



When There's a Crisis, Call a Peer

**How People with Lived
Experience Make
Mental Health Crisis
Services More Effective**

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During the development of this issue brief the Bazelon Center conducted interviews with 16 advocates and leaders in the peer community about the role of peer-led and peer-involved supports in the delivery of mental health mobile crisis services. These interviews were conducted by Bazelon Center summer 2023 interns Sara Cohen, Sydney Marler, Melissa Shang, and Kelsey Waldron, under the supervision of Bazelon Center Director of Engagement Jalyn Radziminski and Senior Staff Attorney Lewis Bossing.

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*Dedicated to our friend and colleague
Christian Jared Aleman*

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I. Introduction & Executive Summary

Over the past several years, states and localities have developed new public safety responses to calls for help involving people with mental health challenges or disabilities,* or people experiencing a mental health crisis.

Implementation of these programs is driven by the harmful outcomes resulting from many of these calls, which historically—and today—too often receive a response from law enforcement officers, not a mental health response. Black and brown people with mental health disabilities or who are in crisis are disproportionately likely to experience deadly harm from a law enforcement response to a call for help.

As state and local governments seek alternatives to a police response to calls involving people with mental health disabilities or who are in crisis, stakeholders are asking critical questions about the effectiveness of alternative approaches. Among these are whether the alternative response will come quickly enough to keep people safe. People calling 911 for help in a crisis expect a timely response—within minutes, not hours. They will not call another number in an emergency, or ask 911 to dispatch a mental health alternative, like a mobile crisis response team, if they lack confidence in the timeliness of the response. Similarly, a 911 call taker will

*This paper discusses services and supports for people who experience changes, sometimes significant, in mood or behavior that affect their daily lives. We often refer to these experiences as a person’s “mental health.” Many of these individuals are protected by federal civil rights laws such as the Americans with Disabilities Act; for that reason, this paper sometimes refers to people who have “mental health disabilities.” However, many people do not use this term to describe themselves. Some people refer to having “lived experience” or “living experience” with mental health disabilities, or with mental health treatment. Some say that they are “in recovery” from experiences of acute mental health symptoms. Other people use other terms to describe themselves. *See, e.g.,* u/MadQueerResearcher, *Queer MMIND (Mad, Mentally Ill, Neurodivergent, and Disabled) College Student Experiences*, Reddit (Oct. 15, 2021), https://www.reddit.com/r/SampleSize/comments/q8ouhg/academic_queer_mmind_mad_mentally_ill/. *See also* Sami Schalk, *Black Disability Justice 7 (2022)* (“Disability Justice Practitioners seek a broader understanding of anti-ableism, one not limited to state-sanctioned individual rights, which often primarily benefit disabled people who are already relatively privileged by race, class, gender, sexuality, and citizenship status.”), <https://library.oapen.org/viewer/web/viewer.html?file=/bitstream/handle/20.500.12657/62545/9781478092681.pdf?sequence=1&isAllowed=y>.

not dispatch a mental health mobile response team instead of a police officer if they think the mobile team will take too long to respond or will not be able to secure the safety of both the individual in question and others in the vicinity.

In addition to the timeliness of the alternative response, whether the response is effective at supporting an individual through a crisis, and then engaging that individual in thinking about how to prevent or ameliorate crises in the future, is critical. Whether individuals with mental health challenges and disabilities receive the supports they need and want, including housing and options from among a robust array of community services, is critical to making our communities stronger and safer. But how can communities better ensure that crisis responses rooted in mental health systems are an effective alternative to a law enforcement response?

There is an answer: **Make the supports provided by people with lived experience serving as peer support workers, working in peer-led organizations, central to the delivery of mental health crisis services.**

Peer-led and peer-staffed organizations have been supporting individuals experiencing mental health crises for years, in some cases decades. The positive outcomes experienced by individuals “in crisis” receiving peer support are, or should be, well known. When peers support those in crisis, individuals who need help are less likely to be admitted to emergency rooms and hospitals to receive inpatient care. They are more likely to participate in community-based services—which can help them avoid future crises and resulting institutionalization or incarceration—and be more engaged in the services they receive. They experience less self-stigma and more self-empowerment and hope. They are less likely to need crisis services in the future. For these reasons, systems that provide peer support services to people in crisis see significant cost savings: individuals spend less time receiving costly inpatient services and more time receiving community-based services—which are more effective at reducing hospitalization rates and lengths of stay, reducing the frequency and intensity of future crises, reducing criminal system involvement, and promoting participation in community activities.

Even though peer support as a component of crisis services is cost effective, states and localities face challenges to building and sustaining the peer crisis workforce. Congress and state legislatures have taken significant steps to support mental health crisis services; the

federal government has endorsed including peer support in these services. But, as with the mental health system writ large, government investment is still lacking—or, as with support through Medicaid reimbursement for services, comes with rules that may seem antithetical to providing peer support services with fidelity to the principles animating these supports. Communities are increasingly looking to other sources of funding to build capacity, including hospitals, private insurers including managed care plans, foundations, and law enforcement agencies for contributions that may be braided along with Medicaid, Medicare, and federal and state grant programs to develop and sustain peer-led and peer-involved crisis support.

This paper endorses peer-led and peer-involved mental health crisis supports because they are what people with lived or living experience with a mental health challenge or disability want and need. They are effective at helping individuals achieve good outcomes, and they are cost-effective. A number of successful models for peer-led and peer-involved crisis services exist and are described below. We urge federal, state, and local governments to take action to expand their reach.

II. The Role of Crisis Services in Mental Health Systems

Mental health crisis services—by one definition, an array of services provided to a person experiencing a mental health crisis¹—have received a lot of attention lately. In large part, this is due to efforts to develop alternatives to what is still the de facto response to calls for help involving people in crisis in the United States—a law enforcement response.² Although police still respond first to most of these calls in most cities and towns, the problems with a police response, as documented in the media and confirmed through research, have garnered more attention.³

Too many people with mental health disabilities or experiencing mental health crises—especially Black and brown people—have been subjected to violent treatment by law enforcement officers responding to calls to 911, or when they are encountered by officers on patrol:⁴

- On September 5th, 2022, a Cleveland Metropolitan Housing Authority police officer tased and then shot and killed Maalik Amar Roquemore, who according to his mother was unarmed and had schizophrenia.⁵
- On February 24th, 2023, a Wallace, North Carolina, police officer shot and killed James Lanier after he walked naked into an Express Mini Mart and store employees called the police.⁶
- On June 20th, 2023, Alabama police officers responding to a call for service involving a man with a knife “experiencing a crisis episode” shot Cornelius S. Ball, who later died at a local hospital.⁷
- On June 23rd, 2023, San Antonio police fatally shot Melissa Perez, a woman with a history of mental health symptoms who swung a hammer toward them after going into her apartment and refusing to come out during a mental health crisis.⁸

Too often, the police have too few options for what to do next, other than taking the person to the emergency room or to jail.⁹

What Is A Crisis?

The term “crisis” is often used to describe a situation in which an individual is engaging in behavior that concerns others, and that may involve a perceived risk of harm to the individual themselves or to others.¹⁰ The crisis is often presumed to be related to a behavioral health issue: bystanders believe that the person “in crisis” is experiencing extreme symptoms associated with a mental health disability, or with a substance use condition.¹¹ A crisis may also result from adverse changes in life experiences, such as the loss of a relationship, a loved one, or a job.¹²

The term “crisis” is both over inclusive and under inclusive of persons who need help. Anyone may engage on occasion in behavior that attracts attention because it is outside the norm seen in public spaces. This may be the product of a cultural difference between observer and observed, or simply behavior that does not align with societal expectations for public conduct.

People with disabilities in particular may behave in ways that relate to their disabilities but that are different from those around them or the expectations of others. Autistic people sometimes engage in public behaviors that may be calming or stimulating for them, but that bother or concern others.¹³ People who are deaf or hard of hearing may not respond to verbal communication as others do.¹⁴ People with intellectual or developmental disabilities may have cognitive issues that affect their behavior.¹⁵ Calls about the behavior of people with disabilities comprise a number of “crisis” calls to 911 and law enforcement, even though the person engaging in the behavior may not appreciate why others are concerned, and do not themselves believe that they are “in crisis.”

Conversely, sometimes people who are in fact experiencing a crisis do not engage in behavior that draws the attention of others. An individual who experiences an episode of major depression may not externalize symptoms, despite feeling significant distress.¹⁶ The same can be said for others with mental health challenges, including anxiety, bipolar disorder, and post-traumatic stress disorder.¹⁷ These individuals may not seek help, or engage in behavior that suggests a need for help, but regardless may be experiencing intense feelings of distress.

Whether a person is experiencing a “crisis” is ultimately a subjective, “in the eye of the beholder,” determination that may sometimes may be inaccurate. Still, this paper will use the term “crisis” as it is commonly understood among policymakers and the public—to describe an event that requires a response to help an individual or secure public safety—often, because an individual is subjectively a “danger to self or others.”

“Too often, public systems respond as if a mental health crisis and danger to self or others were one and the same. In fact, danger to self or others derives from common legal language defining when involuntary psychiatric hospitalization may occur—at best, this is a blunt measure of an extreme emergency. A narrow focus on dangerousness is not a valid approach to addressing a mental health crisis. To identify crises accurately requires a much more nuanced understanding and a perspective that looks beyond whether an individual is dangerous or immediate psychiatric hospitalization is indicated.”

—U.S. Substance Abuse Mental Health Services Administration (SAMHSA)

Against this backdrop—law enforcement responses to what is essentially an acute healthcare need that often harms the individual and that reinforces a misunderstanding that people in mental health crisis have done something wrong—states and localities are developing mental health crisis services as an alternative response. The federal government has provided critical support. For example, recent legislation provided significant, albeit still insufficient, funding for the new nationwide three-digit telephone number for mental health emergencies, 988, which some have called a “mental health 911.”¹⁸ The American Rescue Plan Act (ARPA) enhanced Medicaid reimbursement for qualifying mental health mobile crisis services, sometimes called mobile response services, teams that respond to and resolve crisis incidents in the community.¹⁹ Localities across the country are braiding federal funds with other resources to open new “crisis stabilization” centers intended to serve as an alternative to hospital emergency rooms and jails.²⁰

To be a meaningful alternative to a law enforcement response, mental health crisis services must be effective. A mental health response must be timely—as or more timely than a police response would be—and should actually help resolve the situation. Crisis workers should engage the individual after immediate needs are met to help them consider connecting with other community-based services and supports. To achieve these goals, mental health crisis services must be available as needed in the community, so that people who need someone to talk to can be connected quickly to a listener, and so that mobile crisis services can be dispatched as quickly and easily as are the police. Mental health crisis workers must be trained on skills needed for effective crisis de-escalation, and post-crisis engagement. Importantly, housing and community-based mental health services of sufficient intensity must be available as an alternative to inpatient services for those who want to be linked to them. Participation in housing and services can help individuals avoid future crises. Engaging individuals with serious mental health disabilities in services can help reduce the number and intensity of circumstances in which a crisis response is needed.

Crisis Services and the Peer Support Movement

The national focus on mental health crisis services coincides with an increasingly undisputed truth: people with lived or living experience with mental health challenges and disabilities, mental health treatment (including in hospitals or other institutions), incarceration, and other relevant life experience, can play a uniquely significant role in supporting those who share a similar history and who want and need help.²¹ People with lived experience working as “peers” bring empathy and a sense of mutuality—the sharing of similar experiences—with the person they are supporting. They share an understanding of what the individual is going through, borne of the peer worker’s own experience with a mental health challenge, and participation in mental health services.²² The peer worker may share other aspects of the client’s life experience, such as drug or alcohol use challenges, housing instability, the trauma of having experienced a mental health crisis, involuntary commitment, or incarceration.²³ These shared experiences can help the peer support worker seem credible and relatable, which in turn aids the worker in developing a productive relationship with the individual being supported.²⁴

“Having lived or living experience is more nuanced than it sounds . . . [t]he problem is the term can be defined so broadly that it essentially means nothing. [W]hat it really comes down to is shared experience. And the person who determines whether your experience is shared is the person seeking support.”

-Founder, Peer-Led Support Organization

Evidence indicates that people with lived experience have been supporting each other in peer-to-peer relationships since the 18th century.²⁵ More recently, peer support has been associated with the “recovery movement” in the United States.²⁶ The concept of “recovery” has gained attention and understanding since the 1970s, as individuals who had been institutionalized for mental health treatment transitioned to life in cities and towns, and found each other.²⁷ Many of them supported each other through sharing life experiences; many questioned, or rejected, the centrality of medical professionals, and the “medical model,” in mental health treatment.²⁸ The medical model treats people with lived experience as having an “illness,” or a “diagnosis,” which with treatment can be “cured.”²⁹ By contrast, recovery is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”³⁰

“It is critical for my journey, when I was living with my mental illness . . . trying to connect to services, there was a disconnect in how they were connecting with me, how there were services not being offered I believe that I would not be here . . . if I had not been connected with a peer. A peer is someone who has actually seen the part of a journey of another person, and feeling like you are not alone.”

—Peer advocate

Before supporting someone through the recovery process, peer support workers receive training and on-the-job coaching and mentoring.³¹ Among other things, peer workers learn about mental health disabilities and how they can affect behavior; psychiatric medications, their possible side effects, and their potential benefits and challenges; how to engage the individuals they support, including through strengths-based motivational interviewing and active listening;³² and about other services and supports available in the community.³³

Peer supports are non-clinical services, focusing on how an individual can be supported through recovery, including during times of crises. There may be times when services provided by a professional with clinical services may be needed. As discussed below, however, trained peer workers can and do provide many supports that people experiencing mental health challenges want and need. They support individuals in navigating and accessing community resources; learning self-help and self-management skills; building networks of natural supports among families, friends, and co-workers; managing physical health conditions; and meeting personal goals.³⁴ They are often among the most effective mental health workers at engaging the individuals they support.

