PRESIDENT’S MESSAGE

Reason for Hope

Dear Families, Friends, and Neighbors,

In unsettling times such as these, each of us may question, Is my hope enough to pull me through? This ongoing threat of a deadly public health crisis, which remains unchecked, alongside of racial unrest that has led to major protests and upheaval throughout the nation—given the circumstances it would be astounding if anyone were not in a hopeless mood, especially persons living with mental illness or conditions triggered by situations over which they have little or no control.

With support a person can successfully navigate in such turbulent times of increased uncertainty. The NAMI DC Family can be of enormous assistance in the process of discovering what helps and what doesn’t. One person’s optimistic observation can make a huge difference.

When family and friends keep their eyes and ears attuned to early unhealthy changes or acquired positive healthy changes, hope is born. Caregivers need to be resolute that the work on everyone’s part toward wellness and resilience is beneficial and worthy of consistent effort and hope.

It may seem like a tough time now. The task of finding hope may appear difficult as well. Because it is.

Keep looking for the right mix that brings comfort and hope to you. Check out our last newsletter and our website for ideas. Include NAMI DC in your Hope Chest. There is still Reason to Hope.

Jean Harris, President

NAMI DC’S free, confidential Support Groups are now meeting online on Wednesdays 7–9 pm and Saturdays 2–4 pm.

If you would like to attend, send an email to treasurer@namidc.org.

Stay connected to your circle of support!
Searching for Supports in a Minefield of Racism

By Susan Ousley

As the mother of three African American children and grandmother to their three children, I have been cheered by current efforts to appreciate the severe damage that racism—in all forms—can inflict upon children, and especially on children who are already traumatized or who were born disadvantaged. The many medical manifestations of racism—from low birth weight to lower life expectancy to mental illness—are too often ignored.

In our family, we had to develop new bonds to replace the frayed ones that birth families could not provide. New families need robust, accessible, culturally informed mental health supports from seasoned providers to make this work. Our family had a number of experiences that illustrate the challenges—often subtle.

When we started, every mental health bill was a battle: I had to find providers, pay up front, and then seek the federally mandated reimbursement. There was an agency bias against mental health treatment. One social worker told me “their” kids didn’t need fancy services. That has changed to a degree, but there aren’t enough social workers, psychologists, and psychiatrists to meet DC children’s needs with cultural competency and experience.

I remember one psychiatrist who should not have been trying to treat my then-3-year-old, newly with me and highly energetic. Granted, my son was doing a handstand in his chair, but “there’s always medication” was hardly a thoughtful first response. That is exactly the response that makes parents suspicious of medication recommendations. I gradually realized that he had no life or other experience to inform his interpretations of what my son needed.

A clinical social worker I interviewed as a possible family resource casually asked where I lived. She recoiled in horror, saying “That must be really dangerous.” Thank goodness for the preview.

Even basic testing and educational evaluation that helps direct mental health care can be flawed if the evaluator builds in biases. When my then-4-year-old settled in to name drawings on flash cards, he rattled off, “Car, tree, house—hey, Mama, why does that house have such a big trash can?” Do you know the answer? How many little kids in DC would get that? How many other questions give a flawed portrait of a child?

At 12, one son was being evaluated for suspected learning disabilities. The psychologist urged me to skip testing, saying boys like him could get along, as long as he got C’s. I asked her if she’d read his other scores. She clearly had not. Her prejudice had prevented her from seeing superior reading and intelligence scores. What damage had she inflicted on other boys of color?

Even surgery can affect mental health and development. Babies need to learn to suck and swallow as part of language and cognitive development and to comfort themselves.
When my baby, who had been hospitalized for many months, was whisked away for a planned operation, and the surgeon failed to notify me, he didn’t know that she had just regained the ability to console herself by sucking a preferred thumb. She woke up in an unfamiliar place with no familiar people. As I learned later from the nursing staff, the surgeon’s complete indifference to my concerns was not new and was a reflection of his racist attitudes.

We have a lot of work to do. But a note I found from Son 2 when I was assembling the material for this piece said, “Say hi to NAMI DC.”

