JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

March 21, 2025
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville MD 20852

Re: Mobile Crisis Team Services, An Implementation Toolkit, DRAFT: Comments of the Bazelon Center for Mental Health Law

The Bazelon Center for Mental Health Law is pleased to submit the following comments on the above-referenced draft toolkit concerning mobile crisis service implementation. The Bazelon Center is a national non-profit legal advocacy organization that promotes equal opportunity for individuals with mental disabilities in all aspects of life, including health care, community living, housing, education, employment, voting, and other areas. We support SAMHSA's issuance of this implementation toolkit and believe it will be helpful, but we believe the following additions and clarifications are important.

1. **Clarify that mobile crisis teams should be integrated with 911 call centers:** The toolkit states at various points that MCTs should coordinate with law enforcement but nowhere articulates that, to do that effectively, MCTs should be integrated with 911 call centers such that those call centers can dispatch MCTs instead of law enforcement where appropriate.

   Throughout the toolkit, there are references to the need for MCT to be coordinated with law enforcement so that it can be used to deflect people from criminal justice involvement. For example, the toolkit says on page 15 (in Chapter 1: Mobile Crisis Team Standards and Services), in the section concerning "MCT Role in the Broader Crisis Continuum," that public safety responders should be "partners" with MCTs. On the same page, under "Core Principles," it indicates that MCTs should "[o]perate independently from law enforcement staff but coordinate with them and other responders when necessary." On page 49 (in Chapter 2: Practice-Related Considerations), the toolkit says that MCT services "should seek to deflect people . . . prior to becoming involved in the criminal justice system." On page 113 (Chapter 4: Coordination and Systems-Based Approach Protocols), the toolkit recommends engaging with "critical design partners" including 988/911 call centers. On page 118, the toolkit notes that: "Dispatch agreements should clarify for internal staff and external partners which call types and circumstances should be handled by which entities (MCTs, law enforcement, EMS, fire departments, etc.) as the primary responder."

   Yet the toolkit does not discuss in any of these chapters or sections how this coordination should happen. Without any discussion of strategies for integrating MCTs into 911

emergency call systems, such as embedding crisis clinicians into 911 call centers, there is no clarity for users of the toolkit how to accomplish effective coordination and ensure that MCT can play the role that SAMHSA envisions of helping to avoid criminal justice involvement. Unless the same call center can dispatch MCTs instead of law enforcement responders, MCTs will not be able to systematically "deflect people . . . prior to becoming involved in the criminal justice system."

Accordingly, we urge SAMHSA to include clear statements in Chapters 1, 2, and 4 that MCT must be integrated with 911 emergency response systems along with recommendations concerning how such integration can be accomplished.

2. **Clarify that mental health staff should lead on co-response teams absent a clear public safety risk warranting that law enforcement lead:** On page 15 (in Chapter 1: Mobile Crisis Team Standards and Services), the toolkit states that when both MCT and other responders are present, "the response should be led by MCT staff." The toolkit identifies an exception to this default rule in "situations with a clear public safety risk, requiring law enforcement to lead, or situations involving a physical health emergency, when EMS should lead." The toolkit explains that by taking the lead in responding to behavioral health crises, "MCTs help ensure that the person in need receives the best care available and that public resources are preserved by enabling other responders to engage in their primary responsibilities."

   But the toolkit does not specify that the same approach should apply when both mental health crisis personnel and law enforcement personnel respond together as part of a co-response team. This is an important principle for the same reasons that SAMHSA identifies in Chapter 1.

   Accordingly, we urge SAMHSA to make this principle clear in the section on "Co-Responder MCTs" in Chapter 1.

3. **Clarify that co-responder teams should be used only where a law enforcement response is warranted**: While the toolkit contains a compelling explanation in the section on "Co-Responder MCTs" of why law enforcement involvement often deters use of mobile crisis services, it does not specifically state that co-response teams should be used only where a law enforcement response is needed.

