningful therapeutic treatment at PIW; patients there are not safe. DRDC has placed the District on notice for years about the conditions inside of PIW. DRDC’s investigations into allegations of abuse and neglect at UHS-owned PIW reveal a disturbing, long-standing pattern of abuse and neglect. In June of 2021, DRDC released a report, *A Disturbing Death: Abuse and Neglect at the Psychiatric Institute of Washington*, which described videotape footage of nursing neglect surrounding the death of a patient, as well as many incidents of serious abuse and neglect. In July 2022, Disability Rights DC released another report *Do No Harm: Multiple Incidents of Abuse and Neglect at the Psychiatric Institute of Washington*, which detailed equally alarming incidents of abuse and neglect at PIW, including videotape footage showing (1) multiple staff persons using unauthorized physical restraint techniques, which caused a patient to fall to the ground and sustain head and arm injuries; (2) a male staff person dragging a crying, frightened female patient across the floor twice, then pushing her into the room; and (3) a chaotic incident on the adolescent unit where multiple patients engaged in physical altercations and staff did not adequately intervene, culminating in a frightening scene in which seven DC Metropolitan Police officers arrived on the unit and arrested one youth. During this incident, an adolescent patient was stabbed in the cheek and sustained a laceration and facial fracture and another patient was struck in the face and sustained nasal fractures and a laceration.

According to media reports, in late 2023, D.C. police arrested a male PIW staff person for sexually assaulting a 17-year-old female patient. In our recently released and third report in three years, *Unsafe and Unprotected: Neglect at the Psychiatric Institute of Washington*, Disability Rights DC found evidence of continued staff abuse and neglect, including

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sexual assaults, assaults resulting in fractures and other serious injuries, staff neglect, and overreliance on seclusion and restraint. In one very disturbing incident captured on videotape footage, a female patient was violently punched squarely in the face by a male patient with such tremendous force that it knocked her immediately to the floor, causing her to bleed profusely from her nose and sustain a laceration to her upper lip. The incident may have been preventable. The male patient had been clearly exhibiting signs of agitation for at least 23 minutes prior to the incident, including pacing quickly back and forth across the hallway, balling his fists, and punching into the air, yet staff failed to intervene.

In addition to the serious harms and re-traumatization described above, there are also other collateral consequences to involuntary inpatient treatment that those who have not experienced forced treatment themselves often do not consider. Employment and housing instability can result from being involuntarily detained. When DRDC monitors conditions inside of PIW and speaks with consumers who are currently admitted, it is common to hear that individuals in care are having difficulty contacting people outside of the hospital by phone, including employers. Involuntary detention results in the inability to plan ahead and to notify an employer of an upcoming absence. Further, housing can be placed at risk for a number of reasons, including, for example, if the individual is housed using a voucher and the DC Housing Authority has an inspection scheduled during the time of involuntary admission. Professional licenses and parenting rights may also be negatively impacted by the initiation of involuntary commitment procedures.

Finally, but not less importantly, the Council must consider that, given all of the above, these changes will be most likely to negatively impact low-income Black, indigenous, and other people of color living with disabilities. The priorities of the providers, attorneys, and non-local advocates that endorse forced treatment with whom the Council consulted when drafting this bill - who are all in positions of power - should not be placed above the perspectives of those DC residents whom these changes will most directly impact.

The concern that individuals in need of behavioral health support need more time to receive forced treatment is reflective of the failures in DBH’s current system of care. By extending the emergency detention period, the District is penalizing individuals living with mental illness for systemic failures in the District’s behavioral health system. Pressures on the acute care service system, such as increased emergency department volume and boarding, and backups in local psychiatric inpatient units due to
admissions and barriers to transitioning discharge-ready individuals, are often attributable to nonexistent or underfunded community-based services, including inadequate community-based crisis support services.\textsuperscript{24,25}

