PS&HHS COMMITTEE #1
July 9, 2020

M E M O R A N D U M

July 7, 2020

TO: Public Safety Committee
Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst
Susan Farag, Legislative Analyst

SUBJECT: Special Appropriation to the FY 2021 Operating Budget; Montgomery County Government; Department of Health and Human Services; Mobile Crisis Response; $592,202 (Source of Funds: General Fund Reserves).
Lead Sponsor: County Council

PURPOSE: Worksession; Vote on recommendation expected.

Expected for this Session:
Dr. Raymond Crowel, Director, Department of Health and Human Services
Caroline Sturgis, Assistant Chief Administrative Officer
Dorne Hill, Manager, DHHS Crisis Center
Athena Morrow, Manager, DHHS Adult Forensic Services
Lt. Jennifer McNeal, Deputy Director, 5th District, Montgomery County Police Department (MCPD)
Leslie Graham, Executive Director, Primary Care Coalition (PCC)
Elizabeth Arend, Director, Provider Services, PCC
Hillery Tsumba, Director Organizational Strategy, PCC
Lindsey Lucas, Office of Management and Budget

Summary of Special Appropriation and Background

On June 23, 2020 the Council introduced a $592,202 special appropriation to fund six (6) clinical social worker positions to increase the Department of Health and Human Services/County's capacity to respond to people in a behavioral health crisis. The ability to send a health-based response can de-escalate situations, decreases the reliance for a police-only response, can divert people from emergency department or jail, and connect people more quickly to the help and services they need. Currently, Montgomery County only has the resources to deploy one Mobile

Crisis Team (a two-person team) at any given time. This can result in delays or an inability to respond in a timely manner when there is more than one call, particularly if travel time is significant.

At minimum, the positions funded with this appropriation would create three two-person teams. However, as will be discussed later, if other types of positions, such as peer recovery specialists, are added, these six positions could lead six teams. A clinician is needed for each team and is the reason for the emphasis on clinical positions as the first action.

At this session, the Joint Committee will:

- Have an opportunity to review the current Crisis Center Program and protocols for the Mobile Crisis Team, including their response partnership with MCPD.
- Understand resources the County has in a larger crisis response framework.
- Receive an overview of the Crisis Now framework and a proposed grant application to the Maryland Health Services Cost Review Commission by Nexus Montgomery (a partnership of the County hospitals.)
- Discuss and make a recommendation on this special appropriation.

A public hearing was held on July 7. Testimony that was posted as of the hearing is attached.

Background
24 Hour Crisis Center and Mobile Crisis Team Overview

The County's 24-Hour Crisis Center provides telephone, walk-in, mobile crisis outreach, screenings and referrals to the single adult shelter system, and crisis residential services for persons experiencing situational, emotional, or mental health crisis. The Crisis Center works to stabilize people in the least-restrictive community-based setting, using services appropriate to the client's situation. The Crisis Center has four short-term beds (currently closed due to COVID). The maximum time to stay at the Crisis Center is 72 hours. The Crisis Center can coordinate a hospitalization when needed.

People can directly call the Crisis Center 24-hours a day at 240-777-4000. (This is a separate line from the call/chat/text line provided through EveryMind that is part of the National Suicide Prevention Line.)

The Crisis Center serves as the after-hours center for people in need of a wide range of immediate crisis response including Public Health, STEER (Stop, Triage, Engage, Education, and Rehabilitate), Adult Protective Services, and Child Welfare Services. The Crisis Center also receives referrals from Montgomery County Public Schools and works to stabilize situations using community resources whenever possible.

The FY21 Recommended Budget document shows that in FY19 there were 6,030 walk-ins to the Crisis Center and 6,300 were expected in FY20.

The Mobile Crisis Team is available 24 hours a day, 7 days a week by staff at the Crisis Center. When the Team is deployed it includes a Licensed Mental Health Professional along with a second Crisis Center staff member. The Mobile Crisis Team will provide a crisis evaluation, stabilize the crisis, make recommendations regarding treatment and resources, and facilitate hospital evaluations when needed. The Mobile Crisis Team is requested through the Crisis Center. About one-half of the requests for the Mobile Crisis Team come from the police and the other half through a combination of calls from the community and other programs/agencies. The Mobile Crisis Team always responds jointly with the Police. In some instances, the Police may arrive on the scene first and wait for the Mobile Crisis Team and in other instances the Police may join the Mobile Crisis Team when it arrives.

Montgomery County has only one Mobile Crisis Team available at any time. This can mean some calls cannot receive a response at the time the call is first made. The Crisis Center will prioritize calls and, depending on expected response time, the Crisis Center can stay on the phone with a client while the Team is in route. As the Team is based out of Rockville, travel times can vary significantly.

The Montgomery County System as highlighted in the Maryland Behavioral Health Advisory Council's 2017 Strategic Plan

In 2016, the General Assembly required the Maryland Behavioral Health Advisory Council to submit a Strategic Plan for 24/7 Crisis Walk-in and Mobile Crisis Team Services.[1] The Plan was issued in November 2017 to provide a framework for ensuring that clinical crisis walk-in services and mobile crisis teams are available statewide around the clock. The Plan defines a Mobile Crisis Team as *"community-based mobile crisis services that provide 24/7 availability of face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, whether at home or wherever the crisis may be occurring, to begin the process of assessment and definitive treatment outside of a hospital or health care facility. A multidisciplinary team, including peer support workers, works to de-escalate the person's behavioral care by providing support that continues past the crisis period."*

The Advisory Council included information on crisis services by jurisdiction in Maryland (Plan page 14). It looked at 15 different components of crisis services and often cited Montgomery County as one of only a few jurisdictions in Maryland with a walk-in 24-hour crisis center. **Montgomery County had in place the following 12 of 15 components:**

1. 24/7 Clinical Crisis Line (Crisis Center)
2. 24/7 Hotline (EveryMind)
3. Walk-in Crisis Services
4. Mobile Crisis Team
5. Crisis Residential Beds
6. Emergency Psychiatric Services

[1] https://bha.health.maryland.gov/Documents/The%202017%20Strategic%20Plan%2024-7%20Crisis%20Walk-in%20and%20Mobile%20Crisis%20Team%20Services.pdf

7. Crisis Intervention Stress Management Teams
8. Crisis Intervention Team (Police)
9. Pre and Post Booking Diversion
10. Urgent Care
11. Crisis Stabilization/Case Management
12. Emergency Department Psychiatric Services

Montgomery County was the only jurisdiction in 2017 to have the combination of a clinical line, a hotline, and walk-in crisis services. In 2017, Montgomery County did not yet have a Mental Health Court and so was noted as not having:

13. Hospital Diversion
14. 23 Hour Holding Beds
15. Court Based Diversion

Council staff highlights this to emphasize that the County has worked to have a system of services, but this is not the same as having an adequate supply of these services. For example, no comment was made regarding the adequacy of one Mobile Crisis Team for a population of 1 million or for a large geographic area or whether four short-term residential beds provide adequate crisis bed capacity.