Why Peer Workers?

People with lived experience with a mental health challenge or disability, with mental health treatment, or other relevant life experience are increasingly seen as critical components of an effective mental health system. More and more, public health agencies and other healthcare providers are making use of the experience and expertise of peer support workers. Why?

- **Peers are credible messengers.** When people with lived experience share their stories, others listen and learn. We have seen this happen in a number of healthcare contexts over the years: the healing power of peer-to-peer relationships has been part of life for many, including those with HIV/AIDS and cancer.³⁵ So it should come as no surprise that an individual who has lived with a mental health condition can be a trusted guide for others with such conditions—particularly if the peer has other significant experiences, such as military service, housing instability, or incarceration. The peer’s experience brings credibility that cannot be taught, which can be the basis of an effective support relationship. Studies have shown that peer support workers can be more effective in many service roles than are those without lived experience.³⁶
- **Peers bring cultural responsiveness.** Peer workers who are members of the same racial or ethnic, sexual orientation or gender identity, or religious community as those they support bring not only an understanding of what it is like to have a mental health condition, but also understand the cultural mores of the community. This can be a critical part of what makes peer support effective. Peer workers can also advise their colleagues at provider organization as to how clinical services can be more culturally responsive and less infected by harmful assumptions and biases.³⁷
- **Peer work is cost-effective.** Peer workers can provide many of the community-based supports that people with mental health challenges and disabilities want and need, including as crisis responders, such that use of more costly inpatient care can be reduced. As such, public health and public safety systems should continue to expand their peer workforce. This may require a less intensive initial investment in training than for other

mental health workers, and so the peer workforce can be built up more quickly—and, we hope, at the same time compensated more appropriately for their contributions to recovery.³⁸

- **Peers focus on recovery.** The inclusion of peer workers in the public mental health system has been vital in helping change that system from a “medical” orientation limited to symptom-reduction and restoring safety to one that also embraces recovery, community participation, and informed personal choice.³⁹ This transition to a “recovery” orientation has greatly altered our understanding of the appropriate goals of treatment, both on an individual level and for how we design and implement mental health systems going forward.

Peer-led and peer-involved support services developed over the past 50 years as part of the recovery movement.⁴⁰ More recently, people with lived or living experience are also working in, and leading, mental health crisis services. They answer calls or texts to hotlines and warmlines, confidential, free phone or text services offering mental health support.⁴¹ They serve on mobile response teams that travel to the site of a crisis, to help de-escalate and stabilize onsite.⁴² And people with lived experience lead and work in crisis respite homes and apartments, for when an individual needs to go somewhere for help.⁴³

Peers have been supporting individuals “in crisis” for many years, and the positive outcomes experienced by individuals receiving peer support are, or should be, well known. When peers support those in crisis, individuals who need help are less likely to be admitted to emergency rooms and hospitals to receive inpatient care.⁴⁴ They are more likely to engage and participate in community-based services and be more engaged in the services they want and need.⁴⁵ They experience less self-stigma and more self-empowerment and hope.⁴⁶ They are less likely to need crisis services in the future.⁴⁷ For these reasons, systems that provide peer support services see significant cost savings: individuals spend less time receiving costly inpatient services and more time receiving relatively inexpensive community-based services—which are more effective at reducing hospitalization rates and lengths of stay, reducing the frequency and intensity of future crises, reducing criminal system involvement, and promoting participation in community activities.⁴⁸

This paper explores and explains why peer-led and peer-involved services should play a significant role in the public safety response to mental health crises.

III. What Makes Peer-Provided Crisis Services Effective?

All mental health crisis services are not created equal. Some crisis services provide more effective support to people with mental health challenges or disabilities or those in crisis than do others—which is also how public safety concerns are best addressed. Beyond basic questions around the availability and timeliness of the crisis response, whether services meet the needs of the individual being served is key. Leadership and the significant involvement of people with lived experience working as peers is critical to the effectiveness of these services.

Below we list some factors to consider as systems develop and implement effective, equitable mental health crisis services, an important part of the broader public behavioral health system.

Timeliness People won't call for crisis services if they think the response will be too late to help avoid harm. People are used to calling 911 for emergencies, including when someone is experiencing a mental health crisis. They expect a 911 response, whether an ambulance or a police officer, to arrive within minutes. People will not call another number in an emergency, or ask 911 to dispatch a mental health responder, if they lack confidence in the timeliness of the response. Similarly, a 911 call taker will not dispatch a mental health mobile response team instead of a police officer if they think the mobile team will take too long to respond.⁴⁹

Every state and locality should have the capacity to provide an urgent response to an urgent call for help. Hotlines should be able to respond quickly to calls or texts.⁵⁰ Communities should have enough mental health mobile response capacity so that members of the public, patrol officers, and 911 call takers have confidence that teams will come to the scene in time to take effective action (and are available to respond to less acute calls for assistance before there is a full-blown crisis).⁵¹ Places that people in crisis might go, such as respite homes or apartments, should be able to timely accommodate guests, so that support, stabilization, future planning, and linkage to other community-based services can begin promptly.⁵² Providers of crisis services should monitor response times closely, and make changes as needed to improve them.

Availability 24/7 Mental health crises can happen at any hour of the day or night. Many emergencies take place after the typical workday ends, for some because providers from which an individual is receiving services and who could help meet the individual’s needs are closed and may not have “on call” staff standing by after work hours. Because a crisis can take place at any time, crisis services should be available at any time—24 hours a day, seven days a week, 365 days a year.⁵³ This includes hotlines and warmlines, mobile response teams, and crisis respite homes or apartments.

Voluntariness Many states and localities are currently debating whether to expand their authority to force people with serious mental health disabilities to undergo treatment involuntarily.⁵⁴ Proponents argue that forced treatment—often effected through a law enforcement officer’s execution of an emergency petition, including involuntary transport to a hospital or other receiving center where the person in question may be physically or chemically restrained—is needed to protect others or an individual themselves from imminent harm.⁵⁵ States are also expanding forced treatment where, in the view of a responder or someone who sought and obtained an emergency petition, the person cannot take care of themselves.⁵⁶ In these cases, the argument goes, forced treatment is needed because some people with serious mental health disabilities do not appreciate their condition and will not participate in treatment voluntarily.⁵⁷

These debates continue to play out in many states and localities even though the only large-scale studies conducted to examine forced treatment have not demonstrated its effectiveness.⁵⁸ There is no “black robe” effect making treatment ordered by a judge more effective than voluntary treatment. Forced treatment does not advance better health outcomes, such as fewer hospitalizations or reduced criminal system involvement.⁵⁹ Where good outcomes have been shown from forced treatment, it has been because it was the only treatment option available.⁶⁰ This data likely does not account for the fact that, where there is an opportunity to avoid involuntary care, many may take action to avoid treatment they do not want.⁶¹

Voluntary engagement in services means helping people understand and choose the services and supports they want and need, learn about their options among providers, and then linking them to the supports they choose.⁶² Voluntary engagement is likely to be far more successful over time than forcing services upon individuals with mental health disabilities. Mental health crisis services should be provided consistent with this principle, which also animates the peer recovery movement itself.⁶³

There is debate over whether mental health mobile response teams should execute emergency petitions and involuntarily transport individuals who meet the jurisdiction’s commitment⁶⁴ standard to the hospital. Although having a mental health worker who is not in uniform and does not carry a weapon administer an emergency petition may be less traumatizing than law enforcement officers doing this may be, the difference is merely one of degree. Better that crisis service providers develop the expertise in de-escalation, stabilization, and post-crisis engagement in services to help meet an individual’s needs without resort to forced treatment.

Accessibility Crisis services, like all services provided to people with disabilities, must be accessible. People who experience mental health crises may need disability accommodations to access services. Crisis hotline workers must make accommodations in order to communicate effectively with callers, or those who are the subject of calls for help, who have disabilities affecting communication. This includes people who have a visual impairment or are deaf or hard of hearing, or who have cognitive differences and need information relayed to them in different ways.⁶⁵ Crisis respite homes or apartments must be physically accessible to people with mobility impairments, as should be the vehicles that mental health mobile response teams use to transport individuals to those settings.⁶⁶ Providers of community-based services to which individuals may be connected after a crisis must also ensure that those services are delivered using methods needed to communicate effectively, in spaces that are physically accessible.⁶⁷ Putting peer workers with disabilities to work to provide support to individuals experiencing a crisis, or following a crisis, may help the crisis service provider better understand the need for accessibility.

Accessibility isn’t just about accommodations for people with disabilities. Language access is also key. People who speak languages other than English (including American Sign Language (ASL)) should be able to communicate verbally and in writing with hotlines, warmlines, and textlines, and with mobile crisis teams and the staff of crisis respite homes or apartments.⁶⁸ This can be accomplished through having staff members with fluency in the individual’s language provide supports, or by using in-person or virtual interpretive services.⁶⁹

Leadership of Persons with Lived Experience More and more, people who have “walked the walk” —who have lived with mental health challenges themselves, and who have been involved with systems that provide mental health services, including criminal legal systems—

are leading organizations that provide crisis services to those facing similar challenges.⁷⁰ These peer-led organizations provide services that help support individuals with acute needs, including crisis services of all kinds.⁷¹ These services and supports, like warmlines, mobile response services, and crisis respite homes (often called peer-led respite homes) and apartments, result in positive outcomes for people supported by these programs, and generate savings for the overall system because of reduced reliance on costly inpatient care.⁷²

Not only do people with lived experience lead organizations that provide crisis services, they are often the front-line, “on the ground” workers who interact with and support people experiencing acute symptoms. When people with mental health issues who want help call or text a peer-led warmline, they are likely to be communicating with someone else who has experienced the challenges of living with a mental health challenge— and who can say they have been in crisis themselves.⁷³ The federal government has endorsed peer workers as valued members of mobile crisis teams, along with clinicians, and cities are putting teams with peer workers on the streets to respond to calls for help.⁷⁴ And often the first person you meet at a crisis respite home or apartment is someone who has “been there” and who has thought about what the home’s environment, including the physical space, should be like for a person who is visiting who may be experiencing distress.⁷⁵

Because we think that these peer-led and peer-involved crisis supports are more likely to be more effective at supporting individuals through de-escalation, stabilization, and initial planning for the future, we believe that every community should have the capacity to provide these services.

Supporting Peers Working In Crisis Services

The federal government has endorsed models for crisis services, including mobile response teams and peer-led respite homes and apartments, in which people with lived experience working as peers provide significant support.⁷⁶ Federal agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA) have done so because peer delivery, and peer leadership, of these services has been shown to improve effectiveness and to be cost-effective.⁷⁷ Importantly, building crisis interventions on peer-to-peer support has been demonstrated to provide significant benefit to the persons receiving supports, including by reducing risk of hospitalization and law enforcement involvement.⁷⁸

Crisis work is difficult work. Anyone doing this work may experience trauma and burnout. This may be the case for people with lived experience working as peers, or leading organizations that provide supports, who as a part of each workday may relive painful moments from their own lives.⁷⁹

Employers of peers who support people in crisis must take steps to support these workers. Providing adequate training and coaching to help them feel prepared to do their jobs is a start. So are flexible work schedules, to the extent possible, and liberal leave policies. Having regular opportunities to discuss cases and clients with others on the team can help peer workers feel engaged and supported, as can workplace counseling and other workplace wellness programs.⁸⁰ Hiring peer workers as supervisors also helps, by providing for peer-to-peer relationships that enhance the process of supervision, and by providing for career advancement opportunities for peer workers.⁸¹ For larger employers, giving peer workers opportunities to rotate among crisis services and other services the employer provides, such as peer mentoring, peer-led support groups, or work as housing or employment support specialists, may also help. For any employer, ensuring against “peer drift,” allowing peers to take on non-peer work or roles within the organization, is key.⁸²

Finally, ensuring that peer specialists are paid a premium for their work as crisis service workers can make a big difference, including by sending the message that peer crisis work is valued by the provider and by the public safety system itself.

Trauma-Informed Approaches People with lived experience may be especially expert at providing supports that are trauma-informed—supports that acknowledge that the individual receiving supports has experienced stressful or traumatizing events, that those events have likely affected how the person thinks and feels, and that supports must be individualized to account for this history.⁸³ All people engaged in crisis response work may experience trauma relating to the work, and benefit from implementation of trauma-informed practices.

