April 4, 2022

By electronic mail

The Honorable Frank Pallone, Jr.
Chairman
House Committee on Energy & Commerce
2107 Rayburn House Office Building
Washington, DC 20515

The Honorable Cathy McMorris Rodgers
Ranking Member
House Committee on Energy & Commerce
1035 Longworth House Office Building
Washington, DC 20515

Re: H.R. 7237; Reauthorizing Evidence-Based And Crisis Help Initiatives Needed to Generate Improved Mental Health Outcomes for Patients Act of 2022

Dear Representatives Pallone and McMorris Rodgers:

We write on behalf of the Bazelon Center for Mental Health Law, the Autistic Self Advocacy Network, the Center for Public Representation, and the National Disability Rights Network regarding H.R. 7237, the "Reauthorizing Evidence-Based And Crisis Help Initiatives Needed to Generate Improved Mental Health Outcomes for Patients Act of 2022." We appreciate the Committee's attention to the mental health challenges faced by people with disabilities and their communities, which predate but have been exacerbated by the COVID-19 pandemic.

We support provisions in H.R. 7237 that would provide additional federal support for enhanced behavioral health crisis response services. Especially as the nation prepares for implementation of the 988 system for responding to calls for support from people with behavioral health issues and their friends and family, it is critical that every community develop capacity for a robust behavioral health response to these calls—as a meaningful and timely alternative to a law enforcement response.

Within the behavioral health system, there should be a unit that functions much like 911, receiving and responding to calls directly received, calls redirected from 911, and calls from the police. Many calls can be resolved by providing advice, making referrals, or providing transportation. Others will require dispatching a mobile response team, a team of mental health professionals, including at least one person with lived experience working as a peer specialist and one clinician, trained to de-escalate individuals in behavioral health crisis.

Many calls are resolved by mobile teams in the community; in addition, there should be an array of facilities available for crisis care, including respite apartments, apartments for short-term stays staffed by behavioral health personnel including peers, walk-in or drop-off crisis centers (in urban areas, scattered in neighborhoods), short-term detox centers, and inpatient hospital care. As H.R. 7237 envisions, the behavioral health crisis call unit should have access to accurate, real-time information about the number of beds available in each such unit, the types of issues each unit will address, and other information needed to ensure that individuals experiencing emergent issues.

Individuals in communities across the country are experiencing good outcomes where the behavioral health system has adequate capacity to meaningfully respond to behavior health crises (or to disability-related behavior that prompts calls for service that are not actually crises). In Pima County, Arizona, mobile response teams dispatched by the county's 24/7 call center respond to calls within 30 minutes of a request for assistance by law enforcement, and stabilize over 75% of calls in the community.[1] Studies have found that calls in which mobile response teams are deployed resulted in arrest rates ranging from 2% to 13% of clients, with an average of less than 7%, in contrast to an arrest rate of 21% for typical contacts between police officers and individuals with behavioral health issues.[2] Increased federal support for communities, through grants such as those described in H.R. 7237, seeking to replicate these good outcomes would help create additional models for how these systems can work to help people resolve crisis situations in the community, and avoid law enforcement contact and subsequent incarceration.

Although we appreciate H.R. 7237's focus on support for community-based behavioral health crisis response services, we oppose the bill's provisions extending the Substance Abuse Mental Health Services Administration's (SAMHSA's) Assistive Outpatient Treatment (AOT) grant program. In AOT programs, a person with serious illness is mandated by a court to follow a

[1] Margie Balfour, M.D., Ph.D., Chief Clinical Officer, Crisis Response Center, Connections Health Solutions, *The Tucson Model: Decreasing Justice Involvement Via Mental Health – Law Enforcement Collaborations* (last viewed Apr. 2, 2022), at https://slideplayer.com/slide/14580474/.

[2] H. Richard Lamb, et al., *The Police and Mental Health*, 53 Psychiatric Services 1266, 1268 (Oct. 2002), at https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.53.10.1266.

specific treatment plan, usually requiring the person to take medication and sometimes directing where the person can live and what their daily activities must include.