Crisis Now – Grant Proposal – Analysis of Need

The memo from Councilmember Hucker to his Council colleagues notes that there are different models for crisis response, both partnered with a police officer or without a police response. The memo references Crisis Now. Crisis Now is a partnership led by the National Association of State Mental Health Program Directors (NASMHPD) and developed with the National Action Alliance for Suicide Prevention, the National Suicide Prevention Lifeline, the National Council for Behavioral Health, and RI International that is working to transform crisis response by encouraging implementation of the framework in the National Guidelines for Behavioral Health Crisis Care Best Practices Toolkit, produced by the Substance Abuse and Mental Health Services Administration.[2] (SAMHSA) This is a framework for a comprehensive crisis response system, not just the Mobile Crisis Team response, which is the focus of this special appropriation. The Crisis Now model incorporates many of the recommendations that were also included in the Maryland Behavioral Health Advisory Council's 2017 Strategic Plan (which also referenced SAMHSA best practices). Crisis Now says core elements of a crisis system must include:

1. Regional or statewide crisis call centers coordinating in real time;
2. Centrally deployed, 24/7 mobile crisis teams;
3. 23-hour crisis receiving and stabilization programs; and
4. Essential crisis care principles and practices.

[2] https://crisisnow.com/
https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

The Maryland Health Services Cost Review Commission (HSCRC) has issued notice of a competitive grant for implementation of the Crisis Now model. Only regional hospital partnerships can apply for this funding. Nexus Montgomery, a partnership of Montgomery County's hospitals, is eligible to apply. The Primary Care Coalition has been facilitating the application process with Nexus Montgomery and County departments to submit a grant application. Applications are due July 19th. At this session, the Primary Care Coalition will provide the Joint Committee with an overview of the proposal. **If Nexus Montgomery receives an award to implement a Crisis Now framework, many things will have to be reviewed including how call center services function (with a goal of reducing calls to 911 or visits to an emergency department), protocols for joint response by Mobile Crisis and Police versus Mobile Crisis only, creation of observation chairs and short-term subacute crisis beds, one or more Receiving Centers, increased Assertive Community Teams (ACT team), and peer-led crisis navigation.**

The Crisis Now model and SAMHSA Toolkit specifically address Mobile Crisis Teams. The toolkit says that Mobile Crisis Team Services must:

1. Include a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation;
2. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times; and
3. Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.

The Toolkit addresses other best practices, such as incorporating peers and scheduling follow-up appointments with a warm hand-off to support the connection for ongoing care. The Toolkit identifies as a best practice, "Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion." This would be a change in current practice, but it should also be noted that the model expects a system for triage and screening to assess what support is needed and there are instances when the Mobile Crisis Team is expected to be deployed with police and/or emergency medical services.

"In discussing the situation with the caller, the mobile crisis staff must decide if other first responders, such as police or emergency medical services, should be involved while understanding that this is not the preferred approach and one that should only be used when alternative behavioral health responders are not available or the nature of the crisis indicates that EMS or police are most appropriate. For example, if the person describes a serious medical condition or indicates that he or she poses an imminent threat of harm, the mobile crisis team should coordinate with emergency responders. The mobile crisis team can meet emergency responders at the site of the crisis and work together to resolve the situation. Explicit attention to screening for suicidality using an accepted, standardized suicide screening tool should be a part of triage." (Toolkit page 20)

RI International Crisis Now Consultation Report – Estimate of Need

As a part of the development of the Crisis Now grant application, RI International completed a study on the current capacity of the elements of Montgomery County's crisis system that are included in the Crisis Now framework. At a future worksession, the Joint Committee should review and discuss this evaluation for all components; however, for this discussion Council staff is focused on the Mobile Crisis Team component.

The report notes that "the Crisis Center operates a well-loved Mobile Crisis Outreach Team that has been identified as a strength in the community."

RI International's capacity model estimates that:

- The County should scale to 8 Mobile Crisis Outreach Teams to have sufficient 24/7/365 coverage.
- Potentially 8,140 people would meet the criteria for a mobile intervention per year.
- Almost 28% of all requests for mobile services are "not run" meaning that a response was not sent to support the person in crisis after the initial request was made.
- As many as 7,621 people a year do not receive this level of care that could benefit from it.
- Because calls are not run, stakeholders and first responders do not request Mobile Crisis Team services and direct the person in crisis to the Emergency Department or 911.

Council Staff Recommendation

Council staff recommends approval of this special appropriation.

- Information from both the 2017 Strategic Plan and the Crisis Now Consultation Report indicate that the DHHS Mobile Crisis Team is highly valued.
- The Crisis Now Consultation Report confirms that additional teams are needed to provide an appropriate response in Montgomery County.
- This appropriation will allow DHHS to move forward with the hiring of clinical positions that are needed to support any model of DHHS based mobile crisis response. The funding level is at a mid-point as experience will be important and bi-lingual pay is also budgeted. It will be critical to hire clinicians that can speak with people for whom English is not their primary language.
- Not all details about the deployment of these positions is in place but can be addressed while the hiring process begins. With additional staff, there is an opportunity to have teams that are not based in Rockville and can provide quicker response to areas of the County with higher numbers of calls.
- Additional Mobile Crisis Team staff can enhance other partnerships, such as partnering with Homeless Outreach Teams and others who regularly work with and encounter persons that may be mentally ill or have other behavioral health issues. This could enhance the County's ability to connect people with ongoing behavioral health services.

- Additional Mobile Crisis Team staff means that there can be more assistance when MCPD calls for health and trauma-informed assistance in de-escalating situations.
- Additional Mobile Crisis Team services should result in additional diversion from the criminal justice system, including arrest and possible jail time.
- Additional Mobile Crisis Team services are a critical part of an overall framework (Crisis Now) that would not only reduce police interaction but also divert people from hospital emergency departments through short-term and subacute care with connection to community-based treatment services.

Attached:

Resolution No.: _____
Introduced: _____
Adopted: _____

COUNTY COUNCIL
FOR MONTGOMERY COUNTY, MARYLAND

Lead Sponsor: County Council

SUBJECT: Special Appropriation to the Fiscal Year 2021 Operating Budget
Montgomery County Government
Department of Health and Human Services
Mobile Crisis Response
$592,202 (Source of Funds: General Fund Reserves)

Background

1. Section 308 of the County Charter provides that a special appropriation is an appropriation which states that it is necessary to meet an unforeseen disaster or other emergency, or to act without delay in the public interest. Each special appropriation shall be approved by not less than six Councilmembers. The Council may approve a special appropriation at any time after public notice by news release. Each special appropriation shall specify the source of funds to finance it.

2. Too often, a police-only response is the standard response to a 911 call for a person who may be suffering from a mental health or substance abuse crisis. The Treatment Advocacy Center in its 2015 report, Overlooked and Undercounted, cites data that nationally one-in-ten of all law enforcement responses and one-in-four police shootings involve a person with an untreated mental illness. In Montgomery County and the nation, jails and the criminal justice system play a primary role in housing people with mental illness and substance abuse disorders. A criminal record, even in the form of a citation for non-violent or nuisance crime, can impact the ability to get housing increasing the likelihood of homelessness.

