Statement for the Record of the Bazelon Center for Mental Health Law for March 31, 2025 Roundtable Hearing on "Supporting Humane and Trauma-Informed Responses to Behavioral Health Crises" Resolution

D.C. Council Committee on Health

April 11, 2025

The Bazelon Center for Mental Health Law appreciates this opportunity to provide testimony to the Committee regarding a more coordinated and effective response to behavioral health crises in the District. For the reasons explained below, the Bazelon Center urges the Committee not to expand the number of "beds" for crisis stabilization. Instead, we ask the District to invest in small, home-like "places to go" for brief periods of time, like the respite centers proposed by the Committee, and to focus primarily on expanding and improving its delivery of community-based mental health services for both adults and children.

The Bazelon Center is a national organization based in Washington, D.C. that advocates for the civil rights, full inclusion, and equality of people with mental disabilities, including mental illness, as well as intellectual and developmental disabilities. The Center played a key role in *Olmstead v. L.C. (Lois Curtis*,[1] in which the Supreme Court held that under the Americans with Disabilities Act (ADA) people with disabilities have the right to live and receive services in their own homes and communities and to be free from unnecessary institutionalization. The Center also led numerous class actions advancing these principles in mental health systems, including *Dixon v. Gray*, which led to thousands of institutionalized District residents with mental health disabilities transitioning to living and receiving services in the community, and *M.J. v. District of Columbia*, a federal putative class action on behalf of District children and youth with significant mental health challenges seeking intensive community-based services so they can live in their homes and community, instead of being arrested, removed from their homes, or institutionalized.

The Bazelon Center appreciates the Committee's push to improve crisis response services in the District, and, in particular, its advocacy for the expansion and improvement of voluntary, community-based crisis services instead of a continued overreliance on hospitalization. However, we are concerned by the Committee's interest in expanding "community-based crisis beds" and "observation units," as such beds tend to be hospital-like and can be harmful. We urge the Committee to focus on providing access to small, home-like "places to go" for short periods of time for the infrequent occasions when someone experiencing a mental health crisis needs to be removed from their living situation. We also urge the District to expand community-based services for people with mental health disabilities, which will prevent crises from happening in the first place.

I. The District should make available small, home-like "places to go" for crises that cannot be resolved on site.

As an initial matter, the District should ensure that individuals experiencing a behavioral health crisis receive a healthcare, instead of a police, response. The U.S. Departments of Justice and Health and Human Services have explained that the ADA 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," rather than a police response.[2]

As the Committee has recognized, a crisis response system should have three key components to be effective: someone to talk to, someone to respond, and a place to go.[3] In a well-functioning crisis response system, the vast majority of mental health crises can be resolved on site or in that person's home. In the limited circumstances in which this is not the case, a "place to go" is needed.

A. Places to Go

It is important that places to go be accessible and inviting to those experiencing crises, their families, and their community supports. Most mental health emergencies can be resolved in the person's home or on site in the community. When that is not possible, the first choice should be a ***kinship setting***, temporarily taking the person to the home of a family member or friend until the crisis is resolved and the person is stabilized. If that's not possible, other places to go should be small, home-like settings scattered in communities with the greatest need. They should be staffed by peers and professionals. Such places to go generally fall into three categories: peer respite centers, crisis apartments, and urgent care centers for stays of up to 23-hours in a home-like, living room environment (often referred to as the "living room model"). We urge the District to create and use these places to go.

Peer respite centers, which the Committee references, are home-like settings in which those with lived or living experience support people in crisis, providing stabilization, future planning, and linkage to other community-based services over a short period of time.[4] Peer staff are the key to the success of respite centers.[5] As the Substance Abuse and Mental Health Services Administration (SAMHSA) has stated, "[i]ncluding individuals with lived mental health and substance use disorder experience (peers)…supports…bonding over common experiences while adding the benefits of peer modeling that recovery is possible."[6] Peer respite centers should be available 24 hours a day, 7 days a week, 365 days a year, physically accessible,[7] and voluntary.[8] They are effective for individuals experiencing acute symptoms[9] and help people avoid emergency room visits and hospitalization.[10]

Crisis apartments were developed to ensure that crisis services, like other services, are provided in "home-like, non-hospital environment[s]."[11] Staffed by clinicians and peers, such apartments provide short-term stays during which individuals receive case management, medication, counseling, and practical advice.[12] A crisis apartment should have the components any other residence would—bedrooms, living room, and kitchen—in addition to access to privacy and outdoor space.[13]

Urgent care centers, which are for stays of up to 23 hours, are most effective when they offer a small, home-like environment, based on a living room set up, where people receive immediate services from professionals and peers to resolve the crisis they are experiencing.[14] They should be calming and welcoming in design, and provide privacy without isolation for people in crisis.[15]

Such places to go can effectively de-escalate and resolve crises and avoid unnecessary hospitalization.

