ADDENDUM
HHS/PS Item #1
February 5, 2024
Worksession

M E M O R A N D U M

February 5, 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

COUNCILMEMBER MINK PROPOSED AMENDMENTS

Following the publication of the staff report, Councilmember Mink provided a memorandum with proposed amendments to Bill 43-23. Attached are the memorandum and the proposed amendment text. The attachments to this addendum start at © A1.

COUNCILMEMBER KRISTIN MINK
DISTRICT 5

MONTGOMERY COUNTY COUNCIL

EDUCATION & CULTURE COMMITTEE
PUBLIC SAFETY COMMITTEE
LEAD FOR LIBRARIES

COUNCILMEMBER.MINK@MONTGOMERYCOUNTYMD.GOV ROCKVILLE, MD 240-777-7955

MEMORANDUM
February 5, 2024

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

FROM: Councilmember Kristin Mink

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

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

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

For example, Albuquerque Community Safety (ACS) directly diverted 3,115 calls/month from the Police Department over their first two years[1]. Their response times are 17 minutes for suicidal calls for service (CFS), 34 minutes for behavioral health CFS. They also respond to calls for unsheltered persons, welfare checks, disturbances, needle pick-ups, transport, and more.[2]

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

In Montgomery County:

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

[1] Albuquerque Community Safety Second Anniversary 2-Pager
[2] Albuquerque Community Safety FY24 Q2 Report
[3] New Orleans Mobile Crisis Intervention Unit (MCIU) Implementation and First 90-Days Summary
[4] PS/HHS Committee Memorandum, Briefing: Behavioral Health Crisis Response, January 30, 2023.

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

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

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

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

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

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

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

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

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

Maryland
DEPARTMENT OF HEALTH

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

Subject: Public Notice for Behavioral Health Crisis Services

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

Staffing Requirements

Mobile Crisis Teams

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

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Maryland
DEPARTMENT OF HEALTH

MOBILE CRISIS TEAM	**St. Petersburg, FL** CALL Program	**Toronto, Canada** TCCS	**Denver, CO** STAR Program	**Eugene, OR** CAHOOTS	**Albuquerque, NM** ACS	**Montgomery County, MD** MCOT
TYPES OF INCIDENTS THEY RESPOND TO WITHOUT POLICE All specify these are for calls without weapons or risk of violence. **Standards for what constitutes relevant weapons or risk of violence vary widely.**	1. Suicidal subject 2. Mental health issue 3. Intoxication 4. Drug overdose 5. Transport 6. Homeless Complaints 7. Youth Truancy 8. Disorderly Juvenile 9. Neighborhood Dispute 10. Marchman Act assessment 11. Panhandling	1. Thoughts of Self-Harm/Suicide 2. Wellbeing Check 3. Substance use issue 4. Transport Request 5. Housing crisis 6. Person in Crisis *(Common supports: provide resources, referrals, practical supports like making a phone call or packing belongings, hospital transport)* 7. Disorderly Behavior 8. Dispute 9. Short-term case management (up to 6 months) *may include primary care, addiction care, counseling, employment & housing navigation, other culturally specific supports*	1. Suicidal subject 2. Welfare check 3. Intoxication or Substance abuse 4. Transport request 5. Homeless issues 6. Medical assessment/triage 7. Disturbance 8. Family disturbance 9. Suspicious occurrence 10. Request for support *(Resources, info, or other services requested)*	1. Suicidal subject 2. Welfare check (unresponsive person) 3. Transport request 4. Housing crisis 5. Minor disputes, counseling and mediation 6. Medical assessment 7. Criminal trespass 8. Intoxication 9. Disorderly subject 10. Traffic hazard	1. Suicidal subject 2. Behavioral health 3. Wellness check 4. Welfare check 5. Transport 6. Unsheltered individual 7. Suspicious person 8. Disturbance 9. Needle pick-up 10. Panhandling 11. Abandoned vehicle	1. Person experiencing mental health crisis, with NO ideation of harming self or others
Provide transport?	✅ Yes	✅ Yes	✅ Yes	✅ Yes	✅ Yes	⛔ No
Arrival Time	7 minutes	25 minutes	<30 minutes	2020: 1 hr. 56 mins (1 hr. 11 mins. for police)	Suicidal: 17 mins; BH: 34 mins; Wellness check: 53 mins.; Other: 1-2 hrs.	Up to several hours[1]
# Contacts	316/month[2]	451/month[3]	473/month[4]	1,352/month[5]	3,115/month[6]	125/month[7]

[1] Based on multiple constituent reports and multiple firsthand experiences by members of Councilmember Mink's staff. ("Wait times are also not tracked currently." PS/HHS Committee Memorandum, Briefing: Behavioral Health Crisis Response, January 30, 2023)
[2] "Between May 2021 to April 2022, the CALL team had a total of 3,794 contacts." COMPREHENSIVE EQUITY & PROCESS EVALUATION: Protocol and Data Review, by University of South Florida Center for Justice Research & Policy (June 2022).
[3] 5,868 dispatches from March 31, 2022 to April 30, 2023, per Toronto Community Crisis Service data summary
[4] "Between January 1, 2022 and July 1, 2022, STAR responded to 2,837 calls for service. The team has never had to call for back up due to a safety issue." STAR 2022 Mid-Year Report
[5] "In 2021 there were 16,218 public-initiated CFS where CAHOOTS was both dispatched and arrived." CAHOOTS Program Analysis 2021 Update, by Eugene PD Crime Analysis Unit.
[6] "Halfway through the fiscal year…ACS has responded to 18,687 calls for service, directly diverting over 14,000 calls from Albuquerque PD." ACS Quarterly Report: FY24-Q2
[7] "According to HHS, preliminary data indicates that over the first five months from August 2022 to December 2022, there were 624 MCOT responses." PS/HHS Committee Memorandum, Briefing: Behavioral Health Crisis Response, January 30, 2023.

New Orleans Mobile Crisis Intervention Unit (MCIU)

Implementation and First 90-days Summary

Resources for Human Development

Executive Summary

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

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

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

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Definitions and Acronyms

Avatar: RHD's national electronic health record

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

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

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

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

NOPD- New Orleans Police Department

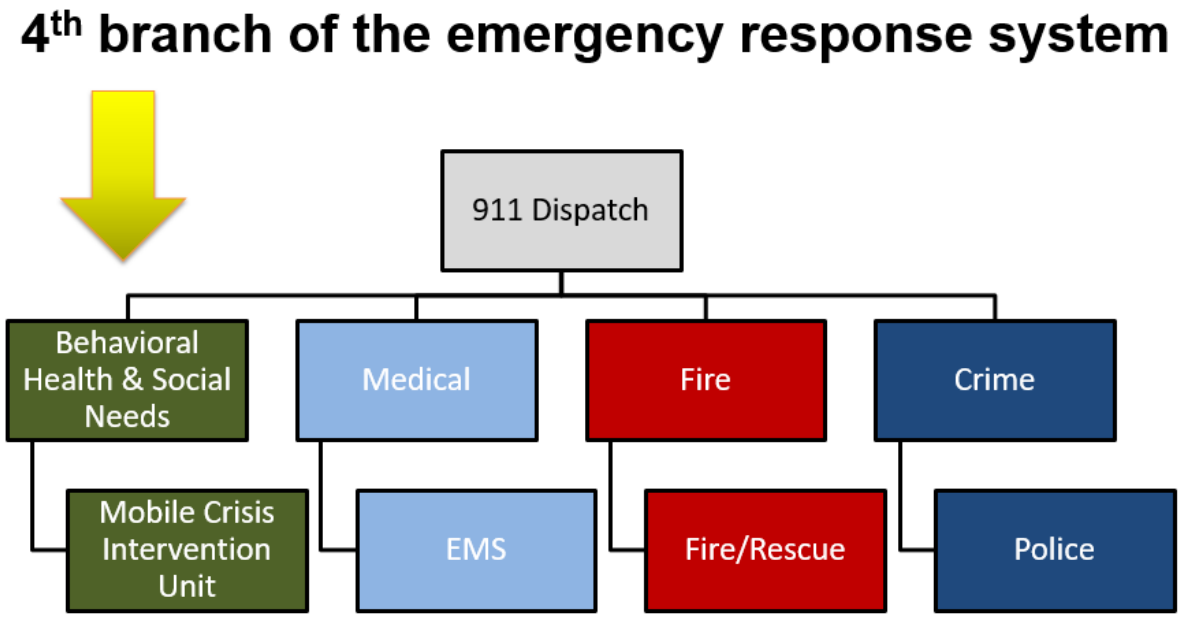
OPCD- Orleans Parish Communications District: 911 dispatch center for New Orleans.