3. Montgomery County's Department of Health and Human Services operates the Crisis Center and staffs one Mobile Crisis Team. The Mobile Crisis Team is a two-person team and can respond to calls made directly to the Crisis Center or when the police request their assistance as a part of a police response. Currently, the County only has resources for one Mobile Crisis Team. The Mobile Crisis Team cannot respond to more than one call at a time. The Mobile Crisis Team is based in Rockville, which can result in substantial response time to many areas of the County.

4. Response from a crisis response team can deescalate a situation and begin immediately to assess a health-based response to the underlying cause of the crisis. There are different models for such response, including a behavioral health professional riding with a police officer, a team that combines behavioral health with emergency medical assistance, and teams that include other behavioral health partners, such as peer support. Key to each of these is the presence of a behavioral health professional and the ability to provide timely response.

5. The County needs to move swiftly to increase its capacity for mobile crisis response. While work on the exact model for enhanced response is underway, there is a need for additional Licensed Certified Social Worker – Clinical positions to lead teams. This special appropriation will fund six Social Worker III positions so that the hiring process may begin and delays in implementation of an enhanced response can be reduced. The funding includes bi-lingual pay and it is critical that these positions be able to serve residents for who English is not their primary language. Funding is included for training, researching best practices, and the experience of other jurisdictions.

6. The Council will work collaboratively with the Executive branch to move forward the work needed to implement this enhanced response with a goal of a full report being completed in eight weeks. The Council's Joint Public Safety and Health and Human Services will convene to discuss best practice and models in other jurisdictions, coordination with other diversion programs, changes that may be required for 911 and non-emergency call-taking and dispatch, metrics to monitor and measure progress, and crisis bed and treatment capacity. Councilmember Navarro requested and the Council President has asked the Office of Legislative Oversight to review 911 and 311 calls to provide data that is critical to the planning process.

7. The Council is committed to assessing and addressing racial equity as a part of this work. Resolution 19-493, Declaration of Racism as a Public Health Crisis, adopted June 16, 2020, notes that compared to White residents, Black residents experience a higher rate of poverty (11.2% compared to 4.0%) and are twice as likely as their share of County residents to be arrested (43.9% compared to 19.8%). The County's Interagency Commission on Homelessness Committee on Decriminalization of Homelessness states that Black residents are also more likely to enter the criminal justice system, receiving more than 47% of the State's criminal citations.

8. Public notice of this special appropriation was given and a public hearing was held.

Action

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

A special appropriation to the FY 2021 Operating Budget of the Montgomery County Government, in the amount of $592,202 is approved as follows:

	Personnel Expense	Operating Expense	TOTAL	Source of Funds
Department of Health and Human Services	$500,202	$92,000	$592,202	General Fund Reserves

This appropriation is needed to act in response to an emergency and to act without delay in the public interest.

This is a correct copy of Council action.

_____

Selena Mendy Singleton, Esq.
Clerk of the Council

MONTGOMERY COUNTY COUNCIL

ROCKVILLE, MARYLAND

COUNCILMEMBER NANCY NAVARRO
DISTRICT 4

CHAIR, GOVERNMENT OPERATIONS AND
FISCAL POLICY COMMITTEE

EDUCATION AND CULTURE COMMITTEE

MEMORANDUM

June 11, 2020

TO: Sidney Katz, Chair, Public Safety Committee & Council President
Gabe Albornoz, Chair, Health and Human Services Committee

FROM: Nancy Navarro, Councilmember, District 4

SUBJECT: Increasing Mental Health Service Capacity

We stand at the precipice of a new era of policing practices in this country; the flaws in our current system have been laid bare for us to see, and as legislators, we must act accordingly. The legislative reforms we have instituted as a council in recent times and those we are currently contemplating will only improve the quality of our respected police department. In light of the ongoing community demands for reform, I am requesting as a matter of urgent priority that a thorough review be conducted of our current law enforcement response capacity for those who need mental health services. The purpose of this review would be to create a base from which we can start to reprogram parts of our Operating Budget to create a structure which best fits our needs as a County.

As part of this review, I am requesting that OLO concurrently review our 911 and 311 calls to help provide a clearer picture of what stresses are being faced by our current system, and provide hard data relevant to our discussions. We need a clear understanding of the current demand for mental health services so that we can enact policies which promote real change.

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All over the country, law enforcement struggles to respond to calls involving mental health issues, and Montgomery County is no exception. Sending someone who is not a trained mental health professional to respond to somebody in crisis creates a dangerous situation. Several models like the CAHOOTS program in Eugene, Oregon and other places show promise as we re-imagine innovative ways to enhance our capacity to provide mental health resources to our vulnerable residents. I look forward to having a fair and open dialogue on how best we can rework our structures to fit our needs as a community.

CC: Marlene Michaelson, Executive Director, County Council
Susan Farag, Council Staff
Chris Cihlar, Director, Office of Legislative Oversight
Marcus Jones, Chief, MCPD
Barry Hudson, Director, Public Information Office

MONTGOMERY COUNTY COUNCIL
ROCKVILLE, MARYLAND

TOM HUCKER
VICE PRESIDENT

PUBLIC SAFETY COMMITTEE
CHAIR, TRANSPORTATION & ENVIRONMENT COMMITTEE

MEMORANDUM

June 18, 2020

TO: Montgomery County Council

FROM: Tom Hucker

SUBJECT: Next steps to expand mobile crisis services response

Colleagues,

I'm writing to follow up on my memo of 6/2/2020 to elaborate on the need to expand our mobile crisis services response. I am providing some more information from our research of best practices and models used by other jurisdictions and reiterate my recommendation to approve a special appropriation for mental health professionals who can support our crisis response.

We must create a more effective crisis response and crisis care system during this moment of national reckoning. To do so, it is imperative we focus on expanding the resources and services available to residents who struggle with mental illness. The police-involved shootings of Emmanuel Okutuga, Robert White, and Finan Berhe in my district highlight the repeated inadequacy of our current strategy for crisis response, our overreliance on law enforcement to act as mental health professionals, and our failure to stand up a system that truly serves and protects people who are experiencing a mental health crisis. The community is demanding changes. And there has never been a better time to establish a robust system of care in which well-trained, trauma-informed, compassionate, unarmed professionals are the first point of contact for residents in psychological and emotional distress.

Data show a troubling correlation between calls to 911 related to mental health crises and the incidence of excessive force. In its 2015 report, "Overlooked and Undercounted," the Treatment Advocacy Center cites data that nationally 1-in-10 of all law enforcement responses and 1-in-4 of all fatal police shootings involve an individual with an untreated severe mental illness. In a

2019 report, NAMI cites NIH/SAMHSA data that over 2 million people with mental illness are booked into jails each year. In fact, former MCPD Chief Manger has estimated that up to half of the MCPD's 911 calls are related to mental health or substance abuse.

In Montgomery County there has been a long-standing partnership between Health and Human Services, MCPD and other members of the criminal justice system. There are positive results from these efforts, including the STEER initiative to divert people with behavioral health challenges to the Mental Health Court rather than traditional detention. Our Homeless Continuum of Care's outreach teams can help reduce police encounters, and our Interagency Commission on Homelessness convened a committee that has forwarded recommendations to decriminalize homelessness.

