HHS/PS Item #1
February 5, 2024
Worksession

M E M O R A N D U M

January 31, 2024

TO: Health and Human Services Committee
Public Safety Committee

FROM: Christine Wellons, Senior Legislative Attorney

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

PURPOSE: Worksession – recommendation expected

Expected Attendees

- Dr. Earl Stoddard, Assistant Chief Administrative Officer
- Dr. James Bridgers, Director, Department of Health and Human Services
- Dr. Rolando L. Santiago, Chief, Behavioral Health and Crisis Services
- Chief Marcus Jones, Montgomery County Police Department (MCPD)
- Captain Jordan Satinsky, MCPD
- Ben Stevenson, Director, Department of Correction and Rehabilitation (invited)
- Luke Hodgson, Director, Office of Emergency Management and Homeland Security Management (invited)
- Shantee Jackson, Office of Management and Budget (invited)
- Michelle Grigsby-Hackett, LCPC, CPRP Montgomery County Mental Health Advisory Committee, Vice-Chair

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. A joint Public Safety (PS) & Health and Human Services (HHS) Committee worksession is scheduled for February 5, 2024.

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

Bill 43-23 would formally establish 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.

The current model of crisis response in the County was discussed by the joint Committee during a worksession on January 30, 2023. The staff packet for that worksession provides detailed background and is available here: 20230130_PSHHS1.pdf (montgomerycountymd.gov)

BILL SPECIFICS

The CIT would 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 Impacts. "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 48-23 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."

ISSUES FOR THE COMMITTEE'S CONSIDERATION

1. Sponsor's Amendments

Councilmember Luedtke intends to move several substantive and technical amendments to the bill. See © 25.

2. Roles of DHHS and MCPS

Under Bill 43-23, DHHS and MCPS would have "equal responsibility" in overseeing the CIT. Each department would designate a co-lead of the CIT. A memorandum of understanding between the departments would further delineate roles and responsibilities.

The Committee might wish to discuss with DHHS and MCPS how they envision their roles and cooperative relationship in carrying out the authorities of the CIT.

3. Authorities of the CIT

The CIT would have several roles, including its main function to:

- 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.

This language contemplates a co-response of DHHS and MCPD under the CIT umbrella. However, the language does not preclude a civilian-led response to incidents, and the bill clarifies that:

- 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.

The Committee might wish to discuss with the departments how they would ensure that mobile crisis services and health clinicians would continue to provide the primary response to behavioral health and substance use disorder issues. How would the departments determine when a co-response is warranted?

4. Membership of the Advisory Committee

The Committee might wish to walk through the membership of the Advisory Committee. Under Bill 43-23, the following:

(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) 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.

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

Sec. 1. Article XI, Sections 24-77, 24-78 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, credentialling 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. Advisory committee – established.

(a) There is an Advisory Committee on Crisis Intervention.

(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) 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.

24-83. 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 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;

(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) 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) 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) 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.

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-equality 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 adaptative 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]

- 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 Petitions [12] – 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]

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.

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.

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.

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] RESJIS 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.

[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

Fiscal Impact Statement

Office of Management and Budget

Bill 43-23 Crisis Intervention Team - Established

Bill Summary

Bill 43-23 establishes a crisis intervention team (CIT) as a joint initiative of both the Department of Health and Human Services (DHHS) and the Montgomery County Police Department (MCPD). The bill requires DHHS and MCPD to develop a sequential intercept model for individuals in the County experiencing crises related to mental health, behavioral health, or substance use disorders. The bill also establishes an advisory committee to support the CIT and requires annual reporting and program evaluation.

Fiscal Impact Summary

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.

Fiscal Year	2025	2026	2027	2028	2029	2030	Total
Personnel Costs	$3,555,900	$3,555,900	$3,555,900	$3,555,900	$3,555,900	$3,555,900	$21,335,400
Operating Expenses	$1,591,400	$314,000	$314,000	$314,000	$314,000	$314,000	$3,161,400
Total Expenditures	**$5,147,300**	**$3,869,900**	**$3,869,900**	**$3,869,900**	**$3,869,900**	**$3,869,900**	**$24,496,800**
Revenues	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Impact	**($5,147,300)**	**($3,869,900)**	**($3,869,900)**	**($3,869,900)**	**($3,869,900)**	**($3,869,900)**	**($24,496,800)**
FTE	31.00	31.00	31.00	31.00	31.00	31.00	

