

Public Safety Responses to Mental Health Situations

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Public Safety Responses to Mental Health Situations

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Summary

Public safety personnel play an essential role in responding to certain mental health situations that are dangerous. However, concerns exist that many jurisdictions rely too much on police for mental health crisis response and lack sufficient mental health crisis services to meet community needs. This OLO report responds to the Council's request to examine the County's capacity to respond to mental health situations. Overall, OLO finds that the County uses several research-supported practices to respond to mental health situations and is currently working to reduce reliance on law enforcement for crisis response. Opportunities exist for more collaboration and additional data tracking.

Research on Public Safety Responses to Mental Health Situations

Research shows that police responses to mental health situations present significant challenges for police and too often result in poor or tragic outcomes for persons with mental illness. Federal guidance calls for communities to develop behavioral health crisis care systems, based on the "Crisis Now" model, that reside outside of the criminal justice system. Although these systems should seek to minimize law enforcement involvement, SAMHSA identifies collaboration between crisis care systems and law enforcement as an "essential principle" of a crisis care system.

Core Elements of a Crisis Care System

1. A crisis call hub (telephonic crisis intervention)
2. Mobile crisis team services (face-to-face interventions to people where they are)
3. Crisis receiving and stabilization services (facility-based crisis care).

Many communities have implemented strategies for collaboration between police, the mental health system and emergency medical services for mental health crisis response, often in combination with one another. Research indicates that these efforts may have positive outcomes that include (1) reducing arrests and uses of force, (2) reducing emergency department visits, and (3) increasing the use of community-based mental health services. The table below summarizes common models and tools for crisis response.

Models and Tools for Crisis Response

Crisis Intervention Team (CIT)	A police-based model, including voluntary 40-hour training program for law enforcement personnel, that emphasizes community partnerships.
Co-Responder Teams	Pairing mental health professionals with police officers to respond to mental health crises.
Mobile Crisis Teams	Mental health teams that provide assessment, intervention, consultation and referrals in the community, sometimes in collaboration with police.
Case Management	Follow-up by police or partner organizations for individuals that are in frequent contact with law enforcement and emergency services.

Comparative Jurisdictions. OLO examined approaches for mental health situation responses in Memphis (TN), Eugene and Springfield (OR), Tucson (AZ), Houston (TX), Olympia (WA), and Phoenix (AZ). The following trends emerged from these case studies:

- Most jurisdictions use more than one approach for mental health responses;
- Some jurisdictions divert certain responses to mental health situations away from police;
- Specialized mental health response teams often have longer response times than police;
- Engagement and training of emergency dispatchers is a key element in several jurisdictions; and
- Trust and relationship-building between mobile crisis teams and police departments is critical.

Non-Public Safety Resources for Mental Health Situations in Montgomery County

Residents may seek assistance during mental health situations through a variety of non-public safety resources in the County, shown below. These resources can help individuals resolve crises, provide referrals to further services, and connect individuals with public safety services when necessary.

Non-Public Safety Resources for Assistance During Mental Health Situations

Resource	Description	Average Volume
Montgomery County Crisis Center	Provides crisis services in person and by phone 24 hours a day, 7 days a week.	104 calls and 15 walk-ins per day
Mobile Crisis Outreach Team (MCOT)	Responds alongside police to community psychiatric emergencies where the emergency is occurring.*	40 incident responses per month
EveryMind Montgomery County Hotline	Free and confidential service that is available 24/7 by phone, and 7 days a week from 8am to midnight by text.	44 calls and 9 texts/chats per day
Maryland 211	Non-profit organization that provides access to information and resources on health, crisis, and social services. Callers from Montgomery County are directed to the call center in Prince George's County, one of four call centers in the State.	25 calls per day**
MC311	The County's non-emergency call center and web portal that provides referrals to mental health and crisis services.	About 3 calls per day**

* DHHS is exploring options for having the MCOT respond without police where appropriate.

**MC311 and Maryland 211 call volumes refer specifically to behavioral health-related calls.

In July of 2020, Nexus Montgomery submitted a grant proposal to the Maryland Health Services Cost Review Commission (HSCRC) that included crisis call center technology improvements, increased capacity for the MCOT, and crisis receiving and stabilization services in a Restoration Center. Although the HSCRC did not approve the grant proposal, stakeholders involved in the proposal continue to work to develop the proposed elements.

Public Safety Capacity for Responses to Mental Health Situations

Public safety responses to mental health situations in Montgomery County are decentralized and may involve Emergency Communications Center personnel, police (including MCPD and other police departments in the County), emergency medical services, the Montgomery County Sheriff's Office, and/or DHHS staff. Police respond to most mental health situations, but MCFRS may assist police or respond without police if the situation is not considered dangerous. Furthermore, the Montgomery County Sheriff's Office responds to court-ordered petitions for emergency evaluations.

MCPD's Crisis Intervention Team is the dedicated mental health response team staffed by two officers and a DHHS clinician. This team uses several researched-supported strategies including:

- Coordinating 40-hour CIT training for MCPD and other law enforcement personnel;
- Responding to complicated mental health situations as a co-responder team and providing telephonic assistance for individuals in crisis that have been in contact with police;
- Providing limited outreach and case management for individuals with repeated contacts; and
- Collaborating with MCPD's Autism/Intellectual, Developmental Disabilities, Alzheimer's/Dementia Outreach Program to effectively serve these populations.

Training for Mental Health Situation Responses. Training varies among personnel within public safety entities involved in mental health situation responses, summarized in the table below.

Training for Mental Health Situation Responses Among Public Safety Entities

Emergency Communications Center (ECC) Staff	ECC staff receive training on handling stressful situations, including suicidal callers, as part of their entry-level and in-service training. MCPD staff report that in the past, ECC staff frequently participated in CIT training. However, due to staffing constraints, staff have been unable to participate in recent CIT trainings.
MCPD Police Officers	At the time of writing, approximately 58% of officers had completed the 40-hour CIT training program, and all MCPD officers had completed either CIT or an 8-hour Mental Health First Aid (MHFA) course. MCPD also provides 1-2 hours of in-service training on mental health situation responses annually. Recruit training includes MHFA, and as of recent weeks, CIT training.
MCFRS	Initial training for EMTs includes about 2-3 hours on behavioral health and substance abuse issues (other than medical issues like overdoses) as part of 160 total training hours. During their clinical rotations, paramedics receive some additional training and observe behavioral health issues.
MCSO Deputies	All MCSO deputies receive training on mental health situation responses during entry-level training and through annual in-service training. All deputies assigned to the Domestic Violence section, which serves petitions for emergency evaluations, must complete the 40-hour CIT training.

Data on Responses to Mental Health Situations

Available data on mental health situation responses is limited. For example, data on the share of responses where a CIT-trained police officer responded are unavailable. However, data from the Emergency Communications Center (ECC) show that between September of 2017 and May of 2020, police responded to an average of 19 mental health situations per day. OLO estimates that 28% of those responses included a dual response by MCFRS. OLO also found that:

- Police responses mental health situations reported via 911 required 154 minutes of police time on average, compared with 75 minutes of police time for all 911 responses;
- About a third of all police responses to mental health situations, and over a third of Mobile Crisis Outreach Team responses, resulted in involuntary hospitalization through a petition for emergency evaluation;
- In 2019, 30% of MCPD uses of force involved suspected mental illness.

Comprehensive demographic data, such as the race, ethnicity, age or gender of individuals involved in incidents are unavailable. However, limited demographic data reveal significant disparities by race and ethnicity. Specifically, Black individuals are greatly overrepresented and Asian and Latinx individuals are underrepresented among individuals served by DHHS's Mobile Crisis Outreach Team and among individuals subject to petitions for emergency evaluation by police.

Recommendations and Discussion Issues

OLO offers two recommendations and two discussion issues for Council consideration, listed below.

Recommendations

1. Request that the Executive discuss with Maryland 211 opportunities for collaboration on responding to mental health and substance use crisis calls.
2. Request that MCPD track and report key data points on responses to mental health situations and associated uses of force.

Discussion Issues

1. Changes and enhancements to public safety resources, training and procedures for mental health responses.
2. The status of ongoing efforts to reduce reliance on law enforcement for mental health situation responses.

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OLO Report 2021-4

Table of Contents

Executive Summary.....	i
Introduction	2
1. Research Literature and Case Studies on Responding to Mental Health Situations.....	4
2. Responses to Mental Health Situations in Montgomery County	24
3. Data on Responses to Mental Health Situations	42
4. OLO Findings and Recommendations.....	58
5. Agency Comments	69

Introduction

Throughout the United States, police are responsible for responding to mental health situations. While police play an essential role in responding to certain situations that are dangerous, concerns exist that many jurisdictions rely too much on police for mental health crisis response and lack sufficient mental health crisis services to meet their community's needs.

Montgomery County residents can receive assistance with mental health situations from a variety of public safety and non-public safety resources, including the Montgomery County Crisis Center, the EveryMind Montgomery County Hotline, MC311, Maryland 211, the Montgomery County Police Department, other local law enforcement agencies, Montgomery County Fire and Rescue Services, and the Montgomery County Sheriff's Office. This Office of Legislative Oversight report responds to the Council's request to examine the County's capacity to respond to mental health situations. In this report:

- **Chapter 1** reviews research on the challenges associated with policing and mental health situations, summarizes federal guidance for crisis care systems, and examines research and case studies on models and tools for mental health crisis response;
- **Chapter 2** describes the County's non-public safety and public safety resources and processes for mental health crisis response;
- **Chapter 3** presents data on calls to the County and its partners regarding mental health situations, including data on public safety responses to mental health situations; and
- **Chapter 4** describes OLO's findings and recommendations for Council discussion and action.

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Chapter 1. Research Literature and Case Studies on Responding to Mental Health Situations

In the late twentieth century, a series of court decisions and federal laws limited state psychiatric hospitals' legal authority for confining persons against their will and reduced their funding, leading to what is referred to as the "deinstitutionalization" of persons with mental illness. While these changes were made to prevent wrongful hospitalizations and confinement, they have also resulted in a dearth of mental health services, especially for persons with severe mental illness.¹

As a result, many situations that were previously addressed in psychiatric institutions now fall within the purview of the police, the criminal justice system more broadly, as well as acute care hospitals.² Today, police often respond to situations involving persons experiencing mental health crises. The Substance Abuse and Mental Health Services Administration (SAMHSA) notes that many communities lack an effective mental health crisis care infrastructure, leading to excessive reliance on law enforcement and the criminal justice system:

*Many communities across the United States have limited or no access to true "no wrong door" crisis services, defaulting to law enforcement operating as community-based mental health crisis response teams with few options to connect individuals experiencing a mental health crisis to care in real time. The available alternatives represent systemic failures in responding to those in need; including incarceration for misdemeanor offenses or drop-off at hospital emergency departments that far too often report being ill-equipped to address a person in mental health crisis.*³

At the same time, SAMHSA emphasizes that some mental health situations, particularly those that are potentially dangerous, necessitate involvement by police.⁴ This chapter describes the research on policing during mental health situations and best practices for crisis response. It is organized as follows:

- **Section A** describes the challenges associated with policing and mental health situations;
- **Section B** summarizes the national guidelines for behavioral health⁵ crisis care systems;
- **Section C** examines models and tools for crisis response and the evidence behind them; and
- **Section D** describes case studies of alternative crisis response models and tools.

¹ Yohanna, D., "Deinstitutionalization of People with Mental Illness: Causes and Consequences," *Virtual Mentor*, 2013;15(10):886-891. doi: 10.1001/virtualmentor.2013.15.10.mhst1-1310. Accessed on 11/5/2020, <https://journalofethics.ama-assn.org/article/deinstitutionalization-people-mental-illness-causes-and-consequences/2013-10>

² Ibid.

³ *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, Substance Abuse and Mental Health Services Administration, 2020, p. 11, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf> accessed 12/10/2020.

⁴ Ibid., p. 33

⁵ Mental health refers to a person's "emotional, psychological, and social well-being." (<https://www.mentalhealth.gov/basics/what-is-mental-health>). Behavioral health incorporates mental health as well as substance use disorders and their treatment (<https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf>). This report is focused on mental health situations, but many of the relevant models, strategies and tools address behavioral health more broadly.

A. Challenges Associated with Policing and Mental Health Situations

Police officers in many communities have become responsible for identifying whether persons they encounter are experiencing a mental health situation and determining the appropriate course of action. Police responses to mental health situations range widely and can include referring a person to community services and resources, transporting a person to the hospital voluntarily or involuntarily (see page 7 on involuntary treatment), or arresting individuals accused of criminal offenses.⁶ This section summarizes the challenges associated with policing and mental health situations.

Police Training. When police encounter persons in crisis, their response may determine whether those individuals receive appropriate care or, conversely, whether the situations escalate or become criminalized. Historically, surveys have found that police officers felt they did not receive adequate training to respond to mental health situations.⁷ In an effort to improve the outcomes of police responses to mental health situations, law enforcement training on responding to mental health situations has become a national priority in recent years. Most states have developed standards for mental health response and de-escalation training for law enforcement officers.

However, the Council of State Governments finds “tremendous variability” among states’ standards, which tend to focus on entry-level training for new recruits.⁸ Mental health response and de-escalation training is complex and costly to implement due to the time and expertise required. A key challenge reported by states is the difficulty of covering the recommended topics in the allotted time effectively given the numerous other mandated and recommended topics that form part of police training.⁹

Use of Police Resources. A Treatment Advocacy Center survey of law enforcement officials found that 21% of total law enforcement time was spent responding to and transporting individuals with mental illness in 2017. Factors influencing police time spent include the number of officers involved, the distances they must drive, and the time they must wait for a hospital bed to become available.¹⁰

Lack of Hospital Capacity for Mental Health Crisis Care. Police often transport individuals experiencing mental health crises to hospital emergency departments, where they may wait for long periods of time for the individual to be admitted. Once in the emergency department, individuals face long waits, sometimes days long, to be admitted for inpatient psychiatric care, contributing to emergency

⁶ Lamb, H.R., Weinberger, L.E., DeCuir, W.J., “The Police and Mental Health,” *Psychiatric Services*, 2002; 53(10): 1266-1271.

⁷ Watson, A. C., and Fulambarker, A. J., “The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners,” *Best Practices in Mental Health*, 8(2), 2012, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769782/>, accessed 11/24/2020.

⁸ Plotkin, M., and Peckerman, T., “The Variability in Law Enforcement State Standards: a 42-State Survey on Mental Health and Crisis De-escalation Training,” The Justice Center of the Council of State Governments, January, 2017, <https://csgjusticecenter.org/wp-content/uploads/2020/02/JC-LE-Survey.pdf>, accessed 11/24/2020.

⁹ Ibid.

¹⁰ “Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey,” Treatment Advocacy Center, May 2019, <https://www.treatmentadvocacycenter.org/storage/documents/Road-Runners.pdf> accessed 11/10/2020.

department overcrowding. These waits are due to a shortage of inpatient psychiatric beds as well as a lack of psychiatrists in hospitals.¹¹

Criminalization of Mental Illness. In some cases, police have discretion to refer an individual accused of a minor crime to mental health treatment, rather than arrest the individual. However, arrests of individuals with mental illness occur for several reasons. For example, an officer may not be aware of the individual's mental illness, or the individual may refuse treatment. If a community has few resources for mental health treatment, police may perceive that an individual is more likely to receive treatment in jail, engaging in a practice known as "mercy booking."¹² In cases that do not result in arrest, police often still place individuals in crisis in restraints, such as handcuffs, and transport them to treatment facilities in marked police vehicles. Experts note that this process has negative consequences including:¹³

- Trauma and stigma that can impact treatment and stop families from seeking help in the future;
- Individuals in crisis may have underlying medical conditions that police cannot identify or treat;
- Police may need to delay transport due to their other public safety duties.

Inadequate Mental Health Services in Correctional Systems. In the United States, inmates in prisons and jails have a constitutional right to adequate health care, including mental health care.¹⁴ However, mental health services in correctional facilities often fail to meet the overwhelming needs of incarcerated populations with high rates of mental illness.¹⁵ Moreover, prisons and jails are harmful to inmates' mental health, due to the following characteristics as described by the World Health Organization and the International Committee of the Red Cross:

...overcrowding, various forms of violence, enforced solitude or conversely, lack of privacy, lack of meaningful activity, isolation from social networks, insecurity about future prospects (work, relationships, etc), and inadequate health services, especially mental health services...¹⁶

¹¹ Nutt, A.E., "Psychiatric patients wait the longest in emergency rooms," The Washington Post, October 18, 2016, <https://www.washingtonpost.com/news/to-your-health/wp/2016/10/18/sickest-psychiatric-patients-wait-the-longest-in-emergency-rooms-survey-shows/>, accessed 11/29/2020.

¹² Lamb, H.R., Weinberger, L.E., DeCuir, W.J., "The Police and Mental Health," Psychiatric Services, 2002; 53(10): 1266-1271; and "Strengthening Partnerships Between Law Enforcement and Homelessness Service Systems," The Council of State Governments Justice Center, 2019, <https://csgjusticecenter.org/wp-content/uploads/2020/02/Strengthening-Partnerships-Between-Law-Enforcement-and-Homelessness-Service-Systems.pdf>, accessed 11/30/2020.

¹³ "Mental Health Crisis Response and Emergency Services Advisory Panel Interim Report," Alternative Transportation Sub-group of SJR 47 Joint Subcommittee, 2016, Virginia Division of Legislative Services, <http://dls.virginia.gov/groups/mhs/final%20interim%20report.pdf>, accessed 11/18/2020.

¹⁴ Cohen F, Dvoskin J, "Inmates with mental disorders: a guide to law and practice," Mental and Physical Disability Law Reporter 16:339-346, 1996.

¹⁵ Stringer, H., "Improving mental health for inmates," American Psychological Association, Feature, March, 2019, <https://www.apa.org/monitor/2019/03/mental-health-inmates>, accessed 11/18/2020.

¹⁶ "Mental Health and Prisons," Joint Statement of the World Health Organization and the International Committee of the Red Cross, 2005, https://www.euro.who.int/_data/assets/pdf_file/0007/98989/WHO_ICRC_InfoSht_MNH_Prisons.pdf?ua=1 accessed 11/17/2020

Involuntary Treatment

When an individual refuses mental health treatment, they may be required to receive treatment involuntarily if they meet criteria established in relevant state law, such as dangerousness to self or others or grave disability. Three types of involuntary treatment exist in the United States:

1. **Emergency psychiatric evaluation** allows for a person to be held involuntarily for a set period of time (e.g. 72 hours) for psychiatric evaluation;
2. **Inpatient civil commitment** refers to court-ordered inpatient hospitalization after the emergency period is over; and
3. **Outpatient civil commitment** is also known as “assisted outpatient treatment” and refers to court-ordered outpatient treatment that is provided while the patient lives in the community.

All states have laws in place regarding emergency psychiatric evaluation and inpatient civil commitment. State laws typically give police the authority to take a person into custody for an emergency psychiatric evaluation. All but three states – Connecticut, Maryland and Massachusetts – allow outpatient civil commitment.

Source: Dailey, L., et. al., “Grading the States: An Analysis of U.S. Psychiatric Treatment Laws,” Treatment Advocacy Center, September, 2020, <https://www.treatmentadvocacycenter.org/storage/documents/grading-the-states.pdf> accessed 12/11/2020.

Escalation and Use of Force. Quantitative data on the use of force by police against persons with mental illness is not collected or reported consistently on a national level. One researcher who examined anecdotal information from news reports describes how police encounters with persons with mental illness too often end in tragedy:

A common pattern emerges from these stories: a family or community member calls the police to assist a person with a mental health condition who is in crisis and holding a weapon (or perceived weapon); the police arrive; the individual becomes agitated; and the police respond with force.¹⁷

A Washington Post database based on news reports, law enforcement websites and social media indicates that almost one in four fatal police shootings during the past five years involved a person suffering from mental illness.¹⁸ These data show that mental health situations are a key risk factor for fatal uses of force by police.