B. Places to Go for Children and Youth

For children and youth, it is especially important that crisis services be provided in their home or natural environment (e.g., school).[16] Crisis care can be traumatizing for children.[17] For the infrequent occasions when children and youth cannot be safely stabilized in their homes or on site in the community, Bazelon urges the District to provide: kinship settings, crisis foster homes, crisis apartments, respite services, and urgent care centers.[18]

If a child or youth cannot be stabilized at home, as with adults, the best practice is to take them to a ***kinship setting*** with family or friends, which can provide a safe place to effectively resolve a crisis in the community. This allows a child or youth to temporarily stay with a relative or close friend while receiving needed crisis stabilization services.[19] Services in a kinship setting may also be appropriate after a child or youth has been stabilized in another setting, but cannot yet safely return home.

Crisis foster homes are foster homes that are a short-term placement for a child or youth experiencing a crisis. ***Crisis apartments*** and ***peer respite centers***, as described above, may be effective for transition-aged youth or older adolescents.[20]

Urgent care centers that offer developmentally suitable supports for children and youth can also be used, as needed.[21] The child or youth should be accompanied by a parent or caregiver if possible.[22]

II. The District should avoid places to go that are institutional in nature.

To the extent the Committee is considering "beds" that would be in institutional or hospital-like settings, and unlike those described above, such facilities should be avoided.

Both nationally and in the District, institutions are rife with abuse, neglect, and mistreatment of people with mental health disabilities. Disability Rights DC, the protection and advocacy agency for the District, has published several reports in recent years detailing incidents of abuse and neglect that have occurred in the District's institutional facilities.[23] On the national level, Acadia Healthcare and Universal Health Services, which operate psychiatric institutions across the country, both recently entered into settlement agreements with the U.S. Department of Justice to resolve allegations of inadequate treatment.[24] Universal Health Services operates the Psychiatric Institute of Washington (PIW) in D.C.

Residential treatment facilities (RTFs) for children and youth are similarly riddled with abuse and neglect. In addition, the evidence is that RTFs are not successful in treating children,[25] and the separation from family is traumatic and harmful in and of itself.[26] In the District, Riverside Residential Treatment Center and Hospital faced allegations of abuse and poor treatment of children and youth[27] before it closed its doors. The District is now facing similar allegations about the Youth Services Center (YSC) and New Beginnings Youth Development Center.[28]

Additionally, unnecessary institutionalization is inconsistent with the "community integration mandate" of the Americans with Disabilities Act (ADA), our nation's landmark civil rights law protecting the rights of people with disabilities. As announced by the U.S. Supreme Court in its seminal decision in *Olmstead v. L.C.*, unnecessary institutionalization of people with disabilities is a form of disability-based discrimination.[29]

III. The District should invest in effective, community-based services, which would reduce the need for crisis stabilization services.

Critically, the District should invest in effective community-based services. The lack thereof is the root of the problems with D.C.'s behavioral health system, and increasing access to effective community-based services will decrease mental health crises.[30]

Effective community-based services—including intensive services such as Assertive Community Treatment (ACT), intensive community-based services for children and youth, intensive case management, supported housing and employment, and respite care—have an impressive record of success, reducing not only mental health crises but also criminal legal system involvement. More of these services are needed to fill existing gaps in the District's behavioral health system.[31]

IV. Conclusion

The District should ensure that individuals experiencing a mental health crisis receive a health, not a police, response. In the limited circumstances in which a crisis cannot be resolved in the home or on site, the District's "places to go" should be small, home-like settings scattered in the communities with greatest need—not institutional or hospital-like settings. To reduce mental health crises and for the reasons explained above, the District should expand and improve its provision of community-based services.

