**<u>JOINT COMMENTS ON</u>**
**<u>SAMHSA'S MODEL BEHAVIORAL HEALTH CRISIS SERVICES DEFINITIONS</u>**

***Submitted on behalf of the Bazelon Center for Mental Health Law and the Center for Public Representation (CPR)***

**Feedback on the 'Someone To Contact: 988 and Other Behavioral Health Lines' Element** (pp. 14-27 of Draft Definitions)

The comments below refer to both adults and children and youth.

We recommend that the definitions make clear that referral of mental health crisis calls to law enforcement should be the exception and only permitted when there is an imminent threat to the health or safety of others.

Regarding coverage and staffing (p. 15), when a call is made about a person with a mental health condition that requires attention, that call should be handled by mental health staff – either working in the mental health system or embedded in the 911, 988, or other emergency call center. That person could be a clinician or a peer with specialized training. Such mental health staff, through on-the-line counseling and advice, in some cases may be able to resolve the situation that prompted the call, including by linking people with community services. For example, in Houston, Texas, the Crisis Call Diversion Program (CCD) places mental health crisis phone counselors within 911 dispatch to provide a 24/7/365 mental health response to mental health crisis calls (www.houstoncit.org/ccd).

We recommend SAMHSA incorporate into its "someone to contact" definitions the following from earlier SAMHSA guidance: "Crisis lines that operate 24 hours a day, 7 days a week and are staffed with clinical and peer staff who can provide crisis intervention capabilities, meet National Suicide Prevention Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide, offer quality coordination of crisis care, and accept all calls and dispatch support based on the assessed need of the caller." *See* SAMHSA, Advisory: Peer Support Services in Crisis Care (June 2022).

When discussing recommended service elements (e.g., pp. 17-18), we ask SAMHSA to make explicit that when crisis call line staff provide warm hand-offs to mobile response teams, they should stay on the line with the caller until the mobile response team arrives.

Finally, for all "someone to contact" services, we ask SAMHSA to add a requirement to track as part of "Data Elements, Metrics, and Quality Measures" the number of calls that result in a response by law enforcement, arrest and detention in jail, or involuntary commitment to a hospital or mandated outpatient treatment and to make that data publicly available.

**Feedback on the 'Someone to Respond: Mobile Crisis and Outreach Services' Element** (pp. 28-45 of Draft Definitions)

These comments refer to both adults and children and youth.

HHS and DOJ have explained that the Americans with Disabilities Act and Section 504 of the Rehabilitation Act require "that people with behavioral health disabilities receive a health

response in circumstances where others would receive a health response." *See* DOJ/HHS*, Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities* 3-4 (2023). Recently, two federal courts in Oregon and Washington, D.C. agreed, finding that the use of police as default first responders to mental health emergencies, when physical health emergencies receive health responses, states a claim of discrimination under the ADA and Rehabilitation Act. *See* Findings and Recommendation, *Disability Rights Oregon et al. v. Washington County et. al*, No. 3:24-cv-00235-SB (D. Or. Aug. 30, 2024); *Transcript of Status Conference, Bread for the City v. D.C.*, No. 23-1945-ACR (D.D.C. Sept. 10, 2014), https://assets.aclu.org/live/uploads/2023/07/Bread-MTD-decision.pdf. We thus urge SAMHSA to omit language indicating that a health response, rather than a law enforcement response, merely be made "whenever possible" (p. 37).

People with behavioral health conditions are disproportionately harmed and killed when law enforcement responds to calls for help. *See* SAMHSA, National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit at 68, 33 (presence of police, even best intentioned and most skilled police, often aggravates the situation). For these reasons, co-responder models should be disfavored.

Peers should be listed within the recommended "provider type" for mobile response teams, not as mere "optional service enhancements." In the nationally-recognized model CAHOOTS program in Oregon, a majority of the program's mobile responders identify as peers. *See Peer-Led Mobile Crisis Response: How It Works* (June 2021), https://peoplesbudgetgreenfield.com/cahoots/.

