JOINT COMMENTS ON
SAMHSA'S NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISIS CARE 2025

Submitted on behalf of the Bazelon Center for Mental Health Law, ACLU (Disability Rights), the Disability Rights & Education Defense Fund (DREDF), and the Center for Public Representation (CPR)

Feedback on the overall framing and the overarching principles for a Behavioral Health Coordinated System of Crisis Care (pp. 12-22 of the Draft Guidelines)

The Bazelon Center, ACLU, DREDF, and CPR appreciate SAMHSA's attention to the elements required to establish and maintain an effective behavioral health system of crisis care, including that it be person-centered, trauma-informed, and responsive to individuals' needs. In addition, we ask SAMHSA to incorporate into its National Guidelines 2025 critical text from its National Guidelines 2020, including: the core principle that "significant use of peers" must be "baked into" comprehensive crisis systems (National Guidelines 2020 at 13); that any out-of-home stabilization services should be provided in "home-like, non-hospital environment[s]" and should generally be short-term (under 24-hour) services (National Guidelines 2020 at 12); and the best practice that mobile crisis teams incorporate peers (National Guidelines 2020 at 18). *See* SAMHSA, *Nat'l Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

When a call is made about a person with a mental health condition in need of 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. For those situations that require an on-site response, call centers should be able to dispatch a mobile response team, which could be a mobile mental health crisis team or a non-police response team that is less medically based. Such teams should be dispatched whenever a response to a mental health call is required, unless there is reliable information that the person poses an immediate threat to life or physical safety. When appropriately staffed by mental health professionals and peers, most of those calls can be resolved in the field.

In only a relatively small number of cases should an individual need to be transported somewhere other than to their home for stabilization. And in most such cases, the individual can quickly return to the community. Places to go should be small home-like settings scattered in communities with the greatest need, be staffed by peers and professionals, and include: peer respite centers (pp. 50, 52); staffed crisis apartments (p. 52); or 23-hour urgent care centers that use the "living room" model and only provide services on a voluntary basis (pp. 53-54). See DOJ/HHS 2023 Guidance.

[Person-Centered, Family-Focused, and Provide the Right Level of Care at the Right Time]

We ask SAMHSA to include language from National Guidelines 2020 into National Guidelines 2025 that crisis services should be available 24 hours a day, seven days a week, 365 days a year. *See* National Guidelines 2020 at 26 (discussing importance of a 24/7 clinically staffed crisis call center for those experiencing mental health crisis). Accordingly, we ask that SAMSHA designate that 24/7/365 coverage for MCT (p. 37) and MRSS (p. 41) is "required."

We agree that "communities should ensure timely access to services and strive for short wait times and high response rates for services" (p. 14). We urge SAMHSA to make clear that the

response rates to 911 calls for mental health crisis services be no less than, and the wait times no more than, for an EMT or paramedic response to a physical health crisis. In other words, crisis services for mental health should generally respond as timely as crisis services for physical health.

[Equitably Accessible and Responsive to Diverse Needs]

We appreciate SAMHSA recognizing the importance of language access (pp. 16-17). As required by federal civil rights laws, people who speak languages other than English (including American Sign Language (ASL)) should be able to communicate effectively with hotlines, warmlines, and text lines, and with mobile crisis teams and the staff of crisis respite homes or apartments. This can be accomplished through staff members with fluency in the individual's language or by using in-person or virtual interpretive services. *See, e.g.*, SAMHSA, Culturally Competent LEP and Low-literacy Services (Mar. 16, 2023) ("Entities that receive federal funding must take reasonable steps to ensure access to services for people with limited English proficiency (LEP)"). The U.S. Department of Justice (DOJ) provides helpful guidance and has issued interpretive regulations implementing the Americans with Disabilities Act (ADA) regarding the requirements for public entities to provide effective communication to people with disabilities. *See* https://www.ada.gov/topics/effective-communication/.