Trauma-informed care also acknowledges that staff working with individuals receiving supports themselves have trauma histories, from prior adverse life experiences or from the

work itself.⁸⁴ All people engaged in crisis response work may experience trauma relating to the work, and benefit from implementation of trauma-informed practices

Trauma-informed crisis care may be a matter of giving the individual receiving supports time and space to appreciate interventions, such as de-escalation, or may involve more tailored approaches to helping the individual with self-regulation and other follow-up skill-building.⁸⁵ Trauma-informed support is critical for helping those whose history with mental health services, and the hospitals or other congregate settings in which the services were delivered, was itself traumatizing.⁸⁶

Cultural Responsiveness Peer supporters who are themselves members of the communities they serve, including because they are Black, Indigenous, or other People of Color (BIPOC), are LGBTQIA++, have disabilities, have past experience with drug or alcohol use, or have been involved with the criminal legal system, are well placed to provide crisis services to others with similar backgrounds. Regardless of these mutualities, becoming a culturally responsive provider may also involve specialized training to help crisis workers understand whether they are bringing explicit or implicit bias about the individuals they support to interactions with them.⁸⁷ In these ways, peer-led or peer-involved work helps make the services provided more culturally responsive—and culturally humble, because we all have much to learn about the unique experiences of everyone we meet.⁸⁸

Experience with Co-Occurring Conditions Even if they do not have personal experience with drug or alcohol use, crisis workers should understand how substance use affects the behavior of the individuals they support. This may involve understanding the symptomology associated with use of various types of drugs or with alcohol use, such as when the individual who is the subject of the call for help has been using prescribed or illegally obtained pharmaceuticals.⁸⁹ Given the prevalence of fentanyl and other drugs that are known to cause a violent reaction or death, mental health mobile crisis responders should know how to use naloxone to help reverse an overdose and save a life.⁹⁰

Relationship with Law Enforcement The public's attention is focused on alternative responses to calls for help involving people with mental health disabilities or those experiencing a crisis because of a perception that law enforcement responses have been and continue to be inappropriate and harmful, or deadly.⁹¹ The cycling of individuals with serious mental health disabilities through contact with police, hospitalization, and incarceration is also a concern.⁹²

The relationship between law enforcement responders and alternative responders rooted in mental health is complicated, however. If a crisis services provider's relationship with local law enforcement agencies means that police are dispatched to a call for help to a hotline, or that a crisis respite home functions as a community's receiving center for persons held on an involuntary treatment petition, this would not be consistent with values of self-determination and confidentiality that animate the recovery movement. But law enforcement agencies and officers are significant stakeholders in public safety and public health systems. Law enforcement can be helpful in getting the word out about alternative responders, and ensuring that calls for help involving people with mental health challenges and disabilities get an appropriate mental health response.⁹³

In some localities, mobile crisis responders carry police radios and are dispatched to some calls by the police themselves⁹⁴ (This may be more likely to happen when the police receive specialized training, such as Crisis Intervention Team (CIT) training, and have a better sense of when an alternative response should be dispatched.). In other places, mental health workers, including peers, are embedded in 911 call centers to triage calls for help to determine whether an alternative responder can be deployed.⁹⁵ In these communities, a meaningful partnership between mental health crisis services providers and law enforcement that helps the behavioral health system “step up” to provide a health response to a mental health crisis, as an alternative to an inappropriate police response, is the goal.⁹⁶

Effective Linkages Over the course of a crisis episode and post-crisis stabilization, engaging individuals in thinking about which services and supports may help them reach goals and meet their needs, and then connecting them to those services and supports, is one of the most important supports that a crisis service worker can provide.⁹⁷ As discussed above, in general peer support workers have significant skills for engaging others with lived experience with mental health challenges. We expect peer-led crisis support providers, or those with significant peer worker involvement, to be more effective at helping individuals connect with other community services. Training peer specialists on the array of services and supports that are available in the community is important to ensure that appropriate linkages are made.

Effective Planning Good crisis services should align with and support an individual's personal crisis plan. Among other things, a crisis or safety plan identifies early indicators of an emerging crisis, effective strategies for crisis reduction, the individual's personal preferences for crisis care, and trusted decision makers who can act on the individual's behalf

if need be. After a crisis intervention, providers should engage the individual in the creation or update of a crisis safety plan.⁹⁸ Such plans should be routine, but effective safety planning is still too rare in practice. Peer workers can support the individual in thinking about safety goals, including by describing their own plan, and identifying and helping to engage a trusted representative for those situations where the individual themselves cannot express a preference for mental health care.

Outcomes The proof is in the pudding—whether individuals have positive outcomes after receiving crisis services is essential to assessing the effectiveness of these services.

Positive outcomes for people who experience a crisis generally include avoiding emergency room visits and subsequent hospitalization or criminal system involvement, subsequently achieving stability in housing, tenure in and personal satisfaction with services, and increased measures of social integration like participating in work or recreational activities.⁹⁹ As discussed above, employing peer workers to support people through crises can help achieve these outcomes.¹⁰⁰ Crisis services providers should be engaged in regular quality review activities to ensure that the individuals they support experience these positive outcomes, and make adjustments in practices as needed—including increasing employment of and leadership by peers.¹⁰¹

Two Things To Know About The Role Of Crisis Services In Mental Health Systems

The subject of this paper is peer-led and peer-provided crisis supports as an alternative to a law enforcement response to mental health crisis calls. This focus is needed—the de facto response to a mental health crisis in many communities remains the police. However, crisis services are only one aspect of an effective community mental health system. States and localities must build the capacity to provide a number of intensive community-based services to people with mental health disabilities with significant support needs. And not all crisis services should get the same degree of attention from policy makers and stakeholders—what happens to try to resolve crises wherever the person is in the community, in order to keep the person in the community, is crucial.

1. Cycling through the crisis service system, instead of through the emergency room or jail, is not a success.

A mental health crisis should receive a mental health response, in the same way that a physical or medical emergency receives a medical response.¹⁰² But repeated visits from a mobile crisis team, or multiple visits to a crisis home, suggests that an individual is not receiving needed services and supports, or that providers have not worked with that person to put together a service plan, or are not monitoring and revising that plan as needed.¹⁰³

Crisis services providers should understand what services and supports are available in the community that might meet a person's wants and needs. They should train staff on how to engage clients in better understanding their options for participation in those services, and how to connect them to providers that can meet their needs. As discussed below, states and localities must develop a robust array of these services, so that intensive services are available to anyone who wants and needs them, including to avoid future crises.

2. Mental health crisis care is not a three-legged stool.

The federal government refers to the need for communities to provide three aspects or categories of crisis services—somewhere to call, someone to come, and somewhere to go.¹⁰⁴ This suggests that all three are equally important to individuals who may want and need such help, and to the systems that serve them. Not true. In more mature crisis service systems, a large percentage of calls or texts—as many as 80%—are resolved virtually, through phone, videophone, or chat.¹⁰⁵ And a large percentage of the remaining number of calls—upwards of 70%—can be resolved in the field by a mobile crisis team.¹⁰⁶ In only a small number of crisis calls does an individual need to be transported somewhere for stabilization and, in most cases, return to the community.¹⁰⁷

Before investing in large numbers of psychiatric stabilization “beds,” communities should consider how to divert more calls, and resources, to trained mental health staff, including peer support workers, to try to improve call response resolution through virtual means. Communities should ensure that

there are enough mental health mobile response teams to respond timely to every call for help they receive. Only after making investments in having more, and more effective, hotlines and warmlines and mobile responders can we make adequate estimates about the needed capacity for “somewhere to go.”

IV. Models for Peer-led and Peer-involved Crisis Services

People with lived or living experience with mental health challenges and disabilities, and who also share other life experiences with the individuals they support as peer workers, are increasingly leading providers of crisis services. People with lived experience are the peer workers answering phone calls or texts seeking help, are working on mobile crisis teams that travel to respond to calls for help, and are the hosts helping meet the needs of visitors to crisis respite homes. Peer support workers also play an important role in connecting individuals experiencing crises to voluntary community-based services and supports, and aiding with service planning and advocacy for the individuals they support, and for improved systems to serve them.

The services provided by peer-led or peer-involved crisis services providers may differ, depending on resources¹⁰⁸ and the needs of the communities they serve. But they often share many of the characteristics described above. Services are timely provided and available 24/7.¹⁰⁹ They are voluntary.¹¹⁰ They are confidential.¹¹¹ They are trauma-informed and culturally responsive.¹¹² Providers' relationships with law enforcement, should they have them, do not result in coercion or unnecessary institutionalization.¹¹³ These providers effectively engage and link the individuals they support to other community-based services. Critically, the crisis services that are provided result in positive outcomes for the individuals served.

A. Someone to Call

As discussed above, in an effective mental health system a significant majority of calls for help can be resolved by trained individuals, including peers, on the other end of the line—whether the call is by phone, video call technology, chat, or text.¹¹⁴

It is critical that the response to a call for help be timely. Minutes matter—indeed, seconds may matter.¹¹⁵ It is also critically important that the call be confidential—that it is the person in “crisis” who decides whether and how personal information will be shared.¹¹⁶ Calls to 988 are not confidential. Individuals who call 988 may have their personal information, including their location, shared with law enforcement responders, whether that was the caller's intent or not.¹¹⁷

As with the other types of crisis services identified in this paper, the effectiveness of the responder's engagement with the person experiencing a crisis, and linkage with other community services and supports, is key. Every day, people with lived experience working with the organizations discussed below are engaging the individuals who contact them, with positive and promising results.



Wildflower Alliance

Based in western Massachusetts, the Wildflower Alliance is a community of people with lived or living experience that supports healing for individuals with mental health challenges, who have experienced trauma, and who may have experienced other challenges such as homelessness or substance use.¹¹⁸

The Alliance provides a number of peer-to-peer supports, including online peer supports through Zoom groups and Discord channels.¹¹⁹ It also operates Afiya, a peer-run respite home that has been recognized by the World Health Organization (WHO).¹²⁰ Since 2012, the Wildflower Alliance has also operated a private peer support phone line, for which a trained peer support worker with experience with mental health diagnosis, trauma, and/or addiction answers calls.¹²¹ The Wildflower phone line is confidential: it does not collect personal information or call other crisis responders such as the police.¹²² Callers are invited to ask for support and resources, connect with another person who can relate to their own circumstances, or just talk.

The Wildflower Alliance peer support line is sometimes referred to as a warmline, but Alliance director Sera Davidow has pushed back on that characterization: “[T]here are warm lines and hotlines, and the implication is that the hotlines deal with the serious crises and the warm lines with something

a few steps down from that. In fact, we have found that people who are calling our line are in a lot of distress, and sometimes specifically because they have found that calling hotlines when they're in that much distress gets them in trouble."¹²³

Wildflower's peer support line is available in the evenings Eastern time, seven days a week. See <https://wildfloweralliance.org/peer-support-line/>.

A Black woman with short hair, wearing a dark blue sleeveless top and large, colorful, teardrop-shaped earrings, is holding a smartphone to her ear. She is looking slightly to the right with a thoughtful expression. The background is a bright, out-of-focus indoor setting with windows.

Call Blackline

Call BlackLine

Call BlackLine (<https://www.callblackline.com/>) is a national hotline serving Black, Indigenous, People of Color (BIPOC) and LGBTQI communities with a Black Femme focus.¹²⁴ The hotline provides “a space for peer support, counseling, reporting of mistreatment, witnessing and affirming the lived experiences for folx who are most impacted by systematic oppression.”¹²⁵ Call BlackLine “prioritizes BIPOC (Black, Indigenous, and People of Color). By us for us.”¹²⁶

User of Call BlackLine can call or text to communicate with volunteer listeners who are based nationwide.¹²⁷ Call BlackLine provides immediate crisis counseling to “those who are upset, need to talk with someone immediately, or are in distress.”¹²⁸ Callers may also anonymously report negative, physical, and inappropriate contact with police and vigilantes.¹²⁹ All calls remain private and are never shared with law enforcement or government agencies of any kind.¹³⁰

Call BlackLine founder Vanessa Green sums up its work this way: “People who are LBGQTQI, Black, Indigenous, people of color, live with mental wellness issues too. We just don’t give them as many services as we should, so I want you just to offer support. Sometimes people just need an ear to listen. They don’t need advice. They actually just want someone to listen. . . . Just listen.”¹³¹



Trans Lifeline

Trans Lifeline

Trans Lifeline (<https://translifeline.org/>) is a grassroots hotline offering direct emotional and financial support to trans people in crisis. The Lifeline operates 24/7.¹³² Callers speak with a trans or nonbinary peer operator.¹³³ All calls are fully anonymous and confidential, meaning that the Lifeline does not use caller ID or have access to the caller's name, address, or phone number unless the caller provides it.¹³⁴

The Trans Lifeline does not practice “non-consensual active rescue,” such as calling 911 or law enforcement.¹³⁵ According to its website, if the caller would like support requesting an ambulance or calling 911, “we can assist you after informing you about that process and what may be triggered.”¹³⁶

The Lifeline also provides microgrants to trans and nonbinary people to help them correct names or gender markers on legal documents, and to support trans people who are incarcerated.¹³⁷



Wings Across Alabama

Wings Across Alabama

Although warmlines may be used by people experiencing a mental health crisis, they may also be used as a method of early intervention, to help callers who want to avoid a call to 911. Based in Montgomery, Alabama, Wings Across Alabama operates the Alabama Warm Line (<https://wingsacrossal.org/warm-line/>), which is available 24/7 for free confidential support from certified peer specialists.¹³⁸ The Alabama Warm Line helps people from across the state and across the country.

Wings Across Alabama is led by individuals with lived experience with mental health challenges and disabilities.¹³⁹ The organization also provides in-person and online community peer support groups via Zoom, and the online planning process Action Planning for Prevention and Recovery (APPR), which helps individuals put together their own plans for their personal wellness journey.¹⁴⁰ All services are voluntary.

T.J. Bradley, a certified peer specialist who has worked with Wings Across Alabama to facilitate APPR, states that warm line call takers will refer callers to other resources as requested. If callers need more support than volunteer call takers can provide, they are referred to Wings Across Alabama staff who are “on call” and who may also recommend contacting 988. As T.J says, “[T]he 24/7 warm line is so needed. . . . if somebody is in need and they need to talk to somebody, they talk to a certified peer specialist and it’s 24/7 going on.”