DRDC continues to receive many complaints about Core Service Agencies (CSAs) and Assertive Community Treatment (ACT) providers failing to provide quality and appropriate community-based services. What DRDC continues to see through our clients’ experiences is poor continuity of care, many consumers not accessing the services they need, such as psychotherapy and case management support to access housing and public benefits, and consumers very often experiencing difficulty reaching and being adequately served by their assigned community support workers. Further, ACT services in the District continue to have poor fidelity and are failing to meet client needs. ACT services were specifically created to serve individuals living with serious mental illness and significant functional challenges in an integrated community setting and to reduce hospital recidivism.\textsuperscript{26} ACT teams should function as the first-line provider, be available to consumers 24/7, and primarily serve consumers in the

\textsuperscript{24} National Association of State Mental Health Program Directors, \textit{The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity} (Aug. 2017) at 7, \url{https://www.nasmhpd.org/sites/default/files/TAC.Paper_4.Housing_in_Determining_Inpatient_BedCapacity_Final.pdf}.

\textsuperscript{25} As part of the District’s current 1115 Medicaid waiver, in 2019, the District proposed to CMS that it would bolster crisis stabilization services “through changes to existing Comprehensive Psychiatric Emergency Program (CPEP) and mobile crisis and outreach services and the addition of psychiatric residential crisis stabilization services.” District of Columbia Proposed Section 1115 Behavioral Health Transformation Demonstration application to CMS dated June 3, 2019 at 19, \url{https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/dc/dc-behavioral-health-transformation-pa.pdf}.

Specifically regarding the addition of psychiatric residential crisis stabilization services, the District proposed to CMS that these services would be “a treatment alternative to psychiatric inpatient hospitalization for persons living in the community who are (1) in need of support to ameliorate psychiatric symptoms; (2) voluntarily participating in treatment; and (3) deemed appropriate for outpatient services within a structured, closely monitored temporary setting (based upon a psychiatric assessment conducted on-site).” \textit{Id.} While this service addition has great potential to prevent unnecessary inpatient hospitalizations, to DRDC’s knowledge, five years later, while the District is nearing the end of this initial 1115 waiver authority, these services have not come to fruition.

\textsuperscript{26} High-Fidelity ACT 101 Webinar Series. Institute for Best Practices, UNC Center for Excellence in Community Mental Health.
community. Unfortunately, we continue to hear that ACT teams in the District fail to respond to their consumers who are experiencing a mental health crisis, resulting in police and other entities being the first-line responders, as well as ACT teams failing to meet with consumers as frequently as is expected. This is low-fidelity ACT and does not meet its intended purpose of preventing hospital recidivism by functioning in this way.

DRDC also continues to see significant deficiencies in discharge planning practices when an individual is discharging from an inpatient psychiatric facility back to the community. Discharge planning is incredibly important in ensuring continuity of care and stability for individuals experiencing acute behavioral health symptoms. It should include active involvement of community behavioral health staff from day one of admission, assessment of housing needs during admission, and an analysis of what other resources the individual will need to be connected with upon return to the community. When these practices are not followed, it can be incredibly difficult for an individual to remain safe and stable in the community, and often results in hospital readmission. DBH’s own FY23 key performance

27 Id.

28 In fall of 2023, DBH changed the process by which providers are required to bill for ACT services. Specifically, among other requirements, rather than billing by 15-minute increments, providers are now required to make a minimum number of contacts with a consumer each month in order to receive a monthly lump payment. Although DRDC supports efforts by the District to bring ACT services closer to fidelity standards, providers initially reported receiving little support from DBH in implementing these changes and some have expressed great concern that they will not be able to remain in business as an ACT provider long-term under these standards. DRDC has great concern that an already strained ACT service system is going to worsen as a result. See the DC Behavioral Health Association’s FY23-FY24 DBH Performance Oversight Testimony discussing the current exhaustion of the DBH community-based provider network and the various barriers toward providers’ ability to offer effective care.

