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The Washington LEGAL CLINIC for the Homeless
A Voice for Housing and Justice

Committee on Health Hearing held on July 11, 2024, on the Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024

Testimony of Joshua M. Drumming, Law Graduate, Amber Harding, Executive Director, and Brittany K. Ruffin, Director of Policy and Advocacy,
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Since 1987, the Washington Legal Clinic for the Homeless has envisioned and worked towards a just and inclusive community for all residents of the District of Columbia—where housing is a human right and where every individual and family has equal access to the resources they need to thrive.

The "Enhancing Mental Health Crisis Support and Hospitalization Amendment Act of 2024" serves as an amendment to the 1964 Ervin Act and proposes dangerous enhancements that will further disadvantage D.C. residents. This legislation was crafted without consultation from D.C. advocate and legal services organizations that serve and represent the community members most impacted by the bill, which may have helped lessen the concerns we testify about today: longer detention periods, an expanded pool of authorized personnel who can initiate FD-12s, the reduction in evidentiary standards, and the increased risk of exposure to the criminal legal system for people with mental illness.

The most alarming provision of this bill allows D.C. residents to be hospitalized, against their will, for longer than the currently allowed statutory period and beyond what is medically necessary. The emergency detention period for assessment and observation would extend from seven (7) to fifteen (15) days and the probable cause hearing time period would extend to seventy-two hours after receipt of the request and no earlier than twenty-four hours after the

hospital or facility where the person is detained receives written notice (except requests on Fridays, as those will be addressed no earlier than the following Tuesday). Cumulatively, these changes could result in an individual being detained for at least twenty-one (21) days without being able to challenge their involuntary detention at a probable cause hearing. This provision ignores fundamental rights, establishing a system that denies individuals their freedom without a timely determination of whether such an action is constitutionally permitted, potentially exposing D.C. to unnecessary and avoidable litigation.

Current law already affords the chance to extend a detention's duration if a doctor believes that the patient is still mentally ill and likely to harm themselves or others. No data supports that mandatory detention improves treatment outcomes or reduces re-hospitalization rates. Increasing the duration of detention only inflicts additional and avoidable trauma. Council should not support an extension of the detention period.

This legislation expands the pool of individuals who are authorized to initiate involuntary commitments, allowing nurse practitioners to initiate an FD-12. We don't believe the pool of authorized personnel should be deeper. Police officers are permitted to initiate involuntary commitments despite having no medical or psychological expertise or training. If nurse practitioners are allowed to issue FD-12s, they should be substituted in for police. We support this bill's provision that aligns D.C. law with federal Stark Law standards. This will increase system-wide efficiency and access to care without deepening the pool of individuals authorized to issue FD-12s (as physicians are already authorized to issue FD-12s in D.C., they simply cannot commit patients to the hospital they work at). Overall, we recommend that Council engage in a thorough analysis of the training and educational requirements for anyone authorized to assess someone's mental state and imminent actions.

This lack of training leads to FD-12s being used to harm our clients. In April, the Legal Clinic was present at an encampment eviction of a young, pregnant woman. She tried to gather her belongings, but a group from MPD and DBH decided she was not leaving quickly enough.

They tore her tent apart, handcuffed her, made her relieve herself while handcuffed in front of strangers, and attempted to FD-12 her to facilitate the clearing of the encampment. This shows how FD-12s are used for non-therapeutic purposes, particularly by non-medical personnel. Furthermore, if this bill reveals itself as an effective means of keeping encamped residents off of the street for longer periods of time, FD-12s' use as a tool to remove homeless people from encampments may increase. In 2023, there were already 2,905 FD-12 cases. In 2024 and beyond, this number stands to substantially increase.

Rising out of homelessness can seem like an insurmountable task under the most opportune conditions. Involuntarily detaining unhoused individuals, without cause, stands to enervate all chances of them attaining stability. Patients are often placed in environments that worsen clinical outcomes, retraumatize them, and disincentivize patients from availing themselves of future, voluntary, and possibly necessary commitments. This bill will not only fail to help some of our clients, it could actively harm them.

Relatedly, another problematic provision in this legislation is the proposal to lower the threshold for probable cause. It makes hearsay evidence admissible to justify involuntary hospitalizations, likely increasing probable cause determinations and reliance on weak evidence. Hearsay evidence should not be admissible.

This legislation also unnecessarily ties carceral consequences to mental illness. It allows for warrants to be issued for patients who have escaped a mental health facility or failed to appear at a hearing. This bill ignores the realities of mental illness. Individuals should not be criminalized for actions related to underlying mental illness. Nationally, Black and Latino people are almost twice as likely as white people to be involuntarily committed. Allowing warrants to be issued for patients will only increase the inequity in involuntary commitments in the criminal legal system and potentially put vulnerable patients into precarious situations.

Ultimately, we must look to the purpose of the proposed bill and the original legislative intent of current law. Involuntary hospitalizations are not meant to be a punitive process that

harms the most marginalized communities in D.C. This bill fails to prioritize supporting individuals with mental illness, attempts to reduce protections, and increases the severity of harm. Instead, D.C. needs to prioritize the social determinants of health: stable housing, healthy food, community-based mental health services, good education, and more. We implore D.C. Council to reconsider the purpose of this legislation, reject punitive measures that reduce legal rights, and oppose the provisions of this legislation that could criminalize poverty and mental illness.