B. Someone to Come

Many calls for help can be resolved by having a trained peer worker answer a call or text. For others, a mental health mobile crisis team, also called a mobile response team, can go to the scene and help de-escalate and stabilize the person exhibiting symptoms of distress.¹⁴¹ Mobile crisis teams have been in operation in the United States since the 1960s. They may be notified of crisis incidents by the police, emergency medical services, behavioral health providers, schools, or through family members or others in the community.¹⁴²

As with hotlines and warmlines, the mobile response must be timely—neither callers seeking help nor other emergency responders, such as the police or ambulance services, will contact a mental health mobile crisis team if they believe that the mobile team will not respond for hours. Public safety systems should strive to build capacity so that a mobile response team—preferably including a peer support worker—can timely arrive to help an individual in crisis. Also as with hotline and warmline call takers, after stabilizing a situation a mobile crisis responder must be skilled at engaging and connecting the person with longer-term services. Mobile responders may also provide some level of follow-up care themselves.¹⁴³



Much has been written about the CAHOOTS program, in Eugene and Springfield, Oregon. CAHOOTS is a mobile crisis intervention program, founded in 1989, that is a partnership between the Eugene and Springfield police departments and the White Bird Clinic, which operates programs serving low income and indigent clients (<https://whitebirdclinic.org/cahoots/>). Although the two-person CAHOOTS mobile teams—including a crisis worker and emergency medical technician (EMT)—carry police radios and may be dispatched by either the police or 911 operators, the program’s goal is to be a free, confidential alternative to a police response to calls for help.¹⁴⁴

What may not be known about CAHOOTS is that a majority of the program’s mobile responders identify as persons with one or more relevant types of 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.¹⁴⁵ Increasingly, the program seeks multilingual candidates who can help extend the reach of CAHOOTS to Latino/a/e¹⁴⁶ communities. The city of Eugene has also explored operating a separate phone line for CAHOOTS that would be completely separate from the police department’s line, an important consideration for implementing crisis response where relationships between the police and Black and brown communities are lacking in trust.¹⁴⁷

CAHOOTS teams may provide “crisis intervention, counseling, mediation, information and referral, transportation to social services, first aid, and basic-level emergency medical care.”¹⁴⁸ They do not enforce petitions for involuntary treatment; all CAHOOTS services are voluntary.¹⁴⁹ CAHOOTS teams may request police as backup (and vice versa), but this rarely happens: in 2019, of the estimated 24,000 calls to which CAHOOTS responded only 311 (1.3%) required police backup.¹⁵⁰ In Eugene, CAHOOTS resolved almost 20 percent of all calls coming to the city’s 911 call center.¹⁵¹

CAHOOTS team members undergo months of training, including 40 hours of classroom instruction and 500-600 hours of field training, before becoming members of the two-person mobile response teams.¹⁵² They are mentored by senior team members throughout their employment with White Bird.¹⁵³



San Francisco Street Crisis Response Team

After George Floyd’s murder in 2020, a number of cities across the United States implemented the CAHOOTS mobile response model in their own communities. That year, the San Francisco Fire Department, Department of Public Health, Department of Emergency Management, and Department of Homelessness and Supportive Community Housing introduced the Street Crisis Response Team (SCRT) program.¹⁵⁴ As of June 2023, the program includes 12 mobile response teams, available 24/7 to respond to calls for help throughout San Francisco.¹⁵⁵ Each team is made up of a “community paramedic,”¹⁵⁶ EMT, and person with lived experience working as a peer support specialist or homeless outreach specialist.¹⁵⁷

The SCRT program makes data about the program and client outcomes publicly available through a page on the City and County of San Francisco website (<https://sf.gov/street-crisis-response-team>). The data report for September 2023 states that the SCRT has handled approximately 32,000 crisis calls since its inception, with an average response time of 17 minutes.¹⁵⁸ Eighty-nine percent of SCRT responses are dispatched by 911, with 10 percent prompted by community observations while a SCRT team is out in the field.¹⁵⁹ Fifty-three percent of response outcomes are resolved on the scene, with the client remaining in the community.¹⁶⁰ In 21 percent of SCRT responses, the client was transported to the hospital, and in 13 percent the client was transported to a community service provider.¹⁶¹ Notably, the SCRT’s community paramedics can initiate petitions for involuntary evaluation; this happened in five percent of responses.¹⁶²

Behavioral health clinicians were originally part of the three-person SCRT mobile team, but as of March 2023 clinicians now work under the Department of Public Health’s Office of Coordinated Care, providing assessment, follow-up services, and care linkages for clients seen by the mobile teams.¹⁶³

Peer support specialists working with the SCRT program are employees of the San Francisco-based peer services provider RAMS, Inc., which offers peer and mental health counseling, school-based programming, and training at over 30 sites throughout the city.¹⁶⁴ The SCRT’s peer workers are supervised by peer supervisors working at RAMS, which provides the peer crisis workers both general and specialized crisis service training.

“Through the current political climate [the SCRT] is a good response, and a good alternative to incarceration in many cases. . . . They meet people where they are. They are based on the ground. They connect them to resources. . . . But there is a lack of housing resources, and there are some barriers . . . especially challenges around diversity and resources. There is such a lack of resources to connect [people] anywhere else right now.”

–Peer advocate



For peer support workers, having shared life experiences means having similar experiences as a person living with a mental health condition, or having similar experience participating in mental health services, or with being institutionalized. This is not the only type of shared experience, however, that may foster the sense of mutuality that enhance the effectiveness of mental health services, including crisis services.

Alaska's Behavioral Health Aide (BHA) program (<https://www.anthc.org/behavioral-health-aide-program/>) has attracted attention for its deployment of paraprofessional workers in many of the rural or remote communities in which Alaska native people live. The BHA program grew out of a statewide "counselor-in-every-village" initiative to provide behavioral health services, including crisis services, in rural Alaska.¹⁶⁵ Founded in 2009, the BHA program is modeled after Alaska's Community Health Aide Program (CHAP), which was developed the 1960s and has since evolved to provide emergent, acute, and chronic medical care in rural tribal communities.¹⁶⁶

BHAs live in the small, rural areas in which they work.¹⁶⁷ They may be identified by members of the tribal village council to serve as a BHA, based on their "innate skills" and relationship to the community.¹⁶⁸ According to Dr. Xiomara Owens, Training Director for the BHA program, "They understand the challenges and strengths that exist for their population, which influence their identity, the workforce, and the services they provide." This helps

reduce the stigma that many people associate with seeking mental health services.

BHAs receive extensive training and must demonstrate a number of defined competencies before becoming certified.¹⁶⁹ They are supervised by master’s level clinicians, and many have lived experience with mental health or substance use issues themselves.¹⁷⁰ They can and do provide crisis de-escalation and stabilization support, but may also help provide clients with service planning, case management, linkage to resources, including counseling, skill coaching, and education on how to recognize symptoms of depression or anxiety, or how to deal with substance use issues, to help them avoid crises.¹⁷¹

Many BHA services are Medicaid reimbursable; some providers also receive limited funding from the federal Indian Health Service (IHS).¹⁷² Other states, including Colorado, Wyoming, and Minnesota, have or are considering implementing adaptations of the BHA model.¹⁷³

“BHAs are really people coming from the community; not pulling people from outside communities into these areas—not importing people. They were created to respond to hyper local culture.”

—Federal official



Brownsville In Violence Out

Photo by Amir Hamja for the New York Times

A different group of community responders based in the Brownsville neighborhood in Brooklyn, New York, are building another alternative to a law enforcement response to 911 calls. Brownsville In Violence Out (BIVO; <https://camba.org/programs/brownsville-in-violence-out/>), an anti-gun violence initiative, seeks to identify youth who have experienced trauma, and who may have been involved in domestic violence or other disputes, and provide them supportive services, including referrals to community-based mental health services.¹⁷⁴

The majority of BIVO workers are natives of Brownsville, a particularly high poverty area in Brooklyn.¹⁷⁵ They are Black and brown people who have themselves experienced gun violence and other forms of trauma, and have credibility among the youth they serve because they are also from Brownsville.¹⁷⁶

Several times a year, 911 phone calls from a two-block area in Brownsville are redirected from the police to BIVO workers.¹⁷⁷ They may be shadowed by police officers while responding to some calls.¹⁷⁸

Although many of the calls to which BIVO workers respond do not involve individuals known to the mental health system, some do: a June 2023 New York Times story told the story of BIVO's response to Alicia, who has schizophrenia and who was pushed out of a car

onto a Brownsville street.¹⁷⁹ BIVO workers bought Alicia food and drove her to a shelter where she could sleep.¹⁸⁰ According to one worker who helped Alicia, at least on that day BIVO’s intervention “provided [her] a moment of safety.”¹⁸¹

C. Somewhere to Go

A majority of calls for help involving people experiencing a mental health crisis can be resolved by trained workers answering a call or text, or by a mobile crisis team. In a system with adequate, timely hotline, warmline, and mobile response resources, relatively few situations should require transporting someone experiencing symptoms of distress to another location.¹⁸²

When transport is needed, it should be to a place that is as home like as possible.¹⁸³ Indeed, it should be a home to its visitors during their stay—think of a “mental health Airbnb.” Homes or apartments that serve visitors who are engaged in stabilization and thinking about next steps should have bedrooms, living rooms, and kitchens.¹⁸⁴ Access to outdoor space for fresh air and recreation is important.¹⁸⁵ Having privacy—being able to lock one’s bedroom, including to store personal items—is a must.

Staff should be welcoming and supportive without being intrusive or coercive. Other providers may also be invited into the home, but the goal should be for the individual guest to identify what help they want and need, and then for staff working in the home to help the guest make those connections in person or virtually as the guest prefers.¹⁸⁶

Peer-run or peer-led respite homes include many of these features and have been operating in the United States since the 1990s, with roots in earlier peer support programs.¹⁸⁷ They provide respectful, trauma-informed support for people experiencing acute symptoms, and help them avoid emergency rooms and hospitalization.¹⁸⁸



People USA—Rose Houses

The four Rose Houses (<https://people-usa.org/rose-houses/>) serving six counties in upstate New York represent a pioneering approach to diverting people experiencing mental health crises from hospitalization or incarceration.¹⁸⁹ Each Rose House is operated by people with lived or living experience—People USA, which operates the Rose Houses, is a peer-led organization—and is typically an at-least three-bedroom home that looks like any other home in the neighborhood, not a facility.¹⁹⁰ Trained “peer companions” staff the houses 24/7.¹⁹¹ Participation in the Rose House program is free and voluntary; guests can come and go as they please.¹⁹²

Guests may stay at a Rose House for up to seven days.¹⁹³ During that time, with their peer companion’s help the guest can connect with and participate in a full menu of customizable services and supports that can help them understand and manage the underlying causes of their crises, including peer support services, recovery and wellness education programs, solution planning, and linkage to other needed services.¹⁹⁴ At the guest’s request, Rose House staff including their peer companion may maintain contact and support after the guest ends their stay.¹⁹⁵ People USA also runs a peer warmline and provides care coordination and supportive housing services.¹⁹⁶

People USA’s Rose Houses have been a model for peer-run respite homes across the country and in Europe.¹⁹⁷ In 2021, 192 unique individuals were guests in the four New York State

Rose Houses.¹⁹⁸ As one of them said, “You all really saved my life. When I got to the Rose House I still really wanted to die but when I left there I no longer felt that. I know that I have to keep working on my mental health and that my struggle isn’t over—but at least now I’ve been motivated to socialize with friends, exercise, complete responsibilities, etc. That’s a pretty big change in motivation.”¹⁹⁹





Kiva Centers – Karaya and Juniper

Kiva Centers is a nationally recognized peer-run, trauma informed organization based in central Massachusetts but offering peer supports, training, and other opportunities across the state.²⁰⁰ Among Kiva Centers' initiatives are the older, larger (six bedroom) Karaya House in Worcester (<https://kivacenters.org/karaya-peer-respite/>), the second largest city in the state, and newer, smaller Juniper House in Bellingham (<https://kivacenters.org/juniper-respite-peer/>), a more rural area.

Both peer-run homes are in residential neighborhoods, and are indistinguishable from other single or multi-family homes in the area.²⁰¹ Both homes have living rooms, kitchens, and dining areas.²⁰² Both have outdoor decks or porches and yards and other outdoor spaces.²⁰³ Both are accessible to people with disabilities.



The average length of stay at both homes is 5-7 days, but guests may stay as long as a month.²⁰⁴ All supports at the home are voluntary

and confidential.²⁰⁵ The homes are operated by people with lived experience, who may lead meditation classes or support groups.²⁰⁶ According to the Kiva Centers' website, "[t]here are no 'service providers' and 'service recipients' in the Kiva Centers. . . . It is assumed that all individuals who come to the center for support will also give support to another at some point, and that each individual will not only approach the center with the attitude of what [they] can get but also what [they] can give."²⁰⁷



Jasmine Quinones, Kiva Centers' director of peer respite services, continues: "If there's one key word that sums it all up, that word is mutuality."²⁰⁸ According to Jasmine, this extends to Kiva employees working at the homes: "If someone needs a mental health day, we will always try to make that happen. We're always mindful that our staff are often trauma survivors too, and it's important to support them just like we support the guests."²⁰⁹

Both Karaya and Juniper also have teams of Mobile Peer-Run Respite Advocates that offer support to people who are experiencing symptoms of a crisis in their homes or wherever they are in the community.²¹⁰ The mobile peer respite provides support for up to four hours at a time, multiple days a week.²¹¹ This program (and a peer support line that supports callers on weekday evenings) expands Kiva's capacity to provide support, as Karaya and Juniper are often operating at full capacity, with a waitlist.²¹²

"We accept people who are unhoused. We ask them if they have somewhere safe to go to. We tell them we only have people stay for 5-7 days, [but] we wouldn't want you to go back to a shelter. . . . We have told people 5-7 days and they've stayed for 30, and that has helped deeply connect them to resources."