[Prioritize Quality and Effectiveness]

Crisis services should strive to ensure that people who experience a mental health crisis avoid emergency room visits, hospitalization, involuntary detention, and arrest or incarceration in jail, as well as achieve stability in their housing, and participate in work or recreational activities. *See See* SAMHSA, Advisory: Peer Support Services in Crisis Care at 1, 5-6, 9 (June 2022), https://store.samhsa.gov/sites/default/files/pep22-06-04-001.pdf. As SAMHSA recognized in its National Guidelines 2020 at p.13, these outcomes should be measured and adjustments should made if they are not being achieved. *See also* Consent Decree, *U.S. v. Louisville*, paras. 307-18, 326-30, 344-50 (Dec. 12, 2024), https://www.justice.gov/crt/media/1379951/dl (requirements for engaging in regular quality review activities and revising policies and practices accordingly).

Additionally, repeated visits from a mobile crisis team or to a crisis home suggests that an individual is not receiving needed services, and hence their services need to be reviewed and revised. *See* National Guidelines 2020 at 21 ("Appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that . . . will prevent future relapse."). We urge SAMHSA to include this language in the National Guidelines 2025.

We appreciate SAMHSA including that data should be disaggregated "by age, race, ethnicity geography and sexual orientation and gender identity SOGI variables, among other demographic metrics" (p. 17). We ask SAMHSA to additionally disaggregate by populations identified in Section D (p. 17), including immigration status, housing status, and physical, mental, or intellectual or developmental disability.

We appreciate SAMHSA recognizing the importance of "tracking the number of instances that trigger law enforcement and child welfare involvement" (p. 17). It is also important to track the number of crisis calls that result in arrest and detention in jail or involuntary commitment. We ask that SAMHSA make tracking these numbers a requirement, and that this data be disaggregated by the communities/identities listed on p. 17, and be made publicly available. We also request that future toolkits on data collection require disaggregation of "sentinel events" (as

mentioned on p. 18) to separately track serious injury by self, serious injury by another, death by self, death by another, and to make that data publicly available.

[Have a Component of Follow-Up Care and Services for Linkage]

We appreciate SAMHSA's attention to the need for crisis systems to effectively link individuals to ongoing services (pp. 20-21). Engaging individuals in thinking about the services they may need and then connecting them to those services are important functions of a crisis system.

We thus encourage SAMHSA to include language from the National Guidelines 2020, including: "[d]uring a mobile crisis intervention, the [behavioral health professional] and peer support professional should engage the individual in a crisis planning process; resulting in the creation or update of a range of planning tools including a safety plan. When indicated, mobile crisis providers should also follow up with individuals served to determine if the services to which they were referred were provided in a timely manner and are meeting their needs" (National Guidelines 2020 at 21), and "[a]ppropriate crisis response . . . address[es] the person's unmet needs" (National Guidelines 2020 at 21).

Feedback on Behavioral Health Crisis Services: Three Essential Elements (pp. 22-56 of the Draft Guidelines)

[Someone to Contact: 988 and Other Behavioral Health Lines]

Regarding "Someone to Contact" (pp. 25, 27, 29, 30): When a call is made about a person with a mental health condition who 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 another 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. We recommend SAMHSA spotlight an example from Houston, Texas, the Crisis Call Diversion Program (CCD), which 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). This is also a requirement of the recently announced Consent Decree between the United States and Louisville, Kentucky. *See* US v. Louisville Consent Decree at paras. 319, 321, https://www.justice.gov/crt/media/1379951/dl.

The ADA requires that a health care response, rather than a police response, be made to mental health crisis calls. *See* 42 U.S.C. § 12132; 28 C.F.R. § 35.130; DOJ/HHS 2023 Guidance at 3-4. Hence, SAMHSA should require, in line with earlier SAMHSA guidance, that: "Crisis lines … 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, ….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), https://store.samhsa.gov/sites/default/files/pep22-06-04-001.pdf.

Finally, when discussing warm handoffs (pp. 32, 43, 55) and what it means to "minimize caller disengagement" (p. 32), we ask SAMHSA to make explicit that when crisis call line staff provide warm handoffs to mobile response teams, they should stay on the line with the caller until the mobile response team arrives. *See, e.g.,* US v. Louisville Consent Decree at paras. 320, 401.

[Someone to Respond: Mobile Crisis and Outreach Services]

These comments on "someone to respond" refer to both adults and children and youth, except as noted.