Fiscal Impact Analysis

The bill requires that the CIT consist of designated DHHS, MCPD, and other law enforcement staff. This fiscal impact statement assumes DHHS will require 17 positions and MCPD will require 14 positions. In total, the cost of new positions is approximately $3.6 million each year. As shown in **Exhibit 1**, operating expenses total $1.6 million in FY25 and $314,000 each year thereafter. Each position will also incur one-time costs of approximately $5,000, for a total of $155,000 in FY25. Some staff will need vehicles to respond to crisis calls. Each police officer, sergeant, and lieutenant requires a marked car, with one-time costs of $82,000 in FY25 and ongoing maintenance costs of $24,000. DHHS will require one vehicle, with one-time costs of $53,000 and ongoing maintenance costs of $6,000. Vehicle costs total $1.4 million in FY25 and $314,000 each year thereafter.

Exhibit 1: Bill 43-23 Operating Expenses

	Per-Unit Cost	Count	Aggregate FY25 Operating Expenses	Aggregate Ongoing Operating Expenses
Department of Health and Human Services				
Vehicle Purchase	$53,000	1.0	$53,000	$0
Annual Vehicle Operating Costs	$6,000	1.0	$6,000	$6,000
One-Time Costs for New Positions	$5,000	17.0	$85,000	$0
Subtotal			*$144,000*	*$6,000*
Montgomery County Police Department				
Marked Police Cars	$82,264	13.0	$1,069,432	$0
Annual Vehicle Operating Costs	$23,693	13.0	$308,009	$308,009
One-Time Costs for New Positions	$5,000	14.0	$70,000	$0
Subtotal			*$1,447,441*	*$308,009*
Total			**$1,591,441**	**$314,009**

Staff Impact

To designate staff to a 24/7 CIT, DHHS could require 17 positions and MCPD could require 14 positions. Position classifications, compensation, and functional roles are described in **Exhibit 2**.

24/7 Staff

In DHHS, four therapists and four peer support specialists would be created so that at least one therapist and one peer support specialist is on call at all times throughout the day.

MCPD advises that it currently has five officers able to provide crisis intervention team response but that this is only sufficient to fully staff one

shift during the busiest time of day. To provide designated staff throughout the day, MCPD estimates that ten additional police officers are needed to staff two shifts of five officers.

Supervision and Program Direction
DHHS and MCPD estimate that each department will require supervisory positions: DHHS will need one Supervisory Therapist; and MCPD will need two Sergeants.

To direct the operations of the team, DHHS and MCPD will designate one Manager III position and one Lieutenant, respectively.

Staff to Support the CIT
Some positions will facilitate the work of the CIT but are not needed 24/7. DHHS will require five new Community Services Aide III positions: two staff will intake calls for mobile crisis response during the busiest times of day; two case managers will assist with ongoing care coordination; and one navigator will assess clients periodically and record long-term data on client outcomes.

DHHS and MCPD will each require a Program Manager II position to carry out the bill's program evaluation and reporting requirements. This estimate assumes that any staffing responsibilities associated with the newly created Advisory Committee on Crisis Intervention would be handled by the new program manager positions designated for DHHS and MCPD.

One Office Services Coordinator will also be needed to support the administrative needs of the team.

Exhibit 2: Bill 43-23 Personnel Costs

	Grade	Per- Position Compensation	FTE	Aggregate Personnel Costs	Function
Department of Health and Human Services					
Community Services Aide III	N18	$95,885	5.0	$479,425	Two dedicated call takers; two case managers; and one navigator
Therapist II	N24	$118,889	4.0	$475,556	One therapist on every shift, 24/7
Community Services Aide II	N16	$89,748	4.0	$358,992	One peer specialist on every shift, 24/7
Manager III	N35	$142,996	1.0	$142,996	Provides operational direction to CIT
Supervisory Therapist	N26	$128,180	1.0	$128,180	Supervises Therapist IIs
Program Manager II	N25	$123,409	1.0	$123,409	Manages data collection, program evaluation, and annual reporting functions.
Office Services Coordinator	N16	$89,748	1.0	$89,748	Supports CIT administrative needs
Subtotal			*17.0*	*$1,798,306*	
Montgomery County Police Department					
Police Officer III	FOP - P4	$120,621	10.0	$1,206,210	Five officers for each dedicated afternoon and evening shift
Sergeant	FOP - A1	$136,984	2.0	$273,968	One Sergeant supervises each shift of five officers
Lieutenant	FOP - A2	$154,052	1.0	$154,052	Provides operational direction to CIT
Program Manager II	N25	$123,409	1.0	$123,409	Manages data collection, program evaluation, and annual reporting functions
Subtotal			*14.0*	*$1,757,639*	
Total			**31.0**	**$3,555,945**	

Note: Positions with an "N" grade are on the County's General Salary Schedule for new positions. Positions with a "FOP" grade are positions in the Fraternal Order of Police (FOP) Bargaining Unit Uniform Salary Schedule and Police Leadership Service Salary Schedule.