At this time, the County has only one Health and Human Services Mobile Crisis Team. This is clearly not adequate for a county of over 1 million people. Geographically, one team based out of the Crisis Center in Rockville cannot respond to emergent crises in different parts of the County in a timely manner. The County government must do more, not only to respond to individuals facing a behavioral health crisis, but also to remodel our response paradigm. And we must do this with a sense of urgency. We must make changes to how our behavioral health crisis response is dispatched. We must revise our 911 protocols, asking callers for additional information that would allow calls to be routed to the County's Crisis Center directly without referral from a police officer; or, when a police response if needed, have mobile crisis deploy at the same time as the police, rather than waiting for police to respond and then request a mobile crisis response. We must have a goal that mental healthcare professionals are immediately available 24/7, and have capacity to respond to more than one call at a time.

There are different models that may be pursued or combined to achieve these objectives including:

- A mental health professional who rides with a police officer;
- A mental health professional who rides with an EMT (Cahoots[1] in Oregon is the best known example); and
- A diverse team that may include peer support or other professionals who could be critical to de-escalation, a best practice recommendation[2] by the Crisis Now partners facilitated by the Substance Abuse and Mental Health Services Administration, and favored by DHHS.

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[1] CAHOOTS. (2020, June 15). Retrieved June 16, 2020, from https://whitebirdclinic.org/services/cahoots/

[2] *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* (pp. 1-80, Rep.). (2020). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

County policymakers need time to thoughtfully work through the approach, operations, and details. And we must acknowledge we will not be able to reach adequate staffing levels all at once. However, we also know that each of these proposals will require LCSW-C positions, and that it will take many months to advertise, recruit and hire the experienced social workers we will need to implement expanded new crisis response services. All efforts should be made to hire people who speak other languages in addition to English, and we should offer and advertise bi-lingual pay to make that message clear. At minimum, 6 LCSW-C positions would allow for the creation of three 2-person teams (in keeping with the current model) or it could evolve into an alternative format if it is later determined that a second team member could be hired to a different type of position or classification. Multiple teams will be needed for geographic assignment and coverage on multiple shifts. Staging locations for each team will have to be determined thoughtfully; two options include fire stations or regional service centers.

As we move forward, we should continue to engage with our General Assembly Delegation and the State to change policies and get financial support for these efforts. This last session, several of our legislators sponsored bills that created a Crisis Intervention Team Center of Excellence. While this effort focuses on best practices for law enforcement ("the Memphis model") it is a partner to the behavioral health crisis system. Having the State step up and help all jurisdictions implement best practices is in the best interest in all our residents and visitors.

I recommend the following immediate steps for the county government to undertake:

1. Appropriate funding to move forward with hiring 6 new LCSW-C III positions.
2. Form an interagency workgroup as soon as possible with a goal of reporting in 8 weeks on a recommended model for the county, partially informed by 911 call data.
3. A schedule to include public input process, briefing, and discussion to joint meetings of the Public Safety and Health and Human Services Committees.

I have attached a draft special appropriation resolution for $592,202 that I am requesting be introduced next Tuesday, June 23. I hope that you will join me as co-sponsors. I know that we are all committed to doing everything we can to provide the most appropriate response in crisis situations that protects everyone's safety, recognizes underlying conditions, and focuses on de-escalation and referral to treatment and services rather than punitive custody.

NEXUS MONTGOMERY

Crisis Now Model for Montgomery County

COUNCIL BRIEFING PACKET 6-22-2020

NEXUS MONTGOMERY

2

Crisis Now Model

Crisis Now is a tiered model for coordinated behavioral health crisis response and care services across a community. See national guidelines from SAMHSA:

www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Goals

- A coordinated, "no-wrong-door" model to provide behavioral health services to anyone, anywhere and anytime for crises related to mental illness and substance use disorders
- Reduce the overuse of law enforcement, hospital emergency departments and correctional facilities as the primary response to behavioral health crises, shifting spending to higher value care
- Increase access to safe and appropriate services for more community members experiencing behavioral health crisis

Behavioral Health Crisis Now Model:

National model has three components, each with gradations of model fidelity

1. **Crisis Call Center** – the "front door" of the crisis system, accepts all calls, dispatches/links to support based on the assessed need of the caller. Best practice: only 1 in a community, NSPL accredited, technology to dispatch MCOTs, real-time access to bed availability
2. **Mobile Crisis Outreach Teams (MCOTs)** – meets people in crisis in the community; law enforcement involvement should occur only in situations where a public safety response is warranted
3. **Crisis Restoration Center** – 23-hour observation with 2 - 5 day sub-acute, short-term stabilization capacity. Serves everyone (drops offs, walk-ins) from all referral sources (largely Police), without initial 'screen-out' criteria; has restraints/security for involuntary patients when needed

Crisis Now model elements are already present in Montgomery County, with some gaps, capacity needs, and significant opportunity for higher model fidelity, better service to more residents, and positive impact for community policing and hospital utilization.

NEXUS MONTGOMERY

Montgomery County: Current State

Crisis Now Component	Provider	Service	Notes
Crisis Restoration Center	None		Jail, emergency departments currently get crisis drop offs
Short Term Stabilization	DHHS Crisis Center	Walk-in; 4 beds, voluntary only, no detox	Some clients are for resolution of housing/ domestic violence crises
	Cornerstone Shepherd Pratt	Short-term crisis stabilization (24 beds now; 40 by June 2021)	Must have severe mental illness diagnosis – criteria for admission Voluntary only
	Hospitals	Adult inpatient psych beds	192 beds, model shows need for ~100 at fidelity
	Avery Road	SUD detox, treatment	
MCOTs	DHHS Crisis Center	1 team providing 24 hour coverage in 3 shifts	Not billing Medicaid; need 2nd 24hour team; operates as a co-responder w/law enforcement
Crisis Call Center	EveryMind	24/7/365 with chat and text	NSPL accredited, a national NSPL service
	DHHS Crisis Center	24/7/365 call only	Community known call number; not NSPL; Shares staff with MCOT; no call center technology

NEXUS MONTGOMERY

HSCRC Regional Catalyst Funding Opportunity

- The Maryland Health Services Cost Review Commission (HSCRC) has issued a competitive 5 year grant – up to $4M/year for Crisis Now model implementation
- Funding can only go to hospital Regional Partnerships (such as Nexus Montgomery)
- Proposal must include commitment of local agencies involved in implementation
  - Department of Health and Human Services
  - Montgomery County Police Department
  - Montgomery County Fire and Rescue Services
- Must have a plan for sustainability at the close of the 5-year grant period
- Proposal due to HSCRC **July 19, 2020**

NEXUS MONTGOMERY

13

Background: About Nexus Montgomery

- Nexus Montgomery is a collaboration among Montgomery County's hospitals
- Works closely with community partners to promote health, reduce hospital use and manage total cost of care for our shared community in ways that no single hospital could achieve on its own
- Since inception four years ago, Nexus Montgomery has worked with DHHS and local nonprofits to build capacity to address serious mental illness and substance use in our community. To date, it has supported:
  - Cornerstone Montgomery to start an Assertive Community Treatment (ACT) Team and an 8-bed residential crisis house
  - Montgomery County DHHS to build and operate a Medical Respite for the Homeless program (in process)
  - Sheppard Pratt to build a 16-bed residential Crisis House up-county (in process)

NEXUS MONTGOMERY

Recommendation for Catalyst Crisis Now Focus

Crisis Restoration Center(s):

- Shared high interest among many stakeholders (DHHS, Police, Fire&Rescue, Hospitals)
- Proposed for 1 mid-county or 2 smaller up- and down-county
- When operational and optimized, will have significant impact for hospitals and police
- Required start-up capital and operating funds can be a barrier to building this essential community capacity; Catalyst grant offers unique opportunity to address

MCOTs:

- Scale existing DHHS teams building up to 2 teams of 16 hour shifts with day time coverage and 1 overnight shift
- Implement Medicaid billing, improve efficiency for existing DHHS teams or contract for services
- Implement response capacity w/o law enforcement except when warranted.
- Use Medicaid revenue and Catalyst start-up funds to scale up number of teams

NEXUS MONTGOMERY

Recommendation for Catalyst Crisis Now Focus (contd.)