– Vesper Moore, Chief Operating Officer, Kiva Centers



Promise Resource Network: Retreat @ The Plaza

Promise Resource Network (PRN; <https://promiseresourcenetwork.org/>) is a peer-run organization based in Charlotte, North Carolina.²¹³ Founded in 2005 and 2006 by a collective of people with lived or living experience, allies, and service providers, PRN provides a number of peer-to-peer supports, including a warmline, virtual classes and support groups, and training.²¹⁴

In 2021, PRN opened the Retreat @ The Plaza, a peer-run respite home modeled after the Wildflower Alliance’s Afiya home in Massachusetts.²¹⁵ The Retreat is a spacious brick home with gardens, water features, and seating areas on patios.²¹⁶ Inside, the space looks like a home, with comfortable couches and chairs in the living room, dining room, and kitchen.²¹⁷ The home can accommodate three guests at a time, who may each stay up to 10 days. Each guest has their own room with a small refrigerator.²¹⁸

A stay at the Retreat is voluntary, and the doors in and out of the Retreat are unlocked.²¹⁹ The Retreat is staffed by people with personal experience with mental health and addiction.²²⁰ Guests at the Retreat are offered 24/7 peer support, linkage to other supports and resources, and activities including yoga, meditation, and bicycling. They can also continue to go to work or school while at the Retreat.

As Cherene Caraco, PRN’s Founder and CEO, has said, “Everything you see [at the Retreat] is

intentional. . . . [f]rom how wide the door frames are to accommodate wheelchairs, to the colors we chose to paint it, in tones that promote relaxation and healing.”²²¹

Caraco has noted that a stay at the Retreat is less costly than a stay at one of the state’s psychiatric hospitals.²²² At its opening in 2021, it cost \$111 per day for a guest to stay at the Retreat, compared to as much as \$2,573 per day for inpatient psychiatric treatment in North Carolina, according to the Kaiser Family Foundation.²²³



“These are people with trauma history so they assume people they come into contact with are experiencing trauma of some sort. . . . They use a ‘what happens to you’ lens vs. ‘what’s wrong with you’ lens. . . . People maintain [their] agency – [they are] not forced to succumb to the will of others for support.”

– North Carolina advocate

MHA of Nebraska: Keya House



The peer-run respite movement has taken root across the country. Since 2013, the Keya House (<https://mha-ne.org/programs-services/keya.html>) has provided supports to guests in a furnished, four-bedroom house in Lincoln, Nebraska.²²⁴ Guests may come and go as they please, and stay for free at Keya House for up to five days.²²⁵ There is an option to stay as a “day guest” for those who do not want to stay overnight.²²⁶ The home is staffed with trained peer specialists 24/7; at a guest’s request, staff can maintain contact and support after the guest leaves the home.²²⁷ Keya also operates a 24/7 warmline.²²⁸

There are rules at Keya House: guests must call to register before coming; must be 19 years or older; must not have an infectious physical illness; must be able to maintain personal hygiene; must be responsible for preparing meals and cleaning up after them; and must have permanent housing to go to after their stay at Keya House.²²⁹

As one former Keya House guest said, “[y]ou guys have an amazing system. When I go to the hospital I’d freak out more because I can’t work. I can’t make money or pay bills so I’d freak out even more and spiral down even more. . . . Thank you for giving me encouragement and hope.”²³⁰

How To Pay For Peer-Led/Peer-Involved Crisis Services

With today's increased focus on building capacity for alternative responses to mental health crises, states and localities are looking for sustainable funding sources for crisis services. The federal government has tried to help, and provided resources that can be used to fund peer-led and peer-involved services. For example, the American Rescue Plan Act, signed into law in 2021, provided enhanced Medicaid reimbursement for “qualifying” mobile crisis teams.²³¹ Although these teams must include a mental health clinician, peer workers may also be members of the team.²³² New Medicare regulations permit increased reimbursement under that program for crisis supports provided in the community.²³³ Other federal funding for mental health services require that a certain portion be set aside to fund crisis services; these may include peer-provided supports.²³⁴

States are also appropriating funds for mental health crisis services. Some states have enacted taxes to pay for mental health hotlines, including local 988 partners.²³⁵ State governments have funded mobile response teams, and have been partners in helping establish and fund statewide peer networks and some of the peer-led organizations that operate warmlines and crisis respite homes.²³⁶

Some cities have developed innovative ways of funding mental health crisis resources. The city of Denver, Colorado, developed and sold social impact bonds to fund various housing and service programs, and provided initial and ongoing financial support for the city's version of a CAHOOTS-type alternative mobile responder, the Support Team Assisted Response (STAR) program.²³⁷

Of course, anyone—not just people with mental health disabilities, and not just people who depend on public health programs like Medicaid for healthcare—may want and need help from mental health crisis services. Communities are increasingly looking to other sources of funding to build capacity, including hospitals, private insurers including managed care plans, foundations, and law enforcement agencies for contributions that may be braided along with

Medicaid, Medicare, and federal and state grant programs to develop and sustain crisis supports.²³⁸

Regardless, states and localities must take care that funding sources do not introduce practice requirements that are inconsistent with peer support guidelines and ethos, and the recovery model. For example, the federal government has stated that to provide services reimbursable by Medicaid peer support workers must be supervised by a “competent mental health professional.”²³⁹ States have interpreted this to mean that peer workers in Medicaid-reimbursed programs must be supervised by clinicians, persons with masters’ level credentials or higher, and not by other peers. Because they do not have relevant life experience and have not done peer work themselves, clinicians may not appreciate the types of support that peers provide, and may not be as effective at supporting peer work as those who have actually done the work themselves would be. This requirement should be changed so that people with lived experience themselves can supervise and support others working as peers.²⁴⁰

V. Peers Are Delivering Other Community-Based Mental Health Services

Many of the peer-led and peer-involved crisis service providers identified above provide other important services and supports to people with mental health disabilities or who experience crises.

For example, both Promise Resource Network and Kiva Centers provide **peer support services**, supports provided by a worker with lived experience that may include skill building, mentoring, service navigation and linkage, and help with development of social networks.²⁴¹ These supports help individuals develop positive relationships with others that in turn help the individual live successfully in their own homes, stay connected to treatment providers, maintain or develop social relationships, and participate in meaningful activities during the day, including employment, education, and social activities in the community.²⁴² Peer support services may be provided on a 1:1 basis or through in-person or virtual peer group sessions.²⁴³

People with lived experience also participate in other services that have been shown to be effective at helping people with mental health challenges and disabilities live successfully in their own homes and communities, and avoid cycling through periods of hospitalization and incarceration. **Assertive Community Treatment (ACT)** is a set of services provided by a multi-disciplinary team that are wrapped around an individual and provided wherever they are in the community.²⁴⁴ Sometimes referred to as a “hospital without walls,” an ACT team provides case management, psychiatric services, medical services and support with medication, behavior support, employment supports, and substance use supports as needed.²⁴⁵ ACT teams should be the frontline crisis responders for their clients.²⁴⁶ To be provided with fidelity to accepted standards for ACT, the team should include a peer support worker.²⁴⁷ People with lived experience are working on ACT teams in states and localities across the country to support ACT program participants, including when they experience crises.²⁴⁸

People with lived experience are also working with providers of **supported housing services**. These services are provided to people with mental health disabilities to help them find and apply for apartments or other types of permanent integrated housing, move in to their new homes, and support them to maintain their households, including by providing help with

financial management and independent living skills.²⁴⁹ Trained peer workers can provide help with housing navigation services—finding potential apartments for the individual being supported to visit and choose from—support with transitioning from institutional settings or homelessness to an individual’s new home, and helping the individual learn how to keep house.²⁵⁰

People with lived experience who have been through the experience of transitioning into a home are often critical support for others who are going through the experience.²⁵¹ They can be highly effective role models for those who may be going through the process of finding and moving into a new home for the first time, or for the first time in a long time.²⁵²

People with lived experience are also helping to provide **supported employment services** to individuals with mental health disabilities. Supported employment providers help clients identify types of employment of interest and that match the client’s skills, help the client develop a resume and engage in a job search, and then provide job coaching and social skills instruction that help the client keep the job and advance in the workplace.²⁵³ Trained peer workers who have been through the process of finding and keeping a job can help provide many of these supports to clients.²⁵⁴

Every state must develop the capacity to provide all of these services to people with mental health challenges and disabilities who need them in order to live successfully in the community. Peer-led and peer-involved mental health crisis services are but one important part of the service array that helps people with mental health disabilities live successfully in the community and avoid unnecessary institutionalization.²⁵⁵

The evidence indicates that all of these services can be delivered more effectively—with more sense of mutuality and in a more culturally responsive manner, among other things—if people with lived or living experience working as peers are supported members of the teams providing services.²⁵⁶

“What’s beautiful about this work is seeing people who have gone through difficult traumatic experiences flourish and reclaim power over their lives after so many degrading, dehumanizing experiences. There’s nothing more powerful. Social disconnection often comes from oppression and power. Peer work creates a reservoir of hope.”

—Peer organization leader

VI. Recommendations

This paper supports increasing access to peer-led and peer-involved mental health crisis services, with a special focus on peer-led organizations that support peer workers in providing effective services to clients. Government authorities, including Congress, the U.S. Department of Health and Human Services (HHS), and state and local governments can and should take action to better support peer-led and peer-involved crisis services.

Congress should:

- Enact legislation to fund peer-involved crisis services through federal grant programs that require grantees to be peer-led and/or to employ significant numbers of people with lived or living experience working as peers, and that require grantees to provide specialized training, assistance with certification, and ongoing support to their peer workers. To the extent that federal grant programs support peer-led hotlines or warmlines, expressly support confidential services as an alternative to the 988 Lifeline.
- Permanently authorize flexibilities, first permitted in response to the COVID-19 pandemic, in Medicaid funding for virtual, telephonic, and digital mental health crisis services, and explicitly permit such funding for virtual crisis services led by people with lived or living experience.²⁵⁷ As a general matter, Congress can enact grant funding programs supporting virtual peer support services, which can help enhance and build capacity for peer-led and peer-involved hotlines, warmlines, and mobile crisis services.²⁵⁸
- Enhance Medicaid reimbursement for peer-led or peer-involved crisis services, including so that Medicaid billing requirements are consistent with principles of the peer support movement, and make such services expressly available through other federal healthcare programs like Medicare and the Children’s Health Insurance Program (CHIP).
- Invest in programs that help expand the mental health workforce, including peer-led and peer-involved crisis services, and provide incentives to individuals with lived or living experience from Black and brown communities, LGBTQIA++ communities, and other underrepresented groups to join the workforce.²⁵⁹

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- Enact legislation that builds support for peer-led and peer-involved services, including crisis services, through federal agency action. For example, the PEER Support Act, introduced in 2023, would: direct the federal Office of Management and Budget (OMB) to create a distinct occupational classification for peer workers so that data on the employment of peer workers can be standardized and better tracked; make permanent the Office of Recovery in the Substance Abuse and Mental Health Services Administration (SAMHSA), to better support professional development of peer workers; and direct the HHS to study states' criminal background screening processes that may pose barriers to peer work.²⁶⁰

The U.S. Department of Health and Human Services should:

- Build on SAMHSA's National Model Standards for Peer Support Certification and the National Association of Peer Supporters' National Practice Guidelines for Peer Specialists and Supervisors by providing additional guidance on training and certification for peer crisis workers.²⁶¹
- Improve Medicaid rules regarding reimbursement for peer services to make them more consistent with principles of the peer support movement, including removing the requirement that peer support services be delivered under the supervision of a clinician.²⁶²
- Provide additional guidance on, and promote and fund, community-based services that include roles for peer support workers, including ACT, mobile crisis services, supported housing, and supported employment.²⁶³
- Provide significant funding to promote peer worker training and employment in Black and brown communities, including through the efforts of the National Network to Eliminate Disparities in Behavioral Health (NNED).²⁶⁴
- Along with foundations, universities, and other funders, fund and support research to continue to study and develop quantitative and qualitative data about the effectiveness of peer-led and peer-involved crisis supports. Studies to date indicate the promise, and

success, of these supports at improving outcomes for the individuals supported, but more research is needed to support implementation of these models.

State and local governments should:

- Work with statewide peer networks and providers of peer support services to develop specialized in-person and virtual training protocols for people with lived or living experience who want to work in crisis services.²⁶⁵
- Collaborate with statewide peer networks and providers of peer support services to develop resources and technical assistance to help support the peer support workforce, including supports for worker mental health.
- Work with CMS to revise Medicaid billing codes and service definitions for peer support work, including peer crisis work, so that they more clearly describe the unique role of peers in provide supports to people with mental health challenges, including those experiencing crises.²⁶⁶
- Conduct rate studies and otherwise rethink the compensation paid to peer workers for their singular contributions to the mental health system.²⁶⁷
- Encourage private insurers working in the state to reimburse peer support services, and to contribute to peer crisis services that benefit everyone in the state, regardless of insurer or health care provider, who may experience symptoms of distress.²⁶⁸
- Take steps to diversify the peer workforce, including by strengthening efforts to recruit and retain peer crisis workers in Black and brown communities, the LGBTQIA++ community, and among those with past criminal system involvement or substance use histories. Peer workers should reflect the lived experiences of people in the communities they serve, including Black and brown communities.
- Create a continuum of alternative responders to calls for help, from street outreach teams, to CAHOOTS-type teams, to mental health crisis teams to handle the wide variety of calls for help involving people with mental health challenges, and ensure that peer workers

are supported in working in all of these types of teams. Affected communities should be centered in decisions about the design, implementation, and evaluation of all alternatives, including through leadership of advisory councils and working groups.