And that reminds me that NAMI DC gives safe harbor to so many of us from every part of DC, so that we have the strength to keep fighting for better care.

Susan Ousley serves on NAMI DC's Board of Directors as Secretary. She volunteered for 30 years in tutoring programs while also working for the DC government.

Disparity in Mental Health Services for Marginalized Groups

By Wilda Black

As a result of both recent and ongoing incidents of disparity in treatment of Black people at the hands of police, there have been numerous protests not only in cities across the United States but around the world proclaiming, “Black Lives Matter.” There is a current movement in this country calling for social justice and equality for marginalized groups. Law enforcement is not the only industry in America where disparity in treatment is being felt by people in the nondominant culture. The healthcare system has its share of woes when it comes to fair and equitable treatment of poor and minority groups as well.

It is well documented in the United States and other countries that individuals from socially and economically disadvantaged backgrounds have a greater risk for a shorter life span, poorer health outcomes, and a higher probability of experiencing limitations in achieving their overall potential in life (Williams, 2014). Racial discrimination and low socioeconomic status are root causes of psychological distress, and people at the bottom of the salary scale have a two-to-three-times higher risk of suffering from mental health disorders (Smith, 2015). As a result of social circumstances, racial and ethnic minorities are at greater risk for developing mental health disorders than non-Hispanic White people (Safran, Mays, et al., 2009).

July is recognized as National Minority Mental Health Awareness Month, and this article aims to bring awareness of social injustice in the healthcare industry and disparity in mental health treatment for minorities, to cite the future impact of demographic changes on the larger society, and to provide needed strategies for improvement. The information in this article is based largely on the work by Smith (2015).

Impact of Treatment Disparity on the Changing Demographic

Healthcare is a rapidly changing industry, and as a result, healthcare professionals are tasked with keeping current to render care that is aligned with best practices to meet the
Barriers to Care, Especially for Ethnic, Racial, and LGBTQ+ Minority Groups

- No insurance, underinsurance
- Mental illness stigma (often greater among minority groups)
- Lack of diversity among mental health care providers
- Language differences
- Distrust of the healthcare system
- Inadequate support in social service and healthcare settings for mental health services

Inequalities in areas such as access to care, inadequate health insurance, and poverty (McNally et al., 2019). The current trend in a changing demographic will result in an even greater overall poorer health status of the American population if this problem is not adequately addressed. In just 24 short years, it is estimated that the majority of the United States will consist of minorities (McNally et al., 2019).

Disparity in Quality of Mental Health Services

According to the National Alliance on Mental Illness (Carrasco, 2014), despite substantial strides in treatment modalities and new discoveries in mental health care, Black Americans have not benefitted from these breakthroughs in the same manner as White Americans. The U.S. Surgeon General’s Report (Carrasco, 2014) states that Black people are less likely to receive mental health services than their White counterparts, and even when they do acquire mental health treatment, the quality of care rendered has serious gaps and is inferior to care received by Whites, even when adjustments are made for income status, insurance coverage, age, and educational levels. “To illustrate, findings from the 2012 Agency for Healthcare Research and Quality’s “National Healthcare Disparities Report” showed that health-care quality and access for minority groups and low-income populations continues to lag behind other groups.” (Phillips & Malone, 2014, p. 46).

Disparity in Mental Health Care Due to Cultural Incompetence

African American clients express feeling culturally misunderstood and are discontented with mental health treatment (Carrasco, 2014). Reports of scarce services and unsatisfactory encounters with culturally incompetent providers substantiate the disparity in mental health care for people of color (Smith, 2015). According to NAMI (Carrasco, 2014), healthcare providers may contribute to the disparity in mental health services to minorities through actions that reflect prejudice, bias, and stereotyping. Black people are less likely to seek counseling services and are more likely to receive treatment at later stages in the disease process (Hatcher, 2012). African Americans are at greater risk of misdiagnosis and have shown a greater tendency to terminate services prematurely (Carrasco, 2014; NAMI, 2012).