29 Hospitals and CSAs must engage in the discharge planning process. CMS Conditions of Participation for Hospitals require that a hospital “must have an effective discharge planning process that focuses on the patient’s goals and treatment preferences and includes the patient . . . as active partner[s] in the discharge planning for post-discharge care.” 42 C.F.R. § 482.43. In addition, DC regulations require hospitals to engage in discharge planning, including a “system for timely evaluation of any discharge planning needs of patients” and “maintenance of a complete and accurate list of community-based services, resources and facilities to which patients can be referred.” 22-B DCMR § 2029.1. DBH policy 200.2B, which applies to St. Elizabeths Hospital and to “private hospitals in the District of Columbia that have arrangements with [DBH] for provision of services to [DBH] consumers,” requires a CSA/ACT provider to “participate in the
indicator (KPI) data shows that only 56 percent of Mental Health Rehabilitative Services (MHRS) consumers who were discharged from a psychiatric hospital had a follow-up service within 30 days.\(^{30}\)

Without effectively functioning ACT services, community support services, and discharge planning services, DC residents living with mental illness are not receiving adequate support to thrive in the community.\(^{31}\) Rather than focusing on involuntarily detaining consumers for a longer period of time, the Council should instead place increased focus on holding DBH, DHCF, and behavioral health providers accountable to their obligations under the law.

_The District is obligated to serve individuals with disabilities in the most integrated setting in accordance with the Americans with Disabilities Act’s (ADA) integration mandate._ In _Olmstead v. L.C._, the United States Supreme Court held that states have an affirmative obligation to provide services to persons with disabilities in the most integrated setting appropriate to their needs and that a states’ failure to do so constitutes discrimination.\(^{32}\) This year marks the 25\(^{th}\) anniversary since this pivotal decision. Forced inpatient treatment in lieu of adequate access to voluntary community-based services is not in line with _Olmstead_ and the ADA’s integration mandate. This bill, if passed, would threaten _Olmstead’s_ promise for community integration because it will result in prolonging unnecessary

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\(^{30}\) DBH FY 23 Oversight Question 11, Attachment 1 of 2: FY23 Performance Plan Key Performance Indicator Status.

\(^{31}\) In addition to changes to ACT billing practices, the District also more recently changed the authorization limits for Community Support Services (CSS). DBH will now automatically authorize consumers for 200 units of CSS upon enrollment and will require providers to seek prior authorization if more than 200 units are clinically needed in a 180-day period. DBH has also placed a significant limit on the number of units that audio-only telehealth can be used under CSS. See DBH Bulletin on Community Support Service Limits dated May 8, 2024, [https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Bulletin%202014%20Community%20Support%20Service%20Limits.pdf](https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Bulletin%202014%20Community%20Support%20Service%20Limits.pdf). DBH has acknowledged that one motivation for these changes is to address fraudulent activity that has been observed by certain providers. Rather than creating greater barriers to consumers receiving the care that they need, the District should instead hold providers accountable in more direct ways.

institutionalization and risks diverting investment from community-based services to institutional services. Behavioral health crises that lead to involuntary commitment can be prevented if the District provided the intensive behavioral health services that District residents need.

Additionally, despite this affirmative obligation, it is evident that the District has been trending toward placing increased focus on inpatient care instead of enhancing investments in community-based behavioral health services. In 2019, the District applied for an 1115 Medicaid waiver to be authorized by the Centers for Medicare and Medicaid Services (CMS) to bill Medicaid for the full-length of short-term, acute psychiatric inpatient stays for individuals age 21-64 [formally referred to as admissions at Institutions for Mental Disease (IMD)]. 33 In June, the District submitted a renewal application to CMS requesting to continue to waive the IMD exclusion for another five years. 34 When the Medicaid program was enacted in 1965, Congress acknowledged that “often the care in [psychiatric hospitals] is purely custodial,” and thus, Congress intentionally carved out IMD admissions from the Medicaid Act to ensure that States maximize their Medicaid dollars to care for individuals living with mental illness in the community, rather than in hospitals. 35 The fact that the District sought out the initial 1115 Medicaid waiver and has now applied for a five-year renewal is further evidence of the District placing an increased focus on institutional care versus community-based care, contrary to individuals with disabilities’ right to live in the community. In the District’s 1115 waiver renewal

33 See District of Columbia Proposed Section 1115 Behavioral Health Transformation Demonstration application to CMS dated June 3, 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/dc/dc-behavioral-health-transformation-pa.pdf. In addition to waiving the IMD exclusion, the District’s 1115 Medicaid waiver also added additional community-based behavioral health services to its array of Medicaid billable services. However, the District did not need to use this waiver in order to bill for these community-based services, and thus CMS required the District to add these services to its State Plan in 2022. All that the District continues to now waive is the ability to bill for IMD stays, as well as an elimination of the $1 copayment for prescriptions for Medication Assisted Treatment (MAT).