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[1] 527 U.S. 581 (1999).
[2] U.S. Department of Justice and U.S. Department of Health and Human Services, *Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities* 3-4 (2023), https://www.justice.gov/d9/2023-05/Sec.%2014%28a%29%20-%20DOJ%20and%20HHS%20Guidance%20on%20Emergency%20Responses%20to%20Individuals%20with%20Behavioral%20Health%20or%20Other%20Disabilities_FINAL.pdf. [hereinafter "DOJ/HHS Guidance"].
[3] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care* 2-3 (Jan. 2025), https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf. [hereinafter "SAMHSA 2025 Guidelines"].
[4] Bazelon Center for Mental Health Law, *When There's a Crisis, Call a Peer: How People with Lived Experience Make Mental Health Crisis Services More Effective* 11 (Jan. 2024), https://www.bazelon.org/wp-content/uploads/2024/01/Bazelon-When-Theres-a-Crisis-Call-A-Peer-full-01-03-24.pdf. [hereinafter "When There's a Crisis"].
[5] DOJ/HHS Guidance at 6.
[6] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit* 28 (2020), https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/samsha-national-guidelines.pdf. [hereinafter 'SAMHSA 2020 Guidelines"].
[7] When There's a Crisis at 12-13.
[8] SAMHSA 2025 Guidelines at 50.
[9] *See* Sarah Kwon, California Healthline, *'Peer Respites' Provide an Alternative to Psychiatric Wards During Pandemic* (Jan. 2021), https://californiahealthline.org/news/article/peer-respites-provide-an-alternative-to-psychiatric-wards-during-pandemic/; Nat'l Empowerment Ctr., Directory of Peer Respites (listing for CSPNJ Wellness Respite Service), https://power2u.org/directory-of-peer-respites/.
[10] When There's a Crisis at 38.
[11] SAMHSA 2020 Guidelines at 12 (noting that such services are an essential element of a good crisis system).
[12] SAMHSA 2025 Guidelines at 52.
[13] When There's a Crisis at 38.
[14] *See generally* DOJ/HHS Guidance.
[15] *See* Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *National Guidelines for Child and Youth Behavioral Health Crisis Care* 27 (2022), https://library.samhsa.gov/sites/default/files/pep-22-01-02-001.pdf. [hereinafter "SAMHSA Child and Youth Guidelines"].
[16] *See* SAMHSA 2025 Guidelines at 54-55; SAMHSA Child and Youth Guidelines at 25.

[17] *See generally id.*
[18] *See* SAMHSA 2025 Guidelines, 55-56.
[19] *See generally id.* at 11, 26-27.
[20] *See* SAMHSA 2025 Guidelines, 55-56.
[21] *See id.* at 56.
[22] SAMHSA Child and Youth Guidelines at 27.
[23] *See* Disability Rights DC at University Legal Services, *A Disturbing Death: Lack of Oversight at the Psychiatric Institute of Washington* (June 2021), https://www.uls-dc.org/media/1209/abuseunabatedfinal.pdf.; Disability Rights DC at University Legal Services, *Do No Harm: Multiple Incidents of Abuse and Neglect at the Psychiatric Institute of Washington* (July 2022), https://assets-global.website-files.com/65792ba62c7815e2cdc139a2/65f22c754f8fbd542831e786_piwreport72022.pdf.; Disability Rights DC at University Legal Services, *Unsafe and Unprotected: Neglect at the Psychiatric Institute of Washington* (July 2024), https://cdn.prod.website-files.com/65792ba62c7815e2cdc139a2/668e98843b8fcf2a8aa8190d_DRDCPIWReport7.10.24.pdf.
[24] *See* Press Release, 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; Press Release, U.S. Dep't of Just. Off. of Pub. Affs., *Acadia Healthcare Company Inc. to Pay $19.85M to Settle Allegations Relating to Medically Unnecessary Inpatient Behavioral Health Services* (Sept. 26, 2024), https://www.justice.gov/archives/opa/pr/acadia-healthcare-company-inc-pay-1985m-settle-allegations-relating-medically-unnecessary.
[25] B.J. Burns et al.., *Improving Outcomes for Children and Adolescents with Serious Emotional and Behavioral Disorders: Current and Future Directions* (1998) ("A dominant observation is that the least evidence of effectiveness exists for residential services, where the vast majority of dollars are spent.").
[26] Philip S. Goldman et al., *Institutionalisation and Deinstitutionalisation of Children 2: A Systematic and Integrative Review of Evidence Regarding Effects on Development*, 4 Lancet Psychiatry 606, 609 (Aug. 2020), https://bit.ly/465xqCs; Glenn D. Walters, *Prosocial Peers as Risk, Protective, and Promotive Factors for the Prevention of Delinquency and Drug Use*, 49 J. Youth & Adolescence 618 (2020).
[27] *See* Letter from University Legal Services, Inc. to District of Columbia Department of Mental Health and District of Columbia Department of Health, *Re: Riverside Residential Treatment Center* (June 6, 2007).
[28] *See* Disability Rights DC at University Legal Services, *Youth at Risk: Dangerous Restraints and Excessive Seclusion at DYRS Facilities* (Nov. 2023), https://cdn.prod.website-files.com/65792ba62c7815e2cdc139a2/663a9daffe4197e0f9768133_5.6.24%20Youth%20at%20Risk%20Report_FINAL.pdf; Disability Rights DC at University Legal Services, *Youth Still at Risk: A Supplement to the Disability Right DC's Youth at Risk Report* (Mar. 2025), https://cdn.prod.website-files.com/65792ba62c7815e2cdc139a2/67c5db15ed3ec4dfa0f7762d_Youth%20Still%20At%20Risk.pdf; Complaint, *K.Y. v. District of Columbia*, No. 1:24-cv-03056 (D.D.C. Oct. 28, 2024).
[29] 527 U.S. 581, 597 (1999).
[30] *See generally* Bazelon Center for Mental Health Law, *Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration* (2019), https://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf.
[31] *Id.*