¹⁷ Shah, P.V., “A Use of Deadly Force: People with Mental Health Conditions and Encounters with Law Enforcement,” Harvard Human Rights Journal, Vol. 32, July 10, 2019, https://harvardhrj.com/wp-content/uploads/sites/14/2019/07/Shah_A-Use-of-Deadly-Force.pdf accessed 11/10/2020

¹⁸ Tate, J., Jenkins, J., and Rich, S., “Fatal Force,” The Washington Post, Updated November 20, 2020, <https://www.washingtonpost.com/graphics/investigations/police-shootings-database/> accessed 11/10/2020.

Racial Disparities. Black, Latinx and Asian individuals are less likely than White individuals to use mental health services, after adjusting for family income.¹⁹ At the same time, Black individuals are significantly more likely than other racial or ethnic groups to use psychiatric emergency services, to be subject to involuntary commitment, and to be admitted for inpatient psychiatric hospitalization.

Further study is needed to understand the reasons for these disparities, which may include cultural stigmas with respect to mental illness and mental health care, the cultural competency of mental health services, fear of deportation in immigrant communities as well as the impacts of living in concentrated poverty. Additionally, racial bias may play a role in psychiatric emergency room use and police involvement:

When community members feel annoyed or threatened by the behavior of an individual with mental illness, they may take direct action, calling the police or public health authorities, who are likely to respond by initiating a psychiatric emergency room visit. Because community members consider African Americans with mental illness more threatening than whites with mental illness, community members may intervene more often when African Americans are disruptive, subjecting them to emergency intervention for social control.

Some evidence supports this social control hypothesis, suggesting that African-American emergency room visitors are especially likely to have been brought in by the police. However, the literature in this area is scant, and more research is needed.²⁰

¹⁹ Wile, M., and Goodwin, K., "The Costs and Consequences of Disparities in Behavioral Health Care," National Conference of State Legislatures, February 2018, https://www.ncsl.org/Portals/1/Documents/Health/DisparitiesBH_32068.pdf, accessed 11/23/2020.

²⁰ Snowden, L.R., Catalano, R., Shumway, M., "Disproportionate Use of Psychiatric Emergency Services By African Americans," *Psychiatric Services*, 60(12), pp. 1664-1671, <https://ps.psychiatryonline.org/doi/full/10.1176/ps.2009.60.12.1664>, accessed 11/23/2020.

Populations with A High Prevalence of Mental Illness

In 2019, an estimated 5% of adults had serious mental illness and 21% had any mental illness.²¹ However, among individuals experiencing homelessness, substance use disorders, and/or who have developmental disabilities, mental illness is more prevalent. These populations also experience high rates of criminal justice system involvement. Addressing these populations' needs effectively may require additional services beyond mental health care.²²

Homelessness. Researchers estimate that at least a quarter of persons experiencing homelessness have serious mental illness.²³ One literature review finds that between 63% and 90% of individuals with serious mental illness that experienced homelessness had also been arrested during their lifetimes, indicating extremely high levels of contact with the criminal justice system within this population.²⁴

Substance Use Disorders. Nearly 1 in 5 of individuals with substance use disorders have a co-occurring serious mental illness. This population has much higher levels of criminal justice system involvement compared with individuals with serious mental illness alone, as well as higher risks of poor treatment outcomes, homelessness, and suicide.²⁵

Intellectual and Developmental Disabilities (I/DD). Limited data indicate that the prevalence of mental illness among persons with I/DD is significantly higher than that in the general population. Persons with I/DD are vulnerable to poor outcomes due to a variety of factors including high rates of victimization, criminalization and lack of access to appropriate treatment. Persons with I/DD are overrepresented in the U.S. prison population.²⁶

²¹ Substance Abuse and Mental Health Services Administration (SAMHSA), 2020, *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality. Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/> on 12/3/2020.

²² "Strengthening Partnerships Between Law Enforcement and Homelessness Service Systems," The Council of State Governments Justice Center, June 2019, <https://csgjusticecenter.org/wp-content/uploads/2020/02/Strengthening-Partnerships-Between-Law-Enforcement-and-Homelessness-Service-Systems.pdf>, accessed 12/2/2020.

²³ "The homeless mentally ill," Harvard Health Publishing, Harvard Medical School, March, 2014, https://www.health.harvard.edu/newsletter_article/The_homeless_mentally_ill, accessed 12/2/2020; and Balasuriya, L., Buelt, E., and Tsai, J., "The Never-Ending Loop: Homelessness, Psychiatric Disorder, and Mortality," *Psychiatric Times*, 37(5), May, 2020, <https://www.psychiatrictimes.com/view/never-ending-loop-homelessness-psychiatric-disorder-and-mortality>, accessed 12/2/2020.

²⁴ Roy, L, Crocker, A., Nicholls, T., Latimer, E., Reyes Ayllom, A., "Criminal Behavior and Victimization Among Homeless Individuals With Severe Mental Illness: A Systematic Review," *Psychiatric Services*, 65(6), June, 2014, <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201200515> accessed 12/2/2020.

²⁵ SAMHSA, 2020, *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*; and Prince, J.D., Wald, C., "Risk of criminal justice system involvement among people with co-occurring severe mental illness and substance use disorder," *International Journal of Law and Psychiatry*, May-Jun 2018: 58:1-8, <https://pubmed.ncbi.nlm.nih.gov/29852999/> accessed 12/3/2020.

²⁶ Pinals, D., Hovermale, L., Mauch, D., Anacker, L., "Assessment #7: The Vital Role of Specialized Approaches: Persons with Intellectual and Developmental Disabilities in the Mental Health System," National Association of State Mental Health Program Directors, August, 2017, https://www.nasmhpd.org/sites/default/files/TAC.Paper_7.IDD_Final.pdf, accessed 12/3/2020.

B. Core Elements of a Crisis Care System (Crisis Now)

A crisis care system as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) resides outside of the criminal justice system and is designed to avoid overreliance on law enforcement for crisis response. SAMHSA recently developed national guidelines for behavioral health crisis care, based on the Crisis Now model, that identify collaboration between crisis care systems and law enforcement as an “essential principle” of a crisis care system. The figure below summarizes the system’s core elements.

Core Elements of a Behavioral Health Crisis Care System

Crisis Call Hub

- Provides 24/7 telephonic crisis intervention services, with trained staff who develop rapport with callers and use the least invasive intervention needed
- Provides clinical triage by call takers (overseen by clinicians), who connect callers with additional services as needed, including mobile crisis team services
- Meets National Suicide Prevention Lifeline guidelines on suicide risk assessment
- Uses caller ID and GPS technology and access regional bed registry data to best assist callers
- Offers text and chat options

Mobile Crisis Team Services

- Provides 24/7 face-to-face interventions to people where they are
- Includes at least one licensed and/or credentialed clinician
- Provides warm hand-offs to facility-based care and transportation to services only as required, avoiding unnecessary use of emergency departments or hospitalizations
- Coordinates with emergency responders such as police or emergency medical services where needed, but should respond without law enforcement unless warranted by circumstances
- Incorporates peers (individuals who have experienced mental illness) in team
- Schedules outpatient follow-up appointments to support ongoing care

Crisis Receiving and Stabilization Services

- Operates on a 24/7 basis and accepts all walk-ins, ambulance, fire and police drop-offs for facility-based crisis care
- Staffed with psychiatrists or psychiatric nurse practitioners, nurses, licensed and/or credentialed clinicians, and peers with experiences similar to those of population served
- Treats individuals of all ages and conditions including intellectual and developmental disabilities (I/DD)
- Makes arrangements for transfer to other facilities such as a hospital as necessary
- Offers a dedicated first responder drop-off area
- Coordinates connections to ongoing care

Source: *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, Substance Abuse and Mental Health Services Administration, 2020, p. 11, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf> accessed 12/10/2020.

Although crisis care systems should seek to minimize law enforcement involvement, law enforcement plays a critical role in crisis response. Law enforcement must respond in dangerous situations as well as refer individuals they encounter to the crisis care system where appropriate. As SAMHSA explains, “the role of local law enforcement in addressing emergent public safety risk is essential and important. With good mental health crisis care in place, the care team can collaborate with law enforcement in a fashion that will improve both public safety and mental health outcomes.”²⁷

988: The New Three-Digit Suicide Prevention and Mental Health Crisis Hotline Number

In July of 2020, the Federal Communications Commission (FCC) approved rules to establish 988 as the new three-digit phone number for suicide prevention and mental health crisis counseling. By July of 2022, phone service providers must direct all calls to 988 to the National Suicide Prevention Hotline, which is an existing national network of 24/7 crisis call centers funded by states and localities and administered by SAMHSA. The goal of this change is to create a number that is as easy to remember as 911 for individuals in crisis and reduce stigma around suicide and mental illness.

Source: “Fact Sheet: 988 and Suicide Prevention Hotline,” The Federal Communications Commission, <https://www.fcc.gov/sites/default/files/988-fact-sheet.pdf> , accessed 12/17/2020.

C. Models and Tools for Crisis Response and Police-Mental Health Collaborations

Many communities have implemented strategies for collaboration between police, the mental health system and emergency medical services for mental health crisis response. The Vera Institute of Justice compiled a list of police-based and other crisis response models and tools and the evidence behind them.

The Vera Institute emphasizes that assessing the effectiveness of these strategies is difficult because communities vary in implementation, often using a combination of the models and tools described below. Furthermore, the level of success often depends on external factors; in particular, the availability and accessibility of mental health services and supports in the local community. Nonetheless, available research suggests that these models may generate a variety of positive outcomes, including:

- Reduced arrests and use of force;
- Reduced emergency department visits; and
- Increased use of community-based mental health services.

The Vera Institute also notes the high prevalence of co-occurring intellectual and developmental disabilities (I/DD) and mental illness, and highlights the lack of research for crisis response models serving individuals with I/DD.²⁸

²⁷ *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, Substance Abuse and Mental Health Services Administration, 2020, p. 33

²⁸ Watson, A., Compton, M.T., and Pope, L.G., “Crisis Response Services for People with Mental Illnesses or Intellectual

1. Crisis Intervention Teams (CIT)

The Crisis Intervention Team (CIT) model was developed in Memphis, Tennessee as a police-based crisis intervention model. CIT emphasizes community partnerships and aims to improve officer and consumer safety and divert individuals with mental illness from the criminal justice system to the health care system. In the CIT model, officers volunteer to complete a 40-hour training program on responding to mental health crises delivered by law enforcement, mental health providers, and advocates. CIT officers are then typically decentralized, serving across their communities. The “core elements” of the Memphis CIT model also include specialized training for emergency dispatchers and an emergency mental health receiving facility available 24-hours a day.²⁹

The CIT model is designed to be flexible to meet each community’s unique needs, so implementation can vary widely. Studies show that CIT increases officers’ knowledge and preference for de-escalation strategies. One study showed that officers that volunteered to be CIT officers scored better on several measures of knowledge, attitudes and skills than those that were assigned without volunteering. Evidence suggests that CIT may reduce arrests and use of force in mental health-related encounters, but existing research in this area is not conclusive. Additionally, evidence shows that the local availability of mental health services affects the ability of CIT to impact mental health or criminal justice outcomes in the long-term.³⁰

2. Co-responder Teams

Often used in concert with the CIT model, co-responder teams pair mental health professionals with police officers to respond to behavioral health crises. In some jurisdictions, police and clinicians travel together to respond to incidents, while in others the officer and the clinician arrive separately, or the clinician provides assistance remotely. Co-responder teams typically aim to reduce emergency department visits, psychiatric hospitalizations and arrests, as well as to improve safety and provide referrals to community-based services.

Available research indicates that co-responder teams may reduce emergency department visits and possibly repeated calls for service. However, co-responder teams are implemented differently in every community, limiting the extent to which research findings from any given jurisdiction are generalizable. Multiple studies have raised a concern that reliance on co-responder teams results in police involvement in situations that should be handled by mental health professionals alone.³¹

and Developmental Disabilities: A Review of the Literature on Police-based and Other First Response Models,” Vera Institute of Justice, October 2019, <https://www.vera.org/downloads/publications/crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities.pdf>, accessed 12/3/2020.

²⁹ Dupont, R., Cochran, S., Pillsbury, S., “Crisis Intervention Team Core Elements,” The University of Memphis CIT Center, September, 2007, <https://cit.memphis.edu/pdf/CoreElements.pdf>, accessed 12/3/2020.

³⁰ Watson, A., Compton, M.T., and Pope, L.G., “Crisis Response Services.”

³¹ Watson, A., Compton, M.T., and Pope, L.G., “Crisis Response Services.”

3. Mobile Crisis Teams

Many jurisdictions in the United States have established mobile crisis teams, which respond directly to mental health situations in the community and provide assessment, intervention, consultation and referrals. Mobile crisis teams are housed in the mental health system, though they often collaborate with police. The teams may include social workers, nurses and/or psychiatrists. Mobile crisis teams can serve individuals who may refuse to travel to a facility for evaluation or treatment by providing services onsite.

Much of the existing research literature is over 20 years old, but it shows high rates of community satisfaction with mobile crisis teams, increased use of community-based services, and reduced use of emergency departments. However, it also shows that in many communities, demand exceeds the capacity of the mobile crisis teams. The research also emphasizes that mobile crisis teams should not be viewed as a replacement for police responses to mental health situations – mobile crisis teams commonly call police for assistance.³²

4. Case Management Services

Law enforcement agencies have developed partnerships with mental health service providers and other agencies to better meet the need of individuals with serious mental illness that are in frequent contact with law enforcement and emergency services in general. Police officers or mental health providers provide short-term follow-up and linkages with services, and may also provide long term case management for high utilizers. One study shows that case management services of this nature can reduce police contacts among high utilizers.³³

5. Officer Notification and Flagging Systems

Some jurisdictions have set up systems that alert officers or 911 call-takers about the health conditions, such as mental illness, of individuals who have given prior consent to participate in the system. Such systems are designed to serve the same purpose as a “medical alert bracelet.” The system may also link the responding officer with a mental health professional by telephone. These systems are designed differently in each jurisdiction and available research on outcomes is extremely limited.

³² Ibid.

³³ Ibid.

6. EMS and Ambulance-Based Responses

Some jurisdictions have made efforts to improve responses by emergency medical services (EMS) to mental health situations. In Wake County, North Carolina, a pilot program was developed to allow EMS to transport individuals experiencing mental health crises directly to psychiatric facilities rather than to an emergency department. In Canada and Australia, some EMS teams include social workers or mental health nurses. The research on these efforts is limited, but available studies suggest these efforts can reduce use of emergency departments.³⁴

7. Stand-Alone Trainings for Law Enforcement

As noted above, the Crisis Intervention Team (CIT) model includes a 40-hour officer training program as well as specialized training for dispatchers. In addition to CIT, police agencies in the United States have also used stand-alone training programs. The 8-hour Mental Health First Aid for Public Safety (MHFA-PS) and the one and a half day Integrated Communications, Assessment and Tactics (ICAT) training are the two most well-known programs.

No published research exists on either of these specific training programs. MHFA-PS is an adapted version of the original Mental Health First Aid (MHFA) course, which has been shown to improve participants' knowledge and confidence in providing assistance during mental health situations and reducing stigma. However, more research is needed on whether brief trainings such as MHFA-PS and ICAT impact outcomes during police responses to mental health situations.³⁵

8. Trained advocates or peers

Trained advocates or peers can provide support to individuals with mental illness when they are arrested or questioned by police. The United Kingdom gives individuals with mental illness the right to request a support person in these situations. In the United States, the Arc, which advocates and serves individuals with I/DD, provides such support services in some communities, developing "personalized justice plans" to educate justice system personnel about resources for individuals with I/DD.³⁶

³⁴ Ibid.

³⁵ Ibid.

³⁶ Ibid.

SAMHSA Guidelines on Data Collection and Monitoring for Crisis Response

SAMHSA's guidelines for crisis care systems recommend that communities track a variety of performance metrics to support continuous quality improvement. SAMSHA also recommends specific performance metrics for Crisis Intervention Team (CIT) programs (the police-based crisis intervention model described on page 12). Examples of recommended metrics for Mobile Crisis Teams and CIT programs are listed below.

Mobile Crisis Team Metrics

- Number served per shift
- Average response time
- Percentage of calls responded to within 1 hour
- Longest response time
- Percentage of incidents resolved in the community

CIT Program Metrics (focused on police training, responses and partnerships)

- CIT training participation by subgroup (e.g. rank, precinct, or outside department);
- Community partnerships and engagement (numbers of partners, surveys or focus groups);
- Mental health calls/encounters as coded by dispatch and by responding officers;
- Response arrival times and duration of responses;
- Responses by CIT-trained versus non-CIT-trained officers by shift/precinct;
- Response outcomes (resolved on scene, voluntary/involuntary transport to facility, arrest);
- Rate at which officers refer individuals to behavioral health services;
- Use of force and injury rates of officers and persons in crisis compared to baseline group;
- Mental health situation characteristics (e.g. demographics, locations, behaviors, risks);
- Rate at which individuals with serious mental illness re-enter the criminal justice system;
- Numbers of calls requesting CIT officers;
- Service use trends across partners (crisis lines, emergency departments, and outpatient; mental health services) as well as among frequent utilizers of emergency services;

SAMHSA recommendations for CIT program metrics are organized into three "tiers" based on the program's data collection and monitoring capabilities. The guidelines recommend that programs begin by collecting data and tracking metrics in the first tier before moving to the next tier. Some jurisdictions use supplemental paper forms filled out by officers for data collection, though they sometimes struggle with inconsistent data collection. Alternatives that may limit the administrative burden on officers include electronic databases or embedded fields and templates in existing report systems as well as detailed disposition codes for mental health situations.

Sources: *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*, Substance Abuse and Mental Health Services Administration, 2020, p. 51, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>, accessed 12/10/2020; and *Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide*, Substance Abuse and Mental Health Services Administration (SAMHSA), 2018, <https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5065.pdf>, accessed 1/8/2021.

D. Case Studies for Crisis Response

This section describes approaches to mental health responses that involve partnerships between police and mental health providers and advocates. As noted above, many communities have used a combination of strategies to improve the mental health and public safety outcomes of responses to mental health situations. The jurisdictions below have taken different approaches, but the following themes emerge:

- Most jurisdictions use more than one approach for mental health responses, such as CIT programs, co-responder teams, case management, and/or mobile crisis teams.
- Some jurisdictions divert some mental health responses, typically for situations not involving crimes, violence or other dangerous elements, away from police and to mobile crisis teams;
- Specialized responders such as co-responder teams and non-police mobile crisis teams typically have longer response times than police and provide either secondary responses after the initial police response or respond to less urgent situations;
- Engagement and training of emergency dispatchers is a key component of both police-based crisis response and efforts to divert mental health responses away from police; and
- Jurisdictions that have diverted some mental health responses to non-police mobile crisis teams have found that trust and relationship-building between mobile crisis teams and police departments is critical to the success of these efforts.

1. Crisis Intervention Team (CIT) in Memphis, Tennessee

The Memphis Police Department's (MPD) Crisis Intervention Team (CIT) is a specialized police unit that responds to mental health situations in the Memphis community. The CIT was created in 1988 in collaboration with the Memphis Chapter of the Alliance for the Mentally Ill (AMI), mental health providers, the University of Memphis and the University of Tennessee.

CIT officers join the unit voluntarily and are stationed in each of the city's Uniform Patrol Precincts. They receive training supervised by mental health providers, family advocates and mental health consumer groups.³⁷ MPD coordinates four 40-hour CIT trainings per year for MPD officers, officers from other jurisdictions in the region, dispatchers, and federal agents. MPD also offers 8-hour in-service trainings on specific issues.