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

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

Introduction

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



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

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

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

Program Implementation and Structure

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

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

Goals:

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

Service Description:

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

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

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

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

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

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

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

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

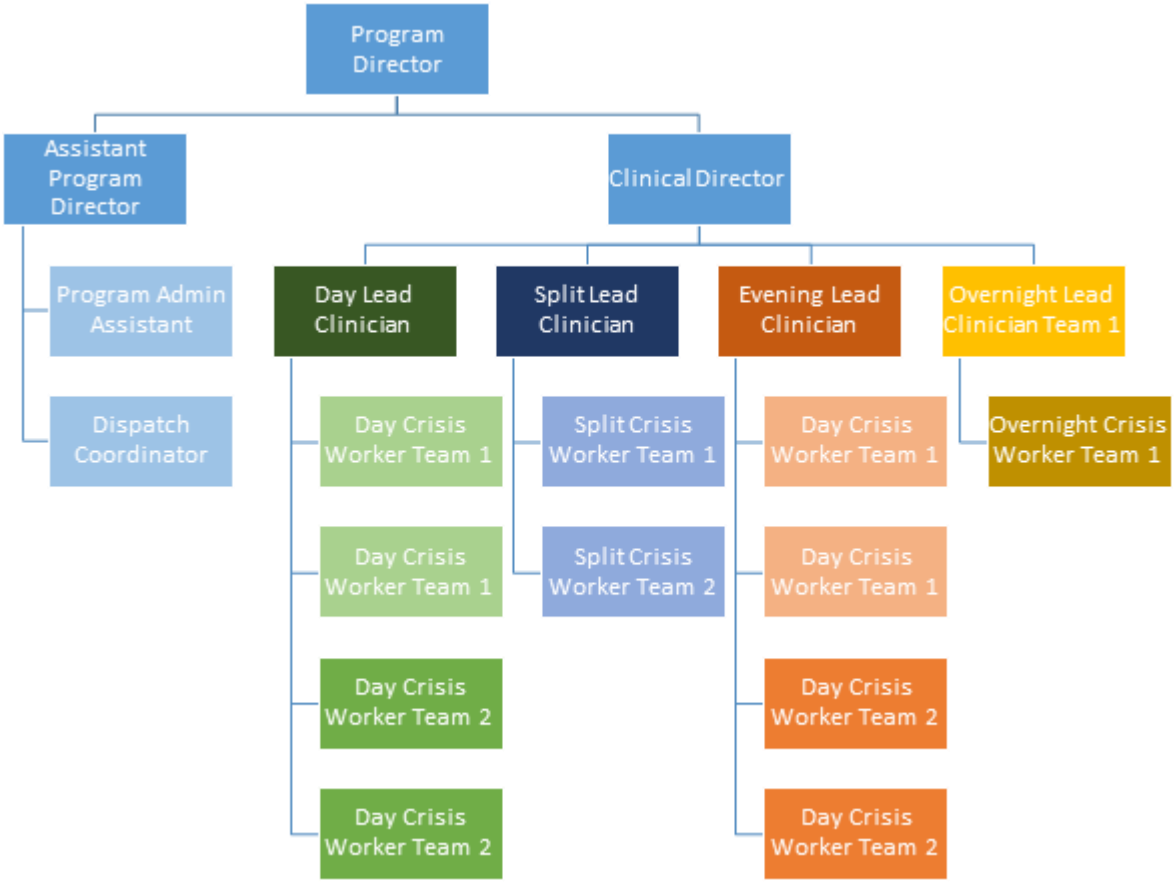
The goal of every intervention is to provide support that will allow the individual to continue their recovery in the least restrictive setting possible. Whenever possible, staff will work with the participant and their natural supports to develop a plan to keep them safe at home including connecting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

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

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

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

Org Chart



Trainings

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

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

Staff wellbeing plan:

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

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

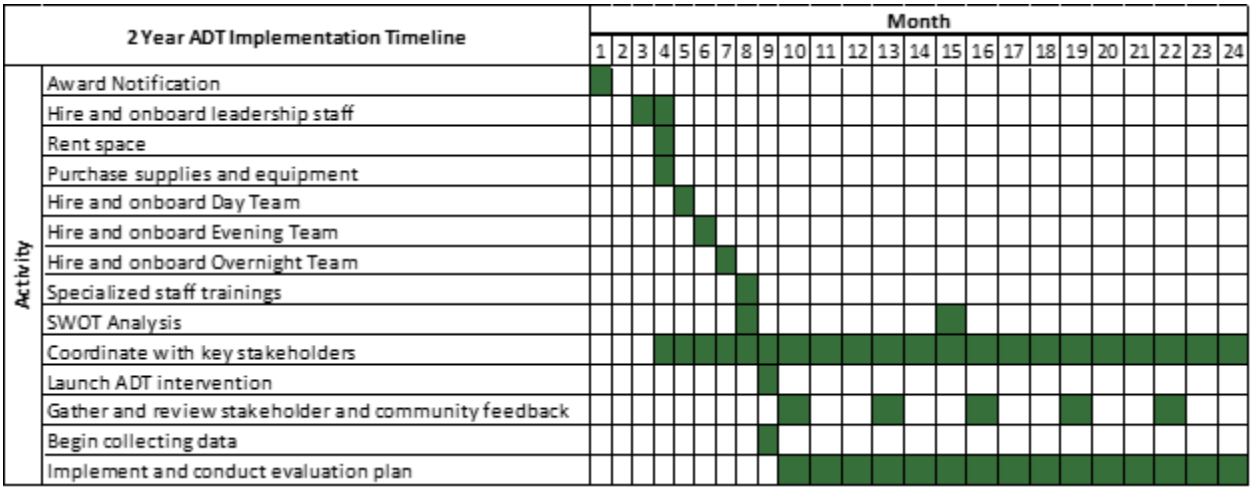
Wellness is often referred to as “self-care”, but RHD believes that we must care for each other. Supervisors are trained to check in with staff not just on clinical cases or administrative tasks but to ask about their emotional health. This includes processing difficult situations, reminders to take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