Twenty years of research has failed to yield evidence that such court ordered treatment outperforms voluntary treatment.[3] Court-ordered outpatient treatment has produced improved outcomes in some communities, but these outcomes appear to result from the intensive services made available in the AOT program, rather than any court order or supervision. Furthermore, the research has not examined whether such programs discourage some individuals from engaging with the treatment system out of a concern that they may lose their liberty, an effect that many service recipients and others believe to be an outcome of expanding involuntary treatment. In one community, it was reported that "when male shelter clients were informed of their potential eligibility for outpatient commitment, almost all fled the shelter and were not seen again."[4]

There are two systematic reviews of the research on involuntary outpatient commitment. Both reached the same conclusion: there is no evidence that mandating outpatient treatment is more effective than providing such treatment on a voluntary basis.[5]

A study conducted in the mid-1990s at Bellevue Hospital in New York City found that, "[o]n all major outcome measures, no statistically significant differences were found" between the group subject to court order and receiving intensive services and the group that only received intensive services.[6] A later study of New York's involuntary outpatient program found

---

[3] : Plahouras JE, Mehta S, Buchman DZ, Foussias G, Daskalakis ZJ, Blumberger DM (2020), Experiences with legally mandated treatment in patients with schizophrenia: A systematic review of qualitative studies, European Psychiatry, 63(1), e39, 1–10 ("[E]vidence regarding the efficacy of treatment in the community for patients with psychiatric illness is mixed."), at https://doi.org/10.1192/j.eurpsy.2020.37 ; S.N. Cripps & M.S. Swartz, Current Psychiatry Reports (2018) 20:112 ("To date, there have been three randomized controlled trials evaluating the effectiveness of AOT programs, with mixed results and no clear consensus about overall effectiveness of AOTs."), at https://doi.org/10.1007/s11920-018-0982-z.

[4] M. Rowe, *Alternatives to Outpatient Commitment*, 41 J. Amer. Acad. of Psychiatry and the Law 332, 333 (Sept. 1, 2013), http://www.jaapl.org/content/41/3/332.full.pdf+html.

[5] S.R. Kisely, L.A. Campbell, and N.J. Preston, *Compulsory community and involuntary outpatient treatment for people with severe mental disorders*, Cochrane Database of Systematic Reviews (Feb. 2012); M.S. Ridgely, R. Borum and J. Petrila, RAND Health, *The Effectiveness of Involuntary Outpatient Treatment* (2001), http://www.rand.org/content/dam/ rand/pubs/ monograph_reports/2007/MR1340.pdf.

[6] The New York study found no statistically significant differences in rehospitalization rates, arrests, homelessness, or other outcomes between participants randomized to receive involuntary outpatient care and those randomized to intensive outpatient care without outpatient commitment. H.J. Steadman, K. Gounis, D. Dennis, *et al*, *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*. 52 Psychiatric Services 330 (2001).

improved outcomes, but did not assess whether providing the same services on a voluntary basis would be equally effective.[7]

In addition, there is evidence that African Americans are overrepresented among those subject to outpatient commitment,[8] raising the specter that court ordered treatment could aggravate racial disparities in the imposition of criminal justice interventions.

We appreciate the House's passage last year of the Build Back Better Act, which would have provided $150 billion in federal funding for home- and community-based services, including those services shown to be effective in helping people with significant behavioral health issues succeed in the community. These include Assertive Community Treatment (ACT), intensive care management, housing services, supported employment, and crisis response services—all services in which people with lived experience working as peer specialists have been shown to provide additional benefits to individuals with behavioral health issues, including those with co-occurring substance-use disorders. We believe that additional federal resources for these services would be far more helpful in addressing our nation's mental health challenges than would additional support for Assistive Outpatient Treatment's "costly, coercive, and unproven approach,"[9] including that in H.R. 7237.

[7] M. Swartz, *Introduction to the Special Section on Assisted Outpatient Treatment in New York State*, 61 Psychiatric Services 1 (2010). The same is true of a study of North Carolina's program. M.S. Swartz, J.W. Swanson, V.A. Hiday, *et al, A Randomized Controlled Trial of Outpatient Commitment in North Carolina*, 52 Psychiatric Services 325 (2001). The most recent study of outpatient commitment, done in the United Kingdom, examined whether outpatient commitment reduced the rate of hospital readmissions and found that it did not. T. Burns, J Rugkåsa, A. Molodynski, *et. al*, *Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial*, 381 Lancet 1627 (2013).

[8] J. Swanson, M. Swartz, R.A. Van Dorn*, et al*, *Racial Disparities in Involuntary Outpatient Commitment*, 28 Health Affairs 816 (2009).

[9] *See* Rowe, Alternatives to Outpatient Commitment, *supra* note 4.

We appreciate the Committee's focus on mental health, and are grateful for this opportunity to contribute to the Committee's consideration of solutions for the challenges we face. Should you have any questions about this letter, please feel free to contact Lewis Bossing, Senior Staff Attorney, Bazelon Center for Mental Health Law, at lewisb@bazelon.org or (202) 467-5730 x1307 (office).

Sincerely,

/s/

Holly O'Donnell
President and CEO
Bazelon Center for Mental Health Law

Julia Bascom
Executive Director
Autistic Self Advocacy Network

Cathy Costanzo
Executive Director
Center for Public Representation

Eric Buehlmann
Deputy Executive Director for Public Policy
National Disability Rights Network