As noted above, mobile response services should be available 24/7/365. We urge SAMHSA to provide more guidance on ways to expand existing crisis systems so that they do not rely on law enforcement, and to make clear that communities need to explore multiple avenues for expanding their behavioral health workforce so that a 24/7/365 behavioral health response can be made as quickly as a police or ambulance response, without resorting to co-responder models, which can result in many of the same harms as a solo police response. (See discussion of law enforcement involvement at p. 42). One way to accomplish this is by employing peers and people with lived experience as much as possible and offering similar pay and benefits to behavioral health crisis responders as to police, paramedics, and other first responders. Hence, we ask SAMHSA to incorporate into its National Guidelines 2025 critical text from its National Guidelines 2020, including: the core principle that "significant use of peers" must be "baked into" comprehensive crisis systems (Nat'l Guidelines 2020 at 13), and the best practice that mobile crisis teams incorporate peers (Nat'l Guidelines 2020 at 18).

We appreciate SAMHSA recognizing at p. 36 that "[p]eers play a crucial role" and noting on p. 37 that "[p]eer support specialists should be incorporated in all models of BHP-only MCT delivery." We note that just this week, the consent decree entered into by the U.S. Justice Department and Louisville Metro Government included multiple roles for "peer support specialists" in the crisis system, including as members of mobile crisis response teams. *See* US v. Louisville Consent Decree at pp. 95, 98, 235. Moreover, we urge SAMSHA to recognize that the nationally recognized CAHOOTS program in Oregon relies heavily on peers. A majority of the program's mobile responders identify as persons with relevant life experience. By one estimate, 75 percent of CAHOOTS responders have lived experience with incarceration, substance use, neurodivergence, homelessness, mental health disabilities, or other relevant life experiences. *See Peer-Led Mobile Crisis Response: How It Works* (June 2021), https://peoplesbudgetgreenfield.com/cahoots/.

[MCT Services – Co-Responder Teams]

We urge SAMSHA to include in National Guidelines 2025 that law enforcement should be deployed in response to crisis calls only when there is an immediate threat to the life or physical safety of others. *See* US v. Louisville Consent Decree at para. 319 (requiring 911 to refer all calls "about behavioral health emergencies that do not pose an immediate threat to life or physical safety" for a non-police behavioral health response). Law enforcement involvement in crisis services should be minimized and, hence, co-responder models should be disfavored.

HHS and DOJ have explained that the ADA and Rehabilitation Act require "that people with behavioral health disabilities receive a health response in circumstances where others would receive a health response." DOJ/HHS 2023 Guidance. "[F]or example, if call centers would dispatch an ambulance or a medic rather than law enforcement to respond to a person experiencing a heart attack or a diabetic crisis, equal opportunity would entail dispatching a health response in similar circumstances involving a person with a behavioral health disability." 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).

We appreciate SAMHSA recommending in National Guidelines 2025 "that communities have mobile crisis services available that do not involve law enforcement, recognizing the potential harm and stigma associated with police involvement in behavioral health crises" (p. 36). We ask SAMHSA to recognize in its National Guidelines 2025 that people with behavioral health conditions are disproportionately harmed and killed when law enforcement responds to calls for help, and that a mental health response is needed and far preferable to a police response for most mental health crises. *See* National Guidelines 2020 at 8, 19, 33 (presence of police, even best intentioned and most skilled police, often aggravates the situation), 68. There should be coordination between the crisis system and law enforcement that results in the behavioral health system "stepping up" to provide a health response to a mental health crisis, rather than an inappropriate police response. *See, e.g.*, DOJ/HHS 2023 Guidance at 3-4.

We also recommend SAMHSA incorporate into the National Guidelines 2025 key components of the Consent Decree between DOJ and Louisville, required for compliance with the ADA, including the "Key Objective" that jurisdictions provide "an emergency response to people experiencing a behavioral health crisis that includes the most behavioral health-involved and least police-involved response appropriate and consistent with public safety," and requiring 911 or other dispatchers to refer all calls "about behavioral health emergencies that do not pose an immediate threat to life or physical safety" for a non-police behavioral health response. *See* US v. Louisville Consent Decree at paras. 307, 319, 350.