- Ensure that peers are working on teams providing other community-based services that have been shown to help people with mental health disabilities avoid crises and subsequent hospitalization or incarceration, including ACT, peer support services, supported housing, and supported employment.
- Conduct public education campaigns to inform people about the availability of alternatives to 911 when help is needed.²⁶⁹ Public communications about alternative responders should highlight the role of peers working with hotlines or warmlines or on mobile response teams.

VII. Conclusion

Peer support work is an essential part of the mental health system, including crisis services. Perhaps no one better understands the journey of recovery that people experiencing acute mental health symptoms traverse than another person with shared life experiences. As the National Association of Peer Supporters has said, “[t]he belief that recovery is possible for all who experience a psychiatric, traumatic, or substance use challenge is fundamental to the practice of peer support.”²⁷⁰

This paper argues that, for a number of reasons, people with lived experience who are working in and leading mental health crisis services make those services more effective—and a more effective and less harmful alternative to law enforcement responses to calls for help. Peer support workers help de-escalate crisis situations, help people stabilize and gain control over their emotions and behavior, and engage them in thinking about next steps and deciding whether to participate in other services and supports, and if so which ones.

Our public health systems must make significant changes to ensure that peer-led and peer-involved organizations can work effectively in mental health crisis services. Building the capacity to provide peer-led and peer-involved supports means finding ways to take full advantage of the life experience and expertise of peer support workers. This should not be accompanied by rules and regulations that impede peer workers from providing the supports they are best placed to provide. Instead, policies for how peers are paid for their work, how they are recruited and trained, and how they are supervised must be changed so that these valuable workers can do their jobs, and be paid commensurate with the value they provide to the systems in which they work, and the individuals they support.

States and localities across the country are making these changes as they realize the benefit to individuals experiencing mental health crises when they receive the supports provided by peers. Much more needs to be done, but the successful models for peer crisis supports described here show that these changes can take place, and benefit the lives of people receiving supports, including those for whom a crisis begins a journey to recovery.

“[M]any people who are hospitalized after an emotional crisis. . . . are treated as a burden and not listened to – certainly not with[] empathic emotional awareness But imagine a different community response to how people in extreme emotional states are treated in the community. [Peer support] is a research-proven compassionate response. It is critical that this resource expand to every community across the country.”

–Peer work advocate (<https://www.madinamerica.com/2021/10/peer-respite/>)

Endnotes

- 1 See, e.g., U.S. Substance Use Mental Health Services Administration (SAMHSA), *Crisis Services: Meeting Needs, Saving Lives* 7 (Aug. 2020) (“The crisis continuum includes various crisis services for individuals with urgent behavioral health needs, the response to such crises and subsequent pathways toward more complete assessment and treatment when needed.”), <https://store.samhsa.gov/sites/default/files/pep20-08-01-001.pdf>.
- 2 See, e.g., SAMHSA, *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit* 33 (2020) [hereinafter SAMHSA National Guidelines] (“In many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the *de facto* mental health mobile crisis system.”), <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>; Margaret E. Balfour et al., *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies*, 73 *Psychiatric Servs.* 6, pp. 658-69 (June 2022) (“Law enforcement agencies, emergency departments (EDs), and jails have become the *de facto* emergency response system for [individuals experiencing behavioral health crises]”), <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000721>.
- 3 See, e.g., Legal Defense Fund & Bazelon Center for Mental Health Law, *Advancing An Alternative to Police: Community-Based Services for Black People with Mental Illness* *passim* (Jul. 2022), <https://www.bazelon.org/wp-content/uploads/2022/07/2022.07.06-LDF-Bazelon-Brief-re-Alternative-to-Policing-Black-People-with-Mental-Illness.pdf>.
- 4 *Id.* at 1-6 (collecting studies and recounting stories of Natasha McKenna, Saheed Vassell, Daniel Prude, and Walter Wallace Jr.).
- 5 See Julia Bingel et al., *Man Dies After Being Shot By CMHA Police Officer*, 19 *News* (Sep. 5, 2022), <https://www.cleveland19.com/2022/09/05/man-dies-after-being-shot-by-cmha-police-officer/>.
- 6 See WITN, *SBI Releases Info On Officer-Involved Shooting That Killed Duplin County Man* (Mar. 2, 2023), <https://www.witn.com/2023/03/02/sbi-releases-info-officer-involved-shooting-that-killed-duplin-county-man/>.
- 7 See Ty Storey, *Opp Man Dies In Officer-Involved Shooting*, *News4* (June 23, 2023), <https://>

www.wtvy.com/2023/06/23/alea-opp-man-dies-officer-involved-shooting/?utm_source=twitter&utm_medium=social&utm_campaign=snd&utm_content=wtvy.

8 See Praveena Somasundaram, *3 Officers Charged With Murder After a Woman In “Crisis” Was Fatally Shot*, Wash. Post (June 26, 2023), <https://www.washingtonpost.com/nation/2023/06/26/san-antonio-shooting-death-charges/>. The stories of Black and brown people with mental health disabilities killed by police summarized above are maintained in the Washington Post’s database of fatal police shootings since 2015. See Washington Post, *Fatal Force: 922 People Have Been Shot and Killed By Police In the Past 12 Months* (updated Oct. 12, 2023), <https://www.washingtonpost.com/graphics/investigations/police-shootings-database/>.

9 See, e.g., National Conf. of State Legislators, *Mental Health Emergencies, Law Enforcement and Deflection Pathways* (Feb. 9, 2022) (“Due to lack of access to alternatives, law enforcement can spend one-fifth of its time responding to and transporting individuals with mental illness to emergency departments or jails. . . . Communities face low capacity for mental health treatment, lack developed mental or behavioral health crisis response systems, and are short of resources even when people are incarcerated.”), <https://www.ncsl.org/state-legislatures-news/details/mental-health-emergencies-law-enforcement-and-deflection-pathways>.

Law enforcement transport to an emergency room introduces additional trauma to an individual’s experience of mental health crisis care, including when an individual in crisis is escorted into the emergency department by police officers in a form of “perp walk.” Individuals experience trauma in these situations even when officers are otherwise treating the individual with respect.

10 See, e.g., National Alliance on Mental Illness (NAMI), *Navigating a Mental Health Crisis* 5 (2018) (“A mental health crisis is any situation in which a person’s behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community.”), <https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis/Navigating-A-Mental-Health-Crisis#:~:text=A%20mental%20health%20crisis%20is,effectively%20in%20the%20community>.

11 See, e.g., SAMHSA, *Peer Support Services in Crisis Care* 4 (June 2022) (“Individuals may experience a crisis or a situation causing significant emotional distress. Many of these individuals, but not all, may have a mental and/or substance use disorder.”), <https://store.samhsa.gov/sites/default/files/pep22-06-04-001.pdf>.

12 *Id.* (“Crises differ for each individual and may result from adverse changes in life circumstances, such as the loss of a relationship, loved one, or job, or they may represent the wors-

ening of untreated mental or substance use disorder.”).

13 See, e.g., Dennis Debbaudt, *Autism Spectrum and Law Enforcement Training* (May 1, 2006) (“When a person displays unusual behavior in a community setting where they are not known, these behaviors may be interpreted by others as suspicious, threatening, criminal in nature, or as someone high on drugs or other substances. . . . When a person displays escalated behavior in the community, at school, or at home, unaware of the person’s autism, citizens will call 911.”), <https://researchautism.org/oaracle-newsletter/autism-spectrum-and-law-enforcement-training/>.

14 See, e.g., Corky Siemaszko, *Colorado Case Shows Police Aren’t Trained to Interact with the Deaf Community*, NBC News (Sep. 30, 2021) (reporting on deaf Colorado man who alleged that two police officers “slammed him to the ground . . . during an arrest despite his attempts to tell them that he could not understand their commands”), <https://www.nbcnews.com/news/us-news/colorado-case-shows-police-aren-t-trained-interact-deaf-community-n1280496>.

15 See, e.g., IACP Law Enforcement Policy Center, *Interactions with Individuals with Intellectual and Developmental Disabilities* 4-5 (Aug. 2017) (“Persons with I/DD might not understand social conventions and appropriate social behavior. This can trigger suspicion on the part of those who witness atypical, offensive, or suspicious actions in public and who subsequently call for assistance.”), <https://www.theiacp.org/sites/default/files/2018-08/IntellectualDevelopmentalDisabledPaper.pdf>.

16 See, e.g., Cleveland Clinic, *What Does Depression Feel Like?* (Sep. 21, 2023) (in discussion of severe or persistent depressive disorders, noting that people with depression may internalize their feelings), <https://health.clevelandclinic.org/what-does-depression-feel-like/>.

17 See, e.g., McKenna Schueler, *Five Warning Signs of Mental Illness that People Miss*, NAMI (May 3, 2021) (emphasizing that not everyone can identify and detect mental health symptoms), <https://www.nami.org/Blogs/NAMI-Blog/May-2021/Five-Warning-Signs-of-Mental-Illness-that-People-Miss>.

18 See Rachel Rouben, *A new 9-1-1 for mental health is on the way*, Wash. Post (Mar. 21, 2022), <https://www.washingtonpost.com/politics/2022/03/21/new-9-1-1-mental-health-is-way/>; Rhitu Chatterjee, *New Law Creates 988 Hotline For Mental Health Emergencies*, npr (Oct. 19, 2020) (discussing the 2020 bipartisan bill that introduced 988 as the number for people experiencing mental health crisis), <https://www.npr.org/sections/health-shots/2020/10/19/925447354/new-law-creates-988-hotline-for-mental-health-emergencies>.

19 See Olivia Randi, *American Rescue Plan Act Allows States to Expand Mobile Crisis Interven-*

tion Services for Children and Youth Through Medicaid, Nat'l Acad. For State Health Pol'y (Oct. 02, 2021) (Section 9813 of the ARPA creates a new state Medicaid option which provides funding for mobile crisis intervention services that meet federally established requirements), <https://nashp.org/american-rescue-plan-act-allows-states-to-expand-mobile-crisis-intervention-services-for-children-and-youth-through-medicaid/#:~:text=Section%209813%20of%20the%20ARPA,starting%20on%20April%201%2C%202022.>

20 See, e.g., Chris Lee, *Amid a Mental Health Crisis in the U.S., A New KFF Report Examines the Steps that State Medicaid Programs Are Taking to Help Shore Up the Availability of Crisis Services*, Kaiser Fam. Found. (May 25, 2023) (reporting that several states have crisis service initiatives including crisis stabilization, diversion, and receiving centers), <https://www.kff.org/mental-health/press-release/amid-a-mental-health-crisis-in-the-u-s-a-new-kff-report-examines-the-steps-that-state-medicaid-programs-are-taking-to-help-shore-up-the-availability-of-crisis-services-beneficiaries/>.

21 See, e.g., Charlene Sunkel & Claudia Sartor, *Perspectives: involving persons with lived experience of mental health conditions in service delivery, development and leadership*, Nat'l Libr. of Med. (June 2022) (“Globally, there has been an emphasis on the importance and value of involving people with lived experience of mental health conditions in service delivery, development and leadership”), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9346508/>.

22 See, e.g., Ana Stefancic et al., “*What We Have in Common*”: *A Qualitative Analysis of Shared Experience in Peer-Delivered Services*, Cmty. Mental Health J. (Mar. 22, 2019) (explaining that although peer specialists rarely reported explicitly sharing experiences related to mental health with clients the shared experience of mental health shaped peer specialists’ approach to service), https://www.researchgate.net/publication/331970159_What_We_Have_in_Common_A_Qualitative_Analysis_of_Shared_Experience_in_Peer-Delivered_Services

23 *Id.* (detailing the experience of a peer worker who engaged with a client by tapping into their shared culture knowledge of African culture).

24 *Id.* (“While peers possess qualifications through training, many reported that the ability to tell clients that they have ‘been there’ is their main source of credibility used to establish trust.”).

25 See, e.g., Wilder Hickney, *The Early Peer Support Movement*, Colorado Mental Wellness Network (Jan. 11, 2022) (“Research suggests that peer support originated in 18th century France, but did not receive widespread attention until the 19th and 20th centuries, when many survivors of the psychiatric system wrote pamphlets, established advocacy groups, and

tried to bring their stories and experiences to the public.”), <https://cmwn.org/the-history-of-peer-support/the-early-peer-support-movement/>.

26 See, e.g., Larry Davidson, *The Recovery Movement: Implications For Mental Health Care And Enabling People To Participate Fully In Life*, 35 Health Affs. 1091, 1094 (June 2016) (noting that the work of peers who support others while in recovery themselves plays a key role in the recovery movement), <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2016.0153>.

27 See, e.g., *The Early Peer Support Movement*, *supra* note 25.

28 See, e.g., Malcolm Payne, *Peer Support in Mental Health: A Narrative Review of Its Relevance to Social Work*, 4 Egyptian J. Soc. Work 1, 22-23 (June 2017) [hereinafter *Peer Support in Mental Health*], https://ejsw.journals.ekb.eg/article_8725_7f1e0ebd3b66b9f49c4575a121fea810.pdf.

29 *Id.* at 22.

30 SAMHSA, *SAMHSA's Working Definition of Recovery* 3, <https://store.samhsa.gov/sites/default/files/pep12-recdef.pdf> (last visited Sep. 26, 2023), *cited in* National Assoc. of Peer Supporters, *National Practice Guidelines for Peer Specialists and Supervisors ii* (2019) [hereinafter *National Practice Guidelines*], <https://www.peersupportworks.org/wp-content/uploads/2021/07/National-Practice-Guidelines-for-Peer-Specialists-and-Supervisors-1.pdf>.