Crisis Call Center:

- Montgomery County has a call center run by DHHS and a National Suicide Prevention Hotline with online chat capability run by EveryMind
- The Crisis Now model calls for a regional or state-level call center with a high tech, "air traffic control" capability to refer callers to inpatient beds and outpatient behavioral health services in real-time, and enable two-way communication with MCOTs
- Wait. Learn from regional (State, DMV) discussions prior to selecting direction; perhaps join regionally for economies of scale

Alignment with Existing Priorities

- Achieves higher fidelity with the Crisis Now model complementing the existing model elements already in place in Montgomery County
- Supports racial equity and social justice by establishing a Crisis Receiving Center that treats all residents regardless insurance status or acuity
- Shifts the culture and reduces engagement of police, EMS, and hospital emergency departments in their behavioral health response in Montgomery County in ways that align with commitment to access, equity, and social justice for all residents

NEXUS MONTGOMERY

Mobile Crisis Team Services – *Someone To Respond*

Mobile crisis team services offering community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. For safety and optimal engagement, two person teams should be put in place to support emergency department and justice system diversion. Emergency medical services (EMS) should be aware and partner as warranted.

Minimum Expectations to Operate a Mobile Crisis Team Services
Mobile crisis team services must:

1. Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation;
2. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times; *and*
3. Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.

Best Practices to Operate Mobile Crisis Team Services
To fully align with best practice guidelines, teams must meet the minimum expectations and:

1. Incorporate peers within the mobile crisis team;
2. Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion;
3. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; *and*
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care.

Community-based mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of the person in crisis in order to achieve the needed and best outcomes for that individual. Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff. For example, a Master's- or Bachelor's-level clinician may be paired with a peer support specialist and the backup of psychiatrists or other Master's-level clinicians who are on-call as needed. Peer support workers often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis.

SAMHSA's 2014 *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* report stated:

> *The main objectives of mobile crisis services are to provide rapid response, assess the individual, and resolve crisis situations that involve children and adults who are presumed or known to have a behavioral health disorder (Allen et al., 2002; Fisher, Geller, and Wirth-Cauchon, 1990; Geller, Fisher, and McDermeit, 1995). Additional*

> *objectives may include linking people to needed services and finding hard-to-reach individuals (Gillig, 1995). The main outcome objective of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission.*

In summary, mobile crisis care:

1. Helps individuals experiencing a crisis event to experience relief quickly and to resolve the crisis situation when possible;
2. Meets individuals in an environment where they are comfortable; *and*
3. Provides appropriate care/support while avoiding unnecessary law enforcement involvement, ED use and hospitalization.

The same report confirmed previous evidence on the effectiveness of mobile crisis service:

> *Four studies were identified with empirical evidence on the effectiveness of mobile crisis services: one randomized controlled trial (Currier et al., 2010) and three that used quasi-experimental designs (Guo, Biegel, Johnsen, and Dyches, 2001; Hugo, Smout, and Bannister, 2002; Scott, 2000; Dyches, Biegel, Johnsen, Guo, and Min, 2002). The studies suggest that mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from the emergency department to services, and better than hospitalization at linking people in crisis to outpatient services.*

The cost-effectiveness of mobile crisis services is noted as well:

> *Scott (2000) analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to regular police intervention. The average cost per case was $1,520 for mobile crisis program services, which included $455 for program costs and $1,065 for psychiatric hospitalization. For regular police intervention, the average cost per case was $1,963, which consisted of $73 for police services and $1,890 for psychiatric hospitalization. In this study, mobile crisis services resulted in a 23 percent lower average cost per case. In another study analyzing the cost impact of mobile crisis intervention, Bengelsdorf et al., (1987) found that mobile crisis intervention services can reduce costs associated with inpatient hospitalization by approximately 79 percent in a six-month follow-up period after the crisis episode.*

SAMHSA asserts that mobile crisis team care is one of three essential elements of a well-integrated crisis system of care. To maximize effectiveness, the availability of mobile crisis services should match needs in the area/region they serve on a 24/7/365 basis and should be deployed and monitored by an air traffic control (ATC)-capable regional call center. Essential functions of mobile crisis services include:

- Triage/screening, including explicit screening for suicidality;
- Assessment;
- De-escalation/resolution;

- Peer support;
- Coordination with medical and behavioral health services; *and*
- Crisis planning and follow-up.

Triage/Screening

As most mobile crisis responses are initiated via phone call to a hotline or provider, the initial step in providing community-based mobile crisis services is to determine the level of risk faced by the individual in crisis and assess the most appropriate response to meet the need. In discussing the situation with the caller, the mobile crisis staff must decide if other first responders, such as police or emergency medical services, should be involved while understanding that this is not the preferred approach and one that should only be used when alternative behavioral health responders are not available or the nature of the crisis indicates that EMS or police are most appropriate.

For example, if the person describes a serious medical condition or indicates that he or she poses an imminent threat of harm, the mobile crisis team should coordinate with emergency responders. The mobile crisis team can meet emergency responders at the site of the crisis and work together to resolve the situation. Explicit attention to screening for suicidality using an accepted, standardized suicide screening tool should be a part of triage.

Assessment

The behavioral health professional (BHP) on the mobile crisis team is responsible for completing an assessment. Specifically, the BHP should address:

- Causes leading to the crisis event; including psychiatric, substance abuse, social, familial, legal factors and substance use;
- Safety and risk for the individual and others involved; including an explicit assessment of suicide risk;
- Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports;
- Recent inpatient hospitalizations and/or any current relationship with a mental health provider;
- Medications prescribed as well as information on the individual's compliance with the medication regimen; *and*
- Medical history as it may relate to the crisis.

De-Escalation and Resolution

Community-based mobile crisis teams engage individuals in counseling throughout the encounter and intervene to de-escalate the crisis. The goal is not just to determine a needed level of care to which the individual should be referred, but to resolve the situation so a higher level of care is not necessary.

Peer Support

SAMHSA's 2009 report (p.8) asserts that mental health crisis services "should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. In addition, peers

can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis" (see Significant Role for Peers in Section 4).