Strategies to Reduce Disparities in Mental Health Treatment

To adequately address disparity in mental health care to minorities, increase financial coverage for minorities, reduce stigma in communities of color, improve the cultural competence of practitioners, and improve the quality of care will require the following: social justice that includes the acknowledgement that sociopolitical oppression and its negative impact on minorities is a reality; and a fair and equitable redistribution of resources, rights, and responsibilities to all members of society (Crethar, Torres-Rivera, & Nash, 2008). Social justice competencies must be integrated in professional codes of ethics. Counseling, social work, and psychology training programs must acquire educators and trainees from minority social groups and restructure curricula reflective of diversity and inclusion (Beer, Spanierman, Greene, & Todd, 2012). Mental health care providers must work collaboratively with clients and create a climate of social justice, multicultural practices, and patient advocacy (Chang, Crethar, & Ratts, 2010). Given the rapidly changing demographic in America, and the current
social injustice and disparity in mental health services for minorities, implementing these strategies will improve the health of minority communities and the overall wellness of this great nation, both now and in the future.

Hatcher, L.S. (2012). African Americans are less likely to seek mental health treatment. HIV Clinician, 11.

My name is Wilda Black, and I have been a member of the NAMI-DC Board of Directors for about two and a half years. I have been a registered nurse for 37 years. I am a veteran; I served in the United States Air Force Nurse Corps for seven years. I am currently enrolled in a doctoral program at Capella University. I have been working in nursing education for the past 14 years, and I have taught mental health for 12 years in both Washington DC and Virginia. My goal for being a member of the BOD is to advocate for underserved populations with serious mental illness through public policy development, supportive services, and outreach education. These strategies will serve to reduce stigma and marginalization related to mental illness and will promote prevention and recovery for individuals and families who are affected.

Race, Class, and Mental Health Services in These United States

By Lark Catoe-Emerson

This time of civil unrest and a health crisis has brought so many emotions and enlightenment along the way. As an Asian woman raising two teenagers that are biracial, one with Autism and the other with ADHD, I have been pushed to my limits as a mom trying to make sure my kids pass their classes. Keeping up with my work responsibilities along with my home life has always been a struggle, but now it is without the school supports we were used to.

Our conversations about race and healthcare haven’t changed from before the pandemic and protests. These were issues we lived with and thought about all the time. My 17-year-old has always asked, What other countries could provide better healthcare? Will you help me figure out medication and therapists? These issues have always been a concern and, sadly, I always find myself disappointed with American health care, especially mental health services.

Two years ago, former United Nations Secretary General Ban Ki-moon denounced the United States’ healthcare system as politically and morally wrong, and urged American leaders to enact publicly financed healthcare as a “human right.” * Don’t get me started about the other 23 United Nations articles of human rights the United States lacks when it comes to education and housing.

For my own mental health services, I have had so many social workers. Therapists and psychiatrists have been completely unrelatable for me and my kids. And just as the education system is filled with White professionals,
so is the mental health specialty. Not only do the same old politics play a role of offering no substantive change, but no effort is being made to fix a very broken and disconnected system for a population that is only seeking stability.

I will always be an advocate for unpopular populations, the “welfare moms” and people with mental illness, as well as elderly people. The stigma that surrounds them also contributes to the poor policies claiming to support them. Since America is super focused on Black lives and how much they matter, I hope these conversations we are finally having will awaken people’s eyes further to how much of a broken society we are in when everything is about making a profit over assuring that the wellbeing of populations is given first priority (case in point, re-opening cities/states too soon during a pandemic and refusing to cancel rent and mortgages). Honestly, cancel all the bills and provide food stamps for folks that need them. The fact that the rich are getting richer and the poor are continually at risk of dying is disturbing, and no amount of charity can replace taxing the rich appropriately to fund effective programs and passing laws that help regular citizens.

Let’s be completely honest with ourselves. America will never get over racism until it gets its own form of therapy to finally confront its genocidal past to Native and Black Americans. And it finally respects the little guy over big money. We are not in just a race war, we are in a class war.

That is why I have always respected NAMI’s approach in respecting lived experiences towards helping and supporting people with different mental challenges, uplifting their voices in creating change. I hope that can be modeled for all types of policy changes in the coming future.