31 See, e.g., NY Peer Specialists, *New York Certified Peer Specialist NYCPS Application* 4 (Jan. 2020) (stating that to be certified, peer specialists must complete 60 hours of training and provide documentation of 2000 hours of experience under supervision of a qualified supervisor), <https://nypscb.org/wp-content/themes/nypscb/files/PDFs/NYCPS%20Application%20Feb%2002-14-2020.pdf>.

32 See, e.g., Jim Winarski, Florida Mental Health Inst., *Motivational Interviewing for Peer Specialists*, <https://prod.myflfamilies.com/sites/default/files/2022-11/Motivational%20Interviewing%20for%20Peer%20Supporters%20Handout.pdf> (last visited Sep. 26, 2023).

33 See generally New York State Office of Mental Health, *NYS OMH Mental Health Outpatient Treatment and Rehabilitative Services Guidance on Youth, Family, Adult, and Older Adult Peer Support Services* 7-8 (Nov. 23, 2022) [hereinafter *NYS OMH Peer Support Guidance*] (peer specialists connect individuals with appropriate services and supports, and “[h]elp[] the individuals identify and become involved in leisure and recreational activities in their community”), https://omh.ny.gov/omhweb/clinic_restructuring/part599/mhotrs-peer-support-services-guidance.pdf.

34 *Id.* at 6, 8 (peer specialists “[a]ssist individuals to identify and set goals and short-term objectives that reflect individual preferences and encourage active participation in life,” “[h]elp[] the individuals to rediscover and reconnect to natural supports already present in their lives”).

35 *See, e.g.*, Rigmor C. Berg et al., *The Effectiveness of Peer Support for People Living with HIV: A Systematic Review and Meta-Analysis*, PLoS ONE 16(6): e-252623 14-20 (2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8211296/pdf/pone.0252623.pdf>; Lidia Schapira, MD, FASCO, *Why Peer Support Is Important for People Coping With Cancer* (June 22, 2017), <https://www.cancer.net/blog/2017-06/why-peer-support-important-people-coping-with-cancer>.

36 *See* Sarah White et al., *The effectiveness of one-to-one peer support in mental health services: a systematic review and meta-analysis*, BMC Psychiatry (Nov. 11, 2020) (concluding that peer support workers are more effective in positively impacting psychosocial outcomes of people with mental health disabilities compared to non-peer support workers), <https://bmcpsy psychiatry.biomedcentral.com/articles/10.1186/s12888-020-02923-3>.

37 *See, e.g.*, Steve Gillard, *New ways of working in mental health services: a qualitative, comparative case study assessing and informing the emergence of new peer worker roles in mental health services in England*, Nat’l Inst. of Health Rsch. (Jul. 2014) (noting that peer workers who share life experiences with individuals they support can improve the care delivered by the staff), <https://www.ncbi.nlm.nih.gov/books/NBK373837/>.

38 *See, e.g.*, SAMHSA, *National Model Standards for Peer Support Certification* 24 (2023) [hereinafter National Peer Standards] (providing an overview of the costs and fees associated with peer support application, training, examination, and recertification), <https://store.samhsa.gov/sites/default/files/pep23-10-01-001.pdf>; NAMI, *Types of Mental Health Professionals* (Apr. 2020) (listing the different credentials and professional requirements of various mental health professionals), <https://www.nami.org/About-Mental-Illness/Treatments/Types-of-Mental-Health-Professionals>.

39 *See, e.g.*, Peer Support in Mental Health, *supra* note 28, at 22-23 (“Within the recovery movement, peer support contests ‘professional centrism’ . . . which gives the greatest importance in recovery to medical, nursing and social treatment and care. This stance sees patients as developing illness, receiving treatment, with their condition improving or being cured. . . . By contrast, recovery perspectives focus on the whole life experiences of people with mental illnesses and social and community reactions to changes in their wellness and illness.”).

40 *See, e.g.*, Larry Davidson, *The Recovery Movement: Implications for Mental Health Care*

and *Enabling People to Participate Fully in Life*, 35 *Health Affairs* 6 (June 2016) (“In its current form, the training and hiring of people who are in recovery from a mental illness to provide support to others within the mental health system began around the same time as passage of the ADA. . . . [P]roviders hoped that some of the benefits they witnessed people deriving from peer-to-peer relationships outside the mental health system could be imported into that system. At first, volunteer positions were created through which people who were doing well could mentor others who were struggling. But by the early 1990s, paid positions were being created for peers to play a variety of roles, from those of case manager aide or housing support staff to the new roles of recovery educator or advocate.”), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0153>; Michael Hlebechuk, *History of Insanity and the Evolution of the Peer Recovery Movement* 78 & *passim* (citing Judi Chamberlain, *On Our Own: Patient Controlled Alternatives to the Mental Health System* (1978)), https://www.oregon.gov/deiconference/Documents/Hlebechuk_Michael%20History%20of%20Insanity%20and%20the%20Evolution%20of%20the%20Peer%20Recovery%20Movement.pdf (last visited Oct. 16, 2023).

41 See generally Rebekah Falkner et al., *States’ Use of Peers in the Mental Health Crisis Continuum*, Nat’l Acad. for State Health Pol’y (Aug. 30, 2022) (explaining how states have utilized peer workers in crisis services), <https://nashp.org/states-use-of-peers-in-the-mental-health-crisis-continuum/>.

42 See generally Kyle Lane-McKinley, *Peer Support Specialists Can Play Important Role in Patients’ Lives*, *Psychiatric News* (Jan. 26, 2023) (highlighting that peer support specialists support an individual experiencing a mental health crisis by acting as “someone to call (988), someone to show up (mobile crisis response teams), and somewhere to go (crisis stabilization centers)”), <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2023.02.2.14>.

43 See, e.g., National Empowerment Center, *Directory of Peer Respite* [hereinafter *NEC Directory*] (listing peer respite homes that “are staffed and operated by people with psychiatric histories or who have experienced trauma and/or extreme states. This means that: 1) 100% of staff have lived experience of extreme states and/or the behavioral health system; 2) All individuals in program/house management positions have lived experience of extreme states and/or the mental health system”), <https://power2u.org/directory-of-peer-respites/> (last visited Oct. 2, 2023).

44 See SAMHSA, *Peers as Crisis Service Providers* 44 (June 10, 2015), https://www.nasmhpd.org/sites/default/files/Peers%20as%20Crisis%20Service%20Providers_SAMSHA_6.10.15.pdf; Larry Davidson et al., *Peer support among persons with severe mental illnesses: A review of evidence and experience*, *World Psychiatry*, 11, 123-128 (2012), <https://www.ncbi.nlm.nih.gov/pmc/arti->

[cles/PMC3363389/](https://pubmed.ncbi.nlm.nih.gov/17269271/).

45 See So-Young Min et al., *Peer support for persons with co-occurring disorders and community tenure: A survival analysis*, *Psychiatric Rehabilitation Journal*, 30, 207-213 (2007), <https://pubmed.ncbi.nlm.nih.gov/17269271/>; see also SAMHSA, *Peers Supporting Recovery from Mental Health Conditions* (2017) [hereinafter *Peers Supporting Recovery*] (citing studies), https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/peers-supporting-recovery-mental-health-conditions-2017.pdf.

46 See *Peers Supporting Recovery*, *supra* (citing studies).

47 See *Peer Support Services in Crisis Care*, *supra* note 11, at 6 (citing Ellen L. Bassuk et al., *Peer-delivered recovery support services for addictions in the United States: A systematic review*, *J. Substance Abuse Treatment* 63, 1-9 (2016), <https://doi.org/10.1016/j.jsat.2016.01.003>).

48 See Mental Health America, *Evidence for Peer Support* 1-2 (May 2019) (collecting studies), <https://www.mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202019.pdf>; Bazelon Center for Mental Health Law, *Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration*, *passim* (2019) [hereinafter *Diversion to What?*] (collecting studies), <https://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication-September-2019.pdf>.

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50 See Fountain House, *Rebuilding the Mental Health Crisis Response System in New York City* (“[W]e urge the City of New York to work quickly to close trust and service gaps . . . so that the people . . . have access to: A peer or mental health professional they can speak to within seconds instead of minutes.”), <https://www.fountainhouse.org/reports/rebuilding-mental-health-crisis-response-ny> (last visited Sep. 28, 2023); Heather Saunders, *Taking a Look at 988 Suicide & Crisis Lifeline Implementation One Year After Launch*, KFF (Jul. 14, 2023) (noting

that average wait time for calls, texts, and chats to the 988 Lifeline decreased from 2 minutes 20 seconds in May 2022 to 35 seconds in May 2023), <https://www.kff.org/mental-health/issue-brief/taking-a-look-at-988-suicide-crisis-lifeline-implementation-one-year-after-launch/>.

51 See National Council for Mental Wellbeing, *Roadmap to the Ideal Crisis System* 99 (Mar. 2021) (“accountable entity” must fund and implement adequately staffed mobile crisis team coverage for community, with “[c]apacity to respond to calls within one hour more than 90% of the time), https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf.

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76 See Peer Support Services in Crisis Care, *supra* note 11, *passim*.

77 *Id.*; see also SAMHSA National Guidelines, *supra* note 72, *passim*; Cost-Effectiveness of Crisis Services, *supra* note 68, at 14-17.

78 See, e.g., Peer Support Services in Crisis Care, *supra* note 11, at 5-6 (peer support staff working in crisis services can “help improve outcomes, such as reduced trauma and agitation, increased trust, reduced hospitalizations and emergency department usage for mental and/or substance use disorders, reduced recurrence of symptoms, and decreased recidivism”).

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80 See, e.g., City of Philadelphia Dept. of Behav. Health & Intellectual Disability Servs., *Peer Support Toolkit* 107-129 (discussion regarding “supporting, supervising, and retaining peer staff”), https://dbhids.org/wp-content/uploads/1970/01/PCCI_Peer-Support-Toolkit.pdf (last visited Oct. 3, 2023).

81 See, e.g., National Practice Guidelines, *supra* note 26, at 2 (“Ideally, all peer support specialists are supervised by people who have lived experience with recovery and peer support. . . . Traditional academic education is not a substitute for the training and life experience of a peer support specialist who practices from the perspective of having lived experience.”).

82 See Peer Support Services in Crisis Care, *supra* note 7, at 9-10 (explaining “organizational” peer drift, when non-peer colleagues marginalize peer workers and assign them tasks that misalign with dedicated job responsibilities, and “individual” peer drift, when peer support worker acts in role that differs from intended role).

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help Groups: A Tool to Assess and Enhance Your Services 22 (2010) [hereinafter STAR Center Toolkit] (focusing on need for peer-led programs to improve cultural competency by learning about different cultures' lifestyles in order to effectively deliver services to clients from those communities), <https://power2u.org/wp-content/uploads/2017/09/CulturalCompetencyInMentalHealthPeer-runProgramsSelf-helpGroups.pdf>.

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91 See, e.g., Currie Myers & Ja’Ron Smith, *Police shouldn’t handle mental health calls. Reform is critical for public safety*, USA Today (Apr. 24, 2023) (“Police are not the appropriate responders to every mental health crisis. Law enforcement should be focused on preventing and solving serious crime, and are often not sufficiently trained and equipped to respond to crisis situations involving people suffering a mental health emergency.”), <https://www.usatoday.com/story/opinion/2023/04/23/rethink-police-response-mental-health-crises-focus-community-care/11652697002/>; Andrew Selksy & Leah Willingham, *How some encounters between police and people with mental illness can turn tragic*, PBS News Hour (Sep. 2, 2022) (chronicling several stories of police officers responding with violence to people with mental health conditions undergoing crisis), <https://www.pbs.org/newshour/health/how-some-encounters-between-police-and-people-with-mental-illness-can-turn-tragic>.

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97 See SAMHSA National Guidelines, *supra* note 2, at 7 (“Crisis providers must address the recovery needs of individuals and families to move beyond their mental health and substance use challenges to lead happy, productive and connected lives each and every day.”).

98 See *id.* at 21 (“Appropriate crisis response . . . requires measures that address the person’s unmet needs, both through individualized planning and by promoting systemic improvements.”); NAMI Minnesota, *Mental Health Crisis Planning*, *passim* (Dec. 2018), https://namimn.org/wp-content/uploads/sites/48/2018/12/MHCrisisPlanningAdult_2018.12.14.pdf.

99 See Peer Support Services in Crisis Care, *supra* note 11, at 1, 5-6, 9;

100 *Id.*; see also SAMHSA, *Peers Supporting Recovery From Mental Health Conditions* 2 (Nov.

20, 2017) (summarizing research supporting effectiveness of peer supports), https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/peers-supporting-recovery-mental-health-conditions-2017.pdf.

101 See, e.g., Michael Fendrich, Ph.D., et al., *Evaluation of Connecticut’s Mobile Crisis Intervention Services: Impact on Behavioral Health Emergency Department Use and Provider Perspectives on Strengths and Challenges, passim* (2018), <https://www.chdi.org/publications/reports/other/evaluation-connecticuts-mobile-crisis-intervention-services/>; SAMHSA National Guidelines, *supra* note 2, at 13 (“significant use of peers” must be “baked into” comprehensive crisis systems).

Crisis services providers should also undertake root-cause analyses of the circumstances of the calls to which they respond, to better understand how crises can be averted and to make, or advocate for, changes to their services and other systems impacting people with mental health disabilities.

102 See, e.g., DOJ-HHS Guidance, *supra* note 96, at 3-4.

103 See, e.g., SAMHSA National Guidelines, *supra* note 2, at 21 (“Appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse.”).