application, it admits to CMS that after almost five years of waiving the IMD exclusion, it has not yet achieved its intended goal of “reduc[ing] preventable readmissions to acute care and specialty hospitals and residential settings” through this waiver, and instead, “a statistically significant increase in unplanned 30-day readmissions to acute care and specialty hospitals and residential settings was observed.” The District further notes that “data specific to preventable readmissions was not available to totally assess progress on meeting this goal.” Essentially, the only data related to this goal that the District has available is that readmissions have actually increased since the waiver’s implementation.

Rather than focusing on seeking out ways to cost-shift behavioral health services to the federal government that have not been proven to be effective in achieving the intended goals and that result in more inpatient treatment, the District must address its failure to provide sufficient and appropriate voluntary and community-based services that people want to seek.

Furthermore, despite the District’s affirmative obligation under the ADA’s integration mandate to serve individuals with disabilities in the most integrated setting, the District is failing to adequately address the housing needs of individuals with disabilities, thereby placing them at greater risk of institutionalization. **Pressures in the acute care service system are also**

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37 *Id.*
38 It is also important to note that the District had already participated in a large federal demonstration pilot program, called the Medicaid Emergency Psychiatric Demonstration program (MEPD), from 2012 to 2015, which allowed the District to waive the IMD exclusion at PIW for eligible individuals. Data from this previous demonstration showed that the use of this waiver was ineffective in reducing inpatient admissions to IMDs, reducing length of stay in IMDs, and reducing ER visits. In addition, the previous demonstration showed no effect on discharge planning. See Crystal Blyer, *et al.*, **MATHEMATICA POLICY RESEARCH**, *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report* (Aug. 18, 2016), https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf. Yet, the District chose to request to waive the IMD exclusion again three years later despite this knowledge, and has now requested to continue to waive the IMD exclusion for another 5 years. The data simply does not support that doing so has prevented hospital readmissions nor has it improved important practices such as discharge planning.
often attributable to a lack of affordable housing. Psychiatric inpatient care often “inappropriately functions as a remedy for homelessness.” The Mayor’s FY25 budget added no new vouchers at a time when point in time data indicates that homelessness in the District has increased by 14 percent. In more recent years, we have also observed a trend in DBH pulling back on its commitment to house individuals with mental illness in need of deeply affordable housing in integrated, community-based settings. Access to safe, affordable housing is central to the safety and treatment of mental health consumers. Long-standing research confirms that people respond better to treatment when they are in safe, stable housing. At one time, DBH acknowledged its role in the development of this essential element by supporting housing development that would add to the inventory of housing possibilities for mental health consumers. For example, in 2012, DBH committed itself to develop a system “that supports individuals with mental illness in integrated, community-based settings.” The 2012 plan committed to increasing the number of Permanent Supportive Housing (PSH) units so that people with mental illness could live in integrated community-based settings, consistent with the Americans with Disabilities Act (ADA) community integration goals. In addition, DBH created a more targeted housing waitlist for its consumers by securing set-aside housing vouchers. Unfortunately, this commitment on housing those with serious and

40 Id. at 7.
44 DBH Supportive Housing Strategic Plan at 2.
45 Id. at 3.
persistent mental illness has waned, and we understand that few, if any, vouchers have been added to DBH’s allotment for years. Furthermore, DBH’s Home First Subsidy Program, which funds many of DBH’s vouchers, is still setting voucher rental caps based on 2011 rates.\textsuperscript{46} This is incredibly low, and DBH staff have openly acknowledged to DRDC that the rental caps for the DBH housing voucher program are lower than other housing assistance programs in the District - many of which are not specifically geared toward housing individuals with disabilities.\textsuperscript{47} As a result of this inequity, many individuals living with mental illness are forced into choosing among rental markets in the lowest-income neighborhoods and in substandard buildings.\textsuperscript{48}