Actuarial Analysis
The bill is not expected to impact retiree pension or group insurance costs.

Information Technology Impact
The bill is not expected to impact the County Information Technology (IT) or Enterprise Resource Planning (ERP) systems.

Other Information

Later actions that may impact revenue or
In FY24, DHHS is using a federal Substance Abuse and Mental Health Services Administration grant to staff a Mobile Crisis Team with 16 full time and 2 part time contractual staff. These federal grant funds will not be available in FY25. Absent additional action by the Executive and Council in the FY25 budget, Mobile Crisis Team services would end unless approximately $2.3 million general funds were appropriated to replace the federal funds. If general funds were appropriated to implement the bill, Mobile Crisis Team services would be substantially similar

expenditures if future spending is projected	to those available in FY24. While contractors are currently used, this estimate assumes that an ongoing program would utilize County merit staff to promote service continuity and employee retention.
Ranges of revenue or expenditures that are uncertain or difficult to project	MCPD has approximately 800 officers that have some crisis intervention training. These officers currently respond to both crisis calls and other types of calls. As the designated CIT within MCPD will now exclusively respond to crisis response, some of the workload associated with crisis calls may be reduced for other officers. However, this analysis does not assume any potential workload reduction as a result creating designated CIT staff. To the extent that existing staff are reassigned to this role, costs would be mitigated accordingly.
Contributors	Grace Pedersen and Derrick Harrigan, Office of Management and Budget Dr. Rolando Santiago and Sheenu Chopra, Department of Health and Human Services Capt. Jordan Satinsky and Dale Phillips, Montgomery County Police Department

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

AMENDMENT # 1 – AUTHORITIES OF THE CIT (AMENDMENT CONSISTS OF PARTS A, B, AND C)

Part A -- Amend lines 10-13 as follows.

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

Part B -- Amend lines 51-52 to read as follows.

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

The crisis intervention team **[[**must**]]** has authority to:

Part C -- After line 165, add a new section as follows.

24-85. Effect of Article.

This Article, including the authorities of the crisis intervention team under Section 24-80, must not be construed to alter standards of civil or criminal liability or to create private rights enforceable by any person or individual.

AMENDMENT #2 – MEMORANDUM OF UNDERSTANDING

Amend lines 39-43 to read as follows.

(d) *Memorandum of Understanding.*

(1) 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, identify locations and staffing of the crisis intervention team, and address other administrative issues.

(2) Prior to execution of the Memorandum of Understanding, the health department and the police department must consult with:

(A) certified employee representatives under Chapter 33; and

(B) the Office of Labor Relations.

(3) The terms of the Memorandum of Understanding must conform with the terms and conditions of collective bargaining agreements to which the County is a party.

AMENDMENT #3 – CLINICAL ACTIVITIES

Amend line 80-89 to read as follows.

(c) *Effects on law enforcement activities, clinical services and 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) clinical activities of the health department, including the provision of clinical or medical services by County employees; or

[[(5)]] (6) collective bargaining under Chapter 33.

AMENDMENT #4 – MEETINGS OF THE ADVISORY COMMITTEE

Amend lines 121-133 to read as follows.

The advisory committee must:

* * *

(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; and

(f) meet at least 4 times a year, with at least one meeting per quarter.

TECHNICAL AND CLARIFYING AMENDMENTS:

AMENDMENT #5

Amend line 3 to read as follows.

ARTICLE XI. CRISIS INTERVENTION TEAM.

AMENDMENT #6

Amend lines 19-23 to read as follows.

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**]]** mental health or substance use treatment.

AMENDMENT #7

Amend lines 31-35 to read as follows.

(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, **[[**credentialling**]]** credentialing and continuing education requirements imposed by State or federal law applicable to the respective disciplines.

AMENDMENT #8

Amend line 57 to read as follows.

(b) adhere to the **[[**principals**]]** principles of the crisis intervention model program;

AMENDMENT #9

Amend lines 52-69 to read as follows.