I serve on NAMI DC’s Board of Directors. I live and breathe advocating for marginalized populations who are usually not considered when policies that will affect us/them the most are discussed. I am a mom of biracial children, a transgender child with autism and another with ADHD, as well as the daughter of an adoptive mother who has paranoid schizophrenia, and I was a teenage runaway. My combined family and life experiences mean that I want to ensure no teen lives a life unheard, that the elderly are taken care of and don’t become hostage to the state and that stigma doesn’t keep people from seeking help.

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**Thank you**

to everyone who is supporting NAMI DC during these difficult times. The need for the support and information that we provide continues to grow with the uncertainty, isolation, and anxiety we now face.

We ask only those of you who are not experiencing financial hardship—for we know that many are—to help NAMI DC survive the pandemic and continue its mission.

You can give at [www.namidc.org/donate](http://www.namidc.org/donate), or send your contribution to NAMI DC at 422 8th St SE, Washington, DC 20003. And thank you!

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**Celebrate Recovery**

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**Online Presentations from NAMICon 2020 Available—”Together Toward Tomorrow”**

If you were unable to watch NAMI’s online convention in mid-July, you can still browse the program for presentations that may interest you—whether updates on research, improvements in quality of care, interventions for young people, or the latest federal legislative and policy initiatives.

Sessions are online at


But don’t delay, the recordings are available only until August 23.
OUT AND ABOUT—NAMI DC at Work

Covid-19 notwithstanding, life goes on. NAMI DC volunteers are working virtually to support, serve, and advocate. While the office remains closed, the helpline is active at 202-546-0646, and all events and support groups have moved online.

President Jean Harris gave an online talk on “Racism and Mental Health Outcomes” to Capital Clubhouse International of Washington and contributed to four NAMI webinars on race relations and mental health. Other NAMI DC members participated as well.

Mrs. Harris and member Judy Barr, with Father Andrew Wakefield, spoke on the panel “Mental Health and Faith During Coronavirus” for the Archdiocese of Washington’s Department of Special Needs Ministries.

With NAMI DC members Christina Bejan and David Thurston, Mrs. Harris participated in a Mental Health Awareness, Poetry, and Conversation online event hosted by Michael Anthony Ingram, a former NAMI DC Board member.

Online Support Groups
For information and to register for a support group, contact Bob Thurston at treasurer@nami dc.org. Thanks to Bob for arranging NAMI DC’s virtual meetings and to the Family Foundation for helping to fund the transition with a grant of $450!

In Our Own Voice—Fighting Stigma
In Our Own Voice presentations change attitudes and assumptions about people with mental health conditions. They provide a personal perspective, as leaders with lived experience talk openly about what it’s like to have a mental health condition. In June, Sarah Strenio and Janiene Ausbrooks presented In Our Own Voice to 25 police cadets at the DC Consortium of Universities Campus Public Safety Institute. The webinar was hosted by American University. To schedule a virtual In Our Own Voice presentation for your staff, civic group, or place of worship, call 202-546-0646.

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DC’s 2021 Budget—Belt-tightening for Behavioral Health Services in the Community

In this time of reduced revenues and greatly increased social and economic need, the Council faced difficult choices when it reviewed the Mayor’s proposed 2021 budget. Among other cuts, the administration proposed to reduce the Department of Behavioral Health operating budget by 7.7% from this year’s budget (about 1% lower than actual expenses were in FY2019).

The $104.4 million budget proposed for operation of St Elizabeths Hospital contained a $3.8 million increase. An increase of $987,000 was proposed for the Comprehensive Psychiatric Emergency Program, for a total of $12.3 million, but with no increase in staffing. CPEP provides 24/7 emergency psychiatric services, extended observation and stabilization care for people in crisis, and mobile crisis response for people in the community, including those without homes, for a total budget of $12.3 million.

