

UPDATED ON 2/24/2026

HHS/PS Item #2
February 26, 2026
3rd Worksession

MEMORANDUM

February 23, 2026

TO: Health and Human Services Committee
Public Safety Committee

FROM: Christine Wellons, Chief Legislative Attorney

SUBJECT: Bill 43-23, Crisis Intervention Team - Established

PURPOSE: 3rd Worksession

Invited Attendees

- Dr. Earl Stoddard, Assistant Chief Administrative Officer
- Dr. Mónica Martín, Acting Chief of Behavioral Health and Crisis Services, DHHS
- Diane Lininger, Program Manager, DHHS
- Chief Marc Yamada, Montgomery County Police Department (MCPD)
- Assistant Chief David McBain, MCPD
- Captain Jordan Satinsky, MCPD
- Captain Gerald Mcfarland, MCPD
- Ben Stevenson, Director, Department of Correction and Rehabilitation
- Luke Hodgson, Director, Office of Emergency Management and Homeland Security Management
- Grace Pederson, Office of Management and Budget (OMB)
- Derrick Harrigan, OMB
- Willie Morales, OMB
- Michelle Grigsby-Hackett, LCPC, CPRP, Vice-Chair, Montgomery County Mental Health Advisory Committee
- Elizabeth (Libby) Nealis, Montgomery County Mental Health Advisory Committee

Council Bill 43-23, Crisis Intervention Team - Established, sponsored by Lead Sponsor Councilmember Luedtke, was introduced on December 5, 2023. A public hearing occurred on January 16, 2024. An initial joint Public Safety (PS) and Health and Human Services (HHS) Committee worksession occurred on February 5, 2024. A second PS/HHS worksession occurred on September 26, 2024. A third worksession is scheduled for February 26, 2026.

After the initial worksession on Bill 43-23, the bill sponsor worked closely with the Executive Branch regarding ongoing implementation of programmatic priorities under the bill. At the second worksession, the sponsor proposed several modifications to the bill in light of the ongoing work and collaboration. (See © 104, Initial Amendments by Councilmember Luedtke). Councilmember Luedtke has since updated those proposed amendments. (See © 216, Amendments by Councilmember Luedtke). In addition, Councilmember Mink has proposed multiple amendments to the bill. (See © 100, Amendments by Councilmember Mink).

As originally introduced, Bill 43-23 would:

- (1) establish a crisis intervention team as a joint program of the Montgomery County Police Department and the County Department of Health and Human Services;
- (2) prescribe the responsibilities and duties of the crisis intervention team;
- (3) permit the participation of other law enforcement entities in the crisis intervention team;
- (4) require the development of a sequential intercept model for individuals in the County experiencing crises related to mental health, behavioral health, or substance use disorder;
- (5) establish an advisory committee to support the crisis intervention team;
- (6) specify the membership, responsibilities, and staffing of the advisory committee;
- (7) require annual reporting and program evaluation; and
- (8) generally amend the laws regarding policing, law enforcement, services for mental and behavioral health needs, and services for individuals with substance use disorders.

BACKGROUND/PURPOSE

As originally introduced, Bill 43-23 would establish by statute a Crisis Intervention Team (CIT) within the County government, for the purpose of more effectively responding to residents' crises involving mental health, behavioral health, or substance use disorder. It also would create an advisory committee to identify best practices in crisis response.

BILL SPECIFICS

As originally introduced, the bill would create a CIT to be jointly staffed and run by the Department of Health and Human Services (DHHS) and the Montgomery County Police Department (MCPD). Participation of other law enforcement entities would be permitted subject to written agreements with the County.

The CIT would have several primary duties, including:

- establishing and enhancing a sequential intercept model for diverting individuals experiencing a mental or behavioral health crisis or substance use disorder crisis from the criminal justice system and into treatment; and
- responding to acute incidents in the County where there is a significant risk of harm to the individual in crisis or to someone else, and there is reason to believe that the individual has an underlying mental or behavioral health condition or co-existing substance use disorder.

The bill would require the co-location of CIT members from DHHS and MCPD in disparate geographic areas throughout the County. The CIT would be required to focus upon mental or behavioral health responses; the bill would provide: “Unless there is a significant risk of harm to the individual in crisis or to someone else, the primary response for an individual experiencing a mental or behavioral health crisis or health crisis related to substance use disorder should be with mobile crisis or emergency medical services clinicians.”

To advise the CIT and to prepare an annual report, the bill would create a 15-member Advisory Committee on Crisis Intervention. The annual report would include detailed information, disaggregated when possible by race, ethnicity, gender, gender identity, and age, regarding: public safety service calls related to mental health, behavioral health, or substance abuse disorders; petitions for emergency evaluations; individuals diverted from emergency rooms to other supports; individuals served by the County’s 24-hour Crisis Center; service calls involving dangerous weapons; and service calls and incidents involving co-occurring criminal activity and charges.

SUMMARY OF IMPACT STATEMENTS

Fiscal Impact. Per the Office of Management and Budget: “This analysis assumes that the bill would be implemented with designated CIT staff, available 24/7. The bill could require 31 new positions: 17.0 FTE in DHHS and 14.0 FTE in MCPD. The bill could also require the purchase of 14 new vehicles: 13 vehicles for MCPD and 1 vehicle for DHHS. Assuming the bill takes effect on July 1, 2024, FY25 costs total \$3.2 million for MCPD and \$1.9 million for DHHS. Ongoing costs each year thereafter total \$2.1 million for MCPD and \$1.8 million for DHHS.”

Racial Equity and Social Justice Impact. “The Office of Legislative Oversight (OLO) finds the anticipated impact of Bill 43-23 on racial equity and social justice (RESJ) is indeterminant. Black community members would be disproportionately impacted by the establishment of a co-responder team model for mental health crisis response in the County. However, research evidence is mixed on the effectiveness of co-responder models to improve outcomes. Further, there are several unknown factors in how the new Crisis Intervention Team (CIT) program would minimize reliance on law enforcement for mental health crisis response, which is necessary for advancing RESJ.”

Climate Assessment. “The Office of Legislative Oversight (OLO) anticipates Bill 43-23 will have no impact on the County’s contribution to addressing climate change as the proposed crisis intervention team is unlikely to have a measurable impact on the County’s overall community climate resilience.”

Economic Impact. “The Office of Legislative Oversight (OLO) anticipates that enacting Bill 43-23 would have an insignificant impact on economic conditions in the County in terms of the Council’s priority indicators.”

SUMMARY OF PUBLIC TESTIMONY

Testimony in favor of the bill included the following points.

- Mental Health Association of Maryland: “Consumer and family advocates have been working for years to expand access to CIT programs across Maryland, a policy goal endorsed by the Maryland General Assembly in 2020 with the passage of SB 305. That bill, which passed unanimously in the Senate and nearly unanimously in the House, established a CIT Center of Excellence to assist local jurisdictions in developing, evaluating and improving CIT programs across Maryland. Bill [43]-23 is an important step in aligning with these goals.”
- Municipal and County Government Employees Organization: “Having heard from our members working in the County Department of Health and Human Services who are front-line service providers for individuals in crisis, we know that specialized Crisis Intervention Teams can make a significant difference. By providing proper training to crisis counselors, law enforcement and first responders, we can ensure they are better equipped to handle situations involving individuals in crisis with empathy, understanding, and de-escalation techniques. It's important to note that our members employed by HHS did not go into their work looking to be law enforcement officers, and when the county removed the law enforcement support from crisis response a few years ago, many expressed their apprehension about responding to situations when they felt they would be in danger, unaccompanied by a law enforcement officer who could help protect them.”
- Cornerstone Montgomery: “Since MCPD started training its officers in CIT, Cornerstone has made it a habit to ask for CIT officers to be deployed when possible, and it has made a noticeable difference in the outcomes of the calls. CIT trained officers are more likely to listen to what our staff has to say and work collaboratively to determine next steps.... This bill would not alter or interfere with the work of Montgomery County’s Crisis Center or the clinician-only Mobile Crisis Outreach Teams (MCOTs). Rather, this bill would add another option for crisis response.”
- Washington Psychiatric Society: “To be sure, the mental health crisis is daunting here and elsewhere. The Crisis Intervention Model embodied in Bill 43-23, and in operation around the country, represents the best way of addressing a critical element of this crisis. By emphasizing an ongoing collaborative relationship between clinicians and law enforcement, robust protocols for responding to and resolving crisis events, ongoing outcome assessment and expert oversight, one could envision its implementing system where patients could be helped to overcome the burden of their illness and embark on a more positive life course. For these reasons, we strongly urge passage of Bill 43-23.”
- Montgomery County Chamber of Commerce: “The Montgomery County Chamber of Commerce (MCCC), the voice of business in Metro Maryland, supports Bill 43-23, Crisis Intervention Team - Established.... Mental and

behavioral health emergencies can and do happen anywhere – in public and privately. When there is a public incident, it can negatively impact local businesses by creating the perception that the surrounding area is unsafe.”

Testimony in opposition to the bill emphasized that the co-response of police officers and health clinicians should be avoided in favor of a civilian-led response.

- Claire Ryder, DHSc(c) & Alisha Nash, MSW: “The American Public Health Association (2018) identifies the need to find alternative to police as the default first responders as a key public health issue. Alternative models focused on behavioral health first responders can decrease interactions with the criminal justice system, reduce involuntary hospitalizations, and increase healthcare responses to behavioral health crises.”
- Vera Institute of Justice: “To be sure, in limited circumstances, the county’s MCOT program may need to continue partnering with the police on scene. However, CIT International, an organization that trains and advises CIT programs across the country on best practices, explains regarding a co-response strategy like the one proposed in this bill, ‘Embedding mental health clinicians in police cars increases the presence of police in situations where they might not be needed.’ Instead, MCOTs should be able to jointly respond with police when necessary while primarily delivering timely crisis responses without police.” (footnote omitted).
- Presbyterians for Police Transformation: “We strongly believe that the county’s focus should be on significantly strengthening and growing the existing civilian crisis response program in DHS - the Mobile Crisis Outreach Teams - so that police involvement can be reduced to where it is actually essential. This bill does not do that and in fact could have the opposite effect.”
- Silver Spring Justice Coalition: “Bill 43-23 would cement the County’s reliance on law enforcement for crisis response by codifying into law the CIT program (co-response by a police officer and a mental health clinician in one vehicle) and creating an advisory committee weighted toward criminal justice. This would set the stage for even greater use of force with people experiencing a mental health or substance use crisis. We are particularly concerned for BIPOC persons, whose lives and well-being would be disproportionately threatened.”
- National Alliance on Mental Illness of Montgomery County: “Now is not the time to codify crisis response in Montgomery County. Here and across the country, we’re seeing an evolution in crisis response systems, spurred in part by the rollout of the 988 Crisis Lifeline and SAMHSA’s National Guidelines for Behavioral Health Crisis Care. With our State and County systems in a period of transformation, enshrining a wholly new program into law does not make sense as research and best practices are developing.”

SUMMARY OF FIRST WORKSESSION

The first worksession focused upon a global discussion of the approach to crisis response in the County. [HHS/PS Joint Committee Worksession \(granicus.com\)](#). The Council staff report for the first worksession is available here: [HHS-PS#1 - Bill 43-23 - February 5, 2024](#).

Key topics discussed at the first worksession included:

- An op-ed in the *Washington Post* regarding crisis response authored by Councilmembers Albornoz and Huckler in 2020, [Opinion | Montgomery County is committed to rethinking responses to mental health crises - The Washington Post](#)
- Challenges about how to direct limited resources towards behavioral health services;
- The ongoing efforts of the State of Maryland regarding the Sequential Intercept Model (SIM);
- Crisis response models in other jurisdictions, including New Orleans, LA;
- The recruitment of crisis response personnel in DHHS;
- The development of an MOU between DHHS and MCPD; and
- The importance of both civilian-led responses and co-responses by DHHS and MCPD, depending upon the circumstances.

SUMMARY OF SECOND WORKSESSION

During the second worksession, the joint committee discussed the following topics (Issues #1 and #2, below). At the conclusion of the worksession, the Committee discussed that it would reconvene after an MOU was established between MCPD and DHHS regarding crisis response. The MOU was expected shortly at the time, but the MOU has not yet been finalized.

The following issues were discussed at the second worksession.

1. State of Maryland – Centers of Excellence and the Sequential Intercept Model

The State of Maryland, through the Governor’s Office of Crime Control and Prevention (GOCCP), has provided a report regarding Sequential Intercept Model Mapping in Montgomery County (the “SIM Report”). (See © 115). The SIM Model Map is at © 122.

Crisis Intervention Team Center of Excellence. In 2020, Maryland established a Crisis Intervention Team Center of Excellence (the “CIT Center”) within GOCCP. [Crisis Intervention Team Center of Excellence - Governor’s Office of Crime Prevention and Policy \(maryland.gov\)](#). The CIT Center is tasked with developing a “crisis intervention model program” and with providing technical support and education to local governments.

In particular, the CIT Center may:

- on request, assist a law enforcement agency or local government in implementing a crisis intervention model program;
- provide educational resources to law enforcement to promote crisis intervention team programs; and
- monitor statewide progress for implementation of crisis intervention model programs.

Md. Code Ann., Public Safety Article § 3-522.

Behavioral Health and Public Safety Center of Excellence. In 2021, the state established the Maryland Behavioral Health and Public Safety Center of Excellence (the “Behavioral Health Center”) within GOCCP. [Maryland Behavioral Health and Public Safety Center of Excellence - Governor’s Office of Crime Prevention and Policy](#). The Behavioral Health Center – among other duties -- facilitates local and regional planning workshops using the Sequential Intercept Model (SIM).

SIM Mapping. As a part of its efforts, the Behavioral Health Center has created a SIM Mapping Dashboard, [Sequential Intercept Model \(SIM\) Mapping Dashboard - Governor’s Office of Crime Prevention and Policy \(maryland.gov\)](#). According to the dashboard (as of February 2026), 10 counties – including Montgomery County – have worked with the state to develop SIM maps.

As described in a report regarding Prince George’s County’s SIM mapping, [Sequential Intercept Model Mapping Workshop Report \(maryland.gov\)](#), “SIM Mapping is a process that results in the development of a map that illustrates how people with mental and substance use disorders enter and move through the criminal justice system. Through the process, facilitators and participants identify opportunities for linkage to treatment and other support services, and for prevention of further penetration into the criminal justice system.

SIM Mapping has three primary objectives:

- The development of a comprehensive picture of how people with mental and substance use disorders enter and move through the criminal justice system along six distinct intercept points: (0) Community Services, (1) Law Enforcement, (2) Initial Detention and Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections.
- Identification of resources, gaps in services, and opportunities at each intercept for individuals in the target population.
- The development of priorities for change and strategic action plans.”

Results in Montgomery County. For Montgomery County, the top priorities identified by GOCCP as a result of the SIM Mapping effort were:

- Enhancing the reentry process;
- Establishing stabilization services;
- Creating a multidisciplinary team or teams to coordinate across intercepts;
- Increasing behavioral health services;

- Improving data sharing;
- Enhancing diversion options;
- Streamlining daily communications;
- Expanding training opportunities; and
- Addressing language barriers.

See SIM Report, © 115 - 213.

The GOCPP report for Montgomery County is also available at [FINAL-Montgomery-Co.-2024-SIM-Mapping-Report-3.pdf](#). It may be cited as follows:

The Centers of Excellence. (2024). *Sequential intercept model mapping report for Montgomery County, Maryland*. Crownsville, MD: Governor’s Office of Crime Prevention and Policy.

2. Existing Advisory Committees Related to Crisis Response

As additional context, staff noted the following advisory boards and commissions that have some responsibilities related to addressing mental and behavioral health issues and/or public safety issues in the County.

- [Alcohol and Other Drug Addiction Advisory Council](#)
Description: Identifies local alcohol and other drug addiction prevention program needs, and assists the Department of Health and Human Services in the development of public education programs and an alcohol and drug addiction plan.
- [Commission on Health](#)
Description: Advises the County Executive and the County Council on public health issues, programs, services and facilities
- [Criminal Justice Coordinating Commission](#)
Description: Evaluates the organization and adequacy of law enforcement and the administration of justice in the County pertaining to local issues and agencies.
- [Mental Health Advisory Committee](#)
Description: Monitors, reviews, and evaluates the allocation and adequacy of publicly-funded mental health services within the County.
- [Policing Advisory Commission](#)
Description: Advises the County Council on policing matters; provides information regarding best practices on policing matters; recommends policies, programs, legislation, or regulations; comments on matters referred to it by the Council; conducts at least one public forum each year for community input on policing matters; and engages in public education.

The SIM Report also identifies relevant boards and commissions within the County. See © 125; [FINAL-Montgomery-Co.-2024-SIM-Mapping-Report-3.pdf](#).

SUMMARY OF CURRENT CRISIS RESPONSE IN THE COUNTY

A thorough briefing regarding the County’s current crisis response services is scheduled to precede the worksession on Bill 43-23. The staff report for the briefing is available through the online agenda.

OUTSTANDING ISSUES FOR THE COMMITTEE’S CONSIDERATION

The Committee might wish to discuss the following potential amendments to Bill 43-23. The reference materials for these amendments are Councilmember Luedtke’s *updated* amendments at © 216, and Councilmember Mink’s amendments at © 100.

1. Potential Amendment – Remove from the Bill the Establishment of the Crisis Intervention Team

Due to the Executive branch’s implementation of many of the goals under the bill – including the co-location of health and public safety specialists – Councilmembers Luedtke and Mink both support an amendment to remove the portions of the bill that would mandate the development of Crisis Intervention Teams.

The amendment is attached at © 220 for the joint Committee’s consideration.

2. Potential Amendments – Establish the Role of the Working Group / Task Force

Councilmember Luedtke and Councilmember Mink each have proposed amendments regarding the role of the Advisory Committee under the bill.

Councilmember Luedtke’s updated amendments are attached at © 216 . The amendments would rename the Committee as the Sequential Intercept Model (SIM) Coordination Working Group. The Working Group, through a lens of racial equity and social justice: (1) would use the Sequential Intercept Model (SIM) to assess and analyze the County’s ability to provide crisis intervention services; and (2) would “direct” the coordination and implementation of the SIM specific to the County.

Councilmember Mink’s proposed amendments are attached at © 100. The amendments would rename the Committee as a Task Force. The Task Force would focus upon studying other jurisdictions’ civilian-led responses to behavioral health and substance abuse crises. In addition, Councilmember Mink has recommended that – with respect to Councilmember Luedtke’s amendments – instead “direct[ing]” the coordination and implementation of the SIM, the Task Force should “coordinate” the implementation of the response model.

Under both sets of amendments, the task force or group would report to the Executive and Council regarding best practices and recommendations.

3. Potential Amendments - Membership the Working Group / Task Force

Councilmembers Luedtke and Mink also have provided potential amendments regarding the membership of the Working Group (or Task Force). Councilmember Luedtke's updated proposed amendments are at © 216. Councilmember Mink's proposed amendments are at © 100-103.

Under Councilmember Luedtke's proposal, membership of the Working Group would include the following 19 positions:

- a designee of the Office of the Public Defender;
- a designee of the county's 9-8-8 call center;
- a designee of the Interagency Commission on Homelessness;
- a designee of the District Administrative Judge for the District Court of Maryland, Montgomery County;
- a designee of the Administrative Judge for the Circuit Court for Montgomery County;
- a designee of the Montgomery County State's Attorney;
- a designee of the Montgomery County Council;
- a designee of the Intellectual and Developmental Disabilities Commission;
- a representative of the Primary Care Coalition or a successor organization;
- a designee of the Montgomery County Fire Chief;
- a designee of the Emergency Communications Center;
- a designee of the County Sheriff;
- a designee of the Director of the Department of Correction and Rehabilitation;
- a designee of the Montgomery County Police;
- a designee of the Department of Health and Human Services;
- two residents with lived experience regarding mental health, behavioral health, or substance use disorders;
- a designee of the Executive Director of the Council who performs analysis for the Council regarding health and human services or public safety; and
- a representative of a peer support organization or community-based behavioral health provider.

Under Councilmember Mink's proposal, membership of the Task Force would include the following 28 positions:

- 2 designees of the National Alliance on Mental Illness of Montgomery County (NAMI MC), including at least one person with personal experience living with a mental or behavioral health condition;
- a designee of the County's 9-8-8 call center;
- 2 designees of the Interagency Commission on Homelessness who represent a Homeless Service Organization or are a person with lived experience;

- 2 designees of the Mental Health Advisory Committee, including at least one person with personal experience living with a mental or behavioral health condition;
- 2 designees of the Alcohol and Other Drug Addiction Advisory Council, including at least one person with personal experience living with a substance use disorder;
- 2 designees of the Commission for People with Disabilities, including at least one person with personal experience living with an intellectual or developmental disability;
- 2 designees of the Advisory Commission on Policing;
- 2 designees of the Intellectual and Developmental Disabilities Commission, including at least one person with personal experience living with an intellectual or developmental disability;
- 2 designees of the Police Advisory Board;
- a designee of the Montgomery County Fire Chief;
- a designee of the Emergency Communications Center;
- a designee of the Department of Health & Human Services – Behavioral Health & Crisis Services;
- a designee of the Street Outreach Network;
- a designee of the Montgomery County Chief of Police;
- 2 mental health professionals serving County residents, at least 1 of whom is not a physician, appointed by the Executive and confirmed by the Council;
- 2 individuals representing nonprofits serving incarcerated or formerly incarcerated County residents, including at least one person who is formerly incarcerated or has faced charges, appointed by the Executive and confirmed by the Council; and
- 2 residents, appointed by the Executive and confirmed by the Council, who are homeless or formerly homeless.

4. Potential Amendment - Reporting Requirements the Working Group / Task Force

Councilmember Luedtke intends to propose amendments to update and clarify the reporting requirements of the advisory committee under the bill. The updated proposed amendments are available at © 216.

5. Transition Clause

Councilmember Luedtke intends to move an amendment to the bill’s transition clause. See © 219 for the proposed amendment, which would alter the due date of the first report of the advisory committee from January 31, 2025 to January 31, 2027.

6. Bill Title – Revisions

Depending upon the amendments adopted to Bill 43-23, the bill title should be updated.

If the Committee adopts Councilmember Luedtke's updated proposed amendments, Council staff recommends making the following additional amendment to the bill's long title. The amendment would update the title to reflect the revised bill.

Amend the long title of Bill 43-23 to read as follows.

Bill 43-23, Crisis Intervention [[Team]] - Sequential Intercept Model (SIM) Coordination Working Group - Established

AN ACT to:

- (1) [[establish a crisis intervention team as a joint program of the Montgomery County Police Department and the County Department of Health and Human Services;
- (2) prescribe the responsibilities and duties of the crisis intervention team;
- (3) permit the participation of other law enforcement entities in the crisis intervention team;
- (4) require the development of a sequential intercept model for individuals in the County experiencing crises related to mental health, behavioral health, or substance use disorder;
- (5)] establish [[an advisory committee to support the]] a working group on crisis intervention [[team]] and application of the sequential intercept model;
- [[6]] (2) specify the membership, responsibilities, and staffing of the [[advisory committee]] working group;
- [[7]] (3) require annual reporting and program evaluation; and
- [[8]] (4) generally amend the laws regarding policing, law enforcement, services for mental and behavioral health needs, and services for individuals with substance use disorders.

If the Committee adopts Councilmember Mink's proposed amendments to the bill, Council staff would recommend the following revisions to the bill title.

Amend the long title of Bill 43-23 to read as follows.

Bill 43-23, Task Force on Crisis [[Intervention Team]] Response - Established

AN ACT to:

- (1) [[establish a crisis intervention team as a joint program of the Montgomery County Police Department and the County Department of Health and Human Services;
- (2) prescribe the responsibilities and duties of the crisis intervention team;
- (3) permit the participation of other law enforcement entities in the crisis intervention team;
- (4) require the development of a sequential intercept model for individuals in the County experiencing crises related to mental health, behavioral health, or substance use disorder;
- (5)] establish [[an advisory committee to support the]] a task force on crisis [[intervention team]] response;
- [[6]] (2) specify the membership, responsibilities, and staffing of the [[advisory committee]] task force;
- [[7]] (3) require annual reporting and program evaluation; and

[[4]] (4) generally amend the laws regarding policing, law enforcement, services for mental and behavioral health needs, and services for individuals with substance use disorders.

<u>This packet contains:</u>	<u>Circle #</u>
Bill 43-23	© 1
Economic Impact Statement	© 9
Climate Assessment	© 12
Racial Equity and Social Justice Impact Statement	© 15
Public Testimony	
Mental Health Association of Maryland	© 22
Montgomery County Health Advisory Committee	© 24
Carie Guthri – Cornerstone Montgomery	© 29
Washington Psychiatric Society	© 31
Montgomery County Chamber of Commerce	© 33
Claire Ryder, DHSc(c) & Alisha Nash, MSW	© 34
Vera Institute of Justice	© 40
Presbyterians for Police Transformation	© 43
Silver Spring Justice Coalition	© 44
Sharon Dietsche, National Alliance on Mental Illness of Montgomery County	© 49
UFWC Local 1994 MCGEO	© 51
Julia Waitt	© 53
Georgine Prokopik	© 54
Dennis Williams	© 55
Joan Butler	© 56
Margaret Worthy	© 58
Mimi Brodsky Kress	© 59
Councilmember Mink’s Memorandum	© 60
Councilmember Mink’s Amendments	© 100
Councilmember Luedtke’s Original Amendments (2 nd Worksession)	© 104
Governor’s Office of Crime Control and Prevention – Letter	© 113
Governor’s Office of Crime Control and Prevention – SIM Report	© 115
Councilmember’s “Dear Colleague” Memorandum, Dated February 18, 2026	© 214
Councilmember Luedtke’ Updated Amendments (3 rd Worksession) (Updated on 2/24/2026)	© 216
Letter from the Department of Corrections and Rehabilitation (2/20/2026)	© 226
Letter from the Office of the Public Defender (2/20/2026)	© 227

Bill No. 43-23
Concerning: Crisis Intervention Team -
Established
Revised: 11/21/23 Draft No. 8
Introduced: December 5, 2023
Expires: December 7, 2026
Enacted: _____
Executive: _____
Effective: _____
Sunset Date: None
Ch. _____, Laws of Mont. Co. _____

COUNTY COUNCIL FOR MONTGOMERY COUNTY, MARYLAND

Lead Sponsor: Councilmember Luedtke

AN ACT to:

- (1) establish a crisis intervention team as a joint program of the Montgomery County Police Department and the County Department of Health and Human Services;
- (2) prescribe the responsibilities and duties of the crisis intervention team;
- (3) permit the participation of other law enforcement entities in the crisis intervention team;
- (4) require the development of a sequential intercept model for individuals in the County experiencing crises related to mental health, behavioral health, or substance use disorder;
- (5) establish an advisory committee to support the crisis intervention team;
- (6) specify the membership, responsibilities, and staffing of the advisory committee;
- (7) require annual reporting and program evaluation; and
- (8) generally amend the laws regarding policing, law enforcement, services for mental and behavioral health needs, and services for individuals with substance use disorders.

By adding

Montgomery County Code
Chapter 24, Health and Sanitation
Article XI, Crisis Intervention Teams
Sections 24-77, 24-78, 24-79, 24-80, 24-81, 24-82, 24-83, and 24-84

The County Council for Montgomery County, Maryland approves the following Act:

Boldface	<i>Heading or defined term.</i>
<u>Underlining</u>	<i>Added to existing law by original bill.</i>
[Single boldface brackets]	<i>Deleted from existing law by original bill.</i>
<u>Double underlining</u>	<i>Added by amendment.</i>
[[Double boldface brackets]]	<i>Deleted from existing law or the bill by amendment.</i>
* * *	<i>Existing law unaffected by bill.</i>

1 **Sec. 1. Article XI, Sections 24-77, 24-78 24-79, 24-80, 24-81, 24-82, 24-83, and 24-**
 2 **84 are added as follows:**

3 **ARTICLE XI. CRISIS INTERVENTION TEAM**

4 **24-77. Definitions.**

5 In this Article, the following terms have the meanings indicated.

6 Advisory committee or committee means the Advisory Committee on Crisis
 7 Intervention established under Section 24-82.

8 Crisis intervention model program has the meaning set forth at Section 3-522
 9 of the Public Safety Article of the Maryland Code, as amended.

10 Crisis intervention team, CIT, or team means a group of individuals designated
 11 under Sections 24-78 and 24-79 to perform the duties specified under Sections
 12 24-80 and 24-81, where law enforcement officers and clinicians are co-located
 13 and deployed in an integrated fashion.

14 Health department means the Montgomery County Department of Health and
 15 Human Services.

16 Law enforcement entity means a public law enforcement agency, other than the
 17 Montgomery County Police Department.

18 Police department means the Montgomery County Police Department.

19 Sequential intercept model means a plan, specific to the County, that details
 20 how individuals with mental, behavioral, and substance use disorders:

- 21 (1) come into contact with and move through the criminal justice
- 22 system; and
- 23 (2) obtain referrals to other wraparound services.

24 **24-78. Crisis intervention team – established.**

25 (a) There is a crisis intervention team within the County government
 26 consisting of:

- 27 (1) designees of the health department;

- 28 (2) designees of the police department; and
- 29 (3) participants of other law enforcement entities under Section 24-
- 30 79.

31 (b) Each member of the team must meet minimum qualifications
 32 established by their home agency to be assigned to the team in addition
 33 to all other licensing, credentialing and continuing education
 34 requirements imposed by State or federal law applicable to the
 35 respective disciplines.

36 (c) A member of the team designated by the Chief of the police department,
 37 and a member of the team designated by the Director of the health
 38 department, jointly must direct the operations of the team.

39 (d) The health department and police department, which will have equal
 40 responsibility in overseeing the crisis intervention team, must establish a
 41 Memorandum of Understanding to carry out the work of the team,
 42 further delineate roles and responsibilities, and address other
 43 administrative issues.

44 (e) The team will follow guidance provided by the Crisis Intervention
 45 Team Center of Excellence at the State level in implementing,
 46 delivering, and enhancing crisis intervention services in the county.

47 **24-79. Participation of other law enforcement entities.**

48 Subject to a written agreement with the County, and approval of the police
 49 department and health department, a law enforcement entity may designate
 50 individuals to participate in the crisis intervention team.

51 **24-80. Crisis intervention team – duties.**

52 The crisis intervention team must:

- 53 (a) in consultation with the advisory committee, establish and enhance the
- 54 sequential intercept model for diverting individuals experiencing a

- 55 mental or behavioral health crisis or substance use disorder crisis from
 56 the criminal justice system and into treatment;
- 57 (b) adhere to the principals of the crisis intervention model program;
- 58 (c) respond to acute incidents in the County where there is a significant risk
 59 of harm to the individual in crisis or to someone else, and there is reason
 60 to believe that the individual has an underlying mental or behavioral
 61 health condition or co-existing substance use disorder;
- 62 (d) co-locate members of the team in disparate geographic areas of the
 63 County;
- 64 (e) interact directly with emergency dispatchers regarding individuals
 65 experiencing mental health, behavioral health, or substance abuse
 66 incidents; and
- 67 (f) provide to each individual or family served by the team information
 68 regarding how to prepare an advance directive for psychiatric care.

69 **24-81. Scope of team activities.**

- 70 (a) Limited scope of team response. The priority response for the crisis
 71 intervention team is for incidents involving acute mental health,
 72 behavioral health, or substance abuse crisis events where there is a
 73 significant risk of danger for the individual in crisis or others as a result
 74 of the crisis.
- 75 (b) Primacy of health response. Unless there is a significant risk of harm to
 76 the individual in crisis or to someone else, the primary response for an
 77 individual experiencing a mental or behavioral health crisis or health
 78 crisis related to substance use disorder should be with mobile crisis or
 79 emergency medical services clinicians.
- 80 (c) Effects on law enforcement activities and collective bargaining.
 81 Nothing in this Article may be construed to limit or supersede:

- 82 (1) law enforcement activities of the police department or other law
- 83 enforcement entities;
- 84 (2) the effectuation of a petition for emergency evaluation by a law
- 85 enforcement officer;
- 86 (3) assistance of law enforcement requested by emergency
- 87 dispatchers, residents, or others;
- 88 (4) police department or law enforcement entity orders; or
- 89 (5) collective bargaining under Chapter 33.

90 **24-82. Advisory committee – established.**

- 91 (a) There is an Advisory Committee on Crisis Intervention.
- 92 (b) The committee consists of:
 - 93 (1) a designee of the Mental Health Association of Maryland;
 - 94 (2) a designee of the county’s 9-8-8 call center;
 - 95 (3) a designee of the Interagency Commission on Homelessness;
 - 96 (4) a designee of the District Administrative Judge for the District
 - 97 Court of Maryland, Montgomery County;
 - 98 (5) a designee of the Administrative Judge for the Circuit Court for
 - 99 Montgomery County;
 - 100 (6) a designee of the Montgomery County State’s Attorney;
 - 101 (7) a designee of the Montgomery County Council;
 - 102 (8) a designee of the Intellectual and Developmental Disabilities
 - 103 Commission;
 - 104 (9) a representative of a county chamber of commerce, appointed by
 - 105 the County Executive and confirmed by the Council;
 - 106 (10) a designee of the Montgomery County Fire Chief;
 - 107 (11) a designee of the Emergency Communications Center;
 - 108 (12) a designee of the County Sheriff;

- 109 (13) a designee of the Director of the Department of Correction and
 110 Rehabilitation; and
- 111 (14) 2 residents, appointed by the Executive and confirmed by the
 112 Council, who:
- 113 (A) have lived experience regarding mental health, behavioral
 114 health, or substance use disorders;
- 115 (B) represent different geographical regions of the County; and
- 116 (C) will be offered the opportunity to participate in the police
 117 department’s “Citizens Academy,” as well as attend any
 118 CIT training or other in-service training offered relevant to
 119 the work of the Advisory Committee.

120 **24-83. Advisory committee – duties and staffing.**

121 The advisory committee must:

- 122 (a) provide advice to, and collaborate with, the crisis intervention team, the
 123 Executive, and the Council regarding best practices for crisis
 124 intervention in the County related to mental health, behavioral health, or
 125 substance use disorders;
- 126 (b) consult with the crisis intervention team regarding the development of
 127 the models under Section 24-80;
- 128 (c) prepare the annual report required under Section 24-84;
- 129 (d) follow the work and recommendations of the Crisis Intervention Team
 130 and Maryland Behavioral Health and Public Safety Centers of
 131 Excellence in the Governor’s Office of Crime Prevention, Youth, and
 132 Victim Services; and
- 133 (e) be staffed by a designee of the County Executive.

134 **24-84. Annual evaluation and reporting.**

135 The advisory committee must submit, no later than January 31 each year, an
136 annual report to the Executive and Council that includes:

137 (a) numerical data, disaggregated when possible by race, ethnicity, gender,
138 gender identity, and age, regarding:

139 (1) public safety service calls involving individuals experiencing a
140 crisis related to mental health, behavioral health, or substance
141 abuse disorders;

142 (2) petitions for emergency evaluation:

143 (A) issued; and

144 (B) served;

145 (3) individuals diverted by the crisis intervention team from the
146 emergency room to other supports;

147 (4) individuals, served in-person or by phone, by the County's 24-
148 hour Crisis Center;

149 (5) service calls under paragraph (1) involving an actual or
150 threatened deadly or dangerous weapon, as defined under
151 Sections 4-101 or 4-102 of the Criminal Law Article of the
152 Maryland Code, as amended;

153 (6) service calls under paragraph (1) involving co-occurring criminal
154 conduct, including the numbers of associated:

155 (A) misdemeanor charges;

156 (B) felony charges;

157 (C) individuals offered a diversion to treatment; and

158 (D) individuals who were not charged due to diversion to
159 treatment; and

160 (7) service calls under paragraph (1) involving an individual where
161 pending criminal charges were at issue;

162 **(b)** achievements and challenges of the crisis intervention team during the
163 prior year; and

164 **(c)** recommendations to improve crisis intervention in the County, in
165 coordination with local, state, and federal partners.

166 **Sec. 2. Transition.** The first report required under Section 24-84, added under
167 Section 1 of this Act, is due by January 31, 2025.

Economic Impact Statement

Montgomery County, Maryland

Bill 43-23

Crisis Intervention Team – Established

SUMMARY

The Office of Legislative Oversight (OLO) anticipates that enacting Bill 43-23 would have an insignificant impact on economic conditions in the County in terms of the Council’s priority indicators.

BACKGROUND AND PURPOSE OF BILL 43-23

Mental Health America lists lack of alternatives to law enforcement among several widespread problems in mental health and substance use crisis response. They note that shortcomings in crisis response could have serious consequences for someone experiencing a behavioral health crisis, including:¹

- ending up in confrontations with law enforcement personnel which have tragic outcomes;
- being transported to emergency rooms and being admitted or committed to inpatient psychiatric facilities when these outcomes are unnecessary and may be harmful to the person; and
- being transported to a jail and subjected to ongoing involvement in the criminal justice system when these outcomes are unnecessary, are harmful to the person and do not lead to increased public safety.

Recognizing the limitations of law enforcement, local jurisdictions throughout the country have considered alternative models for mental health crisis response.² These include models that do and do not involve police. As described by the Congressional Research Service, the co-responder team model in particular “pair[s] law enforcement officers with trained clinicians who together respond to emergency calls involving individuals experiencing a mental health crisis.”³

The purpose of Bill 43-23 is to establish a Crisis Intervention Team (CIT) that would implement the co-responder team model for mental health crisis response in the County. The CIT would be jointly staffed and operated by the Montgomery County Police Department (MCPD) and the Department of Health and Human Services (DHHS).

If enacted, Bill 43-23 would require CIT members from MCPD and DHHS to be co-located throughout the County. Other law enforcement agencies could also participate in the CIT subject to written agreements with the County. The CIT would be required to:⁴

- develop a plan for the County to divert individuals experiencing a mental or behavioral health crisis or substance use disorder crisis from the criminal justice system and into treatment; and

¹ Mental Health America, “Position Statement 59.”

² Congressional Research Service, “Issues in Law Enforcement Reform.”

³ Ibid.

⁴ Introduction Staff Report on Bill 43-23.

- respond to “acute mental health, behavioral health, or substance abuse crisis” incidents “where there is a significant risk of danger for the individual in crisis or others as a result of the crisis.”⁵ Otherwise, the Bill prescribes the primary response for someone experiencing a crisis should be mobile crisis or emergency medical services clinicians.

Bill 43-23 would also create a 15-member advisory committee on Crisis Intervention that would advise the CIT and County officials on best practices for crisis intervention in the County. The committee would also prepare an annual report on the CIT by January 31 of each year.

Bill 43-23, Crisis Intervention Team – Established, was introduced by the County Council on December 5, 2023.

INFORMATION SOURCES, METHODOLOGIES, AND ASSUMPTIONS

Per Section 2-81B of the Montgomery County Code, the purpose of this Economic Impact Statement is to assess the impacts of Bill 43-23 on County-based private organizations and residents in terms of the Council’s priority economic indicators and whether the Bill would likely result in a net positive or negative impact on overall economic conditions in the County.⁶ There is a lack of high-quality evidence on the economic impacts of pre-arrest diversion programs specifically and mental health interventions in the criminal justice system more generally.⁷ For this reason, OLO anticipates that the Bill would have an insignificant impact on private organizations, residents, and overall economic conditions in the County in terms of the indicators prioritized by the Council.

VARIABLES

Not applicable

IMPACTS

WORKFORCE ■ TAXATION POLICY ■ PROPERTY VALUES ■ INCOMES ■ OPERATING COSTS ■ PRIVATE SECTOR CAPITAL INVESTMENT ■ ECONOMIC DEVELOPMENT ■ COMPETITIVENESS

Not applicable

DISCUSSION ITEMS

Not applicable

⁵ Ibid.

⁶ Montgomery County Code, Sec. 2-81B, Economic Impact Statements.

⁷ Bird and Shemilt, “The Crime, Mental Health, and Economic Impacts of Prearrest Diversion of People with Mental Health Problems”; Knapp and Wong, “Economic Evaluations of Mental Health Interventions in Criminal Justice.”

WORKS CITED

Bird, Karen, and Ian Shemilt. "[The Crime, Mental Health, and Economic Impacts of Prearrest Diversion of People with Mental Health Problems: A Systematic Review](#)." *Criminal Behaviour & Mental Health* 29, no. 3 (June 1, 2019): 142–56.

Congressional Research Service. "[Issues in Law Enforcement Reform: Responding to Mental Health Crises](#)." October 17, 2022.

"[Introduction Staff Report on Bill 43-23, Crisis Intervention Team – Established](#)." Montgomery County Council, December 5, 2023.

Knapp, Martin, and Gloria Wong. "[Economic Evaluations of Mental Health Interventions in Criminal Justice](#)." *Criminal Behaviour and Mental Health* 33, no. 2 (2023): 139–48.

Mental Health America. "[Position Statement 59: Responding to Behavioral Health Crises](#)." 2017.

Montgomery County Code. [Sec. 2-81B, Economic Impact Statements](#).

CAVEATS

Two caveats to the economic analysis performed here should be noted. First, predicting the economic impacts of legislation is a challenging analytical endeavor due to data limitations, the multitude of causes of economic outcomes, economic shocks, uncertainty, and other factors. Second, the analysis performed here is intended to *inform* the legislative process, not determine whether the Council should enact legislation. Thus, any conclusion made in this statement does not represent OLO's endorsement of, or objection to, the Bill under consideration.

CONTRIBUTIONS

Stephen Roblin (OLO) prepared this report.

Climate Assessment

Office of Legislative Oversight

Bill 43-23: Crisis Intervention Team - Established

SUMMARY

The Office of Legislative Oversight (OLO) anticipates Bill 43-23 will have no impact on the County's contribution to addressing climate change as the proposed crisis intervention team is unlikely to have a measurable impact on the County's overall community climate resilience.

BACKGROUND AND PURPOSE OF BILL 43-23

Mental Health America lists lack of alternatives to law enforcement among several widespread problems in mental health and substance use crisis response. They note that shortcomings in crisis response could have serious consequences for someone experiencing a behavioral health crisis, including:¹

- ending up in confrontations with law enforcement personnel which have tragic outcomes;
- being transported to emergency rooms and being admitted or committed to inpatient psychiatric facilities when these outcomes are unnecessary and may be harmful to the person; and
- being transported to a jail and subjected to ongoing involvement in the criminal justice system when these outcomes are unnecessary, are harmful to the person and do not lead to increased public safety.

Recognizing the limitations of law enforcement, local jurisdictions throughout the country have considered alternative models for mental health crisis response.² These include models that do and do not involve police. As described by the Congressional Research Service, the co-responder team model in particular "pair[s] law enforcement officers with trained clinicians who together respond to emergency calls involving individuals experiencing a mental health crisis."³

The purpose of Bill 43-23 is to establish a Crisis Intervention Team (CIT) that would implement the co-responder team model for mental health crisis response in the County. The CIT would be jointly staffed and operated by the Montgomery County Police Department (MCPD) and the Department of Health and Human Services (DHHS).

If enacted, Bill 43-23 would require CIT members from DHHS and MCPD to be co-located throughout the County. Other law enforcement agencies could also participate in the CIT subject to written agreements with the County. The CIT would be required to:⁴

- develop a plan for the County to divert individuals experiencing a mental or behavioral health crisis or substance use disorder crisis from the criminal justice system and into treatment; and
- respond to “acute mental health, behavioral health, or substance abuse crisis” incidents “where there is a significant risk of danger for the individual in crisis or others as a result of the crisis.”⁵ Otherwise, the Bill prescribes the primary response for someone experiencing a crisis should be mobile crisis or emergency medical services clinicians.

Bill 43-23 would also create a 15-member Advisory Committee on crisis intervention that would advise the CIT and County officials on best practices for crisis intervention in the County. The committee would also prepare an annual report on the CIT by January 31 of each year.

Bill 43-23, Crisis Intervention Team – Established, was introduced by the County Council on December 5, 2023.

ANTICIPATED IMPACTS

As defined by the U.S. Department of Health and Human Services’ National Health Security Strategy, “resilient communities are composed of healthy individuals, families, and communities with access to health care and the knowledge and resources to know what to do and care for others in both routine and emergency situations.”⁶ Mental health and mental health supports, like crisis intervention teams (CITs), are one component of community resilience.⁷ While evidence suggests CITs can strengthen emergency services for individuals experiencing a mental health crisis, research of CITs do not explicitly mention how it can improve overall emergency responses during large-scale, disasters, such as a natural disaster.⁸ Instead, research shows CITs primarily focus on improvements of interactions between individuals experiencing a mental health crisis and how they interact with the police and the criminal justice system.⁹

OLO anticipates Bill 43-23 will have no impact on the County’s contribution to addressing climate change, including the reduction and/or sequestration of greenhouse gas emissions, community resilience, and adaptative capacity.

RECOMMENDED AMENDMENTS

The Climate Assessment Act requires OLO to offer recommendations, such as amendments or other measures to mitigate any anticipated negative climate impacts.¹⁰ OLO does not offer recommendations or amendments as Bill 43-23 is likely to have no impact on the County’s contribution to addressing climate change, including the reduction and/or sequestration of greenhouse gas emissions, community resilience, and adaptative capacity.

CAVEATS

OLO notes two caveats to this climate assessment. First, predicting the impacts of legislation upon climate change is a challenging analytical endeavor due to data limitations, uncertainty, and the broad, global nature of climate change. Second, the analysis performed here is intended to inform the legislative process, not determine whether the Council should enact legislation. Thus, any conclusion made in this statement does not represent OLO's endorsement of, or objection to, the bill under consideration.

PURPOSE OF CLIMATE ASSESSMENTS

The purpose of the Climate Assessments is to evaluate the anticipated impact of legislation on the County's contribution to addressing climate change. These climate assessments will provide the Council with a more thorough understanding of the potential climate impacts and implications of proposed legislation, at the County level. The scope of the Climate Assessments is limited to the County's contribution to addressing climate change, specifically upon the County's contribution to greenhouse gas emissions and how actions suggested by legislation could help improve the County's adaptive capacity to climate change, and therefore, increase community resilience.

While co-benefits such as health and cost savings may be discussed, the focus is on how proposed County bills may impact GHG emissions and community resilience.

CONTRIBUTIONS

OLO staffer Kaitlyn Simmons drafted this assessment.

¹ [Position Statement 59: Responding to Behavioral Health Crises](#), Mental Health America, 2017.

² [Issues in Law Enforcement Reform: Responding to Mental Health Crises](#), Congressional Research Service, October 17, 2022.

³ Ibid.

⁴ [Introduction Staff Report for Bill 43-23](#), Montgomery County Council, Introduced December 5, 2023.

⁵ Bill 43-23, Introduction Staff Report for Bill 43-23.

⁶ [Community Resilience and Public Health Practice](#), Morton, M. J. and Lurie, N., American Journal of Public Health, July 2013

⁷ [Building Community Resilience – Prevention and Recovery Services Working Together](#), Substance Abuse and Mental Health Services Administration, November 9, 2021; [Community Resilience: Toward an Integrated Approach](#), Berkes, F. and Ross, H., Society and Natural Resources, 26:1, November 30, 2012

⁸ [Crisis Intervention Team Program: A Best Practice Guide for Transforming Community Responses to Mental Health Crises](#), CIT International, August 2019; [What Is Community Resilience?](#), Substance Abuse and Mental Health Services Administration, April 21, 2022.

⁹ [Effectiveness of Police Crisis Intervention Training Programs](#), Rogers, M. S., McNiel, D. E., and Binder, R. L., Journal of the American Academy of Psychiatry and the Law, September 2019.; [Crisis Intervention Team \(CIT\): Methods for Using Data to Inform Practice: A Step-by-Step Guide](#), Substance Abuse and Health Services Administration, 2018.

¹⁰ Bill 3-22, Legislative Branch – Climate Assessments – Required, Montgomery County Council, Effective date October 24, 2022

Racial Equity and Social Justice (RESJ) Impact Statement

Office of Legislative Oversight

BILL 43-23: CRISIS INTERVENTION TEAM – ESTABLISHED

SUMMARY

The Office of Legislative Oversight (OLO) finds the anticipated impact of Bill 43-23 on racial equity and social justice (RESJ) is indeterminant. Black community members would be disproportionately impacted by the establishment of a co-responder team model for mental health crisis response in the County. However, research evidence is mixed on the effectiveness of co-responder models to improve outcomes. Further, there are several unknown factors in how the new Crisis Intervention Team (CIT) program would minimize reliance on law enforcement for mental health crisis response, which is necessary for advancing RESJ.

PURPOSE OF RESJ IMPACT STATEMENTS

The purpose of RESJ impact statements (RESJIS) is to evaluate the anticipated impact of legislation on racial equity and social justice in the County. Racial equity and social justice refer to a **process** that focuses on centering the needs, leadership, and power of communities of color and low-income communities with a **goal** of eliminating racial and social inequities.¹ Achieving racial equity and social justice usually requires seeing, thinking, and working differently to address the racial and social harms that have caused racial and social inequities.²

PURPOSE OF BILL 43-23

Mental Health America lists lack of alternatives to law enforcement among several widespread problems in mental health and substance use crisis response. They note that shortcomings in crisis response could have serious consequences for someone experiencing a behavioral health crisis, including:³

- ending up in confrontations with law enforcement personnel which have tragic outcomes;
- being transported to emergency rooms and being admitted or committed to inpatient psychiatric facilities when these outcomes are unnecessary and may be harmful to the person; and
- being transported to a jail and subjected to ongoing involvement in the criminal justice system when these outcomes are unnecessary, are harmful to the person and do not lead to increased public safety.

Recognizing the limitations of law enforcement, local jurisdictions throughout the country have considered alternative models for mental health crisis response.⁴ These include models that do and do not involve police. As described by the Congressional Research Service, the co-responder team model in particular “pair[s] law enforcement officers with trained clinicians who together respond to emergency calls involving individuals experiencing a mental health crisis.”⁵

The purpose of Bill 43-23 is to establish a CIT program that would implement the co-responder team model for mental health crisis response in the County. The CIT would be jointly staffed and operated by the Montgomery County Police Department (MCPD) and the Department of Health and Human Services (DHHS).

If enacted, Bill 43-23 would require CIT members from MCPD and DHHS to be co-located throughout the County. Other law enforcement agencies could also participate in the CIT subject to written agreements with the County. The CIT would be required to:⁶

RESJ Impact Statement

Bill 43-23

- develop a plan for the County to divert individuals experiencing a mental or behavioral health crisis or substance use disorder crisis from the criminal justice system and into treatment; and
- respond to “incidents involving acute mental health, behavioral health, or substance abuse crisis events where there is a significant risk of danger for the individual in crisis or others as a result of the crisis.”⁷ Otherwise, the primary response for someone experiencing a crisis should be mobile crisis or emergency medical services clinicians.

Bill 43-23 would also create a 15-member Advisory Committee on Crisis Intervention that would advise the CIT and County officials on best practices for crisis intervention in the County. The committee would also prepare an annual report on the CIT by January 31 of each year.

The County Council introduced Bill 43-23, Crisis Intervention Team – Established, on December 5, 2023.

In August 2023, OLO published a RESJIS for Bill 33-23, Voluntary Registry for Emergency 911 Calls – Established.⁸ OLO builds on this RESJIS for this analysis.

MENTAL HEALTH CRISIS RESPONSE, LAW ENFORCEMENT, AND RACIAL EQUITY

Reliance on law enforcement for mental health crisis response and the resulting consequences are a widespread concern throughout the country. According to Serving Safely, a national initiative led by the Vera Institute of Justice in collaboration with the Bureau of Justice Assistance, “[c]onservative estimates show that at least 10 percent of calls to police involve people who have serious mental illnesses, and that a third to a half of all use-of-force incidents involve an individual with some type of disability.”⁹

Locally, OLO found that between September 2017 and May 2020, police responded to an average of 19 mental health situations each day.¹⁰ According to MCPD, mental illness was a contributing factor in 33 percent of use-of-force incidents in 2022.¹¹ Emergency Evaluation Petitions¹² – which arise in more serious mental health situations – increased by 9.5 percent from 2,207 in 2020 to 2,417 in 2022. In 2022, 24 percent of all uses-of-force by MCPD involved an Emergency Evaluation Petition.¹³

The intersection of policing inequities by race, ethnicity and disability compound challenges experienced by Black, Indigenous, and Other People of Color (BIPOC) with disabilities, including BIPOC with mental health conditions, during law enforcement interactions. For instance:

- A study published in 2017 of a nationally representative dataset found that more than half of Black people with disabilities were arrested by age 28.¹⁴
- A study published in 2021 of the Washington Post’s database of police-involved shootings found that “police are more likely to shoot and kill unarmed Black men who show signs of mental illness than [W]hite men who exhibit similar behaviors.”¹⁵

Disparities in law enforcement interactions among BIPOC emerge from a legacy of racial inequity in policing, where the earliest policing efforts, slave patrols, were charged with policing free and enslaved Black people.¹⁶ Today, racial inequities in policing persist with harsher treatment of BIPOC in the criminal justice system, mass incarceration, and the collateral punishment of incarceration on BIPOC families and communities.^{17,18} Locally, while Black constituents account for 18 percent of the County’s population, they account for 30 percent of traffic stops, 44 percent of arrests, and 59 percent of use of force incidents by MCPD.^{19,20,21}

RESJ Impact Statement

Bill 43-23

The Fountain House report, “From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response,” offers a comprehensive framework for addressing mental health emergencies that shifts “from a reactive system driven by public safety goals and procedures, to a preventative, health-first approach that centers racial equity, lived experience, systemic challenges, and cultural competency.” The report identified the following eight principles for crisis response systems, based on a landscape analysis of existing approaches and engagement with subject matter experts, including BIPOC and people with lived experience:²²

- Crisis systems should center racial justice and equity.
- Crisis response should be embedded within a holistic, integrated health care and public health system with high quality, accessible and equitable services.
- Individuals in crisis should have all possible opportunities to maximize self-determination and autonomy in defining when they are in crisis and in shaping the response when one is activated.
- Crisis responders should focus on creating person-to-person connections and trusting relationships with the person in crisis.
- Law enforcement should not be the default or primary responders for mental health crisis.
- The role and expertise of Peers should be centered in crisis response, recovery, and prevention.²³
- Alternatives to emergency departments should be prioritized when possible.
- Every community should have a standard, universal, and publicly supported response to mental health emergencies on par with the response to other health emergencies.

Minimizing reliance on law enforcement is a widely accepted best practice for effective mental health crisis response. As found in OLO Report 2021-4, “Public Safety Responses to Mental Health Situations,” “[f]ederal guidance calls for communities to develop behavioral health crisis care systems that reside outside of the criminal justice system and avoid overreliance on law enforcement to respond to mental health situations.”²⁴

COUNTY’S CURRENT MENTAL HEALTH CRISIS RESPONSE

Understanding the potential RESJ impact of implementing the co-responder team model requires understanding how mental health crisis response currently works in the County.

Two County entities primarily respond to mental health situations in the community: the Mobile Crisis Outreach Team via the Crisis Center Hotline and MCPD via 911. Other community hotlines (e.g., 988 Suicide and Crisis Lifeline and MC311) connect community members to the Mobile Crisis Outreach Team and/or MCPD if comprehensive help is needed for a mental health related situation.

The remainder of this section describes the Mobile Crisis Outreach Team and MCPD’s response to mental health situations, based mostly on OLO staff conversations with DHHS Crisis Center leadership in December 2023 and OLO Report 2021-4, “Public Safety Responses to Mental Health Situations.”²⁵

Mobile Crisis Outreach Team Response. The Mobile Crisis Outreach Team (MCOT) is part of DHHS’s 24-Hour Crisis Center. Community members who need help with a mental health crisis can reach MCOT by calling the Crisis Center Hotline at 240-777-4000.

RESJ Impact Statement

Bill 43-23

The Crisis Center operates 24 hours a day 7 days a week across three sites located in Silver Spring, Germantown, and Rockville. During periods of high volume, the three Crisis Center sites operate simultaneously. Crisis Center staff are cross trained to provide several mental health crisis services. During each shift, staff are assigned to different functions within the Crisis Center, including MCOT. MCOT is typically comprised of two behavioral health professionals – one licensed mental health professional and one peer support specialist. MCOT is dispatched to respond to mental health incidents in the community, providing “crisis evaluation, crisis stabilization, recommendations for treatment and resources, and facilitate[ing] hospital psychiatric evaluations.”²⁶

MCOT was established in the 1980s through a Memorandum of Understanding (MOU) with MCPD. For most of its existence, MCOT has responded to mental health incidents with MCPD officers. In 2022 – after years of work with Crisis Center staff, department leadership, community-based groups, elected leaders, and experts in mental health crisis response – the Crisis Center implemented the Common Triage and Dispatch Protocol. The protocol established two response levels for MCOT based on an assessment of risk: a level one response with no police and a level two response with police.²⁷

Montgomery County Police Department Response. Community members who need help with a mental health crisis typically call 911. In recent years, the County has ramped up efforts to educate the public on the Crisis Center Hotline to divert mental health related calls from 911. While awareness for the Crisis Center Hotline is growing, department staff note that 911 continues to be the primary hotline community members contact for help with mental health situations.

Since 2001, MCPD has operated a CIT program.²⁸ The CIT consists of seven staff members: one MCPD sergeant, five MCPD officers and one DHHS clinician.²⁹ The CIT “coordinates CIT training (see pages 33-34) for MCPD and other public safety personnel, responds to certain situations with mental health components, provides telephonic assistance for individuals in crisis that have been in contact with police, and provides limited outreach and case management for individuals with repeated police contacts.”³⁰ MCPD recently noted that “[t]o address the increasing use of force related to mental health concerns, MCPD requires all new officers to receive forty hours” of CIT training.³¹

911 calls are received by Emergency Communications Center (ECC) staff in MCPD. ECC staff generally put mental health situations into the following categories:³²

- Police only response: ECC staff dispatch MCPD officers;
- Medical only response: ECC staff dispatch Montgomery County Fire and Rescue Services (MCFRS) personnel; or
- Police and medical response: ECC staff dispatch MCPD officers and MCFRS personnel.