For community-based mobile crisis programs, incorporating peers can add complementary qualifications to the team so that individuals in crisis are more likely to see someone they can relate to while they are receiving services. Peers should not reduplicate the role of BHPs but instead should establish rapport, share experiences, and strengthen engagement with the individual experiencing crisis. They may also engage with the family members of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support.

Coordination with Medical and Behavioral Health Services

Community-based mobile crisis programs, as part of an integrated crisis system of care, should focus on linking individuals in crisis to all necessary medical and behavioral health services that can help resolve the situation and prevent future crises. These services may include crisis stabilization or acute inpatient hospitalization and treatment in the community (e.g., community mental health clinics, in-home therapy, family support services, crisis respite services, and therapeutic mentoring).

Crisis Planning and Follow-Up

SAMHSA's essential elements of responding to mental health crisis include prevention. "Appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. *Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements*" (SAMHSA, 2009: p. 7, emphasis in the original). During a mobile crisis intervention, the BHP and peer support professional should engage the individual in a crisis planning process; resulting in the creation or update of a range of planning tools including a safety plan.

When indicated, mobile crisis service providers should also follow up with individuals served to determine if the services to which they were referred were provided in a timely manner and are meeting their needs. This activity is typically completed through telephonic outreach but there may be times when further face-to-face engagement may be warranted or even necessary when the individual cannot be reached by phone.

Crisis Mobile Service Summary

Community-based mobile crisis is an integral part of a crisis system of care. Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment that is likely to produce more effective results than hospitalization or ED utilization. When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, community-based mobile crisis is an effective and efficient way of resolving mental health crisis and preventing future crisis situations.

SARDAA
Maryland Chapter
Schizophrenia and Related Disorders Alliance of America
www.sardaa.org | 5929 Theodore Av., Baltimore, Md 21214
Shattering Stigma – Destroying Discrimination

Montgomery County Council
Testimony re Special Appropriation DHHS $592,202 for Mobile Crisis Response
Hearing Date: July 7, 2020 at 1:30pm
From : Evelyn Burton, Advocacy Chair, Schizophrenia and Related Disorders Alliance of America.
Maryland Chapter Position: Support

The Maryland chapter of The Schizophrenia and Related Disorders Alliance of America (SARDAA), strongly supports the Special Appropriation for expanded Mobile Crisis Services and we thank Councilmember Tom Hucker for sponsoring this proposal. SARDAA is a grassroots non-profit organization promoting improvement in lives affected by serious mental illnesses involving psychosis through support, education, collaboration, and advocacy.

This appropriation is an important step in improving the treatment services for Montgomery County individuals with serious mental illness and diverting them from the criminal justice system and incarceration. Having only one Mobile Crisis Team is not meeting the needs of our County.

I urge you to read the written testimony of Ziva Azhdam concerning the traumatic experiences of her family with Montgomery County police officers who responded to her calls when the Mobile Crisis Team was not available.

However, unless the council takes a broader look to address the countywide policy failures forcing police to serve as de facto mental health professionals, we will continue to experience tragedies and criminalization of those with serious mental illness. Research from the Treatment Advocacy Center found that people with serious mental illness are 16 times more likely to be killed in an encounter with law enforcement than someone without a mental illness. They concluded, "Reducing encounters between on-duty law enforcement and individuals with the most severe psychiatric diseases may represent the single most immediate, practical strategy for reducing fatal police shootings in the United States."

Therefore, counties such as Mariposa County in Arizona, have developed a comprehensive crisis response system (Crisis Now). It includes a high-tech call center, and multiple mobile crisis teams, each with two mental health professionals, who call for police assistance only rarely, if needed. The Crisis Now model also uses separate evaluation centers manned by mental health professionals, instead of a hospital emergency department (ED).

The use of separate evaluation centers provides prompt evaluations by mental health professionals in a quiet environment instead of ED evaluations after a long wait by a physician with limited psychiatric training in a very noisy, anxiety producing environment. It also reduces ED overcrowding and wait problems and can result in significant time saved for a police officer. The Crisis Now model has an average police drop-off time of 3 minutes. Thus, there is no incentive for police to save time by arresting and booking someone to avoid spending more time at a hospital ED. **Earlier this year, Governor Hogan signed House Bill 332 authorizing**

the use of evaluation centers other than hospital ED's. I urge the council to encourage the use of this model in Montgomery County.

The Montgomery County Mobile Crisis Team needs to focus more on helping families prevent tragic outcomes. Families that contact SARDAA would desperately like the Mobile Crisis Team to stop denying services unless the individual is an imminent danger to self or others. When we wait that long, tragedies cannot be prevented. **The team does not appear familiar with the 2017 Maryland Appeals Court decision that even for involuntary hospitalization, the danger criteria can be more broadly interpreted to include expected harmful outcomes after discontinuing needed medication.**

Finally, the County support of expanded hospital inpatient treatment options is vital so that the Mobile Crisis Teams can effectively direct individuals who need that level of care to psychiatric hospitals beds. Otherwise the crisis calls repeat and the county jail continues to serve as the default for institutional care. I urge the County Council to pass a resolution sending a strong message to Governor Hogan, asking his administration to apply for the available federal IMD Medicaid Waiver, which would allow Medicaid payments for inpatient services at psychiatric hospitals such as Adventist Potomac Ridge in Rockville. A sample resolution is attached for your consideration.

SARDAA urges passage of the Special Appropriation for Mobile Crisis Services. Also please consider soon, funding a more comprehensive crisis system. The Crisis Now model saved Maricopa County, Arizona the time equivalent of 37 full time police officers. It could also go a long way to reducing the 25% of the population of the Montgomery County Correctional facility that have serious mental illness. Los Angeles even voted on Wednesday July 2 to cut the Los Angeles Police Department's budget by $150 million and use some of it to replace police officers with unarmed crisis response teams for nonviolent emergency calls. Everyone would benefit, but most grateful would be, those with serious mental illness and their families.

References:

Overview of Crisis Now model: https://www.youtube.com/watch?v=ORq1MkODzQU
Crisis Now website with multiple reports and resources: https://crisisnow.com/
SAMHSA guidelines for mental health crisis care:
https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

House Bill 332: http://mgaleg.maryland.gov/2020RS/bills/hb/hb0332t.pdf

Maryland Appeals Court decision **In re: J.C.N**.,No. 73, September Term, 2017.

https://cases.justia.com/maryland/court-of-appeals/2018-73-17.pdf?ts=1533048292

Attachments:

1. Sample County Council Resolution urging the Governor to apply for the IMD waiver for mental health.
2. Analysis of the Maryland Appeals Court Decision **In re: J.C.N** by the Treatment Advocacy Center

For further information contact Evelyn Burton, Advocacy Chair at 301-404-0680 burtonev@comcast.net

RESOLUTION NO. : ADOPTED: , 2020
MONTGOMERY COUNTY COUNCIL

A RESOLUTION urging the State of Maryland to seek and obtain an SMI/SED Medicaid demonstration waiver under section 1115(a) of the Social Security Act to allow Medicaid reimbursement for inpatient treatment of serious mental illness in hospitals and psychiatric facilities.