The administration proposed to cut local dollars for community-based behavioral health rehabilitation services by $9.4 million, which would also significantly reduce federal Medicaid matching funds. Reimbursement rates for community service agencies were not increased. The reduction in funds for community-based DBH services was a matter of concern for the Committee on Education, because it jeopardized expanding on-site mental health services to all schools. So, the committee cobbled together $9.5 million from other sources to fill the gap. This restoration of funds was reported and accepted at the full Council’s budget meeting, but Chairman Mendelson postponed the Council’s final budget vote to a later meeting.

When the full Council reconvened, its majority had decided to forego a previously approved 3% advertising tax. Additional cuts were thus required, and $4 million from the behavioral health rehabilitation budget was among them.

The Washington Post quoted Council Chairman Mendelson as saying he “removed some funding for mental health services because it was less likely to be spent than funding for other areas.” He pointed out that the Council had provided $5.5 million more than the Mayor had proposed for community-based behavioral health rehabilitation.

The revised economic and revenue projections that are now coming out are expected to require further cuts in the city’s 2021 budget.

Progress on a Unified Health Crisis and Suicide Prevention Telephone Number

On July 16, NAMI thanked the Federal Communications Commission (FCC) for formally designating 988 as a nationwide 3-digit number for mental health crisis and suicide prevention services. The implementation plan approved by the FCC establishes a two-year timeline to make 988 operational nationwide (by July 16, 2022), with calls routing through the National Suicide Prevention Lifeline. Two years will allow telecom providers sufficient time to address technical issues and ensure a smooth nationwide implementation.

“Once fully implemented, 988 will save lives and is a critical component to ensuring people in crisis are diverted from involvement in the criminal justice system and connected to appropriate services and supports,” said Daniel H. Gillison, Jr., NAMI CEO. “The FCC has done its part. Now, it’s time for the House to do theirs.”

NAMI is now focused on the U.S. House of Representatives’ passage of the National Suicide Hotline Designation Act of 2020. In May, the Senate unanimously passed S. 2661, which provides a way to fund the 988 infrastructure and crisis response services and is essential for 988’s success.

NAMI encourages people to contact their U.S. Representative at https://nami.quorum.us/campaign/26570.

Important Note: 988 is not currently active. If you are experiencing a crisis, call the Suicide Prevention Lifeline at 1-800-273-8255.
Crisis Intervention and Jail Diversion: Raising the Bar

Many families in the District have had to make that gut-wrenching decision—whether to call the police when a loved one’s behavioral health crisis is out of hand. For families of color and other minorities, these decisions are even more difficult.

Calling on law enforcement may bring involvement with the criminal justice system, public humiliation, trauma that can exacerbate illness, and loss of freedom, but loss of life is the risk we fear most. While thousands of police responses are handled safely, there are exceptions, and the exceptions carry a high price.

Crisis intervention team (CIT) training educates police about mental illness and improves their skills in handling crises. Widely accepted, CIT reduces arrests of people with mental illness. It has also been shown to reduce officer injuries and police time spent on mental health calls.

Crisis Intervention Evolves

The intent of CIT training was to provide specialized “crisis intervention teams,” highly motivated and specially trained to de-escalate behavioral health crises and other domestic disputes. In practice, however, the training has often been adopted as a module in cadet training, for all police, and its impact on practice varies. Another approach to crisis response that is often suggested is to send a behavioral health professional or a peer support worker, or both, with the police when they respond to a mental health call. In such cases, however, the policies of the police department (on handcuffing, transport, disposition) still govern the response.

Most recently, NAMI and others have called for more reliance on behavioral health crisis hotlines and mobile crisis outreach teams as first responders, allowing behavioral health professionals to judge when law enforcement assistance is needed. To make this system work, greater integration and cooperation are needed between behavioral health crisis staff and law enforcement at the departmental and line staff levels. When mobile crisis teams respond, the person in crisis has immediate access to treatment professionals and to medical transport if needed; can be triaged into the appropriate care situation, such as a psychiatric appointment or a crisis unit; and avoids the trauma and stigma of criminalization.