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

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

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

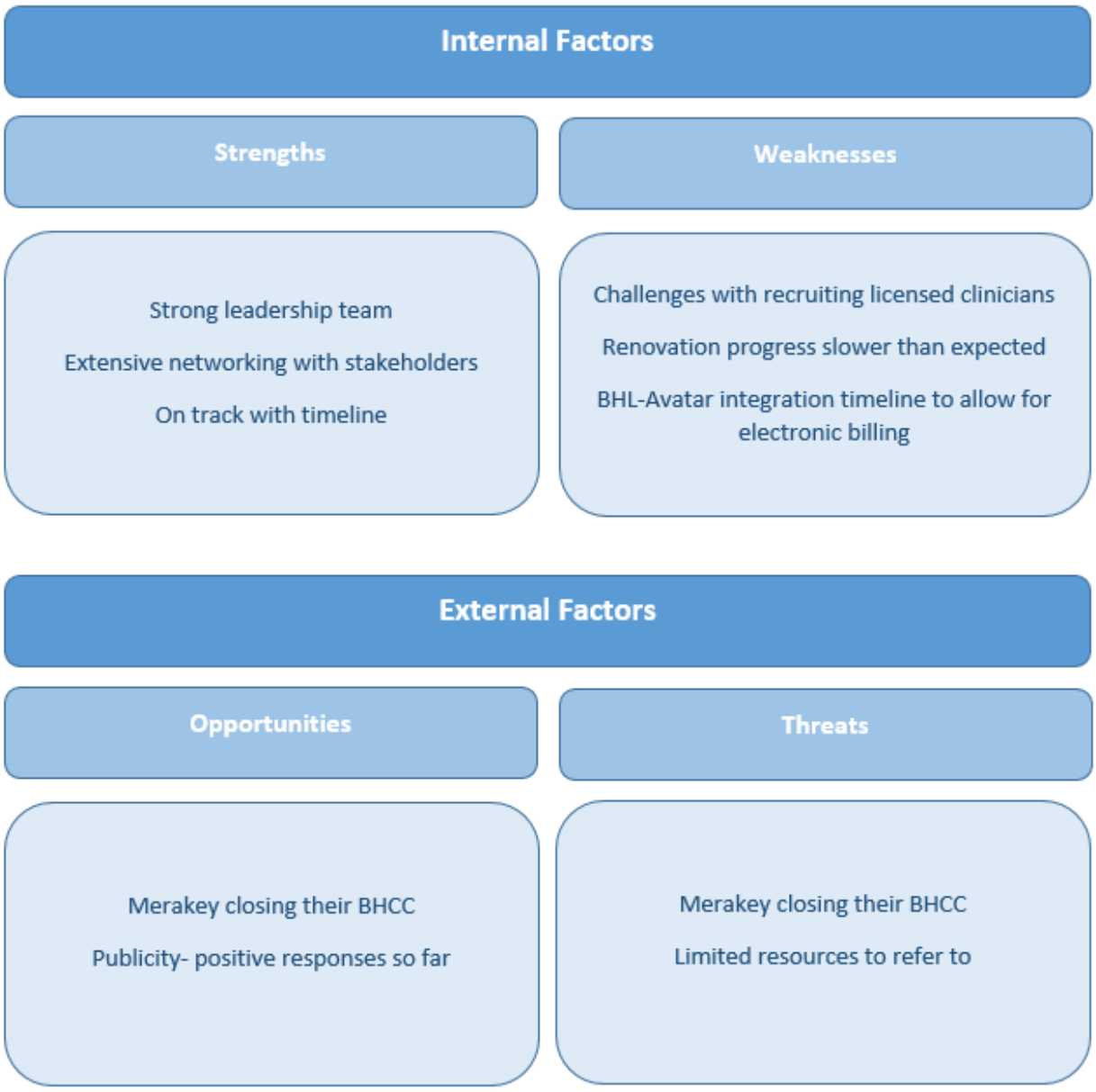
Implementation Timeline



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

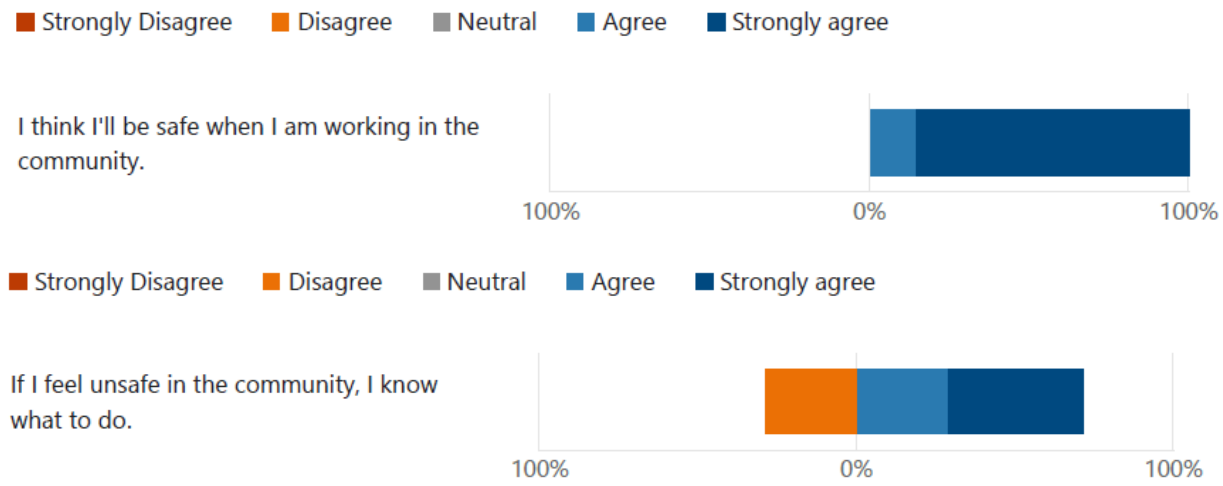
Goals were met and the program launched successfully on June 1, 2023.

A SWOT analysis was completed in April 2022:

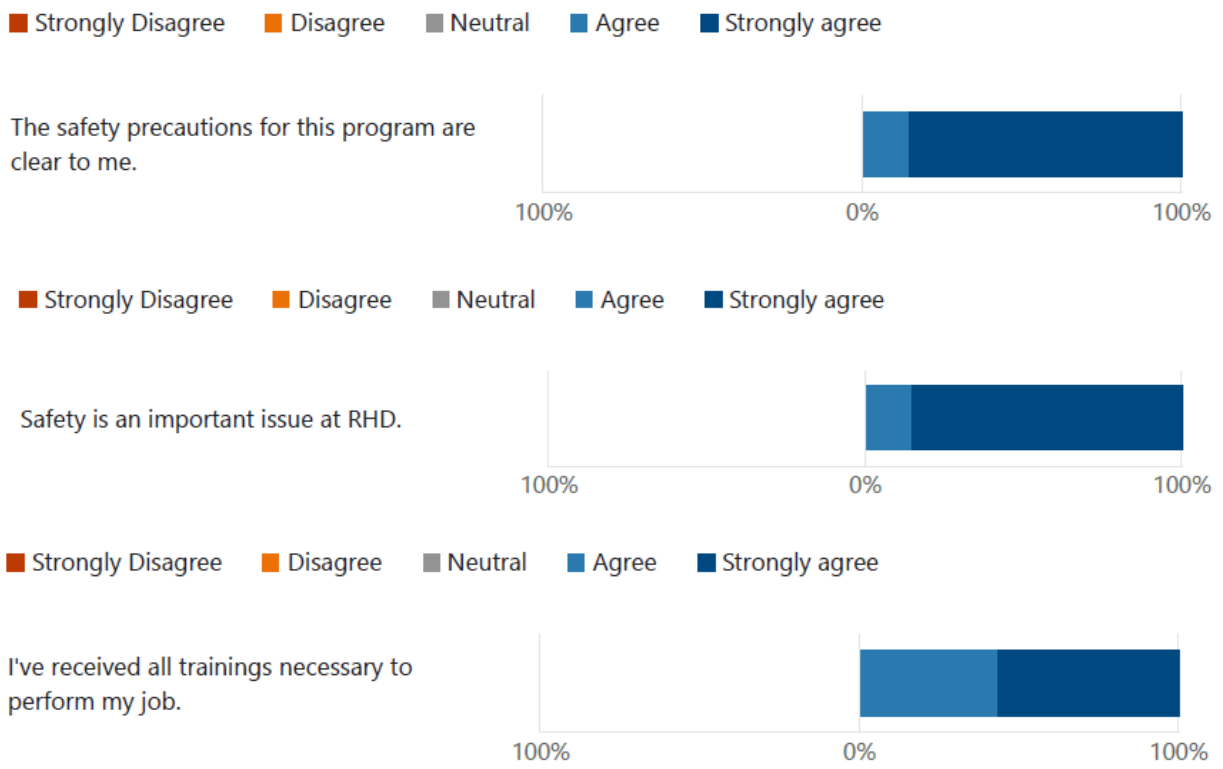


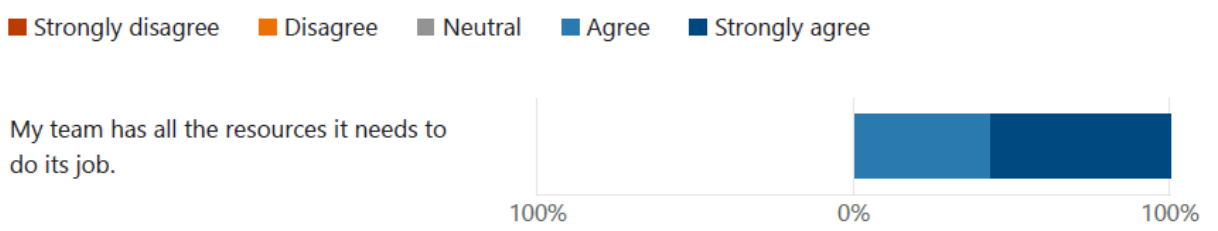
Staff Survey Pre-Launch

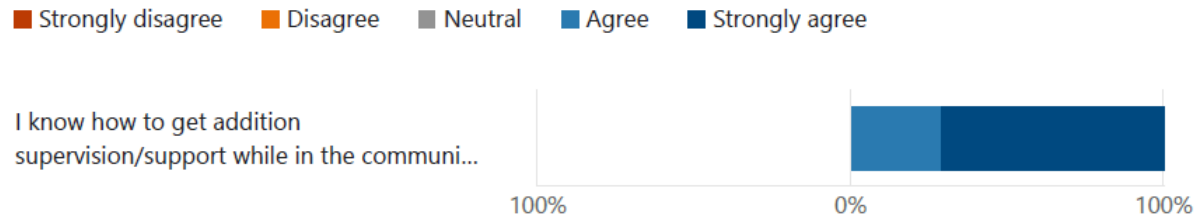
We surveyed staff who were hired by May 2023 to get a sense of how prepared staff felt and if there were any issues we needed to address prior to launch. There were 7 responses.