The crisis intervention team must:

* * *

(c) respond to acute incidents in the County where there is a significant risk of **[[**harm**]]** danger 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;

* * *

(f) provide to each individual or family served by the team existing, publicly available information regarding how to prepare an advance directive **[[**for psychiatric care**]]**, such as the Maryland Department of Health form, *Advance Directive for Mental Health Treatment*.

AMENDMENT #10

Amend lines 75-79 to read as follows.

(b) **[[***Primacy***]]** *Priority of health response.* Unless there is a significant risk of **[[**harm**]]** danger to the individual in crisis or to someone else, the **[[**primary**]]** priority 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.

AMENDMENT #11

Amend lines 92-93 to read as follows.

(b) The committee consists of:

(1) a designee of **[[**the Mental Health Association of Maryland**]]** a designee of a statewide mental and behavioral health advocacy organization;

AMENDMENT #12

Amend lines 92-119 to read as follows.

(b) The committee consists of:

* * *

(14) 2 residents, appointed by the Executive and confirmed by the Council, who:

* * *

(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**]]** advisory committee.

AMENDMENT #13

Throughout the bill, capitalize County*, including in lines 46, 94, and 104.*

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www.mhamd.org

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

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 cahoots 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 establishes 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
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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

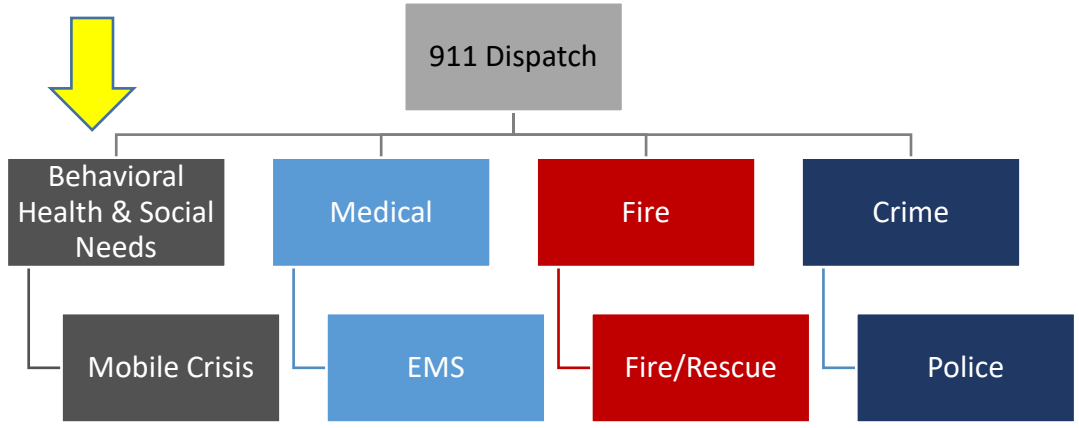
about mental illness, research does not demonstrate the same impact on officer behavior (Marcus & Stergiopoulos, 2022; Seo et al., 2021).

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.

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Vera INSTITUTE OF JUSTICE

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

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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 Outeach 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.

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

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

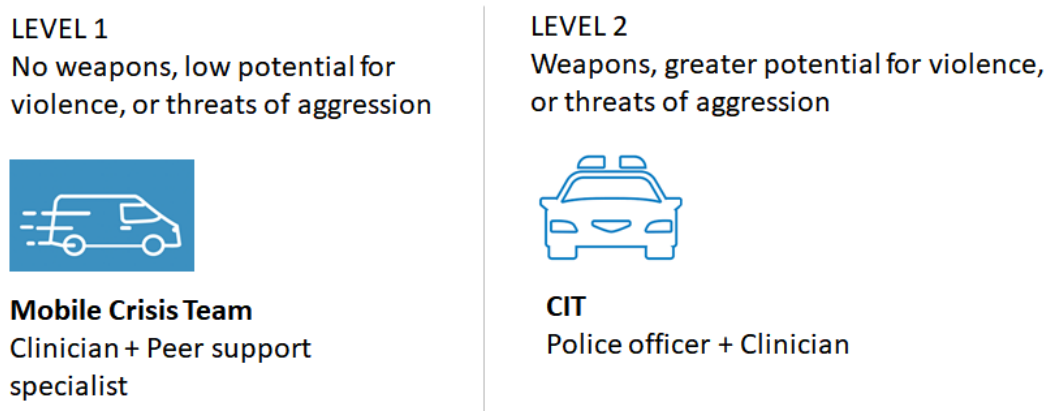
Protocol as introduced with MCOT joint response with police

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:

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:



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 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 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.

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