Upgrading Crisis Hotlines and Responses

Several NAMIcon presentations explored crisis intervention and decriminalization. In one, the head of Georgia’s statewide crisis response system described their operations. Equipped with the latest communications and GPS technology, the center is fully staffed with 16 Master’s level behavioral health professionals, who utilize onsite peer staff as appropriate. The integrated system can access the schedules of doctors and clinics, enabling appointment scheduling while the caller is still on the line. A caller may simply require a supportive conversation with a peer or

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NAMI AND ALLIES RESPOND TO PRESIDENT’S EXECUTIVE ORDER ON POLICING

Section 4 of the executive order addresses police response to mental illness, substance use disorders, and homelessness. It directs the U.S. Department of Justice, in partnership with the Department of Health and Human Services, to train law enforcement and identify resources for law enforcement agencies to hire social workers.

While NAMI has long supported providing law enforcement with training to assist during a mental health crisis, we have also advocated for communities to develop robust crisis response systems that significantly reduce the need for law enforcement interventions.

This joint letter stresses that the executive order does not go far enough to reduce the role of law enforcement in communities’ crisis response. The letter encourages the federal government to allocate resources that help develop crisis systems and improve the capacity of the behavioral health system to respond in times of crisis.

(see page 10)
NAMI and Other Advocates Call for Federal Support
to Transform Behavioral Health Crisis Response Systems

AN OPEN LETTER IN RESPONSE TO THE PRESIDENT’S EXECUTIVE ORDER ON SAFE POLICING FOR SAFE COMMUNITIES

SECTION 4. MENTAL HEALTH, HOMELESSNESS, AND ADDICTION

We are encouraged by the focus of the President’s June 16th Executive Order on shifting responsibility to address the needs of individuals with mental illnesses and substance use disorders, and those experiencing homelessness, away from law enforcement to appropriate social service providers. However, increasing the capacity of social workers and other mental health professionals to work alongside law enforcement to co-respond to address situations does not go far enough in reducing the role of law enforcement. We encourage the Administration, the Bureau of Justice Assistance (BJA), the Substance Abuse and Mental Health Services Administration (SAMHSA) and other federal agencies to provide leadership and funding to communities across the country working to develop crisis system capacity so that behavioral health system providers are available to address urgent and emergent behavioral health needs independently of law enforcement services and only engage law enforcement assistance when indicated by safety or criminal concerns. Crisis Intervention Team (CIT) programs; International Association of Chiefs of Police (IACP) One Mind Campaign; Police, Treatment and Community Collaborative (PTACC); Law Enforcement Assisted Diversion (LEAD); and other models of law enforcement/behavioral health partnerships support collaborations that transform crisis response systems to minimize law enforcement involvement while ensuring that police and behavioral health providers are prepared to co-respond to situations only when necessary.

As we build capacity of the behavioral health system to take primary responsibility for responding to urgent and emergent behavioral health crises, we must ensure that communities of color benefit equally from the expansion of behavioral health system capacity and reduction in the role of law enforcement in behavioral health crises. While current attention is focused on law enforcement, the disparities and discrimination present in the health and behavioral health care systems are well documented. This must be addressed as we move forward in reimaging the role of law enforcement and support the capacity of behavioral health and social services to take on the role that is more appropriately theirs. Engaging and supporting the involvement of members of the most impacted communities will be critical to service planning and provision and holding systems accountable. We must all take an advocacy role to address inadequacies and stigma.

The need for change is immediate and it will be necessary to allocate funding and expand the capacity of behavioral health and social services independent of law enforcement funding. We encourage the Administration and all federal, state, county and municipal agencies to take a thoughtful, incremental and data-driven approach to expand the availability of evidence-based services. This will ensure individuals experiencing behavioral health crises receive optimal responses while minimizing law enforcement involvement whenever possible. We, the undersigned organizations, stand ready to assist.
Take the 2020 Census to Make Mental Health Count

This year, the federal government is holding the 2020 U.S. Census, and we need your help to make sure that Mental Health Counts!

NAMI’s new chief executive officer, Daniel H. Gillison, Jr., delivers the NAMI census message at

https://www.youtube.com/watch?v=z95xRllfQc4&feature=youtu.be

The census count happens every 10 years, and it helps federal, state, and local governments distribute resources for important services, including resources that help people with mental illness, like housing, Medicaid, and transportation.