OLO Report 2021-4 noted that ECC “[s]taff report that they dispatch police resources rather than not based on how the caller describes the nature of the incident.” When MCPD officers are dispatched to respond to mental health crisis incidents, there are several courses of action they may take. These include contact only, making a referral to DHHS, initiating an Emergency Evaluation Petition, or making an arrest.³³

The report further noted that “[f]or complicated mental health situations, officers that respond may request assistance through the ECC from the dedicated Crisis Intervention Team and/or the DHHS [MCOT].”³⁴ Thus, involving the CIT and/or MCOT in an incident is mostly at the discretion of responding MCPD officers. When MCOT is involved, they arrive to the scene of an incident separately from MCPD officers.

RESJ Impact Statement

Bill 43-23

ANTICIPATED RESJ IMPACTS

To consider the potential impact of Bill 43-23 on RESJ in the County, OLO recommends the consideration of two related questions:

- Who are the primary beneficiaries of this bill?
- What racial and social inequities could passage of this bill weaken or strengthen?

For the first question, OLO considered the demographics of community members who would likely interact with the new CIT members, which would include MCPD officers and DHHS behavioral health professionals. As described earlier, BIPOC community members, especially Black community members, are disproportionately impacted by interactions with MCPD officers, including traffic stops, arrests, and use of force. Black community members are also overrepresented among people served by MCOT.³⁵

For the second question, OLO considered how the new CIT could improve racial inequities and disparities in law enforcement interactions with BIPOC experiencing mental health crises. Generally, a 2021 review of research on mental health crisis response models found that “[c]o-responder models evidenced improved outcomes compared to police only models, however, evidence was often mixed.”³⁶

Further, there are several unknown factors in how the new CIT program would be implemented to minimize reliance on law enforcement for mental health crisis response – a recognized best practice for effective mental health crisis response, including to advance RESJ. Unknown factors include:

- How the new CIT program will work alongside the MCOT program, which already has a protocol to respond to mental health situations with and without MCPD officers;
- If establishing the new CIT will redirect community members to call 911 instead of the Crisis Center Hotline for mental health situations;
- If protocols for 911 calls will be changed to allow ECC staff to directly dispatch MCOT to mental health situations where there is not a significant risk of danger;
- How hiring for behavioral health professionals to staff new CITs will be prioritized over hiring for professionals to staff MCOT given current vacancies in the Crisis Center and shortage of behavioral health professionals;³⁷ and
- How resources for mental health crisis response will be prioritized between CIT and MCOT with the CIT program being written into law.

Taken together, OLO finds the anticipated impact of Bill 43-23 on RESJ indeterminant.

RECOMMENDED AMENDMENTS

The Racial Equity and Social Justice Act requires OLO to consider whether recommended amendments to bills aimed at narrowing racial and social inequities are warranted in developing RESJ impact statements.³⁸ OLO finds the anticipated impact of Bill 43-23 on RESJ is indeterminant. As such, OLO does not offer recommended amendments.

RESJ Impact Statement

Bill 43-23

CAVEATS

Two caveats to this racial equity and social justice impact statement should be noted. First, predicting the impact of legislation on racial equity and social justice is a challenging analytical endeavor due to data limitations, uncertainty, and other factors. Second, this RESJ impact statement is intended to inform the legislative process rather than determine whether the Council should enact legislation. Thus, any conclusion made in this statement does not represent OLO's endorsement of, or objection to, the bill under consideration.

CONTRIBUTIONS

OLO staffer Janmarie Peña, Performance Management and Data Analyst, drafted this RESJ impact statement.

¹ Definition of racial equity and social justice adopted from “Applying a Racial Equity Lens into Federal Nutrition Programs” by Marlysa Gamblin, et.al. Bread for the World, and from Racial Equity Tools. <https://www.racialequitytools.org/glossary>

² Ibid.

³ [Position Statement 59: Responding to Behavioral Health Crises](#), Mental Health America, 2017.

⁴ [Issues in Law Enforcement Reform: Responding to Mental Health Crises](#), Congressional Research Service, October 17, 2022.

⁵ Ibid.

⁶ [Introduction Staff Report for Bill 43-23](#), Montgomery County Council, Introduced December 5, 2023.

⁷ Bill 43-23, Introduction Staff Report.

⁸ [RESJS for Bill 33-23](#), Office of Legislative Oversight, August 15, 2023.

⁹ Fact Sheet, [Serving Safely: The National Initiative to Enhance Policing for Persons with Mental Illnesses and Developmental Disabilities](#), Vera Institute of Justice, February 2019.

¹⁰ Natalia Carrizosa, [OLO Report 2021-4: Public Safety Responses to Mental Health Situations](#), Office of Legislative Oversight, March 9, 2021.

¹¹ [MCPD 2022 Annual Use of Force Report](#), Montgomery County Police Department.

¹² An Emergency Evaluation Petition is a process by which someone who is “suspected of having a mental disorder” and “presents a danger to the life and safety of themselves or others” can be taken into custody by law enforcement and transported to an emergency facility for evaluation by a mental health professional. For more information, refer to [“Responding to Behavioral Health Emergencies and Persons with an Altered Mental Status,”](#) Montgomery County Police Department.

¹³ MCPD 2022 Annual Use of Force Report.

¹⁴ Erin J. McCauley, [“The Cumulative Probability of Arrest by Age 28 Years in the United States by Disability Status, Race/Ethnicity, and Gender,”](#) American Journal of Public Health, December 2017.

¹⁵ Minyvonne Burke, [“Policing Mental Health: Recent Deaths Highlight Concerns Over Officer Response,”](#) NBC News, May 16, 2021, citing Marilyn D. Thomas, et. al., [“Black and Unarmed: Statistical Interaction Between Age, Perceived Mental Illness, and Geographic Region Among Males Fatally Shot by Police Using Case-Only Design,”](#) Annals of Epidemiology, January 2021.

¹⁶ Michael A. Robinson, [“Black Bodies on the Ground: Policing Disparities in the African American Community—An Analysis of Newsprint From January 1, 2015, Through December 31, 2015,”](#) Journal of Black Studies, April 7, 2017.

¹⁷ [Report to the United Nations on Racial Disparities in the U.S. Criminal Justice System](#), The Sentencing Project, April 19, 2018.

¹⁸ Andrea Flynn, Susan Holmberg, Dorian Warren and Felicia Wong, *The Hidden Rules of Race: Barriers to An Inclusive Economy*, Roosevelt Institute (Cambridge University Press, 2017)

¹⁹ Natalia Carrizosa, [OLO Memorandum Report 2022-12, Analysis of dataMontgomery Traffic Violations Dataset](#), Office of Legislative Oversight, October 25, 2022.

²⁰ Elaine Bonner-Tompkins and Natalia Carrizosa, [OLO Report 2020-9, Local Policing Data and Best Practices](#), Office of Legislative Oversight, July 12, 2020.

²¹ MCPD 2022 Annual Use of Force Report.

²² [“From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response,”](#) Fountain House.

RESJ Impact Statement

Bill 43-23

²³ In behavioral health, a Peer is usually used to refer to someone who shares the experience of living with a psychiatric disorder and/or addiction. From [What Is a Peer?](#), Mental Health America.

²⁴ Natalia Carrizosa, [OLO Report 2021-4: Public Safety Responses to Mental Health Situations](#), March 9, 2021.

²⁵ Ibid.

²⁶ Ibid.

²⁷ [Video: Dispatch Protocol for Mental Health Crisis Response](#), County Cable Montgomery, May 4 2022.

²⁸ [2022 Annual Report on Crime and Safety](#), Montgomery County Police Department.

²⁹ Natalia Carrizosa, OLO Report 2021-4: Public Safety Responses to Mental Health Situations.

³⁰ Ibid.

³¹ MCPD 2022 Annual Use of Force Report.

³² Natalia Carrizosa, OLO Report 2021-4: Public Safety Responses to Mental Health Situations.

³³ Ibid.

³⁴ Ibid.

³⁵ Ibid.

³⁶ Natania Marcus and Vicky Stergiopoulos, [“Re-examining Mental Health Crisis Intervention: A Rapid Review Comparing Outcomes Across Police, Co-Responder and Non-Police Models,”](#) Health and Social Care in the Community, January 10, 2022.

³⁷ Staff reported there were 14 vacancies in the Crisis Center as of December 2023.

³⁸ Bill 27-19, Administration – Human Rights – Office of Racial Equity and Social Justice – Racial Equity and Social Justice Advisory Committee – Established, Montgomery County Council

Bill 43-23 Crisis Intervention Team – Established

Montgomery County Council

January 16, 2024

TESTIMONY IN SUPPORT

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health and substance use disorders (collectively referred to as behavioral health). We appreciate the opportunity to provide this testimony in support of Bill 48-23.

Bill 48-23 establishes a Crisis Intervention Team (CIT) as a joint program of the Montgomery County Police Department and the County Department of Health and Human Services. CIT is a law enforcement-led, team-based intervention to divert individuals experiencing behavioral health crises away from the criminal justice system and into treatment. It results in less lethal interactions, better outcomes and increased safety for all involved. Per the Substance Abuse and Mental Health Services Administration (SAMHSA):

The Crisis Intervention Team (CIT) program has become a globally recognized model for safely and effectively assisting people with mental and substance use disorders who experience crises in the community. The CIT Model promotes strong community partnerships among law enforcement, behavioral health providers, people with mental and substance use disorders, along with their families and others.¹

Consumer and family advocates have been working for years to expand access to CIT programs across Maryland, a policy goal endorsed by the Maryland General Assembly in 2020 with the passage of [SB 305](#). That bill, which passed unanimously in the Senate and nearly unanimously in the House, established a [CIT Center of Excellence](#) to assist local jurisdictions in developing, evaluating and improving CIT programs across Maryland. Bill 48-23 is an important step in aligning with these goals.

However, it is important to note that CIT is just one part of a robust continuum of community behavioral health services. Mobile crisis teams, crisis phone lines, and other treatment-linked community resources are essential to reducing criminal justice system involvement for individuals with mental health and substance use disorders. Bill 48-23 helps in this aspect too by requiring the establishment and enhancement of a sequential intercept model (SIM) in Montgomery County.

¹ *Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide*. Substance Abuse and Mental Health Services Administration, 2018. <https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5065.pdf>

For more information, contact Dan Martin at (410) 978-8865

SIM was developed to help communities identify ways to address the disproportionate number of people with behavioral health issues in the criminal justice system across six key “intercepts” at which people with behavioral health needs come into contact with and flow through the criminal justice system. By engaging in the SIM process, jurisdictions assess resources and determine critical service gaps; identify opportunities to divert individuals from justice system involvement into alternative treatment services; forge partnerships between different agencies, organizations, and jurisdictions; introduce practitioners to evidence-based practices; enhance relationships across systems and agencies; and create customized plans for community change.²

Furthering a SIM framework in jurisdictions across Maryland is another longtime priority for behavioral health consumer and family advocates, and it is another goal that has been endorsed by the state legislature. In 2021 the General Assembly passed [SB 857/HB 1280](#), with unanimous approval in both chamber, establishing the [Maryland Behavioral Health and Public Safety Center of Excellence](#). Assisting jurisdictions in developing localized SIMs is a primary responsibility of this Center of Excellence.

Bill 48-23 will establish programs in Montgomery County that are designed to divert individuals experiencing behavioral health crises away from the criminal justice system. For this reason, MHAMD supports this bill.

² *Maryland’s Behavioral Health and Public Safety Center of Excellence Strategic Plan*. University of Maryland Crime Research and Innovation Center, September 2023.
https://bsos.umd.edu/sites/bsos.umd.edu/files/EXECUTIVE_SUMMARY_BH_PS_CoE.pdf

Providing Information

Written Testimony to Provide Information on Bill 43-23, Crisis Intervention Team – Established

**Submitted by the Montgomery County Mental Health Advisory Committee
(MHAC)
to the Health and Human Services (HHS) Committee of the Montgomery County
Council
January 16, 2024**

The Mental Health Advisory Committee (MHAC) is providing information on Councilmember Luedtke's legislation. We continue to have concerns with some of the language. We appreciate that you have taken the time to gather feedback from various stakeholders and hear their concerns.

Our greatest concern is that the overarching crisis intervention team model should be embedded within the overarching mental health, substance use, and co-occurring disorders crisis response continuum of care. The model needs to be guided by the values and principles of an integrated system that is consumer-driven, family-driven, youth-driven, culturally and linguistically competent, community-based, and recovery oriented. This model should fuel efforts to decriminalize mental health, substance use, and co-occurring disorders crises and thereby result in less police involvement, less incarceration, and less harm.

The main goal is to support those in crisis and decriminalize mental health, substance use, and co-occurring crises, with reduced law enforcement presence unless absolutely necessary. Given that our county data reveals racial and ethnic disparities in incarceration and access to services, we must work deliberately to address these injustices. This collaborative crisis response model must be designed to promote social justice while reversing the general over-policing of racial minorities and marginalized communities, specific policies that disproportionately affect people of color, and the stigmatization of those who have mental health, substance use, or co-occurring challenges.

In crisis response, which responders become involved should be determined based upon what is the best fit for the situation. A co-responder could be a police officer, a therapist, and/or a peer.

The co-responders need to improve the experiences and outcomes of persons in crisis by providing effective crisis de-escalation, culturally appropriate interactions, diversion from the criminal justice system, and connection to appropriate behavioral health services and resources. When law enforcement involvement is necessary, it is critical to have officers that are trained in responding to individuals in behavioral health crises as

well as having trained behavioral health responders. As such, funds must be dedicated to recruitment and the initial and ongoing training for law enforcement, behavioral health professionals, and crisis peer responders.

Crisis peer responders need to be incorporated into this collaborative model. They play a vital role in crisis care. They provide non-clinical support to individuals who are experiencing a crisis. They can help de-escalate the crisis, conduct non-clinical assessment services and interventions, and provide advocacy and support. Crisis peer responders provide opportunities for individuals in crisis to talk with someone who has similar experiences, embodies recovery, and can offer messages of encouragement and hope. Moreover, the crisis peer responders can offer post-crisis services, such as peer navigation and community support, which are essential for people who recently experienced a crisis.

It is important that the model articulate ways to equalize the power between the mental health clinician and the police officer. These different professionals have their own organizational culture and mandates, and their worldviews can be very different. A newly graduated therapist could be intimidated by the police officer. It will require ongoing support, training, and supervision to build genuine partnerships and to develop respect, trust, and a shared vision in their approach to crises.

We are concerned about handcuffing the individuals in crisis. We do understand that the decision to handcuff is not taken lightly. It is done only in circumstances in which it is necessary to protect the safety of the individual, the officer, and the clinician. There needs to be a paradigm shift and training that supports it to teach alternative methods other than handcuffing individuals experiencing a crisis. If an individual is suffering from a mental health, substance use, or co-occurring challenge and is acutely agitated, putting him/her/they in handcuffs is going to increase that agitation. Another issue is how co-responders will interact with youth or young adults in crisis. Mobile Response and Stabilization Services (MRSS) is a rapid response, home- and community-based crisis intervention model customized to meet the developmental needs of children, youth, young adults, and their families. MRSS is embedded within a full spectrum of effective services and supports for youth with or at risk for behavioral health and emotional challenges. The family member determines if there is a crisis. In MRSS, there is a mobile response without law enforcement. It is used only if absolutely necessary for safety reasons and as a last resort. Input from youth and family must be included in the decision to use law enforcement, and the youth/family must be made aware of the use of law enforcement prior to arrival.

We are also concerned that the details within the composition of the team and its operations are too prescriptive. While we support guidance on the team structure and

responsibilities, we believe that each jurisdiction in Maryland is different; as such, there must be flexibility in the structure of the model and the ability for each jurisdiction to structure use of the departments and design the program to meet the unique needs of the community it services.

Additionally, it is important to ensure that the CIT team and associated support services (such as 911 dispatch) work collaboratively within the existing crisis continuum of care to establish protocols that support a best-fit response model through appropriate triage criteria. Such criteria has been established and currently supported by BHA.

The MHAC wants to be sure that any legislation maintains and strengthens the mental health, substance use, and co-occurring crisis response continuum of care that is currently in existence in the county and is most supportive to the diverse population of Montgomery County residents. As such we have the following additional recommendations:

- Utilize a unified platform to simplify and optimize data collection and information sharing across relevant county departments.
- Incorporate Mobile Response and Stabilization Services (MRSS), an evidence-based, child-focused crisis response service model to reduce the involvement of police responding to youth in crisis. This should be included as a part of the Sequential Intercept Model enhancements and similar to the collaboration with MCOT and CIT;
- Incorporate peers in the Sequential Intercept Model. Peers play an instrumental role in supporting individuals in crisis as individuals with lived experience.
- To address the ongoing shortages and staffing challenges in the workforce, ensure that the mandated activities designated by the legislation come with commensurate funding to implement effectively.
- As an inter- and intragovernmental mechanism for implementing this model, the Advisory Committee should not have an overrepresentation of law enforcement and government representatives. We ask that the membership on the Advisory Committee include: a member of the Montgomery County Mental Health Advisory Committee (MHAC); a member of the Montgomery County Alcohol and Other Drug Addiction Advisory Council (AODAAC); at least two family members who are caring for or have cared for children, youth, or young adult with a mental health and/or substance use disorder; an adult consumer; two young adult consumers; a Certified Family Peer Specialist; a Certified Peer Recovery Specialist; a representative of the forthcoming Diversion Center; and a designee from EveryMind (formerly known as the Mental Health Association of Montgomery County).

Thank you again for the time to hear our concerns and the opportunity to offer our feedback. We are grateful for the work you have done on this legislation and supporting policy, and the diligence you and your staff have demonstrated in your commitment to the well-being of our county residents. We urge you to incorporate these concerns and recommendations into the final legislation and remain diligent through its implementation. We welcome the opportunity to provide ongoing input and support to Councilmember Luedtke and the relevant stakeholders involved in behavioral health, crisis response, and the decriminalization of mental health, substance use, and co-occurring disorders.

Sincerely,

Libby K. Nealis

Libby K. Nealis, MSW

Montgomery County Mental Health Advisory Committee, Chair



Michelle Grigsby-Hackett, LCPC, CPRP

Montgomery County Mental Health Advisory Committee, Vice-Chair

Notes:

1. Mobile Response and Stabilization Services (MRSS) is a rapid response, home- and community-based crisis intervention model customized to meet the developmental needs of children, youth, young adults, and their families (youth and families). The inclusion of MRSS within a comprehensive system of care and crisis continuum is a core component of a good and modern children's behavioral health system. MRSS is embedded within a full spectrum of effective services and supports for youth with or at risk for behavioral health and emotional challenges. In MRSS, there is a mobile response without law enforcement, unless essential for safety reasons and as a last resort. Youth and family's input must be included in the decision to use law enforcement, and the youth/family must be made aware of the use of law enforcement prior to arrival. See national and state documents on MRSS: [Mobile Response & Stabilization Services National Best Practices](#) and

[Comprehensive Mobile Response & Stabilization Services for Children, Youth, Young Adults & Families](#)

2. Peers are individuals with lived experience who are trained and certified to provide support to individuals in their treatment and recovery. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) [infographic on Peers](#), peers increase a patient/client's activation and sustained engagement in treatment; decrease patient hospitalization; and reduce stigma within clinical and public safety settings. Across the country, peers have worked in emergency departments, with law enforcement, in courts, jails, and crisis stabilization health settings. Montgomery County has several peer-led community organizations that support the peer workforce to get trained and certified; and then deploys those certified peers into multiple settings (e.g., the STEER program; Family Peer Support Services to families who have youth with behavioral health challenges). The peer-led organizations also provide backbone support, similar to a union, to protect peers from burnout and potential relapse. Peer organizations also play a primary role in providing respite care (an intervention that can divert from crisis needs), as well as post-treatment recovery-based services.

January 16, 2024 Public Hearing for Bill 43-23, Crisis Intervention Team – Established
Favorable

1. Good afternoon, Council President Friedson and Councilmembers. I am Cari Guthrie, President and CEO of Cornerstone Montgomery a nonprofit that provides community- and evidence-based mental health and substance use disorder services. Our mission is to empower people living with mental health and substance use disorders to thrive in their community through collaboration, treatment, education, and advocacy.
2. Cornerstone Montgomery supports Bill 43-23 Crisis Intervention Team - Established because it would improve Montgomery County's response to individuals experiencing mental health and/or substance use crises using a model that has proven effective in other jurisdictions across the nation and right here in Maryland.
3. This bill would create co-responding Crisis Interventions Teams (CIT) as a joint program of the County Department of Health and Human Services (DHHS) and Police Department (MCPD). Each team would be composed of one clinician and one officer who co-locate, co-deploy, and co-respond to individuals who are experiencing a mental or behavioral health crisis AND also pose a danger to themselves and/or others.
4. Since MCPD started training its officers in CIT, Cornerstone has made it a habit to ask for CIT officers to be deployed when possible, and it has made a noticeable difference in the outcomes of the calls. CIT trained officers are more likely to listen to what our staff has to say and work collaboratively to determine next steps. That means that our clients are not just taken to jail or an ED – we work together to figure out the best outcome for the client – including that they just stay home and get support from their treatment team.
5. This bill would not alter or interfere with the work of Montgomery County's Crisis Center or the clinician-only Mobile Crisis Outreach Teams (MCOTs). Rather, this bill would add another option for crisis response. Crises can present in a wide variety of ways, and the system must be flexible enough to meet folks where they are. CIT is a vital part of the larger landscape of interventions and wraparound services.
6. By supplementing and strengthening the resources we already have, this bill would address the wait time issues that our county's crisis response system currently suffers from which would allow for more access to more mobile crisis support options.
7. This bill would also require DHHS and MCPD to ratify an MOU that delineates individual and shared responsibilities; identifies opportunities for data and resource

sharing; and facilitates greater communication, collaboration, and trust between the departments. This bill would ensure that Montgomery County's crisis response system is organized and accessible.

8. Cornerstone Montgomery supports Bill 43-23 because it would create co-responding Crisis Intervention Teams, which are successful at deescalating dangerous situations, diverting individuals from the criminal justice system, and increasing access to needed follow-up services including supporting the least restrictive environment.



The Washington Psychiatric Society is a District Branch of the American Psychiatric Association. Our membership includes psychiatrists who live and/or practice in Montgomery and Prince George's County. In collaboration with the Maryland Psychiatric Society, we represent the views and interests of Maryland Psychiatrists.

We strongly support Bill 43-23 Crisis Intervention Teams-Established. Like in most other areas of the country, the mentally ill in Montgomery Country face a crisis in treatment. Resources are limited, and the network of treatment providers is fragmented. In the ongoing aftermath of deinstitutionalization, many very ill patients attempt to live in the community. With the contraction of inpatient, partial hospitalization, and intensive outpatient services along with funding mechanisms inadequate to ensure adequate treatment, it is inevitable that crisis-level, disruptive, and possibly dangerous illness exacerbations will occur.

Montgomery County has established elements of the Crisis Intervention Team approach. We clinicians have had positive experiences with dedicated, humane law enforcement officers and members of the mobile crisis intervention team. However, the system within which they work is rudimentary and incomplete, leaving open the possibility that patients will not be directed to the appropriate treatment, that their illness could progress leading to more suffering and disruption, or, worse, a tragic outcome.

For example, when they feel they need immediate help for someone experiencing a mental health crisis, families will often call 911. Most often, a police officer or a group of officers will be dispatched to the scene. Just this scenario can have harmful consequences. First, being confronted with the police can be intimidating for the patient, leading them to resist help. Worse, they could become agitated in response to what they experience as a threat. A dangerous physical confrontation can ensue.

Further, police appear to be tasked with controlling a dangerous situation and then determining if the patient is dangerous enough to seek involuntary hospitalization. It's a binary action. If judged dangerous, the police will transport the patient according to a protocol that requires they be placed in handcuffs and transported in a squad car—sometimes necessary, but often experienced as traumatic and dehumanizing. If the patient is not judged to be dangerous, the interaction is ended, with no referral for treatment or follow-up. The patient is still very ill and could get worse-- and the family is left in the exact same, impossible situation.

Clearly, such complex scenarios cannot be quickly resolved. But if the intentions of Bill 43-23 were to be realized, a team consisting of police and clinicians with an established working relationship, all with clearly defined roles, would be present. The threatening nature of the encounter would be dispelled. A clinical assessment would, based upon an established protocol, determine an appropriate course, either referral to outpatient resources or for inpatient care. It would be more likely that a patient would achieve an optimal outcome.

To be sure, the mental health crisis is daunting here and elsewhere. The Crisis Intervention Model embodied in Bill 43-23, and in operation around the country, represents the best way of addressing a critical element of this crisis. By emphasizing an ongoing collaborative relationship between clinicians and law enforcement, robust protocols for responding to and resolving crisis events, ongoing outcome assessment and expert oversight, one could envision its implementing system where patients could be helped to overcome the burden of their illness and embark on a more positive life course. For these reasons, we strongly urge passage of Bill 43-23.

Thank you very much for your consideration.

Steven B. Israel, MD
Legislative Advocacy Committee
Washington Psychiatric Society.



**Bill 43-23, *Crisis Intervention Team - Established*
Montgomery County Council
January 16, 2024
Support**

The Montgomery County Chamber of Commerce (MCCC), the voice of business in Metro Maryland, supports Bill 43-23, *Crisis Intervention Team - Established*.

Bill 43-23, which seeks to establish a crisis intervention team as a joint program of the Montgomery County Police Department and the County Department of Health and Human Services, would increase the quality of public safety on behalf of all Montgomery County residents and businesses.

MCCC contends that public safety is one of the most important factors for creating a positive business environment and encouraging economic growth. For this reason, MCCC has a strong partnership with Montgomery County's public safety community, going back nearly 50 years.

This crisis intervention team model of co-deployment will yield better outcomes and divert individuals away from the criminal justice system. It is important to seek innovations in crisis response by implementing recognized best practices where possible.

Mental and behavioral health emergencies can and do happen anywhere – in public and privately. When there is a public incident, it can negatively impact local businesses by creating the perception that the surrounding area is unsafe.

For these reasons, the Montgomery County Chamber of Commerce supports Bill 43-23 and respectfully requests favorable consideration of the bill.

The Montgomery County Chamber of Commerce, on behalf of our members, advocates for growth in business opportunities, strategic investment in infrastructure, and balanced tax reform to advance Metro Maryland as a regional, national, and global location for business success. Established in 1959, MCCC is an independent non-profit membership organization and a proud Montgomery County Green Certified Business.

Brian Levine | Vice President of Government Affairs
Montgomery County Chamber of Commerce
51 Monroe Street | Suite 1800
Rockville, Maryland 20850
301-738-0015 | www.mcccmd.com

Civilian Crisis Response Rather than Co-Responder and CIT Programs

White Paper

Resources for Human Development

Claire Ryder, DHSc(c) & Alisha Nash, MSW

“The mere presence of a law enforcement vehicle, an officer in uniform, and/or a weapon... has the potential to escalate a situation.” - International Association of Chiefs of Police

The Problem:

In the last decade, use of excessive force by police towards people during behavioral health crises has come under increasing scrutiny from the public. Police mishandling of behavioral health crises has had tragic outcomes for individuals, families, and communities. A growing body of research indicates the need for change. Behavioral health challenges are a predictor of police violence in a crisis (Rossler & Terrill, 2017). Law enforcement is more likely to use force when the person shows signs of mental illness. In the United States, people with a serious persistent mental illness (SPMI) are 16 times more likely to be killed by police than people who are not experiencing SPMI (Fuller et al., 2015). The American Public Health Association (2018) cited a 2015 estimate that 27% of police killings were of people with a mental illness. When police do use force, people with mental illness are injured a third of the time compared to people without behavioral health challenges who are only injured in a quarter of the incidents.

The American Public Health Association (2018) identifies the need to find alternative to police as the default first responders as a key public health issue. Alternative models focused on behavioral health first responders can decrease interactions with the criminal justice system, reduce involuntary hospitalizations, and increase healthcare responses to behavioral health crises. By virtue of fewer interactions with police, people are less likely to become involved in the criminal justice system when what they really need is healthcare treatment and support. This reduction in law enforcement interactions also reduces the number of excessive force allegations and police shootings because there are fewer opportunities for these tragedies to occur.

Relying on law enforcement as responders to behavioral health crises is expensive and ineffective. It results in high rates of incarceration and lack of appropriate health care for people with mental illness or substance abuse (Assey, 2021; Balfour et al., Irwin & Pearl, 2020; SAMHSA, 2020; 2022; Seo et al., 2021).

Crisis Intervention Training (CIT) & Co-response

Crisis Intervention Training (CIT) provides training to law enforcement officers on a variety of topics related to behavioral health and substance use as well as officer liability, and relevant policies and procedures. Currently, there are no uniform national standards guiding the implementation of CIT. Lack of consistency across programs makes research into the value and impact of the CIT model difficult. Despite numerous attempts, independent researchers have not been able to demonstrate clear or reliable outcomes of CIT due to the lack of uniformity across programs. While research has shown that CIT or co-response models can change officer attitudes

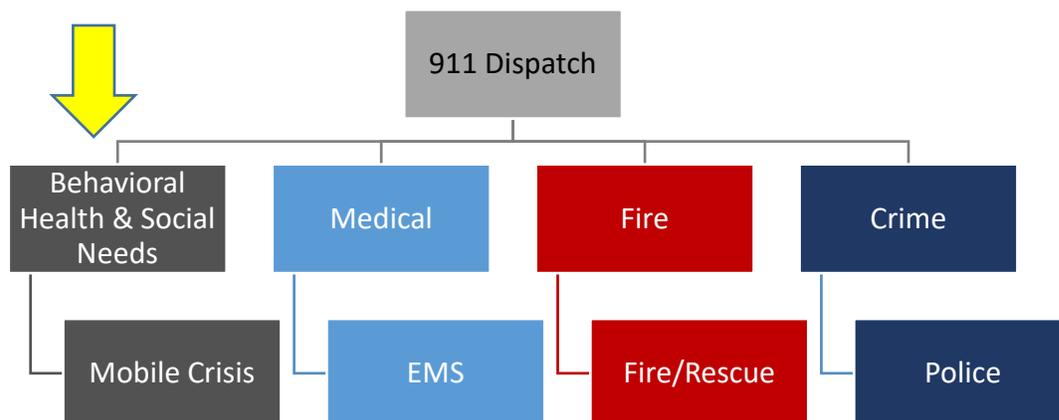
about mental illness, research does not demonstrate the same impact on officer behavior (Marcus & Stergiopoulos, 2022; Seo et al., 2021).

Co-response models pair police officers with specially trained behavioral health professionals to respond to crises in tandem. Unfortunately, co-responder teams face many of the same challenges as traditional police response. Research on the benefits of co-responder models indicates limited impact when police are part of the responding team and suggests that whenever possible, behavioral health first responders should respond without police (Bailey et al., 2018). If police are needed for safety reasons, they should respond with behavioral health first responder teams and leave the scene as soon as it is safe to allow the behavioral health first responders to manage the crisis.

Vice-President of CIT International, Ron Bruno said, “We have to challenge the belief that mental health crisis services must come in a police car,” (SAMHSA, 2020, p. 68). When police arrive, they bring lights, sirens, handcuffs, and weapons, which are a source of anxiety for many people and often escalate a behavioral health crisis. Bruno agreed, saying, “Every time a police officer goes to a crisis situation, it’s going to escalate the person’s emotional state. Yes, we can and will train officers to de-escalate situations, but often, their mere presence is stressful, and the person in crisis can become fearful and enter fight or flight. That’s when we see major problems,” (SAMHSA, 2020, p. 68). During behavioral health crises, de-escalation is key to maintaining health and safety for all those involved. If the mere presence of police has the opposite effect, we have a responsibility to explore alternatives to CIT and co-response models.

The Solution: Civilian Crisis Response

Municipalities looking to reduce unnecessary hospitalizations and incarceration while also reducing costs and improving efficiency have a solution at their fingertips: civilian-only crisis response teams as the fourth branch of the emergency response system. These teams, often referred to as civilian crisis response, mobile crisis outreach teams, alternative dispatch teams, or community responder models, are dispatched by 911 to behavioral health crises in the community. Civilian-only response teams are composed of highly specialized behavioral health crises workers, under the supervision of licensed clinicians. Cities that have adopted these models have seen multiple benefits beyond appropriate treatment, including reduced costs for police overtime, reduction in arrests, and even reduction in crime (Dee & Pyne, 2022).



Parity with Physical Health

Another benefit of civilian response over co-response teams is the opportunity provided for cities, counties, and campuses to offer parity between physical health and behavioral health in their public safety and emergency response systems. A current court case brought suit against the District of Columbia for offering medical-specific first responders while sending police to behavioral health emergencies. The suit identifies this as discrimination against people with mental illness, which is in violation of the Americans with Disabilities Act (American Civil Liberties Union, 2023). Adding a fourth branch of the emergency response system allows for behavioral health first responders to respond with or without police as the crisis calls for.

The last evolution of the emergency response system occurred approximately 50 years ago with the addition of what we now know as the Emergency Medical Service (EMS). EMTs report over 7,770 injuries each year, with one-third attributed to patient violence (Maguire & Amiry, 2023). Reasonable concern over the potential for similar injuries to behavioral health workers has led to support for the co-response model. However, evidence shows that properly trained crisis response workers, skilled in de-escalation, are actually safer without police present. When a scene is known to have higher risks of violence, police and EMS respond together. Behavioral Health First Responders and police can do the same.

Faster Response Time with the Mutual Response Model

There are practical reasons for municipalities to invest in mobile crisis teams who can “mutually respond” over co-responding teams. In mutual response models, two branches of the emergency system send the first available personnel to the scene, rather than wait for the availability of a dedicated behavioral health co-response team. Mutual response can arrive on scene faster because any behavioral health first responder team and any police officers can respond rather than waiting for the co-response team to be available and arrive. This means the closest responders can be dispatched, minimizing response time, which minimizes the chance that the crisis will escalate while waiting for help. Mutual response also allows officers to leave once they secure the scene, so they are free to respond to other calls. In a co-responder model, the officer is tied up with the behavioral health worker, even if they are not needed. This is an inefficient use of officer time.

Example Civilian Crisis Response Program

The New Orleans Mobile Crisis Intervention Unit (MCIU) is an example of a successful adoption of the fourth branch of the emergency response system. Implemented in June 2023, MCIU is staffed by behavioral health first responders who are dispatched from 911 to behavioral health crises to manage the scene, facilitate referrals to treatment, and provide transport if needed. They are able to mutually respond with fire/rescue, EMS, or police but usually respond without one of the other branches.

The average MCIU response time is 15 minutes. New Orleans’ average EMS and police response time is over an hour. The program projects saving 5000 police hours a year. Involuntary hospitalizations account for only 15% of calls, the lowest of any mobile crisis team in the state;

according to data from the New Orleans Police Department, 60% of 911 calls with a mental health signal ended in involuntary hospitalization in 2020 (Chrastil, 2023). There have been zero instances of harm to first responders, individuals in crisis, or bystanders. MCIU has been able to divert situations away from SWAT, saving the city tens of thousands of dollars.

Regarding the success of the MCIU team, New Orleans Police Department CIT Coordinator, Desi Broussard says, “The feedback from the field is amazing. Every time one of my officers encounters someone from the MCIU team, I get nothing but amazing feedback. They are so grateful to have partners in the field with such in depth clinical knowledge to help us make those decisions whenever we just aren’t quite sure what to do. They are so grateful for that partnership and the people you have in place in these green shirts, they are truly heroes.”

Recommendations

A separate team that can provide a mutual response rather than a co-responder model in which an officer is always present is more aligned with the SAMHSA recommendations, which state that mobile crisis should be the sole responder unless there is a specific need for police involvement (SAMHSA, 2020). While CIT and co-responding models provided an improvement from patrol or police-only responders to behavioral health crises, the research has not shown that they are consistently successful. The practical barriers of these models further reduce their efficacy as a resolution to the current gap in the emergency response system. Continuing to send officers, no matter how well trained, to behavioral health crises when we know officer presence escalates these situations will continue to cause harm. Replacing police response to behavioral health crises with specialized mental health response, as we do for physical health, will lead to the best public service by first responders.

References

- American Civil Liberties Union. (2023, July 6). *Court Cases: Bread for the City v. District of Columbia*. <https://www.aclu.org/cases/bread-for-the-city-v-district-of-columbia#:~:text=The%20lawsuit%20contends%20that%20the,responses%20to%20mental%20health%20emergencies>.
- American Public Health Association (2018, November 13). *Addressing Law Enforcement Violence as a Public Health Issue*. <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence>
- Assey, D. (2021). Addressing misconceptions about mental health and violence. *The Council of State Government*. <https://csjusticecenter.org/publications/addressing-misconceptions-about-mental-health-and-violence/>
- Bailey, K., Paquet, S. R., Ray, B. R., Grommon, E., Lowder, E. M., & Sights, E. (2018). Barriers and facilitators to implementing an urban co-responding police-mental health team. *Health & Justice*, 6(1), 1–12. <https://doi.org/10.1186/s>
- Balfour, M. E., Stephenson, A. H., Delany-Brumsey, A., Winsky, H., & Goldman, M. L. (2022). Cops, clinicians or both? Collaborative approaches to responding to behavioral health emergencies. *Psychiatric Services*, 73(6), 658–669. <https://doi.org/10.1176/appi.ps.202000721>
- Chrastil, N. (2023, June 1). *City rolls out non-police 911 mental-health response*. The Lens. <https://thelensnola.org/2023/06/01/city-rolls-out-non-police-911-mental-health-response/>
- Dee, T. S., & Pyne, J. (2022). A community response approach to mental health and substance abuse crises reduced crime. *Science Advances*, 8(23). <https://doi.org/10.1126/sciadv.abm2106>
- Fuller, D. A., Lamb, H. R., Biasotti, M., Snook, J. (2015). *Overlooked in the Undercounted: The role of mental illness in fatal law enforcement encounters*. Treatment Advocacy Center, <https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf>
- IACP Law Enforcement Policy Center, “Responding to Persons Experiencing a Mental Health Crisis” (Alexandria, VA: 2018), available at <https://www.theiacp.org/sites/default/files/2018-08/MentalIllnessBinder2018.pdf>
- Irwin, A. & Pearl, B. (2020, October 28). *The community responder model*. Center for American Progress. <https://www.americanprogress.org/article/community-responder-model/>
- Maguire, B. J., & Amiry, A. (2023). Occupational injuries and illnesses among paramedicine clinicians: Analyses of US Department of Labor data (2010 – 2020). *Prehospital and Disaster Medicine*, 38(5), 581-588. <https://doi.org/10.1017/S1049023X23006118>
- Marcus, N. & Stergiopoulos, V. (2022). Re-examining mental health crisis intervention: A rapid review comparing outcomes across police, co-responder and non-police models. *Health & Social Care in the Community*, 30(5), 1665–1679. <https://doi.org/10.1111/hs>

Rossler, M. T., & Terrill, W. (2017). Mental illness, police use of force, and citizen injury. *Police Quarterly*, 20(2), 189-212.

Seo, C., Kim, B., & Kruis, N. E. (2021). Variation across police response models for handling encounters with people with mental illnesses: A systematic review and meta-analysis. *Journal of Criminal Justice*, 72, 101752. <https://doi.org/10.1016/j.jcrimjus>.

Substance Abuse and Mental Health Services Administration (SAMHSA), 2020. *National guidelines for behavioral health crisis care: A best practice toolkit*. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

Testimony of the Vera Institute of Justice on Bill 43-23

Submitted to the Montgomery County Council

January 16, 2024

Thank you to the members of the Montgomery County Council for the opportunity to submit testimony on Bill 43-23. My name is Jackson Beck, and I am a senior program associate at the Vera Institute of Justice, a national nonprofit working to end mass incarceration, protect immigrants' rights, ensure dignity for people behind bars, and build safe, thriving communities.

As part of Vera's Redefining Public Safety initiative, I research civilian crisis response programs and advise communities on how to develop and expand these responses themselves. While we applaud the acknowledgement that Montgomery County can do more to serve community members who experience behavioral health crises, we oppose this bill because its passage would perpetuate unnecessary police involvement in crisis situations by prioritizing new embedded co-responses (responses that pair police with clinicians in the same vehicle) over the expansion of civilian-led Mobile Crisis Outreach Teams (MCOTs).

As a primary response strategy, embedded co-responses are premised on the assumption that most behavioral health-related calls pose a high safety risk, but civilian crisis responders have shown that they can handle many situations without police when they're given the resources to do so. For example, as of August 2023, Denver's STAR (Support Team Assisted Response) program had operated for three years and never called for police backup because of a safety concern, even after answering 5,700 calls in 2022 alone.¹ Similarly, responders from Durham, North Carolina's HEART (Holistic Empathetic Assistance Response Teams) program have responded to thousands of calls since October 2022 and have reported feeling safe 99 percent of the time.²

In contrast, when a new crisis response approach includes police by default—as with the proposed Civilian Intervention Teams (CITs)—all the same dangers of a status quo police response persist. We are already far too familiar with the dire consequences of a law enforcement response to mental health crises, which are reflected in the disproportionate number of people with behavioral health needs who enter the criminal legal system through contact with police during crises, as well as the disproportionate number killed by police.³ We know that even encounters with officers who possess de-escalation skills can exacerbate feelings of distress for people in crisis and further delay access to appropriate care.⁴ Consequently, federal crisis care guidelines state that the preferred approach is a purely civilian response, like Montgomery County's MCOTs.⁵

Instead of investing in the proposed CITs, which use an embedded co-responder model, Montgomery County should expand its existing civilian crisis response program, which uses MCOTs to support community members in crisis without police. Importantly, the county has already introduced a protocol establishing that many crisis calls—including calls to 911—do not

require a police response.⁶ The county can now follow through on this protocol by analyzing 911 call data to determine the true level of need and further investing in the MCOT program accordingly, with the goal of achieving 24/7 availability. To make civilian crisis response more widely available, the county will also have to ensure that 911 and 988 operators—in addition to call-takers with the county’s 24-Hour Crisis Center—have clear triage and dispatch protocols that are reinforced by training.

To be sure, in limited circumstances, the county’s MCOT program may need to continue partnering with the police on scene. However, CIT International, an organization that trains and advises CIT programs across the country on best practices, explains regarding a co-response strategy like the one proposed in this bill, “Embedding mental health clinicians in police cars increases the presence of police in situations where they might not be needed.”⁷ Instead, MCOTs should be able to jointly respond with police when necessary while primarily delivering timely crisis responses without police.

In the last few years, more than 100 communities have committed to expanding access to civilian crisis responders for people who would otherwise encounter police, with new programs launching in Denver, Colorado; St. Petersburg, Florida; Olympia, Washington; Albuquerque, New Mexico; and Durham, North Carolina, among many others.⁸ In June, Vera partners at the New Orleans Health Department and Resources for Human Development, a contracted behavioral health provider, launched the Mobile Crisis Intervention Unit to ensure access to civilian responders for 911 callers in crisis, responding to more than 600 911 calls in its first three months of operation.⁹

Similar investment in the MCOT program would enable Montgomery County’s program to operate with the success of Eugene, Oregon’s CAHOOTS program, upon which Montgomery County based its Triage and Response Protocols. CAHOOTS is a very early and now well-known example that has dispatched civilian crisis responders through Eugene’s public safety system for more than 30 years, and the program has done so without any reports of serious injuries for staff or community members served by CAHOOTS teams. A 2019 program analysis showed that CAHOOTS handled 13 percent of calls moving through the city’s 911 system without police, demonstrating the great potential of civilian-led approaches when given the time and resources to grow.¹⁰ CAHOOTS teams requested police backup for just 2 percent of calls that they initially responded to on their own.¹¹

With the MCOT program and the council’s attention to this issue, Montgomery County is already making the right choices on mental health crisis response. It should not fall behind by further investing in a police response, as this bill would do. We hope the county will reject this well-intentioned effort and instead forge ahead with true civilian crisis response.

Thank you for your consideration. Please do not hesitate to contact me at jbeck@vera.org if the Vera Institute of Justice may provide further support.

Sincerely,

Jackson Beck
Senior Program Associate
Redefining Public Safety
Vera Institute of Justice

¹Jennifer Peltz and Jesse Bedayn, “Many Big US Cities Now Answer Mental Health Crisis Calls with Civilian Teams — Not Police,” Associated Press News, August 28, 2023, <https://apnews.com/article/mental-health-crisis-911-police-alternative-civilian-responders-ca97971200c485e36aa456c04d217547>.

²Durham Community Safety Department, HEART Data Dashboard, database, accessed January 8, 2024, <https://www.durhamnc.gov/HEART-data>. Select “Overview” and update the date range for the most recent data available.

³Jennifer Bronson and Marcus Berzofsky, *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (BJS), 2017), <https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf>; Jessica Stroop, Jennifer Bronson, and Stephanie Zimmer, et al., *Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009* (Washington, D.C.: BJS, 2017), <https://bjs.ojp.gov/library/publications/drug-use-dependence-and-abuse-among-state-prisoners-and-jail-inmates-2007-2009>.

⁴Michael Hogan, David Morrisette, Debra Pinals, et al., *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020), 68, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>,

⁵Ibid., 20.

⁶Memorandum from Susan J. Farag, Legislative Analyst and Vivian Yao, Legislative Analyst to Joint Public Safety and Health & Human Services Committee re: “Briefing: Behavioral Health Crisis Response,” January 30, 2023, 2, https://www.montgomerycountymd.gov/council/Resources/Files/agenda/cm/2023/20230130/20230130_PSHHS1.pdf.

⁷CIT International, *Why doesn't CIT International Promote the Embedded Co-Responder Model?* (Salt Lake City, UT: CIT International, 2021), <https://www.citinternational.org/resources/Documents/Position%20Papers/CIT%20Int%20Embedded%20Co-response%20Position%20Paper.pdf>.

⁸Indivisible Eastside Community Safety Workgroup, *Directory of Alternative Crisis Response Programs*, (Bellevue, WA: Indivisible Eastside, 2023), <https://drive.google.com/file/d/1Gz8JKZdRe48F417rd5ZTxggUiE7jj5ib/view>.

⁹National Football League Foundation, “Community Impact by the Numbers,” Slide show, 2023, <https://www.flipbookpdf.net/web/site/bf7dc3e5c83250cc4312a87a27cc3f33e8b24adbFBP29511623.pdf.html#page/6>.

¹⁰Eugene Police Crime Analysis Unit, *CAHOOTS Program Analysis* (Eugene, OR: City of Eugene Police Department, 2020), 7 <https://www.eugene-or.gov/DocumentCenter/View/56717/CAHOOTS-Program-Analysis>.

¹¹Ibid., 5.

TESTIMONY of Mary Jacksteit on Bill 43-23 Crisis Intervention Team

January 16, 2024

I am a member of an advocacy group at the Takoma Park Presbyterian Church called Presbyterians for Police Transformation. We are members of the Silver Spring Justice Coalition and fully support and identify ourselves with its position opposing this crisis response legislation, Bill 43-23. We strongly believe that the county's focus should be on significantly strengthening and growing the existing civilian crisis response program in DHS - the Mobile Crisis Outreach Teams - so that police involvement can be reduced to where it is actually essential. This bill does not do that and in fact could have the opposite effect. SSJC has provided you with persuasive arguments and supporting data for why civilian response is the best, most effective and humane way to work with those having mental health crises except where safety requires police involvement. We have nothing to add but our conviction that the Bill before you is not at all the legislation we need.

Having said that I want to switch voices for the rest of my testimony. I am also the mother of someone I consider a highly credible person on the issues presented by this Bill. My adult son has serious bipolar and anxiety disorders but he has been committed to working in the mental health field as much as he can. For six years, until June 2021, he worked as a peer specialist on an ACT team (assertive community treatment) for five of those years here in our county for Cornerstone Montgomery. While ACT teams do not do crisis response per se, as therapists, nurses and peers they work with severely mentally ill homeless people to get them housed and to support their remaining housed and safe, and crises situations are common. Most if not all of this population has interacted at one time or another and often multiple times with crisis teams and police.

My son and I have discussed the merits of combined police-therapist crisis response as opposed to all-civilian response and he is adamant about the preferability of avoiding as much as possible police presence in situations where mental illness is presenting very challenging behavior. In his work he observed and heard common negative reactivity to police by many of his team's clients, and of their desire and efforts to avoid police. In contrast he saw up close how his team members could deescalate situations, identify and address triggering factors and credibly communicate and demonstrate genuine caring. Especially important to the discussion of this Bill, he also experienced the value of his presence as a peer specialist on the team especially in gaining trust and receptivity to help. He could connect with difficult-to-reach people because of his personal approach, his empathy and ability to listen, and his own understanding of what works from his life experience. This contribution was recognized and highly valued by his team members. The absence of peers on CITs is a significant disadvantage compared to civilian teams.

The urgent need to strengthen the County's crisis response capacity is a worthy motive of the sponsors of Bill 43-23 but we urge you to shift your focus and reorient this effort to building civilian crisis response. That is the needed priority.

I appreciate this opportunity to share these perspectives.



SSJC Opposes Bill 43-23, CIT Crisis Intervention Team Established

Bill 43-23 would cement the County's reliance on law enforcement for crisis response by codifying into law the CIT program (co-response by a police officer and a mental health clinician in one vehicle) and creating an advisory committee weighted toward criminal justice. This would set the stage for even greater use of force with people experiencing a mental health or substance use crisis. We are particularly concerned for BIPOC persons, whose lives and well-being would be disproportionately threatened.

Passage of 43-23 would represent a giant leap backward, undermining years of progress toward a crisis response system that promised to provide civilian-led trauma-responsive care to any resident in need. While the current MCOT program is not meeting expectations, it is still preferable to the proposed CIT program.

Since Montgomery County police killed Robert White, an unarmed Black man with a mental health condition, in 2018, SSJC has worked with elected leaders and mental health experts to develop a consensus around a model featuring Mobile Crisis Outreach Teams (MCOTs), each staffed by a clinician and a [peer support specialist](#). Mobile crisis teams are one of three essential elements of the national [Crisis Now](#) standard established by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

In May 2022 the County Department of HHS [introduced](#) a [protocol](#) that would have a joint response of an MCOT and police when the Crisis Center determines a behavioral health crisis involves a significant risk of harm. The County selected that MCOT model because of its effectiveness in delivering exceptional care while reducing unnecessary contact between police and the person in crisis.

If Bill 43-23 passes, when 9-1-1 perceives a behavioral health crisis to involve a significant risk of harm, the protocol would send a CIT co-response (police officer + clinician in one vehicle) instead of sending an MCOT in joint response with police. (See [Appendix](#) below for graphic illustration and more detail about these response types.)

We are not alone in our criticism of the CIT co-response approach. In [Crisis Now](#), a publication of the National Association of State Mental Health Program Directors, the article [The Misunderstanding of the Crisis Intervention Team Program \(5/24/22\)](#), quotes the former head of CIT International, who highlights many of the points we make below:

“While certainly better than a police-only response, the embedded co-responder model is costly, and it’s not as beneficial as other approaches like mobile crisis services. Police departments with embedded co-response either have dedicated officers waiting for mental health crisis calls or clinicians riding along with officers responding to unrelated calls. ‘The problem,’ notes Bruno, ‘is that the same amount of dollars are going toward building multiple programs and systems, and this type of co-response isn’t the most effective or cost-efficient approach.’For example, co-dispatch of a mobile crisis team and CIT-trained officers allows both resources to be used jointly when required but otherwise function independently. ‘That way, mental health assets aren’t riding with a cop all day,’ he says, ‘or a cop isn’t standing around while a clinician provides mental health support.’”

SSJC opposes Bill 43-23 for the following reasons:

This bill would undercut the still-fledgling MCOT program. While we are not satisfied with current MCOT program performance, we believe it can work with proper oversight, staffing, and commitment from the County. The Executive’s proposed budget will expand the MCOT program, and allow for teams to be placed around the county, requiring a significant increase in the number of mental health clinicians. The County found it difficult to hire and retain mental health clinicians for the existing three teams, and this bill would create unnecessary competition for a limited pool of mental health professionals.

MCOTs offer substantial benefits over a CIT co-response. When police response is needed, they should be responding jointly with MCOTs, not as part of a CIT co-response team as the bill would have them do. Mobile crisis programs across the country have shown that when properly staffed, trained, and operationalized, teams of health professionals and peer support specialists, namely MCOTs, provide better, more compassionate care, and prevent harmful, even deadly, interactions with law enforcement. Even the national [Crisis Now](#) standard that the County has committed to, includes MCOTs, not a CIT co-response.

- **The state’s Community-based Mobile Crisis Response system will reimburse for MCOT responses but not for CIT co-responses.** As explained in the November 28, 2023, Maryland state town hall meeting, the state’s behavioral health and Medicaid crisis response funding will cover an MCOT response by either a peer and clinician (or 2 peers with a telehealth clinician), but will not reimburse for a clinician in a CIT co-response. Thus dispatch of a CIT co-response will deprive the County of Medicaid and state money.
- **A CIT co-response would unnecessarily tie up law enforcement and clinician resources, while not providing the benefits of peer presence.** In a joint MCOT and police response, the MCOT can stay afterwards and provide support to bystanders and those involved, allowing the police to leave and avoiding tying up police unnecessarily, while ensuring adequate care is provided. And MCOTs will develop a rapport with people which will be helpful in needed follow-up visits (made without need for police presence), and which can help avoid or de-escalate future crises.

- **The Peer Support Specialists who staff MCOTs are essential to effective crisis response.** The presence of a peer signals to the person in crisis that the response team is civilian-led, making the presence of police – if they must be there – less frightening. Mental health professionals, including peers, are equipped to de-escalate in ways armed law enforcement officers simply cannot, offering their care and insights to the person in distress. We must use MCOTs not only as an alternative to police response in situations deemed safe enough for them to show up first to the scene, but as an additional resource that can make a crucial difference, even and especially in potentially dangerous situations.
- **MCPD data shows that police have been increasing their incidents of use of force each year,** particularly when dealing with people with mental or behavioral health crises. BIPOC people and those with mental illness and other disabilities are disproportionately the victims of police use of force in our county. Thus many are profoundly reluctant to call for crisis intervention because they don't want police to respond, and police are often sent instead of a requested MCOT. Someone may be triggered by the presence of armed police (regardless of their uniform). Jurisdictions with MCOT-type response programs demonstrate that people in crisis are less likely to react or resist if an MCOT team that includes peer support specialists is in the lead, allowing the team to resolve the crisis in a non-coercive manner.
- **MCOT mental health experts should take the lead in responding,** even in the limited number of crises that require a police officer when someone is in imminent danger. MCOTs improve the likelihood of de-escalation, an appropriate trauma-informed response, and a positive outcome.
- **The bill's standard for a CIT co-response is vague.** As we have heard repeatedly from victims of police force, 9-1-1 dispatchers and police are inclined to interpret almost any threat as an "acute incident ... where there is a significant risk of harm to the individual in crisis or to someone else..." For police officers far too many situations look like a significant danger when they aren't. While we are not satisfied with the existing 9-1-1 protocols, which send police to a mental health crisis instead of an MCOT or joint response, this bill is not the answer.
- **MCOT response times could be significantly improved** by the expansion of MCOT teams as expected. The bill's sponsor touts the speed of police cars, but CIT co-response isn't likely to be as fast as regular police response, and with the expansion of MCOTs, MCOT response times will be faster. Additionally, MCOT response times can be reduced using strategies used in other jurisdictions such as: strategic placement of teams (some use vans staged at hot spots), MCOT direct monitoring of dispatch calls, and having a clinician on staff at 9-1-1 dispatch to more quickly identify need for MCOT response.

The composition of the bill's Advisory Committee is inappropriate and its focus and power are too broad. The bill's advisory committee does not adequately represent the needs or perspective of people with mental health issues or members of communities disproportionately affected by police and the police use of force. Nor does it adequately represent the views of those with mental health crisis expertise. The proposed committee's

disproportionate membership would have an emphasis on criminal justice, rather than mental health and community-oriented solutions. Moreover, the bill would give excessive power to advise the Council and Executive on the County's overall crisis response, rather than be limited to the CIT teams. The committee would create yet more bureaucracy and less flexibility when responding to a broad range of 9-1-1 calls that warrant a response from an MCOT. In short, the entire advisory committee proposal is ill-conceived.

Any reliance on recommendations from the CIT Center of Excellence is premature. The bill requires that the CIT co-response "team will follow the guidance provided by the Crisis Intervention Team Center of Excellence at the State level in implementing, delivering, and enhancing crisis intervention services in the county." The state center has not yet even released requirements for CIT co-response, so the county should not agree to their guidance before knowing what they will advise. Deferring to a state center that focuses on CIT responses instead of the coordinated response including MCOTs is inappropriate. That center does not adequately reflect the needs or priorities of Montgomery County and our citizens, including the flexibility in considering what programs we have chosen to implement. We have more than enough expertise in our county to develop and expand appropriate mental health crisis responses.

The County needs to focus on fully implementing the MCOT system as originally planned and provide executive oversight on that collaborative model. This is not the time for the Council to emphasize a separate system and create a separate bureaucracy that is not part of a comprehensive mental health continuum of care response system. To do so will create more problems than it will solve and is likely to confuse and alienate residents at risk.

Appendix: Introduced MCOT response vs CIT co-response

Protocol as introduced with MCOT joint response with police

The [protocol](#) that the county HHS [introduced](#) in May 2022 has the Crisis Center sort crises into two levels. Level 1 allows MCOT-only response when there is no risk. Level 2 allows MCOTs to have police accompany them in a joint response, when a behavioral health crisis involves a “report of weapons or current violence/threats of aggression; active history of violence (within the last 12 months); self-injury; weapons or means of harm; imminent danger to others or self.” The following depicts part of the introduced protocol:

LEVEL 1

No weapons, low potential for violence, or threats of aggression



Mobile Crisis Team

Clinician + Peer support specialist

LEVEL 2

Weapons, greater potential for violence, or threats of aggression



Mobile Crisis Team

Clinician + Peer support specialist



Police

Refer to the official HHS [document](#) for details.

Protocol from bill with CIT co-response team

If Bill 43-23 passes, the protocol would still have MCOT only response for Level 1. However, it would have 9-1-1 decide if a Level 2 response is needed, which would result in a CIT co-response (police officer + clinician team), instead of a MCOT in joint response with police, when there is a behavioral health crisis that is perceived by 9-1-1 to involve a significant risk of harm. The bill’s protocol is depicted as follows:

LEVEL 1

No weapons, low potential for violence, or threats of aggression



Mobile Crisis Team

Clinician + Peer support specialist

LEVEL 2

Weapons, greater potential for violence, or threats of aggression



CIT

Police officer + Clinician

Hello County Councilmembers. Thank you for the opportunity to speak with you regarding BILL 43-23, CRISIS INTERVENTION TEAM.