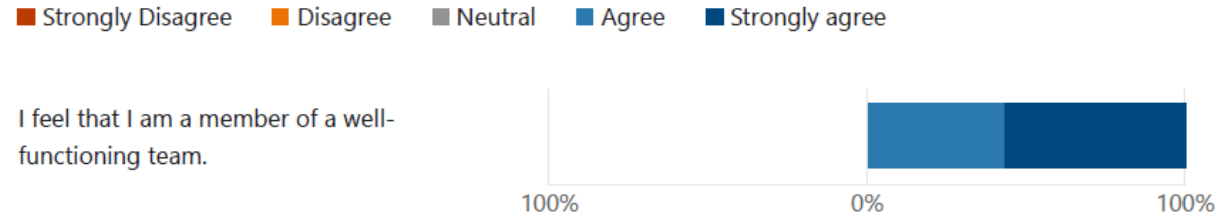


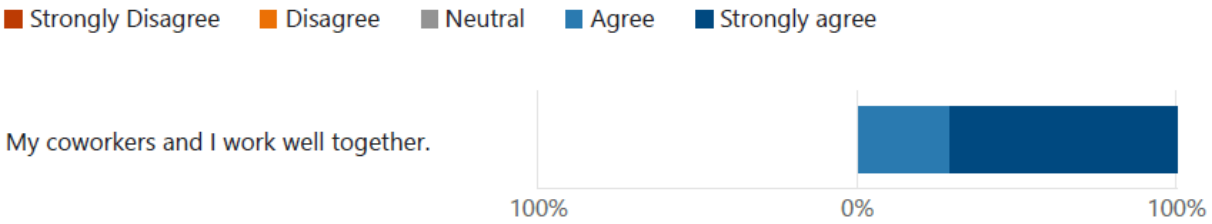
The one response that indicated that a staff person wasn't sure what to do if they felt unsafe in the community resulted in a review for all staff on safety protocols prior to launch.

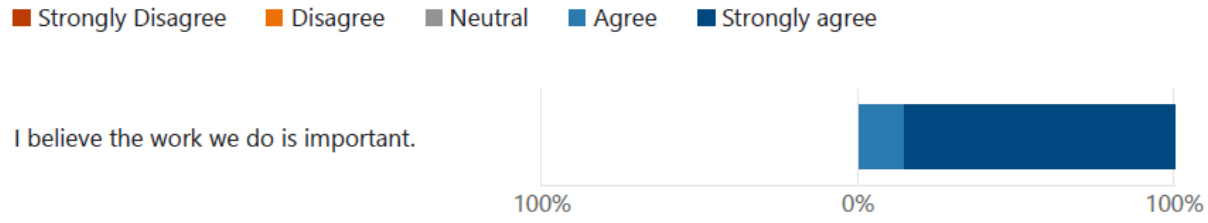


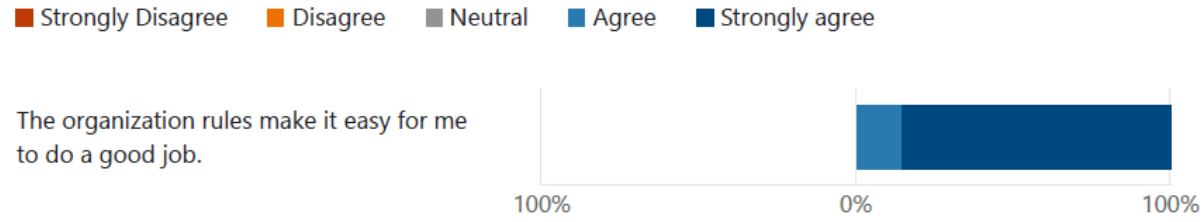

Strongly disagree
Disagree
Neutral
Agree
Strongly agree
My team has all the resources it needs to do its job.
100%
0%
100%

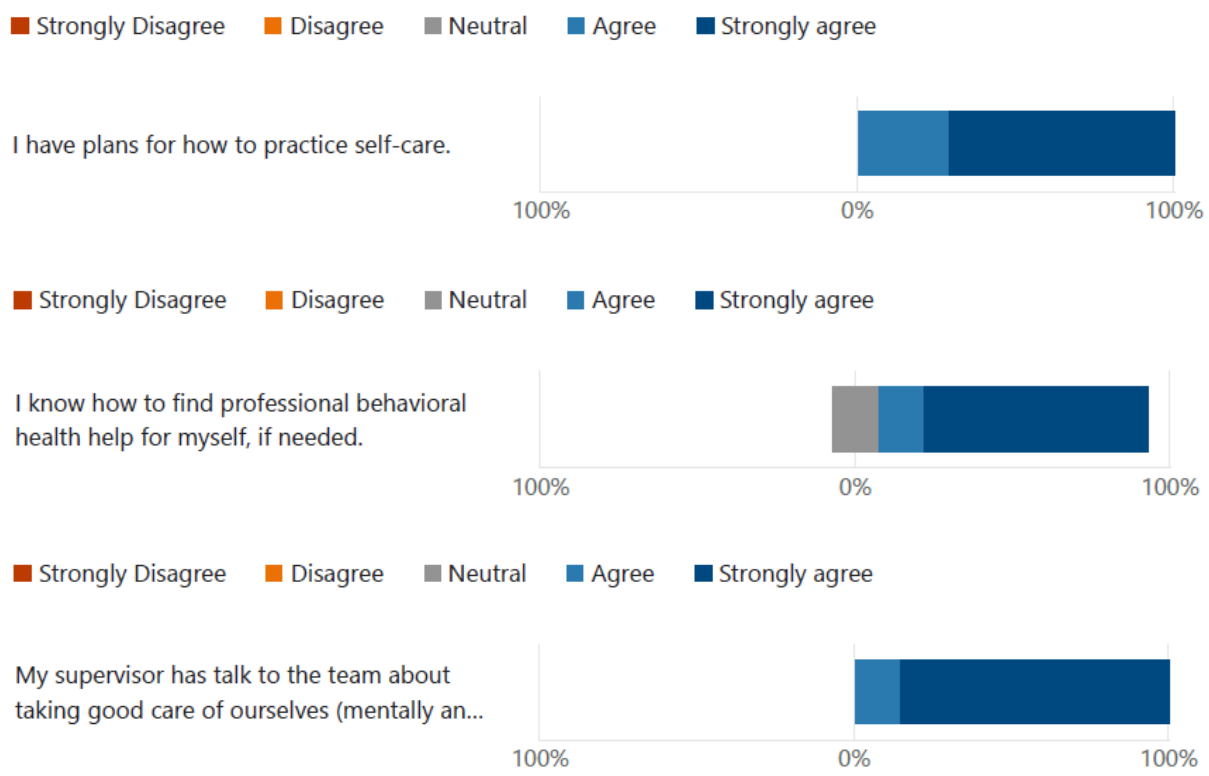

Strongly disagree
Disagree
Neutral
Agree
Strongly agree
I know how to get addition supervision/support while in the communi...
100%
0%
100%


Strongly Disagree
Disagree
Neutral
Agree
Strongly agree
I feel that I am a member of a well-functioning team.
100%
0%
100%


Strongly Disagree
Disagree
Neutral
Agree
Strongly agree
My coworkers and I work well together.
100%
0%
100%


Strongly Disagree
Disagree
Neutral
Agree
Strongly agree
I believe the work we do is important.
100%
0%
100%


Strongly Disagree
Disagree
Neutral
Agree
Strongly agree
The organization rules make it easy for me to do a good job.
100%
0%
100%



Three additional open-ended questions were asked:

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

- no additional trainings were requested

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

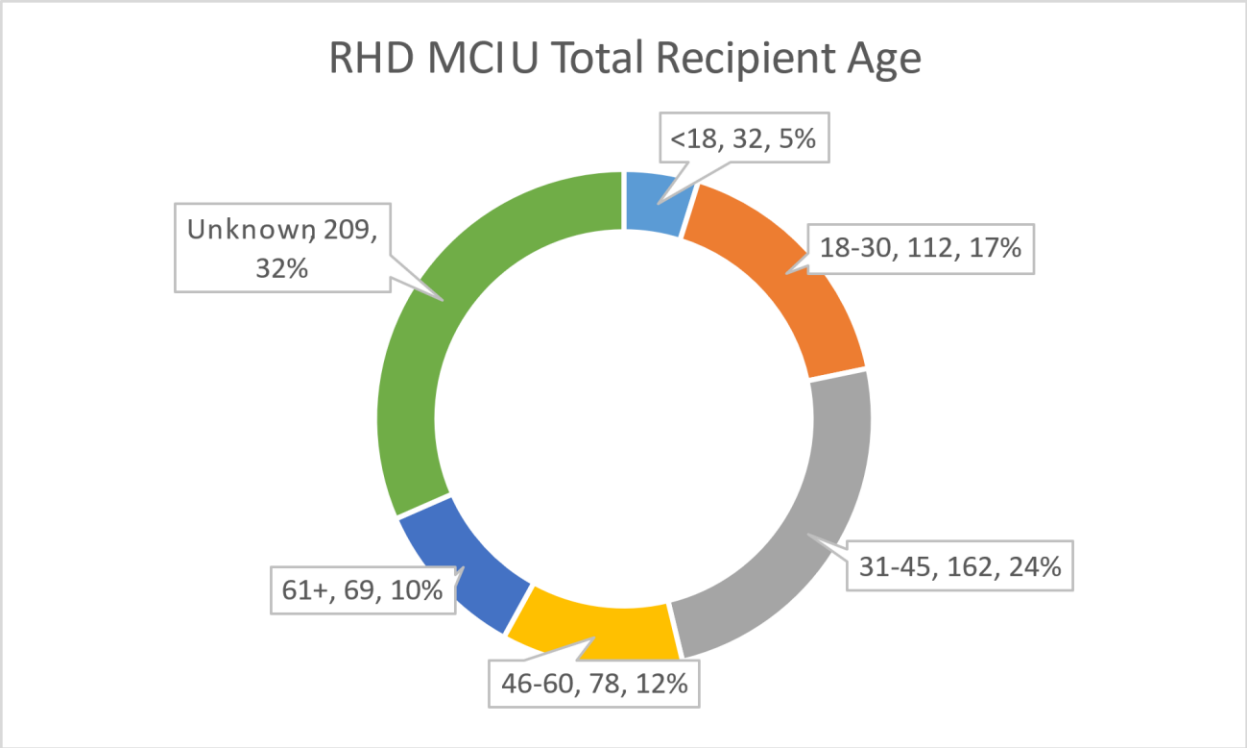
- we may need more males

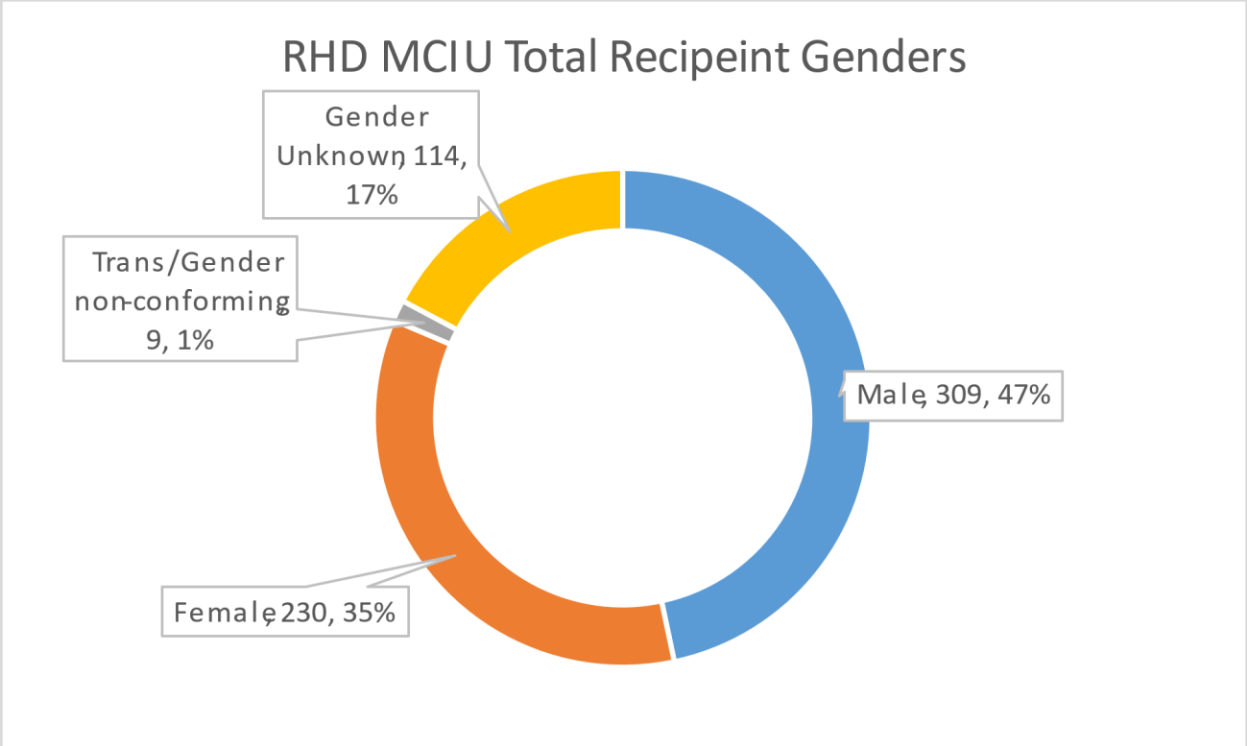
Please share any other information related to your expectations about working in this new program.

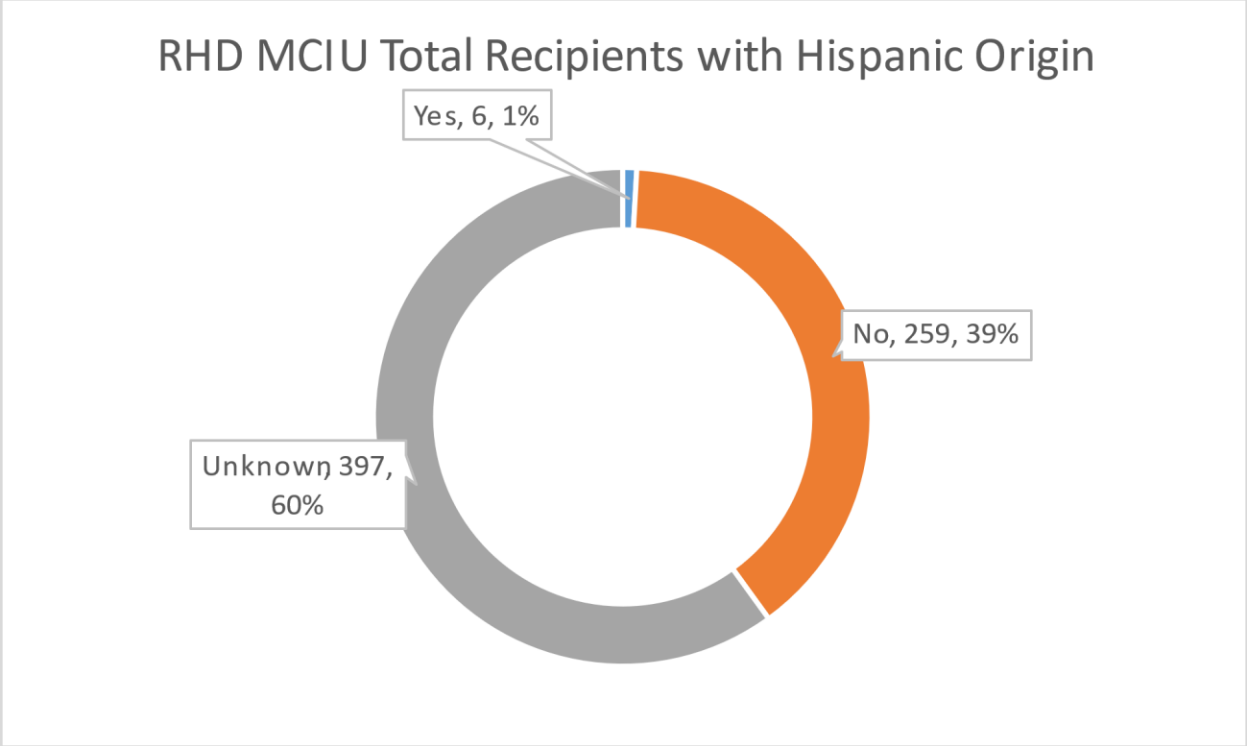
- Has been very supportive
- None just excited to launch
- I expect for us to learn as we go. Training are useful to have a broad idea and a sense of structure. However, I think the best training will be in the field.