To make sure our community gets the resources it deserves, we need you to make sure you are counted.

Your household should have received a letter from the U.S. Census Bureau with instructions on how to fill out the census.

Only one person in your home may complete the census. You can respond online, by phone, or through the mail. The census form is available online and by phone in English and 12 additional languages. If you have a loved one who is currently living somewhere else, visit NAMI’s website to learn how they will be counted.

The census will ask you about things like your name, age, race or sex. Your answers will be kept secret. The census will NOT:

- Ask for your Social Security Number
- Send people to jail for not answering questions
- Ask for money or your bank account information
- Ask if you are a citizen of the United States

To learn more about how people are counted, how you can participate in the census, and how the census impacts people with mental illness, visit

www.nami.org/census.

Thank you for making sure that #MentalHealthCounts.

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NAMI DC Webinars

NAMI DC has launched a series of webinars of two kinds: to facilitate community and wellness, and to explore current issues that are important to us in the District. The first online event, on July 31, celebrated our resilience—in the face of the pandemic, racism, stigma, and other hardships. Dr. Sunyatta Amen and NAMI DC President Jean Harris discussed ways to stay well under stress. David Thurston hosted. Thank you to Courtney Dowe for her wonderful song, to Michael Anthony Ingram and to BYPO PHOENIX for their original poetry, and to Maru García for reading the poetry of her father, Everardo García Origel.

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a referral to services, visit by a mobile crisis team, crisis bed, hospitalization, or law enforcement intervention, but it is the behavioral health professional staff who triage the call and take responsibility for the outcome. The call center always keeps the caller on the line until the appropriate support is in place.

The “plugged-in” GPS-enabled communications system allows staff to arrange for services quickly and efficiently. Besides communications with police, the center staff has access to service providers’ appointment schedules and hospital bed availability across the state.

The Georgia presentation is titled “Crisis Hotlines: The Gateway to Crisis systems,” and is available until August 23 at

# Coming Up! A Free NAMI DC Webinar on De-Escalation and Use of Force in Mental Health Crises

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<thead>
<tr>
<th>2020 Update: De-Escalation, Use of Force, and How to Work with Law Enforcement, Mental Health, Legal, and Community-Based Organizations</th>
<th>Tuesday, August 11, 2020, 6:30 — 8:30 pm</th>
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<td>We invite you to a conversation about crisis de-escalation, decriminalization of mental illness, and jail diversion as now practiced in the District of Columbia. We’ve assembled a panel representing many perspectives on crisis intervention.</td>
<td>Bring your experiences, questions, and concerns to the table!</td>
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<td>The webinar is intended for persons living with mental illness and their families, peer specialists, community support workers, public defenders, law enforcement and security officers, and others who may be involved in a mental health crisis and its aftermath.</td>
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<td>We’ll explore these and many other questions:</td>
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<td>• Who should we call for initial contact in a crisis?</td>
<td>I. THE PERSPECTIVES</td>
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<td>• Does de-escalation work? Is it being used?</td>
<td>Panel moderated by Jean Harris, NAMI DC President</td>
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<td>• Does race influence how an officer chooses to respond?</td>
<td>• Captain Kevin Barrett, D.C. Consortium of Universities Campus Public Safety Institute, American University</td>
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<td>• How does MPD partner with mental health professionals?</td>
<td>• John L. Davie III, Assistant Attorney General, Mental Health Section, D.C. Office of the Attorney General</td>
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<td>• How does the Department of Behavioral Health advertise its Crisis Response telephone number?</td>
<td>• Shannon Goodhue, Director, Disaster Behavioral Health, D.C. Department of Behavioral Health</td>
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<td>• Emily Gunston, Senior Counsel, D.C. Office of the Attorney General</td>
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<td>• Anthony Hall, Director Pre-Arrest Diversion Program, D.C. Department of Behavioral Health</td>
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<td>• Representative, D.C. Metropolitan Police Department (TBD)</td>
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<td>III. CLOSING AND NEXT STEPS</td>
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