My name is Sharon Dietsche and I am a clinical social worker residing in Silver Spring in Montgomery County. I have over 30 years of experience in mental and behavioral health from around the country including crisis intervention. In December, I became the Executive Director of the National Alliance on Mental Illness of Montgomery County also known as NAMI MC.

NAMI MC is part of the National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. We envision a future where all people affected by mental health conditions live healthy, fulfilling lives supported by a caring community. We envision a future in which mental health crises consistently receive supportive and adequate mental health responses.

NAMI MC respectfully opposes Bill 43-23 for the following five reasons:

1. If enacted, **Bill 43-23 would lock in a prescribed crisis response program and restrict the latitude of County agencies** to modify it. Now is not the time to codify crisis response in Montgomery County. Here and across the country, we're seeing an evolution in crisis response systems, spurred in part by the rollout of the 988 Crisis Lifeline and SAMHSA's [National Guidelines](#) for Behavioral Health Crisis Care. With our State and County systems in a period of transformation, enshrining a wholly new program into law does not make sense as research and best practices are developing.
2. The bill tethers law enforcement to mental health crisis response at a time when there is a known shortage of police officers in our county. Many times mental health crises do not require law enforcement intervention. This can allow law enforcement to focus on other safety measures.
3. The bill is out of step with the National Crisis Now model, to which the State and County have committed. As a result, this CIT co-responder model would be comparatively **more expensive** for the County because teams that include police officers would **potentially not** qualify for reimbursement of clinicians' services

under a new [Medicaid](#) plan being finalized by the Maryland Department of Health.

4. The proposed CIT model runs counter to advice in CIT International's [Best Practice Guide](#) that "Cautions About the Embedded Co-Response Approach to Mental Health Crises" for reasons including police presences could deter people from calling for help due to fear of arrest and create an opportunity for the person suffering a crisis to become further involved in the justice system.

5. In the Bill, the composition of the proposed advisory committee is overweighted with criminal justice professionals and does not provide enough weight for community members with lived experience. In addition, the committee, whose purpose pertains to the CIT program specifically, is given undue authority to advise the County Executive and Council more broadly on crisis intervention.

NAMI MC is in support of more Mobile Crisis Outreach Teams also known as MCOTs.

While the implementation of MCOTs in our county needs improvement, the model offers advantages over the bill's proposed CIT program.

Thank you again for your time and for the opportunity to provide testimony regarding this bill. Please know that NAMI MC is always available as a resource to the Council and the community when it comes to discussing mental health policies in Montgomery County.

END

**Testimony in Support of Bill 43-23 – Crisis Intervention Team
by Gino Renne
President, UFCW Local 1994 MCGEO
International Vice President, UFCW**

I am here today on behalf of the members of UFCW Local 1994 MCGEO to express our support for Montgomery County Council Bill 43-23, which seeks to formalize the operation of Crisis Intervention Teams (CIT) in our community. We believe that the formalization of the use of such teams is crucial for the well-being of our residents in crisis and the overall improvement of behavioral health services and public safety in Montgomery County.

Having heard from our members working in the County Department of Health and Human Services who are front-line service providers for individuals in crisis, we know that specialized Crisis Intervention Teams can make a significant difference. By providing proper training to crisis counselors, law enforcement and first responders, we can ensure they are better equipped to handle situations involving individuals in crisis with empathy, understanding, and de-escalation techniques.

It's important to note that our members employed by HHS did not go into their work looking to be law enforcement officers, and when the county removed the law enforcement support from crisis response a few years ago, many expressed their apprehension about responding to situations when they felt they would be in danger, unaccompanied by a law enforcement officer who could help protect them.

We understand that the presence of law enforcement can cause fear for individuals in crisis, but the goal of the CIT is to respond when there is a significant risk of danger to the public and to our first responders. They will not be asked to respond to every single crisis.

Yes, HHS crisis counselors are first responders who are in harm's way every time they respond to a call. A CIT that is properly trained and equipped may hopefully enhance their safety. Furthermore, properly funded CITs can foster collaboration between law enforcement, behavioral health professionals, and community organizations. This collaborative effort can lead to more effective responses to crises related to mental health, behavioral health and substance use disorder, by diverting individuals away from the criminal justice system and towards the appropriate support services they need.

As you well know, behavioral health issues have reached crisis levels in our nation. Montgomery County is not exempt from the crisis. Societal pressures related to Covid and various other issues have exacerbated health problems. It's time for our political leaders to adequately and appropriately fund the services and programs necessary to address this crisis.

Unfortunately, as a county, we are notorious for forming “advisory committees” and setting up programs with the best intent. Then we fail to implement and fund the good ideas emerging from these committees. We hope that this does not happen with this bill.

We support the bill in its concept and are committed to continuing to work with Councilmember Luedtke and her staff to assure that we build out an effective CIT program that meets the intent of this bill. We know that properly investing in mental health resources is an investment in the safety and well-being of our community and the employees who engage in this work. I urge you to support Bill 43-23 and allocate funds necessary to establish and maintain Crisis Intervention Teams in Montgomery County as well as a robust network of alternatives to use in lieu of the criminal justice system when dealing with individuals in crisis.

Thank you for your dedication to the welfare of our community.

TESTIMONY IN OPPOSITION TO BILL 43-23, CRISIS INTERVENTION TEAM - ESTABLISHED
Hearing date: January 16, 2024

I am opposed to Bill 43-23 and in favor of supporting and expanding the MCOT system.

My son is a well adjusted cheerful adult with a cognitive disability. He has a limited ability to understand a complex situation, and very limited ability to express himself, especially under pressure.

When we were traveling he became nervous with a TSA officer who became impatient and authoritative at his slow response and nervousness. In his confusion he began to mirror her aggressive attitude. She called someone over whose approach was nonconfrontational, who noticed my son's sports T-shirt, commented about sports and immediately dispelled the tension.

This kind of non threatening de-escalation, such as is provided by the MCOT mobile units, seems critical to many interactions with cognitively disabled and those with mental health conditions or in crisis. It may also be a way to spare some valuable police time and expense.

Julie Wiatt
Member of Posna (Parents of Special Needs Adults)
Takoma Park

Dear Montgomery County Councilmember,

I would like to state my opposition to Bill 43-23. Here are some of my reasons:

I have an adult daughter who has been diagnosed with paranoid schizophrenia since 2008. Over the years I have used the services of the police several times when my daughter was in crisis.

The police officers who came to our house for crisis calls often had contradictory ideas about their roles as responders. For example, a couple of the officers were physically rough with my daughter and treated her as though she is a violent criminal (she is not at all violent,) some officers acted uncomfortable that they had been called for a mental health crisis, some officers stated that they do not provide hospital transport or fill out paperwork while others said they do provide those services, and so on. The main take-away is that these police officers were armed and primarily focused on apprehending and subduing criminals, and that my daughter did not get services she needed.

By contrast, our experience calling a Montgomery County Mobile Crisis Outreach Teams (MCOT) in 2022 was entirely different and had a much better outcome! The team of two (a man and a woman - clinician and peer counsellor) arrived at our house and greeted my daughter in a cordial and friendly manner. They sat down with her as equals around a table in our back yard, allowing her to feel more comfortable than with a stand-up confrontation. They talked to her for quite a while in an unhurried fashion, performed an assessment, and determine that she would benefit from a visit to the hospital for further evaluation. They also filled out the paperwork required for the hospital visit and included their assessment. In addition, they took the time to listen to my own concerns, gave me a card with their contact information, and encouraged me to call them if I had more to discuss.

For these reasons, I urge you to vote NO on bill 43-23, and to continue to build up the MCOT system as the best way to respond to those on mental health crises.

Thank you reading my comments,

Georgine Prokopik

On the morning of February 22, 2022, my son, 36-year-old Black man with schizoaffective disorder, experienced a crisis. He went to the lobby of his Silver Spring apartment building and began to harass and menace people in the lobby. He had no weapon but aggressively approached the front-desk security officer in a manner that caused her to flee her station and seek help from the property manager. The property manager called the police for a wellness check; they both knew my son and knew that such aggression was highly unusual for him. The property manager also called me. My wife and I, who live five minutes away, rushed to the scene.

When we arrived, we found at least four police cars in front of the apartment building. We spoke with the property manager and security officer who confirmed that no one had been physically harmed, that they were concerned about my son's aberrant behavior, and that he had retreated to his third-floor apartment by the time the police arrived.

Upstairs we found my son on the floor by the elevator, highly agitated and angry, handcuffed and surrounded by several police officers who, we were told, were trying to get him to go to the hospital for evaluation. We confirmed that he had a mental illness. The sergeant at the scene told us that he was also under arrest for assaulting an officer. We spoke to that officer, who assured us that she was unhurt and unfazed. We later learned that these were CIT-trained officers.

My son was successfully transported to Holy Cross Hospital, where he was not admitted after evaluation and taken into custody. At a bond hearing the next day, we learned that he was being charged with assaulting *three* officers at the scene. No one at the apartment building had pressed any charges. He was released on bond. At a later preliminary hearing, we learned that even if my son plead guilty to these charges the county would be demanding jail time.

At his bench trial in May 2023, we learned that the police officers had knocked on his apartment door when they heard him inside talking loudly and incoherently. When they opened the unlocked door, he screamed at them to "leave [him] the f*ck alone" and approached them in the hallway. At that point, one officer pointed a TASER at him. The commotion drew onlookers from nearby apartments who called loudly for the police to leave him alone because he wasn't well. (This became the basis for an additional charge of disturbing the peace.) After a brief standoff with two officers in the hall—he was agitated but made no aggressive moves—a third rushed upon him without warning to handcuff him. That is when my son took a wild swing, contacting one officer in the shoulder and another (the one we had spoken to) in the face. The third injured a finger tackling my son to the floor. The three officers testified at trial that they had followed the protocols of their CIT training.

The judge found my son guilty of three counts of assaulting a police officer and one count of disturbing the peace and sentenced him to three concurrent sentences of 20 years. The prison time was suspended pending three years of supervised probation. When asked for comment before sentencing, my son rose in court and said, "Your honor, I did not commit a crime until the police arrived."

Had this been a non-police intervention, my son would have been released from the hospital 23 months ago and allowed to continue his life under the care of his therapeutic support team. Instead, he lives under the threat that any illness-induced transgression could result in prolonged incarceration. I therefore favor a Mobile Crisis Outreach Team response to episodes such as the one my son experienced and vehemently oppose Bill 43-23.

Dennis Williams, Silver Spring

Testimony in Opposition to Bill 43-23
CIT Crisis Intervention Team Established
January 16, 2023, Public Hearing

My name is Joan Butler, I live in Rockville, MD and have a family member with mental illness. Therefore, this topic is near and dear to my heart.

I am here to testify in opposition to Bill 43-23 which proposes a “co-responder crisis response model” specifically related to a police presence on the team. This proposed bill is not appropriate for our county, which is comprised of a diverse population of constituents, and many fear police.

In 2022, the County shared its plans for improving the county’s mental health crisis response which included the addition of mobile crisis teams. These mobile teams consist of support from a mental health specialist and a clinician, and ensure the flexibility to respond alone or, if necessary, with a separate police presence. Once there is low or no risk of danger, police can leave to focus on their many other required duties.

I strongly recommend the County continues using this model of sending a crisis team and police independently from one another. This allows two mental health professionals (clinician and peer support specialist) to focus on the needs of the person in crisis, which can take hours.

A person in a mental health crisis needs a mental health response, rather than a law enforcement response that can result in causing fear and trauma in the patient and ultimately can lead to tragedy (Irwin & Pearl, October 2020). A joint report issued by The Center for American Progress (CAP) and the Law Enforcement Action Partnership (LEAP) (2014) estimate that between 23 to 39% of mental health related calls are low-risk situations that can be managed successfully by a Mobile Crisis Team solely, without a police presence. This indicates that our County can benefit from more mobile crisis teams.

In cases where police are required, police can and should remain on the periphery. This is because contact with law enforcement can easily exacerbate the symptoms of a person experiencing a mental health crisis. HHS Substance Abuse and Mental Health Services Administration Report (SAMHSA, 2020, p. 1) has stated “Over 2 million people with serious mental illness (SMI) are booked into jail each year, often for non-violent “nuisance” or “quality of life” crimes such as loitering and vagrancy. Not surprisingly, the prevalence of mental illness and substance use disorder (SUD) are 3 to 4 times that of the general population. Once in jail, “people with SMI are incarcerated twice as long, and few receive needed treatment.”

Thank you for your time.

REFERENCES

Dumont, D. M., Brockmann, B., Dickman, S., Alexander, N. & Rich, J.D. (2012). Public Health and the Epidemic of Incarceration. *Annual Review of Public Health*, 33, 325-339.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3329888/>

Health & Human Services Substance Abuse and Mental Health Services Administration (December, 2020). Executive Order *Safe Policing for Safe Communities: Addressing Mental Health, Homelessness and Addiction Report*. pp. 1-31.

<https://www.samhsa.gov/sites/default/files/safe-policing-safe-communities-report.pdf>

Irwin, A. & Pearl B. (October, 2020). The community responder model. Law Enforcement Action Partnership. Center for American Progress. <https://www.americanprogress.org/wp-content/uploads/sites/2/2020/10/Alternatives911-report.pdf>

Treatment Advocacy Center & National Sheriffs Association (2014). The treatment of persons with mental illness in prisons and jails: A state survey.

<https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf>

Written Response/Testimony to Bill 43-23 Crisis Intervention Team.

1. The 988 mental health crisis call system was meant to reduce law enforcement involvement, helping to divert jail and avoidable trauma when 911 is called. This bill requires the involvement of law enforcement, even when a crime has not been committed and the call was made for a mental health crisis. Being mentally ill is not a crime.
2. This bill requires co-locating the police to go out with a crisis worker as the crisis response team (CIT) in disparate areas. Mental Illness, psychosis and mental health crisis are equal opportunity conditions that occur in all areas and all population groups. Crisis responses should be based upon the details of the call and not predetermined by the area. By targeting disparate areas for different policing and crisis response intervention, it establishes a 2-tier system (police CIT for disparate vs. a regular clinician model for non-disparate) adding greater disparity to already disparate areas.
3. This bill cites the Maryland state CIT plan, which references the Ohio and Memphis crisis intervention teams. A trending practice does not make it a best practice, however the bill leaves out key elements such as the required police training and CIT referral facilities, which currently are too often, general emergency rooms. General emergency rooms are ill-equipped to manage psychiatric emergencies, are overly expensive, and do not allow for a rapid hand-off. Crisis stabilization in Montgomery County does not have enough crisis clinician workers, stabilization beds or residential stabilization facilities in the community. This bill will further divert funding from badly needed mental health stabilization services.
4. Mental illness is not a crime. Living in a disparate area is not a crime. However, studies and data show that there is widespread racial bias in the perception of danger and the involuntary commitment of persons with mental illness. Some states approached this concern by increasing their pool of diverse, trauma-informed, crisis responders that reflect the community and may have a greater comfort level serving in disparate areas.
5. Bill 42-23 is in the wrong direction:
 - a. For the progression of equity and reducing disparity in health care.
 - b. For promoting mental health recovery services and best practices that reduce trauma.
 - c. For cost-effectiveness and promoting crisis stabilization facilities.
6. I urge you to vote No on Bill 43-23 as it is currently written, for the reasons written above.

Thank you for allowing me to provide written testimony on Bill 42-23. As the mother of a son who has struggled with severe mental illness for the past twenty years, I am concerned about the involvement of police presence in a crisis situation. Not all mental health crises are a situation where the individual or others are at risk of harm. And the person making the call should be able to let someone know if they believe law enforcement is necessary. I know for my son, the presence of police would have likely caused him to be more afraid and reactive, when the goal is to be calming and de-escalating. We have MCOT teams available and they should be the ones handling situations that do not need police assistance. Montgomery County currently sends police with MCOT when the crisis involves "significant risk of harm" to the person in crisis or others on the scene.

I oppose this bill because added police presence and use-of-force for people who have mental illness is unnecessary and unacceptable. AI have heard too many horror stories where individuals end up in our County jails or State psychiatric facilities because police showed up and the situation quickly escalated. And for those individuals, they end up in a living hell and do not get the treatment needed. There are myriad crisis intervention and peer support programs in our country where trained professional teams provide the appropriate intervention with excellent outcomes.

There is a best practice guide from NAMI National and CIT International which strongly cautions against having police presence on all crisis calls because "law enforcement policies can dictate the response. For example, (they) may strongly encourage transporting an individual... which could override the mental health professional's preference to leave a person at home with their natural supports and a plan for follow-up." Again, this is a recipe for disaster if the individual ends up in the criminal justice system where we know mental illness is not treated and they suffer far more being with the general prison population, and they are often denied what they need to get better.

Our County resources are limited, and it would be better to use our taxpayer money to improve and expand our MCOT system, and invest in programs that decriminalize mental illness and provide better treatment resources.

I appreciate your consideration of my testimony, and hope that you will strongly consider opposition to this bill and focus attention on better ways to serve those in our community who struggle with mental illness.

Respectfully submitted,

Mimi Brodsky Kress



MEMORANDUM

February 5, 2024

TO: Members of the Health & Human Services and Public Safety Committees

FROM: Councilmember Kristin Mink 

SUBJECT: Building a functional Crisis Response System; Amendments to Bill 43-23

Our crisis response system is in dire need of an update, and I appreciate Councilmember Luedtke bringing the conversation to the forefront with Bill 43-23.

Like over 160 other jurisdictions, Montgomery County has launched Mobile Crisis Teams and established the goal of prioritizing civilian responses to crisis calls when scene safety permits. **However, our current model, scope, and staffing levels differ significantly from many jurisdictions that have more robust systems.** (See attached *Mobile Crisis Team chart*)

For example, Albuquerque Community Safety (ACS) directly diverted 3,115 calls/month from the Police Department over their first two years¹. Their response times are 17 minutes for suicidal calls for service (CFS), 34 minutes for behavioral health CFS. They also respond to calls for unsheltered persons, welfare checks, disturbances, needle pick-ups, transport, and more.²

New Orleans' Mobile Crisis Intervention Unit (MCIU) launched just last June. Licensed mental health professionals field calls in coordination with 911 call-takers; MCIU staff are dispatched within 4 minutes and arrive on average in 15 minutes. MCIU conducted 221/month face-to-face interventions over their first 90 days, with police co-response (in separate vehicle) only 18% of the time. Teams carry extensive supply kits to resolve immediate needs (ex. clothes, pregnancy kits, food, fentanyl test strips), and assist with self-regulation and de-escalation (ex. fidgets, coloring books, iPads with music and soothing videos).³ (See attached *MCIU report*.)

In Montgomery County:

- Mobile Crisis Teams responded to 125 calls/month from August-December 2022. Wait times have not been tracked.⁴

¹ [Albuquerque Community Safety Second Anniversary 2-Pager](#)

² [Albuquerque Community Safety FY24 Q2 Report](#)

³ [New Orleans Mobile Crisis Intervention Unit \(MCIU\) Implementation and First 90-Days Summary](#)

⁴ [PS/HHS Committee Memorandum, Briefing: Behavioral Health Crisis Response, January 30, 2023.](#)

- Nonviolent incidents other than mental health crises – including substance use, homelessness, and youth and family crises – are not part of our civilian mobile response protocol.
- Standards used for assessing whether a CFS should receive phone support, civilian mobile response, police response, or co-response are inconsistent across access points (e.g. 911, 988, Crisis Center);
- Mobile Crisis Teams are not equipped to provide transport;
- Staffing of our Mobile Crisis Teams is completely inadequate to handle even the relatively narrow segment of calls for service that fall within their current purview. Wait times can be hours, and some residents and police officers have stopped requesting them as a result.

Meanwhile, much of the public mistakenly believe that our Mobile Crisis Teams are tasked with and staffed to be able to respond to a wide range of nonviolent CFS.

The first step in fixing our crisis response system must be to establish: What does the public want our crisis response system to look like? What calls for service should receive phone support, civilian mobile response, police response, or co-response (which can describe civilians and police arriving together in the same *or* separate vehicles)?

The amendment I've proposed reshapes the advisory committee into a task force to tackle that fundamental question. The revised membership reflects the importance of centering the voices and input of those most likely to be served by a civilian responder program or impacted by the lack of one.

At the same time, we cannot afford to wait to address critical shortfalls in the crisis response service being delivered right now.

I hope the Joint Committees will join me in requesting that the County Executive:

- Complete a full compensation study, including retirement benefits and comparisons to market rate for similarly educated professionals, of the positions that make up our Mobile Crisis Teams;
- Offer a hiring bonus for Mobile Crisis Team staff until compensation packages are updated;
- Support the co-development and implementation of a temporary plan by MCPD, the Crisis Center, and staff at County shelters (and potentially other sites) that are hotspots for mental and behavioral health crises to improve on-site security and/or crisis response times until systemic improvements can be implemented;
- Ensure County representation at meetings of the Maryland Crisis System Workgroup convened by the Maryland Department of Health Behavioral Health Administration.

- Of note: Last year, the Behavioral Health Administration (BHA) announced that **Medicaid will be providing coverage for Mobile Crisis Teams**. At the November 28th, 2023 Workgroup meeting, the BHA presented requirements Mobile Crisis Teams must meet for reimbursement. **CITs or other peace officers (i.e. law enforcement) are not part of teams that qualify for reimbursement.** (See below.)

The previous Council made an informed decision to support the Mobile Crisis Team model. It's time to improve our implementation to meet the model's true potential and the public's expectations.



Maryland

DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

Subject: Public Notice for Behavioral Health Crisis Services

Add'l info: The Maryland Department of Health is amending the State Plan to include coverage for the mobile crisis team service and the behavioral health crisis stabilization center service within the State's Other Diagnostic, Screening, Preventive and Rehabilitative Services benefit. The projected effective date of both services is January 1, 2024.

Staffing Requirements



Mobile Crisis Teams

- Two in-person responders
 - **Model 1:** 2 staff, includes at least 1 licensed mental health professional (who does assessment)
 - **Model 2:** 2 staff, plus 1 licensed mental health professional via telehealth (to complete assessment)
- Independently licensed mental health professional available 24/7 to oversee clinical operations
- When needed on scene, CIT or other peace officer is not considered part of two-person in-person response team
- Follow-up and outreach services may be conducted by any appropriate team member



MOBILE CRISIS TEAM	St. Petersburg, FL CALL Program	Toronto, Canada TCCS	Denver, CO STAR Program	Eugene, OR CAHOOTS	Albuquerque, NM ACS	Montgomery County, MD MCOT
<p>TYPES OF INCIDENTS THEY RESPOND TO WITHOUT POLICE</p> <p>All specify these are for calls without weapons or risk of violence.</p> <p>Standards for what constitutes relevant weapons or risk of violence vary widely.</p>	<ol style="list-style-type: none"> Suicidal subject Mental health issue Intoxication Drug overdose Transport Homeless Complaints Youth Truancy Disorderly Juvenile Neighborhood Dispute Marchman Act assessment Panhandling 	<ol style="list-style-type: none"> Thoughts of Self-Harm/Suicide Wellbeing Check Substance use issue Transport Request Housing crisis Person in Crisis (<i>Common supports: provide resources, referrals, practical supports like making a phone call or packing belongings, hospital transport</i>) Disorderly Behavior Dispute Short-term case management (up to 6 months) <i>may include primary care, addiction care, counseling, employment & housing navigation, other culturally specific supports</i> 	<ol style="list-style-type: none"> Suicidal subject Welfare check Intoxication or Substance abuse Transport request Homeless issues Medical assessment/triage Disturbance Family disturbance Suspicious occurrence Request for support (<i>Resources, info, or other services requested</i>) 	<ol style="list-style-type: none"> Suicidal subject Welfare check (unresponsive person) Transport request Housing crisis Minor disputes, counseling and mediation Medical assessment Criminal trespass Intoxication Disorderly subject Traffic hazard 	<ol style="list-style-type: none"> Suicidal subject Behavioral health Wellness check Welfare check Transport Unsheltered individual Suspicious person Disturbance Needle pick-up Panhandling Abandoned vehicle 	<ol style="list-style-type: none"> Person experiencing mental health crisis, with NO ideation of harming self or others
Provide transport?	✔ Yes	✔ Yes	✔ Yes	✔ Yes	✔ Yes	⊖ No
Arrival Time	7 minutes	25 minutes	<30 minutes	2020: 1 hr. 56 mins (1 hr. 11 mins. for police)	Suicidal: 17 mins; BH: 34 mins; Wellness check: 53 mins.; Other: 1-2 hrs.	Up to several hours ¹
# Contacts	316/month ²	451/month ³	473/month ⁴	1,352/month ⁵	3,115/month ⁶	125/month ⁷

¹ Based on multiple constituent reports and multiple firsthand experiences by members of Councilmember Mink’s staff. (“Wait times are also not tracked currently.” PS/HHS Committee Memorandum, Briefing: Behavioral Health Crisis Response, January 30, 2023)

² “Between May 2021 to April 2022, the CALL team had a total of 3,794 contacts.” COMPREHENSIVE EQUITY & PROCESS EVALUATION: Protocol and Data Review, by University of South Florida Center for Justice Research & Policy (June 2022).

³ 5,868 dispatches from March 31, 2022 to April 30, 2023, per Toronto Community Crisis Service data summary

⁴ “Between January 1, 2022 and July 1, 2022, STAR responded to 2,837 calls for service. The team has never had to call for back up due to a safety issue.” STAR 2022 Mid-Year Report

⁵ “In 2021 there were 16,218 public-initiated CFS where CAHOOTS was both dispatched and arrived.” CAHOOTS Program Analysis 2021 Update, by Eugene PD Crime Analysis Unit.

⁶ “Halfway through the fiscal year...ACS has responded to 18,687 calls for service, directly diverting over 14,000 calls from Albuquerque PD.” ACS Quarterly Report: FY24-Q2

⁷ “According to HHS, preliminary data indicates that over the first five months from August 2022 to December 2022, there were 624 MCOT responses.” PS/HHS Committee Memorandum, Briefing: Behavioral Health Crisis Response, January 30, 2023.

New Orleans Mobile Crisis Intervention Unit (MCIU)

Implementation and First 90-days Summary

Resources for Human Development



Executive Summary

Resources for Human Development launched the Mobile Crisis Intervention Unit (MCIU) in New Orleans on June 1, 2023. This program was created in response to a request by the city's health department and is program funded through the city of New Orleans. MCIU serves as the fourth branch of the emergency response system, responding to behavioral health crises called into 9-1-1. The MCIU vision is that community members receive the most appropriate response to their crisis when they call 911 to create a safer and healthier New Orleans. The MCIU mission is to create the fourth branch of the emergency response system in New Orleans to more effectively respond to behavioral health crises called into 9-1-1 and to provide caring, effective, and innovative crisis response. MCIU deploys highly specialized civilian-only response teams to provide effective, innovative crisis response that centers the dignity and worth of every individual we serve. The program goals include providing a rapid, face-to-face mobile response to provide intervention for those in a behavioral health crisis in the community, 24/7. MCIU offers assessments, supports, and ensures connection in the least restrictive setting possible as an effective resolution to a crisis. All RHD programs, including MCIU, provide services that are consistent with evidence-based practices. The MCIU team offers telephonic support, ensures resource connections, and referrals to the few calls that do not require a face-to-face intervention. MCIU is integrated into the New Orleans' 911 dispatch emergency response system to fill the services gap of behavioral health crisis response. Their work reduces the use of other emergency responders, such as law enforcement and EMS, in crises outside of their professional scope. Finally, the team provides follow up to crisis to ensure community members are successfully connected to the most appropriate level of care and support.

In the first three months of operations, the team conducted 662 face-to-face interventions for an average of 7-8 interventions per day. The team's average response time is 15 minutes and average length of time on scene is 40 minutes. The demographics of the residents served by MCIU generally matched the demographics of New Orleans as a city. Staff feedback was an important part of the first 90 days of service. In 99% of face-to-face interventions, staff reported feeling safe. In 91% of interventions, staff felt that they were successfully able to support the residents in crisis. For 98% of calls, staff felt they had the right training to be able to respond appropriately. When asked if they had enough support during an intervention, 100% of staff reported that they did.

In addition to the positive quantitative data collected in the first 90 days, MCIU leadership heard from a variety of community members and partners about the impact the MCIU team has had on the City of New Orleans and its residents. RHD is proud to partner with The City of New Orleans, the New Orleans Health Department, and the wider New Orleans emergency response system to provide this Mobile Crisis Intervention Unit.

Table of Contents

Executive Summary	1
Table of Contents	2
Definitions and Acronyms	3
Introduction	4
Participant Engagement	15
Data Analysis and Reporting	18
Qualitative Evaluation of Program	21
Challenges and Lessons Learned	23
Collaboration and Stakeholder Engagement	25
Future Plans	33
Conclusion	34
References	35

Definitions and Acronyms

Avatar: RHD's national electronic health record

BHL- Behavioral Health Link: RHD's mobile crisis specific electronic health record

CAD- Computer Aided Dispatch: Systems that are utilized by dispatchers, call-takers, and 911 operators to prioritize and record incident calls, identify the status and location of responders in the field, and effectively dispatch responder personnel. First responders, including the MCIU team, receive information on calls they need to respond to through the CAD system.

MCIU- Mobile Crisis Intervention Unit: The Resources for Human Development program contracted with the City of New Orleans to provide this service.

NOHD- New Orleans Health Department: Health Department for New Orleans who is managing the MCIU program contract.

NOPD- New Orleans Police Department

OPCD- Orleans Parish Communications District: 911 dispatch center for New Orleans.

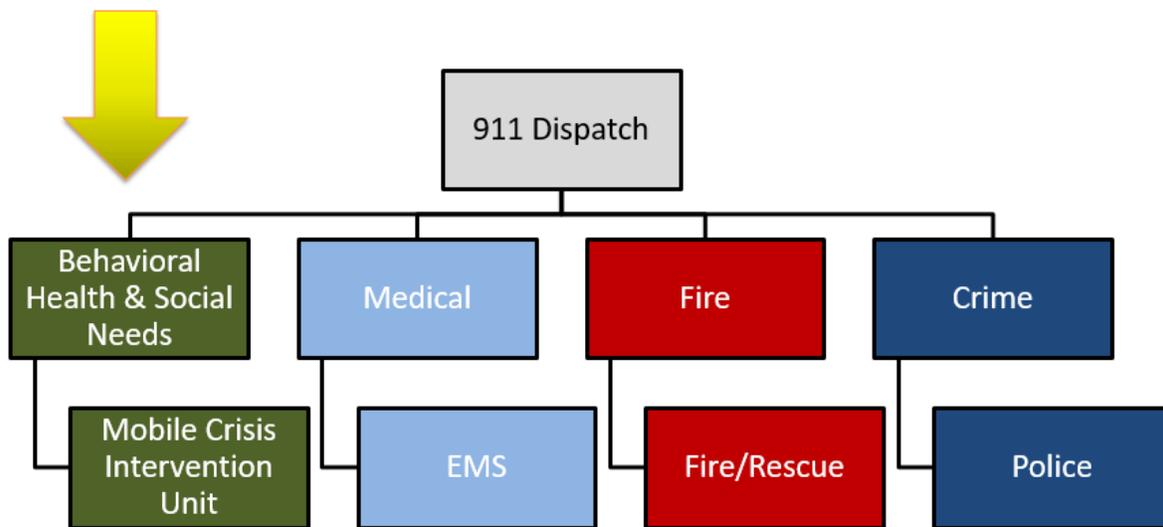
RHD- Resources for Human Development: The national health and human services organization who is contracted with the City of New Orleans to provide this service.

Vera- Vera Institute for Justice: A community advocacy organization working with RHD and NOHD

Introduction

The New Orleans Health Department (NOHD) issued an RFP for a provider to contract with the city to provide civilian crisis response as part of the larger New Orleans emergency response system. Resources for Human Development (RHD) responded to the RFP in January 2022. We received notification of the award from NOHD in February 2022 and signed the contract in September 2022. Planning for implementation began prior to the signing of the contract; hiring began after the contract was signed. During this time, RHD leadership presented to the Crisis Intervention Strategy Task Force Meeting on our plans for bringing a fourth branch of the emergency response system to New Orleans.

4th branch of the emergency response system



Tyesha Rhodes started as program director in December 2022. She approached the role with skill and enthusiasm, hitting the ground running right away. We finalized the contract with our electronic health record vendor, Behavioral Health Link (BHL), signed our lease contract including renovation plans, and made significant supply purchases in December 2022. The first half of 2023 was focused on hiring staff, training staff, developing workflows, and building the electronic health record with BHL. We also got connected with other cities starting similar civilian crisis response programs, joined the International Crisis Response Association (ICRA), and hired ICRA’s executive director, Rachel Bromberg as a consultant. RHD held five focus groups in New Orleans with community members to get input on their hopes and fears for this program. The program launched as planned on June 1, 2023.

The main purpose of the 90-day summary is to provide progress updates and upcoming plans to our stakeholders. It provides a useful progress check internally to ensure we are on track to meet our timeline and goals to date. Finally, it provides an opportunity to review of lessons

learned and develop plans for any upcoming adjustments needed for the overall success of the program.

Program Implementation and Structure

Vision: Community members receive the most appropriate response to their crisis when they call 911 to create a safer and healthier New Orleans.

Mission: Create the fourth branch of the emergency response system to more effectively respond to behavioral health crises called into 911 and to provide caring, effective, and innovative crisis response.

Goals:

- Provide a rapid, face-to-face mobile response to provide intervention for those in a behavioral health crisis in the community, 24/7.
- Offer assessment, support, and ensure connection in the least restrictive setting possible as an effective resolution to a crisis.
- Provide services that are consistent with evidence-based practices.
- Offer telephonic support, ensure resource connections, and referrals to those who do not require a face-to-face intervention.
- Integrate with New Orleans' 911 dispatch emergency response system to fill the services gap of behavioral health crisis response.
- Reduce the use of other emergency responders, such as law enforcement and EMS, in crises outside of their professional scope.
- Provide follow up to crisis to ensure community members are successfully connected to the most appropriate level of care and support.

Service Description:

RHD's Mobile Crisis Intervention Unit (MCIU) is a multidisciplinary mobile crisis outreach team integrated directly with Orleans Parish Communications District (OPCD), Emergency Medical Services (EMS), New Orleans Fire/Rescue, and New Orleans Police Department (NOPD) to provide a rapid, mobile response to meet those in a behavioral health crisis face-to-face in the community. The overall goal of this intervention is to help those in crisis experience quick relief and a resolution to the crisis.

Civilian crisis response models like MCIU divert nonviolent 911 calls for behavioral health away from police. This shift is intended to preserve law enforcement's resources, to prevent unnecessary arrests, hospitalizations, escalation, and use of force, and to mitigate racial disparities in the risks associated with police contact for individuals in crisis, as well as to facilitate access to needed community resources for.

MCIU is staffed by licensed mental health professionals fielding calls for behavioral health crises in close coordination with 911 dispatch call-takers. Dispatch will triage 911 calls, diverting those assessed to be behavioral health related to MCIU clinicians. Highly trained mental health professionals use their clinical judgement to resolve the call by phone, dispatch

MCIU to the scene, or request that another emergency branch responds to the crisis, as appropriate.

MCIU accepts calls and provides crisis intervention 24 hours per day, 7 days per week, 365 days per year. The teams operate every day of the week including weekends and holidays and in all weather. RHD has protocols in place for responding safely during natural disasters. Teams respond to those in need wherever they are, as long as they can do so safely. If safety is in question, the teams will radio to dispatch or directly to police for support in securing staff safety. Locations we might expect to provide care in are public spaces such as parks, other professional environments such as family doctor offices or schools, resident homes, or local businesses. This program follows a “dispatch first” model. When the call comes in, staff immediately begin heading to the scene while obtaining additional information. The goal is for staff to be en route within 4 minutes of receiving the call.

Once on scene, crisis workers use their clinical judgement and experience to support the individual in managing their crisis. Staff will address any immediate needs when arriving on scene, such as providing water, snacks, blankets, before conducting their assessment of the crisis. The assessment will include a risk assessment and mental health and substance use screening. This brief assessment guides the crisis workers’ next steps in de-escalation, conflict mediation, and/or resource connections. The supervisor, a licensed clinician, is available for support before, during, and after each call. Supervisors may offer support virtually or on scene.

Through extensive training, crisis workers learn to practice safety precautions in a variety of situations and settings. They are familiar with the protocols for calling for police assistance when needed. Staff are trained to leave the scene if they feel unsafe and to trust their instincts when a situation feels unmanageable or risky. A key element of implementation for a civilian crisis response program is relationship building with other first responders, such as police, for successful intervention. Likewise, this relationship building allows officers to trust us to identify when a civilian only response is sufficient.

Teams have supply kits in their vans to help resolve immediate needs such as providing Narcan, water, snacks, blankets, home pregnancy tests, etc. In addition, teams have items to assist the individual in self-regulation using sensory tools such as fidgets, stress balls, iPads with music and soothing videos, sensory devices, color books, etc. These tools may be helpful to the individual in crisis as well as their natural supports on scene. Crises may involve family, friends, loved ones, or neighbors. Crisis workers must be prepared to support everyone on scene with any interpersonal conflicts and natural supports may need to de-escalate as well.

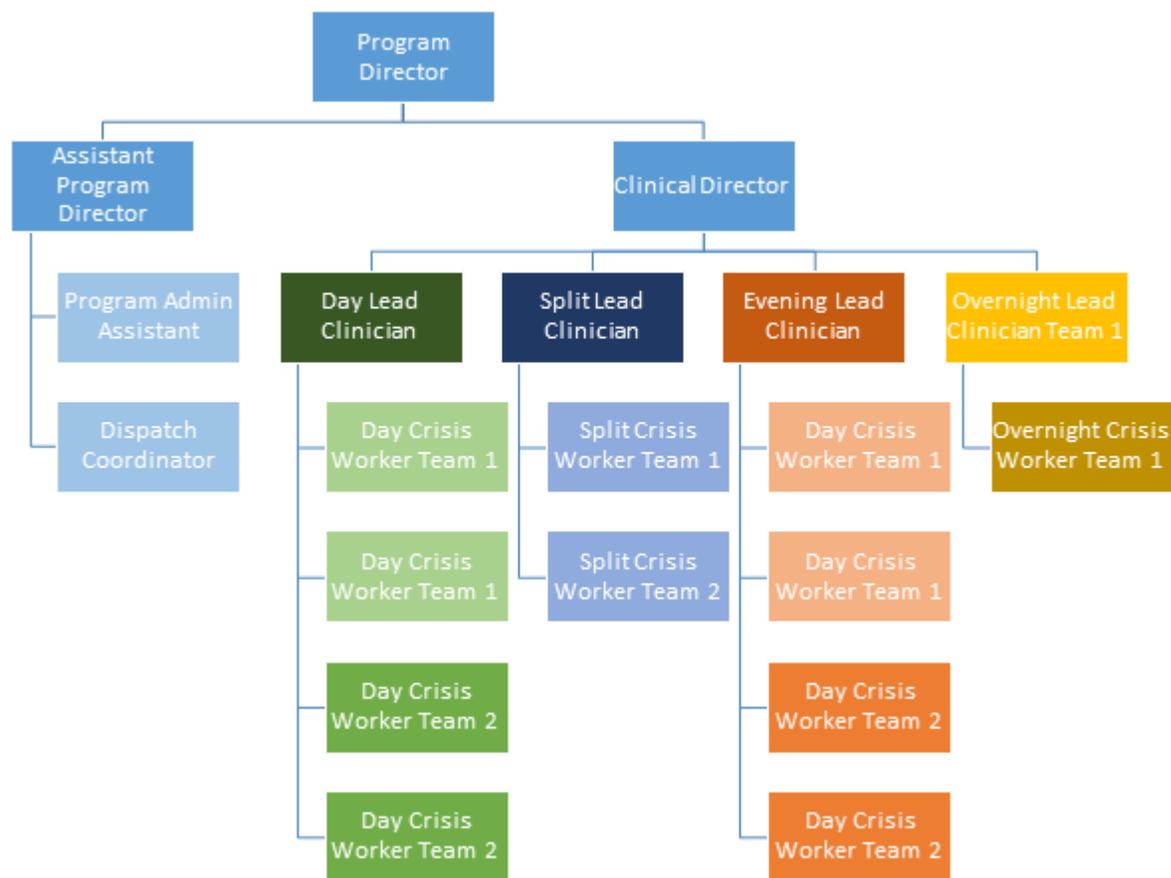
The goal of every intervention is to provide support that will allow the individual to continue their recovery in the least restrictive setting possible. Whenever possible, staff will work with the participant and their natural supports to develop a plan to keep them safe at home including connecting them with ongoing services. If the crisis worker was unable to confirm as referral appointment at the time of the crisis, the follow-up team will ensure a warm handoff on the next available day. For example, if referral agency is only open M-F and the crisis occurs on Saturday, the team will conduct the warm referral on Monday. Referrals may be to physical health, behavioral health, or a community-based organization addressing other social needs.

Teams encourage residents to contact local crisis numbers or 988 instead of 911 for any future crises.

If remaining at home in the moment is not safe, the crisis workers will develop a plan for treatment in a care setting that can meet the needs and wants of the individual. This will include transportation to a facility if the participant is willing. Crisis staff never transport an unwilling participant. If none of the above are possible, the crisis team will facilitate an involuntary hospitalization, as a measure of last resort. The team will walk the participant and natural supports through the process and stay with them until they are transported.

All services are to be provided in a culturally competent and trauma-informed manner. Empathy and respect are at the heart of every interaction. Staff are reminded that we are seeing people on what may be one of the worst days of their lives. We treat them with the compassion and professionalism we would expect for ourselves and our loved ones, regardless of challenging behaviors in that moment. Through training and ongoing supervision, RHD staff become expert in rapport building and de-escalation techniques.

Org Chart



Trainings

- HIPAA
- CPR & First Aid
- Mental Health 101
- Crisis Intervention
- Suicide & Homicide Precautions
- Systems of Care Overview
- Co-Occurring Disorders
- Cultural Linguistic Competencies
- Treatment Planning
- Crisis Management
- Crisis Planning with Families
- Suicide-Specific Interventions/Best Practices
- Trauma Informed Care
- Mandated Reported Training
- Naltrexone Training
- LDH Crisis Response Training
- Mental Health First Aid
- Domestic Violence for First Responders
- CIT
- Columbia Scale Screener

Staff complete additional RHD corporate wide onboarding trainings not specific to this program.

Staff wellbeing plan:

Emphasis on staff wellbeing is a core element of this program model. Recruitment and retention fall within the larger consideration of the staff experience. Feeling effective, supported, engaged, and valued are all important for reducing staff burnout and increasing staff retention. Healthy, stable staff with low turnover and vacancy rates lead to higher quality services and support staff safety. Civilian Crisis Responders are susceptible to the significant risk of burnout that both behavioral healthcare professionals and first respondent experience. Unpredictable workloads, potentially unsafe environments, vicarious trauma, evening and weekend hours, and low pay are all contributors to this burnout. Burnout can lead to low performance, mental and physical health issues, increased callouts, and high turnover, ultimately impacting quality of care.

To mitigate these risks to our staff and the program, we have prioritized our staff wellbeing as part of this program model. Each office will have a staff wellness space, curated by our environmental specialist, to create a place for staff to rest, decompress, and recharge. The office space is designed to support staff health by providing refreshments and a calming atmosphere. In addition to creating an office space that ensures staff feel valued and cared for, the program model includes opportunities for staff to attend local activities outside of work such as art museums, aquariums, and sporting events. When staff have particularly hard days or are putting in extra hours, the director is able to offer them tickets to outside events to support them in maintaining a work-life balance. These tickets can also be used for team building events.

Wellness is often referred to as “self-care”, but RHD believes that we must care for each other. Supervisors are trained to check in with staff not just on clinical cases or administrative tasks but to ask about their emotional health. This includes processing difficult situations, reminders to take breaks, and encouragement to time off when needed. This support also includes discussing staff development and supporting them in growing professionally in whatever way serves their personal goals. RHD also recognizes that financial stability is one of the strongest influences of mental health.

Finally, RHD surveys staff about their experience in two different ways. There is a staff experience survey which is implemented in the mobile crisis programs every six months. This survey asks about safety, workload, education/training, support, team, compensation, effectiveness, and wellness. In addition, after each face-to-face intervention, staff are asked the following questions imbedded within the EHR:

- Did you feel safe on this call?
- Were you able to successfully provide assistance/support to the individual?
- Did you have enough support on this call?
- Are there any training topics that would have made you feel more prepared for this call?
- Open text about the experience of this call:

These answers are reviewed quarterly and followed-up on as needed. The civilian crisis response model is still new to the field and RHD is committed to adapting as we learn more about best practices and grow from our lessons learned.

Implementation Timeline

2 Year ADT Implementation Timeline		Month																								
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
Activity	Award Notification	█																								
	Hire and onboard leadership staff			█	█																					
	Rent space				█	█																				
	Purchase supplies and equipment					█	█																			
	Hire and onboard Day Team						█																			
	Hire and onboard Evening Team							█																		
	Hire and onboard Overnight Team								█																	
	Specialized staff trainings									█																
	SWOT Analysis																									
	Coordinate with key stakeholders																									
	Launch ADT intervention																									
	Gather and review stakeholder and community feedback																									
	Begin collecting data																									
	Implement and conduct evaluation plan																									

<i>Timeline--</i>	<i>Month</i>	<i>Activity</i>
OCT (MONTH ONE using table above for timeline benchmarking)		Contract execution
Oct-Dec	Month 1-3	Recruit and hire leadership staff
Jan 2022	Month 4	Onboard leadership
Jan 2022	Month 4	Identify property/office
Jan 2022	Month 4	Office furnished and operational
Jan 2023-Dec 2024	Month 4-24	Coordinate with key stakeholders
Feb 2023	Month 5	Hire day staff
March 2023	Month 6	Hire after hours staff
May 2023	Month 8	Staff specialized training
May 2023	Month 8	SWOT
Dec 2023	Month 15	
July 2023 Oct 2023 Jan 2024 April 2024 July 2024	Month 10 +Month 13,16,19,22	Stakeholder and community feedback
June 2023	Month 9	Launch Service delivery
June 2023	Month 9	Data collection begins
July 2023	Month 10	Evaluation plan

Goals were met and the program launched successfully on June 1, 2023.

A SWOT analysis was completed in April 2022:

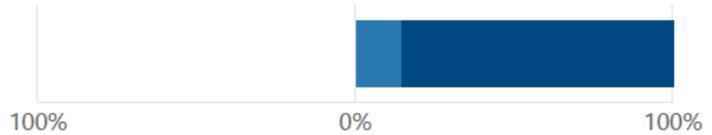


Staff Survey Pre-Launch

We surveyed staff who were hired by May 2023 to get a sense of how prepared staff felt and if there were any issues we needed to address prior to launch. There were 7 responses.

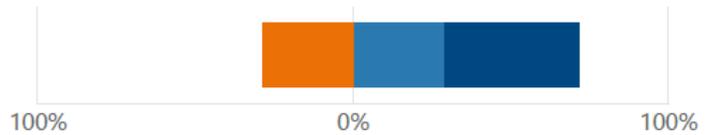
Strongly Disagree Disagree Neutral Agree Strongly agree

I think I'll be safe when I am working in the community.



Strongly Disagree Disagree Neutral Agree Strongly agree

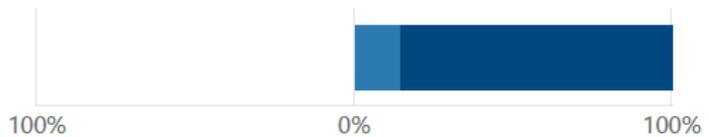
If I feel unsafe in the community, I know what to do.



The one response that indicated that a staff person wasn't sure what to do if they felt unsafe in the community resulted in a review for all staff on safety protocols prior to launch.

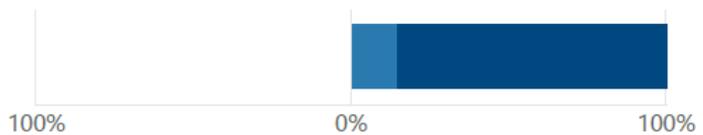
Strongly Disagree Disagree Neutral Agree Strongly agree

The safety precautions for this program are clear to me.



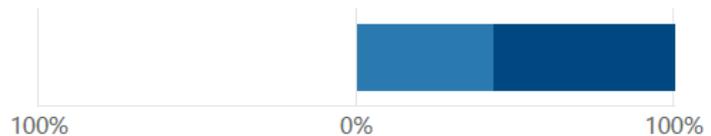
Strongly Disagree Disagree Neutral Agree Strongly agree

Safety is an important issue at RHD.



Strongly Disagree Disagree Neutral Agree Strongly agree

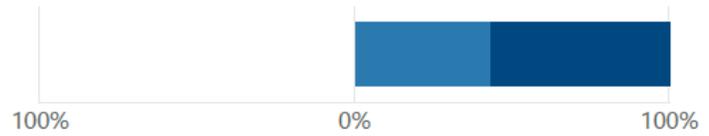
I've received all trainings necessary to perform my job.



MCIU 90 DAY EVALUATION

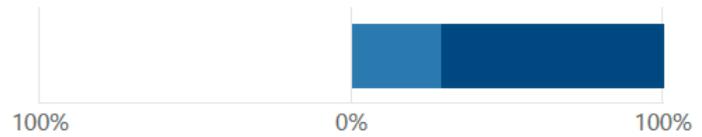
■ Strongly disagree
 ■ Disagree
 ■ Neutral
 ■ Agree
 ■ Strongly agree

My team has all the resources it needs to do its job.



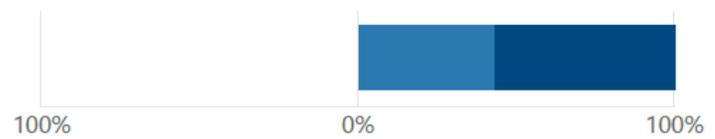
■ Strongly disagree
 ■ Disagree
 ■ Neutral
 ■ Agree
 ■ Strongly agree

I know how to get addition supervision/support while in the communi...



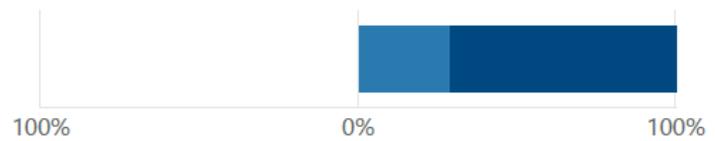
■ Strongly Disagree
 ■ Disagree
 ■ Neutral
 ■ Agree
 ■ Strongly agree

I feel that I am a member of a well-functioning team.



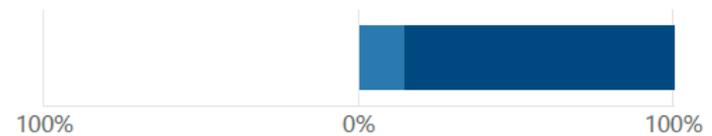
■ Strongly Disagree
 ■ Disagree
 ■ Neutral
 ■ Agree
 ■ Strongly agree

My coworkers and I work well together.



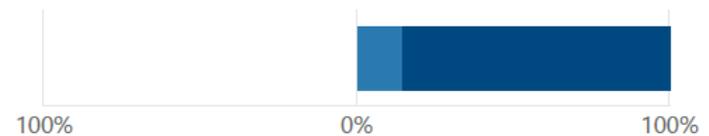
■ Strongly Disagree
 ■ Disagree
 ■ Neutral
 ■ Agree
 ■ Strongly agree

I believe the work we do is important.



■ Strongly Disagree
 ■ Disagree
 ■ Neutral
 ■ Agree
 ■ Strongly agree

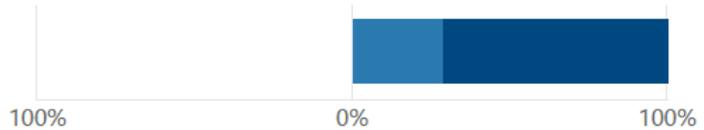
The organization rules make it easy for me to do a good job.



MCIU 90 DAY EVALUATION

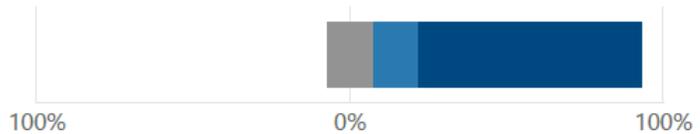
Strongly Disagree Disagree Neutral Agree Strongly agree

I have plans for how to practice self-care.



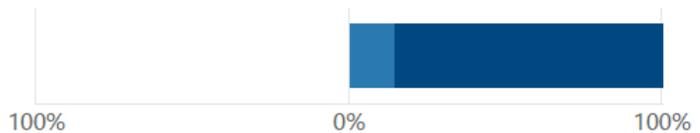
Strongly Disagree Disagree Neutral Agree Strongly agree

I know how to find professional behavioral health help for myself, if needed.



Strongly Disagree Disagree Neutral Agree Strongly agree

My supervisor has talk to the team about taking good care of ourselves (mentally an...



Three additional open-ended questions were asked:

Please share any other training topics you wish you would have received before the program launch.

- no additional trainings were requested

Please share any other safety concerns you have about working in this program.

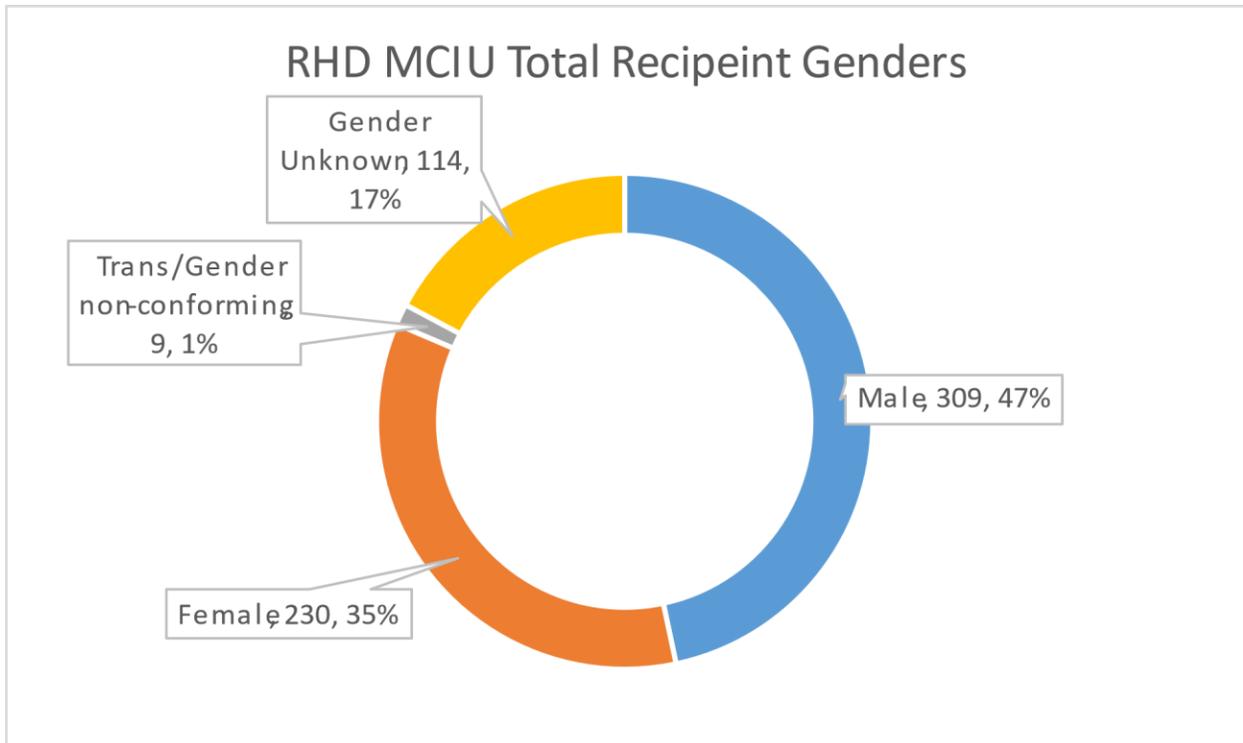
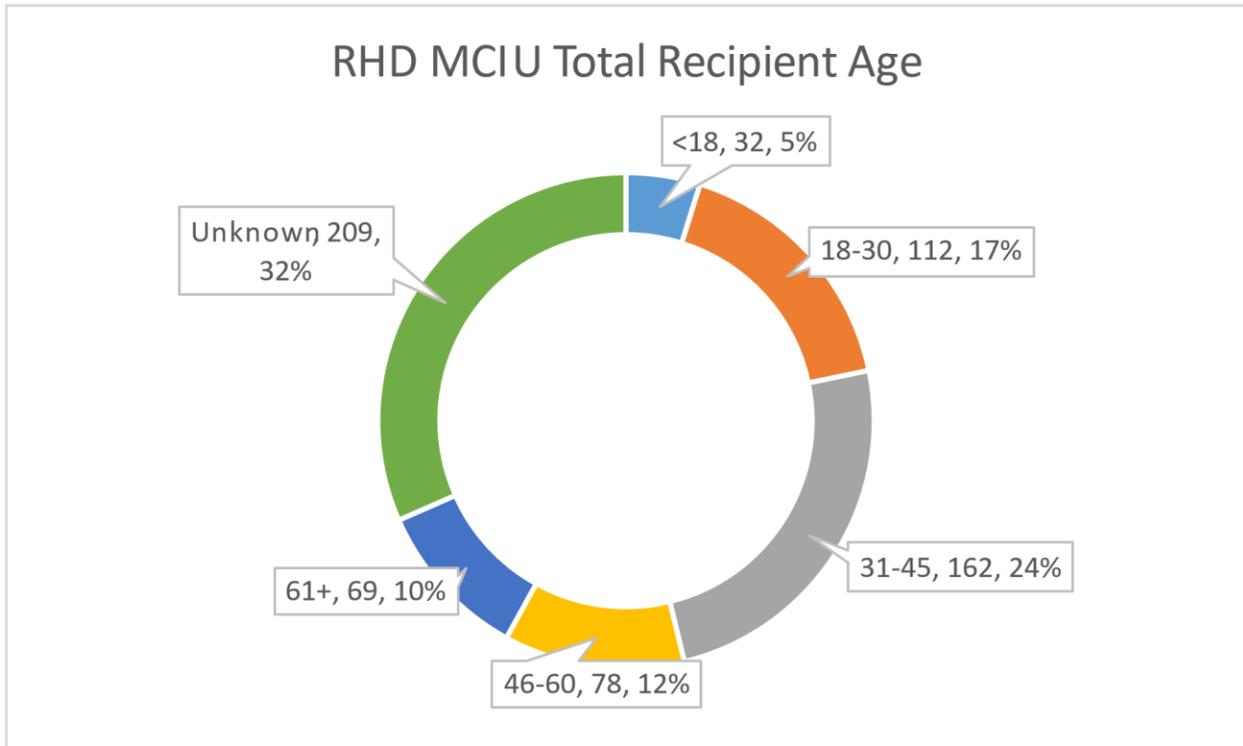
- we may need more males

Please share any other information related to your expectations about working in this new program.