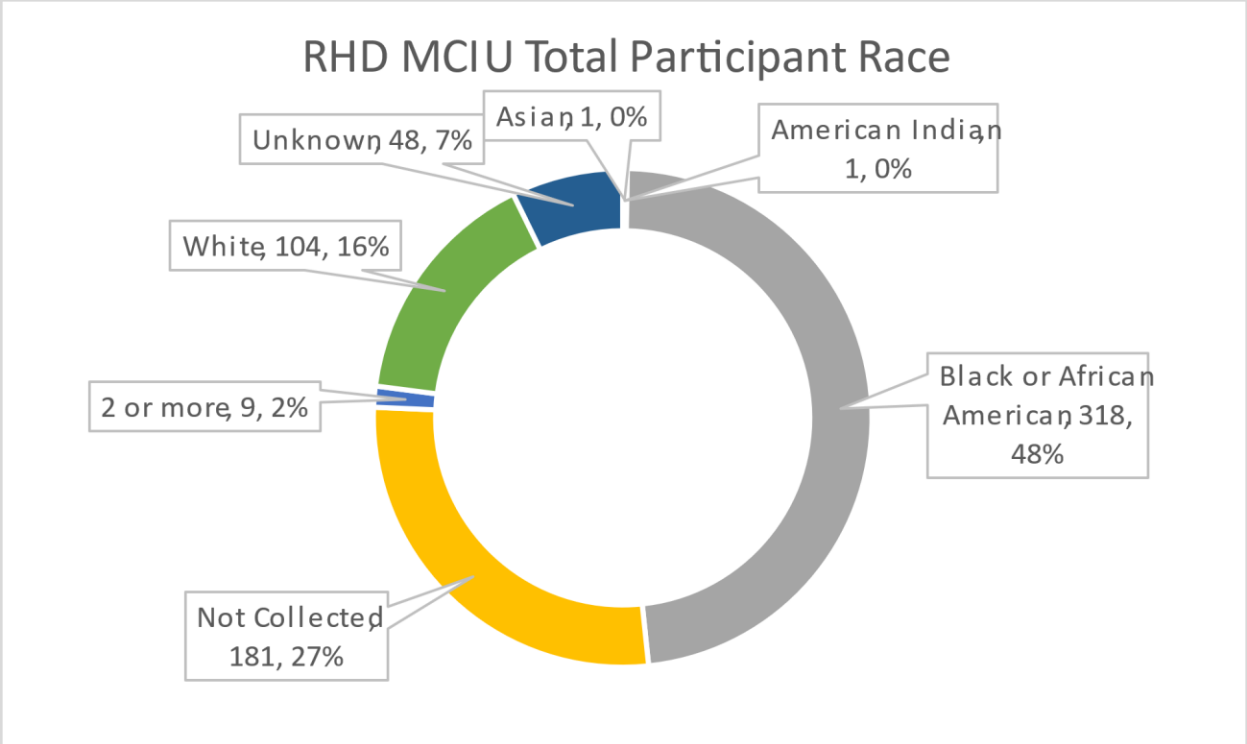
Participant Engagement

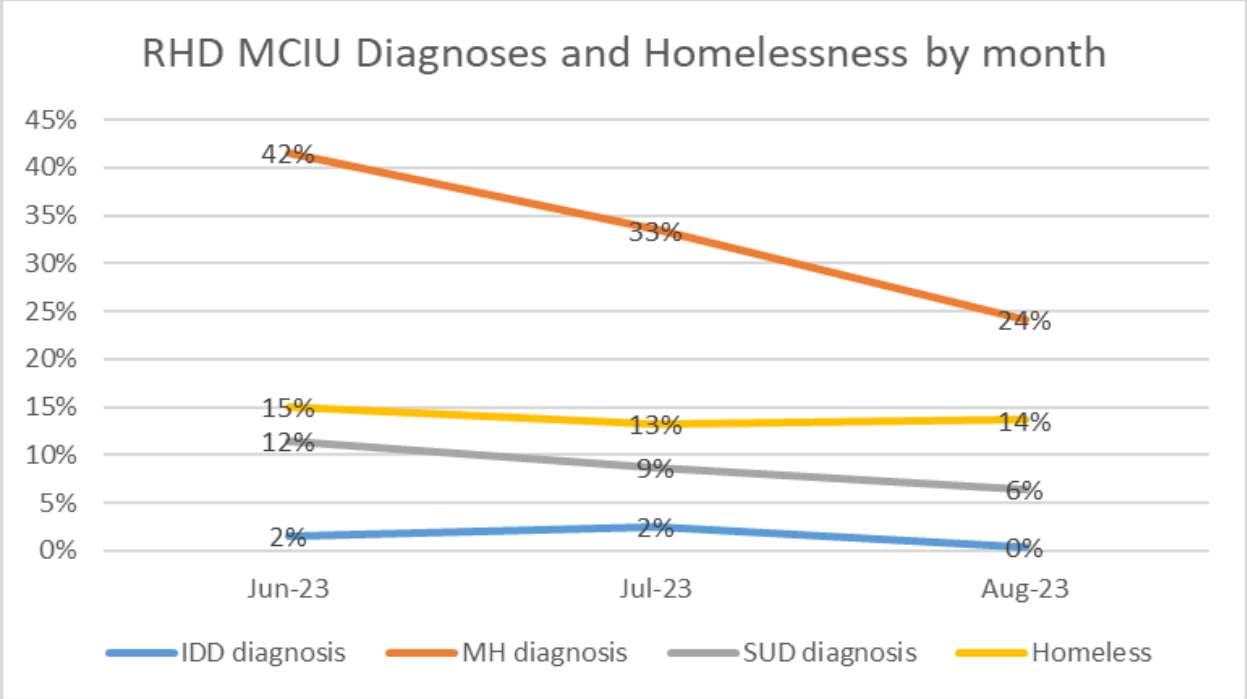
Total calls in first 90 days: 662, average 7-8 calls per day, average 40 minutes on scene

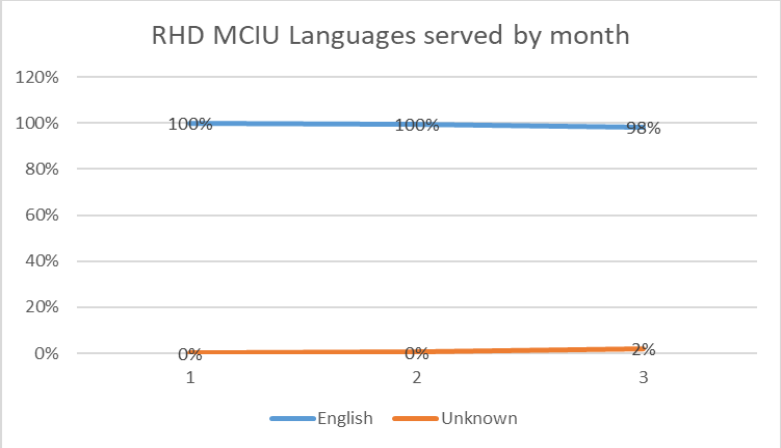


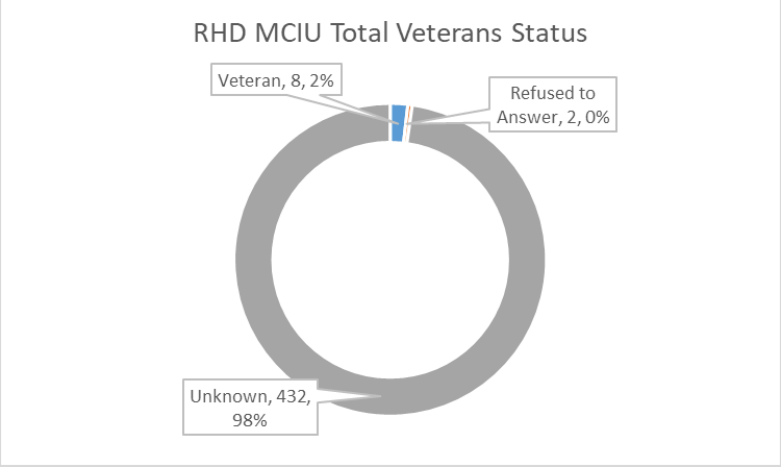



RHD MCIU Total Recipients with Hispanic Origin
Yes, 6, 1%
No, 259, 39%
Unknown, 397, 60%