CIT officers respond to both regular police calls and mental health situations. For police calls related to a mental health situation, police dispatchers dispatch the closest CIT car along with additional patrol vehicles as necessary. The MPD's policies and procedures describe how officers should respond in cases where the individual experiencing a mental health crisis poses a danger to themselves or others,

³⁷ "Crisis Intervention Team," The City of Memphis, Tennessee, <https://www.memphistn.gov/government/police-department/crisis-intervention-team/> accessed 12/8/2020.

has an urgent medical concern, and/or is being charged with a criminal offense.³⁸ MPD has agreements with Regional One Health (a general hospital) and the Crisis Assessment Center, or CAC (part of the Memphis Mental Health Institute, a psychiatric hospital), for receiving individuals in crisis from MPD.³⁹ The CAC offers evaluation, social detoxification, crisis stabilization for up to 3 days, and referrals to community services.⁴⁰ For all crisis calls involving mental illness, officers complete a report that includes the following information:

- Restraining equipment or techniques used;
- Consumer or officer injuries;
- Disposition;
- Other information on the person involved such as veteran status or known diagnosis;
- Transport provided; and
- Officer summary of the interaction and response.

Ongoing challenges include inadequate mental health services in the community as well as demand for CIT training slots for officers from other jurisdictions that exceeds availability.⁴¹

2. Crisis Assistance Helping Out On The Streets (CAHOOTS) in Eugene and Springfield, Oregon

The White Bird Clinic operates the Crisis Assistance Helping Out On The Streets (CAHOOTS) program that provides 24/7 mobile crisis intervention in Eugene and Springfield, Oregon. CAHOOTS was created in 1989 as a partnership with the Eugene Police Department to serve persons experiencing homelessness, substance use disorders, and mental illness that received 911 services frequently.⁴² The annual budget for CAHOOTS is approximately \$2 million, which represents about 2 percent of the Eugene and Springfield police departments' budgets.⁴³

Police and CAHOOTS staff developed criteria to help emergency dispatchers identify non-violent situations with behavioral health components that could utilize CAHOOTS. Situations do not meet program criteria if any of the following are true: any situations involving a crime or a hostile individual, a situation in which the subject or another person is in danger, or an emergency medical situation.

³⁸ "Dealing With Mentally Ill/Crisis Intervention Team," Memphis Police Department Policies and Procedures, 7/5/2018, <https://www.memphispolice.org/pdf/2020%20Memphis%20Police%20Department%20Policy%20and%20Procedure%20Manual.pdf> accessed 12/8/2020

³⁹ "CIT Program Overview (2017-2018)," *Advancing Crisis Intervention Team Programs in Tennessee: Tools, Guidelines and Recommendations*, CIT in TN Task Force, March, 2019, https://www.tn.gov/content/dam/tn/mentalhealth/documents/Advancing_CIT_Programs_in_Tennessee_ALL.pdf, accessed 12/9/2020.

⁴⁰ "Memphis, Tennessee: Interacting with People with Mental Illness," *Due South: Looking to the South for Criminal Justice Innovations*, May, 2011, http://www.justicepolicy.org/uploads/justicepolicy/documents/due_south_-_memphis.pdf

⁴¹ "CIT Program Overview (2017-2018)," *Advancing Crisis Intervention Team Programs in Tennessee: Tools, Guidelines and Recommendations*, CIT in TN Task Force, March, 2019.

⁴² "Media Guide 2020," Crisis Assistance Helping Out On The Streets: White Bird Clinic, Eugene, Oregon, 2020, <https://whitebirdclinic.org/wp-content/uploads/2020/06/CAHOOTS-Media-Guide-20200626.pdf>, accessed 12/2/2020.

⁴³ "Behavioral Crisis Alternatives: Case Study – Eugene, Oregon," Vera Institute of Justice, November, 2020.

Dispatchers receive training on the protocol, which is intended to serve as a guide rather than a rigid rule.⁴⁴

When a dispatcher determines that a situation meets the criteria, they use a special channel to dispatch two-person CAHOOTS teams, composed of a medic and a crisis worker. Most CAHOOTS medics are certified Emergency Medical Technicians (EMTs) with experience in fire departments. CAHOOTS crisis workers include individuals with college degrees in human services, persons with experience as crisis line or shelter workers, and individuals with behavioral health conditions that have chosen to help their peers. CAHOOTS staff complete 40 hours of in-class training and 500-600 hours of field training before joining two-person CAHOOTS teams.⁴⁵ In addition, most Eugene Police Department officers are CIT-trained. When they arrive, CAHOOTS teams can provide the following services:

- Crisis counseling;
- Suicide prevention, assessment and intervention;
- Conflict resolution and mediation;
- First aid and non-emergency medical care;
- Resource connection and referrals; and
- Transportation to services, including to the clinic or the hospital.⁴⁶

CAHOOTS has a long-standing relationship with the police and the community. Community members can directly request assistance from CAHOOTS. When police are the primary responders to a call, they can request assistance from a CAHOOTS team to help de-escalate a situation or provide assistance to a person in crisis after the police have stabilized the scene.⁴⁷

Occasionally, CAHOOTS teams request assistance from police. For example, if a person who presents a danger to themselves refuses treatment, the police must execute an emergency custody order. Police must transport the individual to the hospital in a police vehicle, but the CAHOOTS staff will follow to communicate with the hospital and facilitate continuity of care. CAHOOTS also collaborates with schools, shelters and behavioral health providers.⁴⁸

About 3 out of 5 calls to which CAHOOTS responds involves a person experiencing homelessness while 1 in 3 involves an individual with severe and persistent mental illness. In 2017, CAHOOTS teams were dispatched in response to 17% of calls received by the Eugene Police Department. A caveat to this figure is that Eugene's Chief of Police, has noted that CAHOOTS provides services – such as transport to

⁴⁴ "Behavioral Crisis Alternatives: Case Study – Eugene, Oregon," Vera Institute of Justice, November, 2020, <https://www.vera.org/behavioral-health-crisis-alternatives/cahoots> , accessed 12/7/2020.

⁴⁵ "Behavioral Crisis Alternatives: Case Study – Eugene, Oregon," Vera Institute of Justice, November, 2020.

⁴⁶ "Media Guide 2020," Crisis Assistance Helping Out On The Streets: White Bird Clinic, Eugene, Oregon, 2020.

⁴⁷ Ibid.

⁴⁸ Ibid.

medical appointments – that police would not otherwise provide.⁴⁹ In 2019, CAHOOTS responded to 24,000 calls, of which 150 required assistance from police.⁵⁰

CAHOOTS has faced challenges with response times – in 2019, CAHOOTS teams took an average of almost two hours to arrive, compared with the approximately one-hour average response time of Eugene police. Additionally, CAHOOTS has encountered incidents where callers deliberately misrepresented the nature of an incident to trigger a CAHOOTS instead of a police or EMS response, with dangerous or tragic consequences.⁵¹ Finally, concerns exist that communities of color with histories of tension and distrust with police do not access CAHOOTS services because they must be requested via the police department. As a result, Eugene is exploring a separate phone line for CAHOOTS services.⁵²

3. Mental Health Support Team (MHST) in Tucson, Arizona

In 2014, the Tucson Police Department created the Mental Health Support Team (MHST), a specialized team that supports Tucson's response to mental health situations. In 2017, the MHST included one sergeant, seven officers, and three detectives. The MHST enhances and oversees Tucson's long-standing CIT program (see page 12 for a description of CIT). The MHST differs from the CIT model in that it is focused on prevention, as opposed to crisis response. Over 80% of first responders and dispatchers in the Tucson Police Department are CIT-trained, and all officers receive Mental Health First Aid and crisis mitigation and management training. The City of Tucson is located in Pima County, which also has its own CIT and MHST programs.⁵³

Officers volunteer to serve on the MHST and receive specialized training focused on identifying and developing relationships with individuals with serious mental illness in the community. Officers must have completed CIT training, no history of disciplinary issues or complaints, and must pass an exam to be selected for the MHST. In 2017, Tucson began pairing MHST officers responding to mental health situations with clinician co-responders, who are Masters' level licensed mental health clinicians. MHST teams have three primary functions:⁵⁴

⁴⁹ Gerety, R.M., "An Alternative to Police That Police Can Get Behind," The Atlantic, December 28, <https://www.theatlantic.com/politics/archive/2020/12/cahoots-program-may-reduce-likelihood-of-police-violence/617477/>, accessed 1/29/2020.

⁵⁰ "Media Guide 2020," Crisis Assistance Helping Out On The Streets: White Bird Clinic, Eugene, Oregon, 2020.

⁵¹ <https://www.theatlantic.com/politics/archive/2020/12/cahoots-program-may-reduce-likelihood-of-police-violence/617477/>

⁵² "Behavioral Crisis Alternatives: Case Study – Eugene, Oregon," Vera Institute of Justice, November, 2020.

⁵³ Balfour, M., Winsky, J., Isely, J., "The Tucson Mental Health Support Team (MHST) Model: A prevention focused approach to crisis and public safety," 2017, <https://www.connectionshs.com/wp-content/uploads/2019/03/Tucson-MHST-Model-Full-Version.pdf>, accessed 12/10/2020; and "Tucson (AZ) Police Department," Mental Health Learning Sites, The Justice Center of the Council of State Governments and the U.S. Department of Justice Bureau of Justice Assistance, https://csgjusticecenter.org/wp-content/uploads/2020/02/Law-Enforcement%E2%80%93Mental-Health-Learning-Sites_TucsonAZ3.27.19_508accessible.pdf

⁵⁴ Ibid.

- Serving civil commitment orders (court orders for involuntary mental health treatment);
- Investigating “nuisance” calls flagged as potentially mental health-related and that may require working with an individual’s family and/or treatment providers to resolve; and
- Facilitating and assisting mental health and criminal justice system responses to cases involving alleged criminal components.

In addition to the CIT and MHST programs, the Tucson Police Department works closely with 12 crisis mobile teams that are dispatched by a 24/7 crisis call center. Mobile crisis teams provide assessment and stabilization of mental health situations that do not involve a commitment order or where a law enforcement response is not needed. Mobile crisis teams must arrive within 30 minutes of a call from law enforcement, and within one hour of calls from the public or mental health providers.⁵⁵

MHST officers also coordinate with the Crisis Response Center (CRC), a publicly-funded facility that provides psychiatric triage, urgent care, and 23-hour observation services. The CRC is co-located with the crisis call center, a civil commitment court, an inpatient psychiatric facility, and a hospital emergency department. The CRC has a no-refusal policy for law enforcement and a 10-minute turnaround time, providing a key resource for officers that need to transport an individual to treatment. CRC psychiatrists also offer consultations to the MHST on a 24/7 basis.

Tucson’s criminal justice and behavioral health system leaders meet monthly to exchange data, identify trends and develop plans for high-need individuals.⁵⁶ They monitor the following metrics:⁵⁷

- The number of officer transports to the CRC;
- Patrol time saved by CRC drop-offs versus jail bookings;
- Percentage of involuntary civil commitment orders served out of those attempted;
- Uses of force; and
- Emergency petitions completed.

Data show that in the two years after the MHST’s implementation, the Department reported zero uses of force while serving civil commitment orders. Additionally, Tucson Police Department SWAT deployments for “suicidal barricaded subject” decreased after the MHST program was implemented, from 10 in 2012 and 18 in 2013 to 4 or less per year between 2014 and 2016.⁵⁸

⁵⁵ Balfour, M., Winsky, J., Isely, J., “The Tucson Mental Health Support Team (MHST) Model: A prevention focused approach to crisis and public safety,” 2017.

⁵⁶ “Tucson (AZ) Police Department,” Mental Health Learning Sites, The Justice Center of the Council of State Governments and the U.S. Department of Justice Bureau of Justice Assistance.

⁵⁷ Tucson (AZ) Police Department,” Mental Health Learning Sites, The Justice Center of the Council of State Governments and the U.S. Department of Justice Bureau of Justice Assistance.

⁵⁸ Balfour, M., Winsky, J., Isely, J., “The Tucson Mental Health Support Team (MHST) Model: A prevention focused approach to crisis and public safety,” 2017.

4. The Houston Police Department Mental Health Division Houston, Texas

The mission of the Houston Police Department's Mental Health Division is "To provide a more professional and humane response to individuals in serious mental health crises." The Division oversees the Department's CIT program, which provides training for all officers including CIT training for all cadets, advanced CIT classes for officers, and a crisis communications class for dispatchers and call-takers. The Mental Health Division also operates several specialized programs, summarized in the table below.

Mental Health Division Specialized Programs

The Crisis Intervention Response Team (CIRT)	CIRT's 12 teams pair officers with advanced CIT training with masters-level clinicians to provide back-up support to patrol officers in responding to the most serious mental health situations. CIRT also assists during SWAT call-outs and hostage situations and provides jail assessments and clinical transfers.
Crisis Call Diversion (CCD)	CCD diverts non-emergency 911 calls to a crisis counselor housed in the emergency communications center. Counselors provide telephonic crisis intervention, suicide assessments and intervention and referrals to mental health and social services, including a mobile crisis outreach team.
The Chronic Consumer Stabilization Initiative (CCSI)	The CCSI is a partnership between the Houston Police Department and the Harris Center for Mental Health and IDD. CCSI case workers proactively engage individuals with serious mental illness that have had repeated police contacts and/or psychiatric hospitalizations.
The Homeless Outreach Team (HOT)	The HOT includes uniformed officers and case workers and works with homelessness service providers to connect individuals experiencing homelessness with services and benefits including medical and behavioral health care, permanent supportive housing and Social Security Benefits. The HOT also issues identification to individuals that lack official identification.
Senior Justice Assessment Center (SJAC)	The SJAC serves senior adult victims of abuse, neglect and financial exploitation by providing forensic exams, mental health assessments, no-cost physical exams, psycho-social assessments and service referrals.
The Boarding Home Enforcement Unit (BHEU)	The BHEU enforces the Boarding Home Ordinance, which requires that facilities that house and provide certain services to three or more persons with disabilities or elderly individuals comply with health and safety rules.

Source: "2019 Annual Report," Houston Police Department Mental Health Division, https://www.houstoncirt.org/wp-content/uploads/2020/07/Annual-Report_2019.pdf , accessed 12/16/2020

During 911 calls to the Houston Emergency Center, calls involving mental illness are coded with one of 28 different "CIT" codes. Out of 1 million calls in 2019, 40,500 were labeled as a CIT call. Typically, patrol units assigned to the relevant district and beat will provide the initial response. CIRT teams operate countywide and therefore provide a secondary response where necessary, as they take longer

to arrive – 20 minutes on average. However, many patrol officers that are not part of the CIRT are nevertheless CIT-trained. In 2019, CIT-trained officers responded to 72% of CIT-coded calls.

CIRT teams responded to about 25,000 calls between 2014 and the first half of 2020, including 4,300 in 2019. Of those, 25% were resolved at the scene, 34% resulted in transport to the Psychiatric Emergency Service (PES), which provides crisis stabilization services, 36% resulted in transport to hospital emergency departments (used when the PES was at capacity), and 4% resulted in incarceration.

Additionally, Crisis Call Diversion (CCD) transfers CIT-coded calls without serious criminal components or threats of violence are transferred to a crisis counselor at the HEC. Counselors seek to resolve the situation over the phone; for example counselors can provide community referrals, develop a suicide reduction “safety plan”, or transfer the caller to Houston’s crisis line. However, counselors may also dispatch a non-law enforcement Mobile Crisis Outreach Team (MCOT) or determine that police intervention is still required. In 2019, CCD resolved 2,300 calls without further police intervention.⁵⁹

5. Crisis Response Unit and Familiar Faces Program in Olympia, Washington⁶⁰

The Olympia (WA) Police Department (OPD) contracted with a behavioral health partner to create the Crisis Response Unit (CRU) in 2017. The CRU has six behavioral health specialists that work in teams of two to respond to 911 and non-emergency police calls involving behavioral health issues. The Thurston County 911 Communications Center broadcasts calls that may be appropriate for a CRU response over a shared police frequency that CRU teams listen to via police radios. CRU teams may choose to respond to calls they hear on the radio and they also respond to incidents on referral from OPD officers.

CRU teams also work proactively to develop relationships with and assess the needs of persons that live in Olympia’s sanctioned encampment for persons experiencing homelessness. This outreach work is intended to help the CRU respond more effectively when crises arise as well as address needs that could lead to future police contacts.

In the second quarter of 2020, the CRU completed 511 responses. During all but 86 responses, no law enforcement was present. Of the 511 responses, 175 were initiated by CRU teams, while the remaining were referrals from officers. Over time, CRU has begun to initiate more responses as OPD officers have developed familiarity and trust with the CRU. 911 callers have also begun to request CRU responses.

Shortly after the creation of the CRU, OPD launched Familiar Faces in 2018 to help the department better address the needs of persons with repeated police contacts. Familiar Faces is operated under a contract with Catholic Community Services and is staffed by six peer navigators with personal experiences with poverty, substance use and criminal justice involvement. After an introduction from

⁵⁹ “Crisis Intervention,” City of Houston Mayor’s Task Force on Policing Reform, September, 2020, <http://www.houstontx.gov/boards/policing-reform-report.pdf>, accessed 12/16/2020.

⁶⁰ Beck, J., Reuland, M., Pope, L., “Behavioral Health Crisis Alternatives,” The Vera Institute for Justice, November, 2020, <https://www.vera.org/behavioral-health-crisis-alternatives>, accessed 12/17/2020.

OPD officers, the peer navigators work to develop relationships with individuals with frequent contacts with OPD. As non-clinicians, peer navigators have the flexibility to support clients in a wide variety of ways, such as problem-solving for housing and child care issues, transporting clients to treatment, and helping with laundry. The program aims to serve 60 individuals.

OPD, the CRU, and Familiar Faces participate in regular stakeholder meetings along with behavioral health partners, the county public defender, and others to review difficult cases. Stakeholders report that collaboration among OPD, the CRU and Familiar Faces is growing as OPD officers observe how clients benefit from these programs.

6. The Crisis Response Network in Phoenix, Arizona⁶¹

The Crisis Response Network is a non-profit organization that operates the Central Arizona crisis line and 27 mobile crisis teams. Since 2001, CRN has worked with the Phoenix (AZ) Police Department (PPD), which also has a CIT program, to provide mobile crisis services on request from PPD officers. As a result of a 2014 court settlement, CRN received a significant increase in funding that increased its mobile crisis capacity. CRN receives an average of 15,000 crisis calls and dispatches mobile crisis teams 1,400 times per month in Central Arizona. Of these dispatches, 150 per month come from police referrals. CRN mobile crisis teams respond within 30-45 minutes on average.

Over the past two years, CRN and PPD have worked to change their dispatch processes to allow for mobile crisis teams to be dispatched at the same time as police, and where appropriate, respond without police. In 2019, PPD introduced training for PPD dispatchers on mental health, the PPD CIT program, the Phoenix crisis system, and the types of calls that CRN can handle. In 2020, PPD and CRN piloted a co-dispatch program for a neighborhood with a high volume of mental health-related calls, so that a mobile crisis team could be dispatched at the same time as police.

PPD and CRN have also developed processes for dispatchers to divert calls that do not require police intervention to CRN specialists.⁶² CRN specialists can conduct in-depth assessments to determine the type of intervention needed.

However, PPD and CRN have found that dispatchers are reluctant to divert calls from police in an effort to err on the side of caution, and are working to develop trust between dispatchers and CRN. PPD and CRN now engage in frequent discussions on mental health related calls, reviewing specific calls to understand the best way to respond. Within PPD, some believe that it may be necessary to explicitly direct dispatchers to divert certain calls to CRN under certain circumstances (CRN specialists can send calls back to PPD as needed).