[Children and Youth Mobile Crisis Services]

Crisis services should be available to all children and youth who need them. We appreciate SAMHSA's strong recommendation that youth crisis care systems prioritize keeping youth in their homes, providing developmentally appropriate services and supports, integrating family and youth peer support, and providing culturally and linguistically appropriate services (p. 40). We also appreciate that SAMHSA has highlighted the importance of in-home stabilization, noting that "[i]f it is safe for the young person and their family, every effort should be made to help them stay in their current living environment" (p. 40). This is critically important. We also agree that mobile crisis providers who serve children and youth should have specialized training and expertise in working with children and families (pp. 40-41).

[A Safe Place for Help: Crisis Stabilization Services]

Places to go for help 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 and, both for clinical effectiveness and participant utilization, by only providing services in those settings on a voluntary basis and with the informed consent of the individual. They should be staffed by peers and professionals and include: peer respite centers (pp. 50, 52); staffed crisis apartments (p. 52); or 23-hour urgent care centers that use the "living room" model and only provide services on a voluntary basis (pp. 53-54). *See* DOJ/HHS 2023 Guidance.

We ask that SAMHSA 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).

SAMHSA should make clear, as it did in its 2020 Guidelines, that any out-of-home stabilization services should be provided in "home-like, non-hospital environment[s]," and should generally be short-term (under 24-hour) services. *See* National Guidelines 2020 at 12. Hospital-like crisis stabilization units (such as those described on pp. 46-48, 51) and longer-term "crisis residential programs" (such as those described on pp. 46-49, 54) are generally not the most integrated setting appropriate and should only be used in rare circumstances, if ever. We are concerned that SAMHSA has included considerably more hospital-like settings in its National Guidelines 2025 than it did in its National Guidelines 2020, at risk of undermining its recognition that these are not the most integrated setting appropriate as required by federal law or the most effective setting for most people.

This is especially true for children and youth, who should receive services, including crisis services, primarily in a family setting. Stabilization services should be provided to children and youth in the home or community (e.g., school), unless it is not safe to do so. *See* NASMHPD, *A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth* (2022) 6, 10-13. Any services provided in "facilities" should generally be for less than 24 hours. We therefore ask SAMHSA to remove the reference to "short-term crisis residential centers" for children and youth described on p. 54, and recommendation that facilities provide out-of-home stabilization up to "two or three weeks" (p. 54). Instead, for the small number of children and youth who cannot be safely stabilized in their homes, we urge SAMHSA to recommend the provision of small, non-institutional, home-like settings, such as crisis homes, family respite (p. 53), and crisis foster homes (which are short-term treatment foster homes that are not part of the child welfare system, *see* NASMHPD, *A Safe Place to Be* at 20).

Feedback on Developing a Behavioral Health Coordinated System of Crisis Care (pp. 56-84 of the Draft Guidelines)

We appreciate SAMHSA's recognition in the National Guidelines 2025 that behavioral health crisis services are a critical and equal component of a crisis system that "provides the necessary emergency capable services" for communities. *See* National Guidelines 2025 p. 73 ("This investment is critical because an effective CSCC serves everyone, saves lives, and creates healthier communities, just as other essential services such as police, fire, and EMS do."). A critical element of this is, as SAMHSA notes, that emergency responses be generally available regardless of the ability to pay, admissions criteria, or clearance protocols. *See* National Guidelines 2025 p. 9 ("As with public safety and emergency medical situations, behavioral health emergency response capability should be present across contact centers, mobile response, and stabilization settings to help ensure access to services and parity within the CSCC.").

Any additional comments or feedback?

We recommend SAMHSA incorporate into the 2025 National Guidelines key components of the Consent Decree between DOJ and Louisville, required for compliance with the ADA, including the "Key Objective" that jurisdictions provide "an emergency response to people experiencing a behavioral health crisis that includes the most behavioral health-involved and least police-involved response appropriate and consistent with public safety," and requiring 911 or other dispatchers to refer all calls "about behavioral health emergencies that do not pose an immediate threat to life or physical safety" for a non-police behavioral health response. *See* US v. Louisville Consent Decree at paras. 307, 319, 350 (https://www.justice.gov/crt/media/1379951/dl). The Decree also requires that behavioral health

triage workers (who may be a Peer Support Specialist) be embedded in the dispatch call center to receive 911 calls 24 hours a day. *See* US v. Louisville Consent Decree at paras. 319, 321.