RHD MCIU Total Participant Race
Asian, 1, 0%
American Indian, 1, 0%
Unknown, 48, 7%
White, 104, 16%
Black or African American, 318, 48%
2 or more, 9, 2%
Not Collected, 181, 27%


RHD MCIU Diagnoses and Homelessness by month
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
42%
33%
24%
15%
13%
14%
12%
9%
6%
2%
2%
0%
Jun-23
Jul-23
Aug-23
IDD diagnosis
MH diagnosis
SUD diagnosis
Homeless


RHD MCIU Languages served by month
120%
100%
80%
60%
40%
20%
0%
100%
100%
98%
0%
0%
2%
1
2
3
English
Unknown

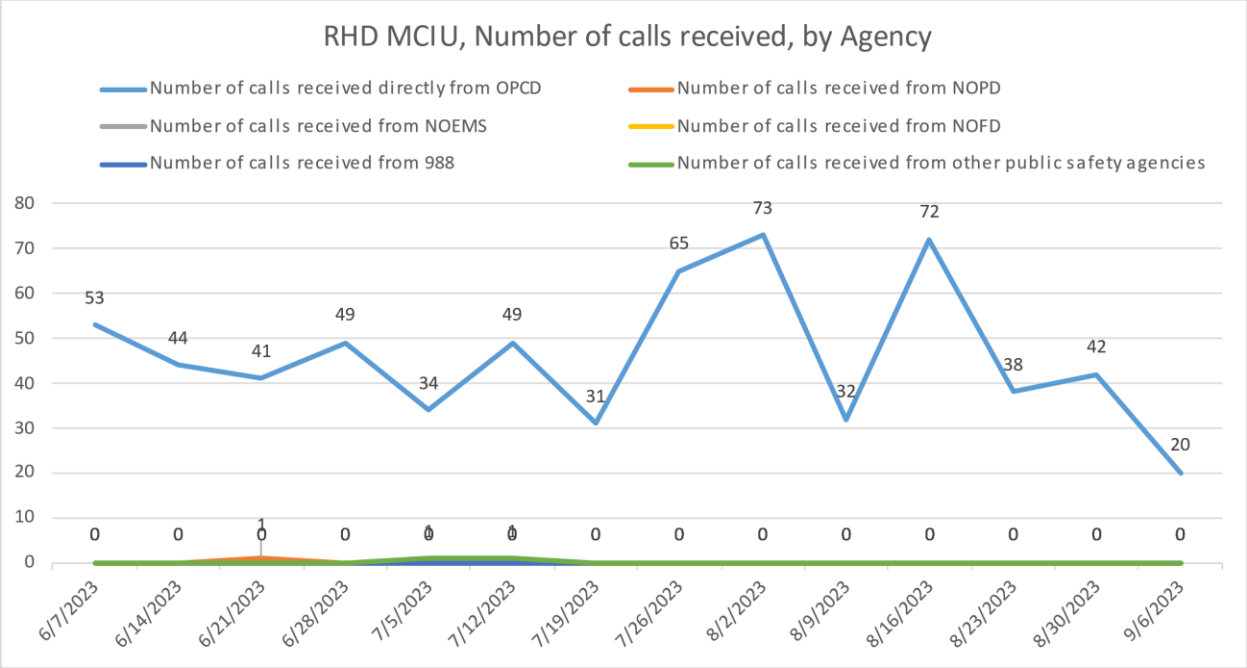

RHD MCIU Total Veterans Status
Veteran, 8, 2%
Refused to Answer, 2, 0%
Unknown, 432, 98%

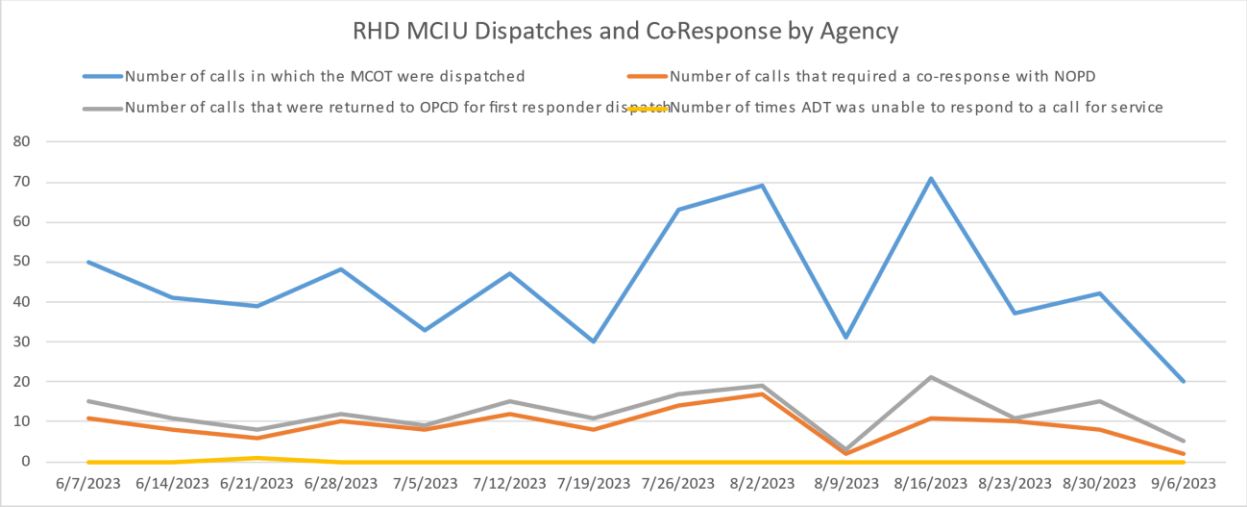
(A22)