⁶¹ Beck, J., Reuland, M., Pope, L., “Behavioral Health Crisis Alternatives,” The Vera Institute for Justice, November, 2020, <https://www.vera.org/behavioral-health-crisis-alternatives>, accessed 12/17/2020.

⁶² Dispatchers ask callers a set of 10 questions – the “10 Ws”, which include “Was anyone hurt?” and “Any weapons?” that allow them to assess safety threats that would require a police response. See <https://www.phoenix.gov/policesite/Documents/phxpdcomguidelines.pdf>

Chapter 2. Responses to Mental Health Situations in Montgomery County

In Montgomery County, community members may seek assistance during a mental health crisis via a variety of non-public safety and public safety entities. The Montgomery County Crisis Center (including the Mobile Crisis Team), Montgomery County Hotline operated by EveryMind, MC311, and the State's Maryland 211 call centers provide assistance during mental health situations. In the public safety arena, the Montgomery County Police Department (MCPD), other local law enforcement, and the Montgomery County Fire and Rescue Service (MCFRS) are often first responders to mental health situations. The Montgomery County Sheriff's Office (MCSO) also responds to some mental health situations.

This chapter summarizes the resources available in Montgomery County for providing initial assistance or response when individuals experience mental health crises. Because the scope of this report was public safety's response to mental health crises, it further details public safety agencies' training and procedures for responding to mental health situations. The chapter is organized as follows:

- **Section A** provides an overview of the non-public safety resources for individuals seeking assistance during a mental health crisis;
- **Section B** describes the public safety resources for responses to mental health situations;
- **Section C** summarizes the training available to public safety personnel for responding to mental health situations;
- **Section D** describes public safety agencies' mental health situation response procedures; and
- **Section E** summarizes observations from staff on responses to mental health situations in Montgomery County.

A. Non-Public Safety Resources for Mental Health Situation Assistance and Response

Members of the community may seek assistance during mental health situations through a variety of different non-public safety resources. These resources can help individuals resolve crises, provide referrals to further services, and connect individuals with public safety services when necessary. This section provides a brief overview of these resources. Chapter 3 provides data on calls received by each of the resources described below.

1. Montgomery County Crisis Center and Mobile Crisis Outreach Team

The Montgomery County Crisis Center is located in Rockville and provides crisis services in person and by phone 24 hours a day, 7 days a week. The Department of Health and Human Services (DHHS) operates the Crisis Center, which is, at the time of writing, staffed by 23 licensed mental health professionals, four supervisory therapists, two psychiatrists, three behavioral health technicians, one case manager, one nurse and four administrative and managerial staff.

The Crisis Center provides crisis assessments and treatment referrals and has four crisis beds that offer an alternative to hospitalization for individuals in crisis. A psychiatrist is onsite 4 days per week and on-call 24 hours a day and 7 days per week to provide short-term treatment for individuals who are uninsured or enrolled in Medicaid. The Crisis Center works in partnership with Montgomery County Public Schools (MCPS), MCPD, area hospitals and community organizations.

The Crisis Center operates the Mobile Crisis Outreach Team (MCOT) program. Based in Rockville, the MCOT responds to community psychiatric emergencies where the emergency is occurring. The program includes a two-person team with a licensed mental health professional and a second Crisis Center staff member. The MCOT always responds with police¹ and provides crisis evaluation, crisis stabilization, recommendations for treatment and resources, and facilitates hospital psychiatric evaluations. About half of its referrals come from MCPD, and the remainder come from the community or other programs and agencies.

As part of a state grant proposal (see page 28), RI International² analyzed the capacity of the MCOT in 2020 and estimated additional resources needed to meet community demand. The RI International analysis found the following:³

- 28% of requests for the MCOT could not be fulfilled at current capacity;
- An estimated 8,140 individuals would meet criteria for MCOT services annually; and
- To meet the estimated need, Montgomery County would require eight MCOTs.

In July of 2020, the Council approved a special appropriation for six new positions to increase the capacity of the MCOT program.

2. EveryMind Montgomery County Hotline

EveryMind is a Montgomery County-based nonprofit organization that provides access to crisis prevention and intervention services, school and community-based mental health services, case management, mental health, and education and advocacy in the National Capitol Region. The majority of services are provided through contracts with Montgomery County Government, including the Montgomery County Hotline.

EveryMind has been administering the Montgomery County Hotline for over 50 years. The Montgomery County Hotline is a free and confidential service that is available 24 hours a day, 7 days a week by phone, and 7 days a week from 8am to midnight by text and chat. EveryMind is accredited by the American Association of Suicidology and is a core center for the National Suicide Prevention

¹ Executive Branch staff report that they are working on a strategy to allow the Mobile Crisis Team to respond without Police where appropriate.

² <https://riinternational.com/>

³ McMillan, L. Memo to the Health and Human Services and Public Safety Committees, October 6, 2020.

Lifeline (NSPL), answering calls and chats to the NSPL phone number and chat portal and exceeding NSPL standards on suicide screenings. EveryMind’s call and text/chat specialists provide supportive listening, information and resources, and crisis intervention, and are trained in military cultural competency. Specialists are also trained to conduct suicide screenings and work with community partners and government agencies to help develop safety plans. When necessary, specialists provide warm transfers to the Montgomery County Crisis Center and to 911.

Prior to FY21, the hotline had a very limited budget and relied heavily on volunteer specialists to answer calls, texts and chats. Supplemental funding provided during FY21 allowed for additional paid specialists to be recruited, trained and hired, and for those specialists to have the technology and protected hardware to work remotely in response to the COVID-19 pandemic. This supplemental funding increased the capacity of the Montgomery County Hotline, allowing it to answer nearly 40% more calls, texts and chats (see Chapter 3 for more detailed annual call volume data).

3. MC311

MC311 is the County’s non-emergency call center and web portal for County services and information. 311 telephone lines were originally created to divert non-emergency calls from 911 lines, but have since expanded to multiple channels of communication with residents (phone, text, social media, etc.) and to cover a wide range of government information and service request types, including non-emergency requests related to mental health services. All emergency calls are transferred to 911. The MC311 system has two main components:

- **Call Center.** At the MC311 Customer Service Center (the “Call Center”), customer service representatives (CSRs) answer resident calls and create service requests Monday-Friday from 7:00 a.m. to 7:00 p.m.
- **Web Portal.** On the MC311 self-help Web Portal, which is available 24/7 on the Montgomery County Government website (www.montgomerycountymd.gov/mc311/), residents can find County information and request some (but not all) County services on their own.

MC311 has a service database called Siebel. Siebel contains knowledge-based articles for specific service topics which direct CSRs on how to respond to specific requests. For example, if a caller requests information on the Montgomery County Crisis Center, the CSR can access the relevant knowledge-based article to find a description and contact information for the Crisis Center.

If an individual calls MC311 regarding a mental health situation, CSRs follow specific procedures depending on the urgency and nature of the situation. If the situation is an emergency, the representative will instruct the caller to hang up and immediately dial 911. If the CSR does not believe the caller is able to hang up and dial 911, the CSR will immediately initiate a “warm transfer” to 911. CSRs are instructed to note certain key words stated by the caller and flag these as urgent for 911. The CSR will stay on the line, identify themselves and announce they are transferring a caller. Once the 911 call-taker has answered the call, the CSR can hang up.

If the caller reports an urgent mental health situation that is not imminently dangerous, the CSR may either initiate a warm transfer to the Crisis Center or provide the caller with the telephone number for the Crisis Center. If a caller reports being distressed, anxious, experiencing loneliness or needs to talk to somebody about mental health issues, including suicide, but the situation is not urgent, the CSR may refer the caller to either the Crisis Center or the EveryMind Montgomery County Hotline. For other types of non-urgent mental health situations, such as a person seeking mental health services, the CSR may use the Siebel database to identify specific programs that meet the caller's needs.

4. Maryland 211

Maryland 211 is a non-profit organization that provides access to information and resources on health, crisis, and social services available in the State. A partnership between four State agencies, 211 enables residents to contact (through phone or email) an information and referral service network of community services available. Trained call specialists answer calls 24 hours a day, 7 days a week and can provide information on nearly 5,000 agencies and programs across the state.

Maryland 211 has four call centers throughout the state. Callers from Montgomery County are directed to the call center in Prince George's County. Although Montgomery County does not have a 211 call center, staff report that opportunities exist for collaboration between Maryland 211 and Montgomery County. 211 call centers can provide information on the following topics:

- Arts, Culture and Recreation
- Clothing/Personal/Household Needs
- Disaster Services
- Education
- Employment
- Food/Meals
- Health Care
- Housing
- Income Support/Assistance
- Information Services
- Legal, Consumer and Public Safety Services
- Mental Health/Addictions
- Other Government/Economic Services
- Transportation
- Utility Assistance
- Volunteers/Donations

Crisis Intervention. Maryland 211 provides information and referrals for crisis intervention services under the larger topic area of Mental Health/Addiction. If a resident calls 211, he/she is immediately prompted to press 1 if the caller is in a crisis. If 1 is pressed, the caller is put to the front of the queue of the crisis call takers, who receive additional training for responding to callers in crisis. Call-takers follow specific protocols for crisis situations, including calling 911 if necessary.

Crisis Now Grant Proposal

The Nexus Montgomery Regional Partnership is a collaboration between Montgomery County's six hospitals as well as a network of community organizations, and is coordinated by the Primary Care Coalition, a local nonprofit organization. In July of 2020, Nexus Montgomery submitted a grant proposal to the Maryland Health Services Cost Review Commission (HSCRC) on behalf of Montgomery County hospitals, local government agencies and local nonprofits to fund a "comprehensive and integrated behavioral health crisis structure". The proposal aimed to increase the County's alignment with the Crisis Now model for behavioral health crisis care systems. The proposal included the following elements:⁴

1. A collaborative body – the Community Crisis System Collaborative (CCSC) – that brings together government, health system and nonprofit stakeholders to set objectives and targets and work collaboratively to solve problems;
2. Increased capacity for the Mobile Crisis Outreach Team (MCOT) program to allow it to meet community needs, changes its procedures to allow it to respond without law enforcement, and incorporation of peers in crisis response;
3. A Restoration Center to provide a 24/7 crisis stabilization services for adults;
4. Technology improvements for the Crisis Center phone system and the Montgomery County Hotline operated by EveryMind.

In October of 2020, the Council received information that HSCRC did not approve the grant proposal. However, stakeholders involved in the proposal continue to work to develop the proposed elements, for example through funding for increased staffing for the MCOT program approved by the Council in July of 2020.

⁴ Crisis Now Catalyst Grant Proposal, Proposal to the Health Services Cost Review Commission, Prepared by Nexus Montgomery, July 19, 2020.

B. Public Safety Organizational Structures for Mental Health Situation Responses

Within MCPD, MCFRS and MCSO, specific divisions provide response, training and support for addressing mental health situations in the community. This section summarizes the organizational structures for mental health situation responses in public safety agencies in Montgomery County.

1. MCPD Structure and Resources

This section describes several entities within MCPD that are involved in responding to as well as supporting and building capacity for mental health situation responses by public safety personnel.

Emergency Communications Center (ECC). The ECC is responsible for answering 911 calls and non-emergency police calls in Montgomery County and for dispatching public safety personnel to incidents, including mental health situations. MCPD operates the ECC, which is staffed by both MCPD and MCFRS personnel. As of October, 2020, the ECC had 185 civilian MCPD staff, an MCFRS Communications Chief and 39 uniformed MCFRS staff. The FY21 Operating Budget created a new MCPD social worker position to provide mental health support to staff. In recent years, the ECC has experienced high levels of staff attrition and difficulties with recruitment due to challenges with background checks as well as the stressful nature of the job. Efforts to address these concerns include the creation of a new employee classification series to allow for promotions and pay increases as well as the creation of the 911 Dispatch Academy at Montgomery College.⁵

Patrol Services Bureau. The County's six District Stations provide direct police patrol services to the public by responding to incidents in the community, including mental health situations. They are often first on the scene of a mental health situation. The Patrol Services Bureau also manages the School Resource Officer program, which assigns law enforcement officers to provide support to Montgomery County Public Schools. The Patrol Services Bureau is staffed by 919 sworn officers.

Crisis Response and Support Section. The MCPD Crisis Response and Support Section, which is part of MCPD's Field Services Bureau, provides specialized supports and outreach for mental health situations. It includes the following programs that support MCPD's capacity to respond to these situations:

- *The Crisis Intervention Team* is MCPD's dedicated mental health response team. It has three staff: two officers and one DHHS clinician. This team 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. The Crisis Intervention Team also works with other jurisdictions to help them establish and develop CIT programs. MCPD is currently working on expanding this dedicated team in a decentralized manner.

⁵ Farag, S., Memo to the Public Safety Committee, October 12, 2020.

The Autism/Intellectual, Developmental Disabilities, Alzheimer's/Dementia Outreach Program provides education to officers and new recruits on interacting with individuals with Autism/IDD, conducts community outreach and education, and follows up after calls for service involving a person with Autism, IDD, Alzheimer's or dementia to link caregivers with resources. Two MCPD officers coordinate the program, which also provides assistance to the Crisis Intervention Team as needed. MCPD participates in Project Lifesaver, a national search and rescue program that provides a tracking bracelet to individuals that wander.

The MCPD Training and Education Division manages the training and performance evaluation of police recruits and develops and provides in-service training for MCPD personnel, including specialized training in mental health situation responses (see training section below).

Petitions for Emergency Evaluations

In Maryland, a petition for emergency evaluation is the first step in the legal process for involuntary admission for inpatient psychiatric treatment. Any interested person (a "petitioner") can make a petition for emergency evaluation of another person (the "respondent"), if the petitioner believes that the respondent has a mental disorder and presents a danger to the life or safety of the individual or others. If a "peace officer" (such as a police officer or Sheriff's deputy), or a qualifying health professional, makes the petition, no court order is needed and the responding officer or a Sheriff's deputy must take the respondent into custody and transport the individual to the nearest emergency facility. If a private individual makes the petition, that petitioner must present the petition to the District Court for review. The Sheriff is responsible for serving court-ordered petitions.

Once at the emergency facility, a physician must evaluate the respondent within six hours to determine if the respondent meets the requirements for involuntary inpatient admission. The emergency facility may request that the officer remain onsite to assist if the individual is violent. The emergency facility may keep an individual for up to 30 hours - if the respondent does not meet the requirements for involuntary admission or does not agree to voluntary admission, the emergency facility must release the individual.⁶ If the respondent meets the requirements, the physician must arrange for their admission to an appropriate facility or contact the Maryland Department of Health to provide for admission to an appropriate facility (e.g. a state psychiatric hospital).

Extreme Risk Protective Order (ERPO). If a person poses an immediate and present danger to self or others by having firearms, certain individuals may file an Extreme Risk Protective Order against that person. An ERPO requires the respondent to surrender any firearms or ammunition to law enforcement and prohibits the respondent from purchasing or possessing firearms or ammunition. The court can also refer an ERPO respondent for an emergency evaluation. Maryland ERPO law went into effect in 2018.⁷

⁶ MD Code, Health - General, § 10-620, § 10-621, § 10-622, § 10-623, § 10-624; § 10-625; and Emergency Evaluation of Mentally-Disordered Individuals, F.C. No.: 921, 6/10/2005, Montgomery County Police Department.

⁷ "Extreme Risk Protective Orders," District Court of Maryland, <https://mdcourts.gov/district/ERPO>, accessed 1/28/2021.

2. MCSO Structure and Resources

The Montgomery County Sheriff's Office is tasked with, among other duties and responsibilities, executing legal process and court orders. The Domestic Violence Section of the Family Division of the Montgomery County Sheriff's Office (MCSO) has primary responsibility for the serving of petitions for emergency evaluations filed by private individuals, health professionals or Montgomery Crisis Center staff. The Domestic Violence Section is staffed by 24 sworn deputies and 10 civilians. It is located at the Family Justice Center, which offers a centralized location to provide coordinated services from multiple agencies for victims of family violence, including counseling and legal services.

3. Other Law Enforcement Departments or Agencies in Montgomery County

In addition to MCPD and MCSO, several other law enforcement departments and agencies operate in Montgomery County and may respond to mental health situations including:

- Rockville City Police Department
- Gaithersburg Police Department
- Takoma Park Police Department
- Chevy Chase Village Police Department
- Maryland-National Capital Park Police
- Maryland State Police
- Maryland Transportation Authority Police
- Prince George's County Police Department

4. MCFRS Structure and Resources

On a daily basis, there are approximately 300 MCFRS staff throughout 37 stations in the County. MCFRS staff are allocated to stations based on the expected demand for services of the response area thus – stations that have more calls or certain types of calls are staffed accordingly. Generally, MCFRS apparatus are staffed as follows :

- Each fire engine is staffed with three emergency medical technicians (EMT) and one paramedic;⁸ and

⁸ Emergency medical technicians or EMTs are the most common types of emergency care providers, while paramedics are trained to provide advanced medical care in the case of an emergency. The basic difference between EMTs and paramedics lies in their level of education and the kind of procedures they are allowed to perform. While EMTs can administer CPR, glucose, and oxygen, paramedics can perform more complex procedures such as inserting IV lines, administering drugs, and applying pacemakers. <https://www.medicaltechnologyschools.com/emt/emt-vs-paramedic#:~:text=The%20basic%20difference%20between%20EMTs,administering%20drugs%2C%20and%20applying%20pacemakers>.

- Transport units (ambulances) have two staff; most have two EMTs, but a few have a paramedic as a primary care provider.

Emergency Medical and Integrated Healthcare Services (EMIHS). EMHIS is the section of MCFRS that manages MCFRS emergency medical services (EMS). EMHIS has twelve staff including a medical director, a community health nurse and a licensed clinical social worker. EMHIS's responsibilities include:

- Developing MCFRS policies applicable to EMS;
- Providing quality assurance/improvement and oversight for EMS care;
- Assisting in the development and administration of EMS training initiatives; and
- Providing operations support for all emergency response providers.

Additionally, EMHIS manages MCFRS's Mobile Integrated Health Program (MIH). The MIH program works in partnership with local hospitals, DHHS, and community organizations to serve individuals that are frequent users of 911 services and have chronic health concerns. MIH connects these individuals with medical and social programs to help meet their needs.

Stop, Triage, Engage, Education and Rehabilitation Program (STEER). STEER is a team of peer specialists with personal experience with substance use disorders that provide support to individuals that experienced opioid overdoses and/or severe substance use disorders. MCFRS works closely with the STEER program, which is operated by DHHS. STEER was initially intended to accept referrals from MCPD, but the program's focus was shifted to individuals served by MCFRS.

C. Training on Mental Health Situation Response for Public Safety Personnel

As described above, several entities and numerous personnel within MCPD, MCFRS and MCSO are involved in public safety responses to mental health situations. The following describes the training available to public safety personnel related to responding to mental health situations.

The Maryland Police Training and Standards Commission

The Maryland Police Training and Standards Commission (MPTSC) prescribes standards for entrance-level and in-service training for law enforcement personnel. PTSC regulations state that entrance-level training must include at least 750 hours of instruction and that non-supervisory police officers must complete a minimum of 18 hours of approved in-service training each year.⁹

State law dictates that Commission must require entrance-level and in-service training on: “individuals with physical, intellectual, developmental and psychiatric disabilities,” as well as, “special training, attention to, and study of the application of antidiscrimination and use of force de-escalation training.”¹⁰

MCPD. MCPD provides three types of training on mental health situation responses to police officers: the 8-hour Mental Health First Aid (MHFA) training course, the 40-hour Crisis Intervention Team (CIT) training program, and 1-2 hours of annual in-service training for all officers.