   On page 26 (in Chapter 1: Mobile Crisis Team Standards and Services), the toolkit explains:

   "Decision-makers exploring co-responder MCTs should remember that in many communities, law enforcement involvement is a deterrent to requesting mobile crisis services, and not all communities will be receptive to crisis services that routinely include law enforcement. This reflects a long-standing approach to mental health care in the

United States that too often relies on law enforcement as the only available entity to respond to crisis situations, even when it lacks the capacity to provide necessary public health services. As a result, many people receive minimal treatment while experiencing repeated hospital admissions or criminal justice interactions. Research indicates that people with SMI account for as many as 10% of police calls, 17% of use-of-force cases, and 20-25% of people killed by law enforcement."

The implication of this data and explanation is that using co-response teams with law enforcement responders creates risks of disproportionate use of force on people with serious mental illness and risk of death that are not associated with MCT that does not include law enforcement responders.

Accordingly, we urge SAMHSA to clarify that, to avoid these risks, MCT without law enforcement should be dispatched rather than co-response teams that include law enforcement officers unless, consistent with the statements in other portions of the toolkit, there is a clear public safety risk warranting a law enforcement response.

4. **Separate Recommendations Concerning Modified Law Enforcement Conduct from the Section on Equal Treatment:** On page 29 (in Chapter 1: Mobile Crisis Team Standards and Services), in the section concerning "The Parity Principle and Law Enforcement," the toolkit identifies ways that law enforcement officers might modify their behavior to facilitate positive interactions between law enforcement personnel and community members experiencing crises. For example, the toolkit notes that police officers may work in plain clothes instead of uniforms and that jurisdictions may allow officer discretion in handcuffing for transportation.

   While these recommendations may in fact facilitate better interactions, they should be discussed separately from the section on "The Parity Principle," which describes how the primary reliance on law enforcement to respond to emergency calls involving people with mental health disabilities may violate the Americans with Disabilities Act (ADA) by denying equal opportunity for people with mental health disabilities to benefit from the emergency response system. While modifications to law enforcement conduct may be required separately under the ADA and as a matter of good practice, it would not create "parity" or equal opportunity to continue to have law enforcement officers serve as the default responders to emergency calls involving people with mental health disabilities as long as the officers are in plain clothes.

   Accordingly, we urge SAMHSA to discuss recommendations concerning modifications to law enforcement conduct separately from the section titled "The Parity Principle."

5. **<u>Omit the Term "Anosognosia:"</u>** On page 88 (in Chapter 3: Training and Continuous Professional and Workforce Development), under the section on "How to Screen and Assess," the toolkit states: "people experiencing psychosis may experience a symptom called anosognosia and not be aware of their condition. At times the symptoms they are experiencing, like paranoia, may prevent them from being able to self-report symptoms and/or otherwise engage in their own care."

   Whatever one's views on the use of the term "anosognosia" to describe symptoms experienced by some people with mental health disabilities, the use of the term in this context has been associated with justifications for involuntary or coercive interventions. Its use here is not necessary to the discussion and may be misunderstood by some to suggest to some that coercive interventions are called for.

   In light of that, we urge SAMHSA to avoid using that terminology when referencing people experiencing crises, as involuntary or coercive interventions may not be warranted and should not be the default response. SAMHSA can describe common symptoms experienced by people having a mental health crisis without using this terminology.

6. **<u>Replace "Crisis Stabilization Facilities" with "Crisis Stabilization Settings:"</u>** Throughout the toolkit, in Chapters 1, 2, 5, 7, 9, and 10, SAMHSA uses the term "crisis stabilization facilities." But the Olmstead decision and the ADA's integration mandate apply to crisis settings, and crisis stabilization services must be offered in the most integrated setting appropriate. There are settings in which these services may be provided that are more integrated than a crisis stabilization unit in a hospital or other "facility," such as crisis apartments, peer crisis respite centers, and "Living Rooms."

   Accordingly, to avoid suggesting that crisis stabilization services must be delivered in a "facility," we urge SAMHSA to reference "crisis stabilization settings" rather than "crisis stabilization facilities." If possible, SAMHSA should also identify integrated settings in which crisis stabilization services may be delivered.