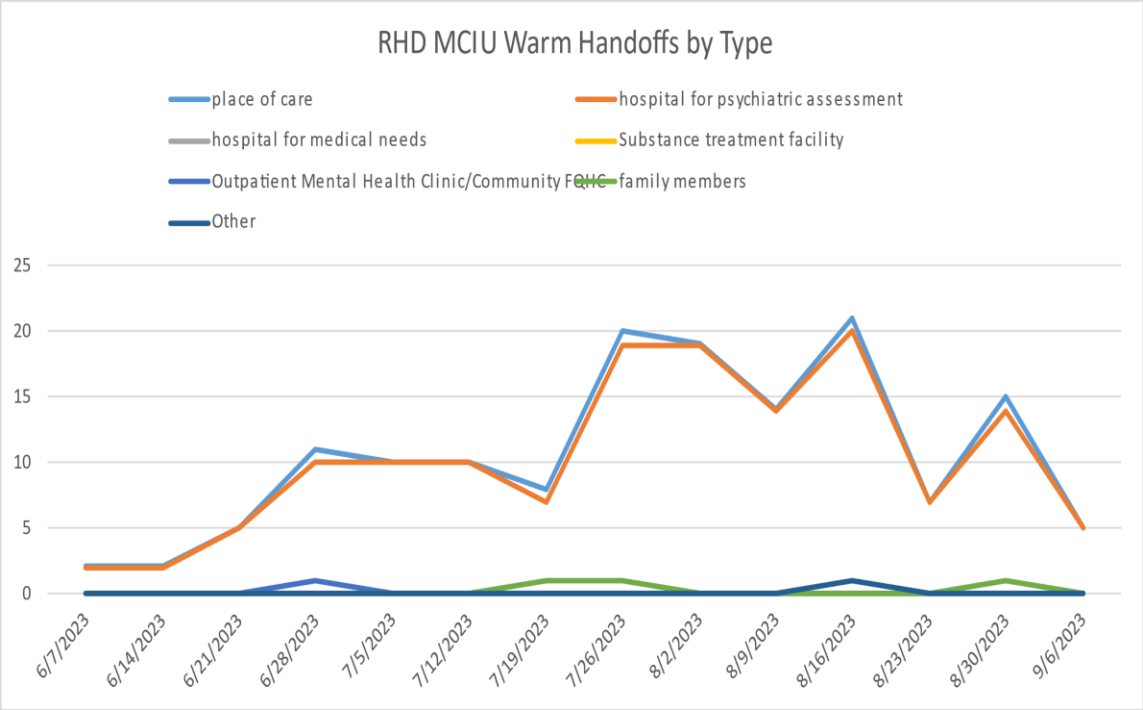
Data Analysis and Reporting

Data

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

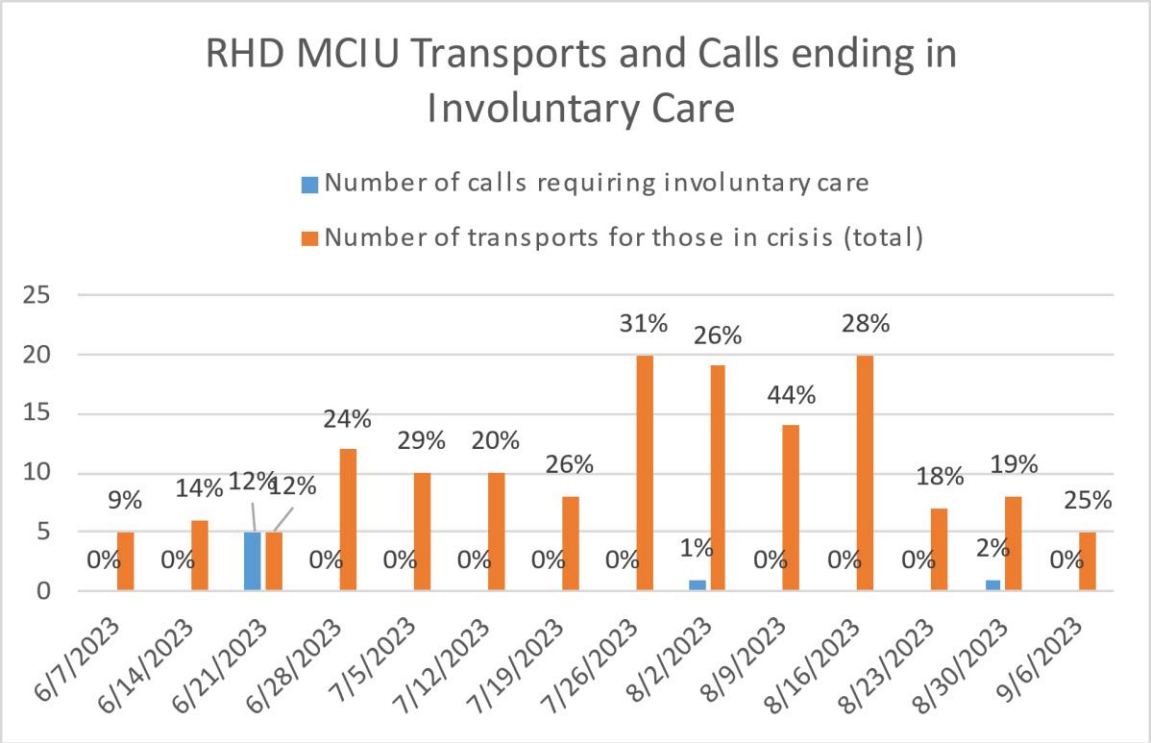






We are continuing to refine our documentation process so this graph may not reflect all warm-handoffs.

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



Staff Experience Feedback

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

Do you feel safe on this call?

99% said YES

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

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

91% said YES

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

Did you have enough support on this call?

100% said YES

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

98% said NO

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

Qualitative Evaluation of Program

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

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

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

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

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

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

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

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

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

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

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

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

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

Challenges and Lessons Learned

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

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

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

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

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

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

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

Collaboration and Stakeholder Engagement

Focus Groups

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

Methods

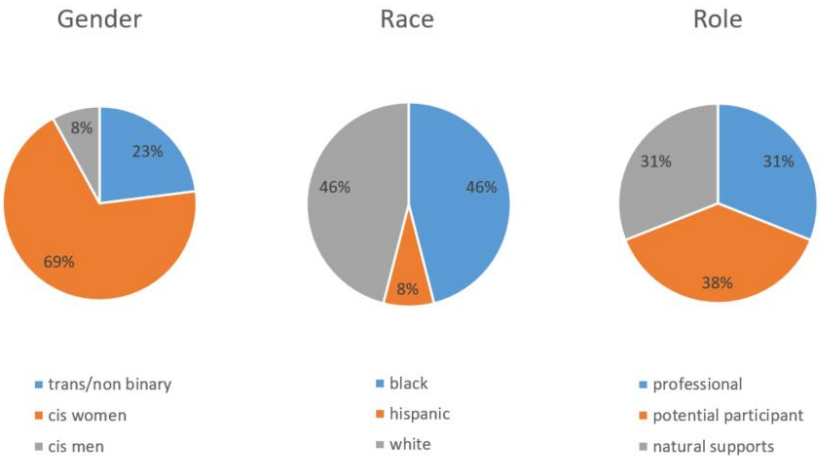
The same two RHD staff from the Business Development Team attended all focus groups. One staff facilitated the conversation and the other took notes. Before beginning, participants were provided with informed consent documents that explained the purpose and use of the focus groups. RHD staff shared that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

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

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

Demographics

Formal focus groups: total of 13 participants



Impressions

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

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

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

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

911 BH crisis experience:

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

Were Natural Supports included in the resolution of the crisis?

NO

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

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

Follow Up

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

What were you hoping for in the response?

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

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

Special populations:

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

What should responders have with them?

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

Logos & Identification:

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

Dispatch

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

Suggestions/Misc.

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

Participant Experience

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

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

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

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

Participant Experience Committee

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

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

Participant Experience Survey Results

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

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

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

Community Engagement

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

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

National Landscape

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

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

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

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

Future Plans

Future outreach:

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

Potential Expansions:

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

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

Program Evaluation:

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

Conclusion

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

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

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

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

References

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

Bill 43-23, Crisis Intervention Team – Established

Amendments by Councilmember Mink

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

Delete lines 4 – 89 of the Bill.

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

Amend line 3 of the bill to read as follows.

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

Amend lines 90 – 138 to read as follows.

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

(a) There is **[[**an Advisory Committee on Crisis Intervention**]]** a Task Force on Crisis Response.

(b) The **[[**committee**]]** task force consists of:

(1) **[[**a designee of the Mental Health Association of Maryland**]]** 2 designees of the National Alliance on Mental Illness of Montgomery County (NAMI MC), including at least one person with personal experience living with a mental or behavioral health condition;

(2) a designee of the **[[**county's**]]** County's 9-8-8 call center;

(3) **[[**a designee of the Interagency Commission on Homelessness**]]** 2 designees of the Interagency Commission on Homelessness who represent a Homeless Service Organization or are a person with lived experience;

(4) **[[**a designee of the District Administrative Judge for the District Court of Maryland, Montgomery County**]]** 2 designees of the Mental Health Advisory Committee, including at least one person with personal experience living with a mental or behavioral health condition;

(5) **[[**a designee of the Administrative Judge for the Circuit Court for Montgomery County**]]** 2 designees of the Alcohol and Other Drug Addiction Advisory Council, including at least one person with personal experience living with a substance use disorder;

(6) **[[**a designee of the Montgomery County State's Attorney**]]** 2 designees of the Commission for People with Disabilities, including at least one person with personal experience living with an intellectual or developmental disability;

(7) **[[**a designee of the Montgomery County Council**]]** 2 designees of the Advisory Commission on Policing;

(8) **[[**a designee**]]** 2 designees of the Intellectual and Developmental Disabilities Commission, including at least one person with personal experience living with an intellectual or developmental disability;

(9) **[[**a representative of a county chamber of commerce, appointed by the County Executive and confirmed by the Council**]]** 2 designees of the Police Advisory Board;

(10) a designee of the Montgomery County Fire Chief;

(11) a designee of the Emergency Communications Center;

(12) a designee of the **[[**County Sheriff**]]** Department of Health & Human Services – Behavioral Health & Crisis Services;

(13) a designee of the Street Outreach Network;

[[(13)**]]** (14) a designee of the **[[**Director of the Department of Correction and Rehabilitation; and**]]** Montgomery County Chief of Police;

[[(14)**]]** (15) 2 **[[**residents**]]** mental health professionals serving County residents, at least 1 of whom is not a physician, appointed by the Executive and confirmed by the Council;**[[**, who:**]]**

[[(A) have lived experience regarding mental health, behavioral health, or substance use disorders;**]]**

[[(B) represent different geographical regions of the County; and**]]**

[[(C) will be offered the opportunity to participate in the police department's "Citizens Academy," as well as attend any CIT training or other in-

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

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

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

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

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

The **[[**advisory committee**]]** task force must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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