The 8-hour MHFA course is based on an internationally-recognized curriculum. The curriculum for public safety covers the following topics but does not include a significant cultural competency component:¹¹

- Basic information around mental health and mental illness;
- Recognizing signs and symptoms of mental illness;
- How to defuse crises; and
- How to connect individuals to care.

MCPD provides Crisis Intervention Team (CIT) training four to six times per year at the Montgomery County Crisis Center in collaboration with the Department of Health and Human Services, and is now mandatory for all police recruits as part of their field training. MCPD officers can also take CIT training on a voluntary basis, which is also available to civilian MCPD employees as well as other law enforcement agencies. Officers must complete CIT training in order to receive an electronic control

⁹ COMAR 12.04.01.09 and COMAR 12.04.01.12

¹⁰ MD Code, Public Safety, § 3-207

¹¹ <https://www.mentalhealthfirstaid.org/wp-content/uploads/2018/07/Mental-Health-First-Aid-Public-Safety-One-Pager.pdf>

weapon or “taser”. The 40-hour training is co-taught by clinicians and law enforcement officers and covers the following topics:

- Trauma-informed policing;
- Traumatic brain injury;
- De-escalation;
- Substance use disorders;
- Psychiatric disorders;
- Psychotropic medications;
- Dementia/Alzheimer’s;
- Intellectual and developmental disabilities (IDD);
- Cultural competency specific to Montgomery County’s demographics; and
- Awareness of community resources.

At the time of writing, approximately 750 out of 1,300 or 58% of MCPD officers had completed the 40-hour CIT training program, and all MCPD officers had completed either CIT or MHFA training. MCPD does not have a goal or requirement for repeating or refreshing CIT training, beyond the annual 1-2 hours of in-service training. All School Resource Officers (SROs) must complete CIT training.

MCPD is also working with the Police Executive Research Forum to roll out Integrating Communications Assessment and Tactics (ICAT) training, which is a training on responding to situations in which an unarmed individual is behaving erratically in 2021. Additionally, MCPD staff report they are planning to offer Advanced CIT¹² training beginning in 2021.

Emergency Communications Center. As part of the initial six-month training program for ECC Public Safety Emergency Communications Specialists (PSECS), staff complete a 40-hour basic emergency telecommunicator certification, which includes training on handling stressful situations, including suicidal callers. ECC staff also receive continual in-service training which includes refreshers on handling stressful calls and suicidal callers one to two times per year. MCPD staff report that in the past, ECC staff frequently participated in CIT training. However, due to ECC staffing constraints, ECC staff have been unable to participate in recent CIT trainings.

MCFRS. EMTs and paramedics receive a minimum amount of formal training regarding behavioral health issues. Initial training for EMTs includes about 2-3 hours on behavioral health and substance abuse issues (training on medical issues such as overdoses is separate to this) out of 160 total training hours. During their clinical rotations, paramedics receive some additional training and observe behavioral health issues. EMS clinicians must also complete continuing education: EMTs receive 24

¹² Advanced CIT training is in-service training that reviews and expands on the core competencies of the 40-hour CIT training.. CIT International, Inc. recommends that departments offer it every two years at a minimum and ideally annually. See “Advanced/In-Service Training,” CIT International, May 2019, https://www.citinternational.org/resources/Documents/CIT%20In-service_Final%20Report.pdf, accessed 1/28/2021.

hours of training every three years and paramedics receive 60 hours of training every two years. This training can include topical issues (such as opioids), which may include behavioral health issues.

MCSO. Entry-level training for MCSO deputies complies with MPTSC requirements and covers the factors to consider when handling individuals with mental illness, the circumstances when involuntary treatment is appropriate and the process for initiating involuntary treatment (through a petition for emergency evaluation). Additionally, all MCSO personnel must receive a refresher training, at least annually, on mental illness, appropriate responses and the processes for emergency petitions for evaluations.¹³ Furthermore, all deputies assigned to the Domestic Violence section must complete the 40-hour CIT training offered by MCPD.

D. Public Safety Response Process for Mental Health Situations

Public safety responses to mental health situations include the initial call intake and dispatch, which occurs at the ECC, followed by police and/or MCFRS personnel response. Public safety personnel may also receive assistance from DHHS's mobile crisis team and/or the Montgomery County Crisis Center, described above. Furthermore, MCSO responds to court-ordered petitions for emergency evaluations.

Call Intake and Dispatch. When a call comes into 911 Emergency Communications Center (ECC), a Public Safety Emergency Communications Specialist (PSECS) answers the call. The PSECS requests the caller's name, address and phone number, along with the nature of the incident as described by the caller. Once the nature of incident is determined, the PSECS enters the information, as appropriate, into one of three protocols:¹⁴

- Emergency Fire Dispatch – allows emergency dispatchers to handle a wide range of cataclysmic events;
- Emergency Medical Dispatch - standard for emergency dispatchers taking calls for a broad range of field and triage responses; or
- Emergency Police Dispatch - gathers essential information, including descriptions of people, vehicles, and weapons involved to send appropriate response.

All calls either get some type of dispatch (see below) or a referral for further services is provided. ECC staff report that responses to mental health situations can fall into the following categories:

- Police only response (MCPD);
- Medical only response (MCFRS - ambulance, engine, etc. depending upon nature of incident); or
- Police and medical response.

¹³ Mental Disorders, Montgomery County Sheriff's Office General Operational Procedures, No. 3.13, Effective 10/22/2020.

¹⁴ Definitions from International Academies of Emergency Dispatch - <https://www.emergencydispatch.org/home>.

The ECC dispatches police to any mental health situation considered to be dangerous. Staff report that they dispatch police resources rather than not based on how the caller describes the nature of the incident. If the caller asks for police or emergency medical services, they will be dispatched.

It is important to note that the call information about the incident may not be accurate and situations have the potential to evolve quickly. Responders may not know it is a mental health situation until they arrive and then must act accordingly. Responders must have situational awareness - the ability to identify, process, and comprehend the critical elements of information about what is happening at any given incident.

MCPD Response. When police are dispatched to respond to a mental health situation, the nature of the response depends on whether the individual has been accused of a crime, the nature of any alleged criminal offenses, as well as whether the individual presents a danger to self or others. Responses by police may include:

- **“Contact only”:** officers provide the individual and/or the individual’s family with information about community resources for meeting the individual’s behavioral health needs;
- **Referrals/voluntary transport to facilities:** officers can provide voluntary referrals and/or transportation to facilities such as shelters or the Crisis Center (see pages 24-25);
- **Referral of minors to DHHS:** Police can refer minors, who are being charged with a misdemeanor offense and are first-time offenders, for screening in the Juvenile Justice Services program of DHHS. This program is a voluntary alternative to formal juvenile justice system involvement through the Maryland Department of Juvenile Services (DJS). DHHS conducts behavioral health assessments and drug screenings, followed by treatment recommendations for referred youth who meet program eligibility requirements.
- **Petition for emergency evaluation:** officers may determine that the individual meets the criteria for petition for emergency evaluation (see page 30) and transport the individual to the nearest emergency department. Officers may also be dispatched to serve petitions initiated by Crisis Center staff, health professionals and private individuals if Sheriff’s deputies are not available (see pages 39-40);
- **Arrest:** if the alleged criminal offense is serious, or if the individual is accused of a minor criminal offense and the officer determines that the individual is not mentally ill, the officer will process the individual into the criminal justice system.

For complicated mental health situations, officers that respond may request assistance through the ECC from the dedicated Crisis Intervention Team and/or the DHHS Mobile Crisis Team (see pages 24-25). The Crisis Intervention Team responds as a co-responder team, meaning that it includes the team’s clinician as well as a uniformed officer. This team also responds to mental health situations on request from mental health and other service providers as well as to situations that occur while they are in the vicinity (“on-view” responses).

MCPD Function Code No. 921 and its appendices describe procedures for pre-booking diversions from the criminal justice system for individuals experiencing mental health situations and for petitions for emergency evaluations. The current version of the document was approved in 2005 and includes some information that is out of date. For example, the policy states that officers responding to mental health situations must complete form MCP 922 to document the response. However, staff report that this form is not currently being used. MCPD staff submitted a revised draft of the policy in 2018 to the MCPD Policy and Planning Section, but it has not yet been approved. The sections below describe procedures as described in the current version of the policy with updates as reported by staff.

Pre-booking diversion from the criminal justice system. If an officer determines that an individual accused of a non-violent, minor crime suffers from mental illness, the officer must transport the individual to the Central Processing Unit (CPU), which is the Department of Corrections and Rehabilitation (DOCR) facility used to process arrested offenders. DHHS staff from the Crisis Center meet the individual at the CPU to conduct an assessment to determine if the individual qualifies for diversion from the criminal justice system. However, between the hours of 9:00 pm and 8:00 am,¹⁵ officers must transport the individual directly to the Crisis Center for assessment.

Petitions for emergency evaluations. If the officer determines that the individual presents a danger to themselves or others, the officer must transport the individual to the nearest emergency facility (a hospital emergency department). At the hospital, the officer must complete a Petition for Emergency Evaluation and a Peace Officer Certification and provide the forms to the hospital emergency physician. The officer must also provide hospital staff with pertinent information about the individual, including the individual's identity and location of relatives.

Function Code 921 gives officers discretion as to the types of restraints they may use when transporting individuals for emergency evaluation. Restraints may include handcuffs, leather restraints, ankle cuffs, and waist chains. In cases where the officer deems that the individual is "aggressive," the policy directs officers to request an ambulance via the ECC and assist MCFRS personnel in applying restraints as appropriate. One officer must ride inside the ambulance and another officer must follow the ambulance in a police vehicle.

In accordance with State law, hospital staff may request that the officer remain at the hospital if the individual is violent. As noted on page 30, the hospital must evaluate the individual within six hours. If the physician does not certify the individual for admission to a state psychiatric hospital, the hospital must release the individual within 30 hours of the individual's arrival at the hospital. MCPD provides transportation to released individuals back to the location where they were taken into custody. However, if the individual is certified for admission to a state psychiatric hospital, a private ambulance

¹⁵ The hours during which officers must transport individuals to the Crisis Center for pre-booking diversion assessment were increased due to the COVID-19 pandemic. Previously and as stated in Function Code 921, officers transported individuals directly to the Crisis Center between midnight and 8:00am.

company contracted by the County provides transport. MCPD does not transport patients to other facilities following the evaluation.¹⁶

MCFRS Response. When responding alongside MCPD, MCFRS personnel take the lead when the issue presents as primarily medical in nature. If the situation is potentially dangerous, then law enforcement takes the lead.

The MCFRS Operation Doctrine Statement (ODS) provides overall guidance for fire/rescue incidents of all complexities. All operations have the same incident priorities: life safety, incident stabilization, and property conservation. The goal is to address all of these priorities simultaneously unless it is not possible and then addressed in following order: life safety, incident stabilization, and property conservation.

Behavioral Health Response. When responding to medical emergencies, MCFRS is guided by the Maryland Medical Protocols for Emergency Medical Services.¹⁷ There are protocols for treating behavioral health emergencies. First, when arriving on a scene, responders follow the following protocols:

- Consider Body Substance Isolation (BSI);¹⁸
- Consider Personal Protective Equipment (PPE);
- Evaluate the scene safety;
- Determine the number of patients; and
- Consider the need for additional resources.

The responders then assess the mental status of persons involved including the level of alertness. If MCFRS arrives at a scene and determines that there is a mental health situation, and that the patient is alert, and competent to make decisions, allowable treatments are dependent upon the level of patient consent (or proxy). If there is no consent given and the police are not present, and MCFRS believe that the patient may need further treatment and may be a danger to themselves or others, MCFRS will call the police.

For behavioral emergencies, responders should recognize critical incident stress as a state of emotional distress that does not necessarily pose a threat to oneself or others. Before the use of medications or other more invasive treatments, responders are to implement the SAFER model:

¹⁶ Emergency Evaluation of Mentally Disordered Individuals, Function Code No. 921, Montgomery County Police Department, 6/10/2005.

¹⁷ Maryland Medical Protocols for Emergency Medical Services. Maryland Institute for Emergency Medical Services Systems Effective August 1, 2020. http://www.miemss.org/home/Portals/0/Docs/Guidelines_Protocols/MD-Medical-Protocols-2020-20200914.pdf?ver=2020-09-15-084650-297

¹⁸ BSI is a practice of isolating all body substances (blood, urine, feces, tears, etc.) of individuals undergoing medical treatment, particularly emergency medical treatment of those who might be infected with illnesses such as HIV, or hepatitis so as to reduce as much as possible the chances of transmitting these illnesses.

- Stabilize the situation by containing and lowering the stimuli.
- Assess and acknowledge the crisis.
- Facilitate the identification and activation of resources (chaplain, family, friends, or police).
- Encourage patient to use resources and take actions in their best interest.
- Recovery or referral—leave patient in care of responsible person or professional or transport to appropriate facility.

The Doctrine also states that the responders should not be placed in any physical jeopardy or assume any law enforcement functions, especially when weapons and/or acts of violence are involved and law enforcement should be requested on all calls involving potentially violent patients.

MCFRS paramedics have the training and are equipped to administer certain medications to treat patients who are moderately to severely agitated. For example, paramedics can use Haldol to calm patients who may be moderately agitated, or Ketamine to calm and treat patients who are severely agitated and present a danger to themselves or others.

MCFRS have also put in place a mechanism for follow-up on certain incidents. On MCFRS reports, there is a box that can be checked if follow-up is required. If this box is checked, MCFRS will follow up with the patient. MCFRS will also sometimes offer patients references to other existing resources or pass the patient on to other existing resources.

MCSO Response. MCSO deputies in the Domestic Violence Section are responsible for the service of several types of court orders and related process, including petitions for emergency evaluations (or EEPs – emergency evaluation petitions) as well as domestic violence protective orders, peace orders and extreme risk protective orders. The Domestic Violence Section serves approximately 11,000 orders per year, approximately 500 of which were petitions for emergency evaluation in FY20 (see page 55). Because of their urgency, MCSO assigns petitions for emergency evaluations a high level of priority.

In addition to serving EEPs filed by qualifying health professionals or private individuals, MCSO deputies also initiate a few on-view EEPs per year in the course of their duties. Private individuals must present petitions for emergency evaluations to a judge of the District or Circuit Courts, or a District Court Commissioner if the courts are closed. MCSO cannot serve a petition from a private individual unless a judge signs it.

When MCSO receives an EEP, the first step is for the petitioner to meet with Domestic Violence Section staff at the Family Justice Center (or at their location if the EEP is received outside of business hours) for a safety interview to ensure deputies have the necessary information to serve the EEP safely. MCSO also works closely with other agencies, including MCPD patrol officers as well as the Crisis Intervention Team Program, to obtain relevant information about individuals that are familiar to MCPD. In addition, the Shift Sergeant on duty is responsible for reviewing the order to ensure all required items have been completed.

A minimum of two deputies must be assigned to serve an EEP, though MCSO staff report that they often send at least three and often more. If possible, at least one deputy should be of the same sex as the individual being evaluated. Deputies may forcibly enter the premises only if they have probable cause to believe that the individual is on the premises. If MCSO deputies are not available to serve the EEP, MCPD officers can serve the petition if a delay would be dangerous.

If the individual being petitioned becomes combative, deputies are trained to respond with a proper level of force, with the aim of preventing injuries. Deputies must search, restrain and transport individuals to the nearest emergency facility (a hospital emergency department) in accordance with MCSO procedures for the custody and transport of prisoners. If deputies determine that the individual cannot be safely transported in an MCSO vehicle, they must request assistance from MCFRS.

Once at the hospital, staff report that it typically takes 15-20 minutes to transfer custody of the individual to the hospital. However, in some cases deputies must remain onsite on request from hospital staff if the individual is violent. Unless a deputy is the petitioner, or the individual is an inmate of the Department of Corrections and Rehabilitation (DOCR), deputies do not provide transportation to the individual following release from the hospital. Deputies do not provide transport to other medical or psychiatric facilities.¹⁹

E. Staff Observations on Mental Health Situation Response Resources and Procedures

OLO spoke with department and agency staffs about resources and capacity for responses to mental health situations, focusing on public safety responses. Staff report that Montgomery County has significant public safety resources for crisis response. These include MCPD's long-standing CIT program as well as effective collaborations between MCPD, MCFRS, DHHS and MCSO. DHHS staff report that some MCPD officers are as skilled as clinicians for mental health crisis response. MCSO staff report that deputies in the Domestic Violence section are able to serve petitions for emergency evaluations safely and effectively because of the CIT training they receive through MCPD and because the deputies that serve petitions do so on a regular basis.

Staff identified two major challenges regarding mental health situation responses. First, MCPD and DHHS staff have limited options for addressing the needs of individuals experiencing mental health situations for individuals that refuse treatment. In some cases, staff have concluded that arresting an individual for a minor crime is the best method for compelling the person to receive treatment. Staff cited the lack of an outpatient civil commitment law in Maryland (outpatient civil commitment allows for court-ordered outpatient mental health treatment) as a key barrier.

Second, a significant need exists for alternative short- and intermediate-term resources for patients in mental health and substance use crises other than hospital emergency departments (EDs). The Montgomery County Crisis Center's four-bed capacity is too limited to offer a viable alternative for

¹⁹ Mental Disorders, Montgomery County Sheriff's Office General Operational Procedures, No. 3.13, Effective 10/22/2020.

most patients. EDs are poor environments for caring for individuals experiencing mental health crises, and hospitals in the County lack sufficient inpatient psychiatric beds to meet the demand. As a result, individuals in crisis must remain or “board” for extended periods of time in the ED, which must often assign a dedicated staff member to that individual. This detracts from the resources and space that an ED can make available for the treatment of patients suffering from other emergencies.

EDs also only board mental health patients that are a danger to themselves or others; this often leads to a revolving door situation whereby public safety personnel bring moderately ill patients to the ED on an almost daily basis, only to see the patient discharged back to the street within a couple of hours. Under these circumstances, patients often do not receive adequate treatment.

Staff also emphasized that mental health situations are often complex and may involve or be confused with other issues such as intimate partner violence, human trafficking, intellectual and developmental disabilities (I/DD), co-occurring substance use disorders, and homelessness and may require a multi-faceted response. Staff also noted the following additional opportunities for improvement:

- Further collaboration among County departments and crisis service providers would be beneficial;
- The County would benefit from a more fully resourced hotline/call center for mental health support and crisis intervention services.
- Public Safety personnel could benefit from more intensive training in behavioral health evaluation techniques such as Motivational Interviewing

Chapter 3. Data on Responses to Mental Health Situations

Montgomery County Government and its partners receive thousands of calls every year regarding persons experiencing mental health situations. This chapter summarizes data on calls received by the Montgomery County Crisis Center, Montgomery County Hotline operated by EveryMind, MC311, and Maryland 211. This chapter also examines incidents reported to the Emergency Communications Center and data on public safety responses to mental health situations. It is organized as follows:

- **Section A** summarizes data from the Montgomery County Crisis Center, EveryMind, MC311, and Maryland 211 on requests for assistance with mental health situations; and
- **Section B** describes data on public safety responses to mental health situations dispatched by the Emergency Communications Center.

This chapter compiles information about a variety of different types of mental health situations, from emergencies to requests for information. It is not possible to know the specific nature of every situation to which the County or its partners responded. Furthermore, it not possible to know which situations not categorized as mental health-related may have involved mental health components – this chapter discusses data on situations specifically categorized as mental health or involving mental health services. It is also important to note that data on the demographics of persons served, including the race, ethnicity and gender, is extremely limited.

Finally, co-occurring mental illness and substance use disorders are common, and crisis care providers often address both mental health and substance use concerns. OLO could not distinguish between mental health and substance use calls in some cases, so the data include both where indicated. The focus of OLO’s analysis of public safety responses is on mental health situations specifically.