WHEREAS, the decades-long exclusion of Medicaid payments for Institutions for Mental Diseases (IMDs) is a contentious feature of our nation's mental health system, prohibiting the use of federal Medicaid funds for care provided to most patients in mental health and substance use residential treatment facilities with over 16 beds; and

WHEREAS, this prohibition dates back to the original Medicaid legislation and was meant to encourage a transition from institutional warehousing of the mentally ill to community-based treatment; and WHEREAS, in actuality the prohibition creates a major barrier for those with severe mental illness, as residential and inpatient treatment are critical components in the continuum of psychiatric care; and

WHEREAS, as of November 2017, states may apply for a waiver of the IMD exclusion for individuals with substance use disorder (SUD), and as of November 2018, for individuals with serious mental illness (SMI). Specifically, the waiver allows Medicaid to reimburse IMDs with more than 16 beds for patients with mental illnesses; and

WHEREAS, a number of states have since pursued these waivers to help increase bed capacity. MRYLAND has obtained an IMD waiver for SUD, but has not yet requested an amendment to also include SMI; and

WHEREAS, persons in crisis or in need of acute stabilization may require the type of structured inpatient treatment that IMDs can provide, and the Medicaid program is a crucial source of mental health funding; and

WHEREAS, lifting the IMD exclusion could help lessen the access and funding gaps between outpatient systems and more acute levels of care, reducing the psychiatric bed shortage; and

WHEREAS, the argument that reducing funds for inpatient care will reduce rates of institutionalization ignores the forced institutionalization of seriously mentally ill individuals in jails and prisons as well as the inappropriate use of emergency departments and unspecialized hospital beds; and

WHEREAS, many people in need of treatment are instead being warehoused in jails precisely because there are often no treatment options available to them in the community; and

WHEREAS, appropriate hospital capacity will enhance the provision of outpatient care; and

WHEREAS, by seeking an amendment to its existing waiver, the State could apply now for this additional funding to help complete our mental health system, end some of the misery perpetuated by antiquated policy, and, over time, curtail the number of people with mental illness in our jails, prisons, and state hospitals; NOW THEREFORE

BE IT RESOLVED BY THE COUNCIL OF THE COUNTY OF MONTGOMERY, That the State is hereby asked to seek amendment to its existing IMD waiver to extend such funding to those with serious mental illness.

Analysis of In re J.C.N. decision of the Maryland Court of Appeals by Brian Stettin, Esq., Policy Director of the Treatment Advocacy Center.

In a decision issued on July 30, 2018, the Maryland Court of Appeals made two important rulings interpreting the Maryland Mental Health Law. In re J.C.N., 2018 Md LEXIS 384 (2018) [attached].

The petitioner J.C.N. challenged her 2015 civil commitment by an administrative law judge to the inpatient psychiatric unit of the University of Maryland's Baltimore Washington Medical Center (BWMC).

J.C.N. was originally admitted to BWMC after suffering a stroke. She spent 7 days receiving medical treatment in the hospital's emergency department before being transferred involuntarily to the psych unit. Her civil commitment hearing took place 7 days after the transfer.

At the hearing, evidence was presented that J.C.N. was suffering from severe mental illness, and would likely do significant damage to her career and finances and forego critical medical treatment for both her mental illness and her serious thyroid condition if released from the hospital in her present state. In civilly committing J.C.N. to the hospital, the ALJ relied on this evidence to find that J.C.N. "present[ed] a danger to the life or safety of [herself] or of others" as required by the Maryland civil commitment statute. HG § 10-632(e)(2)(iii).

J.C.N. asked the Court of Appeals to reverse the decision on two grounds -- one procedural and one substantive:

(1) J.C.N. argued that since her hearing occurred 14 days after her hospitalization for the treatment of her stroke, it violated the requirement of HG § 10-632(b) that the hearing take place "within 10 days of the date of the initial confinement of the individual."

(2) J.C.N. argued that the evidence presented did not rise to the level of establishing "a danger to life or safety" within the meaning of HG § 10-632(e)(2)(iii).

The Court of Appeals denied both claims.

In rejecting the procedural claim, the Court held that the term "initial confinement" in HG § 10-632(b) referred to the point at which an individual was placed in an "inpatient institution that provides evaluation, care, or treatment for individuals who have mental disorders." Thus, J.C.N.'s hearing was timely because it occurred within 7 days of her transfer to BWMC's psych unit.

In rejecting the substantive claim, the Court summarized and affirmed the finding of the ALJ:

"Although some of J.C.N.'s delusions, taken alone or in combination with others, might not suggest that at the time of the hearing J.C.N. posed a

danger to herself or others, at least one—the delusion that she could function normally without medication and follow-up treatment—did pose a danger. The ALJ, evidently basing his decision on the credited testimony of [the treating psychiatrist], found that J.C.N.'s "lack of judgment, lack of insight, and these issues about finances as well," demonstrated that she did not have "sufficient judgment" to "maintain [her]self" outside of an institutional setting. Based on that ultimate finding, the ALJ decided that J.C.N. be involuntarily admitted.

The record supports the ALJ's decision. The evidence presented at the involuntary admission hearing, viewed through the prism of the applicable standard of review, ... was such that a reasonable person in the position of the ALJ could accept the evidence as adequately supporting his ultimate finding, by clear and convincing evidence, that at the time of the hearing J.C.N. was a danger to herself or others."

This latter ruling has great significance for civil commitment in Maryland.

While many other states use the phrase "danger to life or safety" or one very much like it in their statutory criteria for civil commitment, almost all other states supply an expansive statutory definition for such terminology, making clear that "danger" is not limited to circumstances where the individual is violent or suicidal. These definitions typically specify that an individual's inability to provide for his/her essential survival needs, such as food, clothing, shelter and essential medical care, is grounds for finding the individual a danger to self. The Treatment Advocacy Center classifies statutory language of this nature as a "gravely disabled" standard for civil commitment.

By contrast, the Maryland Mental Health Law does not supply a definition for "danger to life or safety," which has until now left the meaning of the phrase to the discretion of each ALJ. Historically, some ALJs have interpreted the phrase to incorporate a gravely disabled standard, while others have interpreted the phrase narrowly -- insisting on evidence of imminent violence or intentional self-harm.

In re J.C.N. now clarifies that "danger to life or safety" should be read to incorporate a gravely disabled standard. While the facts of this particular case led to the court to invoke the evidence of J.C.N.'s inability to seek essential medical care, the logic of the decision dictates that an individual's inability to meet ANY essential survival need would be an equally appropriate basis for civil commitment.

In other words, In re JCN interprets the current Maryland civil commitment law to incorporate a gravely disabled standard. This should be made known to all ALJs across the state who preside over civil commitments and all clinical professionals in Maryland hospitals who make determinations as to whether to seek civil commitment.

It should also be noted that the court's reasoning rests upon the evidence *en masse* that J.C.N. was unlikely to comply with prescribed treatment for her multiple serious illnesses. The court draws no distinction in importance between the testimony that J.C.N. was unlikely to take her psychiatric medication and the testimony relating to her thyroid medication. This strongly suggests that the decision stands for the proposition that, irrespective of other illnesses that may be present, evidence that an individual is unlikely to comply with treatment for mental illness alone, provided that

such treatment is essential to safeguarding the individual's life or safety, is enough to sustain a finding that the individual presents a "danger to life or safety" within the meaning of HG § 10-632(e)(2)(iii).