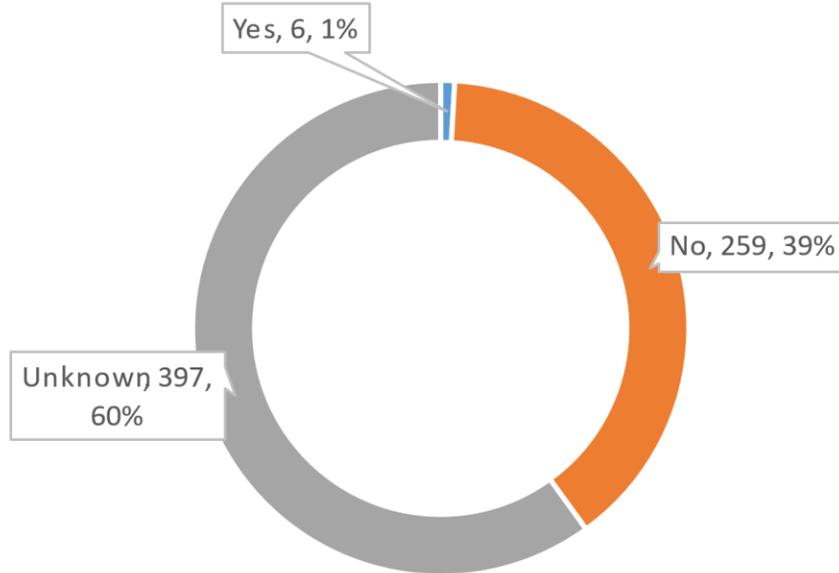
- Has been very supportive
- None just excited to launch
- I expect for us to learn as we go. Training are useful to have a broad idea and a sense of structure. However, I think the best training will be in the field.

Participant Engagement

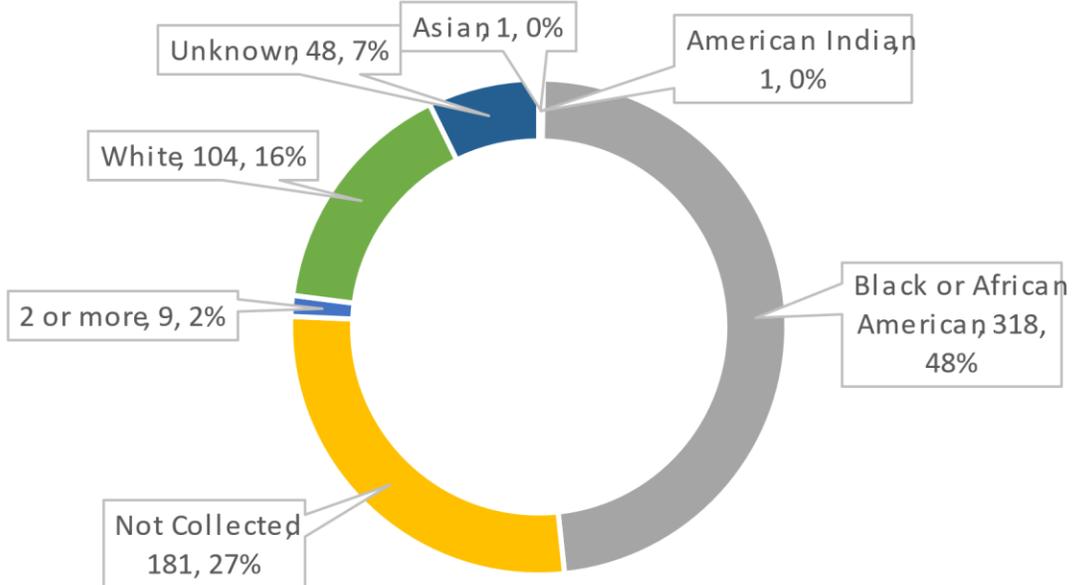
Total calls in first 90 days: 662, average 7-8 calls per day, average 40 minutes on scene

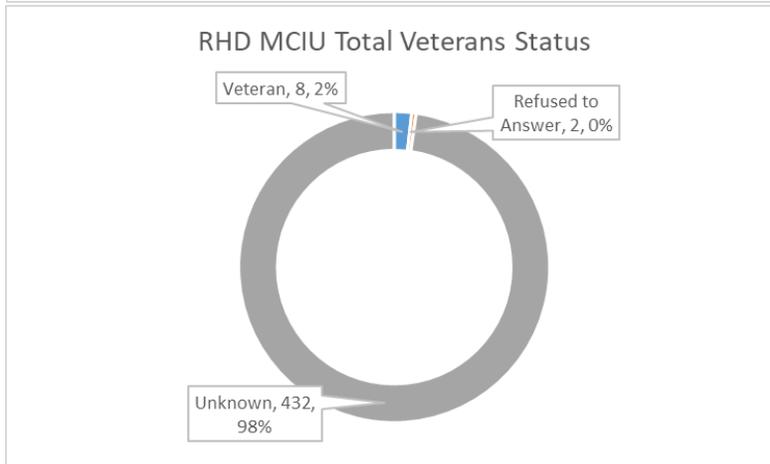
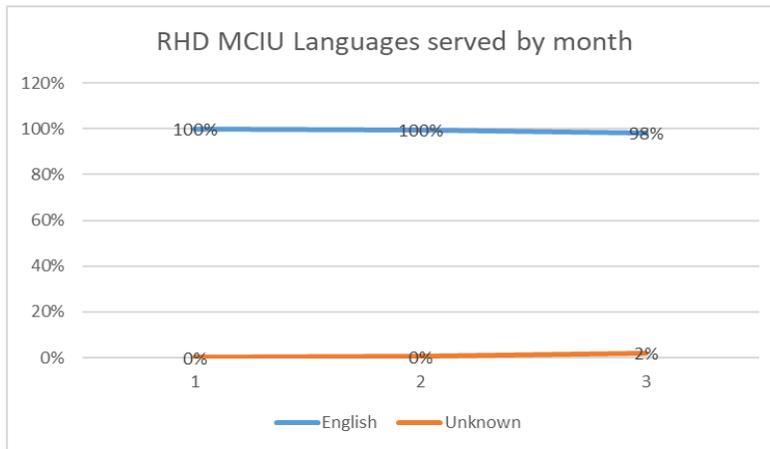
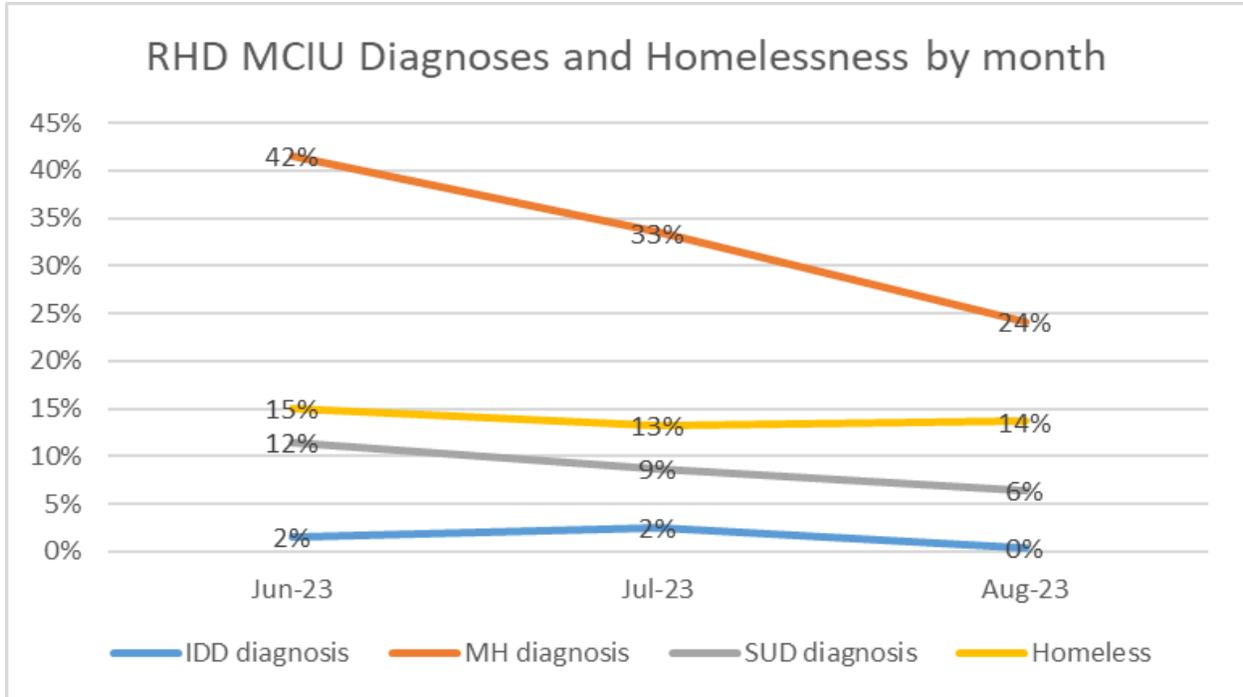


RHD MCIU Total Recipients with Hispanic Origin



RHD MCIU Total Participant Race

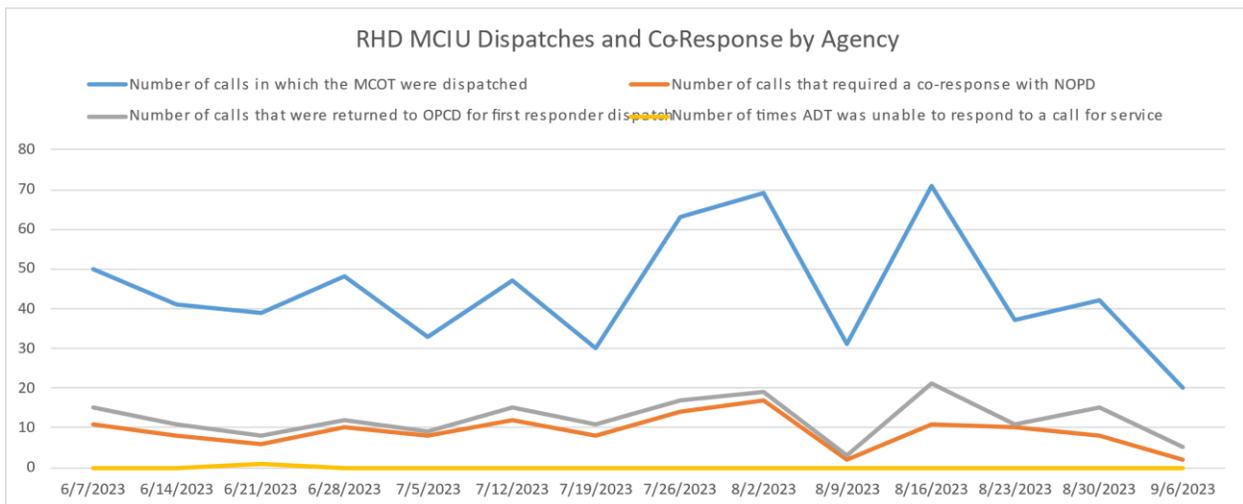
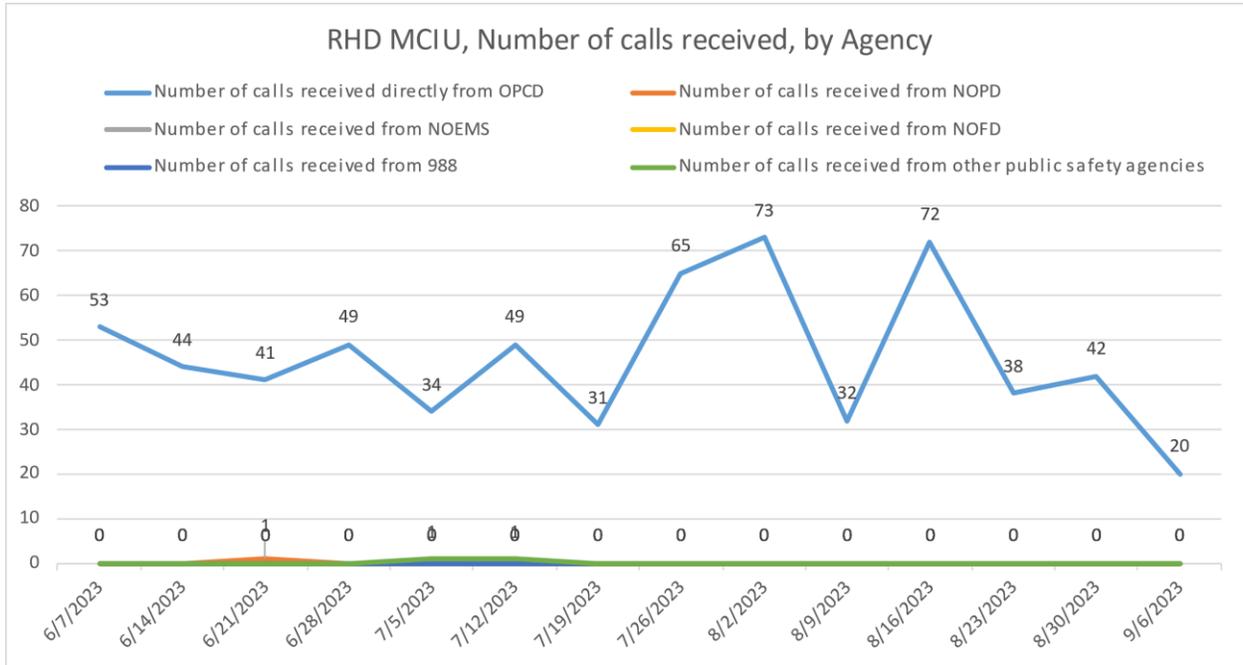




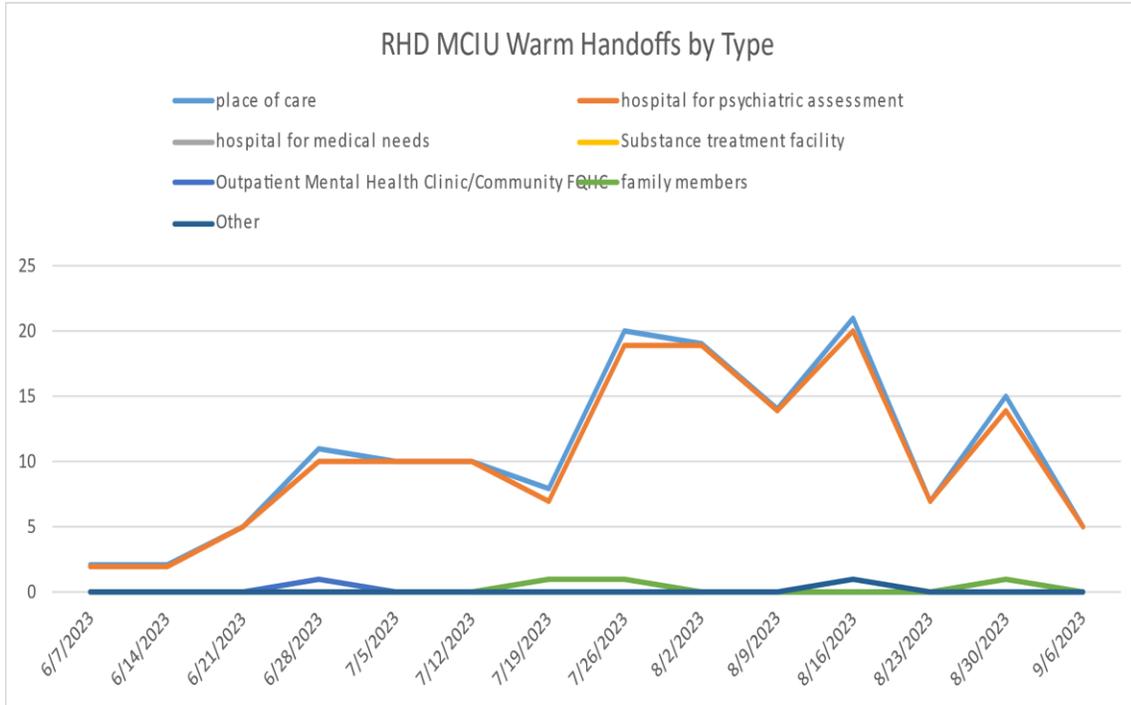
Data Analysis and Reporting

Data

All data should at this point be considered an approximation as there have been challenges in data collection, as described below. Although these numbers may not be precise, we believe that they provide useful information about the need for this service. The priority for the first 90 days was providing a safe and effective service, which we believe we've done based on stakeholder feedback. The priority for the next 90 days will be to improve data collection and reporting. Details on these plans can be found in the Challenges and Lessons Learned section.

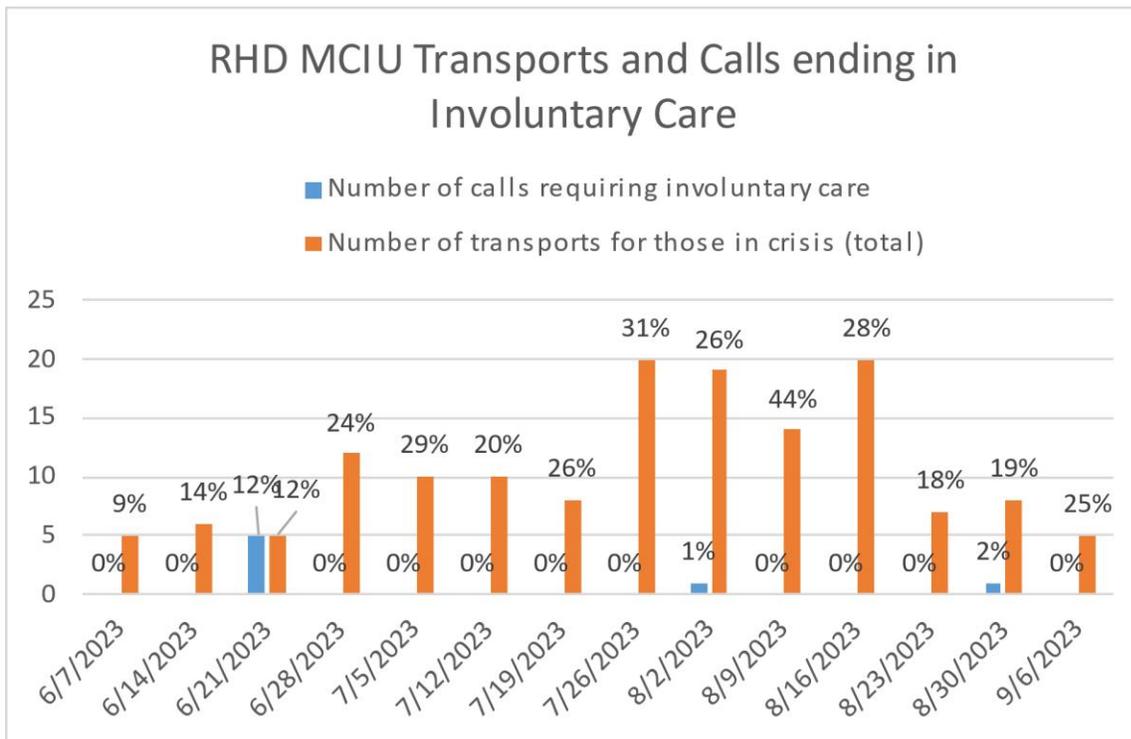


MCIU 90 DAY EVALUATION



We are continuing to refine our documentation process so this graph may not reflect all warm-handoffs.

Calls requiring involuntary care are transported by NOPD rather than MCIU for safety reasons.



Staff Experience Feedback

In our electronic health record, at the end of each face-to-face intervention, we ask our staff a series of questions about their experience. The data below are the results from the first 90 days.

Do you feel safe on this call?

99% said YES

The two reasons given for not feeling safe were both related to the participant being violent/combative.

Were you able to successfully provide assistance/support to the individual?

91% said YES

- 50% of the NOs were due to “gone on arrival”
- 24% of the NOs were due to “resident unwilling to engage”
- The remaining reasons were due to PD response, EMS response, or no phone # and location.

Did you have enough support on this call?

100% said YES

Are there any training topics that would have made you feel more prepared for this call?

98% said NO

The three training topics requested were autism, non-documented people, and what to do about representatives that call for someone they don't know and are unable to help.

Qualitative Evaluation of Program

Below is qualitative feedback we have received from partners, community members, and staff. We have also included some success stories that highlight the impact this team has had in New Orleans.

Dr. Avegno, NOHD (August 2023): Just wanted to share some positive feedback with you - [a community member] (who has lived several other places) had some interaction with MCIU recently, and said "your behavioral health crisis unit is amazing ... much better than Chicago!" He thought we were doing a great job.

Anne Gallagher (August 2023): I'm writing to commend your team for a quick and efficient response. Today I called 911 and requested the Crisis Intervention Unit for a lady who has been living outside a building near my house and shouting angrily for days. I was worried she was in a mental health crisis and didn't want her to die of heat stroke. Your team responded within twenty minutes! I don't know what was said but the situation did not escalate and I saw them provide her with cold water. I know you can't force anyone to get help if they're not a risk to themselves or others, but even showing that someone cares can be lifesaving for people going through hard times.

Thank you for everything you and your employees are doing for our city. We truly need more empathy and resources for addiction and mental health and I think your program is a step in the right direction. I'll donate to the New Orleans branch as much as I can, and I'd love to be alerted to any volunteer opportunities you might have.

Participant's Mother (August 2023): While running errands, MCIU staff were stopped by the mother of a previous participant who expressed her gratitude for the Mobile Crisis Intervention Unit. She stated that MCIU had saved her son's life.

Gladys Campbell, NAMI New Orleans (June 2023): Gladys gave MCIU Director feedback about staff's recent response to a call, that she called in for one of her participants. Staff followed the workflow and delivered exemplary services to the participant.

Karl Fasold (August 2023): New Orleans is extremely happy with the MCIU team. The police department is very happy to have a place to send people for resources and reduce their calls.

Success Stories:

(August 2023) Housing Authority of New Orleans (HANO) called 911 requesting MCIU to support for a pregnant woman who was suicidal. HANO had 6 officers on scene prior to MCIU arrival. Initially the client was refusing to go with PD, however after engaging with us she was willing to go to the hospital. When she went inside to get shoes and a couple of other items she was disgruntled about having to go to the hospital. She stopped to ask her significant other if she would be able to return to the house. When he replied no, she would not be allowed to return, she bolted out of the door and jumped from the second-floor balcony. HANO PD attempted to go

behind her, but she maneuvered away and jumped from the second story. She landed on her backside but was able to get up and run. MCIU staff were the first out of the door, with a family member leading on foot pursuit and MICU staff following to engage her if she could be stopped. Police followed in their vehicles. 2 1/2 blocks later, MCIU staff were able to catch up to her and de-escalate her enough for PD to transport her to get the help she needed. Although it was a jarring experience for staff to watch someone jump, they remained engaged and were ultimately able to ensure she safely got to a facility to receive care.

(June 2023) The MCIU team responded to a situation in which a resident was barricaded in his home and would not engage with the police. Without the MCIU team, the next step for police would have been to call SWAT. They were preparing to do this when the MCIU team offered to intervene. Crisis Worker, Jasmine, text the resident who called her back, talked with her, and eventually came out of his home safely and was able to access the help he needed. This success was highlighted by local media: <https://www.fox8live.com/video/2023/06/16/new-orleans-health-department-launches-new-program-aimed-tackling-mental-health-issues/>

While this was undeniably a success both in the life saved and the collaboration between law enforcement and the MCIU team to save the resident, this type of a response is out of the ordinary scope for MCIU. The MCIU team's primary responsibilities are to respond independently from other first responders to non-violent behavioral health calls. However, as team members within the larger emergency services system, MCIU is able to make exceptions and go above and beyond in extraordinary circumstances such as these.

(June 2023) MCIU were on scene to consult with the police on two other potential SWAT calls but police had to eventually ask them to leave the scene due to safety concerns. The consultation with the police on those calls were still considered successes because it showed the collaboration of multiple first responder branches to ensure the least restrictive and most appropriate response was explored prior to more restrictive and high intensity actions being taken.

Staff Experience:

(Holly Broussard, August 2023): I must say again that having amazing leadership and wonderful coworkers keep my energy on the job very high. Additionally, the work is so rewarding to me. I never know what to expect when we respond to a call, but the confidence I have knowing that Tyesha has our back, and Jasmine with all her knowledge is my partner, makes me feel like there's no challenge we can't tackle together. We set out with the goal of saving that person's life and that's what we're going to do without question. I love this work and I love them. I feed off their energy and we all have love for the people in our community. Thank you all for making this happen!

Challenges and Lessons Learned

The primary unforeseen challenges in the first 90 days were related to data. We designed our electronic health record for crisis services, Behavioral Health Link (BHL), based on our experience with traditional mobile crisis teams imbedded in the community and on BHL's experience with 988 call centers. After the launch of the program, it quickly became apparent that our design did not support the first responder speed at which our team was operating. There were several elements that we found would not serve the needs of this new team.

We meet regularly with BHL to work through each of these issues to identify solutions. We believe we have a good plan for adjusting the functionality of BHL to meet the needs of a fast-paced, first responder team. These fixes required new mapping of processes and programming effort of BHL's side which will take a few months to implement. In the meantime, we have hired a dispatch coordinator to assist with the data entry of new calls to ensure we are capturing all call data not only for Computer Aided Dispatch (CAD) but also for calls received over the radio. We are also hiring a new data analyst dedicated to BHL to ensure the complex and ever-evolving data needs are being met. We hope to have that position filled by the end of the calendar year.

Finally, we are working with OPCD to develop an API that will allow call data from CAD to feed directly into BHL within a few minutes of being received by OPCD. This will reduce data entry needs for RHD staff and reduce the likelihood of data entry errors. OPCD is also exploring the option of adding the Chrome browser to the CAD devices so that staff can access BHL through the CAD devices rather than having to carry a second device such as a tablet or laptop. BHL is planning to release an app within the next year which would enable easy access on phones as well.

The first lesson learned within service delivery was the implementation of a "dispatch first" model. The program was designed for a crisis worker to field the call from OPCD and screen it from a behavioral health perspective before dispatching a mobile team. The MCIU director quickly realized that this approach unnecessarily slowed the team's response time. She moved the team to a "dispatch first" model in which the team leaves for the scene as soon as an address is provided and the screening occurs while the team is en route. If the screening results in the call being cancelled (resolved by phone, medical emergency, violence, etc.) the team is simply instructed to turn around. In most cases, the team is needed on the scene and screening while en route allows for improved response time. Our average response time in the first 90 days is 15 minutes.

The second lesson learned in service delivery was related to staffing. The program design intended that each pair of responders would include one licensed staff and one peer support. During the hiring phase it became clear that finding licensed staff who were interested in being first responders would be a barrier to launching the program. Instead, the MCIU director pivoted to having one licensed staff support all pairs of responders. The pairs could then be staffed by peer supports, bachelors level, or masters level staff. The licensed staff is able to provide support either virtually or in-person at the scene, as the situation calls for. What we found was that most

situations did not require the interventions of a licensed staff. The characteristics of staff that were most important were compassion, strong teamwork, ability to be trained, enthusiasm for the work, and willingness to respond to a variety of different high intensity situations in all New Orleans neighborhoods. Our experience is consistent with the work done by Dr. Amy Watson who was commissioned by NAMI to explore the characteristics and credentials needed for civilian crisis response staff (Watson, 2023).

Finally, from the service delivery perspective, we have learned that the initial plans for technology need to be adapted. We started with tablets for each staff to support documentation in the field. Two problems arose with these tablets. The first is that the tablets made participants uncomfortable, especially if they were having symptoms of paranoia. Staff quickly learned to leave their devices in their bags or in the car so as not to distress those they were supporting. The second issue, magnified by tablets being left in cars, was that they overheated easily. The New Orleans summers made the use of these devices impractical. The immediate change was for staff to take notes by hand on paper and then enter them into BHL back at the office. While this solution meets minimum documentation requirements, it is not efficient and leads to less complete data, limited by notes and memory. To support staff in close to real time data entry, RHD is working with OPCD to determine if the CAD devices, which don't overheat, can be used for BHL documentation.

Collaboration and Stakeholder Engagement

Focus Groups

In February-March of 2023, prior to launch, RHD conducted four focus groups with adults in New Orleans to obtain feedback on how behavioral health crises have been handled in New Orleans previously and what are people's hopes and fears for the new Mobile Crisis Intervention Unit (MCIU).

Methods

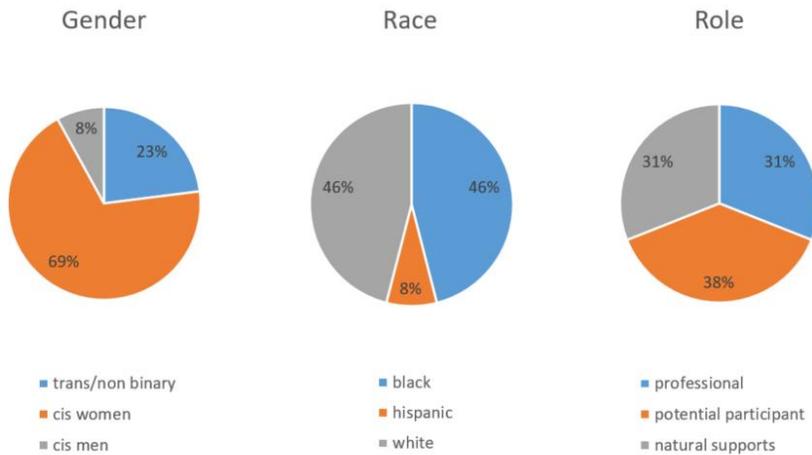
The same two RHD staff from the Business Development Team attended all focus groups. One staff facilitated the conversation and the other took notes. Before beginning, participants were provided with informed consent documents that explained the purpose and use of the focus groups. RHD staff shared that there is minimal risk involved in participating in the focus groups. Possible risks shared were difficult feelings related to discussions of behavioral health crises and police interactions. RHD staff asked that everyone respect the privacy of other participants by not discussing the content of the conversations outside of the session. The benefit to those participating in the focus groups was a chance to help inform the development of a program designed to support the community. RHD staff did not attribute any of the specific comments made in the sessions to any individual participant.

The participants were provided with contact information for the facilitators and assured that they were free to leave at any time without consequence. To facilitate participation, RHD provided Uber codes to participants to get them to and from the focus groups. To pay participants for their time and expertise, RHD provided \$100 Visa gift cards. The amount was decided after consultation with Vera.

Participants were given an overview of the MCIU program and goals before the discussion began. The facilitator asked focused questions about previous 911 experiences, what ideal responders would do and how they would provide the service, their experiences of follow up from behavioral health crises, any involvement of natural supports, and questions about staff uniforms and vehicles. Participants' conversations lead to other topics, as well.

Demographics

Formal focus groups: total of 13 participants



Impressions

Both RHD staff felt the focus groups had robust engagement from all participants in every group. Participants were eager to share their experiences and provide suggestions. There was positive feedback to the design of the MCIU program and hope that it will help improve crisis response in New Orleans. Some of the participants asked to be kept updated on the program and offered to help in any way they could. The RHD staff will invite the participants who expressed interest to participate in the Participant Experience Committee when it is formed.

There were some universal feelings across the focus groups. All participants agreed the current behavioral health response system is inadequate and often harmful. Common feedback was that people want to be patiently and compassionately listened to and believed about their own experience when in crisis. There was also consensus that being in crisis shouldn't always result in hospitalization, which is currently the default, according to participants. There was also a general hope that the MCIU program will result in police being able to respond to crimes faster, which was universally described as a concern.

Finally, participants were in agreement about how MCIU staff should present. They shared that if staff vehicles have lights, alarming color, or the word "crisis" on it, community members will not be receptive to the program. Staff themselves should look as much like civilians as possible, with just an MCIU t-shirt using the program logo and an RHD staff badge. Participants all agreed that if staff had conspicuous radios, they would not be welcomed on the scene and it would hurt trust with the responders.

Below are the common themes and responses to different topics discussed during the focus groups.

911 BH crisis experience:

- Non-911 crisis response program are hard to utilize fully because people lose the phone number
- Police don't respond quickly, even to crimes
- Don't spend time to talk to the person or family members
- We need response for the group of people who aren't in immediate danger but also isn't fine... they are getting lost with no support
- People need help but are worried about getting arrested- police look for evidence, scare people when they knock, investigate rather than de-escalate, seem angry to be called for BH especially if not OPC, don't have the patience to listen
- Dispatch does not understand BH (unanimous in this feeling)
- Sometimes people say they have suicidal thoughts as a way to get someone's attention for their needs
- Buzz words get you involuntarily hospitalized

Were Natural Supports included in the resolution of the crisis?

NO

Not all supports have the practical or emotional capacity to be involved as a true support

- The participant should identify who is the best person
- Supports often have the same problems
- We need supports for our supports (family can get overwhelmed/burnt out by repeated crises)

Follow Up

- Not getting prescriptions explained properly
- In aftercare there are too many wrong doors—this can be a barrier to seeking care at all
- Problem: give resources but don't follow up... the person who did the crisis call should be the person who follows up
- Want us to repeat follow-up over weeks or months

What were you hoping for in the response?

- Want to be listened to and believed about their own experiences
- Don't be too quick to hospitalize; don't want to call if it ends in restraints
- Talking to us about what soothes us (ex. Bubbles)
- Able to respond to SDOH needs- Check on things like “did you eat?” or changing the location (do you want to take a walk?)
- Ability to set up outpatient services
- People worry about the cost of an ambulance ride or medical treatment so people decline care; We need to make sure we tell people the crisis service is free
- Giving information in ways they can understand

- Getting people comfortable
- Cultural approach / attitudes re: MH
- Team needs to get along
 - Debrief
 - Supports
 - Team reflects the community
- Hire people from their community/tribe
- Steady, calm energy without the “soft child voice” but use real voice
- Address the patient first, not the caller
- Patience- not rushing or being distracted
- Not “othering” between staff and patient
- Body language- not tense, defensive, aggressive, or authoritative

Special populations:

- Ability to provide dementia response- even when they have to be admitted, there should be a gentler way
- Response specific to neuro-divergent & IDD needs as these populations react differently
- Transgender, gender non-conforming, and gender-neutral community should be represented by our teams.

What should responders have with them?

- Resource sheet (magnets?)
- A phone the participant can use to call supports
- Narcan, fentanyl testing strips, clean needles (syringe service program)
- Condoms, lube, harm reduction supplies
- HIV test (at home tests)/pregnancy tests
- Hygiene kits
- Feminine products
- Extra clothes (bigger sizes)/robe
- Socks
- Blankets
- Cigarettes
- Bubbles
- Fidget toys
- Like the color purple (have things in multiple colors so people can choose what is soothing to them)
- Apps that have soothing distracting shapes to help with breathing (Triangle breathing on YouTube)
- Food/water (big part of culture)

Logos & Identification:

- Plain clothes with MCIU t-shirt that has logo and maybe initials but not the word “crisis”
- Identification badge
- NO LIGHTS (on vehicles)
- Vehicles: RHD green, RHD or MCIU initials only
- Don’t have the word “crisis” on vehicles
- Inspirational message instead of logos on vehicle
 - Humans for humans
 - People for people
 - We’re here for you

Dispatch

- Sensitivity trainings (to not be judgmental & be patients)
- When we’re calling y’all it’s the worst day of my life even if it’s the 50 in call for dispatch
- Vicarious trauma trainings for dispatch
- Mental Health First Aid (MHFA) for dispatch

Suggestions/Misc.

- Universal Home Visit Program (NOHD)- get training for staff
- Suggestion: Get Pods - physical locations – around the city for drop in etc. - partner with other orgs/church/rec center, etc.
- Suggestion: have a patient advocate with the police to serve as a witness or observer, someone there to give them their dignity
- Question from participants: How does MCIU push back against how the system works and advocate for a better system
- Positive feedback on the LEAD program
- We need to ramp up staffing during Mardi Gras

Participant Experience

To maintain a relationship with our participant and their natural supports throughout the life of the program, we have a participant experience webpage: <https://www.rhd.org/nomciu/experience/>. This page provides a link to a participant experience survey, participant experience committee, and community advisory board. When the MCIU team provides an intervention they leave a card with a QR code for this website and encourage either participants or their natural supports to provide feedback. Our teams also have paper versions of the survey with self-addressed and stamped envelopes to mail back to RHD for people who can’t or don’t want to use technology. These paper surveys also have a line to express interest in joining the participant experience committee or the community advisory board.

The participant experience survey is available for anyone who has interacted with the MCIU team—participants, their supports, other professionals. The survey results are used to inform program quality—to preserve what we’re doing well and correct for what isn’t working for our participants.

The participant experience committee is another way for RHD to elicit feedback from community members, particularly those we have served. The participant experience committee meets quarterly in person. The committee members are paid a \$100 consulting fee and provided with an Uber voucher for transportation to and from the meeting. RHD staff provide data and programmatic updates to the committee members. We ask for feedback on anything new that we’ve implemented and give the members a chance to share what they’ve heard in the community about the MCIU service.

In addition to RHD’s efforts engage community members, to promote community oversight and ongoing collaboration with program leaders, the New Orleans Health Department (NOHD) is launching a Community Advisory Board (CAB) for the MCIU. Broadly, CAB members will be tasked with sharing feedback on MCIU policies and performance with NOHD and RHD staff, as well as other relevant agency representatives, to ensure that program activities reflect the insights of directly impacted community members and ultimately meet community needs. A link to the CAB application is available on RHD’s MCIU participant experience website.

Participant Experience Committee

The first Participant Experience Committee occurred at the end of June 2023. The five committee members were participants in the focus groups who expressed interest in staying involved. There were two individuals who had personal lived experience with mental illness and substance use, and three individuals who were family members of individuals with mental illness and substance use. RHD staff presented the data on call volume, discussed the workflow adjustments such as dispatch first, and shared success stories from the first month. The Director met with the committee to answer questions, show the uniform for MCIU staff, and show the vehicle. All the feedback from the committee was positive. They felt the uniforms were the right balance of identifiable but not militaristic. They were particularly excited about the vehicles which they described as looking like someone coming to help.

The next participant experience committee will be held in October 2023 when we hope to have new members who interacted with the MCIU team in the first few months.

Participant Experience Survey Results

Unfortunately, there were only two participant experience survey results received during the first 90 days. MCIU staff are continuing to encourage participants and their natural supports to complete the participant experience survey and have already seen an increase in responses. Staff leave a card with a website and QR code that links to the [participant experience page](#) with information on the survey, Participant Experience Committee, and Community Advisory Board.

If participants prefer, the staff have paper surveys with self-addressed, stamped envelopes that can be completed and mailed in. There were no paper surveys received in the first 90 days.

The two survey respondents had opposite experiences. One left a comment praising two of the staff who responded and saying, “awesome service speedy professional I’m very impressed with this service will use in my family as well thank a lot will recommend to everyone.” The other respondent was unhappy with the outcome of their intervention which had led to involuntary hospitalization. Feedback was provided to the program leadership to consider in future interventions, while recognizing that involuntary hospitalizations will often lead to negative survey results, even if all protocols were followed. Both respondents stated that MCIU responded in a timely manner and that they weren’t aware of the team prior to this interaction. Additional community outreach will be pursued to increase public awareness and understanding of the team’s purpose.

Community Engagement

Organic and ad hoc community engagement events were conducted by the Director and Regional Director during the first 90 days of the program. However, a focus on community engagement was designed to occur after the first 90 days. The first 90 days was focused on service delivery and safety< requiring the Director to be in the field and available to staff. During the first 90 days, program leadership developed the upcoming community engagement plan which involves awareness events, attending existing community events, and scheduling on-on-one meetings with community stakeholders. Below are some of the outreach that occurred in the first 90 days. As much of the early community outreach was organic, not all connections are listed here.

- New Orleans public school- student support and attendance
- Start Cooperation- FQHC
- Bethune Elementary
- Kipp Central City Academy
- Harmony Oaks Community Center
- Ochsner Baptist
- LCMC - UMC
- LCMC - Touro
- LCMC – NOEH

National Landscape

During implementation, RHD joined the International Crisis Response Association (ICRA) which brings together cities from the U.S. and Canada who are looking to start civilian crisis response programs. The monthly meeting allows for sharing of ideas and asking for advice from other cities. RHD continues to be an active and regular participant.

Through ICRA and word of mouth, RHD has become connected with entities in other cities who are pursuing a civilian crisis response model. RHD met one-on-one with people from several cities in the US and Canada to share information about the MCIU program. These cities

include Vancouver, BC, Barrie, ON, Chicago, IL, Sacramento, CA, Cleveland, OH, and Cambridge, MA. RHD remains available to other cities to provide advice or answer specific operational questions to support a national adoption of civilian crisis response programs.

Upcoming opportunities for national collaboration include CrisisCon23 conference being held in North Carolina in November 2023, following the work of Amy Watson and NAMI on staffing qualifications for this model, and the development of best practices.

Future Plans

Future outreach:

- Universities emergency response/counseling systems
- Urgent Care Clinics & FQHCs
- Homeless Shelter System
- Other BH providers
- Community Organizations
- Recreation Centers & Libraries
- Attend Community Events (ex. Halloween at schools and in neighborhoods)

Potential Expansions:

A key boundary that MCIU has had to navigate is the “scope creep” that could easily happen unintentionally due to the enthusiasm of staff and needs in the community. NOHD and RHD leadership have agreed that in the first year of the program, MCIU will stick to the original goals and responsibilities of the service to ensure that we are providing a high quality service and not overwhelming the staff with additional requests outside of their scope.

That being said, RHD is listening to the feedback from city departments and community members about ideas for expansion when the time comes. Some of these suggestions have included expanded call response with law enforcement, specialized school teams, city-wide disaster response, and formal designation of MCIU staff as first responders. All of these opportunities will be considered and discussed after the first year of success MCIU service.

Program Evaluation:

Because of the newness of the civilian crisis response model, it is necessary to evaluate the program impact. To do this, RHD is partnering with outside organizations as well as NOHD to conduct a robust program evaluation. This evaluation will evaluate the first year of the program (June 1, 2023-May 31, 2024) initially and may be extended to evaluate future years. Below are the broad sections of the evaluation plans.



Conclusion

From RHD's perspective, the implementation and the first 90 days of the MCIU program were successful. The implementation timeline was adhered to and we were able to launch the program on June 1, 2023 as we had planned with NOHD. The team was able to ramp up quickly to serve as many people as possible early on in the program launch. There were several significant success stories in the first 90 days which showed the skill and value of the MCIU team. In addition to what the data showed about the team's performance, the experience of the community and our partners when interacting with MCIU was overwhelmingly positive based on the feedback we received.

As the program continues to develop and grow, MCIU hopes to be able to expand their scope and reach in the New Orleans community. The leadership team is in ongoing conversations with NOHD about where else MCIU can be supportive within the emergency response system. In future years, we hope to have a specific roll for the MCIU team during city-wide emergencies such as natural disasters. MCIU is also continuing to work with our technology partners to ensure that the data we are collecting is complete and accurate.

RHD and the MCIU team are so grateful to the New Orleans Health Department for the support they have provided from the first day of the program implementation. The RHD and NOHD partnership has been a key driver of the success of the program. Likewise, we want to thank the Orleans Parish Communication District which has welcomed MCIU into the larger emergency response system and helped to ensure we are efficient and safe. The New Orleans Police Department has also been a strong partner from the launch of the program, particularly the CIT branch of NOPD. Patrol officers organically created relationships and practices with the MCIU team as they encountered new situations.

We have also been supported by a variety of other cities and entities who provided information on other similar programs and evolving best practices. For all those who have supported the launch of this critical service, we are so grateful. Most of all, RHD leadership thanks the program leadership and staff who continue to show up daily to support residents and provide the highest quality care as the fourth branch of the New Orleans emergency response system.

References

Watson, A. C., Pope, L., & Compton, M. (2023). Interim Report: Building the community behavioral health crisis response workforce. NAMI National.

Bill 43-23, Crisis Intervention Team – Established
Amendments by Councilmember Mink

AMENDMENT #1 – The amendment would delete the creation of a co-response Crisis Intervention Team under the bill.

Delete lines 4 – 89 of the Bill.

AMENDMENT #2 – The amendment would revise the composition and functions of the advisory committee. Note: the amended text is **highlighted** for ease of reading.

Amend line 3 of the bill to read as follows.

**ARTICLE XI. [[CRISIS INTERVENTION TEAM]] TASK FORCE ON CRISIS
RESPONSE**

Amend lines 90 – 138 to read as follows.

24-82. [[Advisory committee]] Task force – established.

- (a) **There is [[an Advisory Committee on Crisis Intervention]] a Task Force on Crisis Response.**
- (b) **The [[committee]] task force consists of:**
- (1) **[[a designee of the Mental Health Association of Maryland]] 2 designees of the National Alliance on Mental Illness of Montgomery County (NAMI MC), including at least one person with personal experience living with a mental or behavioral health condition;**
 - (2) **a designee of the [[county’s]] County’s 9-8-8 call center;**
 - (3) **[[a designee of the Interagency Commission on Homelessness]] 2 designees of the Interagency Commission on Homelessness who represent a Homeless Service Organization or are a person with lived experience;**
 - (4) **[[a designee of the District Administrative Judge for the District Court of Maryland, Montgomery County]] 2 designees of the Mental Health Advisory Committee, including at least one person with personal experience living with a mental or behavioral health condition;**

- (5) [[a designee of the Administrative Judge for the Circuit Court for Montgomery County]] 2 designees of the Alcohol and Other Drug Addiction Advisory Council, including at least one person with personal experience living with a substance use disorder;
- (6) [[a designee of the Montgomery County State’s Attorney]] 2 designees of the Commission for People with Disabilities, including at least one person with personal experience living with an intellectual or developmental disability;
- (7) [[a designee of the Montgomery County Council]] 2 designees of the Advisory Commission on Policing;
- (8) [[a designee]] 2 designees of the Intellectual and Developmental Disabilities Commission, including at least one person with personal experience living with an intellectual or developmental disability;
- (9) [[a representative of a county chamber of commerce, appointed by the County Executive and confirmed by the Council]] 2 designees of the Police Advisory Board;
- (10) a designee of the Montgomery County Fire Chief;
- (11) a designee of the Emergency Communications Center;
- (12) a designee of the [[County Sheriff]] Department of Health & Human Services – Behavioral Health & Crisis Services;
- (13) a designee of the Street Outreach Network;
- [[13]] (14) a designee of the [[Director of the Department of Correction and Rehabilitation; and]] Montgomery County Chief of Police;
- [[14]] (15) 2 [[residents]] mental health professionals serving County residents, at least 1 of whom is not a physician, appointed by the Executive and confirmed by the Council;[[. who:]]
 - [[A) have lived experience regarding mental health, behavioral health, or substance use disorders;]]
 - [[B) represent different geographical regions of the County; and]]
 - [[C) will be offered the opportunity to participate in the police department’s “Citizens Academy,” as well as attend any CIT training or other in-

service training offered relevant to the work of the Advisory Committee.]]

(16) 2 individuals representing nonprofits serving incarcerated or formerly incarcerated County residents, including at least one person who is formerly incarcerated or has faced charges, appointed by the Executive and confirmed by the Council; and

(17) 2 residents, appointed by the Executive and confirmed by the Council, who are homeless or formerly homeless.

(c) Task force membership should reflect the regional, racial, cultural, and socioeconomic diversity of the County.

24-83. [[Advisory committee]] Task force – duties and staffing.

The [[advisory committee]] task force must:

(a) [[provide advice to, and collaborate with, the crisis intervention team, the Executive, and the Council regarding best practices for crisis intervention in the County related to mental health, behavioral health, or substance use disorders]] examine the structure, standards, and protocols of jurisdictions that prioritize civilian responses to mental and behavioral health and substance use crises, including jurisdictions also prioritizing civilian responses to homelessness, disorderly juveniles, minor disputes, and other nonviolent calls for service;

(b) [[consult with the crisis intervention team regarding the development of the models under Section 24-80]] examine best practices, research, and recommendations for community-based crisis response and mental and behavioral health crisis care by the International Crisis Response Association (ICRA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and Resources for Human Development (RHD);

(c) prepare the initial and annual report required under Section 24-84;

(d) [[follow the work and recommendations of the Crisis Intervention Team and Maryland Behavioral Health and Public Safety Centers of Excellence in the Governor's Office of Crime Prevention, Youth, and Victim Services]] consider existing models, research, and recommendations within the context of Montgomery County's needs and characteristics; the Maryland Department of Health's Strategic

Vision for Comprehensive Mobile Response and Stabilization Services For Children, Youth, Young Adults, and Families; and Maryland requirements for Medicaid reimbursement of mobile crisis team service and behavioral health crisis stabilization center service; and

- (e) be staffed by a designee of the County Executive. In staffing the task force, the Executive should engage the assistance of a consultant specializing in building and supporting local crisis response models that prioritize civilian responses to mental and behavioral health and substance use crises.

24-84. [[Annual]] Initial and annual evaluation and reporting.

- (a) The ~~[[advisory committee]]~~ task force must submit and present to the Council, no later than ~~[[January 31 each year, an annual]]~~ 6 months after its first meeting, a report to the Executive and Council that includes:

~~[[a]] (1) [[numerical data, disaggregated when possible by race, ethnicity, gender, gender identity, and age, regarding:]] standards for what types of calls should default to phone response, civilian mobile response, co-response, and emergency services;~~

Delete lines 139 – 161. Amend lines 162 – 167 to read as follows.

~~[[b]] (2) [[achievements and challenges of the crisis intervention team during the prior year]] protocols for triage, dispatch, arrival, and, when appropriate, warm hand-offs and ensuring continuum of care; and~~

~~[[c]] (3) [[recommendations to improve crisis intervention in the County, in coordination with local, state, and federal partners]] staffing types and levels that would accommodate the recommendations under subsection (a) and enable appropriate arrival times by all responders including civilians.~~

- (b) After submission of the report under subsection (a), the task force annually must submit a report to the Council and County Executive assessing the implementation by the County of the standards, staffing, and protocols recommended by the task force under subsection (a).

[[Sec. 2. Transition. The first report required under Section 24-84, added under Section 1 of this Act, is due by January 31, 2025.]]

Bill 43-23, Crisis Intervention Team – Established
Amendments by Councilmember Luedtke

AMENDMENT # 1 – DELETE ASPECTS OF THE BILL BEING IMPLEMENTED PURSUANT TO AN MOU

Delete lines 1-89.

AMENDMENT #2 – ESTABLISHMENT OF ADVISORY COMMITTEE

Amend line 91 to read as follows.

- (a) There is an Advisory Committee on Crisis Intervention and Application of the Sequential Intercept Model.

AMENDMENT #3 – COMMITTEE MEMBERSHIP

Amend line 92-119 to read as follows.

- (b) The committee consists of:

* * *

- (13) a designee of the Director of the Department of Correction and Rehabilitation;
[[and]]
- (14) a designee of the Montgomery County Police;
- (15) a designee of the Department of Health and Human Services; and
- (14) [[2]] 3 residents, appointed by the Executive and confirmed by the Council,
who:
- (A) have lived experience regarding mental health, behavioral health, or
substance use disorders;
- (B) represent different geographical regions of the County; and
- (C) will be offered the opportunity to participate in the police department’s
“Citizens Academy,” as well as attend any CIT training or other in-
service training offered relevant to the work of the Advisory
Committee.

AMENDMENT #4 – ADVISORY COMMITTEE DUTIES

Amend lines 121-127 to read as follows.

The advisory committee must:

- (a) [[provide advice to, and collaborate with, the crisis intervention team, the Executive, and the Council regarding best practices for crisis intervention in the County related to]] use the Sequential Intercept Model to assess and analyze the County’s ability to provide crisis intervention services, crisis response, and diversion from the criminal justice system to treatment for individuals with mental health, behavioral health, or substance use disorders;
- (b) [[consult with the crisis intervention team regarding the development of the models under Section 24-80]] advise the Executive and Council regarding best practices in crisis intervention, diversion programs, and wraparound services;

AMENDMENT #5 – REPORTING REQUIREMENTS

Amend lines 135-161 to read as follows.

The advisory committee must submit, no later than January 31 each year, an annual report to the Executive and Council that includes:

- (a) numerical data, disaggregated when possible by race, ethnicity, gender, gender identity, and age, regarding:

* * *

- (4) individuals[[,]] served [[in-person or by phone,]] by the County’s 24-hour Crisis Center;
- (5) individuals served by the County's 9-8-8 call center;
- [[~~(5)~~]] (6) service calls under paragraph (1) involving an actual or threatened deadly or dangerous weapon, as defined under Sections 4-101 or 4-102 of the Criminal Law Article of the Maryland Code, as amended;
- [[~~(6)~~]] (7) service calls under paragraph (1) involving co-occurring criminal conduct, including the numbers of associated:
 - (A) misdemeanor charges;
 - (B) felony charges;

- (C) individuals offered a diversion to treatment; and
- (D) individuals who were not charged due to diversion to treatment; and
- [[~~(7)~~]] (8) service calls under paragraph (1) involving an individual where pending criminal charges were at issue;

AMENDMENT #6 – TRANSITION CLAUSE

Amend lines 135-161 to read as follows.

Sec. 2. Transition. The first report required under Section 24-84, added under Section 1 of this Act, is due by January 31, [[2025]] 2026.

On the following pages, the six proposed amendments are shown in the context of the text of Bill 43-23.

Councilmember Luedtke's Amendments Shown in the Text of Bill 43-23:

Sec. 1. Article XI, Sections 24-77, 24-78, and 24-79[[, 24-80, 24-81, 24-82, 24-83, and 24-84]] are added as follows:

ARTICLE XI. CRISIS INTERVENTION TEAM

[[24-77. Definitions.

In this Article, the following terms have the meanings indicated.

Advisory committee or committee means the Advisory Committee on Crisis

Intervention established under Section 24-82.

Crisis intervention model program has the meaning set forth at Section 3-522 of the Public Safety Article of the Maryland Code, as amended.

Crisis intervention team, CIT, or team means a group of individuals designated under Sections 24-78 and 24-79 to perform the duties specified under Sections 24-80 and 24-81, where law enforcement officers and clinicians are co-located and deployed in an integrated fashion.

Health department means the Montgomery County Department of Health and Human Services.

Law enforcement entity means a public law enforcement agency, other than the Montgomery County Police Department.

Police department means the Montgomery County Police Department.

Sequential intercept model means a plan, specific to the County, that details how individuals with mental, behavioral, and substance use disorders:

- (1) come into contact with and move through the criminal justice system; and
- (2) obtain referrals to other wraparound services.]]

[[24-78. Crisis intervention team – established.

(a) There is a crisis intervention team within the County government consisting of:

- (1) designees of the health department;
- (2) designees of the police department; and
- (3) participants of other law enforcement entities under Section 24-79.

(b) Each member of the team must meet minimum qualifications established by their home agency to be assigned to the team in addition to all other licensing, credentialing

and continuing education requirements imposed by State or federal law applicable to the respective disciplines.

- (c) A member of the team designated by the Chief of the police department, and a member of the team designated by the Director of the health department, jointly must direct the operations of the team.
- (d) The health department and police department, which will have equal responsibility in overseeing the crisis intervention team, must establish a Memorandum of Understanding to carry out the work of the team, further delineate roles and responsibilities, and address other administrative issues.
- (e) The team will follow guidance provided by the Crisis Intervention Team Center of Excellence at the State level in implementing, delivering, and enhancing crisis intervention services in the county.]]

[[24-79. Participation of other law enforcement entities.

Subject to a written agreement with the County, and approval of the police department and health department, a law enforcement entity may designate individuals to participate in the crisis intervention team.]]

[[24-80. Crisis intervention team – duties.

The crisis intervention team must:

- (a) in consultation with the advisory committee, establish and enhance the sequential intercept model for diverting individuals experiencing a mental or behavioral health crisis or substance use disorder crisis from the criminal justice system and into treatment;
- (b) adhere to the principals of the crisis intervention model program;
- (c) respond to acute incidents in the County where there is a significant risk of harm to the individual in crisis or to someone else, and there is reason to believe that the individual has an underlying mental or behavioral health condition or co-existing substance use disorder;
- (d) co-locate members of the team in disparate geographic areas of the County;
- (e) interact directly with emergency dispatchers regarding individuals experiencing mental health, behavioral health, or substance abuse incidents; and

- (f) provide to each individual or family served by the team information regarding how to prepare an advance directive for psychiatric care.]]

[[24-81. Scope of team activities.

- (a) Limited scope of team response. The priority response for the crisis intervention team is for incidents involving acute mental health, behavioral health, or substance abuse crisis events where there is a significant risk of danger for the individual in crisis or others as a result of the crisis.
- (b) Primacy of health response. Unless there is a significant risk of harm to the individual in crisis or to someone else, the primary response for an individual experiencing a mental or behavioral health crisis or health crisis related to substance use disorder should be with mobile crisis or emergency medical services clinicians.
- (c) Effects on law enforcement activities and collective bargaining. Nothing in this Article may be construed to limit or supersede:
 - (1) law enforcement activities of the police department or other law enforcement entities;
 - (2) the effectuation of a petition for emergency evaluation by a law enforcement officer;
 - (3) assistance of law enforcement requested by emergency dispatchers, residents, or others;
 - (4) police department or law enforcement entity orders; or
 - (5) collective bargaining under Chapter 33.]]

[[24-82]] 24-77. Advisory committee – established.