A. Requests for Non-Public Safety Assistance With Mental Health Situations

As noted in Chapter 2, Montgomery County residents have several non-public safety options for seeking assistance during mental health situations: the Montgomery County Crisis Center, the Montgomery County Hotline operated by EveryMind, MC311, and Maryland 211. These data show that in recent years on average:

- The Montgomery County Crisis Center received 104 calls per day as well as 15 walk-ins per day,
- The Mobile Crisis Outreach Team program responded to 40 incidents per month;
- MC311 referred just under 3 calls per day to DHHS Behavioral Health and Crisis Services programs, about half of which were for the Crisis Center;
- The Montgomery County Hotline received an average of 44 calls and answered 9 texts or chats per day; and
- Maryland 211 received 25 mental health or substance use-related calls per day from Montgomery County.

1. The Montgomery County Crisis Center and Mobile Crisis Outreach Team

The table below summarizes data provided by DHHS staff on calls to the Montgomery County Crisis Center's 24/7 hotline, crisis services provided on a walk-in basis, and incidents to which the Mobile Crisis Outreach Team responded. The Crisis Center's hotline received between 37,000 and 39,000 calls per year between FY18 and FY20, or an average of 104 calls per day. The Crisis Center also received between 5,000 and 6,000 walk-ins per year, an average of 15 per day. The Mobile Crisis Outreach Team responded to about 400 to 500 incidents per year, or an average of 40 incidents per month. Slightly over a third - 35% - of Mobile Crisis Outreach Team incidents resulted in involuntary hospitalization through a petition for emergency evaluation.

Montgomery County Crisis Center Services, FY18-FY20

Service	FY18	FY19	FY20
24/7 Hotline Calls	38,951	36,889	37,761
Walk-ins	5,902	6,030	4,669
Mobile Crisis Outreach Team Incidents	527	514	397

DHHS also provided demographic data on persons served by the Mobile Crisis Outreach Team in FY20. These data show that Black individuals were overrepresented among persons served by the MCOT and Asian and Latinx individuals were underrepresented, relative to their population percentages. These disparities are consistent with research on national mental health disparities by race and ethnicity.

Race, Ethnicity and Gender of Persons Served by the Mobile Crisis Outreach Team in FY20

Group	Persons Served		Population
	#	%	
Race or Ethnicity			
White	178	46%	43%
Black	144	37%	19%
Asian	35	9%	15%
Latinx	28	7%	20%
Other			4%
Gender			
Female	209	53%	52%
Male	184	47%	48%

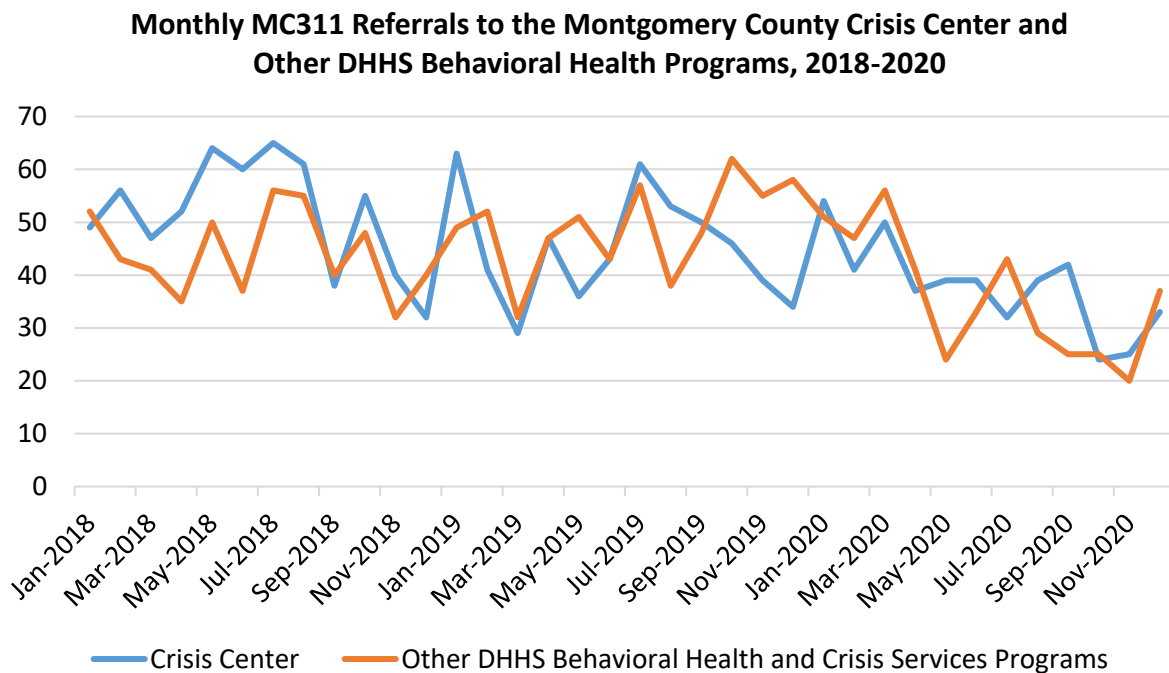
Sources: DHHS and American Community Survey 2019, 1-Year Estimates

2. MC311

As noted in Chapter 2, MC311 Customer Service Representatives (CSR) follow different procedures when assisting callers reporting mental health situations, depending on the urgency and nature of the situation. For urgent mental health situations, CSRs may refer or transfer the caller to the Emergency Communications Center (ECC) via 911, or refer or transfer the caller to the Crisis Center. For other types of mental health situations, CSRs may refer callers to the Montgomery County Hotline or to the

relevant DHHS program, such as the Mental Health/Substance Abuse Screening and Referral program (known as Access to Behavioral Health).

Between January of 2018 and December of 2020, MC311 referred an average of 577 callers per month to the ECC. There is no way to know how many were mental health-related as none of these calls categorized as specifically mental health-related. MC311 also referred 38 calls during the three-year period to the Montgomery County Hotline operated by EveryMind. Finally, during the three-year period MC311 referred 3,168 calls, or an average of 88 per month, to DHHS Behavioral Health and Crisis Services programs, of which just over half were for the Crisis Center. The chart below shows that these referrals declined between January and December of 2020.



As noted in Chapter 2, MC311 Customer Service Representatives can either execute a “warm transfer” of a caller to the Crisis Center, or they provide the caller with the Crisis Center phone number. MC311 provided OLO with data for warm transfers to the Crisis Center between July of 2019 and August of 2020. During this time, MC311 conducted 382 warm transfers to the Crisis Center, which represents 62% of all Crisis Center referrals from MC311.

3. EveryMind Montgomery County Hotline

EveryMind staff provided OLO with the data below on calls, texts and chats to the Montgomery County Hotline from FY18 to FY20, which shows that the Montgomery County Hotline received between 15,000 and 18,000 calls per year, or an average of 44 per day. Calls increased by 16% from FY18 to FY20. Additionally, the Montgomery County Hotline answered between 1,600 and 5,200 texts or chats annually during this period, or an average of 9 per day. Texts/chats answered increased significantly during this period, from 4 per day on average in FY18 to 14 per day in FY20.

Montgomery County Hotline Calls, Texts and Chats and 911 Referrals, FY18-FY20

	FY18	FY19	FY20
Calls			
# of Calls Answered by the Montgomery County Hotline	15,504	15,162	17,991
# of Referrals to 911	139	243	357
Texts/Chats			
# of Texts/Chats Answered	1,590	2,643	5,231
# of Text/Chat Referrals to 911	69	144	231

4. Maryland 211

Maryland 211 staff provided OLO with detailed call data from Montgomery County from June 2018 through September 2020. During this 28-month period, a total of 39,458 calls placed to Maryland 211 from individuals in Montgomery County. Of those, 21,272 calls were for mental health and substance use disorder services (the category in which crisis intervention falls), by far the largest category and accounting for 25 calls per day. In FY20, Montgomery County accounted for 6% of Maryland 211's call volume overall, but 23% of all mental health and substance use-related calls.

Of the mental health and substance use disorder services calls from Montgomery County, about three-quarters of them were for talklines/warmlines. Crisis intervention calls during that period accounted for about 17% of all calls each year. The following table below shows that mental and substance use disorder calls, including crisis intervention calls, increased during the 28-month period.

Mental Health and Substance Use Disorder-Related Calls to Maryland 211 from Montgomery County, July 2019 – September 2020

	FY19		FY20		FY21 (through Sept. 30)	
Total Calls	7,939		10,734		2,599	
Type	#	%	#	%	#	%
Crisis Intervention	1,389	17%	1,829	17%	540	21%
Talklines/Warmlines	6,063	76%	8,390	78%	1,912	74%
All Others	487	6%	515	5%	147	6%

The following table summarizes the types of crisis intervention calls from Montgomery County. Most crisis intervention calls, a bit more than half each year, were for suicide prevention, followed by another third each year of general crisis intervention services. Of note, domestic violence calls tripled from FY19 to FY20 and are on track to increase again in FY21.

Crisis Intervention Calls to Maryland 211 from Montgomery County, July 2019 – September 2020

	FY19		FY20		FY21 (through Sept. 30)	
Total Calls	1,389		1,829		540	
Type	#	%	#	%	#	%
Suicide Prevention	770	55%	972	53%	273	51%
General Crisis Intervention Services	457	33%	659	36%	208	39%
Domestic Violence Hotlines	27	2%	94	5%	38	7%
Psychiatric Mobile Response Teams	70	5%	55	3%	11	2%
Other	65	5%	49	3%	10	2%

B. Data on Public Safety Responses to Mental Health Situations Dispatched by the Emergency Communications Center

Public safety departments collect data on responses to mental health situations in several ways. The most comprehensive source of data on these responses is the County's Computer-Aided Dispatch (CAD) system. Each time that Emergency Communications Center (ECC) receives a call from a resident or report from public safety personnel of an incident in the community, the County's Computer-Aided Dispatch system (CAD) generates an electronic record of the incident.

Incidents captured in the CAD include calls to 911 and the Police non-emergency number, requests from other agencies, and self-dispatches by public safety personnel to incidents in the community. Furthermore, they include responses by law enforcement and fire and rescue organizations in the County, including MCPD, MCFRS, the Montgomery County Sheriff's Office, municipal police departments, M-NCPPC Park Police, Maryland State Police, and local fire and rescue corporations. In addition to the CAD, public safety organizations track the following data on mental health situation responses:

- MCPD Use of Force reports, which record uses of force by MCPD officers and note if mental illness is suspected;
- Patient Care Reports completed by MCFRS for all EMS responses; and
- MCPD's Records Management System (E-Justice), which MCPD officers use to generate detailed incident reports where law and policy requires them, including some mental health situations.

In order to respond to the Council's request to analyze 911 data on public safety responses to mental health situations, this section summarizes data from the CAD on responses to incidents classified in the system as mental health situations. The County's current CAD system was acquired in 2017. MCPD provided OLO with data from the CAD for incidents between September 1, 2017 and May 31, 2020. This section also includes figures from MCPD's most recent Use of Force Annual Report, public data from E-Justice, and MCFRS Patient Care Reports. In summary, the data reveal:

- Public safety personnel respond to mental health situations numerous times each day;
- Responses to mental health situations, especially emergency petitions for evaluation, require significantly more time from public safety personnel than the average response to a 911 call; and
- One third of police responses to mental health situations result in involuntary hospitalization through emergency petitions for evaluation;
- Black individuals are overrepresented among persons subject to involuntary hospitalization through petitions for emergency evaluation; and
- Mental illness was suspected to be a contributing factor in 30% of all uses of force by MCPD.

Limitations of Available Data on Public Safety Responses to Mental Health Situations

This chapter describes numbers of public safety responses to mental health situations, the time spent by public safety personnel on the responses and the types of incidents ultimately classified as mental health situations by police. However, the following information is not available in the data analyzed by OLO:

- Demographics of callers or persons involved in incidents including race, ethnicity, gender or age, except for incidents involving petitions for emergency evaluations;
- Incidents classified as other types of situations, but that involved a person with mental illness;
- Whether violence or threats of violence occurred during incidents classified as mental health situations;
- Whether mental health situations had associated medical components and their level of severity;
- The numbers of responses where the situation was resolved on scene or resulted in voluntary transport to treatment;
- The issuance of citations during responses to mental health situations;
- The share of responses to mental health situations that received a response from CIT-trained officers;
- Uses of force or injuries during incidents involving CIT-trained officers versus incidents where responding officers were not CIT-trained;
- Uses of restraints when transporting individuals experiencing mental health crises;
- The number of responses involving individuals with repeated contacts with police.

E-Justice, the County's records management system used to generate incident reports, contains additional data on some mental health situation responses, including demographic data such as the race, ethnicity and gender of persons involved in incidents as well as the use of restraints. Incident reports are not required for every mental health situation response, and about 60% of mental health situation responses reviewed by OLO did not have an associated E-Justice incident report.

1. Police Responses

This section describes police¹ responses to mental health situations based primarily on data from the CAD. To quantify as accurately as possible the number of mental health situations to which police responded, OLO used the disposition codes assigned to incidents by responding officer. OLO also analyzed information on the nature of the incident as initially reported by the caller to determine which types of calls generated mental health situation-related dispositions. It is not possible to identify every incident involving a person with mental illness or involving mental health components. Some caveats to OLO's analysis include:

- The accuracy of officers' classifications of incidents as mental health situations (or not mental health situations) cannot be confirmed;
- Incidents correctly assigned to non-mental health dispositions may nonetheless have involved mental health components;
- Persons with mental illness may also have other issues and concerns that generate calls for service.
- When a person is accused of a serious crime that has occurred, responding officers assign the disposition code for the crime, regardless of the person's mental health status.

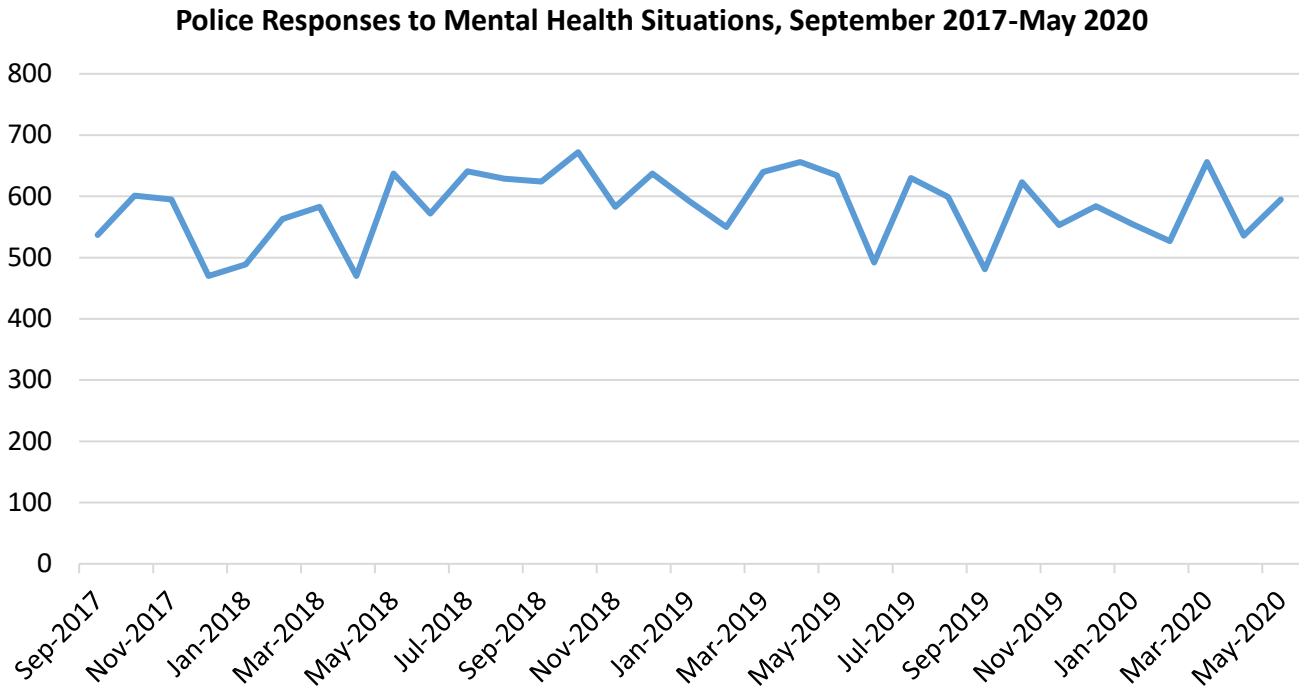
Mental Health Situation Trends and Call Types. Between September 2017 and May 2020, the ECC dispatched police to approximately 840,000 incidents, of which police classified 19,205 (2.3%) as mental health situations. Specifically, police assigned the following dispositions to these incidents:²

- Mental illness;
- Suicide;
- Attempted suicide; or
- Petition for emergency evaluation.

These incidents represent an average of 582 mental health situations per month and 19 per day. The vast majority of these incidents (96%) were classified simply as mental illness. Staff report that this disposition category can include any type of response to a mental health situation, from "contact only" (meaning providing information and referrals to services), to filing a petition for emergency evaluation and transporting the individual to the hospital. As shown in the following chart, the number of incidents varied by month, but the CAD data do not show a clear upward or downward trend over time.

¹ CAD data described in this section may include responses by any law enforcement department in Montgomery County including MCPD, the Montgomery County Sheriff's Office, as well as municipal police departments, M-NCPPC Park Police and Maryland State Police.

² Page 30 describes the process in Maryland for filing petitions for emergency evaluation. Staff report that if a police officer initiates a petition for emergency evaluation and transports the individual to the hospital for evaluation, that incident should be categorized under the "mental illness" disposition category. However, if police serve a petition filed by another person, that should be coded as a "petition for emergency evaluation" in the CAD.



The following chart shows incidents with mental-health related dispositions by the source of the call. Of the 19,205 incidents assigned a mental-health related disposition, three quarters were reported through 911. About 1 in 6 incidents were reported via the Police non-emergency number, and the remainder were reported by police in the field via radio or mobile data computers.

Source of Police-Dispatched Incidents With Mental Health Situation-Related Dispositions, September 2017-May 2020



A variety of different types of call types were ultimately assessed by police to be mental health situations. The following table shows the 14 call types that generated mental health situation-related dispositions at least 5 times per month on average. It shows that calls regarding mental disorders or suicidal persons/attempted suicide generated the most mental health-situation related dispositions. However, a variety of other call types ranging from domestic disputes to assaults and burglaries also generated numerous mental health-related dispositions per month.

Call Types that Resulted in a Mental Health Situation-Related Disposition, September 2017-May 2020

Nature of Incident Based on Call Information	Average Total Monthly Dispatched Incidents	Monthly Mental Health Situation Dispositions	% Mental Health
Mental Disorder	285	142	49.8%
Suicidal Person/Attempted Suicide	190	111	58.6%
Check Welfare	774	56	7.2%
Domestic Dispute/Disturbance/Violence	1,106	42	3.8%
Assist Other Agency	227	41	17.8%
Suspicious Circumstance/Persons/Vehicle	1,635	37	2.2%
Emergency Petition Service*	39	21	53.7%
Assault	499	17	3.4%
Disturbance/Nuisance	1,109	17	1.5%
Harassment/Stalking/Threats	295	12	3.9%
Burglary	257	11	4.4%
Missing/Runaway/Found Person	261	10	3.7%
Theft/Larceny	1,558	9	0.6%
Trespassing/Unwanted	524	5	1.0%

* About 40% of calls to the ECC for emergency petition service were assigned a disposition of "Sheriff" which indicates that MCSO served the petition

Initial Call Description vs. Final Call Disposition

Of the incidents where the caller described the incident as involving a "mental disorder" or a "suicidal person/attempted suicide", about half were ultimately assigned non-mental health-related dispositions. In other words, half of the time that an incident was initially reported to the ECC as a mental health situation, responding officer(s) classified it as another type of issue. Other dispositions assigned to these incidents include "Other miscellaneous calls" (11%), "Ill person" (9%), "Suspicious person/vehicle/situation" (7%), "Family trouble" (6%), and "Disorderly conduct" (3%).