Brian Stettin

Policy Director

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I am Kate Sugarman, MD. I have been practicing as a licensed family physician since 1991. My entire work career has been with indigent, underserved populations in public health clinics. I have extensive experience working with immigrants, refugees and asylum seekers. I live in Potomac MD.

I am strongly in favor of the initiative to remove police from mental health crisis response teams. Instead, I support hiring licensed and linguistically and culturally competent social workers to staff these mobile teams.

Many of my patients are Montgomery county residents who are part of the Latinx, Ethiopian and Eritrean communities. It is critical that we have mental health workers deal with their mental health emergencies so that we do not have more deaths like Finan.

I frequently see mentally ill patients in my clinic and it is very clear from my experience that de-escalation is so critical without the use of weapons.

Kate Sugarman, MD

Silver Spring Justice Coalition Statement
On Council Member Hucker's Special Appropriation to HHS

The Silver Spring Justice Coalition (SSJC) supports a community mental health model to respond to 911 calls where individuals may be suffering from mental health crises or related mental health issues. SSJC was formed after the police killing of a man who faced mental illness, Robert White, in 2018 and our coalition continues to advocate for non-violent and non-racist mental health crisis intervention after the recent police killing of Finan Behre who was in distress at that time.

The coalition urges the County Council to create a multi-culturally appropriate Montgomery County model based on Crisis Assistance Helping Out on the Street (CAHOOTS) a mental health crisis intervention program in Eugene, OR that has been emulated across the country.

SSJC demands a fully-funded program supporting 24/7 response capacity in all districts of the county. The program should be staffed by licensed mental health professionals, including, but not limited to, licensed social workers, professional counselors and marriage and family therapists who are fully linguistically and culturally attuned to our diverse county population.

Mental health professionals should also staff dispatch through 911 in order to ensure that a community mental health team is deployed on mental health emergency calls. Dispatchers should be trained to work in tandem with mental health dispatchers, and first responders should be trained to know when to contact the community mental health response team.

We propose a safer, more humane, and culturally appropriate response to mental health crises in our county. The county community mental health response team should be part of the Montgomery County Department of Health and Human Services, fully funded by cost-savings from money reallocated from MCPD. SSJC rejects any model that includes officers from the Montgomery County Police Department as part of any response related to mental health.

SSJC urges the Council to seek input from impacted communities for the development and implementation of the program. In addition, we demand public access to data to evaluate the program on an annual basis and the creation of a working group of impacted people to work closely with the mental health team staff to ensure that implementation meets community needs and is responsive to cultural and racial barriers to accessing mental health care.

Finally we propose a community-wide public education program to inform the public about how to access the emergency mental health team. We highly recommend that the County adopt peer health educator and peer counselor

approaches that have worked to create greater trust and access to mental health services in other jurisdictions.

Good afternoon, I am Marilyn Kresky-Wolff, testifying on behalf of Jews United for Justice. I am a recently retired ED of a DC housing program for homeless women with mental illnesses. I am also past Director of Homeless Outreach Services at Everymind, ED of NAMI-Baltimore and the founder of a residential crisis care program in DC.

We offer a Jewish framing for our testimony: Rabbi Jill Jacobs writes: "If human pain directly causes an injury to God, then the death of a human being—especially someone innocent of any crime—even more greatly diminishes the divine image." It is tragically obvious that the time is overdue to address these life and death issues.

Montgomery County is not alone in confronting the deaths caused by police officers ill-suited to responding to mental health crises. People in psychiatric crisis are suffering. They need to treated by mental health specialists and trained peer counselors. Criminalization of psychiatric crisis is not good for anybody.

The Treatment Advocacy Center reports, "more than $17.7 million was spent in 2017 by reporting law enforcement agencies which transported people with severe mental illness. If extrapolated... nationwide, this number is approximately $918 million or 10% of law enforcement's annual operating budget. Additionally, mental illness is the most prevalent disability in the United States. The time is ripe to solidify better access to crisis care ... instead of filling jails and crowding emergency departments." (TAC)

JUFJ joins with the Silver Spring Racial Justice Coalition to embrace the CAHOOTS model of Eugene, Oregon for psychiatric crisis intervention. The adoption of this model in Montgomery County would entail:

Full involvement immediately of the new **Racial Equity Office**.
A public health-driven model, not a police driven model, with licensed mental health practitioners comprising the team
Presence in all six police districts
Representation of impacted communities in advisory and oversight groups
A countywide informational campaign on reaching the Mental Health Team practitioners through 911
Reallocation of cost savings from PD to fully fund this program at 24/7 level
Transparency in public access to MH and Police data
No money from this appropriation to train police

On behalf of JUFJ, we urge you to embrace this model in full for the welfare of Montgomery County's citizens.

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Showing Up for Racial Justice (SURJ) Montgomery County
Testimony on Special Appropriation to the County Government's FY21 Operating Budget,
DHHS - $592,202 for Mobile Crisis Response
July 7, 2020

POSITION: SUPPORT

Showing Up for Racial Justice (SURJ) Montgomery County, which represents over 2,600 members, supports the special appropriation of $592,202 to fund mobile crisis response in Montgomery County. SURJ supports a community mental health model in which licensed mental health professionals respond to situations that involve mental health concerns. Robert White and Finan Berhe, both killed by MCPD in the past two years, would likely still be alive if Montgomery County had already implemented a community mental health model.

SURJ MoCo urges the Council to create a culturally appropriate Montgomery County model based on Crisis Assistance Helping Out on the Street (CAHOOTS) a mental health crisis intervention program in Eugene, OR that has been replicated across the country.

This model must be implemented as quickly as possible to support a fully-funded program with 24/7 response capacity in all districts of the county. Program staff should include, but not be limited to, licensed social workers, professional counselors and marriage and family therapists. Staff must reflect the diverse county in which they serve - linguistically, racially, and culturally - and they should be grounded in anti-racism and cultural competence.

The county community mental health response team should be part of the Montgomery County Department of Health and Human Services, fully funded by cost savings from money reallocated from MCPD. SURJ rejects any model that includes officers from the Montgomery County Police Department as part of any response related to mental health.

Mental health professionals should dispatch through 911 to ensure that a community mental health team is deployed on mental health emergency calls. Dispatchers should be trained to work in tandem with mental health dispatchers, and first responders should be trained to know when to contact the community mental health response team.

SURJ urges the Council to seek input from impacted communities for the development and implementation of the program. In addition, we demand public access to data to evaluate the program on an annual basis. A working group of impacted residents should be created to work closely with the community mental health response team to ensure that implementation of the model meets community needs and is responsive to cultural and racial barriers to accessing mental health care.

Finally, we recommend a county-wide public education campaign that provides information on how to access the community mental health response team. In addition, the county should

adopt peer health educator and peer counselor approaches that have worked to create greater trust and access to mental health services in other jurisdictions.

Thank you to Councilmember Hucker and all co-sponsoring councilmembers for this necessary step toward creating a county that is safer and healthier for all residents, but especially those most affected by lack of community resources and overpolicing.