- (a) There is an Advisory Committee on Crisis Intervention and Application of the Sequential Intercept Model.
- (b) The committee consists of:
 - (1) a designee of the Mental Health Association of Maryland;
 - (2) a designee of the county's 9-8-8 call center;
 - (3) a designee of the Interagency Commission on Homelessness;
 - (4) a designee of the District Administrative Judge for the District Court of Maryland, Montgomery County;

- (5) a designee of the Administrative Judge for the Circuit Court for Montgomery County;
- (6) a designee of the Montgomery County State’s Attorney;
- (7) a designee of the Montgomery County Council;
- (8) a designee of the Intellectual and Developmental Disabilities Commission;
- (9) a representative of a county chamber of commerce, appointed by the County Executive and confirmed by the Council;
- (10) a designee of the Montgomery County Fire Chief;
- (11) a designee of the Emergency Communications Center;
- (12) a designee of the County Sheriff;
- (13) a designee of the Director of the Department of Correction and Rehabilitation;
[[and]]
- (14) a designee of the Montgomery County Police;
- (15) a designee of the Department of Health and Human Services; and
- (14) [[2]] 3 residents, appointed by the Executive and confirmed by the Council, who:
 - (A) have lived experience regarding mental health, behavioral health, or substance use disorders;
 - (B) represent different geographical regions of the County; and
 - (C) will be offered the opportunity to participate in the police department’s “Citizens Academy,” as well as attend any CIT training or other in-service training offered relevant to the work of the Advisory Committee.

[[24-83]] 24-78. Advisory committee – duties and staffing.

The advisory committee must:

- (a) [[provide advice to, and collaborate with, the crisis intervention team, the Executive, and the Council regarding best practices for crisis intervention in the County related to]] use the Sequential Intercept Model to assess and analyze the County’s ability to provide crisis intervention services, crisis response, and diversion from the criminal justice system to treatment for individuals with mental health, behavioral health, or substance use disorders;

- (b) [[consult with the crisis intervention team regarding the development of the models under Section 24-80]] advise the Executive and Council regarding best practices in crisis intervention, diversion programs, and wraparound services;
- (c) prepare the annual report required under Section 24-84;
- (d) follow the work and recommendations of the Crisis Intervention Team and Maryland Behavioral Health and Public Safety Centers of Excellence in the Governor's Office of Crime Prevention, Youth, and Victim Services; and
- (e) be staffed by a designee of the County Executive.

24-84. Annual evaluation and reporting.

The advisory committee must submit, no later than January 31 each year, an annual report to the Executive and Council that includes:

- (a) numerical data, disaggregated when possible by race, ethnicity, gender, gender identity, and age, regarding:
 - (1) public safety service calls involving individuals experiencing a crisis related to mental health, behavioral health, or substance abuse disorders;
 - (2) petitions for emergency evaluation:
 - (A) issued; and
 - (B) served;
 - (3) individuals diverted by the crisis intervention team from the emergency room to other supports;
 - (4) individuals[[,]] served [[in-person or by phone,]] by the County's 24-hour Crisis Center;
 - (5) individuals served by the County's 9-8-8 call center;
 - [[5]] (6) service calls under paragraph (1) involving an actual or threatened deadly or dangerous weapon, as defined under Sections 4-101 or 4-102 of the Criminal Law Article of the Maryland Code, as amended;
 - [[6]] (7) service calls under paragraph (1) involving co-occurring criminal conduct, including the numbers of associated:
 - (A) misdemeanor charges;
 - (B) felony charges;
 - (C) individuals offered a diversion to treatment; and

- (D) individuals who were not charged due to diversion to treatment; and
- [[7]] (8) service calls under paragraph (1) involving an individual where pending criminal charges were at issue;
- (b) achievements and challenges of the crisis intervention team during the prior year; and
- (c) recommendations to improve crisis intervention in the County, in coordination with local, state, and federal partners.

Sec. 2. Transition. The first report required under Section 24-84, added under Section 1 of this Act, is due by January 31, [[2025]] 2026.

WES MOORE
Governor

ARUNA MILLER
Lieutenant Governor



DOROTHY LENNIG
Executive Director

Subject: Bill 43-23, Advisory Committee on Crisis Intervention and Application of the Sequential Intercept Model

September 16, 2024

Governor Wes Moore's Office of Crime Prevention and Policy (GOCP) advises the Governor on criminal justice strategies, coordinates across public safety agencies, and allocates resources statewide to support public safety. An important part of GOCP's work runs through the Maryland Behavioral Health and Public Safety Center of Excellence¹ and the Crisis Intervention Team Center of Excellence². Collectively known as the Centers of Excellence, this unit provides technical support to local governments, law enforcement, public safety agencies, behavioral health agencies, and crisis service providers to evaluate behavioral health resources available in the State as well as reduce and improve criminal legal system responses to people with behavioral health conditions. Additionally, the Centers facilitate statewide, local, and regional planning workshops using the Sequential Intercept Model (SIM).

Bill 43-23, pending before the Montgomery County Council, would create an Advisory Committee on Crisis Intervention and Application of the Sequential Intercept Model to formalize the ongoing interagency, collaborative work to strengthen and continually evolve Montgomery County's crisis response models and enhance diversion and support services.

The Sequential Intercept Model (SIM), developed by Drs. Mark R. Munetz and Patricia A. Griffin, is a framework to help communities assess available behavioral health resources, identify service gaps, and plan for community change. A SIM workshop allows community stakeholders to discuss and then map the various intervention opportunities (intercepts) on a person's path between their community and the criminal legal system.³ Participants leave the workshop with a map that shows them all the points at which their community can provide a resource to a person with special behavioral health needs who is at risk of or already involved in the criminal legal system. Importantly, the map also shows which resources are currently available at each intercept and where their community lacks resources.

¹ Section 13-4202 of the Health Article of the Maryland Code

² Section 3-522 of the Public Safety Article of the Maryland Code

³ Intercepts 0 - 5: (0) Community Services, (1) Law Enforcement and Emergency Services, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections/Community Support.

In May 2024, the Centers of Excellence, joined by two trained SIM facilitators, met with a group of behavioral health and criminal legal system stakeholders from Montgomery County, Maryland, at the Montgomery County Executive Office Building. The Centers of Excellence staff provided a brief presentation on the SIM and facilitated discussions focused on identifying:

- Existing resources for responding to the needs of adults with mental health and substance use conditions who are involved or at risk for involvement in the criminal legal system.
- Gaps in services for systems-involved individuals with behavioral health needs.
- Opportunities to divert people out of the criminal legal system and instead connect them with treatment and other support services in the community.
- Opportunities for cross-system collaboration and partnerships.

The discussions touched on all the SIM intercepts,⁴ and afterward, participants reviewed the information and identified short- and long-term goals.

As a coordinating office, we at GOCPP highly value cross-sector and interagency coordination. GOCPP's primary goals in the SIM workshop are facilitating collaborative problem-solving and empowering local communities to better meet their neighbors' behavioral health needs. Montgomery County had a tremendous showing by people who work or are otherwise engaged in serving County residents and are well-positioned to change how the County provides those services. This is a critical component of a successful SIM workshop and effective implementation of the recommendations that come out of the workshop.

GOCPP enthusiastically supports this proposed legislation to implement the recommendations of the Montgomery County Sequential Intercept Model Mapping Workshop. It will be a model for other counties to advance services for some of Maryland's most vulnerable residents and thus advance public safety.

Best,



Bethany Young
Director of Policy and Legislation
Governor's Office of Crime Prevention and Policy
bethany.young@maryland.gov

⁴ See note 3.

Sequential Intercept Model Mapping Report for Montgomery County, Maryland

Final Report
May 2024

Governor's Office of Crime Prevention and Policy
Centers of Excellence



Acknowledgments

This report was prepared by the Centers of Excellence within the Governor’s Office of Crime Prevention and Policy. The Centers of Excellence wishes to thank all local stakeholders who have participated in the discussion while acknowledging James A. Bonifant, Administration Judge for Montgomery County’s Circuit Court, Marina Sabett, Associate Judge for Montgomery County’s District Court, Sara Rose, Director of Montgomery County’s Local Behavioral Health Authority, and Amanda Williams, Supervisor of Criminal and Civil Case Management in the Montgomery County Circuit Court, for leading this effort.

Recommended Citation

The Centers of Excellence. (2024). *Sequential intercept model mapping report for Montgomery County, Maryland*. Crownsville, MD: Governor’s Office of Crime Prevention and Policy.

CONTENTS

Background	4
Introduction	5
Agendas	6
Sequential Intercept Model Map for Montgomery County, Maryland	8
Resources and Gaps at Each Intercept	9
Intercept 0 and Intercept 1	10
Intercept 2 and Intercept 3	37
Intercept 4 and Intercept 5	52
Priorities for Change	61
Quick Fixes/Low-Hanging Fruit	66
Parking Lot	68
Resources	71
Appendices	93

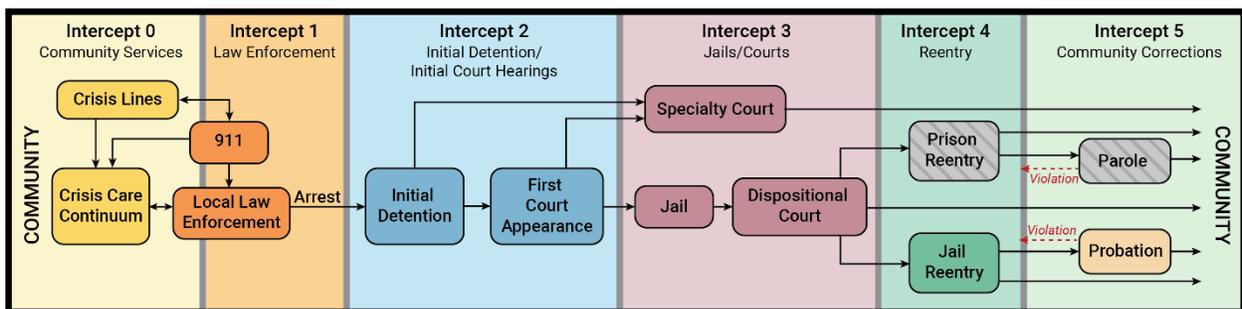
BACKGROUND

The sequential intercept model (SIM), developed in the early 2000s by Mark R. Munetz, M.D., and Patricia A. Griffin, Ph.D., has been used as a framework to help states and communities assess available resources, determine gaps in services, and plan for community change.¹ These activities are best accomplished by a team of stakeholders across multiple systems, including behavioral health, law enforcement, pretrial services, courts, jails, community corrections, housing, social services, peers, family members, and many others.

The SIM illustrates how people with behavioral health needs come into contact with and flow through the criminal legal system. Through a SIM mapping workshop, facilitators and participants identify opportunities for linkage to services and prevention of further penetration into the criminal legal system. Additionally, SIM workshops guide communities in connecting individuals with services as they exit the criminal legal system.

The sequential intercept mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal legal system along six distinct intercept points: (0) Community Services,² (1) Law Enforcement and Emergency Services, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections/Community Support.
2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.
3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.



© 2019 Policy Research Associates, Inc.

¹ This image is included for illustrative purposes only and may not be an exact representation of the local system. Munetz, M., & Griffin, P. (2006). A systemic approach to the decriminalization of people with serious mental illness: The sequential intercept model. *Psychiatric Services*, 57, 544-549.

² Community services are provided by civilians and include community resources; preventative and chronic care; and acute and urgent care.

INTRODUCTION

Section 3-522 of the Public Safety Article of the Maryland Code established the Crisis Intervention Team Center of Excellence to develop and implement a crisis intervention model program. Section 13-4202 of the Health Article of the Maryland Code established the Maryland Behavioral Health and Public Safety Center of Excellence as a statewide information repository for behavioral health treatment and diversion programs related to the criminal legal system and more. Collectively known as the Centers of Excellence, this unit within the Governor’s Office of Crime Prevention and Policy provides technical support to local governments, law enforcement, public safety agencies, behavioral health agencies, and crisis service providers to evaluate and improve the intersections of behavioral health, public safety, and criminal justice. Additionally, the Centers facilitates statewide, local, and regional planning workshops using the sequential intercept model (SIM). By May 2024, the Centers of Excellence had hosted three facilitator trainings certifying 55 individuals across the state to assist with conducting mapping workshops.

In May 2024, the Centers of Excellence, joined by two trained SIM facilitators, met with a group of behavioral health and criminal legal system stakeholders from Montgomery County, Maryland, at the Montgomery County Executive Office Building. The Centers of Excellence staff provided a brief presentation on the SIM and facilitated discussions focused on identifying:

- Existing resources for responding to the needs of adults with mental health and substance use conditions who are involved or at risk for involvement in the criminal legal system.
- Gaps in services for systems-involved individuals with behavioral health needs.
- Opportunities for diverting individuals in the target population out of the criminal legal system and connecting them with treatment and other support services in the community.
- Opportunities for cross-system collaboration and partnerships.

The discussions touched on all the intercepts of SIM. The Centers of Excellence captured information about the resources, gaps in services, and opportunities. Following this discussion, the group reviewed the gathered information and identified short and long-term goals. This process assisted in identifying priorities for community change. At the conclusion of this meeting, the stakeholders in attendance voted on the identified priorities found on page 61.

AGENDAS



Sequential Intercept Model Mapping Workshop Montgomery County, Maryland

May 29, 2023

8:30 a.m. - 4:00 p.m. Eastern Time

AGENDA DAY ONE

8:30 a.m. - 8:45 a.m.	Welcoming/Opening Remarks
8:45 a.m. - 9:00 a.m.	Overview of Sequential Intercept Model
9:00 a.m. - 10:45 a.m.	Intercept 0/1 Resources and Gaps
10:45 a.m. - 11:00 a.m.	Break
11:00 a.m. - 11:40 a.m.	Intercept 0/1 Resources and Gaps
11:40 a.m. - 12:15 p.m.	Intercept 2/3 Resources and Gaps
12:15 p.m. - 1:15 p.m.	Lunch
1:15 p.m. - 2:10 p.m.	Intercept 2/3 Resources and Gaps
2:10 p.m. - 3:40 p.m.	Intercept 4/5 Resources and Gaps
3:40 p.m. - 3:50 p.m.	Break
3:50 p.m. - 4:00 p.m.	Next Steps/Expectations for Day Two



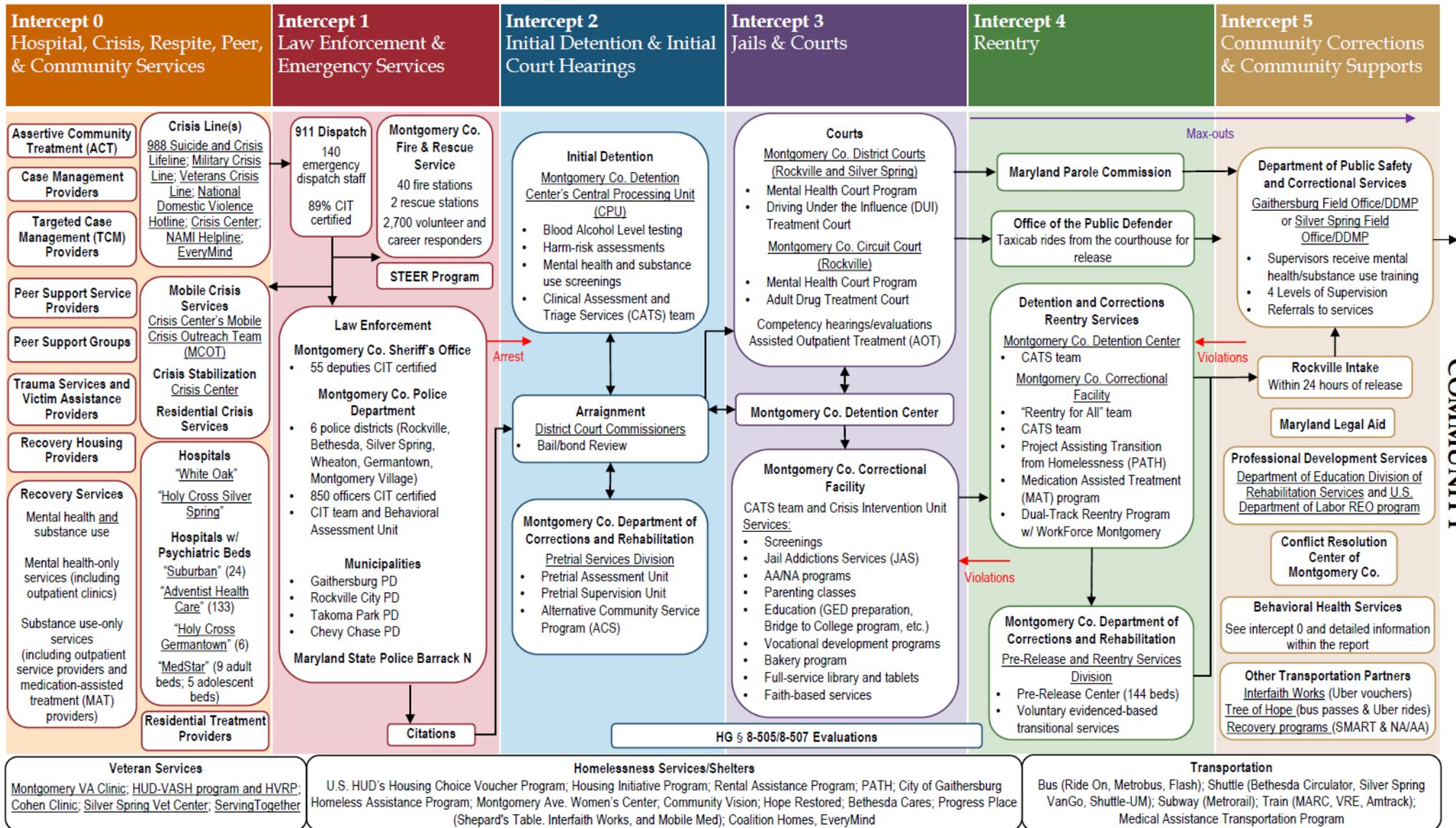
**Sequential Intercept Model Mapping Workshop
Montgomery County, Maryland**

**May 30, 2023
8:30 a.m. - 12:30 p.m. Eastern Time**

AGENDA DAY TWO

8:30 a.m. - 10:15 a.m.	Review Day One Conversation
10:15 a.m. - 10:30 a.m.	Break
10:30 a.m. - 11:00 a.m.	Identifying Low-Hanging Fruit and the Parking Lot
11:00 a.m. - 11:20 a.m.	Small Group Discussions - Brainstorming Priorities
11:20 a.m. - 12:20 p.m.	Identifying Priorities for Change
12:20 p.m. - 12:30 p.m.	Voting on Priorities for Change and Clarifying Next Steps
12:30 p.m.	Adjournment

SEQUENTIAL INTERCEPT MODEL MAP FOR MONTGOMERY COUNTY, MARYLAND

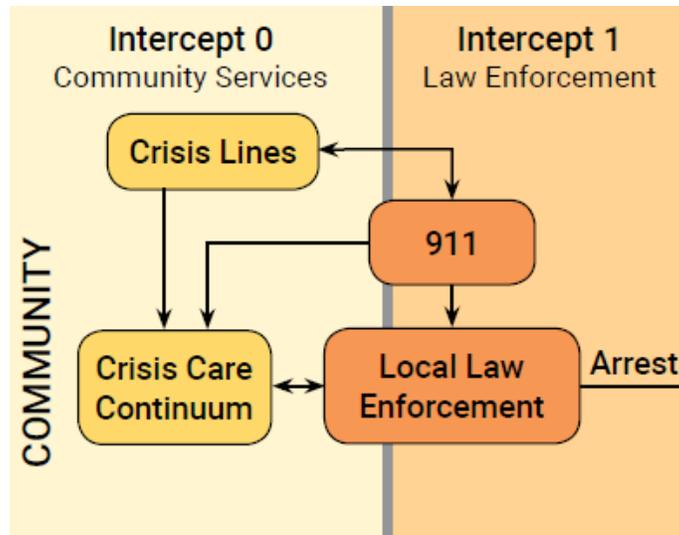




RESOURCES AND GAPS AT EACH INTERCEPT

The focus of this workshop is the development of a sequential intercept model map. Thus, the facilitators work with the workshop participants to identify resources and gaps at each intercept. This process provides contextual information for understanding the local map as the criminal legal system and behavioral health services are ever-changing. Furthermore, this catalog can be used by planners to expand opportunities for improving public safety and public health outcomes for people with behavioral health conditions, intellectual and developmental disabilities (IDD), and neurocognitive conditions by addressing the gaps and building upon existing resources. Please note that the information in this report reflects the status at the time of the workshop unless otherwise noted.

³ Image link: <https://roubler.com/za/wp-content/uploads/sites/52/2020/04/COVID19-Recovery-1.jpg>



INTERCEPT 0 AND INTERCEPT 1

INTERCEPT 0/1 RESOURCES

Community Services

Montgomery County is Maryland's most populous jurisdiction with over one million residents. While the county as a whole is a suburb of the nation's capital, Washington, D.C., the southern portion is more urban. The county contains the incorporated cities of Rockville, Gaithersburg, and Takoma Park and incorporated municipalities, including Barnesville, Brookeville, Chevy Chase, Friendship Heights, Garrett Park, Glen Echo, Kensington, Laytonsville, Poolesville, Somerset, and Washington Grove. With 497 square miles of land area, it is the fifth-largest county by land area in the state. Montgomery County is adjacent to Washington, D.C., Arlington County, Virginia, Fairfax County, Virginia, Loudoun County, Virginia, Frederick County, Maryland, Howard County, Maryland, and Prince George's County, Maryland. Montgomery County is the most affluent and diverse⁵ jurisdiction in the state; based on the 2022 American Community Survey data, 34.1% of the county's residents are immigrants, and 43.2% of residents aged 5 years and over speak a language other than English at home, with 17.2% speaking Spanish. Although the overall poverty rate (7.0%) and the poverty rate for minors (6.3%) are below the state averages,⁶ the demand for services has increased, particularly for the county's most vulnerable individuals.

⁴ This image (Munetz and Griffin, 2006) is included for illustrative purposes only and may not be an exact representation of the local system.

⁵ The [2023 American Community Survey 1-year estimates](#) provide the following snapshot of racial and ethnic makeup: 41.8% white, 18.9% Black or African-American, 15.0% Asian, 0.7% American Indian and Alaska Native, 11.6% other race, 11.9% two or more races, 21.1% Hispanic or Latino of any race, and 39.4% White non-Hispanic.

⁶ See [2023 American Community Survey 1-year estimates](#) for additional details.

Coordination: In Montgomery County, the Local Behavioral Health Authority (LBHA) is located within the Department of Health and Human Services' (HHS) service area of Behavioral Health and Crisis Services (BHCS). Numerous programs within BHCS provide a range of behavioral health services for children, adolescents, adults, and older adults, including treatment services, crisis intervention, behavioral health support, assessments and referrals, case management, transitional psychiatry, and forensic-based services, among others. Approximately 230 employees work within BHCS, one of five service areas within HHS. The other four service areas include 1) Public Health; 2) Services to End and Prevent Homelessness; 3) Children, Youth, and Family Services; and 4) Aging and Disabilities Services. HHS employs over 1,600 staff across more than 120 distinct programs, serving over 100,000 Montgomery County residents annually. HHS was formed in July 1995 with the merger of four Montgomery County departments including the Department of Addiction, Victims, and Mental Health Services (DAVMHS), the Department of Family Resources (DFR), the Department of Social Services (DSS), and the Health Department.

Advisory boards and commissions guide the County Executive and County Council to identify specific needs in Montgomery County and review the County's efforts to address those needs. The County has 16 boards, committees, and commissions related to the work of HHS; these groups often include representatives from various community organizations and individuals with lived experience. The LBHA works closely with 2 commissions concerning behavioral health, the [Alcohol and Other Drug Abuse Advisory Council \(AODAAC\)](#) and the [Mental Health Advisory Committee \(MHAC\)](#). The [Interagency Commission on Homelessness \(ICH\)](#) advises the County Executive and County Council on matters influencing provisions of services, County government policies and procedures, development and implementation of State and Federal laws, and other issues affecting the lives, rights, and welfare of people experiencing homelessness in Montgomery County; the ICH also maintains a [homeless services guide](#) for public use.

The LBHA ensures access to, and delivery of quality publicly funded behavioral health services for individuals who live with mental health concerns and/or substance use disorders. The LBHA's target population includes individuals with behavioral health concerns who have active Medical Assistance, are eligible for Medical Assistance, or are uninsured and meet income limits. Additionally, the broader target population includes individuals of all ages who access publicly funded behavioral health services and reside in Montgomery County, Maryland.

As mandated by Section 10-10-1203 of the Health General Article of the Maryland Code and at the direction of the Secretary of the Maryland Department of Health (MDH), the LBHA reports directly to the Behavioral Health Administration (BHA), which is housed within MDH and oversees the delivery of all specialty (not offered through primary care) behavioral health

services to Medicaid recipients. HHS services are accessible in each region of the county: Down-County (four sites in Silver Spring), Mid-County (eight sites in Rockville), and Upcounty (one site in Germantown). The LBHA maintains a continuously updated public [LBHA Resource Directory](#) to promote resources to stakeholders and the community.

Housing and Homelessness Services: Residents may access programs and services designed to prevent or end homelessness. The U.S. Department of Housing and Urban Development (HUD) funds the Housing Choice Voucher Program (HCV or "Section 8") to provide rental assistance to income-eligible applicants, helping them access suitable housing or paying a portion of the monthly rent where the family currently lives; the current wait time is approximately 6.5 years for county residents. The local [Housing Initiative Program \(HIP\)](#) is designed to reduce the incidence of homelessness in Montgomery County by providing permanent supportive housing for those individuals and families that live in emergency or transitional shelters, are exiting an institution, or are sleeping unsheltered. [Montgomery County Coalition for the Homeless](#) advocates for and provides emergency shelter, permanent supportive housing through a combination of rental subsidy and supportive services, and access to [Coalition Homes](#) (an affiliate organization that develops and manages properties throughout the county specifically for people who are exiting homelessness).

Montgomery County residents experiencing homelessness can access multiple shelters across the county and in nearby Washington, D.C. Within the county, HHS assesses homeless families for service eligibility in one of the three Regional Service Centers, while homeless single adults can access shelter through day services and outreach services offered by the following organizations: City of Gaithersburg Homeless Assistance Program (Gaithersburg), Montgomery Avenue Women's Center (Rockville), Community Vision (Silver Spring), Hope Restored Inc. (Silver Spring), and [Bethesda Cares](#) (Bethesda).⁷ Montgomery County owns [Progress Place](#), a facility that offers services to the homeless population in the Silver Spring area through three programs: [Shepherd's Table](#), [Interfaith Works](#), and [Mobile Med](#).

To support individuals with disabilities including but not limited to diagnosed behavioral health conditions, the federal [Continuum of Care \(CoC\) Program](#) (24 CFR part 578) promotes a community-wide commitment to ending homelessness. Households experiencing homelessness with at least one disabled family member are eligible to access programs within the Montgomery County CoC through HHS; 387 [qualifying](#) Montgomery County households receive services through this grant. Within the Montgomery County CoC, Housing Stabilization Services (HSS) provides needs assessments, emergency financial assistance, and case management to help households maintain or obtain housing, prevent or restore utility disconnection, and move

⁷ Adult day services are community-based programs that are designed to meet the needs of functionally and/or cognitively impaired adults through an individual plan of care.

or store belongings. The following Montgomery County CoC programs provide financial assistance to eligible low-income residents: the [Rental Assistance Program \(RAP\)](#) for referred low-income individuals with disabilities or individuals aged 55 and older who are homeless (street/car/shelter) or at imminent risk of homelessness; the [Senior Assisted Living Subsidy \(SALS\) Program](#) for residents residing in local assisted living facilities; and the [Utility Assistance Program](#) for individuals requiring assistance with heating costs, electric bills, and water/wastewater bills. The Shelter Services Program provides outreach, emergency shelter, transitional housing, and permanent supportive housing. The program also offers case management to link clients to services, including housing referrals, treatment, employment, and entitlements. The current wait time for rapid and permanent rehousing programs is approximately 459 days.

Montgomery County LBHA maintains the SSI/SSDI Outreach, Access, and Recovery (SOAR) program to improve Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) application outcomes for adults experiencing homelessness and living with behavioral health conditions. The Social Security Administration and the Department of Disability Services have an agreement with HHS to expedite the review of SOAR applicants who are homeless or at risk of homelessness. This expedited review process boasts an 86% cumulative approval rate in Maryland. Currently, a dedicated state-funded SOAR case manager is housed at [EveryMind](#), a mental health provider currently contracted to offer several services in Montgomery County. HHS is reportedly increasing SOAR-trained staff to better meet the time-intensive demand of this valuable program; training is available to the public including behavioral health providers (notably community psychiatric rehabilitation programs and targeted case management), problem-solving court staff, and community volunteers.

Transportation: [Public transit](#) is available within and beyond the county via bus (Ride On and Metrobus), shuttle (Bethesda Circulator, Silver Spring VanGo, and Shuttle-UM University of Maryland), subway (Metrorail), and train (MARC, VRE, and Amtrak); access to these services varies by location. Another transportation option is [Flash](#), a planned bus rapid transit network with limited-stop bus service along nine routes; Flash currently operates on US Route 29 with expansion plans underway. Free and reduced fare programs also exist for qualifying individuals. Eligibility varies by transit modality, but specific programs exist for older adults, students, children, individuals with disabilities, and low-income individuals. The county operates an escorted transportation program for adults who qualify based on income and disability and other eligibility-based programs that cover taxicab fare. Additionally, residents can apply to the [Medical Assistance Transportation](#) grant program, which coordinates “last-resort” non-emergency medical transportation services for selected Medicaid recipients who reside within the county and need transportation to access medically necessary services. Community-based transportation services include the Senior Connection program, which

connects residents over age 60 with volunteer drivers, and transportation is also available on a limited basis through the following partners: Interfaith Works (Uber vouchers); Tree of Hope Association (bus passes and Uber rides); Office of the Public Defender (taxicab rides from the courthouse for release); recovery programs such as Alcoholics Anonymous and Narcotics Anonymous; and participating treatment centers.⁸

Veterans Services: The [Montgomery County Commission on Veterans Affairs](#) advises the County Executive and County Council on the status of programs and services related to the needs of Veterans; this commission maintains an electronic [Veterans directory](#) that includes services offered by the federal, state, and local government and non-profit agencies. EveryMind (mentioned on the previous page) also offers [ServingTogether](#), which uses technology and its partner network to guide Veterans, service members, and their families to the most appropriate services and resources available in the Greater National Capital Region.

The U.S. Department of Veterans Affairs (VA) has a main regional location at the Washington VA Medical Center in Washington, D.C., and several local clinics across the state. Veterans residing in Montgomery County can access primary and specialty healthcare, including mental health services, at the [Montgomery County VA Clinic](#) in Gaithersburg, a local community-based outpatient clinic (CBOC). The [Silver Spring Vet Center](#) offers confidential help for service members, Veterans, and their families at no cost in a non-medical setting. Vet Center services include individual and group counseling and linkage to the VA and the community. The Center does not share records with other VA offices, the U.S. Department of Defense (DoD), military units, or other providers except by permission or to avert a life-threatening situation. Nationally, all VA healthcare facilities offer same-day assistance for individuals with behavioral health needs. The [Steven A. Cohen Military Family Clinic \(“Cohen Clinic”\)](#) at Easterseals provides high-quality and accessible behavioral healthcare focused on post-9/11 Veterans, service members (including National Guard and Reserves), and their families. The Cohen Clinic’s services are available regardless of discharge status to individuals, couples, families, and children aged 4 years and older.

Montgomery County utilizes U.S. Department of Housing and Urban Development VA Supportive Housing (HUD-VASH) program vouchers. The HUD-VASH program pairs HUD’s housing choice voucher (HCV) rental assistance with VA case management and supportive services designed to help homeless Veterans and their families obtain permanent housing and access the health care, mental health treatment, and other supports necessary to help them improve their quality of life and maintain housing over time. Eligible Veteran families can also participate in the VA Supportive Services for Veterans and their Families (SSVF) Program, which provides individuals with case management and assistance in obtaining VA and other benefits

⁸ Tree of Hope Association is further described in the “Peer Services” section on page 21.

and time-limited payments to third parties that facilitate eviction prevention (EP) or rapid rehousing (RRH). Veterans experiencing or at risk of homelessness who are enrolled in HUD-VASH or SSVH-RRH can access the [Easterseals Homeless Veterans Reintegration Program \(HVRP\)](#), which assists with reintegration into the labor force.

Language Services: As previously mentioned, Montgomery County’s population is culturally and linguistically diverse. To address diverse language preferences, all government agencies can access interpretation and translation services through the current contractor, LanguageLine Solutions Inc. (866-874-3972). To provide more readily accessible and culturally sensitive interpretation services, many local agencies maintain multilingual staff and/or specialty translators. Additionally, the LBHA has deaf and hard of hearing grant funds for interpretation services available to PBHS outpatient mental health clinic (OMHC), residential rehabilitation program (RRP), and psychiatric rehabilitation program (PRP) providers.

Outreach and Education: Several phone lines are available to help residents access resources in the community. 211 Maryland (211) is a resource line that operates 24/7 connecting individuals across the State with referral specialists. MC311 Customer Service Center (311; 240-777-0311 outside the county; 711 for MD Relay) is the county’s source for non-emergency government resources with availability Monday through Friday from 7 a.m. through 7 p.m. Public spaces like shelters, schools, and libraries are ideal locations for outreach efforts given that individuals often first seek assistance within the community. Successful initiatives targeting food insecurity and harm reduction are reportedly underway across the county. See Figure 1 on page 16 for a visual representation of person-centered care in Montgomery County.

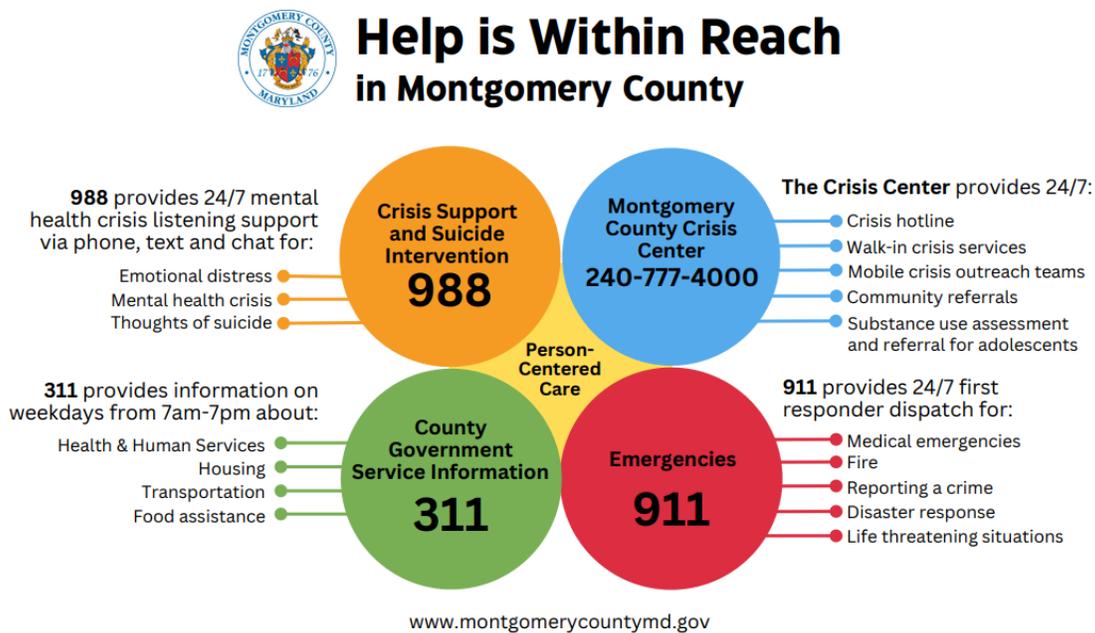
Many residents in need of behavioral healthcare present to primary care providers, specialty care providers, or federally qualified health centers (FQHCs). The [Primary Care Coalition \(PCC\)](#) is a 501(c)(3) that aims to provide a continuum of care for people who are uninsured or underinsured, have limited financial resources, and experience health inequities or barriers to achieving healthy lives. The PCC manages the Nexus Montgomery Regional Partnership (“Nexus Montgomery”) portfolio as well as programs including Montgomery Cares. [Nexus Montgomery](#) is a hospital-led collaborative focused on reducing hospital use by connecting people to community-based care and support services. [Montgomery Cares](#) is a public-private partnership comprising 11 independent safety-net primary care clinics, six hospitals, HHS, the PCC, volunteer health practitioners, and other community-based organizations. Approximately 2,600 individuals are served annually through Montgomery Cares’ mission to provide high-quality, efficient, accessible, equitable, and outcome-focused health services including crisis care and medications for opioid use disorder (MOUD) to low-income, uninsured adults in Montgomery County. Participating providers also offer co-located behavioral health services (including telehealth) within primary care.

Service agencies are uniquely well-suited to coordinate efforts that support vulnerable populations. The Community Action Agency (CAA) housed within HHS coordinates a spectrum of social and economic mobility services. For example, the CAA operates the [Takoma East Silver Spring \(TESS\)](#) Community Action Center, a walk-in site providing information and referrals, social service assistance, interpretation and translation, education, Volunteer Income Tax Assistance (VITA), and legal services in partnership with nonprofits, public agencies, and community groups.

Community education regarding the signs and symptoms of mental illness and how to access help can assist with early detection, stigma reduction, and linkage to services. For example, the Mental Health Association of Maryland offers a monthly Mental Health First Aid (MHFA) class that teaches the skills to respond to the signs of mental illness; this evidence-based class is free for Maryland residents

Figure 1

Person-Centered Care in Montgomery County



Note. The graphic illustrates how person-centered care is coordinated between community services and public safety in Montgomery County.

Primary, Long-Term, and Recovery Services

The Montgomery County Department of Health and Human Services (HHS) coordinates mental health and substance use programs for county residents who are Medicare and Maryland Medicaid recipients. [Access to Behavioral Health Services \(“Access”\)](#), a program within HHS,

offers telephone and walk-in screening and referral services including assessment, linkages, brief counseling, and case management for low-income adults living in the county without commercial insurance. For uninsured individuals requiring a bridge to behavioral healthcare, all local providers can submit exception requests to the LBHA for most substance use and/or mental health services, except intensive outpatient (IOP) services; notably, this option is not available for outpatient mental health clinics (OMHCs) that operate in spaces regulated by the Health Services Cost Review Commission (HSCRC). Uninsured and uninsurable individuals can seek services through Montgomery Cares partners. Residents without home computer access reportedly utilize providers, community partners, and local libraries to participate in virtual behavioral health appointments.

Two care models have been empirically shown to improve early identification and treatment outcomes for mental health conditions. The [collaborative care model](#) addresses common conditions such as anxiety and depression in primary care through screening and immediate access to a behavioral health specialist and a consulting psychiatrist. [Coordinated specialty care for early psychosis](#) is a model that utilizes a multidisciplinary team to provide comprehensive care following a first episode of psychosis, including mental healthcare, vocational and educational support, family education and support, care management, and peer support.

Mental Health Services: Many agencies in Montgomery County are operating outpatient mental health clinics (OMHCs) that serve adults.⁹ When necessary, residential rehabilitation program (RRP) services that support the transition to independent housing are available in the county through [Cornerstone Montgomery](#), [Sheppard Pratt](#), and the [Rock Creek Foundation](#). Any mental health or substance use treatment professional, with or without licensure, may make referrals to Montgomery County LBHA, which manages the waitlist. The wait time varies considerably depending on the level of care requested, specialty needs, and the referral source. Integrated behavioral health programs that provide outpatient services that address both mental health and substance use issues are available through various providers including [Vesta](#) (Germantown and Silver Spring locations) and Torch Treatment Center/[Elevate Recovery Centers](#) (Silver Spring location).

Psychiatric medication assistance programs are available to county residents through [Bethesda Cares](#), [Medbank](#), and the LBHA. Bethesda Cares assists people experiencing homelessness, while Medbank connects low-income county residents who are uninsured or underinsured with free medications from pharmaceutical organizations through the patient assistance program.

⁹ Although the number of service providers fluctuates, records at the time of the workshop indicate 29 agencies in Montgomery County operating outpatient mental health clinics (OMHCs) that serve adults including one that specifically serves adults aged 65 and older.

Several housing programs specifically target individuals living with mental illness. [Projects for Assistance in Transition from Homelessness \(PATH\)](#) is a grant-funded outreach program provided through the Access program for county residents with mental health diagnoses (and possibly co-occurring substance use concerns) who are homeless or at risk of becoming homeless; this program accepts all referral sources including self-referral, providing outreach and case management, advocacy efforts, and assistance with applying for housing and Supplemental Security Income (SSI). [Housing Unlimited Inc. \(“Housing Unlimited”\)](#) is a local 501(c)(3) that promotes community integration and independence for individuals in mental health recovery by providing permanent independent scattered-site supportive housing for over 150 extremely low-income adult residents. Sheppard Pratt offers affordable permanent shared housing for adults with serious mental illness with a minimum monthly income of \$400 and a demonstrated ability to independently manage finances and successfully manage a medication regimen. Furthermore, Consumer Support, a grant from the Behavioral Health Authority, is a safety net service available to individuals actively engaged in the Public Behavioral Health System; eligible applicants with mental health disorders with or without substance use disorders can request up to \$1,000 per fiscal year to assist with rent, mortgage, and/or utility arrearages when all other resources have been denied.

Vocational services for young adults/transitional age youth (TAY) living with mental illness are available through Cornerstone Montgomery’s TAY program and Sheppard Pratt’s job training and employment programs. Adults seeking supported employment services can access programs through Cornerstone Montgomery, the Rock Creek Foundation via the Santé Group, and [Vocational Support Systems \(VSSI\)](#).

Substance Use Treatment Services: For people who use drugs, Montgomery County HHS operates a harm reduction program in Rockville that offers syringe services, naloxone, fentanyl test strips, wound care supplies, sexual health supplies and education, HIV testing, and referrals. Harm reduction services are provided anonymously to the public every Tuesday, Thursday, and Friday from 10 a.m. through 4 p.m. and on Wednesdays from 1 p.m. through 7 p.m.

Residents in need of early intervention services have access to DUI education as well as assessment and education for people at risk of developing a substance use disorder. At the time of the workshop, four resources offer DUI classes, six offer at-risk assessment and education services, and 18 offer a combination of both.

There are currently three medication-assisted treatment (MAT) providers with a total of four locations across all three regions of the county.¹⁰ There are 25 distinct providers of ASAM Level

¹⁰ MAT is the use of medications in conjunction with counseling and behavioral therapies for the treatment of substance use disorders. The U.S. Food and Drug Administration has approved three medications for MAT of opioid use disorder: methadone, buprenorphine, and extended-release naltrexone. Sublocade is an injection of

1 (outpatient/OP) services in Montgomery County; two OP providers also offer integrated behavioral health programs as described above. Of the 25 Level 1 providers, 16 also provide Level 2.1 (intensive outpatient/IOP) services along with five additional providers for a total of 21 providers. Of the 21 Level 2.1 providers, three provide Level 2.5 (partial hospitalization/PHP) care along with one additional provider for a total of four Level 2.5 providers. See Table 1 on page 20.

For individuals requiring residential treatment services, Maryland Treatment Centers (MTC) operates four programs. MTC Avery House provides Levels 3.1 (clinically managed low-intensity residential) and 3.3 (clinically managed population-specific residential) treatment for women aged 18 and older including pregnant/postpartum women and women accompanied by up to two children aged 12 and under. For adults aged 18 and older, MTC Lawrence Court Halfway House offers Level 3.1 care, while MTC Avery Road Combined Care offers Level 3.3 and 3.5 (clinically managed high-intensity residential) care. [The Valley](#) provides Level 3.5 care at three locations, two of which also provide Level 3.1 care. MTC Avery Road Treatment Center (“Avery Road”), which serves adults aged 18 and older, is the only Level 3.7 (medically monitored residential) care provider that accepts Medicaid. See Table 1 on the following page.

State Care Coordination services are designed to help individuals remain engaged in their recovery and to promote independence and self-sufficiency. Maryland State Care Coordinators are based in each jurisdiction at the county health departments. State Care Coordinators receive referrals from residential programs while patients are in treatment and assist with the transition into the recovery community by providing linkages to community/faith-based services and other human services organizations. Maryland Treatment Centers is contracted to provide Maryland State Care Coordination to eligible county residents, i.e. clients receiving Levels 3.3, 3.5, and 3.7 residential treatment supported by BHA funding. For individuals receiving Maryland State Care Coordination, Maryland Recovery Net (MDRN) is an \$8,000 grant from the Behavioral Health Administration that provides up to \$1,000 per client per fiscal year to individuals actively engaged in fee-for-service substance use disorder treatment through the Public Behavioral Health System and enrolled in Maryland State Care Coordination. MDRN client support funds are intended to assist in achieving treatment goals and can be applied to an array of services including pharmacy, transportation, employment services, vital records, medical/dental services, and other unmet needs. Funding is retroactive (i.e., for reimbursement) only and requires a completed request for client support form and receipt or invoice; MDRN housing funds are available to MDRN-qualified residents of certified recovery housing.

buprenorphine; Suboxone is an oral buprenorphine/naloxone combination medication. Vivitrol is an injection of naltrexone.

Recovery housing for Montgomery County residents is available but limited. Many Montgomery County residents utilize alternative (non-certified or self-run) sober living arrangements. Non-certified housing options include Oxford House, Stepping Stones Recovery House, and the Clubhouse of Damascus. Maryland Wellness and Recovery clients enrolled in PHP or IOP are eligible to participate in a fee-for-service community housing program composed of six houses with eight beds each; participants can stay for up to six months during their treatment, receiving peer support and case management. Currently, there are only four certified recovery residences within the county. While [Mike’s Place](#) and [Sandstone Care](#) only accept men, Great Compassion Ministries Inc. and Potomac Pathways accept men and women. Of the four recovery residences, three serve young adults; Great Compassion Ministries Inc. is the only option for the rest of the adult population. See Table 1 below.

Table 1

American Society of Addiction Medicine (ASAM) Criteria Continuum of Care in Montgomery County

ASAM Criteria Level of Care	Providers (#)
Recovery Residence ¹¹	4
Level 1 (Outpatient)	24
Level 2.1 (Intensive Outpatient, IOP)	25
Level 2.5 (High-Intensity Outpatient, HIOP)	9
Level 3.1 (Clinically Managed Low-Intensity Residential)	2
Level 3.3 (Clinically Managed Population-Specific Residential)	1
Level 3.5 (Clinically Managed High-Intensity Residential)	2
Level 3.7 (Medically Managed Residential)	2

Note. *This table illustrates the number of distinct providers in Montgomery County providing adult addiction treatment at the time of publication. Released in October 2023, the fourth edition of the ASAM criteria includes updates to the continuum of care but still retains four whole number treatment levels (1-4) with decimals to express further gradations of intensity and types of care provided. Although ASAM criteria have been updated, the Code of Maryland Regulations (COMAR) reflecting the new distinctions in levels of care have not been finalized as of the date of this report. As such, the county’s resource directory does not yet identify providers of Level 2.7 (Medically Managed Intensive Outpatient) services or subdivide Level 1 care. (For reference, Level 1.5 refers to outpatient therapy, Level 1.7 refers to medically managed outpatient, and the newly-added Level 1.0 refers to long-term remission monitoring.)*

Case Management and Assertive Community Treatment: [The Social Security Act](#) defines case management as services that assist eligible individuals in accessing medical, social, educational,

¹¹ Only certified recovery residences are noted here.

and other services. Case management is available through four agencies and/or programs: the Neighborhood Safety Net program at Sheppard Pratt, the Jewish Social Service Agency, Pathways to Housing, and HHS Mental Health Services Projects Assisting Transition from Homelessness (PATH). Targeted case management (TCM) is a type of case management for certain groups of people, like those with chronic illnesses or developmental disabilities. TCM can involve more frequent contact, longer-term support that can last for years, and coordination across multiple areas of life; individuals can self-refer or be referred by non-professionals such as family members. Targeted case management (TCM) is provided by three agencies: Volunteers of America Chesapeake, Vesta, and CRI.

Assertive community treatment (ACT) is a client-centered, community-based mental health service model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most severe and persistent mental illnesses and have not benefited from traditional outpatient programs. Community providers refer clients to ACT teams that work with clients in their homes, neighborhoods, and community locations, providing on-call phone support 24 hours a day, 7 days a week. There are currently five ACT teams in the county for high-risk, high-needs individuals; [People Encouraging People \(PEP\)](#) and Cornerstone Montgomery operate two each, and Pathways to Housing operates one. Caseload capacity and enrollment by team (illustrated as a fraction within parentheses) are as follows: PEP North team (81/100), PEP South/FACT team (87/100), Cornerstone Montgomery Upcounty team (78/100), Cornerstone Montgomery Down-county team (74/100), and Pathways to Housing (65/80).

Peer Services: Several dedicated organizations provide peer support in Montgomery County. [NAMI Maryland](#) provides education, support, and advocacy for persons with mental illnesses, their families, and the wider community; the local chapter, [NAMI Montgomery County](#), offers free, peer-led support groups such as Connection Recovery Support Group for adults with mental health conditions and Family Support Group for adult family members, significant others, and friends. The following peer support groups operate in the community: [Washington Area Intergroup Association of Alcoholics Anonymous](#), Narcotics Anonymous, Al-Anon Family Groups, and Nar-Anon Family Groups, [Depression and Bipolar Support Alliance](#).

Through funding from the Maryland Behavioral Health Administration, a network of peer-led wellness and recovery centers (WRCs) are operated across the state as part of the Maryland Public Behavioral Health System (PBHS) continuum of care. WRCs offer resources, socialization, and activities within the context of a community of peer support. [The Santé Group's Silver Spring Wellness and Recovery Center](#) is a WRC serving adult residents with a history of mental health conditions; the county is currently soliciting the grant for the second county WRC that was previously contracted through Common Ground by Sheppard Pratt.

[Tree of Hope Association \("Tree of Hope"\)](#) is a local 501(c)(3) volunteer-run organization that provides group and one-on-one peer mentoring, peer training, and social integration programming for people new to recovery. Tree of Hope relies in part on private foundation funding to assist with transportation and housing. Tree of Hope receives referrals from treatment centers, shelter systems, and local government agencies, as well as the Stop, Triage, Engage, Educate, and Rehabilitate (STEER) program. Peer recovery specialists are also embedded in the 24/7 mobile crisis outreach teams (MCOTs) discussed in more detail below.

Urgent and Acute Services

Hotlines/Warmlines: Montgomery County residents can access various national hotlines and warmlines. The 988 Suicide and Crisis Lifeline (988), operated by EveryMind in Montgomery County, is available 24/7 by call, text, or web-based [chat](#) with a goal of live response within 25 seconds; an option for video chat is available for individuals who communicate through sign language. The Veterans Crisis Line and Military Crisis Line are available 24/7 regardless of VA enrollment to military-connected individuals and their loved ones; services are available by call (988 option 1), text (838255), or web-based chat. The Crisis Text Line can be accessed 24/7 by texting “home” (or “ayuda” for services in Spanish) to 741741 or via WhatsApp. The National Domestic Violence Hotline (800-799-7233) is also available 24/7 by call, text, or chat. The NAMI HelpLine (800-950-NAMI), is a free, nationwide peer-support warmline accessed by call, text, or chat between 10 a.m. and 10 p.m.

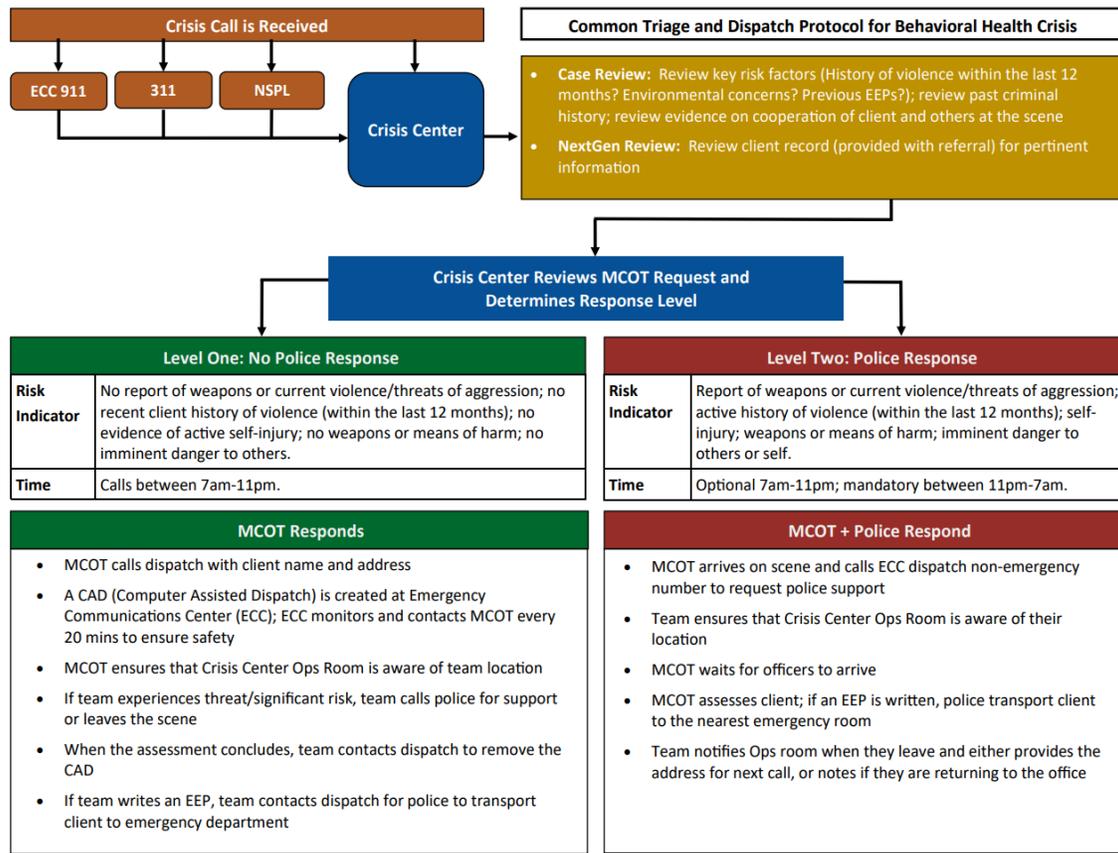
Montgomery County residents also have access to local hotlines and warmlines. The [Montgomery County Crisis Center](#) (“Crisis Center”) within HHS provides free crisis services 24/7/365 by telephone (240-777-4000) or in person at the walk-in facility in Rockville. [EveryMind](#) (301-738-2255), which operates 988 in Montgomery County, also provides free and confidential supportive listening, resource referrals, and crisis intervention (including suicide assessment) 7 days a week via telephone (24-hour coverage), text (8 a.m. - 12 a.m.), and chat (8 a.m. - 12 a.m.). Beginning in fiscal year 2025, EveryMind will have two dedicated positions for follow-up and outreach to connect appropriate consumers with substance use disorder treatment.

Mobile Crisis Services: Mobile crisis services provide no-cost, immediate, on-site behavioral crisis intervention and debriefing services (supportive, crisis-focused discussion of a traumatic event) for community members experiencing severe situational, emotional, or behavioral crises. The local mobile crisis provider for the county is the Crisis Center, which operates a 24/7 mobile crisis outreach team (MCOT). Responding MCOTs provide full crisis assessments and treatment referrals; however, MCOTs do not have transport capacity. While on-scene co-response with law enforcement has been the model in the county for decades, the current MCOT protocol involves

a fully civilian response by a clinician and a peer for calls with a low risk of violence (see Figure 2 below).

Figure 2

Common Triage and Dispatch Protocol for Behavioral Health Crisis



Updated February 2022

Note. This graphic illustrates how protocol determines the criteria for two levels of crisis response: (1) civilian response, and (2) co-response with police.

Given that approximately 5% of county calls that initially receive a civilian response escalate to require a law enforcement response, the county is integrating its Montgomery County Police Department CIT Team (discussed below) and MCOT into a cohesive mobile response strategy. Calls will be triaged and handled via one of three options: (1) MCOT response, 2) separate responses from MCOT and MCPD patrol officers, or (3) a co-response by a CIT Team officer and a clinician in the same vehicle. Implementation of this tiered response strategy is pending.

Crisis Receiving and Stabilization Facilities: [Announced](#) on March 8, 2024, by Governor Wes Moore, the Maryland Department of Health has awarded \$13.5 million in grants to 19

jurisdictions across the state to help promote health equity and improve access to behavioral health crisis services for Marylanders; among other projects, this funding is designated to establish a behavioral health crisis stabilization center in Montgomery County.¹² The county's current plan for this project involves using state-braided funds to develop a facility capable of serving 45 individuals with behavioral health needs who require either a discharge or hospital diversion plan. This population includes individuals transported by first responders, diverted by hospitals, released from detention, released from courts, or released from incarceration; triage by law enforcement or the Crisis Center may be required, but that has not yet been established. This center is projected to open in 2027. The project may seek philanthropic support, hospital contributions, and county funding to promote sustainability.

In addition to operating a local hotline and the MCOT discussed above, the Crisis Center provides crisis services at its walk-in facility located in Rockville. Between the MCOT and the walk-in facility, approximately 5,000 consumers are served annually. Services are available 24/7 to all ages and include full crisis assessments and referrals to options including ACT and residential treatment as needed. The Crisis Center Stabilization Room composed of four recliners is available for brief stays of up to 23 hours; the Stabilization Room is an allowable behavioral health transport destination for fire/EMS and voluntary law enforcement transport.¹³ Since the workshop, MDH has provided funding for the Crisis Center's Stabilization Room to stay in operation and expand to eight recliners to serve the lifespan to meet recently finalized COMAR regulations.

Residential crisis services (RCS) are short-term mental health treatment and support services in a structured environment for uninsured or PBHS-insured individuals who require 24-hour support due to a psychiatric crisis. RCS programs are intended to prevent psychiatric inpatient admission, shorten the length of inpatient stay, effectively utilize hospital emergency departments, and provide an alternative to psychiatric inpatient admission. The Crisis Center maintains four on-site co-located residential crisis beds; RCS admissions typically start at 10 days but can be extended to 30 days as clinically warranted. Additional RCS programs are available through Cornerstone Montgomery (capacity of 16), [Safe Journey House](#) (capacity of eight), and Sheppard Pratt WayStation residential crisis program (capacity of 16).