The following table displays numbers of incidents classified by police as mental health situations by the election district³ to which police responded. The table shows that District 4, which includes Rockville, had the largest number of mental health situations (as classified by police), relative to its population, followed closely by District 9 (Gaithersburg, Montgomery Village and south Germantown). Of note, the Montgomery County Crisis Center is located in Rockville.

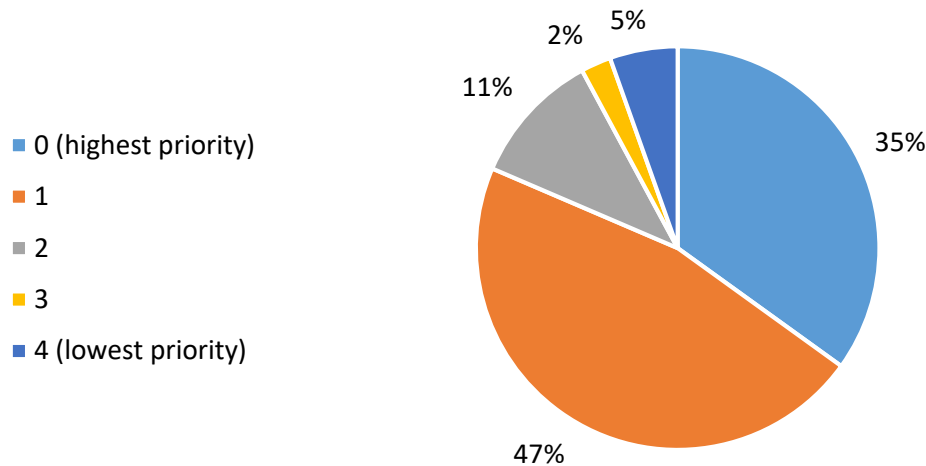
Mental Health Situations by Geographical Area, September 2017-May 2020

Election District	Place	Mental Health Responses		
		Total	Per 10,000 Population	% of Total Incidents
4	Rockville	3,135	243	2.5%
9	Gaith., Mont. Vill. & south Germantown	4,354	237	2.6%
13	Silver Spring & Wheaton-Glenmont	5,357	198	2.2%
2	Clarksburg & north Germantown	1,100	183	2.3%
5	Burtonsville and White Oak	1,939	173	2.3%
6	Darnestown & North Potomac	676	134	3.2%
8	Olney & Brookeville	643	131	2.8%
1	Laytonsville	272	124	1.6%
7	Bethesda, Glen Echo & Somerset	1,104	109	1.7%
12	Damascus	207	105	2.5%
11	Barnesville	22	97	1.4%
3	Poolesville	63	93	2.1%
10	Potomac	301	82	1.7%

³ Election districts are relatively large subdivisions of the County in which polling places are located and to which registered voters are assigned (voters are assigned to a district and a precinct). Montgomery County has 13 election districts (for a detailed map, see the Montgomery County Board of Elections website: <https://www.montgomerycountymd.gov/Elections/Resources/Files/pdfs/maps/UpdateYear/PrecinctswElectionDistricts2018.pdf>).

Mental Health Situation Response Characteristics. The chart below displays the priority level assigned by the ECC to incidents that were ultimately classified by police as mental health situations. About a third of incidents were assigned the highest priority level (0) and almost half were assigned the next highest priority level, 1. About 19% of incidents were assigned priority levels of 2, 3 or 4. Incidents assigned a higher priority level receive a more urgent response than those with lower priority levels.

**Priority Level of Police Dispatches to Mental Health Situations,
September 2017 - May 2020**



Accordingly, response times for mental health situations varied by priority level. Overall, the median response time, or the typical amount of time from dispatch to the first unit's arrival, was 6.5 minutes for mental health situation responses.⁴ The following table shows median response times by priority level. For incidents assigned a priority level of 0, the ECC always dispatches two units.

Median Response Times for Police Dispatches to Mental Health Situations by Dispatch Priority Level⁵

Priority level	Median Response Time (minutes)
0	4.9
1	8.0
2	8.0
3	8.7
4	10.2

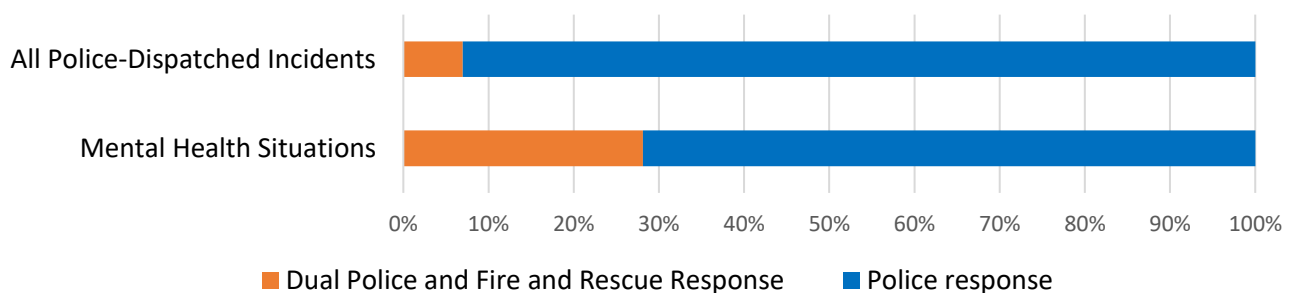
⁴ Median response times are calculated for responses to 911 and police non-emergency calls and do not include incidents reported by police in the field.

⁵ Includes dispatches in response to 911 and police non-emergency calls. Response time refers to the number of minutes from the time the first unit was dispatched until the first unit arrived on the scene.

The data further reveal that the typical police mental health situation response lasted longer than other police responses. On average, police responses to 911 calls, including the time spent by each unit from dispatch to clearance, required 75 minutes of police time, while responses to mental health situations reported via 911 required 154 minutes of police time on average. Mental health situations accounted for about 4% of 911 calls but 8% of police time responding to 911 calls.

In addition, responses to mental health situations were more likely than other types of police responses to also involve a response by Fire and Rescue services. As shown on the chart below, OLO estimates that about 7% of police-dispatched incidents included a dual response by Fire and Rescue personnel, compared with 28% of incidents classified by police as mental health situations.⁶

Police-Dispatched Incidents with Dual Response from Fire and Rescue



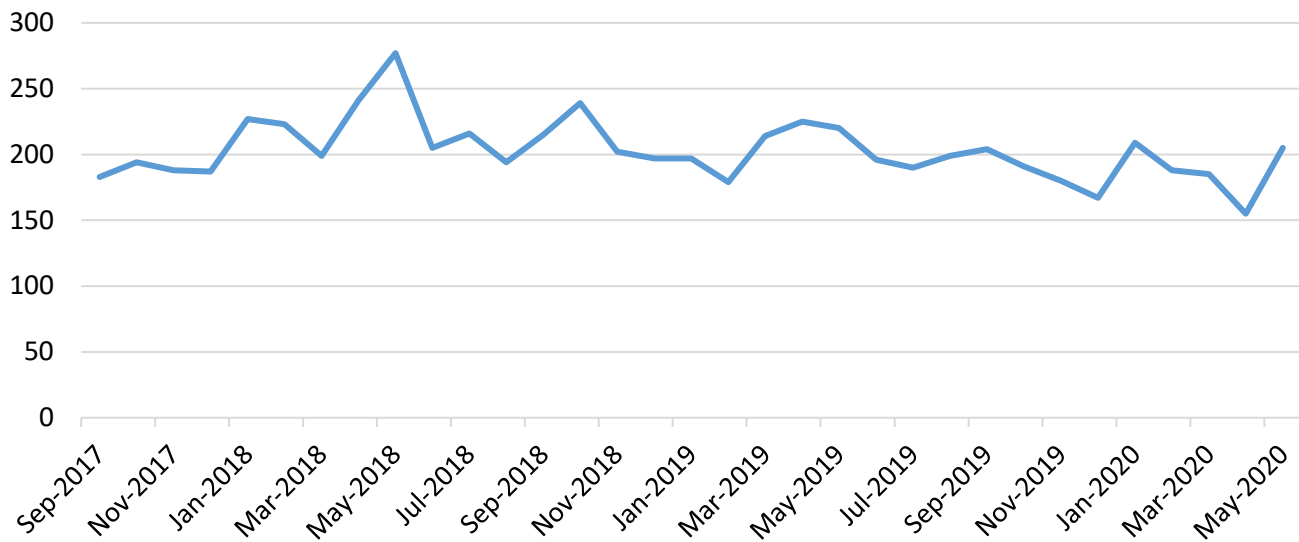
Petitions for Emergency Evaluations. For some mental health situations, police are required to complete an incident report using E-Justice, MCPD’s records management system. These include situations during which police filed or served emergency petitions for evaluation or where a crime was reported, even if no charge was made. In addition, it is optional to write an incident report if police provided voluntary transport to services.

To determine the number of petitions for emergency evaluations filed or served by MCPD, OLO used the Data Montgomery “Crime” dataset, which contains incident report data from E-Justice. These data show that MCPD officers filed or served an average of 202 petitions for emergency evaluation per month, or approximately 7 per day. Then data suggest that about a third of police responses to mental health situations resulted in involuntary hospitalization via a petition for emergency evaluation.⁷ OLO found that these responses required 251 minutes of police time on average, or about 4 hours (including the time spent by each unit from dispatch to clearance).

⁶ OLO identified dual responses by MCFRS by matching MCFRS-dispatched incidents to MCPD-incidents that were dispatched to the same location within an hour of each other. This approach may overestimate dual-dispatched incidents if separate incidents occurred at the same location at the same time, for example at a hospital or other medical facility.

⁷ OLO linked incident reports for petition for emergency evaluation to the associated incident record in the CAD. Approximately 5% of incident reports (or about 10 per month) were associated with CAD incidents with non-mental health disposition codes. These disposition codes may reflect additional aspects of the incident beyond the mental health situation. Additionally, OLO was unable to link another 5% of petition for emergency evaluation records to CAD records.

Monthly Petitions for Emergency Evaluation, September 2017 - May 2020



OLO also found 312 records in the Crime dataset for “mental transports,” or about 9 per month. However, because it is optional for police to complete incident reports for voluntary transports of individuals to mental health services, these data are probably incomplete.

MCPD provided additional data on the race, ethnicity and age of certain respondents of petitions for emergency evaluations, listed in the table below.⁸ These data show that, similar to individuals served by DHHS’s MCOT program, Black individuals were overrepresented among respondents of petitions for emergency evaluation, accounting for 38% of respondents but only 19% of the population. Asian individuals were significantly underrepresented and Latinx individuals were somewhat underrepresented.

Race, Ethnicity and Gender of Respondents of Selected Petitions for Emergency Evaluations

Race/Ethnicity	Gender			Total		Population
	Female	Male	Unknown	#	%	
White	367	472	1	840	42%	43%
Black	307	441		748	38%	19%
Latinx	91	178		269	14%	20%
Asian	38	49		87	4%	15%
Unknown/Other	26	9	1	36	2%	4%
Total	829	1,149	2	1,980	100%	100%

⁸ MCPD identified a total of 6,816 incident reports in E-Justice involving petitions for emergency evaluations, slightly more than the 6,691 identified by OLO in the Data Montgomery Crimes dataset. Of those, MCPD provided demographic data for 1,980 incidents or 29% of the total. The remaining 4,836 reports included offenses such as assaults, disorderly conduct and trespassing, which may have involved other individuals. It is not possible for MCPD to extract the demographic information for the correct individuals in these cases without reviewing each incident report manually.

Petitions for Emergency Evaluation Served by the Montgomery County Sheriff's Office (MCSO)

As noted in Chapter 2, MCSO has primary responsibility for serving petitions for emergency evaluations filed by health professionals or private individuals and reviewed and approved by the court where required. MCSO staff provided OLO with data on petitions served between FY18 and FY20 and noted that petitions for emergency evaluations have increased significantly in recent years. The data show that petitions served by MCSO increased from 439 in FY18 to 496 in FY20, which represents an increase of 13% over two years.

Year	Petitions Served
FY18	439
FY19	485
FY20	496

Arrests and Uses of Force. Disposition code data from the CAD indicate that out of 19,205 police responses to mental health situations between September of 2017 and May of 2020, 38 included an arrest. Additionally, MCPD policy⁹ requires officers to complete a Use of Force Report (MCP 37) for the following types of incidents:

- Any time force is used to counteract a physical struggle.
- Following the use of any force that results in an injury to an individual.
- When an individual claims to have been injured as a result of use of force.
- Whenever force is applied using a protective instrument.
- Whenever a firearm is discharged other than authorized target practice.
- Whenever a department canine inflicts injury on any subject or suspect.
- Any time an officer is assaulted or ambushed.

MCPD's Annual Use of Force Report for 2019 states that officers reported a total of 553 uses of force in 2019. In 167 of those uses of force (30%), mental illness was reported as a suspected contributing factor.¹⁰

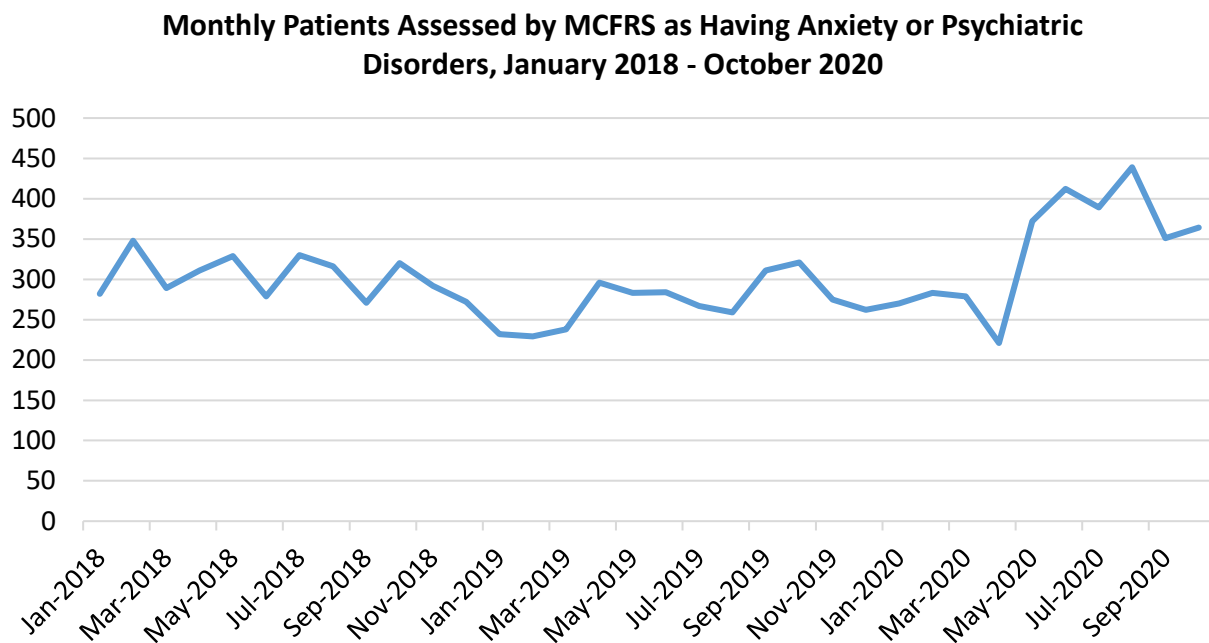
⁹ "Use of Force," FC No. 131, 9/21/2016, Montgomery County Police Department

¹⁰ "Annual Use of Force Report: 2019," Montgomery County Department of Police, https://www.montgomerycountymd.gov/pol/Resources/Files/annual-reports/UseOfForce/2019%20MCPD%20Use%20of%20Force%20Report_FINAL.PDF accessed 1/10/2020.

2. Fire and Rescue Responses

Data on Fire and Rescue responses to mental health situations is less detailed in the CAD than police responses, because the system does not include information on EMS personnel's assessment of whether incidents involved mental health concerns (similar to MCPD disposition codes). As noted above, OLO estimates that Fire and Rescue responded with police to incidents classified by police as mental health situations 28% of the time, or an average of 164 incidents per month between September of 2017 and May of 2020.

OLO identified an additional 916 incidents during this time period, or about 28 per month, which OLO could not link to an MCPD response, that were initially reported to the ECC as mental health situations (using the code "MO", which stands for "Mentally Observant"). These figures do not capture incidents that were not initially reported as mental health situations, but which were assessed as such at the scene. To offer further detail on MCFRS responses to mental health situations, MCFRS provided OLO with aggregate Patient Care Report data, which reports the conditions treated by MCFRS personnel. As shown on the chart on the following page, MCFRS personnel treated between 221 and 439 individuals each month, or about 10 per day, that were experiencing anxiety or psychiatric disorders from January of 2018 to October of 2020.



Source: MCFRS Patient Care Reports

Chapter 4. OLO Findings and Recommendations

This chapter summarizes the findings of this report and presents recommendations developed by the Office of Legislative Oversight (OLO) based on these findings.

A. Findings

Research shows that police responses to mental health situations present significant challenges for police and too often result in poor or tragic outcomes for persons with mental illness. Many communities in the United States lack sufficient mental health crisis care services and instead rely on police for mental health crisis response. As a result, these communities face several challenges:

- Training on mental health situation responses competes with the numerous other mandated and recommended topics for police training;
- Mental health situation responses require more police time than many other types of calls because of the number of officers involved, the distance required for transport, and wait time for a hospital bed;
- Limited hospital capacity for inpatient psychiatric care;
- Criminalization of mental illness resulting in police encounters ending in arrest or transport to the hospital under restraint in marked police cars, causing trauma, stigma and negative effects on treatment outcomes;
- Inadequate mental health services in correctional systems;
- Escalation and use of force - police encounters with persons with mental illness too often end in tragedy; and
- Racial disparities - Black individuals are less likely than White individuals to use mental health services but more likely to use psychiatric emergency services, to be subject to involuntary commitment, and to be admitted for inpatient psychiatric hospitalization.

The remainder of this section summarizes OLO's findings on public safety responses to mental situations, both best practices and in the County, that attempt to combat some of these challenges.

Best Practices

Finding #1. Federal 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.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently developed national guidelines for behavioral health crisis care systems that are based on the Crisis Now model. These guidelines describe the following core elements of crisis care systems:

- A crisis call hub (telephonic crisis intervention);
- Mobile crisis team services (face-to-face interventions to people where they are); and
- Crisis receiving and stabilization services (facility-based crisis care).

Although crisis care systems should seek to minimize law enforcement involvement, SAMHSA identifies collaboration between crisis care systems and law enforcement as an “essential principle” of a crisis care system. SAMHSA guidance recommends that crisis care systems track a variety of metrics to support continuous quality improvement. SAMHSA also offers specific recommended performance metrics for Crisis Intervention Team (CIT) model, the most established model for police-based crisis response. Chapter 1 of this report summarizes SAMHSA’s guidance on performance metrics for crisis response.

Finding #2. Research suggests that police-mental health collaborations and other efforts to improve mental health crisis response can generate positive outcomes, though these are dependent on the local availability of mental health services.

Many communities have implemented strategies, summarized below, for collaboration between police, the mental health system and emergency medical services for mental health crisis response, often in combination with one another. Research indicates that these efforts may have positive outcomes that include reducing arrests and use of force, reducing emergency department visits, and increasing the use of community-based mental health services, but that outcomes often depend on the availability of mental health services in the community.¹

- **Crisis Intervention Team (CIT).** A police-based model, known for its voluntary 40-hour training program, that emphasizes community partnerships and aims to improve officer and consumer safety and divert individuals away from the criminal justice system.
- **Co-Responder Teams.** Pairing mental health professionals with police officers to respond to behavioral health crises.
- **Mobile Crisis Teams.** Mental health teams that provide assessment, intervention, consultation and referrals in the community, sometimes in collaboration with police.

