**"Support With Amendments"**

**Written Testimony in Support, With Amendments, 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 interested in supporting Councilmember Luedtke's legislation, but we continue to have concerns with some of the language and are requesting amendments to the final legislation. We appreciate that you have taken the time to gather feedback from various stakeholders and hear their concerns. We appreciate reference to the Governor's Crisis Intervention Team Center of Excellence and the effort to capture best practices. We also want to get this right, so we have consulted local mental health consumer and advocacy groups who are familiar with Montgomery County's currently existing CIT program and how to improve upon the good work that has begun, incorporating improvements through lessons learned.

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.