The Nexus Montgomery Regional Partnership ("Nexus Montgomery") provides emergency department and/or inpatient psychiatric care at Adventist Health Care ("Adventist Health Care," locally known as "Shady Grove"), Adventist White Oak Medical Center ("White Oak"), Holy Cross

¹² Crisis stabilization programs offer short-term "sub-acute" care for individuals who need support and observation, but not hospital-based acute care in the emergency department or inpatient care.

¹³ The Crisis Center Stabilization Room is not an allowable destination for involuntary transport for emergency evaluation petitions (EEPs) at this time; EEPs are discussed in more detail within the "First Responders" section on the following page.

Hospital (“Holy Cross Silver Spring”), Holy Cross Germantown Hospital (“Holy Cross Germantown”), Johns Hopkins Suburban Hospital (“Suburban”), and MedStar Montgomery Medical Center (“MedStar”). Psychiatric licensed inpatient capacity is as follows: White Oak (0), Holy Cross Silver Spring (0), Holy Cross Germantown (voluntary only; 6 adult beds; 0 pediatric beds), MedStar (voluntary only; 9 adult beds; 5 adolescent beds), Suburban (24 adult beds with admission for 16- and 17-year old patients on a case-by-case basis), and Adventist Health Care (133 licensed beds with staffed capacity of 91; 103 adult beds with staffed capacity of 73; 30 adolescent beds with staffed capacity of 18). If a given inpatient psychiatric unit is full, referrals can be provided to other inpatient units; if all units are full, patients can be referred out of county.

Trauma services and victim assistance are provided via the HHS Abuse Intervention Program and the Victim Assistance and Sexual Assault Program (VASAP); both programs provide linkages, advocacy, counseling, support, and compensation services to Montgomery County crime victims and their families/significant others.¹⁴

First Responders

Organization: Montgomery County emergency communications (911) for police, fire, and EMS are handled through one public safety answering point (PSAP) which links calls to appropriate dispatchers for the various first responder agencies. All 911 calls are vetted via a comprehensive protocol system for emergency call-taking that includes a structured, standardized script and procedures; approximately 70% of calls screened for behavioral health concerns result in the dispatch of first responders due to the potential for harm to self or others.

The [Montgomery County Police Department \(MCPD\)](#) serves as the lead law enforcement agency for the county. The Patrol Services Bureau oversees most of MCPD’s uniformed officers on patrol; the Patrol Services Bureau is divided into six police districts: Rockville (1st District), Bethesda (2nd District), Silver Spring (3rd District), Wheaton (4th District), Germantown (5th District), and Montgomery Village (6th District). The [Montgomery County Sheriff’s Office](#) provides law enforcement services for the judicial system. Municipal agencies include the Gaithersburg Police Department, Rockville City Police Department, Takoma Park Police Department, and Chevy Chase Police Department. Maryland State Police maintains [Barrack N](#) in Rockville.

The [Montgomery County Fire Rescue Service \(MCFRS\)](#) is a combination system of nearly 2,700 volunteer and career responders that handles over 120,000 emergency calls for service

¹⁴ In the context of substance use concerns, the term “abuse” only appears in this document when quoting an existing proper name; this document uses the terms “use” or “misuse” as recommended by the [National Institute on Drug Abuse](#).

annually. MCFRS has maintained the prestigious status as an accredited agency by the Commission on Fire Accreditation International since 2007. MCFRS provides oversight to two rescue stations and 40 fire stations county-wide.

Training: Efforts are underway to provide behavioral health and crisis intervention team (CIT) training to first responders in Montgomery County. Of the 140 emergency dispatch staff, 124 (89%) have completed the eight-hour CIT course. All officers receive entry-level instruction on responding to behavioral health calls through the academy curriculum as well as continued education mandated through the Maryland Police and Correctional Training Commission. All county law enforcement agencies are striving for 100% of officers to be CIT-trained. The Montgomery County Sheriff's Department, which is authorized 155 deputies, currently employs 134 fully sworn deputies; 55 deputies have attended the full 40-hour CIT training, and 100% have received an introduction to CIT. MCPD's revamped CIT program includes a 40-hour training provided through the Crisis Center; with approximately 850 officers trained, the department is more than halfway to the county's target of 100%.

Response: Effective Law Enforcement for All Inc. (ELEFA) partnered with local officials, the MCPD, the Reimagining Public Safety (RPS) Task Force, and residents to audit county public safety programs and provide recommendations; of note, a section about mental health response is included in the [final report](#).

At any given time, 600 MCPD patrol officers are serving over one million county residents; the approximately 7,000 mental health calls cleared last year underscore the demand behavioral health needs place on law enforcement. To address this obligation, MCPD has reimagined its CIT program by dividing it into two complementary programs that have been successfully operating for over a year and a half: the CIT team and the Behavioral Assessment and Administration Unit. To respond to in-progress situations, MCPD staffs the CIT team with five full-time CIT officers who respond to 911 calls for service across all six districts in "soft" uniforms with a less tactical aesthetic. The CIT team is responsible for calls involving suicidal intent, physical violence, SWAT call-outs, barricades, or calls for special assistance by a patrol officer; these officers also oversee victim reunification centers. For responses that do not involve active situations, the Behavioral Assessment and Administrative Unit provides follow-up and community threat assessment. Two sworn officers dedicated to serving individuals on the autism spectrum and a third sworn officer dedicated to serving individuals with behavioral health needs comprise this unit that identifies and serves the top 1% of high-need consumers including those with chronic mental health needs and those who are considered a danger to public safety. This unit meets consumers in the field in civilian uniforms to identify needs and provide linkages to care, working closely with HHS and first responder counterparts in MCFRS.

A petition for emergency evaluation (often referred to as a petition, an emergency petition/EP, or an emergency evaluation petition/EEP) initiates an emergency psychiatric evaluation due to the belief that an individual is a danger to themselves or others. In 2023, 1,641 of these petitions (locally referred to as EEPs) were executed. Anecdotally, trends indicate that these numbers are increasing; the current total for 2024 at the time of the workshop is 393. Extreme risk protective orders (ERPOs) are often issued in conjunction with EEPs; ERPOs, often referred to as “red flag laws,” are court orders that temporarily require a person to surrender any firearms or ammunition to law enforcement and not purchase or possess firearms or ammunition. Approximately 30 ERPOs are executed annually in the county. The ERPO process varies; the Special Victims Investigations Division handles all domestic-related incidents while all others are handled by the Criminal Investigations Division. The department intends for the Behavioral Assessment and Administrative Unit to oversee all ERPOs once fully staffed.

Efforts to meet the needs of residents with behavioral health needs extend beyond law enforcement agencies. The Montgomery County Fire Rescue Service (MCFRS) established the Montgomery County Non-Emergency Intervention and Community Care Coordination initiative to connect high utilizers to existing medical/social programs within their communities. Housed within the Division of Operations and overseen by the Emergency Medical and Integrated Healthcare Services (EMIHS) section, this initiative has been renamed to highlight its key strategy: mobile integrated health (MIH), a national care-delivery model using patient-centered, mobile resources in the out-of-hospital environment. MIH strives to avert unnecessary ambulance transports, emergency department visits, and hospital admissions/readmissions, while ultimately improving patient outcomes for highly vulnerable residents with chronic needs. The MIH team is composed of two full-time paramedics, a registered nurse (RN), and a currently open position for a certified social worker - clinical (LCSW-C); the RN and LCSW-C positions reside within HHS adult protective services program but are detailed full-time to MIH. Leveraging existing interagency partnerships with HHS, local hospitals, and a variety of public and private care providers, MIH links high-need consumers to programs most appropriate to treat their conditions while preserving emergency response capacity. As a result, call volumes for EMS services among the highest users of EMS services have reduced significantly. Clients are identified to participate in this free program by fire/EMS data surveillance or referred by hospital partners; the MIH program has served over 70 vulnerable residents to date, the majority of whom have chronic behavioral health needs.

The Stop, Triage, Engage, Educate, and Rehabilitate (“STEER”) program is a drug treatment linkage program that aims to provide rapid identification, deflection, and access to treatment for people who use drugs.¹⁵ Originally intended as a diversion program embedded within MCPD to provide an alternative to conventional arrest, the STEER program has evolved and now

¹⁵ The term “deflection” is used to indicate community-based pre-arrest diversion.

operates more as an overdose response program in which peers offer support and linkage to treatment after a call for service. While there has been a decrease in the number of MCPD referrals to STEER, the program anticipates providing training and education to MCPD, MCFRS, and emergency department (ED) personnel on STEER practices and procedures with at least eight training workshops to be provided to local police departments in fiscal year 2025. Data from the fiscal year 2024 reports a total of 2,463 STEER-coordinated responses.¹⁶

Data Collection and Sharing

Given that most services in the county are grant-funded, much of the relevant data is collected and maintained by grant management. Most data sharing occurs within the local health department, although the LBHA engages in outreach events with outside stakeholders.

Data platforms facilitate data sharing across agencies. Community ServicePoint (CSP) is a web-based data collection tool by WellSky adopted by Montgomery County to meet Congress' mandate of maintaining a homeless management information system (HMIS); HHS is the HMIS implementing organization. In 2005, HUD chose 80 communities nationwide including Montgomery County to participate in an HMIS pilot, intending to produce the first Annual Homeless Assessment Report (AHAR); this initiative has resulted in AHAR reports annually through 2023. Additionally, Chesapeake Regional Information System for our Patients Inc. (CRISP), a database that facilitates the sharing of health information among doctors, hospitals, labs, and other healthcare organizations, provides safer, more efficient patient-centered care for individuals who do not opt out and whose providers participate; CRISP also prevents duplication and diversion of medication. MIH program information is reflected in CRISP, facilitating information sharing with emergency departments regarding MIH's high-frequency, high-need participants.

Per the Montgomery County Open Data Act (Montgomery County Code §§ 2-152 – 159), the [dataMontgomery](#) website operates as a platform dedicated to making county public data freely available in an open and consumable format to promote transparency, accessibility, and efficiency. Through the end of the fiscal year 2022, Montgomery County has published over 371 datasets on the dataMontgomery website; these datasets include police 911 computer-aided

¹⁶ Other notable data points include: 595 unduplicated individuals served, 473 new individuals enrollments, 433 individuals screened/assessed, 419 individuals determined eligible, 390 total participants who received STEER model educational training and supports, and 440 overdose referrals.

dispatch (CAD) calls for service, allowing for analysis of behavioral health calls for service including initial type, close type, and disposition.¹⁷

INTERCEPT 0/1 GAPS

Community Services

Coordination: Concerns raised during the workshop can be organized into the following three coordination objectives: (1) improving transparency, (2) streamlining existing efforts, and (3) expanding partnerships. Transparency relies on standard definitions and consistent, accessible language, which are increasingly challenging as the definition of crisis and the crisis continuum are evolving. Streamlining involves consolidating and connecting existing councils/boards/committees to eliminate information silos, improve efficiency, and prevent duplicative efforts. Partnership expansion calls for the community to leverage existing connections to widen resource promotion within and across intercepts, ensuring that the resources and the criteria for access are readily available when and where assistance is requested; for example, clients of the Office of the Public Defender may request assistance with transportation, housing, and funds, demonstrating the importance of integration between community services and legal services. Reportedly, reliance on partners like Tree of Hope to serve as intermediaries slows the process of connecting individuals to needed services and support. Coordinating councils and multidisciplinary groups such as the Primary Care Coalition (PCC) have demonstrated effectiveness and could be expanded or replicated as appropriate to meet the three objectives. The PCC in particular is acknowledged as an underutilized resource that can facilitate collaboration.

Evaluation, a central component of systems management, is one area the community would like to improve to inform all three coordination objectives. Participants report a disconnect between intent and implementation in various programs; evaluation is necessary to determine impact and inform strategic planning. Without proper evaluation, community members question if there is a lack of resources or instead a misappropriation of existing resources compounded by barriers to access. For example, eligibility requirements based on factors such as age and history fail to address privilege and social determinants of health; vulnerable populations may be disproportionately affected by these requirements, but without evaluation, the impacts are speculative.

¹⁷ To review the “Police Dispatched Incidents” dataset, please see: https://data.montgomerycountymd.gov/widgets/98cc-bc7d?mobile_redirect=true. Behavioral health calls are typically coded as “Check Welfare” in the “Initial Type” and “Close Type” columns or as “Mental Transport” in the “Disposition Desc.” column.

The community shares a commitment to address the needs of vulnerable residents, but a shared optimism is necessary to address barriers to communication and collaboration. Participants emphasize their desire to focus on possibilities when exploring solutions. Further, the deeply ingrained communication pathways that exist within and between agencies and organizations fuel reluctance to identify barriers candidly; workshop participants express a history of being chastised for attempting to highlight areas for improvement or to advocate for legislative change. The community must encourage honest communication and create a safe and inclusive environment where stakeholders and community members feel comfortable sharing their ideas and concerns; trust and rapport are essential for effective collaboration.

Housing and Homelessness Services: Housing is a significant concern for Montgomery County stakeholders. Gaps in housing services are discussed in detail within the [“Parking Lot”](#) section.

Transportation: Transportation is an obstacle for many residents, particularly those who reside outside of the urban southern portion of the county. The existing transportation is inaccessible geographically and/or financially for many consumers. Given the shortage of services in the Upcounty region, the lack of public transportation from that region to the services elsewhere only serves to compound the barriers to community services. While the county has innovatively addressed gaps by utilizing the support of local partners such as Tree of Hope when possible, the funds for these organizations are limited.

Language Services: Strategies that address the language access needs of diverse and non-English language preference (NELP) consumers would improve person-centered care in various settings. Written material such as websites, printed resources, and vital documents must be available in multiple languages; effective and inclusive interpretation and staff training to effectively engage and assist individuals with diverse language preferences are essential. It is particularly important to note that while there is reported heavy reliance on Google Translate, court orders cannot be translated using Google Translate due to formatting incompatibility.

Outreach and Education: Education is a valuable tool for improving the wellness of residents. Partnerships can be leveraged to expand resource promotion and harm reduction strategies to existing community resources such as libraries and faith organizations to maximize accessibility and ensure that all populations are being reached. Stakeholders express a desire to target implicit bias and stigma in the workforce and the community through programs like [Just Five](#), an online, self-paced program that intends to raise awareness, reduce stigma, and provide education about addiction prevention and treatment. The community also seeks to promote understanding of the difference between availability and eligibility; for example, stakeholders note that the requirements for inpatient mental healthcare are a regular source of confusion, and the resulting frustration erodes trust between professionals and the community. Advocacy also plays a powerful role in community development. Barriers to accessing and fully utilizing

insurance can be addressed by consumer health advocacy while legislative efforts are underway to address county, state, and federal obstacles such as voucher requirements, medication access challenges, mental health coverage policies, and stigma. The creation of an Office of Consumer Affairs within the county could elevate and prioritize consumer voices. Connections with national, state, and local advocacy groups such as NAMI, On Our Own of Maryland Inc., and Shatterproof can involve individuals in advocacy on a broader scale. Stakeholders are encouraged to engage with government representatives given the expressed commitment of representatives in attendance to addressing the issues facing the community; at the same time, legislators can elicit open and honest feedback by acknowledging and actively dismantling the rigid communication pathways mentioned above that impede professional and community trust and engagement.

Primary, Long-Term, and Recovery Services

It is important to note that not all people who use drugs need or are ready to enter treatment; for that population, awareness of harm reduction services is invaluable. While the community reports successful harm reduction efforts, workshop participants express a need for increased promotion of efforts. For those who are ready for treatment, obtaining behavioral health services is challenging in terms of professional availability and physical access to providers. Many services have been curtailed due to the Covid-19 pandemic, and the resulting lengthy waitlists for services are a source of frustration for individuals and families. Medicaid-eligible and low-income population health professional shortage area designations have been given to portions of Montgomery County for primary care and mental health disciplines. These shortages decrease the likelihood of early screenings; stakeholders specifically note the lack of assessment and care for fetal alcohol syndrome and neuro-informed behavioral health treatment. As previously mentioned, some participants express the belief that the county is not facing a provider workforce shortage but rather a need to address barriers to access and reallocate resources; this process is particularly pressing given that barriers such as existing eligibility requirements may exacerbate health disparities. However, the workforce is facing acknowledged challenges; specifically, providers report financial strain due to inflation and Medicaid reimbursement policies. Adequate housing is lacking for individuals with behavioral health conditions, and the requirements associated with voucher programs compound the shortage; the relationship between stable housing and behavioral health then becomes a feedback loop of instability as each reinforces the other.

Further complicating the issue, insurance is an obstacle for many residents needing care. Gaps are particularly prominent when transitioning from one type of service to another and when seeking coverage for longer-term mental health or substance use treatment services such as those following detoxification or residential treatment; stakeholders recognize a need and

opportunity for advocacy through organizations such as the [Community Behavioral Health Association \(CBH\) of Maryland](#). Since the time of the workshop, the Maryland Insurance Administration has developed the [Health Coverage Assistance Team](#), a resource that assists individuals in navigating health insurance obstacles. Although eligible for service coordination through the MDH Developmental Disabilities Administration, individuals with intellectual and developmental disability (IDD) diagnoses who require behavioral healthcare face the added barriers of waitlists and waiver eligibility limitations associated with day and residential programs for this population.

Mental Health Services: Gaps exist across the spectrum of mental health services, creating long wait times for consumers. While there are reportedly openings for community psychiatric rehabilitation programs (PRPs) and case management, there are wait times for therapy. There is no drop-in psychiatric day program in the county. Demand for residential rehabilitation program (RRP) beds (referenced on page 17) exceeds capacity, particularly for intensive-level RRP beds. While Housing Unlimited provides permanent independent scattered-site housing options to over 150 vulnerable individuals, there is currently a waitlist of over 200 consumers in need; Cornerstone Montgomery reports vacancies for group supportive housing but insufficient single-occupancy capacity at the county level to meet demand. Workshop participants expressed concerns that individuals with serious and persistent mental illness and those with psychotic features may be overlooked in terms of community care.

Substance Use Treatment Services: Specific gaps also exist along the spectrum of substance use treatment services pertaining to housing. Maryland Wellness and Recovery is reportedly seeking licensure for Level 3.1 to assist in addressing the critical need for residential services. Additionally, certified recovery housing is lacking; only three certified recovery housing options are available within the county, and the rigid requirements for state certification can be a financial barrier to providers who ultimately decide to offer alternative (non-certified) sober living arrangements. The stigma surrounding housing for people who use addiction medications compounds the shortage. Stakeholders report that existing recovery housing is uninhabitable, requiring significant improvement for ethical referral.

Peer Services: While positions are being created and funded to provide peer support, there are challenges associated with hiring appropriate staff. By law, hiring cannot be limited to individuals with lived experience; however, authentic lived experience is an essential component of the peer role. Stakeholders expressed concern that while all professionals must be mindful of the need for self-care to avoid burnout, non-peers in peer roles are particularly vulnerable to compassion fatigue and apathy. A strategy to consider could be hiring certified peer professionals credentialed through an entity that utilizes SAMHSA's recommended

self-attestation requirement to promote authenticity and lived experience across the peer workforce.

Urgent and Acute Services

Participants expressed a desire to better include family when addressing individuals requiring urgent and acute care services. Coordination of care for high-acuity, high-complexity consumers is a challenge; one solution is an operational cross-agency workgroup similar to those used by problem-solving courts.

Hotlines/Warmlines: The county seeks to further develop 988 at the local level to follow the air traffic control (ATC) model for crisis services. The ATC model is characterized by the following targets according to SAMHSA: status disposition for intensive referrals, 24/7 crisis outpatient scheduling, crisis bed registry, GPS-enabled mobile crisis dispatch, and real-time performance outcomes dashboards.

Mobile Response Services: There is a broad misconception that the mobile crisis outreach team (MCOT) and the Crisis Center are separate entities; in reality, the Crisis Center collectively operates an on-site (facility) and mobile service option. MCOT teams cannot transport consumers or respond reliably to calls for service as they are simultaneously providing service at the Crisis Center facility, limiting reliance on MCOT. At the time of publication, new county and state funding has been allocated to expand MCOT from three teams to five teams by October 1 and to seven teams by early 2025. Staffing shortages could be addressed through hiring incentives and reallocation of HHS staff based on program volume to increase overall efficiency, a strategy that requires an investment of time more than funding. A co-responder officer/clinical team with radio-to-radio contact is an additional strategy the Montgomery County Police Department is actively striving to implement.

Crisis Receiving and Stabilization Facilities: The county is experiencing a gap in services for individuals in need of immediate behavioral health treatment due to the combination of a lack of capacity and eligibility barriers. [Certified community behavioral health clinics \(CCBHCs\)](#) are designed to ensure access to the full spectrum of behavioral healthcare for the entire population (including children and youth) with an emphasis on coordination of care; HHS is a certified CCBHC, and several entities are under federal CCBHC-Expansion (CCBHC-E) grants in Maryland including Cornerstone Montgomery. The expansion of CCBHCs could address many of the county gaps noted in crisis receiving and stabilization as well as primary, long-term, and recovery behavioral healthcare.

Involuntary admission in community hospitals presents another set of challenges. White Oak and Holy Cross Silver Spring hospitals have no psychiatric beds; however, state law dictates that patients must be transported to the nearest hospital, leaving these hospitals to handle

psychiatric patients without adequate services. This particular obstacle can only be addressed legislatively. Hospitals with psychiatric beds for high-acuity and psychotic patients are routinely at capacity as hospitals report an increase in both volume and acuity. At the same time, all hospitals are facing staffing shortages; these workforce issues are exacerbated by violence endured by staff. A contributing factor to these bidirectional issues is the increasing reliance on hospitals as a last resort for law enforcement, fire/EMS, and the Crisis Center. Additional training to ensure the safety of hospital staff may address some workforce shortages.

Consumers who do not consent to treatment but do have the mental capacity to consent are reportedly frequent utilizers of MCFRS services who remain undetected until there is contact with law enforcement. There is currently no funding for prevention services through MCFRS. A potential strategy is pooling funds across MCFRS, HHS, and other stakeholders similar to the cross-hospital strategy employed by Nexus Montgomery.

First Responders

Organization: Limited resources require constant prioritization, and staffing shortages present a complication. While overtime opportunities abound, there are concerns about burnout and sleep deprivation for the committed public servants willing to work additional hours.

Training: Stakeholders recognize the need for standardized CIT training; agencies report historical variances in training, although refresher courses are now provided every two years for the sake of uniformity. Efforts are underway by the Centers of Excellence within the Governor's Office of Crime Prevention and Policy in partnership with the Maryland Police and Correctional Training Commission to standardize CIT initial and refresher training statewide for quality assurance and data evaluation purposes; agencies should collaborate with the Centers of Excellence to benefit from these efforts. Trauma-informed care and implicit bias training are also recommended to ensure public safety.

Response: Notably, the Reimagining Public Safety audit performed by ELEFA opens the section on mental health response with the astute observation that, "Safe and effective responses to mental and behavioral health crisis calls require a coordinated, inter-agency response. Focusing exclusively on MCPD's policies and practices will not achieve necessary improvements."

While a protocol ensures consistency, the script for dispatchers also prohibits deviation due to liability concerns. Calls to 988 that go unanswered are routed to 911, resulting in the dispatch of a patrol officer rather than the support 988 is intended to provide. Given that there is no penalty for misuse of 911 in Maryland, it is difficult to intervene to support frequent callers; participants indicate that while punishment is not the desired outcome, an option for legal involvement due to 911 misuse would allow for intervention with consumers who are not

immediately suicidal but are in what participants describe as a “grey area of self-harm.” Advocacy and legislation is required to address this concern.

The community reports a deep desire for a “no wrong door” policy for individuals in crisis; however, the community lacks a widely available system of diversion.¹⁸ Currently, law enforcement personnel report having to choose between three undesirable responses to a person in crisis who is unwilling or unable to seek care voluntarily: transport to a hospital that may not have a behavioral health unit, arrest, or leave the scene. Attempts have been made to address the need for diversion options identified in a prior county gap analysis; however, deflection gaps still exist as MCOT and STEER responses are reportedly either unavailable or unreliable for providing expeditious warm hand-offs. Data collection is needed to document strategy effectiveness given that partner agencies such as Tree of Hope express willingness to assist with coordination.

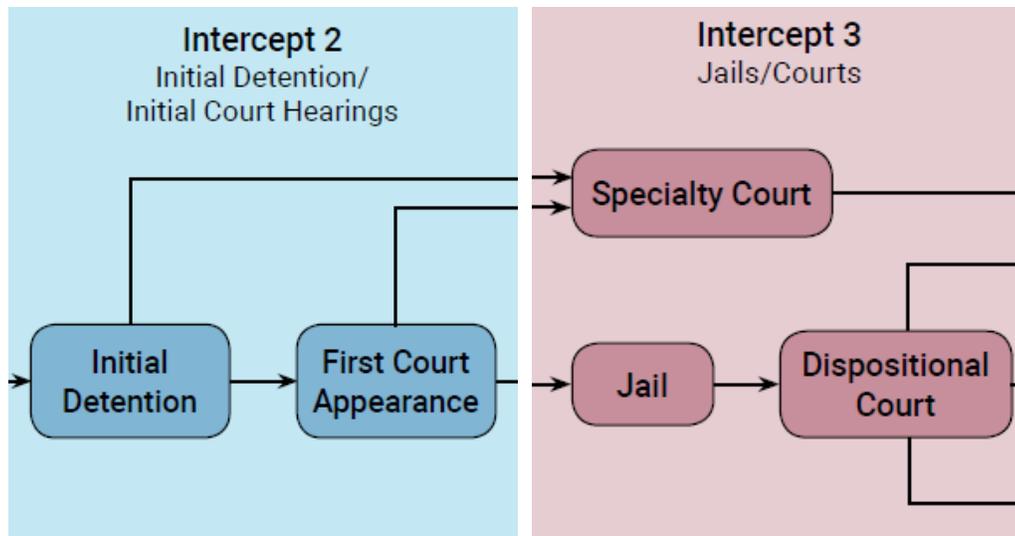
For individuals with chronic needs, efforts are underway to extricate first responders from case management through partnerships between HHS and units such as the MCPD Behavioral Assessment and Administration Unit and the MCFRS MIH team. Ordinances present a major obstacle. For example, a local statute prohibits MIH from asking consumers about insurance; this law prevents MIH from connecting individuals to existing entitlements and promoting consumer choice. County law also prohibits MIH from billing for services other than transport, thus on-site services (“service in place”) are not billable. Medicaid would reimburse \$150 per home visit, which only requires paramedic care; representatives report the capacity and eagerness to continue providing this service. Legislative correction to allow for treatment in place, transport to alternative destinations, and MIH would ensure the sustainability of these efforts and reduce demand on the already-strained workforce; however, corrected language for the EMS transport billing law has been approved for over two years by the executive branch and awaiting a legislative vote as MCFRS leadership has experienced several administrative transitions.

Education for the community and providers regarding law enforcement protocol can aid in establishing a partnership based on trust and mutual understanding. Some behavioral health agencies are being trained to request CIT officers for calls for service, which reflects a misunderstanding of the county’s law enforcement strategy of providing CIT training for all patrol officers while reserving the dedicated CIT Team for specific calls. Education about EEPs and ERPOs can prevent the frustration of feeling ignored and the unintended consequences of derailed law enforcement deflection efforts.

¹⁸ The term “diversion” is used in this document to indicate a criminal legal strategy to address the needs of people who could benefit from treatment and intervention; diversion includes pre-arrest (“deflection”) and post-arrest strategies. The term is also used in a more broad sense in other contexts such as hospital diversion.

Data Collection and Sharing

Stakeholders acknowledge a need to unify and streamline practices. Participants express interest in county-level guidance on HIPAA/FERPA to facilitate information sharing; a memorandum of understanding (MOU) exists according to HHS, but it may not be clear or expansive enough to meet the needs of the county. In the meantime, the Primary Care Coalition has created hospital-specific HIPAA infographics by collaborating with hospital internal legal departments; two illustrative examples (not intended for outside use) can be found in this report's [Appendices](#). [Maryland Active Assailant Interdisciplinary Work Group \(AAIWG\)](#) has developed a collection of resources designed for public and private sector entities, communities, and individuals; templates for a Release of Medical Authorization form (specifically for first responders to use with individuals who may need coordination of care) and a broader Release for Coordination of Care form (for coordination across multiple entities) are available in this report's [Appendices](#).



INTERCEPT 2 AND INTERCEPT 3

INTERCEPT 2/3 RESOURCES

Intake (Processing)

Once taken into custody, detained persons (“detainees”) are transported to the Central Processing Unit (CPU) located within the Montgomery County Detention Center (MCDC) in Rockville, Maryland. Staff physically search detainees and conduct a suicide screening which assesses any safety concerns including a history of suicidal ideation, self-harm, mental health issues, substance use concerns, head injury, and psychotropic medication prescriptions. During this time, the arresting officer completes the statement of charges. If detainees require medical clearance from the hospital, the arresting officer may take them to the hospital and return them to the detention center. Detainees exhibiting signs requiring immediate assessment for lethality risk are promptly transferred to the Crisis Center; this determination can also be made by medical staff during assessment upon entry to the correctional facility.

Upon intake by correctional officers, medical staff from the Montgomery County Department of Correction and Rehabilitation (DOCR) conduct screenings to assess physical and mental health; detainees are asked the same questions detailed above with a few additional questions. Those who demonstrate mental health concerns are referred to the Montgomery County Department of Health and Human Services (HHS) Clinical Assessment and Triage Services (CATS) team housed within the detention center. The team’s working hours are from 7:30 a.m. to 11:00 p.m. Monday through Friday and from 7:30 a.m. to 4:00 p.m. on Saturdays and Sundays. Depending on individual circumstances, CATS may refer to programs such as Avery Road, the drug court, mental health court services, or pretrial services. Reportedly, referrals to Avery Road have varying success rates with placement, treatment compliance, and treatment outcomes. If a

detainee is deemed unsafe for general population housing, CATS informs the staff at MCDC accordingly to ensure appropriate management and care. Once booked and processed, detainees are held at MCDC pending an initial court appearance.

Initial Appearance

While wait times vary by situation, an initial appearance before the District Court Commissioner to determine bond conditions must occur within 24 hours of arrest. Detainees attend initial appearances virtually due to transport difficulties. Commissioners may hold an individual without bond or release an individual on personal recognizance or bond; those who cannot meet bond conditions or would like a review of their bond conditions see a judge the following business day at 1:00 p.m. An estimated 10-60 bond review hearings occur per day, and the number of people held without bond has increased due to the [Bail Reform Act of 1984](#). Occasionally, detainees are transported in person for bond reviews in the circuit court. If not released on bond, detainees are transferred to Montgomery County Correctional Facility (MCCF). Detainees may be held for up to 72 hours in MCDC before transferring to the Montgomery County Correctional Facility (MCCF); however, workshop participants reported that individuals may wait 1-2 weeks for transfers due to high holding counts at MCCF.

The Office of the Public Defender (OPD) is responsible for speaking to every detainee before the initial appearance; a public defender is the first person expressly on a detainee's team. The agency's policy mandates that public defenders prepare to represent clients even if the commissioner suggests they hire private counsel. Clients must explicitly decline public defender services during bond hearings for OPD to withdraw from representation. Typically one public defender covers bond hearings at both MDC and MCCF due to reduced staffing; interviews are done by call down to MCDC and in person at MCCF. Public defenders have daily access to clients at both facilities in person or via Polycom video. Public defenders report that they cannot enter MCDC and speak to clients in person. Consequently, public defenders may not interact with their clients until the day of a virtual hearing, ultimately delaying the determination of bond hearings and presenting several barriers to representing the client's best interest. Notably, correctional staff report that public defenders are permitted to enter MCDC and speak to clients in person, but have not done so since the restrictions imposed during the Covid-19 pandemic.

Court-Ordered Services

Pretrial Services: The Pre-trial Services Division within DOCR oversees four programs: the Pre-trial Assessment Unit, the Pre-trial Supervision Unit, the Alternative Community Service Program (ACS), and the Intervention Program for Substance Abusers (IPSA). The Pre-trial Assessment Unit is housed within MCDC and is responsible for interviewing all new detainees. The unit comprises a program manager and four correctional specialists who work with the

CATS team and Crisis Intervention Unit (CIU) to determine eligibility for pretrial release. Eligibility is determined based on criminal history and the likelihood of appearing in court. The OPD also assesses detainees to present recommendations to the court. The Pre-trial Supervision Unit, on the other hand, comprises a program manager, case management supervisor, nine correctional specialists, an electronic monitoring specialist, a program aide, and security personnel. This unit monitors defendants released to pretrial supervision; there are approximately 500 people on pretrial supervision on any given day. Supervision in the community varies from telephone interactions to frequent face-to-face contact depending on the risk of individual clients. When warranted, visits to the defendant's home, drug testing, and GPS and electronic monitoring may also occur. Violations of release conditions are reported to the court immediately upon discovery; the judge will then decide whether to issue a summons or a warrant.

ACS is a diversion program that reopened in February 2023 for adult detainees arrested for offenses or infractions against individuals or the community; as a condition of a stet agreement, detainees in this program perform community services as a sanction.¹⁹ The ACS staff comprises a pretrial diversion manager, office service coordinator, and three correctional specialists; the program is working to reestablish work crew supervisors, but in the meantime, individuals can perform service at various community locations. The program is not used to address individuals with behavioral health needs but will accept individuals who have drug possession cases, excluding felony distribution charges or possession of fentanyl. The referral form for this program can be found in the "[Resources](#)" section.

The IPSA program is a substance use and intervention diversion strategy for first-time detainees charged with misdemeanor drug crimes; the program includes drug testing, education, treatment, and community service. Urinalysis hours of operation are on Mondays (11:30 a.m. - 3:00 p.m. and 3:30 p.m. - 6:30 p.m.) and Thursdays (1:00 p.m. - 5:00 p.m.). Some participants are required to complete four 1.5-hour drug education courses; there is also an exclusive course that is offered once a month focusing on marijuana use. The program is inactive at this time; however, staff has historically comprised a pretrial diversion manager, an office service coordinator, correctional specialists (2), and laboratory technicians (2).

Competency Evaluation: Incompetency to stand trial can be understood as the lack of capacity to understand the nature and objective of proceedings, to consult with counsel, and to assist in preparing a defense; incompetency determinations require a mental disorder or intellectual disability. Competency dockets are held in Montgomery County's district and circuit courts; these dockets operate differently, but each process has been streamlined. The district court

¹⁹ A stet is defined as a conditional stay of all further proceedings in a case; the court may indefinitely postpone trial of a charge by marking the charge "stet" on the docket.

team comprises a judge, HHS staff/clinicians, the mental health court coordinator, and a mental health court clerk; this docket is held every Tuesday. The circuit court team comprises a judge, the supervising criminal and civil case manager, and the administrative judge's judicial assistant and law clerk; this docket is held at the first available date of the court and relevant parties. Referrals for competency evaluations are made by the Pre-trial Services Unit, prosecutors, defense attorneys, or judges; evaluations must occur within 7 days of submission. Individuals detained without bond are held in the detention center for competency evaluation. The Maryland Department of Health conducts evaluations in person and virtually (depending on the defendant's bond status). If, after a hearing, the court finds that the defendant is incompetent to stand trial but is not dangerous to the defendant or others, the court may set bond conditions for the defendant or authorize the release of the defendant on recognizance. If, however, the court finds that the defendant is incompetent to stand trial and is a danger to the defendant or the public, the court orders the defendant committed to a facility designated by the Maryland Department of Health until the court determines that the defendant no longer is incompetent to stand trial; the defendant no longer meets the standard of dangerousness; or there is not a substantial likelihood that the defendant will become competent to stand trial in the foreseeable future. Those hospitalized under competency statutes are transported to one of the five state inpatient psychiatric hospitals; hospitalization at Clifton T. Perkins Hospital Center may occur if the person has charges of a violent nature. Due to insufficient state hospital capacity, there are reportedly over 30 people in the detention center awaiting hospital placement to receive court-ordered competency restoration services; service delays are linked to decompensation and increased symptom acuity. There is also no formalized process for connecting individuals who are found competent but need mental health treatment or intervention to services. OPD represents clients declared incompetent by the commissioner, as these individuals cannot communicate with commissioners and require competency determination before making decisions about legal counsel.

Petition for Emergency Evaluation: Emergency petitions can be another entry point to the judicial system.²⁰ An emergency petition is a legal process to allow a person to be taken into custody and examined by a medical professional; this statute is used for individuals who present a mental illness and are a danger to themselves or others. Mental health professionals (e.g. physicians, psychologists, clinical social workers), law enforcement, and anyone interested in an individual's mental well-being may file an emergency petition to a circuit court. If a judge grants a petition for emergency evaluation, law enforcement will take the individual to an emergency facility for rapid evaluation. However, emergency facilities may only keep an individual who is emergency petitioned for up to 30 hours unless a physician or a psychologist completes

²⁰ A petition for emergency evaluation may also be referred to as a petition, an emergency petition/EP, or an emergency evaluation petition/EEP). In Montgomery County, the common term is "EEP."

certificates for involuntary admission.²¹ Involuntary admission may only be deemed when an individual has a mental disorder, is a danger to themselves or others, unable or unwilling to be admitted voluntarily, and there is no less restrictive form of care or treatment to meet the individual's needs.

Assisted Outpatient Treatment: Sections 10-6A-01 through 10-6A-12 of the Health General Article authorize (not require) counties to establish assisted outpatient treatment (AOT) programs. For counties that do not develop programs independently, the Department of Health must establish a program by July 1, 2026. These programs provide court-ordered treatment for individuals with severe mental illness who meet specific criteria, such as a history of non-compliance with treatment that has led to hospitalization or incarceration. The law outlines the eligibility criteria for AOT, details the procedure for initiating AOT including court hearings and legal representation for the individuals involved, specifies provisions for training mental health professionals and law enforcement officers on AOT processes and protocols, and allocates funding for the implementation and administration of AOT programs. The law further requires MDH to collect and analyze AOT program data to evaluate the programs' impact on reducing hospitalizations and incarcerations while improving adherence to treatment plans.

Health General Commitment Evaluation: Sections 8-505 and 8-507 of the Health General Article allow for court-ordered evaluations for drug or alcohol use.²² These orders are valuable resources for addressing substance use or co-occurring diagnoses, offering specialized support, and integrated care for individuals with multiple conditions. These evaluations can be ordered at all stages of the criminal proceedings.

Court Structure

The county's court system includes two Montgomery County District Courts (Rockville and Silver Spring), the Montgomery County Circuit Court (Rockville), the Mental Health Court programs embedded in both the district and circuit courts, the Adult Drug Court in the circuit court, and the Driving Under the Influence (DUI) Treatment Court in the district court.

Problem-Solving Courts: Montgomery County established Mental Health Court programs in the circuit (December 2016) and district (January 2017) courts to divert eligible defendants who have committed crimes due to a mental illness away from jail and provide wrap-around services. The program within the district court is offered as a diversion option while all participants enrolled in the circuit court program enter as a condition of probation. The teams

²¹ §10-624(b) of the Health-General Article:

<https://mgaleg.maryland.gov/mgaweb/Laws/StatuteText?article=ghg§ion=10-624&enactments=False&archived=False>

²² Certification Manual: HG § 8-507 Court Ordered Treatment:

[https://health.maryland.gov/bha/Documents/12.18.2017%20MDH%208-507%20Providers%20Manual%20\(5\).pdf](https://health.maryland.gov/bha/Documents/12.18.2017%20MDH%208-507%20Providers%20Manual%20(5).pdf)

in both courts comprise a judge, defense attorneys, prosecutors, mental health court coordinators, clinical staff, case managers, parole and probation officers, and behavioral health technicians; however, the individuals who fill these roles in each court differ. While there are no restrictions on who may refer an individual to the program, judges, prosecutors, defense attorneys, law enforcement, the Department of Correction and Rehabilitation, Parole and Probation, state hospitals, private mental health providers, and family members typically make referrals. The State's Attorney's Office receives all referrals and recommends probation or diversion based on the information provided. The Mental Health Court Coordinator simultaneously screens referred defendants using questions from a clinical manager; from here, the screened referrals are passed to the clinical team with records to conduct a thorough evaluation to determine further eligibility for the program. Eligible participants are aged 18 or older, residents of Montgomery County, deemed competent, impaired by a mental illness, and charged with an offense connected to or caused by their mental illness. Program participation lasts about 18 months; as of May 2024, the district court serves 50 participants (capacity of 75) while the circuit court serves 15 participants (capacity of 25). Graduation from the program requires participants to achieve the goals of their individualized treatment plan, which may include taking all prescribed medication, abstaining from substance misuse, participating in therapy, and other directives.

In 2004, Montgomery County established the Adult Drug Court through the Circuit Court of Maryland to provide intensive substance use disorder services and supervision, ultimately reducing recidivism. The team comprises a judge, a public defender, a state's attorney, a drug court coordinator, an attorney liaison, a case manager, and a probation officer who communicate weekly; the team works with treatment providers, community organizations, law enforcement agencies, educational institutions, and correctional facilities. There are no restrictions on who may refer an individual to Adult Drug Court, however, referrals are typically made by judges, prosecutors, and defense attorneys. Eligible detainees must be county residents, have nonviolent charges and a substance use disorder diagnosis, and express willing capacity to consent to the program requirements. Detainees may also participate in the program if sanctioned and approved by the Office of the State's Attorney as a part of a binding plea agreement. The voluntary, four-phase program lasts a minimum of 20 months and serves a maximum of 100-125 detainees at a time (depending on DUI Treatment Court enrollment). As of May 2024, there are approximately 60 program participants. Graduation from the program requires completing all program and probation requirements, including restitution and costs, 180 continuous days of clean urinalysis, community service, and other assignments. Eligible graduates must also participate in an exit interview and attend a Graduation Review Board where the drug court team provides a positive recommendation and the judge approves graduation. Graduates may qualify for an expunged record and avoid jail time.

Montgomery County District Court has also established a DUI Treatment Court, which has been operational since October 2023. The team comprises a judge, prosecutors, a DUI Court Coordinator, two case managers, probation officers, and HHS treatment providers. There are no restrictions on who may refer an individual to the DUI Treatment Court; referrals are made to the State's Attorney's Office which assesses eligibility for participation. Eligible participants are at least 18 years old, have a substance use disorder, and have a pending non-violent offense. As of May 2024, the docket serves 26 participants. An additional DUI Court Coordinator has been hired to help expand the program; the court anticipates an increased capacity limit of 50 participants before the end of the fiscal year 2025. An alternative track has been developed to address defendants referred to DUI Treatment Court due to older impaired driving charges. These individuals have been assessed to be in remission from alcohol use with a substantial history of impaired driving indicating that they could benefit from greater supervision rather than standard probation. Alternative track participants wear a Secure Continuous Remote Alcohol Monitoring (SCRAM) device for the first 30 days of program enrollment to ensure abstinence from alcohol, appear in court and meet with a case manager monthly for one year, meet with a case manager approximately once a month, and submit random urinalysis throughout their time in the program; any compliance issue is a violation of probation. If a participant receives four violations, the participant may receive backup time (time remaining on an individual's sentence) or be diverted to the traditional DUI Treatment Court program track. The alternative track serves five participants at this time.

Detention and Corrections

Structure: The Montgomery County Detention Center (MCDC) is located on Seven Locks Road in Rockville, Maryland; in conversation, it is often referred to as "Seven Locks." MCDC was originally built in 1961. Today, the detention center has a maximum capacity of 200 detainees with an average of 150 detainees at a time; however, about 13,000 detainees are booked into the Central Processing Unit (CPU) at MCDC annually. MCDC operates as the intake unit providing psychological screening, medical screening, and risk assessment to determine the appropriate classification level of detainees and to provide for initial care, custody, and security of detainees for up to 72 hours before their transfer to the Montgomery County Correctional Facility (MCCF). Staff in the detention center comprises a Deputy Warden, correctional supervisors and officers, case management staff, food services professionals, and medical staff. All new professional and support employees receive a minimum of 16-32 hours of orientation and complete the State's Correctional Entry Level Training Program within their first year of employment; mandated staff receive a minimum of 18 hours of in-service training annually. MCDC also houses a small number of detainees (pretrial and sentenced) who serve as facility workers to perform kitchen, housing, and general custodial duties; these individuals receive diminution program credits and expanded institutional privileges.

MCCF is located in Boyds, MD, and was originally built in 2003. Today, the correctional facility has a maximum of 1,028 detained or incarcerated individuals. As of May 2024, the correctional facility holds an average of 800 individuals. MCCF is organized into three major functional areas managed by a Deputy Warden: “Custody & Security,” “Inmate Services & Programs,” and “Facility Operations.”²³ Staffing for the correctional facility is responsible for the custody and care of male and female detained or incarcerated individuals in a pre-trial status or serving sentences of up to 18 months; professional and support employees receive the same training as those in MCDC (described above).

Services: Given that MCDC is primarily an intake and processing center functioning as a 72-hour holding facility, there are limited services. When detainees arrive at MCDC, correctional officers perform an initial intake and classification including housing assignment and any medical or mental health concerns within 24 hours. A case management intake, including a needs assessment and other screenings indicated in the [“Intake \(Processing\)”](#) section above, typically occurs after the bond hearing, within the first week, and usually before transfer to MCCF. Medical intake manages medications for detainees who require medication while held at MCDC by coordinating with local pharmacies through the release of information (ROI) requests for documented prescriptions. Orders placed by noon ensure detainees receive their medication(s) by 6 pm; certain medications are kept in stock for immediate use. Detainees showing signs of withdrawal are transferred to MCCF to consult with medical staff and initiate medication administration as necessary. MCCF handles prescription continuations and inductions, while medical personnel at the detention center refer to Maryland's Prescription Drug Monitoring Program (MPDP) protocols to verify previous withdrawal management medications or medication-assisted treatment (MAT) services.

As part of the booking and intake process, a detainee or incarcerated individual is assigned an identification number, photographed, showered, searched, and put through a full body x-ray scanner to detect any potential hidden contraband before being placed in an intake housing area at MCCF. Each detainee or incarcerated individual is assigned a case manager tasked with providing frontline assistance to address needs and questions. A classification and case management system determines risk and custody levels and assesses each detainee or incarcerated individual’s needs. The correctional facility uses medical staff from DOCR and contracted staff from HHS who conduct mental health, substance use, and suicide risk assessments for every detainee; staff also screens for intellectual or developmental disability and traumatic brain injury (TBI). There is no formal timeframe for the duration of this assessment; however, staff aims to complete assessments within an hour while recognizing that some may exceed this timing due to the nature of care required. Two contracted psychiatric

²³ Per Section 1-101 of the Correctional Services Article of the Maryland Code, the term “inmate” has been repealed; the term only appears in this document when it is quoting an existing proper name.

nurse practitioners provide services for 40 hours a week at MCCF and as needed for 8 hours a week at MCDC and the Pre-Release Center (PRC). The medical department uses two employees certified as multilingual by the county to address language barriers; language interpreter line services are also available.

The Mental Health Services (MHS) staff works with the following teams within HHS: Clinical Assessment and Triage Services (CATS), Jail Addictions Services (JAS), and Project Assisting Transition from Homelessness (PATH). These teams assist in providing assessment and treatment services to incarcerated individuals with behavioral health needs. All incarcerated individuals who appear at risk of self-harming behaviors or are referred by staff, family, or other providers are assessed by the CATS team for service needs. The team comprises one clinical supervisor, five licensed therapists in MCDC, and three in MCCF who conduct bio-psychological assessments of referred individuals, provide reentry services, and track the competency docket. The CATS team recommends clinically appropriate diversion options and “Custody and Security staff handling plans” for incarcerated individuals with significant mental health or adjustment issues. Mental health services include crisis intervention, mental health evaluations, recommendations for handling plans, housing, and referrals for psychiatric evaluation and follow-up; eligibility is based on the individual’s level of functioning. Approximately 50% of the overall population is prescribed psychotropic medication.

The correctional facility maintains a Crisis Intervention Unit (CIU) to ensure a safe environment for incarcerated individuals with acute or chronic symptoms. The CIU team comprises a Supervisory Therapist and six other licensed therapists who provide basic mental health services for the entire incarcerated population and manage the admission, discharge, and treatment of individuals housed in the facility’s male and female CIUs and the Step-Down Unit. The CIU staff and assigned officers receive extensive mental health training to reduce impulsive and high-risk behaviors and promote rehabilitation. Notably, the CIU is the location of the first jail-based dialectical behavioral therapy (DBT) program for individuals with mental illness in the nation, established to provide individual and group therapy sessions aimed at enhancing problem-solving skills and improving maladaptive behaviors. Although it has been discontinued and restarted multiple times over the years due to staffing and other challenges, this program has most recently run from 2014 to 2017 and is no longer offered. Staff trained in DBT continue to use these interventions with the population. The male CIU has 32 cells with a maximum capacity of 40 individuals; however, some of the units’ cells are shared and cannot always be filled due to the acuity levels of individuals in the unit. The average census for fiscal year 2024 is 31 individuals in the male CIU. The female CIU has eight cells with a maximum capacity of 14 individuals; the average census for fiscal year 2024 is 14 individuals with the highest monthly average at 20 (above capacity). The Step Down Unit has 32 cells with a maximum capacity of 62 individuals; the average census for fiscal year 2024 was 33 individuals with the highest monthly

average at 42 (above capacity). Approximately 10% of the overall population is housed in mental health housing; many of these individuals are not willing to take psychotropic medications to treat their disorders, resulting in symptoms and behaviors deemed unsafe for general population housing.

Substance use treatment services include two voluntary programs with access to peer support specialists on-site. The Jail Addiction Services (JAS) program provides Level 2.1 (intensive outpatient, IOP) treatment to eligible incarcerated individuals.²⁴ JAS staff are trained to support a Therapeutic Community Model of addiction treatment.²⁵ Participants are housed in therapeutic units where they undergo treatment that includes two phases: a ten-week education phase and an ongoing aftercare phase. Program activities include community meetings, task groups, education, and therapy groups, peer counseling, self-help meetings, and cognitive behavior skill building. All JAS participants receive Narcan training from the care coordinator; 1-2 trainings are offered per month. In compliance with sections 9-603 and 9-603.1 of the Correctional Services Article, the correctional facility's medication-assisted treatment (MAT) program has expanded addiction treatment for incarcerated individuals since January 2020. This program includes a Level 2.1 (Intensive Outpatient, IOP) with opioid use disorder screening, evaluation, and treatment (specifically medications to treat opioid use disorder in conjunction with counseling services and reentry planning). The program has no official capacity limit; however, the therapist-to-client ratio should not exceed 50:1. Approximately 50 individuals are enrolled as of May 2024. HHS provides the correctional facility with methadone, buprenorphine, and/or naltrexone while DOCR's medical staff administers medications to each participant based on their clinical needs.

In addition, the correctional facility also offers a variety of programs aimed at rehabilitation and skill development for detained and incarcerated individuals. Programs include Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), parenting classes, and general educational development (GED) test preparation. A Bridge to College program provides referrals to Montgomery County Community College. An employment development program teaches positive work habits and skills to enhance employability post-release, supported by the American Job Center for skills assessment and job search assistance. The Model Learning Center operates full-time educational and special education programs. The facility also includes a full-service library that is considered an official branch of the Montgomery County Public Libraries system complete with multi-purpose and recreation program areas. A bakery program, run by food services, teaches hard and soft skills, including producing bread, cookies, and treats,

²⁴ See Table 1 on page 20 for details regarding the ASAM criteria continuum of care.

²⁵ De Leon, G., & Unterrainer, H. F. (2020). The Therapeutic Community: A Unique Social Psychological Approach to the Treatment of Addictions and Related Disorders. *Frontiers in psychiatry, 11*, 786. <https://doi.org/10.3389/fpsy.2020.00786>

and providing catering services; participants can earn certification upon completion. "Choice for Change" is a unit that offers treatment for participants aged 21 and under; a similar program exists to support adult men and women. Tablets are becoming available in June of 2024, increasing access to educational resources, library books, and communication with family and friends. Religious services are also offered. Despite the numerous services, individuals have varying lengths of stays at the correctional facility which can impact service access. Additionally, programs that require specific eligibility criteria restrict some individuals from using them.

Data Collection and Sharing

The circuit court constantly communicates with the CATS team regarding the current status of pending cases involving competency and pleas of "not criminally responsible" (NCR).²⁶ Reports including reentry plans are provided to the district court for cases where an individual may be released if already restored to competency. For continuity, the judges who oversee mental health court program cases share a binder of information for each client; this information is updated and reviewed by the presiding judge before each meeting.

INTERCEPT 2/3 GAPS

Intake (Processing)

While staff can access 24/7 Language Line services for translation assistance, participants report that language barriers during the intake process can lead to misunderstandings and miscommunications. These barriers significantly impact detainees by hindering their ability to understand their rights, the charges against them, and the procedures they must follow.

Initial Appearance

Public defenders report that they cannot enter MCDC and speak to clients in person and consequently may not interact with their clients until the day of a virtual hearing, ultimately delaying the determination of bond hearings and presenting several barriers to representing the client's best interest. Notably, correctional staff reports that public defenders are permitted to enter MCDC and speak to clients in person but have not done so since the restrictions imposed during the Covid-19 pandemic. The disconnect between policies must be clarified to ensure a seamless process, as any misalignment can lead to unnecessary delays in scheduling.

Notably, family members should be encouraged to be involved in judicial processes if it is safe for them and they choose to do so. Some detainees and their family members are unfamiliar

²⁶ Defendants found guilty but not criminally responsible (NCR) are mandated into the custody of a state hospital and committed for an indefinite term until they no longer require hospitalization as determined through future legal proceedings.

with mental health needs, compounding their lack of understanding of court appearances and the criminal legal system. Language barriers may prevent detainees from being able to read and comprehend court orders, leading to confusion and potential non-compliance with legal requirements. Virtual initial appearances can also create a gap between counsel representation and defendants who may have trouble hearing and understanding, leaving some individuals feeling disconnected from the process, unable to speak for themselves, or dehumanized. Ensuring all parties involved are well-informed and sufficiently supported throughout court appearances is crucial.

Court-Ordered Services

Pretrial Services: The Pre-trial Assessment Unit may not recommend pretrial supervision, but a judge may overrule this and decide that an individual must be placed under pretrial supervision. When judges override these recommendations, pretrial supervision resources may be strained, potentially leading to inadequate monitoring and support for those who genuinely need it. Additionally, this can undermine the trust and efficacy of pretrial services, creating a disconnect between judicial decisions and the intended use of pretrial resources. On the other hand, if a judge cannot determine eligibility for pretrial services or diversion despite recommendations by OPD representatives or the Pre-Trial Services Division, then they must release individuals to the community to await legal proceedings. Ultimately, judges must adhere to many legal principles.

Competency Evaluation: Unlike mental capacity, which is determined by a clinical evaluation based on criteria established by state law, competency determinations are made by a judge according to a Constitutional standard. The state psychiatric hospitals only accept competency placements, creating a gap for legally competent individuals with a need for inpatient mental health treatment. In addition, the state-level lack of beds results in long wait times and increased acuity levels among individuals waiting for competency restoration in jail. Montgomery County reportedly has the longest competency restoration waitlist in the State of Maryland.²⁷

There are no comparable services to inpatient substance use disorder treatment for those with serious mental illness; however, sections 10-6A-01 through 10-6A-12 intend to address this concern by mandating AOT programs in each county across the state. AOT has garnered various critiques that policymakers should consider; critiques address ethical, legal, and practical concerns such as infringement of rights, the effectiveness of programs, resource allocation, and implementation challenges.

²⁷ As of August 19, 2024, 46 Montgomery County residents are awaiting state psychiatric care.

Health General Commitment Evaluation: Reportedly, HG § 8-505 and 8-507 orders are underutilized; there is a dedicated workgroup in development to improve the management and utilization of these services.

Court Structure

Judges' options for diversion are limited, and judges have reported an interest in greater communication between the judiciary and community service providers to enhance court orders and recommendations. Public defenders must uphold client autonomy; as such, representation is aligned with clients' expressed interests, not necessarily their best interests. If a client is not ready or interested in change, recommended interventions may not be ideal. In such cases, public defenders must still encourage compliance with court requirements, balancing the client's wishes with the need to avoid negative legal consequences. At times, detainees have open cases in other jurisdictions that interfere with timely placement in treatment programs in Montgomery County. The need to coordinate between multiple jurisdictions can cause delays, complicating the process and potentially prolonging the period before the individual receives the necessary treatment.

Problem-Solving Courts: Problem-solving courts are voluntary programs with specific eligibility standards designed to address the underlying issues contributing to criminal behavior, such as substance use or mental health disorders. Participation in these courts is not mandatory, even if individuals meet the qualifications and could benefit from the interventions offered; individuals must choose to enter the program. This voluntary nature respects participants' autonomy but can result in suitable candidates declining to receive the services and support provided by problem-solving courts.

Additionally, individuals who do not meet the criteria for problem-solving courts, such as those with intellectual developmental disabilities, cognitive impairments, or autism spectrum disorders, are often excluded from these intervention opportunities. Despite demonstrating a clear need for support and tailored interventions, these individuals fall through the cracks, as there is a lack of alternative programs and resources available to address their needs. This exclusion highlights a significant deficiency in the support system for vulnerable populations who require specialized assistance, yet are not eligible for problem-solving court programs. Furthermore, even if judges are receptive to considering mitigation for these cases, OPD is inadequately staffed to handle these specialized cases. There is reportedly an opportunity to utilize targeted case management for support and linkages to services through [CRi](#), a resource further described in the "[Intercepts 0/1 Resources](#)" section.

The clinical staff's primary role in the Mental Health Courts is to support the case managers and the broader team by referring participants to service providers. In cases where there is a lapse

in connecting participants to services, however, clinical staff may provide therapeutic interventions. When clinical staff provide necessary services outside their intended scope, it can create a notable gap that leads to increased workloads and larger caseloads, contributing to overwork and potential burnout. On the other hand, drug court participants have access to therapists from HHS to support their recovery and rehabilitation. However, there is a significant shortage of therapists, which can result in delayed or inadequate treatment for participants, undermining the goal of drug courts to provide comprehensive and timely interventions for those struggling with substance use concerns. In general, the problem-solving courts would benefit from hiring additional therapist positions embedded within the judiciary system to support participants; there are reportedly six or seven total as of May 2024.