In addition to DBH’s continued failure to provide adequate community-based housing options for its consumers, DBH’s provider network has been failing to provide adequate housing assistance that is required by DC regulations and DBH policy. Over DRDC’s many years as the Protection and Advocacy organization, we have represented many individuals with serious and persistent mental illness who have been failed by their mental health agencies because they have not received the kinds of skilled, concerted efforts necessary to promote stability in the community. What we too often encounter with our clients are CSAs failing to meet their obligations under DC regulations and DBH policies\textsuperscript{49} by providing incredibly little assistance to

\textsuperscript{46} 22-A DCMR § 2208.1 (“The Department may approve a Home First Subsidy in an amount equivalent to eighty percent (80%) of the 2011 Fair Market Rent Value calculated by the U.S. Department of Housing and Urban Development for the Metropolitan Washington D.C. area.”)

\textsuperscript{47} As an example, a DRDC client was awarded a DBH housing voucher in fall of 2023 for a one-bedroom apartment with a total rent not to exceed $1,230 per month. This was not an atypical amount for a DBH voucher.

\textsuperscript{48} Furthermore, DBH recently stated to DRDC that its Housing Eligibility and Assessment List (HEAL) applications are “no longer valid, as DBH does not maintain a housing waiting list.” This statement conflicts with DBH policy 511.1, which is still current to DRDC’s knowledge. When DRDC followed up with DBH leadership for clarification on this apparent policy change, and how DBH is now ensuring that consumers’ housing needs are being identified, tracked, and supported in accordance with D.C. regulations and DBH policy, DBH did not provide a substantive response.

\textsuperscript{49} 22-A DCMR §2201.1 requires Core Service Agencies to “assess consumers for supported housing needs as part of the treatment plan process.” 22-A DCMR §2201.3 further requires that when a consumer is assessed as needing housing, “the mental health provider shall assist the consumer in applying for any... housing assistance program for which the consumer is eligible, including but not limited to the District of Columbia Housing Authority (DCHA) Housing Choice Voucher Program and other
their consumers in connecting to housing resources. We have seen CSAs lose consumers’ housing applications, fail to update necessary housing applications, fail to be transparent with consumers on their housing status, fail to supervise and properly train staff, and lack familiarity with community resources. Further, we too frequently encounter CSA housing liaisons who are entirely unresponsive to consumer inquiries and needs.\(^{50}\) Again, rather than focusing on involuntarily detaining consumers for a longer period of time in inpatient settings, the Council should instead place increased focus on the District adequately funding affordable, community-based housing options for this population and holding DBH and community behavioral health providers accountable to their obligations under the law.\(^{51}\)

**Allowing the issuance of arrest warrants for individuals with disabilities who fail to appear in court or for treatment inappropriately criminalizes disability and is unnecessary because the Act as written already has well-functioning mechanisms in place.**

This bill also proposes to add an amendment to the Act that would allow a court to issue a warrant “for the apprehension and appearance” of any person who has been ordered to outpatient commitment who then “fails to appear for any hearing scheduled by the court.”\(^{52}\) In addition, this bill proposes to add an amendment that would allow the court to issue a warrant for civilly committed individuals who fail to “comply with their mental health treatment by absconding from the facility” or fail “to appear for treatment at

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\(^{50}\) DBH Policy 511.1 § 5c mandates that all certified providers “shall...provide and/or arrange all housing supports needed to assist the consumer in obtaining housing.” DBH Policy 511.1 § 8a(6) further requires certified providers to “make a concerted effort to assist the consumers in identifying other housing options not provided by [DBH] when none are readily available through [DBH].”

\(^{51}\) DBH Policy 511.1 § 5c requires all certified providers to “designate a Housing Liaison for the CSA to serve as the central point of contact with the [DBH] Housing Division and as coordinator of CSA housing resources, requests and compliance.”

\(^{52}\) Given the U.S. Supreme Court’s recent ruling in *City of Grants Pass v. Johnson*, which held that laws that criminalize sleeping in public when no safe and accessible shelter options are available are not cruel and unusual punishment, DRDC emphasizes that it is more important than ever for the Council to place increased focus on investing in affordable housing and effective, evidence-based, community-based healthcare services for District residents with disabilities, rather than focusing on more punitive measures such as increased involuntary detention time. Individuals living with mental illness are disproportionately impacted by homelessness.