For Mobile Response and Stabilization Services (MRSS) for children and youth, we ask that SAMHSA expand the "target population" from the current very narrow formulation on p. 42. We recommend that the eligibility criteria be defined broadly or not at all, as there are no proposed eligibility criteria for the adult mobile response services. SAMHSA should make clear that mobile response teams should provide warm hand-offs and direct linkage to longer-term services to prevent future crises.

**Feedback on the 'A Safe Place for Help: Crisis Stabilization Services' Element** (pp. 46-78 of Draft Definitions)

Places to go should be accessible and inviting to those experiencing crises, their families, and their community supports. This is best achieved by scattering small home-like "places to go" in communities with the greatest need. They should be staffed by peers and professionals and include: peer respite centers (pp.69-70); staffed crisis apartments; or 23-hour urgent care centers that use the "living room" model. *See* SAMHSA, *Nat'l Guidelines for Behavioral Health Crisis Care* 8 (2020); DOJ/HHS, *Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities* (May 2023) ("DOJ/HHS 2023 Guidance"). SAMHSA should make clear that other settings (like on pp.50-57) are generally not the most integrated setting appropriate and should only be used in rare circumstances.

We urge SAMHSA to add crisis apartments to the described “safe places for help.” Crisis apartments were developed to ensure that crisis services can be provided in an integrated setting and, in particular, “home-like, non-hospital environments[s].” SAMHSA, *Nat’l Guidelines for Behavioral Health Crisis Care* 12 (2020). Crisis apartments are an effective and critical option for a “safe place for help,” as recognized by SAMHSA and DOJ. *See* DOJ/HHS 2023 Guidance. Crisis apartments have also been included as an appropriate and necessary service to remedy an Olmstead violation. *See* Settlement Agmt in *Amanda D. v. Hassan*, Civ. No. 1:12-cv-53-SM (D.N.H. 2014).

SAMHSA also should recognize that peer respites are appropriate for people experiencing acute symptoms (pp.47-49). *See* Sarah Kwon, California Healthline, *‘Peer Respites’ Provide an Alternative to Psychiatric Wards During Pandemic* (2021); Nat’l Empowerment Ctr, Directory of Peer Respites (listing for CSPNJ Wellness Respite Service).

Hospital-like crisis stabilization units (e.g., pp.50-67) are generally not the most integrated setting, especially for children and youth. *See* NASMHPD, *A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth* (2022) 6, 10-13. Stabilization services should be provided in the home or community (e.g., school), unless it is not safe to do so. We therefore ask SAMHSA, for example, to remove “and appropriate” from p.73, which may unduly expand out-of-home stabilization for children and youth. Crisis foster homes, including short-term treatment foster homes that are not part of the child welfare system, should be available to children and youth.

**Any additional comments or feedback?**

We appreciate SAMHSA’s recognition that centering peers in mental health crisis service delivery reduces hospitalization rates, lengths of stay, future crises, and criminal system involvement, and promotes participation in community services. *See, e.g.*, SAMHSA, *Peer Support Services in Crisis Care* (2022); SAMHSA, *Peer-run Respites: An Effective Crisis Alternative*. We recommend SAMHSA revisit the summary tables at pp. 15-16, 29-30, 47-49 to identify additional settings that could benefit from incorporating peers.

We urge SAMHSA to make clear that crisis services should be available 24/7/365, timely provided (at least as timely as a police response would be) (pp. 31-32), trauma-informed, and culturally responsive. *See* SAMSHA, *Trauma-Informed Care in Behavioral Health Services* (2014). For MCT (pp. 31-32) and MRSS (p. 40), we ask SAMHSA to designate 24/7/365 coverage as “required,” rather than “preferred.”

In each instance of “suggested data elements,” we ask SAMHSA to: (1) track disability & disability type (e.g., mental health, physical, visual, auditory, developmental/intellectual) as part of “demographics;” (2) disaggregate “sentinel event” to separately track serious injury by self, serious injury by another, death by self, death by another; and (3) to make that data publicly available.