Detention and Corrections

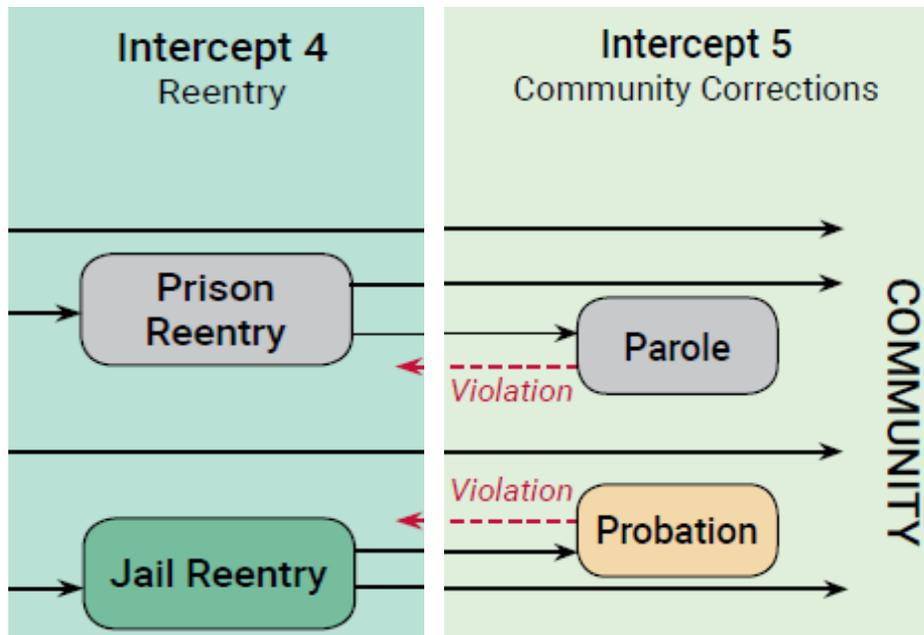
Services: Staffing challenges in the correctional facility significantly affect the availability of services. Most programs do not regularly rely on waitlists; however, participation in JAS, a successful, intensive, and specialized program, is limited based on staffing ratio and physical space; most individuals in the facility cannot or do not access these services, and only 5-8% of the population reportedly participates. With insufficient staff, it becomes difficult to provide consistent and adequate mental health care, rehabilitative programs, and other necessary support to detainees. To ensure that services are client-centered and respect autonomy, workshop participants indicate that there should be incentives for engagement.

Lapses in insurance coverage during incarceration also present barriers to services and medication; there is an opportunity to advocate for Medicaid express sign-up at intake, during incarceration, and at reentry to address these gaps. Utilizing targeted case management could further provide essential support and linkages to services. Additionally, correctional facilities across the state have faced implementation challenges due to costly MAT medications and staffing shortages; all facilities may seek technical assistance from the [Justice Reinvestment](#) team at the Governor's Office of Crime Prevention and Policy.

The absence of mental health peer support in jails and the general lack of peer support during criminal proceedings remain a critical deficiency. This concern could be remedied by seeking additional funding streams; for example, the [Performance Incentive Grant Fund](#), administered by the Governor's Office of Crime Prevention and Policy, supports reentry programming and services, behavioral health treatment, resources, and services, enhancement for victims and restitution, training and education, alternatives to incarceration, and pretrial services and programming for and systems-involved individuals; this fund can be used to assist with providing peer support services.

Data Collection and Sharing

The judiciary has expressed a need for quick access to information on mental health treatment services. There is also a need for increased communication between all parties involved in court hearings to effectively make recommendations and determinations for individuals with behavioral health needs.



INTERCEPT 4 AND INTERCEPT 5

INTERCEPT 4/5 RESOURCES

Corrections Reentry Services

Services and Referrals:

One of two teams may provide reentry services to the approximately 800-1,000 individuals in custody at a given time. DOCR reentry and CATS reentry teams work together but serve different subpopulations within the facility based on behavioral health acuity criteria. The DOCR “Reentry for All” team of one full-time and one part-time case manager plus a social worker initiates tracking of individuals one year before release; cases are typically assigned based on staffing bandwidth between three and six months ahead of release with a 100-person caseload on average. Individuals prescribed psychotropic medication, including 10% who are housed in specialized mental health or substance use units, meet the criteria to receive reentry services through the CATS team. This team includes two licensed clinicians, a behavioral health technician coordinating with MTC Avery Road, and a forensic liaison coordinating with the courts. The CATS team initiates services for pretrial cases upon identification and for sentenced individuals six months before release; individuals with detainers (i.e., warrants in other locations) or significant charges are ineligible.

Reentry services through DOCR and CATS teams include individualized and targeted reentry plans, community reentry photo identification cards (county government-approved temporary identification), linkages to benefits, and referrals to shelters and treatment services. HHS also

collaborates with the Mental Health Services section at MCCF to provide Project Assisting Transition from Homelessness (PATH) services by referral to support effective community integration for individuals reentering the community after incarceration. Both teams develop a reentry service plan for participants which can be provided to parole or probation; reentry sheets are also available for non-county residents to assist with connection to services. Although the Office of the Public Defender does not formally create reentry service plans for the courts, they reportedly frequently provide these plans to be included in conditions of release. Before release, individuals with somatic or psychiatric prescriptions are dosed if present when medications are dispensed (i.e., “med passes”) and discharged with 14-day prescriptions and treatment referrals; individuals discharged to substance use treatment facilities receive 30-day prescriptions. Individuals identified as high risk (including but not limited to MAT program participants) are supplied with Narcan rescue kits in their property bags at release.

Bridging Intercepts 4 and 5, the Pre-Release and Reentry Services (PRRS) Division of DOCR oversees the 144-bed Montgomery County Pre-Release Center (PRC), providing voluntary evidenced-based transitional services to soon-to-be-released incarcerated adults. An additional home confinement component increases capacity by an additional 5-20 participants on average; calculations at the time of the workshop indicate overall ample capacity. By law, all participants must have one year or less time remaining on their sentences; PRRS is authorized to determine eligibility based on the full social background of all sentenced detainees 120 days before release but requires judicial consent for actual placement at the PRC. JAS participants receive aftercare follow-up; each participant works with a case manager and work release coordinator to develop an individualized reentry plan including employment, housing, treatment, family, and medical services. Family participation in reentry planning is encouraged when possible to facilitate success. Notably, CATS clients are eligible to participate, and there is a therapist position at PRC to ensure that they are equipped to serve this population. The PRC reports that a majority of participants re-engage in community-based treatment and boast a 75% employment rate at release.

Supervision: The community supervision portion of the Department of Public Safety and Correctional Services (DPSCS) operations ensures that reentering individuals uphold individual requirements set forth by courts and the Parole Commission. Supervision is provided at one of four levels ranging from low (for individuals with no prior history and no present disorders) to high; home monitoring via GPS is typically reserved for mandatory releases and parolees.

All Montgomery County supervision intakes are to be completed in person within 24 hours of release at Rockville Intake, where individuals are fingerprinted and photographed; various documents are signed and individuals are assigned an agent. The agent reviews all 10

state-standard conditions and any special conditions imposed by the court with the individual.²⁸ Supervision is determined by residency rather than the location of a criminal charge and assigned to one of the two county DPSCS facilities: Gaithersburg Field Office/DDMP or Silver Spring Field Office/DDM. Montgomery County has two agents who are assigned Problem-Solving Court caseloads; an agent in Gaithersburg supervises Drug Court (Circuit), Mental Health Court (Circuit), and DUI Court (District), while an agent in Silver Spring supervises Mental Health Court (District). The DPSPS Division of Parole and Probation maintains specialized caseloads based on offenses (sexual, domestic violence, interstate, drug-related, pretrial services investigation, and individuals assigned to the violence prevention initiative via screening for individuals under the age of 30). General caseloads are 150+ active cases per supervisor; DDMP caseloads exceed 300. Home visits are completed monthly; as a result of the pandemic, supervision has become more flexible to allow for virtual check-ins via state-issued cell phones in some instances.

Through the Justice Reinvestment initiative, the Division of Parole and Probation is striving to dispel the historically adversarial understanding of supervision. Supervisors complete mandated training on mental health and substance use disorders and provide referrals to the community for resources and graduated sanctions when permitted by the court with the ultimate goal of successful termination of supervision.

Community Reentry Services

Supportive Funding: As mentioned in the “[Intercepts 0/1 Resources](#)” section, Consumer Support and Maryland Recovery Net (MDRN) grant funds are available to eligible applicants with behavioral health needs. Consumer Support is a safety net service to assist with rent, mortgage, and/or utility arrearages when all other resources have been denied. MDRN is a safety net service that develops partnerships with services statewide and funds access to clinical and recovery support services treatment and recovery support needs for individuals with substance use/co-occurring disorders; all Maryland RecoveryNet service recipients receive care coordination through which they can access funding for recovery housing as well as other services related to transportation, employment, vital records, peer/recovery coaching, medical/dental services, and other unmet needs.

Behavioral Health Services: Several agencies provide behavioral healthcare services for systems-involved individuals with substance use and mental health disorders; these services are discussed in the “[Intercepts 0/1 Resources](#)” section. Case management and ACT complete intakes before release when possible. While many programs were halted during the Covid-19

²⁸ The DPSPS Division of Parole and Probation administers two distinct monitoring entities: criminal supervision and the Drinking Driver Monitor Program (DDMP). DDMP is designed to gain compliance with court-ordered treatment or education and monitor compliance with terms of probation.

pandemic, Tree of Hope reports maintaining a listserv of 428 providers and peers across Maryland, Virginia, Delaware, and Washington, D.C. to facilitate linkage to support.

Professional Development: The Maryland State Department of Education [Division of Rehabilitation Services \(DORS\)](#) and the Maryland State Department of Labor assist with training, job coaching, resume building, workforce opportunities, and education, including preparation for the GED tests. The U.S. Department of Labor [Reentry Employment Opportunities \(REO\)](#) program provides funding, authorized as Research and Evaluation under Section 169 of the [Workforce Innovation and Opportunity Act \(WIOA\)](#) of 2014, for systems-involved youth and young adults and adults who were formerly incarcerated for the development of strategies and partnerships that facilitate the implementation of successful programs at the state and local levels to improve the workforce outcomes for this population. [WorkSource Montgomery](#) is the county's fiscal agent responsible for local administration of the WIOA and coordination of the local workforce development system in Montgomery County. In partnership with MCCF, WorkSource Montgomery operates its Dual-Track Reentry (DTR) program for justice-impacted individuals comprising a nationally recognized re-entry initiative within the correctional facility (Track 1) and a comprehensive suite of services for individuals housed in the community (Track 2). DTR has expanded its continuum of care to include a community-based program specialist providing career coaching and wraparound case management and a dedicated Talent Placement Consultant to connect individuals to open positions. Services offered at the career center within MCCF include one-on-one career coaching, mock interviewing, group workshops, and career-based programming. Community-based services include one-on-one career coaching, industry-focused training, and soft skills workshops; the Empowerment Center in Wheaton provides a dedicated space for career services for justice-involved individuals. This justice-impacted transitional program assists individuals with securing permanent, long-term employment through job placement partnerships with local businesses, and financial support through training funds up to \$5,000 and paid stipends to obtain work experience for up to 12 weeks. The public and internal (for staff and authorized partners) electronic referral forms are included in this report's "[Resources](#)" section. The WorkSource Montgomery Community Impact Team and Mobile Job Center are available to attend community events; representatives express an eagerness to arrange for mobile presentations by the Community Impact Team at reentry-affiliated locations with the Mobile Job Center present to connect justice-impacted individuals immediately following presentations, removing any transportation barriers.

Legal Assistance: [Maryland Legal Aid \(MLA\)](#) is Maryland's largest provider of free direct legal services and the state's third-largest law firm. As a private, non-profit law firm, MLA provides a full range of free civil (i.e., not criminal) legal services to low-income people in all 24 jurisdictions statewide from 12 office locations; cases involve a wide range of issues, including child custody, housing, public benefits, bankruptcy/debt collection, and criminal record

expungements to remove barriers to obtaining child custody, housing, and employment. The MLA Montgomery Office is located in Rockville.

Housing: The homeless management information system (HMIS) administered by HHS is a local information technology system used to collect client-level data and data on the provision of housing and services to individuals and families at risk of and experiencing homelessness. HMIS is designed to collect data on housing and services for individuals and families who are at risk of or experiencing homelessness. Information about HMIS, housing vouchers, and housing stability coordination is detailed in the [“Intercepts 0/1 Resources”](#) section.

Transportation: As discussed in the [“Intercepts 0/1 Resources”](#) section, [public transit](#) is available within and beyond the county via bus, shuttle, subway, and train; access to these services varies by location. Additional transportation is available on a limited basis through Interfaith Works, Tree of Hope, Office of the Public Defender, participating treatment centers, and recovery programs such as SMART, NA, and AA.

Community and Family Support: As detailed in the [“Intercepts 0/1 Resources”](#) section, family and community members can access peer support through organizations such as the National Alliance on Mental Illness (NAMI), which offers support groups and classes for families who have a loved one who is mentally ill to provide education, support, and advocacy. The [Conflict Resolution Center of Montgomery County](#) offers free or low-cost mediation and restorative conflict resolution services. When possible, pre-parole investigation can engage with family members, explain conditions of supervision, and incorporate family members in the reentry process, thereby helping the reentering citizen remain stable and avoid violations.

Data Collection and Sharing

The DOCR internal jail management system supports booking, intake, and housing records along with the calculation diminution of confinement release date records.

INTERCEPT 4/5 GAPS

Corrections Reentry Services

Services and Referrals: Overall, the county requires improved coordination between corrections reentry services and community reentry services to enhance reintegration. Improved collaboration can ensure a seamless transition, providing continuous support and access to essential resources while reducing the risk of recidivism. This gap has been highlighted in the [“Priorities for Change”](#) section below.

Reentry case management is time-consuming, as connecting individuals to support and services can involve lengthy applications. With the removal of the full-time on-site benefits specialist position, Medicaid and benefits enrollment has become disjointed, often failing to reach individuals in custody. While HHS works to reestablish the benefits specialist position, case managers are completing 17-page SNAP²⁹ benefits applications to the best of their abilities. Even as SOAR remains reportedly underutilized nationally in criminal-legal settings, local demand exceeds capacity. The county has been approved through three SOAR grant phases, and SOAR IV is approved to begin October 1, 2024; however, the state-funded SOAR case manager maintains an 8-10-person waitlist. Programs like SNAP, SOAR, and PATH all report a need for additional trained staff. Given limited resources, reentry teams are forced to prioritize some cases over others; as a result, those individuals who are receiving pretrial services are less likely to receive reentry services than in-facility individuals, particularly those pretrial individuals not being followed by the CATS team. Unfortunately, this gap is exacerbated by changes in the reentry landscape as a result of the Covid-19 pandemic; current estimates indicate that 80% of individuals are receiving pretrial supervision compared to 60% before the pandemic. This increase reflects a growing number of individuals who may not be receiving reentry services.

Unplanned releases are a widely acknowledged statewide challenge, reducing the time available to coordinate necessary supports including transportation from incarceration. This lack of preparation can complicate the reentry process, hindering effective reintegration into the community, increasing the risk of recidivism, and making it difficult to ensure that individuals receive the assistance they need. Stakeholders report that unplanned releases are especially problematic in regard to providing proper identification, without which housing, employment, and social services are difficult to access. For the 80% of the in-custody population receiving pretrial supervision, these challenges are amplified by uncertainty surrounding benefits activation. Participants report an opportunity to utilize targeted case management (TCM) to address some of the challenges presented by unplanned releases, especially given the broad eligibility for TCM; as previously mentioned in the “[Intercepts 0/1 Resources](#)” section, individuals can self-refer or be referred by non-professionals such as family members, and services can follow participants for several years.

Facilitating continuity of care before release is best practice but difficult to implement. Ideally, treatment appointments are scheduled in advance; however, Access (mentioned in the “[Intercepts 0/1 Resources](#)” section) faces a Medicaid billing barrier and is not able to enter the correctional facility; individuals are provided the information to navigate the challenging process of self-activating healthcare benefits within 60 days of release, but completion is not assured. All PRC residents are connected to HHS and apply for healthcare or services within 30

²⁹ The Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program, is a federal government program that provides food-purchasing assistance for low- and no-income individuals and households.

days of release; however, this is challenging for reentry staff given the previously described obstacles to benefits enrollment. Further, some PRC residents could obtain healthcare benefits or Medicaid through employment or family coverage (if under age 26). Individuals are not provided psychiatric or addiction medication upon release; instead, individuals leave with a two-week prescription and must have health insurance to find a pharmacy to fill it. With only a two-week supply of medication and many obstacles, scheduling follow-up appointments can be particularly challenging.

There are gaps in peer services as well. Individuals participating in substance use treatment programs within the correctional facility have access to peer recovery specialists on-site; however, those who do not meet eligibility for programs or are exclusively living with mental health conditions do not have similar access. Notably, connection to peers in the community before release is absent, although Tree of Hope has volunteered to support this initiative.

Supervision: Geographical barriers exist for supervised individuals. As mentioned previously, all Montgomery County supervision intakes must be completed in person within 24 hours of release at Rockville Intake. While virtual intakes are not possible, a change in protocol to allow supervision intakes at the three county locations and even outside of the county would reduce the burden of reporting individuals not located near Rockville.

Peer support is an identified need. Peers can aid in addressing the grave gap created by the fact that counsel from the Office of the Public Defender is not permitted to accompany clients to supervision intake appointments to ensure an understanding of supervision conditions. Peers can also assist with developing one-on-one meaningful interactions, freeing supervisors to provide intensive supervision given existing caseloads. When gaps in service exist and clients require assistance, peers (unlike supervisors) are uniquely positioned to assist with providing linkages to services.

Community Reentry Services

Within Montgomery County, barriers to resources vary by population. There is a desert of services for the broader systems-involved population as opposed to the acute mental health population; the undocumented population is even more challenging to serve. Generally, transportation, housing, and state hospital inpatient capacity are major gaps in the current system that require strategic planning within the county and with state-level stakeholders. The "[Parking Lot](#)" section addresses these critical issues, exploring potential solutions and strategies for improvement.

Self-determination is a growing force in public health, not just for persons with psychiatric disabilities. The county reports a significant number of reentering individuals not interested in reentry services, including but not limited to CATS participants. Reportedly, there is a need for

increased awareness between Intercepts 0 and 5 regarding the harm reduction services for people who use drugs who are disinterested or unwilling to enter into treatment; existing services are detailed in the [“Intercepts 0/1 Resources”](#) section. The county identifies an opportunity to promote voluntary participation by community-based organizations (both workforce-related and not) on the WorkSource Montgomery web-based community asset map to offer consumers the opportunity to connect with services at their discretion.

Behavioral Health Services: Targeted case management and psychiatric rehabilitation programming are reportedly underutilized. For other services, capacity shortages in the county result in the public receiving referrals to providers that cannot accommodate them. Although residential facilities are expanding capacity, these beds are reserved for psychiatric hospital discharges; participants note the overlap between Intercepts 0 and 5 consumers. Forensic assertive care teams (FACTs) are oversubscribed but are the least restrictive and best option for many clients. Newly legislated assisted outpatient treatment (AOT) is in the early stages of statewide development, and ACT teams are expecting to be included in implementation, likely increasing demand on staff.

Insurance acts as a major obstacle to reentry. Inactive insurance upon release from incarceration significantly hinders reintegration efforts; without active insurance, individuals struggle to access necessary healthcare services, complicating the transition back into the community. For individuals with substance use disorders, insurance gaps hamper efforts to continue recovery services received during incarceration.

Housing: Housing is an identified gap across intercepts that presents unique challenges based on need. Broadly, affordable housing presents an issue to all county residents, impacting access to safe and suitable living arrangements and community resources including but not limited to reentry-related services. For families, this issue is particularly challenging. Transitional housing is absent at the state level for individuals who are not diagnosed with mental health or substance use conditions (or do not admit to these conditions). Judges report that warm handoffs to transitional housing are needed to prevent unnecessary incarceration and to ensure a smooth and supportive transition, promoting successful reintegration into the community. Unfortunately, the current system in Montgomery County requires that systems-involved individuals who are unhoused must access the Crisis Center to seek shelter; there is no direct pipeline to beds which is a noticeable gap in service.

Community and Family Support: A notable gap across all intercepts is the need to improve family involvement; family support can be crucial to the reentry and reintegration process.

Data Collection and Sharing

Official recidivism data is not tracked but would be notably beneficial to evaluate reentry programming. Workshop participants indicated a need for quick access to information on eligibility for and availability of services. There is also a need for increased communication between all parties involved in reentry to support reintegration into the community effectively. Reportedly, DOCR does not have a digital case management system and staff does not utilize the DPSCS Offender Case Management System which allows DPSCS to compile, store, and share information about reentering individuals under its jurisdiction with multiple moduli which include but are not limited to case planning, booking, community supervision, corrections, and pretrial services.



PRIORITIES FOR CHANGE

At the conclusion of the workshop, participants are asked to identify a set of priorities followed by an opportunity for each participant to cast three distinct votes in order to rank the priorities. The top three priorities are highlighted in bold text.

- 1. Enhance the reentry process. (27 votes)** A robust and clear reentry process is vital for individuals transitioning from incarceration back into society, as it significantly impacts their ability to reintegrate successfully. A well-defined process helps ensure individuals returning to society may access essential services such as housing, employment, education, and healthcare. It also provides a structured framework that reduces the risk of recidivism by addressing the root causes of criminal behavior and supporting positive change. Clear guidelines and support mechanisms can empower individuals to rebuild their lives, improve public safety, and reduce the social and economic costs associated with high rates of reoffending. Efforts to enhance reentry may include developing a collaboration council or reentry workgroup to provide oversight, foster collaboration among stakeholders, and guide strategic planning efforts for reentry. Key objectives for this group may include establishing centralized case management to streamline services and ensure continuity of care, which can help address individual needs effectively. This group may also be uniquely suited for addressing reentry insurance barriers to ensure that individuals may access necessary healthcare services. Finally, this group may be able to cooperatively seek funding through sources such as the Performance Incentive Grant Fund administered by the Governor's Office of Crime Prevention and Policy referenced in the "[Intercept 2/3 Gaps](#)" section of this report.

- 2. Establish stabilization services. (25 votes)** An inability to access community-based behavioral healthcare on demand results in heavy reliance on the emergency department, law enforcement, and already overextended crisis response services. The county’s plan for a behavioral health crisis stabilization center is an opportunity to offer the community no-wrong-door access to mental health and substance use care, filling an essential role in a continuum of care that is fully integrated with the local community behavioral health and hospital systems. By following national guidelines for behavioral crisis care and implementing best practices, this center can establish complete and authentic hospital and criminal-legal diversion. To address stabilization and deflection needs before this center is available to residents, county executives have developed a proposal in coordination with MDH to expand the Crisis Center’s Stabilization Room; at the time of publication, MDH has provided funding for the Crisis Center’s Stabilization Room to stay in operation and expand to eight recliners to serve the lifespan to meet recently finalized COMAR regulations. Additionally, certified community behavioral health clinics (CCBHCs) are a promising practice offering a comprehensive range of mental health and substance use disorder services to vulnerable individuals; per federal criteria, they must directly provide or contract with partner organizations to provide nine types of services, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care. In addition to expanding crisis stabilization services, the CCBHC model addresses other identified priorities such as the need for behavioral health services across the continuum of care (Priority 4) and diversion options for law enforcement (Priority 6). HHS is a certified CCBHC, and federal grant money is available to aid in adopting the CCBHC model; there are currently several CCBHC-E grantees in Maryland including Cornerstone Montgomery.
- 3. Create a multidisciplinary team or teams to coordinate and inform across intercepts. (21 votes)** There is a desire to create a multidisciplinary team (or multiple teams) to foster inter-organizational cooperation across all intercepts. Identified objectives include planning for assistant outpatient treatment (AOT) legislation implementation, addressing insurance barriers across intercepts, eliminating information silos, and addressing the needs of the most challenging consumers. A notable obstacle is the hesitation to provide candid feedback that exists due to deeply ingrained historical procedures, chains of command, and perceived penalties. For this team or teams to synchronize strategies, mission partners must identify common goals, develop trust, and establish processes to coordinate across a diverse group of organizations with differing cultures, policies, priorities, authorities, capabilities, and procedures. Transparency, inclusive access, and shared operating procedures foster unity of effort.

4. Increase behavioral health services across the continuum of care. **(18 votes)** Residential services (Level 3) lie between inpatient and outpatient services and are essential for preventing or providing an alternative to inpatient admission. Service capacity is the key to ensuring that people with behavioral health conditions who need more intensive and longer-term services over a longer term can live supported in the community; residential crisis services also make it possible for people to be discharged successfully from stays in local hospitals or state psychiatric care institutions. As noted in the [“Intercept 0/1 Gaps”](#) section, Montgomery County currently has one provider of Levels 3.1, 3.3, and 3.5 care; while one additional provider is reportedly seeking licensure for Level 3.1, there is a critical need for residential services. The county must actively advocate to restore capacity while seeking additional funding to preserve and expand existing local resources to improve care for residents.
5. Improve data sharing among agencies. **(16 votes)** Effective data sharing among agencies at the intersection of behavioral health and the criminal legal system is essential for enhancing the coordination of care and appropriately addressing the needs of individuals. Currently, siloed information systems hinder the ability to track individuals’ progress and identify gaps in services, leading to fragmented care and missed opportunities for intervention. By establishing robust data-sharing protocols, agencies can collaborate more effectively, ensuring that all relevant parties have access to comprehensive information about an individual's history and needs. This increased transparency can help identify patterns, reveal areas requiring additional resources or interventions, and facilitate the development of targeted programs and services. Jurisdictions across the state express the need for additional HIPAA/FERPA guidance as noted in the [“Intercept 0/1 Gaps”](#) section of this report; the Governor’s Office of Crime Prevention and Policy is researching the legal requirements and parameters of this issue in the hopes of providing guidance that can be applied at the state level. One possibility to explore is the development of a database that expands the current resource directory. By providing a search option with filters for insurance, eligibility, location, and current openings, the county can provide a more accessible and user-friendly resource while also tracking trends in usage and availability to inform strategic planning.
6. Enhance diversion options for law enforcement other than mobile crisis. **(12 votes)** There is a pressing need to enhance response options for law enforcement. Hospitalization and arrest are often costly and ineffective for individuals experiencing a crisis, and the mobile crisis outreach team (MCOT) capacity is insufficient to meet the deflection demand. These limited options can lead to repeated interactions with public safety agencies and contribute to the entanglement of individuals in the criminal legal system. Expansion of diversion options could include establishing community-based crisis centers, providing access to mental health professionals who can work alongside law enforcement, and implementing

specialized training programs that equip officers with skills to de-escalate situations and connect individuals to appropriate services. These alternatives can reduce the burden on emergency and legal systems while promoting more compassionate and effective responses to those in crisis. Notably, Bill 43-23 pending before the Montgomery County Council, sponsored by Councilmember Dawn Luedtke, would create an Advisory Committee on Crisis Intervention and Application of the SIM to formalize the ongoing interagency, collaborative work that must be done to strengthen and continually evolve Montgomery County's crisis response models and enhance diversion and support services.

7. Streamline daily communications across agencies and intercepts; this priority is specifically targeting the coordination of "boots on the ground" communications rather than policy or data as listed in the priorities above. (11 votes) Essential cross-agency collaboration is realized through personal relationships, memorandums of understanding (MOUs), and shared protocols; one highly effective strategy to align efforts advanced technology such as real-time bed registries and shared GPS-enabled communication to support dispatch and coordination of care. The ultimate goal, best described by summarizing the Department of Homeland Security, is the ability to communicate as needed, on demand, and as authorized at all levels and across all disciplines.
8. Expand training opportunities (e.g. trauma-informed care, implicit bias/anti-stigma, crisis intervention team training, and integrated behavioral health in primary care). (8 votes) The state has a legitimate interest in providing care to those who are unable to care for themselves; the state also has authority under its police power to protect the community.³⁰ To ensure the safety of individuals with behavioral health needs, those who provide services to them, and the general public, there is a need for continuous education and training. Professionals and the lay community can benefit from an expanded and shared knowledge base. There are widely available training opportunities through local, state, and national organizations. Trauma-informed care training and education is offered to clinicians, educators, service providers, medical providers, and the community through SAMHSA, the Mental Health Association of Maryland, the Collaborative within the University of Maryland School of Social Work, and the University of Maryland Medical Center. Implicit bias and anti-stigma education are available to the general public through Shatterproof and Just Five (described in the "[Intercept 0/1 Gaps](#)" section) and to Maryland healthcare professionals through the Maryland Department of Health Office of Minority Health and Health Disparities. To ensure equity, education should be provided by organizations with experience supporting diverse populations, and when possible, by instructors who reflect the community's demographics.

³⁰ Under *parens patriae*, a state or court has a protective role over its citizens or others under its jurisdiction.

9. Address language barriers between providers and community members. (3 votes)

Montgomery County is one of the most diverse regions in the United States, characterized by a rich tapestry of cultures, languages, and ethnicities. This diversity is reflected in the wide range of languages spoken within the community, which can present challenges in behavioral health and criminal legal settings. Stakeholders have expressed concerns about language barriers between providers and clients/patients, noting that these obstacles hinder the quality of care and outcomes. Addressing these barriers is essential to ensure equitable access to services and support for all individuals, regardless of their linguistic background. Providing culturally competent care and language support, such as interpreters or multilingual staff, are crucial to meeting the needs of the community in these settings. Notably, there is an open solicitation for mental health providers to access translation services through the Local Behavioral Health Authority, aiming to improve service delivery and outcomes. This resource is underutilized and should be promoted widely to community providers.



QUICK FIXES/LOW-HANGING FRUIT

While most priorities identified during a sequential intercept model mapping workshop require significant planning and resources to implement, quick fixes are priorities that can be implemented with minimal investment of time and little if any, financial investment. Nonetheless, quick fixes can have a significant impact on the trajectories of people with behavioral health needs in the justice system.

1. A discussion was held about enhancing information sharing among agencies; participants emphasized the importance of improved communication and collaboration to better serve individuals in crisis. This initiative aims to streamline the referral process and ensure that those in need receive timely and appropriate support.
 - a. In an effort to address this concern, the workshop's planning group provided participants with a QR code linking to a resource directory developed by the Local Behavioral Health Authority. This live-maintained directory includes a list of employers who hire individuals recently released from incarceration. However, due to its extensive nature, it may not be the most practical solution for professionals who do not provide case management such as patrol officers and public defenders.
 - b. Law enforcement participants expressed a need for business-like cards with reliable and attainable resources to provide to individuals in crisis; representatives from the Office of the Public Defender expressed a similar desire. They noted that while the community has many resources and services available, few meet the eligibility criteria for those in immediate need. The Primary Care Coalition offered to begin this project, aiming to create a more effective and accessible support system.

- c. The Active Assailant Interdisciplinary Work Group (AAIWG) website (<https://aaiwg.maryland.gov/>) was noted as a useful tool that provides valuable resources, including forms for the release of medication information and coordination of care.
2. Judges reportedly feel limited in their options for diversion due to a lack of awareness of and linkages to appropriate resources. Judges also expressed a need for more information about community resources and their eligibility criteria to offer alternatives to incarceration. This report will serve to educate this intercept on gaps and available resources, potentially providing judges with more informed options for diversion programs.
3. Participants repeatedly discussed the importance of training to properly serve systems-involved individuals with behavioral health needs, emphasizing the necessity for specialized knowledge and skills. Notably, Shatterproof and SAMHSA's anti-stigma education were highlighted as valuable training programs for judges and other stakeholders. Additionally, SSI/SSDI Outreach, Access, and Recovery (SOAR) training was mentioned as a valuable resource for anyone in the community. The training is designed to help case managers and other service providers assist individuals who are experiencing or at risk of homelessness in applying for Social Security disability benefits (SSI/SSDI). SOAR aims to improve access to critical benefits for vulnerable populations, enhancing their financial stability and access to necessary services. It was noted that individuals involved in the mental health court, psychiatric rehabilitation programs, and targeted case management have already been SOAR-trained. Representatives from the Tree of Hope expressed interest in receiving this training.
4. As discussed in the "[Intercept 4/5 Resources](#)" section, representatives from WorkSource Montgomery have expressed an eagerness to coordinate with DPSCS and other reentry partners to arrange mobile presentations from the WorkSource Montgomery Community Impact Team at reentry-affiliated locations with the WorkSource Montgomery Mobile Job Center on-site to allow individuals to be connected with services immediately, removing any transportation barriers.
5. As mentioned in the "[Intercept 0/1 Gaps](#)" section, updated language for the EMS transport billing law has been awaiting a legislative vote for over two years. Councilmember Luedtke and her staff have expressed a willingness to engage with MCFRS Chief Smedley and Montgomery County Chief Administrative Officer (CAO) Madaleno to prompt a vote to ensure sustainable funding for EMS diversion strategies; workshop participants widely express a willingness to support this legislation.



PARKING LOT

Some gaps identified during the sequential intercept model mapping are too large or in-depth to address during the workshop. Given the importance of these concerns, however, they are included in the report to inform future strategic planning at the local and statewide levels.

1. Address the lack of housing options for individuals with behavioral health needs. Safe and affordable housing is a basic necessity; its absence is one of the most significant barriers to recovery. Without stable housing, individuals may struggle to achieve goals while cycling in and out of homelessness, shelters, hospitals, and jails. The county has identified gaps across the housing spectrum detailed in the [“Intercept 0/1 Gaps”](#) and [“Intercept 4/5 Gaps”](#) sections. In summary, affordable housing is difficult to obtain for the general population and more so for special populations. Requirements associated with voucher programs, shortages of supportive housing, rigid certification requirements for recovery housing, and indirect connections to transitional housing from hospitalization or incarceration all impede the county’s housing goals; stigma surrounding housing for these populations creates challenges as well. Lowering or eliminating barriers can serve as a simple step to capitalize on existing effective strategies; by expanding existing programs, the county can work to address the need for community-based transitional housing from the hospital, housing for "grey-zone" individuals who are not an immediate safety threat but are non-compliant with care, peer-run forensic housing, and adequate recovery housing. The LBHA is reportedly exploring replicating the successful model used by Miracle House and Harmony House for use by individuals with mental illness who are not involved in problem-solving courts.
2. Expand in-patient capacity at the state level. There are five state inpatient psychiatric hospitals in Maryland with a total of 1,056 beds: Clifton T. Perkins Hospital Center, Springfield Hospital Center, Spring Grove Hospital Center, Thomas B. Finan Center, and Eastern Shore Hospital Center. Among them, Perkins is the sole designated

maximum-security forensic facility; however, all five hospitals treat court-ordered patients. Courts have ruled repeatedly that delays in court-ordered mental health assessments and care violate the law.³¹ Maryland law requires that a defendant under court-ordered commitment be transferred to a health facility within 10 days of the order; however, individuals are waiting up to 180 days or more.³² Maryland Department of Health has testified that while 500 court orders per year were typical five years ago, the latest data shared by the state reports 1,126 admission orders in 2023, a sharp increase even from the 865 total from the year before. Montgomery County reportedly has the longest waitlist in the State; as described in the “[Intercept 2/3 Gaps](#)” section. Efforts are underway to expand capacity by creating 44 additional beds at Thomas B. Finan Center by the end of 2025; there are also long-term plans to expand capacity at Perkins Hospital Center. In June 2023, Section 13-4801 through 13-4807, 13-4901 through 13-4907, 15-141.2 of the Health General Article of the Maryland Code established the Commission on Behavioral Health Care Treatment and Access, under which the Criminal Justice-Involved Behavioral Health Workgroup and the legislative task force are mandated to oversee this issue over the next four years. Additional efforts in Montgomery County include the development of a multidisciplinary group comprising representatives from the Maryland Department of Health, the Department of Correction and Rehabilitation, the Montgomery County Police Department, the Department of Health and Human Services, court personnel, and the State Attorney's Office. This group convened twice a month from December 2023 to June 2024 to address the county's critical concerns with hospital waitlists; meetings facilitated comprehensive discussions on current inmate populations, projected trends, and potential solutions to manage overcrowding; representatives also worked through individual cases to optimize bed usage and promote rehabilitation of those on the waitlist. While service gaps in diversion efforts were identified, minimal progress was made in identifying long-lasting solutions.

3. Enhance transportation options for individuals with behavioral health needs across intercepts. Enhancing transportation options for individuals with behavioral health needs before, during, and after involvement with the criminal legal system is essential for promoting equitable access to services and support. Montgomery County offers a range of public transportation options, including buses, shuttles, subways, and trains; additional transportation options are listed in the “[Community Services](#)” section above. However, many services require payment and their accessibility varies depending on the location. Transportation barriers pose significant challenges to systems-involved individuals with behavioral health conditions, especially those reentering the community following incarceration. These barriers can be described as the 5 A's: affordability, accessibility,

³¹ See *Powell v. Md. Dep't of Health*, 455 Md. 520 (2017) and *State v. Crawford*, 239 Md. App. 84, 119 (2018).

³² See Sections 3-106, 3-112 of the Criminal Procedure Article of the Maryland Code.

applicability, availability, and awareness. Reliable transportation enables individuals to easily access community prevention services, attend court hearings, and make it to crucial appointments post-release, such as probation meetings, counseling, and job interviews. Federal funding for transportation initiatives is available; programs can also seek support from the community and private foundations. In the resource [Getting There: Helping People With Mental Illnesses Access Transportation](#), the U.S. Department of Health and Human Services provides more detailed evidence-based recommendations to address transportation barriers.

4. Expand services for individuals with developmental disabilities and neurocognitive disabilities. Systems-involved individuals with behavioral health needs and co-occurring developmental disabilities and/or neurocognitive conditions, often face significant challenges in accessing appropriate community services. These individuals are frequently underserved in essential areas such as housing. Community services often lack the necessary resources and specialized programs to address the unique needs of this population, leading to inadequate support and care. Additionally, the judicial process lacks the appropriate resources to serve this population. Communities often establish specialized courts or dockets to address specific issues such as mental health, substance use, and Veterans' needs. However, specialized courts or dockets for individuals with IDD and NC conditions are far less prevalent. Montgomery County faces significant barriers in providing adequate services for this population within the judiciary system. The absence of specialized courts in the county leaves individuals with IDD and NC conditions without tailored judicial support. Additionally, the Office of the Public Defender (OPD) cannot reportedly manage this specialized caseload effectively with only two social workers on staff, exacerbating the challenges these individuals face in navigating the justice system. These gaps in services result in heightened vulnerability and a cycle of repeated involvement with the criminal justice system, further complicating their ability to achieve stability and rehabilitation.
5. Host a SIM mapping workshop for systems-involved youth with behavioral health needs to expand and enhance youth services. The SIM is primarily designed for the adult population, leading to a lack of in-depth discussions about youth under the age of 18. Recognizing the critical need for youth services, Montgomery County emphasizes the importance of prevention and intervention at a young age. Early intervention is essential to address behavioral health issues before they escalate, reducing the risk of future justice involvement and promoting long-term well-being. In response to this national need, SAMHSA is working to establish a youth-specific SIM model. This initiative aims to adapt the existing framework to better address the unique needs of young people, integrating prevention and intervention strategies that are developmentally appropriate and effective for this age group.

RESOURCES

LOCAL RESOURCES

Community Services

- Alcohol and Other Drug Addiction Advisory Council (AODAAC):
<https://www.montgomerycountymd.gov/HHS-Program/BHCS/AODAAC/NewAODAAC/Index.html>
- Behavioral Health Resource Directory:
<https://drive.google.com/drive/folders/13xG7qO3OcXo22IsIdWIS5dgcDrMzblAl>
- Bethesda Cares: <http://bethesdacares.org/our-services/>
- Coalition for the Homeless: <https://mcch.net/>
- Coalition Homes: <https://mcch.net/affordable-housing/>
- Commission on Veteran Affairs:
<https://www.montgomerycountymd.gov/HHS-Program/ADS/CVA/CVAIndex.html>
- Department of Health and Human Services (HHS):
<https://www.montgomerycountymd.gov/HHS-Program/BHCS/BHCSLBHA.html>
- Department of Transportation Public Transit:
<https://www.montgomerycountymd.gov/DOT-DIR/commuter/pubtrans/index.html>
- Easterseals Homeless Veterans Reintegration Program (HVRP):
<https://www.easterseals.com/DCMDVA/programs-and-services/military-veteran-services/veterans-employment.html>
- Flash Bus Rapid Transit Network: <https://www.montgomerycountymd.gov/brt/>
- Homeless Services Guide:
<https://www.montgomerycountymd.gov/HHS/Resources/Files/pdfs/Homeless%20Resource%20Guide-July%202015.pdf>
- Housing Initiative Program (HIP):
<https://www3.montgomerycountymd.gov/311/Solutions.aspx?SolutionId=1-6IWbMT>
- Interagency Commission on Homelessness (ICH):
<https://www.montgomerycountymd.gov/homelessness/>
- Interfaith Works: <https://www.iworksmc.org/>
- Just Five: <https://justfive.org/>
- Maryland Treatment Centers (MTC):
<https://health.maryland.gov/newsroom/Pages/Program-for-youth-struggling-with-substance-and-opioid-use-disorders.aspx>
- Medical Assistance Transportation:
<https://www.montgomerycountymd.gov/dot-transit/special-transportation/medical-assistance-transportation-program.html>

- Mental Health Advisory Committee (MHAC):
<https://www.montgomerycountymd.gov/HHS-Program/BHCS/MHAC/Index.html>
- Mobile Med: <https://mobilemedicalcare.org/home/about-mobile-med/>
- Montgomery Cares:
<https://www.primarycarecoalition.org/what-is-montgomery-cares.html>
- Network of Care for Behavioral Health:
<https://mentalhealth.networkofcare.org/Montgomery-md>
- Nexus Montgomery: <https://www.nexusmontgomery.org/>
- Primary Care Coalition (PCC): <https://www.primarycarecoalition.org/about-pcc.html>
- Progress Place: <https://silverspringdowntown.com/go/progress-place>
- Rental Assistance Program (RAP):
<https://www.montgomerycountymd.gov/HHS-Program/SNHS/SNHSRental-p743.html>
- Senior Assisted Living Subsidy (SALS) Program:
<https://aging.maryland.gov/Pages/Senior-Assisted-Living-Subsidy-Program.aspx>
- Serving Together: <https://servingtogetherproject.org/>
- Silver Spring Vet Center: <https://www.va.gov/silver-spring-vet-center/>
- Steven A. Cohen Military Family Clinic (“Cohen Clinic”):
<https://www.easterseals.com/DCMDVA/programs-and-services/cvn-home.html>
- Takoma East Silver Spring (TESS) Community Action Center:
<https://www.montgomerycountymd.gov/HHS-Program/OCA/OCATESS-p351.html>
- The Valley: <https://www.thevalleydmv.com/index>
- U.S. Census Bureau American Community Survey, Montgomery County:
<https://data.census.gov/all?q=american%20community%20survey%20montgomery%20county%20md>
- Utility Assistance Program:
<https://www.montgomerycountymd.gov/HHS-Program/SNHS/SNHSUtilityA-p746.html>
- VA Clinic:
<https://www.va.gov/washington-dc-health-care/locations/montgomery-county-va-clinic/>
- Veterans Directory: <https://www.montgomerycountymd.gov/vnd>

Community Reentry Services

- Worksource Montgomery Internal Electronic Referral Form:
<https://worksourcemontgomery.jotform.com/211883831363054>
- Worksource Montgomery External Electronic Referral Form:
<https://worksourcemontgomery.com/home/contact/>
- Division of Rehabilitation Services (DORS):
<https://dors.maryland.gov/consumers/Pages/about.aspx>
- Reentry Employment Opportunities (REO): <https://www.dol.gov/agencies/eta/reentry>

- Workforce Innovation and Opportunity Act (WIOA) of 2014:
<https://www.dol.gov/agencies/eta/wioa>
- Maryland Legal Aid (MLA): <https://www.mdlab.org/>
- Conflict Resolution Center of Montgomery County:
<https://www.courts.state.md.us/macro/adr/montgomery>

Court-Ordered Services

- Emergency Evaluations, Maryland Courts:
<https://www.mdcourts.gov/district/emergencyevaluations>
- Pre-trial Services, Department of Correction and Rehabilitation:
<https://www.montgomerycountymd.gov/COR/PTS/index.html>
- ACS Program Referral Form:
https://www.montgomerycountymd.gov/COR/Resources/Files/DOCR-ACS-Probation-Referral-Form_NEW_2023.docx

Court Structure

- Adult Drug Court, Montgomery County:
<https://www.montgomerycountymd.gov/cct/drug-court.html>
- Adult Drug Court Treatment Program, Montgomery County:
<https://www.montgomerycountymd.gov/HHS-Program/BHCS/BHCSAdultDrugCourt-p487.html>
- Mental Health Court Montgomery County, State’s Attorney’s Office:
<https://www.montgomerycountymd.gov/SAO/other/mentalhealthcourts.html>

Data Collection and Sharing

- dataMontgomery: <https://data.montgomerycountymd.gov/>
- Maryland Active Assailant Interdisciplinary Work Group (AAIWG):
<https://aaiwg.maryland.gov/>

Detention and Corrections

- Montgomery County Detention Center:
<https://www.montgomerycountymd.gov/COR/MCDC/index.html>
- Montgomery County Correctional Facility:
<https://www.montgomerycountymd.gov/COR/MCCF/index.html>
- Medical Services:
<https://www.montgomerycountymd.gov/COR/MCCF/MedicalServices.html>

- Mental Health Services:
<https://www.montgomerycountymd.gov/COR/MCCF/MentalHealth.html>
- Mental Health Services Addictions Treatment:
<https://www.montgomerycountymd.gov/COR/MCCF/AddictionsTreatment.html>
- Mental Health Services Crisis Intervention Unit (CIU):
<https://www.montgomerycountymd.gov/COR/MCCF/CIU.html>
- Mental Health Services Dialectical Behavior Therapy:
<https://www.montgomerycountymd.gov/COR/MCCF/DBTProgram.html>
- Montgomery County Department of Correction and Rehabilitation, Detention Services Division. (n.d.). *Facility programs and services*.
<https://www.montgomerycountymd.gov/COR/Resources/Files/PDF/MCDOCR-DSD-FacilityProgramServiceSummary.pdf>

First Responders

- Effective Law Enforcement For All Inc. (June 2021). *Review of the Montgomery County, Maryland Police Department (MCPD)*.
<https://www.montgomerycountymd.gov/rps/Resources/Files/reports/ELEFA-MCPD-Full-Report-v7.pdf>
- Maryland State Police Barrack N:
<https://mdsp.maryland.gov/Organization/Pages/FieldOperationsBureau/BarrackNRockville.aspx>
- Montgomery County Fire Rescue Service (MCFRS):
<https://www.montgomerycountymd.gov/mcfrs/>
- Montgomery County Police Department (MCPD):
<https://www.montgomerycountymd.gov/pol/>
- Montgomery County Sheriff's Office: <https://www.montgomerycountymd.gov/Sheriff/>

Primary, Long-Term, and Recovery Services

- Access to Behavioral Health Services (“Access”):
<https://www3.montgomerycountymd.gov/311/Solutions.aspx?SolutionId=1-5WY9AU>
- Community Behavioral Health Association (CBH) of Maryland:
<https://www.mdcbh.org/about-us>
- Cornerstone Montgomery: <http://www.cornerstonemontgomery.org/>
- Depression and Bipolar Support Alliance: <https://www.dbsalliance.org/>
- Elevate Recovery Centers: <https://elevaterecoverycentermd.com/>
- Housing Unlimited Inc. (“Housing Unlimited”): <https://www.housingunlimited.org/>
- Medbank: <http://www.needymeds.org/>
- Mike’s Place: <https://mikesplacerockville.com/>

- NAMI Maryland: <http://namimd.org/>
- NAMI Montgomery County: <https://namimc.org/>
- People Encouraging People (PEP): <http://www.peponline.org/>
- Projects for Assistance in Transition from Homelessness (PATH): <https://www.samhsa.gov/homelessness-programs-resources/path>
- Rock Creek Foundation: <https://www.rockcreek.org/>
- Sandstone Care: <https://www.sandstonecare.com/locations/north-bethesda-transitional-living-program/>
- Santé Group's Silver Spring Wellness and Recovery Center: <https://www.thesantegroup.org/where-we-work/montgomery-county-md/>
- Sheppard Pratt: <http://www.sheppardpratt.org/>
- Tree of Hope Association ("Tree of Hope"): <https://www.treeofhopeassn.com/>
- Vesta: <https://www.vesta.org/>
- Vocational Support Systems (VSSI): <https://vssi4jobs.com/index.html>
- Washington Area Intergroup Association of Alcoholics Anonymous: <https://aa-dc.org/>

Urgent and Acute Services

- Certified community behavioral health clinics (CCBHCs): <https://www.samhsa.gov/certified-community-behavioral-health-clinics>
- EveryMind: <https://www.everymind.org/>
- Montgomery County Crisis Center: <https://www.montgomerycountymd.gov/HHS-Program/Program.aspx?id=BHCS/BHCS24hrcrisiscenter-p204.html>
- Safe Journey House: <http://www.safejourneyhouse1.com/>

STATE RESOURCES

- Kahlert Foundation. (n.d.) <https://www.thekahlertfoundation.org/>
- Maryland Department of Health, Behavioral Health Administration. (2016.) *BHA continuum of care policy and procedure manual*. [https://health.maryland.gov/bha/Documents/CoC%20Policy%20and%20Procedure%20Manual rev 2 8 17.pdf](https://health.maryland.gov/bha/Documents/CoC%20Policy%20and%20Procedure%20Manual%20rev%202%208%2017.pdf)
- Maryland Courts. (2018). *Extreme risk protective orders*. <https://mdcourts.gov/district/ERPO>
- Maryland Department of Education Division of Rehabilitation Services. (n.d.) *About DORS*. <https://dors.maryland.gov/consumers/Pages/about.aspx>
- Maryland Department of Health, Behavioral Health Administration. (n.d.). *Maryland certification of recovery residences*. <https://health.maryland.gov/bha/Pages/Recovery-Residences.aspx>

- Maryland Department of Health, Maryland Medicaid Administration (n.d.). *Collaborative Care Model Provider Information*.
<https://health.maryland.gov/mmcp/Pages/Collaborative-Care-Providers.aspx>
- Maryland Department of Health and Mental Hygiene (DHMH). (2007). *Rights of persons in Maryland's psychiatric facilities*.
<https://health.maryland.gov/bha/Documents/Rights%20of%20Persons%20in%20Maryland%27s%20Psychiatric%20Facilities%20Handbook%20rotate.pdf>
- Maryland Department of Veterans Affairs. (n.d.). *Veterans*.
<https://veterans.maryland.gov/>
- Maryland Judiciary. (2022). *Petition for Emergency Evaluation (Maryland Code, Health General Article § 10-620 et seq.)*.
<https://www.courts.state.md.us/sites/default/files/court-forms/courtforms/joint/ccdc013.pdf/ccdc013.pdf>
- Maryland Legal Aid. (2023). <https://www.mdlab.org/>
- NAMI Maryland. (2024). <http://namimd.org/>
- On Our Own of Maryland Inc. (2024). <https://www.onourownmd.org/s/>
- Sheppard Pratt. (2023). *Assertive community treatment (ACT)*.
<https://www.sheppardpratt.org/care-finder/assertive-community-treatment-act/>
- Sklar, J. (2022). *Maryland launches new program to help reduce suicides for veterans*. State of Reform.
<https://stateofreform.com/news/2022/12/maryland-launches-new-program-to-help-reduce-suicides-for-veterans/>
- Maryland Insurance Administration. (n.d.). *Health Coverage Assistance Team*.
<https://insurance.maryland.gov/Consumer/Pages/Health-Coverage-Assistance-Team.aspx>

x

NATIONAL RESOURCES

Brain Injury

- National Association of State Head Injury Administrators. (2020). *Criminal and juvenile justice best practice guide: Information and tools for state brain injury programs*.
https://static1.squarespace.com/static/5eb2bae2bb8af12ca7ab9f12/t/5f66af29885b214e6f2b34ef/1600565034533/Criminal+and+Juvenile+Justice+Best+Practice+Guide_Final+edits+9-9-20.pdf
- National Association of State Head Injury Administrators. (2023). *Criminal and juvenile justice best practice guide for state brain injury programs: Supporting materials*.
<https://www.nashia.org/cj-best-practice-guide-attachments-resources-copy>

Competence Evaluation and Restoration

- Finkle, M., Kurth, R., Cadle, C., and Mullan, J. (2009). Competency courts: A creative solution for restoring competency to the competency process. *Behavioral Science and the Law*, 27, 767-786.
<http://onlinelibrary.wiley.com/doi/10.1002/bsl.890/abstract;jsessionid=5A8F5596BB486AC9A85FDFBEF9DA071D.f04t04>
- Policy Research Associates. (2023). *Competence to stand trial*.
<https://www.prainc.com/competence/>
- Policy Research Associates. (2020). *Quick fixes for effectively dealing with persons found incompetent to stand trial*.
<https://www.prainc.com/wp-content/uploads/2020/09/ISTRebrand-508.pdf> Original work published 2007)

Crisis Care, Crisis Response, and Law Enforcement

- Abt Associates. (2020). *A guidebook to reimagining America's crisis response systems*.
https://www.abtassociates.com/files/Projects/PDFs/2020/reimagining-crisis-response_20200911-final.pdf
- Bureau of Justice Assistance. (n.d.). *Police-mental health collaboration toolkit*.
<https://bja.ojp.gov/program/pmhc>
- Cordico. (2023). *Wellness apps*. <https://www.cordico.com/>
- Center for American Progress. (2020). *The community responder model: How cities can send the right responder to every 911 call*.
<https://www.americanprogress.org/issues/criminal-justice/reports/2020/10/28/492492/community-responder-model/>
- Crisis Intervention Team International. (2019). *Crisis intervention team (CIT) programs: A best practice guide for transforming community responses to mental health crises*.
<http://citinternational.org/Sys/Store/Products/20523>
- International Association of Chiefs of Police. (n.d.). *One Mind Campaign: Enhancing law enforcement engagement with people in crisis, with mental health disorders and/or developmental disabilities*. <https://www.theiacp.org/projects/one-mind-campaign>
- International Association of Chiefs of Police. (2016). *Improving police response to persons affected by mental illness: Report from March 2016 IACP Symposium*.
<https://www.theiacp.org/sites/default/files/all/i-j/ImprovingPoliceResponsetoPersonswithMentalIllnessSummaryGuide.pdf>
- National Association of State Mental Health Program Directors. (n.d.). *Crisis Now: Transforming crisis services*. <https://crisisnow.com/>

- National Association of Counties. (2010). *Crisis care services for counties: Preventing individuals with mental illnesses from entering local corrections systems.*
https://www.uwgb.edu/UWGBCMS/media/bhttp/files/Crisis_Care_in_CJ.pdf
- National Association of State Mental Health Program Directors. (2020). *Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies.*
<https://www.nasmhpd.org/sites/default/files/2020paper11.pdf>
- National Association of State Mental Health Program Directors and Treatment Advocacy Center. (2017). *Beyond beds: The vital role of a full continuum of psychiatric care.*
https://nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf
- Open Society Foundations. (2018). *Police and harm reduction.*
<https://www.opensocietyfoundations.org/uploads/0f556722-830d-48ca-8cc5-d76ac2247580/police-harm-reduction-20180720.pdf>
- Optum. (2015). *In Salt Lake County, Optum enhances jail diversion initiatives with effective crisis programs.*
https://www.optum.com/content/dam/optum3/optum/en/resources/white-papers/8782_GOV_SLCCountyJailDiversion_Final_HR.pdf
- Policy Research Associates and the National League of Cities. (2020). *Responding to individuals in behavioral health crisis via co-responder models: The roles of cities, counties, law enforcement, and providers.*
<https://www.prainc.com/wp-content/uploads/2020/03/RespondingtoBHCrisisviaCRModels.pdf>
- R Street. (2019). *Statewide policies relating to pre-arrest diversion and crisis response.*
<https://www.rstreet.org/wp-content/uploads/2019/10/Final-187.pdf>
- Substance Abuse and Mental Health Services Administration. (2014). *Crisis services: Effectiveness, cost-effectiveness, and funding strategies.*
<https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848>
- Substance Abuse and Mental Health Services Administration. (2019). *Tailoring crisis response and pre-arrest diversion models for rural communities.*
https://store.samhsa.gov/product/Tailoring-Crisis-Response-and-Pre-Arrest-Diversion-Models-for-Rural-Communities/PEP19-CRISIS-RURAL?referer=from_search_result
- Substance Abuse and Mental Health Services Administration. (2020). *Crisis services: Meeting needs, saving lives.*
<https://store.samhsa.gov/product/crisis-services-meeting-needs-saving-lives/PEP20-08-01-001>
- Substance Abuse and Mental Health Services Administration. (2020). *National guidelines for behavioral health crisis care: Best practice toolkit.*

<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

- Suicide Prevention Resource Center. (2013). *The role of law enforcement officers in preventing suicide*.
<https://www.sprc.org/resources-programs/role-law-enforcement-officers-preventing-suicide-sprc-customized-information>
- Urban Institute. (2020). *Alternatives to arrests and police responses to homelessness: Evidence-based models and promising practices*.
<https://www.urban.org/research/publication/alternatives-arrests-and-police-responses-homelessness>
- Vera Institute of Justice. (2020). *Behavioral health crisis alternatives: Shifting from policy to community responses*. <https://www.vera.org/behavioral-health-crisis-alternatives>

Housing

- Alliance for Health Reform. (2015). *The connection between health and housing: The evidence and policy landscape*.
https://www.allhealthpolicy.org/wp-content/uploads/2017/01/Health-and-Housing-Toolkit_168.pdf
- Community Solutions. (2023). *Built for Zero*.
<https://community.solutions/built-for-zero/the-movement/>
- Corporation for Supportive Housing. (2022). *Guide to the frequent users systems engagement (FUSE) model*. <https://www.csh.org/fuse/>
- Corporation for Supportive Housing. (2022). *NYC frequent user services enhancement – evaluation findings*.
<https://www.csh.org/2014/03/nyc-fuse-evaluation-decreasing-costs-and-ending-homelessness/#:~:text=What%20the%20evaluation%20indicates%20is,spent%20by%20the%20comparison%20group.>
- Corporation for Supportive Housing. (2022). *Housing is the best medicine: Supportive housing and the social determinants of health*.
<https://www.csh.org/resources/housing-is-the-best-medicine-supportive-housing-and-the-social-determinants-of-health/>
- Economic Roundtable. (2013). *Getting home: Outcomes from housing high cost homeless hospital patients*. <http://economicrt.org/publication/getting-home/>
- Substance Abuse and Mental Health Services Administration. (2015). *TIP 55: Behavioral health services for people who are homeless*.
<https://store.samhsa.gov/product/TIP-55-Behavioral-Health-Services-for-People-Who-Are-Homeless/SMA15-4734>

- Urban Institute. (2012). *Supportive housing for returning prisoners: Outcomes and impacts of the Returning Home-Ohio pilot project*. <https://www.urban.org/research/publication/supportive-housing-returning-prisoners-outcomes-and-impacts-returning-home-ohio-pilot-project>
- Substance Abuse and Mental Health Services Administration. (n.d.). *Homelessness programs and resources*. <https://www.samhsa.gov/homelessness-programs-resources>
- State of Hawaii Office on Homelessness and Housing Solutions (OHHS). *100,000 Homes: Housing First self-assessment*. <https://homelessness.hawaii.gov/wp-content/uploads/2015/10/Housing-First-Self-Assessment-Tool-FINAL1.pdf>
- U.S. Department of Housing and Urban Development. (2024). *Continuum of Care Program*. https://www.hud.gov/program_offices/comm_planning/coc

Information Sharing/Data Analysis and Matching

- American Probation and Parole Association. (2014). *Corrections and reentry: Protected health information privacy framework for information sharing*. <http://www.appa-net.org/eweb/docs/APPA/pubs/CRPHIPFIS.pdf>
- Council of State Governments Justice Center. (2010). *Information sharing in criminal justice-mental health collaborations: Working with HIPAA and other privacy laws*. <https://csgjusticecenter.org/publications/information-sharing-in-criminal-justice-mental-health-collaborations/>
- Data-Driven Justice Initiative. (2016). *Data-driven justice playbook: How to develop a system of diversion*. <https://www.naco.org/resources/data-driven-justice-playbook>
- Legal Action Center. (2020). *Sample consent forms for release of substance use disorder patient records*. <https://www.lac.org/resource/sample-forms-regarding-substance-use-treatment-confidentiality>
- Mental Health Intergovernmental Support Systems Interactive Online Network (MHISSION) Translational Systems. (n.d.). *Jail Data Linkage Project: A data matching initiative in Illinois*.³³ <http://mhiission.com/index.php/solutions/criminal-justice/cook-county-jailink>
- New Orleans Health Department. (2016). *New Orleans Mental Health Dashboard*. <https://www.nola.gov/getattachment/Health/Behavioral-Health/NO-Behavioral-Health-Dashboard-June-2016.pdf/>

³³ The Cook County, Illinois Jail Data Linkage Project: A data matching initiative in Illinois became operational in 2002 and connected the behavioral health providers working in the jail with the community mental health centers serving the Greater Chicago area. It quickly led to a change in state policy in support of enhanced communication between service providers. The system has grown in the ensuing years to cover significantly more of the state.