\(^{52}\) Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024 at 4.
the Department or facility.”\textsuperscript{53} It should go without saying that the Council should not criminalize disability. In the civil commitment context, the individual in care is often not provided with the opportunity to give input and by nature of the process does not consent to their treatment plan. The Council must not criminalize their failure to “comply.” The use of arrest warrants in the Ervin Act is even further inappropriate because the Act already makes clear that the individual in care may never be “confined in jail or in a penal or correctional institution.”\textsuperscript{54} Furthermore, under the Act, there is only one part of the process in which individuals in care are actually compelled to attend – the examination conducted by the Commission doctors prior to the Commission hearing.\textsuperscript{55} Finally, when an individual fails to appear for the examination, if they were properly served with a subpoena, the Court already has a well-functioning mechanism in place by possessing the ability to issue a writ of attachment, which commands the United States Marshal’s Service to take the individual into custody and bring them before the Commission for their evaluation. However, the use of this process is so rare that this highlights how few instances there are of individuals failing to appear.\textsuperscript{56} Similar to this, the Act already has a process in place to re-hospitalize or revoke a person’s outpatient status if deemed necessary,\textsuperscript{57} and also to apprehend an individual who has eloped from a facility.\textsuperscript{58} The above proposed amendments are inappropriate and unnecessary.

Expressly allowing an individual to voluntarily agree to remain inpatient for longer than 14 days after being ordered to outpatient commitment may not solve the lack of stability that they will return to once discharged and risks prolonging unnecessary institutionalization in violation of the ADA’s integration mandate.

\textsuperscript{53} \textit{Id.}
\textsuperscript{54} D.C. Code § 21-585.
\textsuperscript{55} D.C. Code § 21-542(a).
\textsuperscript{56} Per data provided by the Public Defender Service for the District of Columbia, the court issued writs of attachment in just 4 (0.1\%) of the 2,975 Ervin Act cases that were filed in 2023.
\textsuperscript{57} D.C. Code § 21-548 already governs when and how an individual who has been ordered to outpatient commitment and is residing in the community may be re-hospitalized and/or have their outpatient status revoked.
\textsuperscript{58} D.C. Code § 21-592 already allows for an order of return to be issued by the court. However, per data provided by the Public Defender Service for the District of Columbia, the court issued orders of return under this provision in just 2 (.1\%) of the 2,905 FD-12 cases that were filed in 2023, again highlighting how few instances there have been of individuals absconding.
Currently, the Act as written requires a person who is ordered to outpatient commitment to be discharged from inpatient status within 14 days of the date of the hearing.\(^{59}\) This bill proposes to add an amendment that states “Nothing in this section shall prohibit a person from voluntarily agreeing to remain in an inpatient status until an appropriate discharge plan is implemented.”\(^{60}\) While DRDC already sees this occur in practice for individuals who are currently admitted to St. Elizabeths Hospital, it is also our understanding that this is not always the case, and that individuals falling into this category are sometimes abruptly discharged from St. Elizabeths without having proper housing and/or supports in place. Given the above discussion about the District’s failure to ensure adequate connection to affordable housing options for persons with disabilities and the failures of the current DBH service system, including inadequate discharge planning services, DRDC has great concern that if these greater problems are not addressed, an individual voluntarily agreeing to remain inpatient for a longer period of time will not solve the lack of stability that they will return to once discharged, and thus they will then be unnecessarily institutionalized in violation of the ADA’s integration mandate.

In conclusion, DRDC has serious concerns about this bill, including that the proposed changes seem to be centered on the perspectives of providers and other entities unfamiliar with the District’s local needs, rather than on the perspectives of individuals who will be directly impacted themselves. In addition, DRDC has great concern that the proposed changes in this bill will threaten Olmstead’s promise for community integration under the ADA because they will result in prolonging unnecessary institutionalization and risk diverting investment from integration to segregation. Again, the District must focus on investing in and creating better quality, accessible, voluntary, community-based treatment options that people want to seek for assistance.

Thank you again for this opportunity to submit testimony on this important issue.

For further information:

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\(^{59}\) D.C. Code § 21-526.
\(^{60}\) Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024 at 3.
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