104 *Id.* at 8.

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106 *Id.*

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236 See, e.g., Connecticut State Dep't of Mental Health & Addiction Servs. (DMHAS), *Crisis Services* (“The Mobile Crisis Teams are mostly located across the DMHAS Local Mental Health Authority (LMHA) Network and DMHAS funds and operates MCT services throughout the state.”), <https://portal.ct.gov/CrisisServices> (last visited Oct. 9, 2023); Massachusetts Dep't of Mental Health, *Recovery Learning Communities: Information about DMH Recovery Learning Communities* (describing state's support for peer-run support networks, including Wildflower Alliance/Afiya and Kiva Networks/Karaya), <https://www.mass.gov/info-details/recovery-learning-communities> (last visited Oct. 9, 2023).

237 See City & Cty. of Denver, *Support Team Assisted Response (STAR) Program*, <https://www.denvergov.org/Government/Agencies-Departments-Offices/Agencies-Departments-Offices-Directory/Public-Health-Environment/Community-Behavioral-Health/Behavioral-Health-Strategies/Support-Team-Assisted-Response-STAR-Program> (last visited Oct. 9, 2023).

238 See, e.g., National Ass'n of Counties (NACo), *County Funding Opportunities To Support Community Members Experiencing a Behavioral Health Crisis* (Feb. 8, 2023) (describing federal, state, county, and non-governmental resources; “[c]ounties can blend and braid these resources to build a robust, accessible and sustainable behavioral health crisis continuum of care”), <https://www.naco.org/resources/county-funding-opportunities-support-community-members-experiencing-behavioral-health>.

239 See CMS, *Dear State Medicaid Director Letter 2* (Aug. 15, 2007), <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf>.

240 See, e.g., Dana Fogelson et al., *Perceptions of Supervisors of Peer Support Workers (PSW) in Behavioral Health: Results from a National Survey*, *Community Ment. Health J.* 58(3): 437-443 (June 4, 2021) (“Organizations best suited to maintain peer support programs that avoid rule confusion and provide professional development to [peer support workers] will be those that adopt [peer support] as the model for supervision, who utilize a co-model of both [peer supervisors] and [non-peer supervisors] when a licensed supervisor is required, and/or who engage in peer-led, collective co-reflection through group supervision or in communities of

practice . . .), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8177034/>.

241 See Promise Resource Network, *Our Initiatives*, *supra* note 214 ; Kiva Centers, *Welcome to the Kiva Centers* (links to peer-led Zoom, phone support groups), <https://kivagroups.carrd.co/> (last visited Oct. 9, 2023).

242 See, e.g., Diversion to What?, *supra* note 48, at 11.

243 See, e.g., NYS OMH Peer Support Guidance, *supra* note 33, at 3 (“Peer Support Services may be provided in individual or group settings, at the MHOTRS program site or offsite, as well as via telehealth. Peer Support Services may include but are not limited to providing resiliency/recovery-based skills training, facilitating groups, support, nonclinical crisis support, as well as modeling effective coping skills, facilitating community connections and engaging in informed decision making, resilience and recovery.”).

244 See, e.g., U.S. Dep’t of Health & Hum. Servs., *Building Your Program: Assertive Community Treatment 5* (2008) [hereinafter Building Your ACT Program], <https://store.samhsa.gov/sites/default/files/sma08-4344-buildingyourprogram.pdf>.

245 *Id.*; see also New York State Office of Mental Health, *Assertive Community Treatment*, <https://omh.ny.gov/omhweb/act/> (last visited Oct. 9, 2023); U.S. Dep’t of Health & Hum. Servs., *The Evidence: Assertive Community Treatment 19 & passim* (2008), <https://store.samhsa.gov/sites/default/files/sma08-4344-theevidence.pdf>.

246 See, e.g., Building Your ACT Program, *supra* note 244, at 5 (“Principles of ACT” include “24/7 crisis availability”).

247 See, e.g., Deborah Allness, M.S.S.W., & William Knoedler, M.D., *National Program Standards for ACT Teams 2* (June 2003) (ACT standards include “multidisciplinary staffing with at least one peer specialist”), <https://oceact.org/wp-content/uploads/2015/07/National-Provider-Standards-for-ACT.pdf>.

248 See, e.g., Ohio Coordinating Center for ACT, *Peer Support and ACT* (describing peer specialists working on ACT teams in Hawaii, Ohio, and Washington, D.C.), http://www.advancingstates.org/sites/nasud/files/hcbs/files/130/6499/peer_support_and_act.pdf (last visited Oct. 9, 2023); The Bridge, *Assertive Community Treatment (ACT)* (describing peer support staff working on ACT teams in Manhattan and the Bronx, New York), <https://www.thebridgeny.org/act> (last visited Oct. 9, 2023).

249 See, e.g., Diversion to What?, *supra* note 48, at 5.

250 See, e.g., Coordinated Care Services, Inc. (CCSI), *Supportive Housing Peer Specialist* (Apr. 29, 2022) (job posting for Peer Support Specialist to work in supportive housing program in Onondaga and Madison counties in New York), <https://www.ccsi.org/job-posting/supportive-housing-peer-specialist/>.

251 See, e.g., Sam Tsemberis, Ph.D., & James Zenner, LCSW, *Why We Hire Peer Specialists for Housing First Programs* (“Peers can play a crucial role in helping [Housing First] teams to provide treatment and support services in a manner that is grounded in recovery principles. . . . Peer support staff understand how clients feel after they are housed and what it’s like adjusting to a new home and a new community. Peers can offer practical help with basic needs and everyday living, such as finding the right grocery store or laundromat. Providing this meaningful and practical assistance with day-to-day struggles and offering effective and sustained support is the basis of a caring and trusting relationship, and hopefully serves as a model for developing other relationships.”), <https://housingfirsttoolkit.ca/implement/supplemental-resources/why-we-hire-peer-specialists-for-housing-first-programs/> (last visited Oct. 9, 2023) [hereinafter *Why We Hire Peers*].

252 See, e.g., Nicola Hancock et al., *Peer Worker-Supported Transition from Hospital to Home—Outcomes for Service Users*, *Int. J. Environ. Res. Pub. Health* 19(5): 2743 (Feb. 26, 2022) (individuals supported by peer workers experienced seven positive outcomes: “(a) a better, less traumatic inpatient experience; (b) felt understood, cared about, and less alone; (c) easier to leave hospital; (d) easier to back into life and daily routines; (e) built and re-established community connections; (f) gained new strategies, knowledge, understanding and skills; and (g) felt more hopeful about my recovery”), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8910236/>.

253 See, e.g., *Diversion to What?*, *supra* note 48, at 9.

254 See, e.g., SAMHSA, *Transforming Lives Through Supported Employment (SE) Program* (Apr. 21, 2022) (describing peer work in supported employment programs), <https://www.samhsa.gov/criminal-juvenile-justice/grant-grantees/transforming-lives-through-supported-employment-program>.

255 See, e.g., *A New Day?*, *supra* note 117, at 14 (“People who receive crisis care often lack access to ongoing behavioral health services. . . . Every community should have an array of community-based services, of adequate quantity and intensity. First responders should quickly and easily connect people to these services.”).

256 See, e.g., *Why We Hire Peers*, *supra* note 251 (citing studies and noting that, because they have walked in the shoes of those they support, peer workers “are especially expert in

establishing and maintaining caring and meaningful relationships with program participants. And since peers have made some gains in successfully integrating back into community after overcoming similar challenges, peers can provide the support and skills needed for reconnecting with families or others in the community. . . . [Also, since some] of the participants' network members may still be homeless, . . . ties have been severed after the person is housed. With few or no other supports, the role of the peer and other team members is vitally important, especially in the early months and first year after exiting homelessness”); October Road Inc., *Taking Steps to Become Involved with an Assertive Community Treatment Team* (Jul. 7, 2022) (“Peer support specialists are the uniquely beautiful players of the ACT team who actually share the experience of mental health and/or addiction of the client Peer support specialists often have gone through the recovery journey themselves, therefore, they can offer a completely unique support to those in active recovery. Peer support specialists are able to provide a sense of relation and trust because they, too, have lived through the trials of addiction.”), <https://www.octoberroadinc.net/taking-steps-to-become-involved-with-an-assertive-community-treatment-team/>.

257 See, e.g., Madeline Guth, *Telehealth Delivery of Behavioral Health Care in Medicaid: Findings from a Survey of State Medicaid Programs*, Kaiser Family Foundation (KFF) (Jan. 10, 2023) (“The 2022 Bipartisan Safer Communities Act requires CMS to issue guidance on Medicaid and telehealth by the end of 2023. The Consolidated Appropriations Act passed in December 2022 authorized additional telehealth provisions, including requirements or funding related to provider directories, crisis services, and virtual peer mental health supports. In the future, Congress could pass additional legislation suggested in a Senate Finance Committee draft on mental health and telehealth.”), <https://www.kff.org/mental-health/issue-brief/telehealth-delivery-of-behavioral-health-care-in-medicaid-findings-from-a-survey-of-state-medicaid-programs/>.

258 See, e.g., Catherine Cortez Masto, *Cortez Masto Introduces Legislation to Fund Virtual Peer Support Behavioral Health Programs* (Aug. 4, 2020) (Virtual Peer Support Act would provide \$50 million in grants to fund implementation of new virtual peer support programs), <https://www.cortezmasto.senate.gov/news/press-releases/cortez-masto-introduces-legislation-to-fund-virtual-peer-support-behavioral-health-programs>.

259 See, e.g., Bipartisan Policy Center, *Filling the Gaps in the Behavioral Health Workforce* 35-36 (Jan. 2023) (federal programs hoping to help fill the mental health workforce pipeline “must emphasize maintaining the current behavioral health workforce and building shorter-term solutions for enlarging and diversifying the workforce with” behavioral health support specialists, including peer specialists), <https://bipartisanpolicy.org/download/?file=/wp-content/>

[uploads/2023/01/BPC_2022_Behavioral-Health-Integration-Report_RV6Final.pdf](#).

260 PEER Support Act, S. 2733 (Sep. 6, 2023), <https://www.congress.gov/bill/118th-congress/senate-bill/2733/text?s=1&r=4&q=%7B%22search%22%3A%22Peer+support+Act%22%7D>.

261 National Peer Standards, *supra* note 38.

262 *See, e.g.*, National Practice Guidelines, *supra* note 30, at 1-2 (“Many states funded peer support worker positions through Medicaid reimbursement (Smith, 2007), which required supervision by a licensed (qualified) mental health professional as defined by each state. While this led to substantial growth in the peer support specialist workforce, it also resulted in peer support worker supervisors with no direct knowledge of peer support values; the supervisors’ ethical codes often prevented practice of essential aspects of peer support such as self-disclosure (sharing relevant elements of one’s own personal story to connect with someone else). . . . Ideally, all peer support specialists are supervised by people who have lived experience with recovery and peer support.”).

263 *See, e.g.*, SAMHSA, *Transforming Lives Through Supported Employment Program* (Feb. 28, 2023), <https://www.samhsa.gov/grants/grant-announcements/sm-23-008>; SAMHSA, *Assertive Community Treatment Grants*, <https://www.samhsa.gov/sites/default/files/grants/pdf/other/fy-2023-act-pre-application-webinar-presentation.pdf> (last visited Oct. 9, 2023).

264 National Network to Eliminate Disparities in Behavioral Health (NNED), <https://nned.net/> (last visited Oct. 9, 2023).

265 *See, e.g.*, MA Peer Workforce Coalition, *Our Vision* (“We seek to expand the existing peer support ecosystem in Massachusetts and be at the forefront of all legislation about peer support and lived experience professions. Together, we strive to build more peer-run models, programs, and approaches in our state.”), <https://www.mapeerworkforce.org/> (last visited Oct. 9, 2023).

266 *See, e.g.*, Open Minds, *State Medicaid Reimbursement for Peer Support Services* (Mar. 2018), https://static1.squarespace.com/static/56d5ca187da24ffed7378b40/t/5e4e2ecc21989a778bc3db5f/1582182093508/OMCircle_ReferenceGuide_PeerSupport.pdf.

267 *See, e.g.*, Allen S. Daniels, et al., *National Survey of Compensation Among Peer Support Specialists* (Jan. 2016), https://papersupportcoalition.org/wp-content/uploads/2016/01/CPS_Compensation_Report.pdf.

268 *See, e.g.*, Optum Maryland, *Maryland Peer MA Reimbursement FAQs 3* (Jan. 20, 2023) (“In-

dividuals with private insurance are not eligible to receive peer services These individuals can be connected with peer services that are funded in non-reimbursable settings including our extensive network of Wellness Recovery and Recovery Community Centers.”), <https://maryland.optum.com/content/dam/ops-maryland/documents/provider/information/resources/Maryland%20Peer%20MA%20Reimbursement%20FAQs.pdf>; Robert Shaw, M.A., NASHMPD, *Financing Mental Health Crisis Services 2* (2020) (“If a state wants to increase funding by Medicaid and private insurance, it may be able to work with their SMHA, State Medicaid Agency, State Insurance Commissioners and private insurers to support including more crisis services as essential insurance services.”), <https://www.nasmhpd.org/sites/default/files/2020paper7.pdf>.

269 See, e.g., New York State Governor Kathy Hochul, *Governor Hochul Announced 988 Suicide and Crisis Lifeline Education and Awareness Toolkit Available* (Aug. 4, 2023), <https://www.governor.ny.gov/news/governor-hochul-announces-988-suicide-and-crisis-lifeline-education-and-awareness-toolkit>.

270 National Practice Guidelines, *supra* note 30, at ii.