- Substance Abuse and Mental Health Services Administration. (2019). *Data collection across the sequential intercept model: Essential measures*.
<https://store.samhsa.gov/product/data-collection-across-the-sequential-intercept-model-sim-essential-measures/PEP19-SIM-DATA>
- Substance Abuse and Mental Health Services Administration. (2018). *Crisis intervention team (CIT) methods for using data to inform practice: A step-by-step guide*.
<https://store.samhsa.gov/product/Crisis-Intervention-Team-CIT-Methods-for-Using-Data-to-Inform-Practice/SMA18-5065>
- The Council of State Governments Justice Center. (2011). *Ten-step guide to transforming probation departments to reduce recidivism*.
<https://csgjusticecenter.org/publications/ten-step-guide-to-transforming-probation-departments-to-reduce-recidivism/>
- The People’s Law Library of Maryland. (n.d.). *Legal Services Directory*. Thurgood Marshall State Law Library.
<https://www.peoples-law.org/directory?combine=&county=69&services=All>.
- Urban Institute. (2013). *Justice reinvestment at the local level: Planning and implementation guide*.
<https://www.urban.org/sites/default/files/publication/24076/412930-Justice-Reinvestment-at-the-Local-Level-Planning-and-Implementation-Guide-Second-Edition.PDF>
- Vera Institute of Justice. (2012). *Closing the gap: Using criminal justice and public health data to improve identification of mental illness*.
<https://www.vera.org/publications/closing-the-gap-using-criminal-justice-and-public-health-data-to-improve-the-identification-of-mental-illness>

Information/Services for Incarcerated Individuals

- NAMI California. (2020). *Arrest guides and medication forms*.
<https://namica.org/resources/arrest-guides-medication-forms/>
- NAMI California (2020.) *Inmate mental health information forms*.
<https://namica.org/resources/inmate-mental-health-information-forms/>
- R Street. (2020). *How technology can strengthen family connections during incarceration*.
<https://www.rstreet.org/wp-content/uploads/2020/09/Fina-No-203-Family-connections-in-incarceration.pdf>
- National Institute of Corrections. (n.d.). *Thinking for a Change*.
<https://nicic.gov/resources/resources-topics-and-roles/topics/thinking-change>
- Urban Institute. (2018). *Strategies for connecting justice-involved populations to health coverage and care*.

https://www.urban.org/sites/default/files/publication/97041/strategies_for_connecting_justice-involved_populations_to_health_coverage_and_care.pdf

Mental Health, Behavioral Health & Co-Occurring Disorders

- Al-Khouja, M., & Corrigan, P. (2017). Self-stigma, identity, and co-occurring disorders. *The Israel Journal of Psychiatry and Related Sciences*, 54(1), 56–60.
https://www.researchgate.net/publication/321018240_Self-Stigma_Identity_and_Co-Occurring_Disorders
- Assey, D., & Wurzburg, S. (2020). *Improving responses to people who have co-occurring mental illnesses and substance use disorders in jails*. The Council of State Government Justice Center.
https://csgjusticecenter.org/publications/improving-responses-to-people-who-have-co-occurring-mental-illnesses-and-substance-use-disorders-in-jails/?mc_cid=37fd794dde&mc_eid=b7966726f8
- Substance Abuse and Mental Health Services Administration. (2023). *Coordinated specialty care for first episode psychosis: Costs and financing strategies*.
<https://store.samhsa.gov/sites/default/files/pep23-01-00-003.pdf>
- Substance Abuse and Mental Health Services Administration. (2022). *The case for screening and treatment of co-occurring disorders*.
<https://www.samhsa.gov/co-occurring-disorders>

Medication-Assisted Treatment (MAT)/Opioids/Substance Use

- American Society of Addiction Medicine. (2020). *National practice guideline*.
<https://www.asam.org/Quality-Science/quality/2020-national-practice-guideline>
- Hyatt, J. M., & Lobmaier, P. P. (2020). Medication-assisted treatment (MAT) in criminal justice settings as a double-edged sword: balancing novel addiction treatments and voluntary participation. *Health & Justice*, 8(1), 7.
<https://doi.org/10.1186/s40352-020-0106-9>
- Journal of Addiction Medicine. (2020). *Executive summary of the focused update of the ASAM national practice guideline for the treatment of opioid use disorder*.
https://journals.lww.com/journaladdictionmedicine/Fulltext/2020/04000/Executive_Summary_of_the_Focused_Update_of_the.4.aspx
- Mace, S., Siegler, A., Wu., K., Latimore, A., & Flynn, H. (2020). *Medication-assisted treatment for opioid use disorder in jails and prisons: A planning and implementation toolkit*. The National Council for Behavioral Health and Vital Strategies.
<https://www.thenationalcouncil.org/resources/medication-assisted-treatment-mat-for-opioid-use-disorder-in-jails-and-prisons-a-planning-and-implementation-toolkit/>

- National Commission on Correctional Health Care and the National Sheriffs' Association. (2018). *Jail-based medication-assisted treatment: Promising practices, guidelines, and resources for the field*. <https://www.ncchc.org/jail-based-MAT>
- Substance Abuse and Mental Health Services Administration. (2015). *Federal guidelines for opioid treatment programs*. <https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP>
- Substance Abuse and Mental Health Services Administration. (2015). *Medication for the treatment of alcohol use disorder: A brief guide*. <https://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907>
- Substance Abuse and Mental Health Services Administration. (2019). *Medication-assisted treatment inside correctional facilities: Addressing medication diversion*. <https://store.samhsa.gov/product/mat-inside-correctional-facilities-addressing-medication-on-diversion/PEP19-MAT-CORRECTIONS>
- Substance Abuse and Mental Health Services Administration. (2019). *Use of medication-assisted treatment for opioid use disorder in criminal justice settings*. <https://store.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS>
- Substance Abuse and Mental Health Services Administration. (n.d.) *Medication-assisted treatment inside correctional facilities*. <https://store.samhsa.gov/sites/default/files/d7/images/pep19-mat-corrections.png>
- U.S. Department of Health and Human Services. (2018). *Facing addiction in America: The Surgeon General's spotlight on opioids*. https://addiction.surgeongeneral.gov/sites/default/files/OC_SpotlightOnOpioids.pdf
- US Food and Drug Administration. (2023). *Information about medication-assisted treatment (MAT)*. <https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat>

Mental Health First Aid

- Gorman, C. D. (2022). *Mental Health First Aid: Assessing the evidence for a public health approach to mental illness*. Manhattan Institute. <https://media4.manhattan-institute.org/sites/default/files/Gorman-Mental-Health-First-Aid.pdf>
- Illinois General Assembly. (2013). *Public Act 098-0195: Illinois Mental Health First Aid Training Act*. <http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=098-0195>

- National Council for Mental Wellbeing. (2023). *Mental Health First Aid*.³⁴
<http://www.mentalhealthfirstaid.org/cs/>
- Mental Health First Aid. (n.d.). *Mental Health First Aid for Public Safety*. Sheppard Pratt.
<https://www.sheppardpratt.org/files/resources/mental-health-first-aid-public-safety-on-e-pager.pdf>

Peer Support/Peer Specialists

- Center for Psychiatric Rehabilitation. *The impact of Covid-19 on peer support specialists: Findings from a national survey*.
<https://cpr.bu.edu/research/effects-of-the-covid-pandemic-on-peer-specialists/>
- George, K. (2022). *Peer support specialists: Connections to mental health care*. National Conference of State Legislatures.
<https://www.ncsl.org/news/details/peer-support-specialists-connections-to-mental-health-care>
- Mental Health Association of Nebraska. (2024). *MHA reentry programs: Honu Home*.³⁵
<https://mha-ne.org/programs-services/honu.html>
- Mental Health Association of Nebraska. (2024). *Programs and services: Keya House*.³⁶
<https://mha-ne.org/programs-services/keya.html>
- Mental Health Association of Nebraska. (2024). *Programs and services: The REAL Referral Program*.³⁷ <https://mha-ne.org/programs-services/real-program.html>
- Philadelphia Department of Behavioral Health and Intellectual Disability Services and Achara Consulting Inc. (2017). *Peer support toolkit*.
<https://dbhids.org/peer-support-toolkit/>
- Policy Research Associates. (2020). *Peer support roles across the sequential intercept model*. <https://www.prainc.com/resource-library/peer-support-roles-sim/>
- Poremski, D., Kuek, J. H. L., Yuan, Q., Li, Z., Yow, K. L., Eu, P. W., & Chua, H. C. (2022). The impact of peer support work on the mental health of peer support specialists. *International Journal of Mental Health Systems*, 16(51).
<https://doi.org/10.1186/s13033-022-00561-8>
- Substance Abuse and Mental Health Services Administration. (2022). *Peer support workers for those in recovery*.
<https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>

³⁴ Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues.

³⁵ Honu Home is a peer-operated respite for individuals coming out of prison or on parole or state probation.

³⁶ Keya House is a four-bedroom house for adults with mental health and/or substance use issues, staffed with peer specialists.

³⁷ The REAL Referral Program works closely with law enforcement officials, community corrections officers, and other local human service providers to offer diversion from higher levels of care and to provide a recovery model form of community support with the help of trained peer specialists.

- University of Colorado Anschutz Medical Campus, Behavioral Health and Wellness Program. (2015). *DIMENSIONS: Peer support program toolkit*.
<https://www.bhwellness.org/toolkits/Peer-Support-Program-Toolkit.pdf>

Pretrial/Arrest Diversion

- CSG Justice Center. (2015). *Improving responses to people with mental illness at the pretrial stage: Essential elements*.
<https://csgjusticecenter.org/publications/improving-responses-to-people-with-mental-illnesses-at-the-pretrial-stage-essential-elements/>
- Laura and John Arnold Foundation. (2013). *The hidden costs of pretrial diversion*.
<https://nicic.gov/hidden-costs-pretrial-detention>
- National Resource Center on Justice Involved Women. (2016). *Building gender informed practices at the pretrial stage*.
<https://cjininvolvedwomen.org/wp-content/uploads/2016/05/Pretrial-Monograph-Final-Designed.pdf>
- Picard, S., Watkins, M., Rempel, M., & Kerodal, A. (2019). *Beyond the Algorithm: Pretrial Reform, Risk Assessment, and Racial Fairness*. Center for Court Innovation.
https://www.innovatingjustice.org/sites/default/files/media/documents/2019-06/beyond_the_algorithm.pdf
- Pilnik, S., Hankey, B. (Ed.), Simoni, E. (Ed.), Kennedy, S. (Ed.), Moore, L. J. (Ed.), & Sawyer, J. (Ed.). (2017). *A Framework for Pretrial Justice: Essential Elements of an Effective Pretrial System and Agency* (Accession No. 032831). The National Institute of Corrections. <https://s3.amazonaws.com/static.nicic.gov/Library/032831.pdf>
- Police Executive Research Forum. (2020). *New Challenges and Promising Practices in Pretrial Release, Diversion, and Community-Based Supervision*.
<https://www.policeforum.org/assets/PretrialRelease.pdf>
- Substance Abuse and Mental Health Services Administration. (2015). *Municipal courts: An effective tool for diverting people with mental and substance use disorders from the criminal justice system*.
<https://store.samhsa.gov/product/Municipal-Courts-An-Effective-Tool-for-Diverting-People-with-Mental-and-Substance-Use-Disorders-from-the-Criminal-Justice-System/SMA15-4929>

Procedural Justice

- American Bar Association. (2016). *Criminal justice standards on mental health*.
https://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/mental_health_standards_2016.authcheckdam.pdf

- Center for Court Innovation. (2019). *Procedural justice at the Manhattan Criminal Court*. <https://www.courtinnovation.org/publications-Manhattan-procedural>
- Chintakrindi, S., Upton, A., Louison A.M., Case, B., & Steadman, H. (2013). *Transitional case management for reducing recidivism of individuals with mental disorders and multiple misdemeanors*. <https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201200190>
- National Institute of Justice. (2011). *Program profile: Hawaii Opportunity Probation with Enforcement (HOPE)*.³⁸ [https://crimesolutions.ojp.gov/ratedprograms/49#:~:text=Hawaii%20Opportunity%20Pr obation%20with%20Enforcement%20\(HOPE\)%2C%20or%20Hawaii%20HOPE,use%2C%20Recidivism%2C%20and%20incarceration.](https://crimesolutions.ojp.gov/ratedprograms/49#:~:text=Hawaii%20Opportunity%20Pr obation%20with%20Enforcement%20(HOPE)%2C%20or%20Hawaii%20HOPE,use%2C%20Recidivism%2C%20and%20incarceration.)

Racial Equity and Disparities

- Actionable Intelligence for Social Policy. (2020). *A toolkit for centering racial equity throughout data integration*. <https://www.aisp.upenn.edu/centering-equity/>
- National Institute of Corrections. (2014). *Incorporating racial equality Into criminal justice reform*. <https://www.aisp.upenn.edu/centering-equity/>
- Vera Institute of Justice. (2015). *A prosecutor's guide for advancing racial equity*. <https://www.vera.org/publications/a-prosecutors-guide-for-advancing-racial-equity>

Reentry

- Antenangeli, L., & Durose, M. R. (2021). *Recidivism of Prisoners Released in 24 States in 2008: A 10-Year Follow-Up Period (2008–2018)* (NCJ 256094). U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. <https://bjs.ojp.gov/library/publications/recidivism-prisoners-released-24-states-2008-10-year-follow-period-2008-2018>
- Community Oriented Correctional Health Services (COCHS). (2014). *Technology and continuity of care: Connecting justice and health [nine case studies]*. <https://cochs.org/files/health-it-hie/nine-case-studies.pdf>
- National Institute of Corrections and Center for Effective Public Policy. (2015). *Behavior management of justice-involved individuals: Contemporary research and state-of-the-art policy and practice*. <https://info.nicic.gov/nicrp/system/files/029553.pdf>
- Reentry Coordination Council. (2022). *Coordination to reduce barriers to reentry: lessons learned from COVID-19 and beyond*. <https://www.justice.gov/opa/press-release/file/1497911/download>

³⁸ HOPE is a community supervision strategy for probationers with substance use disorders, particularly those who have long histories of drug use and involvement with the criminal legal system and are considered at high risk of failing probation or returning to prison.

- Substance Abuse and Mental Health Services Administration. (2017). *Guidelines for the successful transition of people with behavioral health disorders from jail and prison*. <https://store.samhsa.gov/product/Guidelines-for-Successful-Transition-of-People-with-Mental-or-Substance-Use-Disorders-from-Jail-and-Prison-Implementation-Guide/SMA16-4998>
- Substance Abuse and Mental Health Services Administration. (2016). *Reentry resources for individuals, providers, communities, and states*. https://www.samhsa.gov/sites/default/files/topics/criminal_juvenile_justice/reentry-resources-for-consumers-providers-communities-states.pdf
- Substance Abuse and Mental Health Services Administration. (2020). *After incarceration: A guide to helping women reenter the community*. <https://store.samhsa.gov/product/After-Incarceration-A-Guide-To-Helping-Women-Reenter-the-Community/PEP20-05-01-001>
- Stovell, M., & Wurzburg, S. (2018). *Best practices for successful reentry for people who have opioid addictions*. The Council of State Governments Justice Center & The National Reentry Resource Center. <https://csgjusticecenter.org/publications/best-practices-for-successful-reentry-for-people-who-have-opioid-addictions/>
- The Council of State Governments Justice Center. (2009). *National Reentry Resource Center*. <https://csgjusticecenter.org/publications/about-the-national-reentry-resource-center/>
- Washington State Institute of Public Policy. (2014). *Predicting criminal recidivism: A systematic review of offender risk assessments in Washington State*. http://www.wsipp.wa.gov/ReportFile/1554/Wsipp_Predicting-Criminal-Recidivism-A-Systematic-Review-of-Offender-Risk-Assessments-in-Washington-State_Final-Report.pdf
- U.S. Department of Labor. (n.d.). *Reentry employment opportunities*. <https://www.dol.gov/agencies/eta/reentry>
- U.S. Department of Labor. (n.d.). *Workforce Innovation and Opportunity Act*. <https://www.dol.gov/agencies/eta/wioa>

Screening and Assessment

- American Society of Addiction Medicine (ASAM). (2023). *ASAM Criteria: Free paper-based ASAM criteria assessment interview guide*. <https://www.asam.org/asam-criteria/criteria-intake-assessment-form>
- Center for Court Innovation. (2015). *Digest of evidence-based assessment tools*. <http://www.courtinnovation.org/sites/default/files/DigestEvidencebasedAssessmentTools.pdf>

- Desmarais, S. L., & Lowder, E. M. (2019). *Pretrial risk assessment tools: A primer for judges, prosecutors, and defense attorneys*. Safety + Justice Challenge. <https://www.safetyandjusticechallenge.org/wp-content/uploads/2019/02/Pretrial-Risk-Assessment-Primer-February-2019.pdf>
- Multi-Health Systems (MHS). (2004). *Level of Service/Case Management Inventory (LSCMI) brochure*. https://www.assessments.com/assessments_documentation/LSCMI_Tech_Brochure.pdf
- Picard-Fritsche, S., Rempel, M., Kerodal, A., & Adler, J. (2018). *The Criminal Court Assessment Tool: Development and validation*. Center for Court Innovation. https://www.innovatingjustice.org/sites/default/files/media/documents/2018-02/ccat_validation.pdf
- Substance Abuse and Mental Health Services Administration. (2019). *Screening and assessment of co-occurring disorders in the justice system*. <https://store.samhsa.gov/product/Screening-and-Assessment-of-Co-Occurring-Disorders-in-the-Justice-System/PEP19-SCREEN-CODJS?print=true>
- Steadman, H.J., Scott, J.E., Osher, F., Agnese, T.K., and Robbins, P.C. (2005). Validation of the Brief Jail Mental Health Screen. *Psychiatric Services*, 56, 816-822. <https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.56.7.816>
- The Stepping Up Initiative. (2017). *Reducing the number of people with mental illnesses in jail: Six questions county leaders need to ask*. https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail_Six-Questions.pdf

Sequential Intercept Model

- Bonfire, N., Munetz, M. R., & Smiera, R. H. (2018). Sequential intercept mapping: Developing systems-level solutions for the opioid epidemic. *Psychiatric Services*, 69(11), 1121-1194. <https://doi.org/10.1176/appi.ps.201800192>
- Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., and Schubert, C. A. (2015). *The sequential intercept model and criminal justice*. New York: Oxford University Press. <https://global.oup.com/academic/product/the-sequential-intercept-model-and-criminal-justice-9780199826759?cc=us&lang=en&>
- Munetz, M. R., and Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57, 544-549. <http://ps.psychiatryonline.org/doi/10.1176/ps.2006.57.4.544>
- National Criminal Justice Association. (2021). *The sequential intercept model: Building blocks for strategic planning and stakeholder engagement*. https://www.ncja.org/files/ugd/cda224_c2d5900354b8480591c30f75a5d6c847.pdf?index=true

- Policy Research Associates. (n.d.). *The sequential intercept model: Advancing community-based solutions for justice-involved people with mental and substance use disorders*.
https://mn.gov/dhs/assets/pr-sequential-intercept-model_tcm1053-434949.pdf
- Willison, J. B., McCoy, E. F., Vasquez-Noriega, C., Reginal, T., & Parker, T. (2018). *Using the sequential intercept model to guide local reform*. Urban Institute.
https://www.urban.org/sites/default/files/publication/99169/using_the_sim_to_guide_l_ocal_reform_0.pdf

SSI/SSDI Outreach, Access, and Recovery (SOAR)

- Dennis, D., Ware, D., and Steadman, H.J. (2014). Best practices for increasing access to SSI and SSDI on exit from criminal justice settings. *Psychiatric Services*, 65, 1081-1083.
<https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201400120>
- Substance Abuse and Mental Health Services Administration. (n.d.). *SOAR online course: Adult curriculum*.
<https://soarworks.samhsa.gov/course/soar-online-course-adult-curriculum>
- Substance Abuse and Mental Health Services Administration. (n.d.). SSI/SSDI in legal settings: FAQs. <http://soarworks.prainc.com/article/working-justice-involved-persons>

Training

- Crisis Prevention Institute. (2023). *Crisis prevented*. <https://www.crisisprevention.com/>
- National Alliance on Mental Illness (NAMI). (2023). *Crisis intervention team (CIT) programs*.
[https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-\(CIT\)-Programs](https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs)
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2023). *Training opportunities*.
<https://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals/training-opportunities>

Transition-Aged Youth

- Harvard Kennedy School Malcolm Weiner Center for Social Policy. (2016). *Public safety and emerging adults in Connecticut: Providing effective and developmentally appropriate responses for youth under age 21*.
<https://www.hks.harvard.edu/centers/wiener/programs/criminaljustice/research-publications/young-adult-justice/public-safety-and-emerging-adults-in-connecticut>

- National Institute of Justice. (2016). *Environmental scan of developmentally appropriate criminal justice responses to justice-involved young adults*. <https://www.ncjrs.gov/pdffiles1/nij/249902.pdf>
- Roca Inc. (2023). *Young adults*. <https://rocainc.org/who-we-work-with/young-adults/>
- UMass Chan Medical School. *Transitions to Adulthood Center for Research (Transitions ACR)*. <https://www.umassmed.edu/TransitionsACR/>

Transportation

- Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. (2004). *Getting there: Helping people with mental illnesses access transportation* [DHHS Pub. No. (SMA) 3948]. *Advancing States*. https://www.advancingstates.org/sites/nasuad/files/hcbs/files/141/7048/mental_health_consumer_transportation_barriers.pdf
- The Hilltop Institute [University of Maryland, Baltimore County (UMBC)]. (2008). *Non-emergency medical transportation (NEMT) study report*. <https://www.hilltopinstitute.org/publication/non-emergency-medical-transportation-nemt-study-report/>
- Policy Research Associates. (2021). *Transportation after incarceration: Where the rubber meets the road for sustainable reentry*. <https://www.prainc.com/gains-transportation-after-incarceration/>

Trauma and Trauma-Informed Care

- Freeman, D., Lautar, A. (2015). *Trauma-specific interventions for justice-involved individuals*. SAMHSA's GAINS Center. <https://mha.ohio.gov/static/learnandfindhelp/TreatmentServices/TCC/Trauma-Specific-Interventions-for-Justice-Involved-Individuals-SAMHSA.pdf>
- Facer-Irwin, E., Blackwood, N. J., Bird, A., Dickson, H., McGlade, D., Alves-Costa, F., & MacManus, D. (2019). PTSD in prison settings: A systematic review and meta-analysis of comorbid mental disorders and problematic behaviors. *PLOS ONE*, 14(9). <https://doi.org/10.1371/journal.pone.0222407>
- Institute for Intergovernmental Research. (2023). *VALOR officer safety and wellness program*. <https://www.valorforblue.org/>
- Maruschak, L. M., Bronson, J., & Alper, M. (2021). *Indicators of mental health problems reported by prisoners* (NCJ 252643). U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/imhprpspi16st.pdf>
- Menschner, C., & Maul, A. (2016). *Key ingredients for successful trauma-informed care implementation [issue brief]*. Center for Health Care Strategies Inc.

https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

- National Resource Center on Justice-Involved Women. (2015). *Jail tip sheets on justice-involved women*. <http://cjinvolvedwomen.org/jail-tip-sheets/>
- National Center for State Courts. (2022). *Trauma and trauma-informed responses*. https://www.ncsc.org/_data/assets/pdf_file/0034/77677/Trauma-and-Trauma-Informed-Responses.pdf
- National Institute of Corrections. (2020). *The association between ACEs and criminal justice involvement, part I*. <https://nicic.gov/association-between-aces-and-criminal-justice-involvement-part-1>
- Noether, C. (2012). *Toward creating a trauma-informed criminal justice system*. Policy Research Associates. <https://www.prainc.com/creating-a-trauma-informed-criminal-justice-system/>
- National Governors Association. (2021). *State actions to prevent and mitigate adverse childhood experiences*. https://www.nga.org/wp-content/uploads/2021/12/NGA_State_Actions_to_Prevent_Mitigate_ACEs_Dec_2021.pdf
- Substance Abuse and Mental Health Services Administration. *Trauma training for criminal justice professionals*. <https://www.samhsa.gov/gains-center/trauma-training-criminal-justice-professionals>
- Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. <https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884>
- Substance Abuse and Mental Health Services Administration. (2014). *TIP 57: Trauma-informed care in behavioral health services*. <https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>
- Substance Abuse and Mental Health Services Administration's National Center on Trauma-Informed Care and GAINS Center. (2011). *Essential components of trauma informed judicial practice*. https://www.nasmhpd.org/sites/default/files/DRAFT_Essential_Components_of_Trauma_Informed_Judicial_Practice.pdf
- Substance Abuse and Mental Health Services Administration's GAINS Center. (2011). *Trauma-specific interventions for justice-involved individuals*. <https://www.usf.edu/cbcs/mhlp/tac/documents/cj-ij/cj/trauma-specific-interventions.pdf>

Veterans

- Justice for Vets. (2017). *Ten key components of Veterans treatment courts*.
<https://justiceforvets.org/resource/ten-key-components-of-veterans-treatment-courts/>
- Substance Abuse and Mental Health Services Administration's GAINS Center. (2008). *Responding to the needs of justice-involved combat Veterans with service-related trauma and mental health conditions*.
https://www.prainc.com/wp-content/uploads/2012/01/CVT_IssueBrief.pdf
- U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. (n.d.). *Criminal court assessment tool: Veterans-Short Screen (VET-S)*.
<https://bjia.ojp.gov/doc/veterans-short-screen.pdf>
- US Department of Veteran Affairs (n.d.). *Welcome to VA.gov*. <https://www.va.gov/>

APPENDICES

APPENDIX A

Primary Care Coalition. (2022). *HIPAA cheat sheet: Disclosing PHI to law enforcement.*

APPENDIX B

Primary Care Coalition. (2022). *HIPAA cheat sheet for behavioral health.*

APPENDIX C

State of Maryland Active Assailant Interdisciplinary Work Group (AAIWG). (n.d.). *Release of medical authorization template.*

APPENDIX D

State of Maryland Active Assailant Interdisciplinary Work Group (AAIWG). (n.d.). *Release for coordination of care template.*

HIPAA CHEAT SHEET: DISCLOSING PHI TO LAW ENFORCEMENT



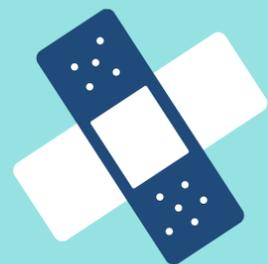
DO I HAVE TO DISCLOSE PHI IF A LAW ENFORCEMENT OFFICIAL REQUESTS IT?

The law does not require you to provide information or take actions simply because law enforcement has asked you to do so. It is your responsibility to comply with HIPAA and patient privacy laws; it is not law enforcement's responsibility.



WHEN AM I REQUIRED TO RESPOND TO LAW ENFORCEMENT PHI REQUESTS?

There are very limited instances in which you will need to respond to law enforcement immediately: 1) A valid search warrant (determine if valid), or 2) a crime is in progress.



Even with a valid search warrant, law enforcement may allow time for counsel to be contacted. A valid search warrant should typically: (1) Have the signature of a judge or magistrate; (2) have a date in close proximity to the date it is executed (usually 10 days); (3) have the correct address; and (4) be accurate and specific about what is to be seized.



WHEN AM I ALLOWED TO SHARE PHI WITH LAW ENFORCEMENT?

You may disclose patient information to law enforcement with the individual's signed HIPAA authorization. You also may disclose patient information to anyone, including law enforcement, if you make a professional determination that immediate disclosure is necessary to provide for the patient's emergency health care needs or to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.



We are permitted to share patient information for select law enforcement purposes, but only certain information and with the potential requirement that we provide prior notice to the patient:



- To identify or locate a fugitive, suspect, material witness, or missing person;
- To respond to a request about a victim of a crime (with the victim's consent);
- To comply with certain administrative requests (such as requests from oversight agencies for medical records);
- To meet any mandated reporting requirements; and
- To respond to a lawful order, subpoena, warrant, etc.



Remember that undocumented patients have rights, including under HIPAA and many other laws.



QUESTIONS?

Contact the Organizational Integrity Team at OIP@adventisthealthcare.com.



HIPAA CHEAT SHEET FOR BEHAVIORAL HEALTH

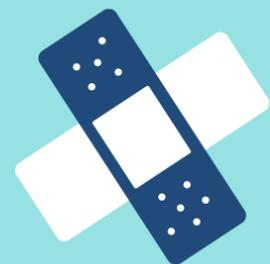


CAN I SHARE PROTECTED HEALTH INFORMATION WITH SOMEONE WHO IS NOT COVERED BY HIPAA?

Yes, under certain circumstances. HIPAA allows health care providers to disclose the minimum necessary protected health information (PHI), including behavioral health PHI, for treatment purposes to any health care or social service provider--including those that are not covered by HIPAA.



HIPAA also permits a covered health care provider to disclose the minimum necessary PHI to a third party, such as a homeless services provider or the Local Behavioral Health Authority, which are involved in the health care coordination or management of an individual.



For example, a primary care provider may send a copy of an individual's medical record to a specialist who needs the information to treat the individual. A hospital may send a patient's health care instructions to a nursing home to which the patient is transferred.



DO I NEED PATIENT PERMISSION TO SHARE PHI?

No, not always. Covered entities--including health care providers, insurance plans, and health care clearinghouses--are allowed to disclose the minimum necessary PHI for treatment purposes without obtaining a patient's authorization. This is sometimes referred to as "the treatment exception." "Treatment" means the provision, coordination, or management of health care and related services among health care or third party providers, consultation between providers regarding a patient, or a referral from one health care provider to another.



Health care providers are also allowed to disclose information directly relevant to an individual's involvement with care to a family member or individual close to the patient if:



- The patient has had the opportunity to object and did not or the provider reasonably infers that the patient does not object; OR
- In the professional opinion of the health care provider, a clear and significant risk of death or imminent serious injury or harm to a patient or recipient exists.



QUESTIONS?

Contact Max Siegel, Holy Cross Health's Integrity and Compliance Officer, at: max.siegel@holycrosshealth.org





Active Assailant Interdisciplinary Work Group

How to Use this Document:

This document is a template and should be modified to fit the specific needs of each jurisdiction, as appropriate. Please place the text of this document on your organization's letter head or another appropriate template. Highlighted text appears in brackets throughout the document [Update text] and should be removed and replaced with the appropriate information for your jurisdiction.

Release of Medical Information Authorization

Name: _____ Date of Birth: _____

I hereby authorize the [Insert organization/agency name] to disclose to and obtain from (NAME OF AGENCY/PERSON): _____ the following information:

Records and/or documentation of mental health, medical, substance use, legal, social history, diagnosis, medications, attendance or participation in treatment, results of psychological and educational testing, information pertaining to and participation in treatment program, prognosis and recommendations based on specific needs.

For the purpose of: facilitating treatment recommendations, referrals and coordination of care.

- I understand that the information authorized for release may contain substance use, psychiatric, HIV testing or results, or AIDS information.
- I understand that the information used, disclosed, or obtained under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.
- I have the right to refuse to sign the Authorization Form. **If signed, I have the right to revoke the authorization, in writing, at any time.** I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocations may not affect those actions.
- I understand that once the information is released, the [Insert organization/agency name], cannot prevent the recipient from further disclosing the information.
- I understand that this consent automatically expires in one year from the date it is signed, with the exception of:
 - Criminal justice referrals which shall be valid until 30 days following the final disposition;
or
 - Residents of a nursing home, which shall be valid until revoked, or for any time period specified in the authorization.

PROHIBITION ON REDISCLOSURE:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part2). The Federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by writing a consent to the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rule restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Updated [Insert Date]



Active Assailant Interdisciplinary Work Group

Signature of Consumer _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____



Active Assailant Interdisciplinary Work Group

How to Use this Document:

This document is a template and should be modified to fit the specific needs of each jurisdiction, as appropriate. Feel free to use the text of this document on your organization's letter head or another appropriate template. Highlighted text appears in brackets throughout the document [Update text] and should be removed and replaced with the appropriate information for your jurisdiction.

Release for Coordination of Care Authorization

This form should be updated annually

Name: _____ Date of Birth: _____

The purpose of this form is to allow me to choose how my services are coordinated. I understand that this is my decision to make and that I can change my mind. If I change my mind, I need to make a written request to cancel this consent. This request will go to the agency or program's Medical Record or Health Information Department for processing. I also understand that I can ask a staff member to assist me with this process. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf.

By checking yes, I am allowing these providers to communicate, and exchange information needed to coordinate and continue care, treatment and services. If I check no, I do not want the information exchanged with that provider.

Yes	No	Provider/Agency Name	Yes	No	Provider/Agency Name
<input type="checkbox"/>	<input type="checkbox"/>	Crisis Response System Services: including mobile visits, phone contacts, interventions	<input type="checkbox"/>	<input type="checkbox"/>	Shelters: [Insert shelter names]
<input type="checkbox"/>	<input type="checkbox"/>	[Insert jurisdiction] Core Service Agency	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Provider: [Insert major mental health providers]
<input type="checkbox"/>	<input type="checkbox"/>	Police Department: [Include State and local entities]	<input type="checkbox"/>	<input type="checkbox"/>	Residential Rehabilitation Program: [Insert names]
<input type="checkbox"/>	<input type="checkbox"/>	Fire Department: [Include county and municipalities as appropriate]	<input type="checkbox"/>	<input type="checkbox"/>	Case Management/Psychiatric Rehabilitation Program: [Insert names]
<input type="checkbox"/>	<input type="checkbox"/>	Hospitals: [Insert names of regional hospitals]	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Disabilities Association
<input type="checkbox"/>	<input type="checkbox"/>	Emergency Contact:	<input type="checkbox"/>	<input type="checkbox"/>	[Insert Jurisdiction] Department of Aging
<input type="checkbox"/>	<input type="checkbox"/>	[Insert Jurisdiction] Department of Health	<input type="checkbox"/>	<input type="checkbox"/>	[Insert Jurisdiction] Department of Social Services
<input type="checkbox"/>	<input type="checkbox"/>	[Insert Jurisdiction] State's Attorney	<input type="checkbox"/>	<input type="checkbox"/>	School:
<input type="checkbox"/>	<input type="checkbox"/>	Maryland Office of the Public Defender	<input type="checkbox"/>	<input type="checkbox"/>	[Insert Jurisdiction] Department of Juvenile Services
<input type="checkbox"/>	<input type="checkbox"/>	Crisis Beds: [Insert names]	<input type="checkbox"/>	<input type="checkbox"/>	Detention Facilities: [Insert names]
<input type="checkbox"/>	<input type="checkbox"/>	SUD Provider: [Insert names]	<input type="checkbox"/>	<input type="checkbox"/>	[Insert Jurisdiction] Parole, Probation & Pretrial
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Secret Service, Federal Bureau of Investigation, National Security Agency
<input type="checkbox"/>	<input type="checkbox"/>	SUD Housing: [Insert names]	<input type="checkbox"/>	<input type="checkbox"/>	Other:

Updated [Insert Date]



Active Assailant Interdisciplinary Work Group

INFORMATION REGARDING THE ABOVE-NAMED INDIVIDUAL FOR THE PURPOSE OF:

Coordination of Care and Entitlement Eligibility

INFORMATION RESTRICTED TO: Attendance, services received, adherence with recommendations, diagnosis, medications and side effects (if clinically necessary) with individual treatment plans, testing results, applications, previous providers, treatment plans, discharge summaries, and after care plans.

This permission expires automatically at the end of one year unless otherwise stated but may be revoked by the patient's written request at any prior time except to the extent that action has been taken on it. Parent or legal guardian must sign in the case of a minor child (under age 16 for outpatient mental health services and under 18 for other medical and health services) unless an otherwise minor child is emancipated, or permission is not necessary due to protection under the Minor Right Law.

BEFORE SIGNING - PLEASE READ CAREFULLY AND ASK QUESTIONS IF YOU HAVE ANY:

Patient/Parent/Guardian Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Agency Completing This Form: _____

Date: _____

Release Valid Through: _____



MONTGOMERY COUNTY COUNCIL
ROCKVILLE, MARYLAND

DAWN LUEDTKE
COUNCILMEMBER
DISTRICT 7

MEMORANDUM

February 18, 2026

TO: Chairs Sayles and Katz, Councilmembers Mink and Friedson
FROM: Dawn Luedtke, Councilmember, District 7 
SUBJECT: Upcoming HHS/PS Worksession for Bill 43-23

Dear colleagues,

In advance of the February 26 joint Health and Human Services and Public Safety worksession on Bill 43-23, I am sharing an update on Bill 43-23.

Over the last three years, the bill has evolved significantly. When it was first introduced, the focus was intentionally narrow and operational: formalizing a Crisis Intervention Team structure and pairing it with an advisory committee to support that work. At the time, the goal was to strengthen crisis response by building out a co-response model and defining how that team should function inside the County government.

As implementation progressed and we had subsequent meetings with partners across corrections, behavioral health, the courts, and emergency response, a consistent message emerged. What we heard repeatedly is that the larger issue is fragmentation across intercepts: the transitions between crisis response, diversion, courts, treatment, and reentry. Even where individual programs are strong, the system does not always operate as a coordinated continuum. The challenges we are trying to address are not confined to a single team, and the amendments reflect that collective learning. Rather than codifying the internal structure of a specific crisis team, something agencies are now managing through interagency agreements, the legislation I propose to amend shifts toward creating a standing coordination framework.

The Sequential Intercept Model (SIM) Coordination Working Group is designed as an implementation body, not a traditional advisory committee. Recognizing that each agency is

already prioritizing this work within its own sphere, I am proposing a structure that allows all of our partners to wrap their arms around the full scope of the work and move as a unified body. The working group would look across systems, identify where capacity is breaking down, and help align agencies around practical, operational solutions. It would also play a central role in capturing funding and logistical needs so we can advance unified, strongly supported requests at the local, state, and federal levels.

This represents a deliberate move from a unit- or team-centered model to a systems-centered one. The amended bill recognizes that crisis response is only one piece of a broader continuum, and that sustainable progress depends on consistent coordination across early intervention, diversion, treatment access, and reentry. The intent is to institutionalize that cross-system lens and create shared accountability for how those pieces connect.

The direction we are taking is grounded in stakeholder feedback, ongoing SIM work at the state level, and the reality that effective improvement requires governance structures that match how people actually move through the system. I appreciate the time and expertise that many of you have contributed in helping shape this path forward, and I look forward to continuing the conversation as the committee reviews and takes action on the bill.

Cc: Natali Fani-González, Council President
Marilyn Balcombe, Council Vice President
Shebra Evans, Councilmember
Evan Glass, Councilmember
Will Jawando, Councilmember
Kate Stewart, Councilmember
Christine Wellons, Chief Legislative Attorney
Susan Farag, Senior Analyst
Nicole Rodriguez-Hernandez, Analyst

Bill 43-23, Crisis Intervention Team – Established
Amendments by Councilmember Luedtke

AMENDMENT # 1 – DELETE ASPECTS OF THE BILL BEING IMPLEMENTED PURSUANT TO AN MOU

Delete lines 1-89.

AMENDMENT #2 – ESTABLISHMENT OF A WORKING GROUP

Amend lines 90- 91 to read as follows.

24-82. [[Advisory committee]] Working group – established.

- (a) There is [[an Advisory Committee on Crisis Intervention]] a Sequential Intercept Model (SIM) Coordination Working Group.

AMENDMENT #3 – WORKING GROUP MEMBERSHIP

Amend line 92-119 to read as follows.

- (b) The [[committee]] working group consists of:
- (1) a designee of the [[Mental Health Association of Maryland]] Office of the Public Defender;
 - (2) a designee of the county’s 9-8-8 call center;
 - (3) a designee of the Interagency Commission on Homelessness;
 - (4) a designee of the District Administrative Judge for the District Court of Maryland, Montgomery County;
 - (5) a designee of the Administrative Judge for the Circuit Court for Montgomery County;
 - (6) a designee of the Montgomery County State’s Attorney;
 - (7) a designee of the Montgomery County Council;
 - (8) a designee of the Intellectual and Developmental Disabilities Commission;

- (9) a representative of [[a county chamber of commerce, appointed by the County Executive and confirmed by the Council]] the Primary Care Coalition or a successor organization;
- (10) a designee of the Montgomery County Fire Chief;
- (11) a designee of the Emergency Communications Center;
- (12) a designee of the County Sheriff;
- (13) a designee of the Director of the Department of Correction and Rehabilitation;
[[and]]
- (14) a designee of the Montgomery County Police;
- (15) a designee of the Department of Health and Human Services;
- [[14]] (15) 2 residents, appointed by the Executive and confirmed by the Council, who:
 - (A) have lived experience regarding mental health, behavioral health, or substance use disorders;
 - (B) represent different geographical regions of the County; and
 - (C) will be offered the opportunity to participate in the police department's "Citizens Academy," as well as attend any CIT training or other in-service training offered relevant to the work of the Advisory Committee;
- (16) a designee of the Executive Director of the Council who performs analysis for the Council regarding health and human services or public safety; and
- (17) a representative of a peer support organization or community-based behavioral health provider.

AMENDMENT #4 – WORKING GROUP’S DUTIES

Amend lines 121-127 to read as follows.

The [[advisory committee]] working group must, through a lens of racial equity and social justice:

- (a) [[provide advice to, and collaborate with, the crisis intervention team, the Executive, and the Council regarding best practices for crisis intervention in the County related

- to]] use the Sequential Intercept Model to assess and analyze the County's ability to provide crisis intervention services, crisis response, and diversion from the criminal justice system to treatment for individuals with mental health, behavioral health, or substance use disorders;
- (b) [[consult with the crisis intervention team regarding the development of the models under Section 24-80]] advise the Executive and Council regarding best practices in crisis intervention, diversion programs, and wraparound services;
- (c) direct the coordination and implementation of a Sequential Intercept Model specific to the County;

AMENDMENT #5 – REPORTING REQUIREMENTS

Amend lines 135-161 to read as follows.

The [[advisory committee]] working group must submit, no later than January 31 each year, an annual report to the Executive and Council that includes:

- (a) numerical data, disaggregated when possible by race, ethnicity, gender, gender identity, and age, regarding:

* * *

(4) individuals[[,]] served [[in-person or by phone,]] by the County's 24-hour Crisis Center;

(5) individuals served by the County's 9-8-8 call center;

[[5]] (6) service calls under paragraph (1) involving an actual or threatened deadly or dangerous weapon, as defined under Sections 4-101 or 4-102 of the Criminal Law Article of the Maryland Code, as amended;

[[6]] (7) service calls under paragraph (1) involving co-occurring criminal conduct, including the numbers of associated:

(A) misdemeanor charges;

(B) felony charges;

(C) individuals offered a diversion to treatment; and

(D) individuals who were not charged due to diversion to treatment; and

[[7]] (8) service calls under paragraph (1) involving an individual where pending criminal charges were at issue;

- (b) metrics and data regarding housing stability, outpatient treatment engagement, and other social determinants of health;
- (c) metrics and data regarding racial equity and social justice, as related to the Sequential Intercept Model;
- (d) achievements and challenges regarding implementation of the [[crisis intervention team]] Sequential Intercept Model in the County during the prior year; and
- [[c)] (e) recommendations to improve [[crisis intervention]] the Sequential Intercept Model in the County, in coordination with local, state, and federal partners.

AMENDMENT #6 – TRANSITION CLAUSE

Amend lines 135-161 to read as follows.

Sec. 2. Transition. The first report required under Section 24-84, added under Section 1 of this Act, is due by January 31, [[2025]] 2027.

On the following pages, the six proposed amendments are shown in the context of the text of Bill 43-23.

Sec. 1. Article XI, Sections 24-77, 24-78, and 24-79[[, 24-80, 24-81, 24-82, 24-83, and 24-84]] are added as follows:

ARTICLE XI. [[CRISIS INTERVENTION TEAM]] SEQUENTIAL INTERCEPT MODEL
(SIM) COORDINATION WORKING GROUP

[[24-77. Definitions.

In this Article, the following terms have the meanings indicated.

Advisory committee or committee means the Advisory Committee on Crisis Intervention established under Section 24-82.

Crisis intervention model program has the meaning set forth at Section 3-522 of the Public Safety Article of the Maryland Code, as amended.

Crisis intervention team, CIT, or team means a group of individuals designated under Sections 24-78 and 24-79 to perform the duties specified under Sections 24-80 and 24-81, where law enforcement officers and clinicians are co-located and deployed in an integrated fashion.

Health department means the Montgomery County Department of Health and Human Services.

Law enforcement entity means a public law enforcement agency, other than the Montgomery County Police Department.

Police department means the Montgomery County Police Department.

Sequential intercept model means a plan, specific to the County, that details how individuals with mental, behavioral, and substance use disorders:

- (1) come into contact with and move through the criminal justice system; and
- (2) obtain referrals to other wraparound services.]]

[[24-78. Crisis intervention team – established.

(a) There is a crisis intervention team within the County government consisting of:

- (1) designees of the health department;
- (2) designees of the police department; and
- (3) participants of other law enforcement entities under Section 24-79.

- (b) Each member of the team must meet minimum qualifications established by their home agency to be assigned to the team in addition to all other licensing, credentialing and continuing education requirements imposed by State or federal law applicable to the respective disciplines.
- (c) A member of the team designated by the Chief of the police department, and a member of the team designated by the Director of the health department, jointly must direct the operations of the team.
- (d) The health department and police department, which will have equal responsibility in overseeing the crisis intervention team, must establish a Memorandum of Understanding to carry out the work of the team, further delineate roles and responsibilities, and address other administrative issues.
- (e) The team will follow guidance provided by the Crisis Intervention Team Center of Excellence at the State level in implementing, delivering, and enhancing crisis intervention services in the county.]]

[[24-79. Participation of other law enforcement entities.

Subject to a written agreement with the County, and approval of the police department and health department, a law enforcement entity may designate individuals to participate in the crisis intervention team.]]

[[24-80. Crisis intervention team – duties.

The crisis intervention team must:

- (a) in consultation with the advisory committee, establish and enhance the sequential intercept model for diverting individuals experiencing a mental or behavioral health crisis or substance use disorder crisis from the criminal justice system and into treatment;
- (b) adhere to the principals of the crisis intervention model program;
- (c) respond to acute incidents in the County where there is a significant risk of harm to the individual in crisis or to someone else, and there is reason to believe that the individual has an underlying mental or behavioral health condition or co-existing substance use disorder;
- (d) co-locate members of the team in disparate geographic areas of the County;

- (e) interact directly with emergency dispatchers regarding individuals experiencing mental health, behavioral health, or substance abuse incidents; and
- (f) provide to each individual or family served by the team information regarding how to prepare an advance directive for psychiatric care.]]

[[24-81. Scope of team activities.

- (a) Limited scope of team response. The priority response for the crisis intervention team is for incidents involving acute mental health, behavioral health, or substance abuse crisis events where there is a significant risk of danger for the individual in crisis or others as a result of the crisis.
- (b) Primacy of health response. Unless there is a significant risk of harm to the individual in crisis or to someone else, the primary response for an individual experiencing a mental or behavioral health crisis or health crisis related to substance use disorder should be with mobile crisis or emergency medical services clinicians.
- (c) Effects on law enforcement activities and collective bargaining. Nothing in this Article may be construed to limit or supersede:
 - (1) law enforcement activities of the police department or other law enforcement entities;
 - (2) the effectuation of a petition for emergency evaluation by a law enforcement officer;
 - (3) assistance of law enforcement requested by emergency dispatchers, residents, or others;
 - (4) police department or law enforcement entity orders; or
 - (5) collective bargaining under Chapter 33.]]

[[24-82]] 24-77. [[Advisory committee]] Working group – established.

- (a) There is [[an Advisory Committee on Crisis Intervention]] a Sequential Intercept Model (SIM) Coordination Working Group.
- (b) The [[committee]] working group consists of:
 - (1) a designee of the [[Mental Health Association of Maryland]] Office of the Public Defender;
 - (2) a designee of the county's 9-8-8 call center;
 - (3) a designee of the Interagency Commission on Homelessness;

- (4) a designee of the District Administrative Judge for the District Court of Maryland, Montgomery County;
- (5) a designee of the Administrative Judge for the Circuit Court for Montgomery County;
- (6) a designee of the Montgomery County State’s Attorney;
- (7) a designee of the Montgomery County Council;
- (8) a designee of the Intellectual and Developmental Disabilities Commission;
- (9) a representative of [[a county chamber of commerce, appointed by the County Executive and confirmed by the Council]] the Primary Care Coalition or a successor organization;
- (10) a designee of the Montgomery County Fire Chief;
- (11) a designee of the Emergency Communications Center;
- (12) a designee of the County Sheriff;
- (13) a designee of the Director of the Department of Correction and Rehabilitation;
[[and]]
- (14) a designee of the Montgomery County Police;
- (15) a designee of the Department of Health and Human Services;
[[(14)]] (15) 2 residents, appointed by the Executive and confirmed by the Council, who:
 - (A) have lived experience regarding mental health, behavioral health, or substance use disorders;
 - (B) represent different geographical regions of the County; and
 - (C) will be offered the opportunity to participate in the police department’s “Citizens Academy,” as well as attend any CIT training or other in-service training offered relevant to the work of the Advisory Committee;
- (16) a designee of the Executive Director of the Council who performs analysis for the Council regarding health and human services or public safety; and
- (17) a representative of a peer support organization or community-based behavioral health provider.

[[24-83]] 24-78. [[Advisory committee]] Working group – duties and staffing.

The [[advisory committee]] working group must, through a lens of racial equity and social justice:

- (a) [[provide advice to, and collaborate with, the crisis intervention team, the Executive, and the Council regarding best practices for crisis intervention in the County related to]] use the Sequential Intercept Model to assess and analyze the County's ability to provide crisis intervention services, crisis response, and diversion from the criminal justice system to treatment for individuals with mental health, behavioral health, or substance use disorders;
- (b) [[consult with the crisis intervention team regarding the development of the models under Section 24-80]] advise the Executive and Council regarding best practices in crisis intervention, diversion programs, and wraparound services;
- (c) direct the coordination and implementation of a Sequential Intercept Model specific to the County;
- [[c)] (d) prepare the annual report required under Section 24-84;
- [[d)] (e) follow the work and recommendations of the Crisis Intervention Team and Maryland Behavioral Health and Public Safety Centers of Excellence in the Governor's Office of Crime Prevention, Youth, and Victim Services; and
- [[e)] (f) be staffed by a designee of the County Executive.

24-84. Annual evaluation and reporting.

The [[advisory committee]] working group must submit, no later than January 31 each year, an annual report to the Executive and Council that includes:

- (a) numerical data, disaggregated when possible by race, ethnicity, gender, gender identity, and age, regarding:
 - (1) public safety service calls involving individuals experiencing a crisis related to mental health, behavioral health, or substance abuse disorders;
 - (2) petitions for emergency evaluation:
 - (A) issued; and
 - (B) served;
 - (3) individuals diverted by the crisis intervention team from the emergency room to other supports;

- (4) individuals served [[in-person or by phone,]] by the County's 24-hour Crisis Center;
- (5) individuals served by the County's 9-8-8 call center;
- [[5]] (6) service calls under paragraph (1) involving an actual or threatened deadly or dangerous weapon, as defined under Sections 4-101 or 4-102 of the Criminal Law Article of the Maryland Code, as amended;
- [[6]] (7) service calls under paragraph (1) involving co-occurring criminal conduct, including the numbers of associated:
 - (A) misdemeanor charges;
 - (B) felony charges;
 - (C) individuals offered a diversion to treatment; and
 - (D) individuals who were not charged due to diversion to treatment; and
- [[7]] (8) service calls under paragraph (1) involving an individual where pending criminal charges were at issue;
- (b) metrics and data regarding housing stability, outpatient treatment engagement, and other social determinants of health;
- (c) metrics and data regarding racial equity and social justice, as related to the Sequential Intercept Model;
- (d) achievements and challenges regarding implementation of the [[crisis intervention team]] Sequential Intercept Model in the County during the prior year; and
- [[c]] (e) recommendations to improve [[crisis intervention]] the Sequential Intercept Model in the County, in coordination with local, state, and federal partners.

Sec. 2. Transition. The first report required under Section 24-84, added under Section 1 of this Act, is due by January 31, [[2025]] 2027.



DEPARTMENT OF CORRECTION AND REHABILITATION

Marc Elrich
County Executive

Benjamin A. Stevenson
Director

February 20, 2026

The Honorable Councilmember Dawn Luedtke
100 Maryland Avenue
Rockville, Maryland 20850

Dear Councilmember Luedtke,

I am writing this letter of support for the amendments being made to Bill 43-23 in advance of the February 26 joint Health and Human Services and Public Safety work session. The Department of Correction and Rehabilitation (DOCR) supports and believes that the implementation of Sequential Intercept Model (SIM) Coordination Working Group would be beneficial to align and collaborate across judicial, public safety and behavioral health systems.

Evidence supporting Sequential Intercept Model (SIM) mapping shows it is an effective, evidence-based, and widely utilized strategic planning tool for reducing the justice system involvement of people with mental and substance use disorders. I believe the proposed workgroup would further discussion and action, ultimately providing improved continuity of care, communication, and alignment of services for those we are charged to serve.

A large cross-system work group would provide more opportunities for DOCR to improve existing service gaps, reduce recidivism, improve cross-system collaboration, and create a more data-driven plan to divert individuals from incarceration. Our agency is committed to participating and allocating the necessary time and resources to ensure the success of the SIM workgroup. We believe this cross-system approach is essential to achieving better outcomes for our residents and creating a more efficient, compassionate system.

Thank you for your dedication to improving our community's response to behavioral health needs within the justice system.

Sincerely,

Ben Stevenson, Director
Montgomery County Department of Correction and Rehabilitation

22880 Whelan Lane • Boyds, Maryland 20841 • 240-773-9700 • 240-777-9966 FAX
www.montgomerycountymd.gov



NATASHA DARTIGUE
PUBLIC DEFENDER

KEITH LOTRIDGE
DEPUTY PUBLIC DEFENDER

SEAN MUKHERJEE
DISTRICT PUBLIC DEFENDER FOR DISTRICT SIX

ELIZABETH ZOULIAS
DEPUTY DISTRICT PUBLIC DEFENDER FOR DISTRICT SIX

February 20, 2026

Ms. Natali Fani-González,
President,
Montgomery County Council

Re: Support for Bill 43-23,

Dear Council President Fani-González and Montgomery County Council,

I am writing to you today in support of Bill 43-23, and the efforts by Councilmember Luedtke, various agencies, and community partners to implement the tenets of the Sequential Intercept Model (“SIM”) in Montgomery County. As you may know, the SIM is designed to help communities map, assess, and improve services for individuals with mental health or substance use disorders involved in the justice system. It aims to divert people from involvement in the criminal legal system, reduce recidivism, and link them to treatment and services likely to stabilize their lives in our community. By its very nature, the SIM operates to reduce the costly, inefficient and harmful processing of people through the criminal legal system with a series of coordinated interventions which will ultimately increase the efficiency and focus of the judicial system and law enforcement in the County, help maximize the value of the support services available in our community, and dramatically reduce the collateral damage and human cost that deep-end involvement in our criminal legal system inflicts on our society.

This Bill codifies the coordination and attention that is vital to the success of the SIM in this jurisdiction. I strongly support this common-sense effort and thank Councilmember Luedtke, among others for championing this initiative. It is my view that, as a community, it is time to put a coordinated emphasis on our County’s crisis response efforts and SIM implementation. I therefore strongly support this Bill.

Sincerely,

Sean B. Mukherjee, Esq.
District Public Defender
District Six – Montgomery County