¹ Researchers also note the high prevalence of co-occurring intellectual and developmental disabilities (I/DD) and mental illness, and highlight the lack of research for crisis response models serving individuals with I/DD.

- **Case Management Services.** Follow-up by police or partner organizations for individuals that are in frequent contact with law enforcement and emergency services.
- **Flagging Systems.** Systems that alert officers or emergency communications staff about the health conditions, such as mental illness, of participating individuals.
- **EMS/Ambulance-Based Responses.** Efforts to improve responses by emergency medical services (EMS) to mental health situations, such providing direct transport to psychiatric facilities or including mental health professionals in EMS teams.
- **Law Enforcement Training.** Stand-alone training for law enforcement such as Mental Health First Aid for Public Safety (MHFA-PS) or Integrating Communications, Assessment and Tactics (ICAT).
- **Trained Advocates/Peers.** Trained advocates or peers that provide support to individuals with mental illness when they are arrested or questioned by police.

Finding #3: Case studies of jurisdictions that have implemented different types of police-mental health collaborations reveal several trends in approaches to crisis response.

OLO examined approaches for mental health situation responses in Memphis, Tennessee; Eugene and Springfield, Oregon; Tucson, Arizona; Houston, Texas; Olympia, Washington; and Phoenix, Arizona. The following trends emerged from these case studies:

- Most jurisdictions use more than one approach for mental health responses, including CIT programs, co-responder teams, case management, and/or mobile crisis teams.
- Some jurisdictions divert certain mental health responses, typically for situations not involving crimes, violence or other dangerous elements, away from police and to mobile crisis teams or telephonic crisis intervention;
- Specialized responders such as co-responder teams and non-police mobile crisis teams typically have longer response times than police and provide either secondary responses after the initial police response or respond to less urgent situations;
- Engagement and training of emergency dispatchers is a key component of both police-based crisis response and efforts to divert mental health responses away from police; and
- Jurisdictions that have diverted some mental health responses to non-police mobile crisis teams have found that trust and relationship-building between mobile crisis teams and police departments is critical to the success of these efforts.

Montgomery County**Finding #4. Montgomery County residents have multiple options for seeking non-public safety assistance with mental health situations.**

Residents may seek assistance during mental health situations through a variety of non-public safety resources. These resources can help individuals resolve crises, provide referrals to further services, and connect individuals with public safety services when necessary. The table below summarizes the services these resources provide and the volume of calls or incidents they respond to.

Non-Public Safety Resources for Assistance During Mental Health Situations

Resource	Description	Average Volume
Montgomery County Crisis Center	Provides crisis services in person and by phone 24 hours a day, 7 days a week.	104 calls and 15 walk-ins per day
Mobile Crisis Outreach Team	Responds alongside police to community psychiatric emergencies where the emergency is occurring.*	40 incident responses per month
EveryMind Montgomery County Hotline	Free and confidential service that is available 24 hours a day, 7 days a week by phone, and 7 days a week from 8am to midnight by text.	44 calls and 9 texts/chats per day
Maryland 211	Non-profit organization that provides access to information and resources on health, crisis, and social services available in the State. Callers from Montgomery County are directed to the call center in Prince George's County – there is no call center in Montgomery County.	25 calls per day**
MC311	County's non-emergency call center and web portal for County services and information that provides referrals to mental health and crisis services	About 3 calls per day**

* DHHS is exploring options for having the Mobile Crisis Outreach Team respond without police where appropriate.

**MC311 and Maryland 211 call volumes refer specifically to behavioral health (mental health and substance use) related calls.

Finding #5. The lack of alternatives to hospital emergency departments for short- and intermediate-term care for individuals experiencing mental health crises limits the County's ability to effectively serve this population.

Staff report that hospital emergency departments (EDs), by their nature, are poor environments for caring for individuals experiencing mental health crises, and that hospitals in the County lack sufficient inpatient psychiatric beds to meet the demand. The Montgomery County Crisis Center's four-bed capacity is too limited to offer a viable alternative for most patients. As a result, individuals in crisis must remain or "board" for extended periods of time in the ED, which must often assign a dedicated staff member to that individual. This detracts from the resources and space that an ED can make available for the treatment of patients suffering from other emergencies.

Furthermore, EDs only board mental health patients that are a danger to themselves or others, and discharge other patients after short periods of time, though they may still need care. Under these circumstances, patients often do not receive adequate treatment.

Finding #6. Stakeholders in Montgomery County are currently working to strengthen the County's behavioral health crisis care system.

In July of 2020, Nexus Montgomery submitted a grant proposal to the Maryland Health Services Cost Review Commission (HSCRC) on behalf of Montgomery County hospitals, local government agencies and local nonprofits to fund a "comprehensive and integrated behavioral health crisis structure". The proposal aimed to increase the County's alignment with the Crisis Now model for behavioral health crisis care systems. The proposal included the following elements: a collaborative body to provide direction, increased capacity for the Mobile Crisis Outreach Team (MCOT), a Restoration Center, and call center technology improvements. In October of 2020, the Council received information that HSCRC did not approve the grant proposal. However, stakeholders involved in the proposal continue to work to develop the proposed elements.

Finding #7. Public safety responses to mental health situations in Montgomery County are decentralized and may involve police, emergency medical services, the Montgomery County Sheriff's Office, and/or DHHS staff.

Public safety responses to mental health situations include the initial call intake and dispatch, which occurs at the Emergency Communications Center, followed by police and/or MCFRS emergency medical services (EMS) response. Police respond to most mental health situations, but MCFRS may assist police or respond without police if the situation is not considered dangerous. Furthermore, the Montgomery County Sheriff's Office responds to court-ordered petitions for emergency evaluations.

The Montgomery County Police Department (MCPD)'s six District Stations provide direct patrol services to the public by responding to incidents in the community, including mental health situations. They are typically the first on the scene of a mental health situation. For complicated mental health situations, officers may request assistance from the dedicated MCPD Crisis Intervention Team, from DHHS's Mobile Crisis Outreach Team and/or the Montgomery County Crisis Center.

Finding #8. The MCPD Crisis Intervention Team (CIT) program uses several strategies that are consistent with research-supported practices to promote safe and appropriate law enforcement responses to mental health situations.

The Crisis Intervention Team is MCPD's dedicated mental health response team staffed by two officers and a DHHS clinician. This team uses several strategies supported by research including:

- Coordinating 40-hour CIT training for MCPD and other law enforcement personnel;
- Responding to complicated mental health situations as a co-responder team and providing telephonic assistance for individuals in crisis that have been in contact with police;
- Providing limited outreach and case management for individuals with repeated police contacts; and
- Collaborating with MCPD's Autism/Intellectual, Developmental Disabilities, Alzheimer's/Dementia Outreach Program to effectively serve these populations.

The Crisis Intervention Team also works with other jurisdictions to help them establish and develop CIT programs. MCPD is currently working on expanding this dedicated team and updating its policy for responses to mental health situations. Of note, MCFRS also works with individuals with repeated 911 contacts through its Mobile Integrated Health Program (MIH), which connects these individuals with medical and social programs to help meet their needs.

Finding #9. Training for mental health situation responses varies among County public safety personnel.

As noted above, public safety responses to mental health situations are decentralized among a variety of public safety entities. Training varies among personnel within these different entities, as summarized below.

Training for Mental Health Situation Responses Among Public Safety Entities

Group	Training for Mental Health Situation Response
Emergency Communications Center (ECC) Staff	ECC staff receive training on handling stressful situations, including suicidal callers, as part of their entry-level and in-service training. MCPD staff report that in the past, ECC staff frequently participated in CIT training. However, due to staffing constraints, staff have been unable to participate in recent CIT trainings.
MCPD Police Officers	At the time of writing, approximately 750 out of 1,300 (58%) of officers had completed the 40-hour Crisis Intervention Team (CIT) training program, and all MCPD officers had completed either CIT or an 8-hour Mental Health First Aid (MHFA) course. MCPD also provides 1-2 hours of in-service training on mental health situation responses annually. Police recruit training includes MHFA, and CIT training was recently made mandatory for police recruits.
MCFRS	Initial training for EMTs includes about 2-3 hours on behavioral health and substance abuse issues out of 160 total training hours (training on medical issues such as overdoses is separate to this). During their clinical rotations, paramedics receive some additional training and observe behavioral health issues.
MCSO Deputies	All MCSO deputies receive training on mental health situation responses during entry-level training and through annual in-service training. All deputies assigned to the Domestic Violence section, which serves petitions for emergency evaluations, must complete the 40-hour CIT training.

As noted in the table above, MCPD recently made CIT training mandatory for all police recruits. Of note, the CIT model was originally designed to train officers on a voluntary basis, and research suggests that CIT training may be more effective among individuals that volunteer to participate.

Finding #10. Public safety personnel respond to mental health situations numerous times each day, and these responses take significantly more time than the typical 911 call response. Suspected mental illness is also a key risk factor for uses of force by MCPD officers.

Between September of 2017 and May of 2020, the ECC dispatched police to approximately 840,000 incidents, of which police classified 19,205 (2.3%) as mental health situations. These incidents represent an average of 582 mental health situations per month and 19 per day.

On average, police responses to 911 calls required 75 minutes of police time, while responses to mental health situations reported via 911 required 154 minutes of police time on average, including each responding unit's time from dispatch to clearance.² Mental health situations accounted for about 4% of 911 calls but 8% of police time responding to 911 calls. Responses that resulted in involuntary hospitalizations through petitions for emergency evaluations required 251 minutes of police time on average, or about 4 hours (including the time spent by each unit from dispatch to clearance).

In addition, responses to mental health situations were more likely than other types of police responses to also involve a MCFRS response. OLO estimates that 28% of incidents classified by police as mental health situations included a dual response by MCFRS personnel, compared with 7% of all police-dispatched incidents. MCFRS patient care reports show that MCFRS treated between 221 and 439 individuals each month, or about 10 per day, that were experiencing anxiety or psychiatric disorders from January of 2018 to October of 2020.

Use of Force. MCPD's Annual Use of Force Report for 2019 states that officers reported a total of 553 uses of force in 2019. In 167 of those uses of force (30%), mental illness was reported as a suspected contributing factor.³

Finding #11. About a third of all police responses to mental health situations, and over a third of Mobile Crisis Outreach Team responses, result in involuntary hospitalization.

MCPD officers filed or served an average of 202 petitions for emergency evaluation per month, or approximately 7 per day between September of 2017 and May of 2020. The data suggest that about a third of police responses to mental health situations resulted in involuntary hospitalization via a petition for emergency evaluation. Similarly, slightly over a third - 35% - of Mobile Crisis Outreach Team incidents in FY20 resulted in involuntary hospitalization through a petition for emergency evaluation.

² OLO only included responses to 911 calls, rather than incidents reported in the field or police non-emergency calls, to ensure a fair comparison.

³ "Annual Use of Force Report: 2019," Montgomery County Department of Police, https://www.montgomerycountymd.gov/pol/Resources/Files/annual-reports/UseOfForce/2019%20MCPD%20Use%20of%20Force%20Report_FINAL.PDF accessed 1/10/2020.

Finding #12. Available demographic data on police and DHHS responses to mental health situations reveal significant disparities by race and ethnicity.

Nationally, Black individuals are less likely than White individuals to use mental health services but more likely to use psychiatric emergency services and to be subject to involuntary commitment. In Montgomery County, Black individuals are overrepresented and Asian and Latinx individuals are underrepresented among individuals served by DHHS's Mobile Crisis Outreach Team (MCOT) and among individuals subject to petitions for emergency evaluation (EEPs) by police.

Race and Ethnicity of Individuals Served by the MCOT and Individuals Subject to EEPs

Race/Ethnicity	Served by MCOT	EEP Respondents*	Population
White	46%	42%	43%
Black	37%	38%	19%
Latinx	7%	13%	20%
Asian	9%	4%	15%

* Data reflect the 29% of EEP respondents for which demographic data were provided

Finding #13. Available data on public safety responses to mental health situations in Montgomery County have several limitations.

This report describes numbers of public safety responses to mental health situations, the time spent by personnel on the responses and the types of incidents ultimately classified as mental health situations by police. However, the following information is not available in the data analyzed by OLO:

- Demographics of callers or persons involved in incidents including race, ethnicity, gender or age, apart from incidents involving the MCOT or petitions for emergency evaluations;
- Incidents classified as other types of situations, but that involved a person with mental illness;
- Whether violence or threats of violence occurred during incidents classified as mental health situations;
- Whether mental health situations had associated medical components and their level of severity;
- The numbers of responses where the situation was resolved on scene or resulted in voluntary transport to treatment;
- The issuance of citations during responses to mental health situations;
- The share of mental health situations that received a response from CIT-trained officers;
- Uses of force or injuries during incidents involving CIT-trained officers versus incidents where responding officers were not CIT-trained;
- Uses of restraints when transporting individuals experiencing mental health crises;
- The number of responses involving individuals with repeated contacts with police.

B. Recommendations and Discussion Issues

OLO offers two recommendations and two discussion issues, detailed below, for Council consideration.

Recommendation #1. Request the Executive discuss with Maryland 211 opportunities for collaboration on responding to mental health and substance use crisis calls.

Montgomery County residents may seek assistance during mental health situations through a variety of non-public safety County resources as well as Maryland 211. Maryland 211 receives approximately 25 calls per day from Montgomery County residents regarding mental health and substance use issues, significantly more than the volume of calls to MC311 for these issues. In FY20, Montgomery County accounted for 6% of Maryland 211's call volume overall, but 23% of all mental health and substance use-related calls. Although Montgomery County does not have a 211 Call Center, OLO's interviews indicated that opportunities exist for collaboration between Maryland 211 and Montgomery County. The Council may wish to request that the County Executive discuss these potential opportunities.

Recommendation #2. Request that MCPD track and report key data points on responses to mental health situations and associated uses of force.

OLO found that the MCPD Crisis Intervention Team (CIT) program uses several strategies that are consistent with research-supported practices described above to promote safe and appropriate law enforcement responses to mental health situations. However, available data on program outcomes is limited. OLO recommends that MCPD prioritize tracking and reporting of data points recommended by Federal guidance for CIT programs, including the following:

- CIT training participation by subgroup (e.g. rank, district, bureau, or non-MCPD department);
- Numbers of mental health situation responses both as coded by the ECC at the time of dispatch and by responding officers;
- Numbers of mental health situations responded to by CIT-trained versus non-CIT-trained officers by district;
- Mental health situation responses by outcome including: resolved on scene, voluntary transport to treatment, involuntary transport to treatment, and arrest, with data on race, ethnicity and gender; and
- Use of force and injury rate during mental health calls including lethal and non-lethal uses of force compared with use of force in all calls, including data on race, ethnicity and gender.

Discussion Issue #1. Changes and enhancements to public safety resources, training and procedures for mental health responses.

As noted above, MCPD plans to expand its capacity to provide specialized responses to mental health situations, and is in the process of updating its policy for mental health responses. Additionally, MCPD recently made Crisis Intervention Team (CIT) training mandatory for police recruits, which represents a shift from the traditional CIT model that emphasizes voluntary participation by officers. At the same time, some public safety personnel including ECC staff and MCFRS personnel receive limited training for addressing mental health situations. The Council may wish to discuss with public safety stakeholders:

- The level and type of training for mental health response that is appropriate for police recruits and experienced officers and the resources necessary to provide it;
- Options for enhancing training for ECC and MCFRS personnel on responding to mental health situations;
- Plans for enhancements to MCPD's Crisis Intervention Team program.

Discussion Issue #2. The status of ongoing efforts to reduce reliance on law enforcement for mental health situation responses.

County stakeholders are currently working to strengthen the County's behavioral health crisis care system. Councilmembers may wish to discuss the status of these efforts, including:

- Efforts to increase the County's capacity within each of the three elements of the Crisis Now model (the crisis call hub, the Mobile Crisis Outreach Team Program, and crisis receiving and stabilization services);
- Development of procedures for the Mobile Crisis Outreach Team to respond without police; and
- Efforts to apply a racial equity lens as part of the above efforts.

Chapter 5. Agency Comments

The Office of Legislative Oversight (OLO) shared final drafts of this report with staff from Montgomery County Government and the Montgomery County Sheriff's Office. OLO appreciates the time taken by staff to review the draft report and to provide technical feedback. This final report incorporates technical corrections and feedback from agency staffs.

The written comments received from the Chief Administrative Officer are attached in their entirety beginning on the following page.



OFFICE OF THE COUNTY EXECUTIVE

Marc Elrich
County Executive

Richard S. Madaleno
Chief Administrative Officer

M E M O R A N D U M

March 3, 2021

TO: Chris Cihlar, Director
Office of Legislative Oversight

FROM: Richard S. Madaleno, Chief Administrative Officer

SUBJECT: Draft OLO Report 2021-4: Public Safety Responses to Mental Health Situations

Thank you for the opportunity to comment on the Office of Legislative Oversight's (OLO) Draft Report 2021-4: Public Safety Responses to Mental Health Situations. I commend OLO for this timely, impactful, and forward-looking report that will certainly continue to improve public safety responses to mental health situations.

The draft report included the following recommendations:

Recommendation #1: Request the Executive discuss with Maryland 211 opportunities for collaboration on responding to mental health and substance use crisis calls.

CAO Response: This recommendation is consistent with current efforts to develop a common triage protocol designed to clarify the most appropriate response to a mental health or substance use crisis. This common triage protocol is expected to be developed with the assistance of Crisis Assistance Helping Out on the Streets (CAHOOTS) consultant's clinic that will bring specialized training and consultation across our crisis responders in Montgomery County within the next six months. This effort will involve partners such as the Montgomery County Police Department (MCPD), Montgomery County Fire and Rescue Services (MCFRS), and EveryMind, the local non-profit behavioral health organization which manages the national suicide hotline in Montgomery County.

Additionally, the CAHOOTS consultants will examine the call records from 911, the Crisis Center, 311, and EveryMind call centers and hotlines. These call records will provide detailed information about how each call center or hotline dispatches responders to a behavioral health crisis. The common triage protocol will also provide clarity on instances when the 24/7 Mobile Crisis and Outreach Team (MCOT) at the Department of Health and Human Service's (DHHS) Crisis Center will respond to a behavioral health crisis without a police escort.

Once this common triage protocol is established, it will be appropriate to contact the State's 211 call center and communicate with its staff the triage tool developed for Montgomery County. Discussions will take place with the 211 staff on how best to refine 211 procedures for dispatching calls to the most appropriate partner in Montgomery County, especially calls pertaining to a behavioral health crisis.

Recommendation #2: Request that MCPD track and report key data points on responses to mental health situations and associated uses of force.

CAO Response: Staff at DHHS and the Emergency Communications Center have already begun to discuss data points described in this recommendation and how best to collect these data points from MCPD and MCFRS records, especially records of responses to mental health or substance use crises. CAHOOTS consultants will also provide guidance to MCPD on how best to gather the information from the experience that CAHOOTS has had gathering and reporting similar police data in Eugene, Oregon.

We look forward to discussing these items at the Council session.

c: Fariba Kassiri, Deputy Chief Administrative Officer
Caroline Sturgis, Assistant Chief Administrative Officer
Raymond Crowel, Director, Department of Health and Human Services
Marcus Jones, Chief, Montgomery County Police Department
Scott Goldstein, Chief, Montgomery County Fire and Rescue Services
Gail Roper, Director, Department of Technology Services
Barry Hudson, Director, Office of Public Information