PS/HHS ITEM #1
January 30, 2023
REVISED

M E M O R A N D U M

January 25, 2023

TO: Joint Public Safety and Health & Human Services Committee

FROM: Susan J. Farag, Legislative Analyst
Vivian Yao, Legislative Analyst

SUBJECT: Briefing: Behavioral Health Crisis Response

PURPOSE: To receive an overview of the County's current multi-agency behavioral health crisis response protocols and discuss how key agencies and partners can collaborate to deliver a comprehensive, integrated response.

Those expected to attend the meeting include:

Department of Health and Human Services
- Dr. Raymond Crowel, Director
- Dr. Rolando Santiago, Chief, Behavioral Health Services
- Amanda Harris, Chief, Services to End and Prevent Homelessness
- Dorné Hill, Senior Administrator for Crisis, Intake, and Trauma Services
- Beth Tabachnick, Manager, Crisis Center

Montgomery County Police Department
- Chief Marcus Jones, Montgomery County Police Department
- Captain Jordan Satinsky, Director, Community Engagement Division
- Lieutenant Kevin Parker, Deputy Director, Community Engagement Division
- Sergeant. Chad Matthews, Crisis Intervention Team

Anne Arundel County Crisis Response
- Jen Corbin, Director, Anne Arundel County Crisis Response System
- Lt. Steven Thomas, Crisis Intervention Team, Anne Arundel County Police

Councilmember Luedtke, as lead for crisis services, requested this Joint Committee item to better understand the County's crisis response system and multi-agency protocols for responding to community members experiencing behavioral health crises. The Joint Committee will have the

opportunity to identify potential opportunities to improve services and collaboration among key agencies and partners.

Council staff requested information on the Crisis Center, Mobile Crisis Outreach Teams, and its Police Crisis Intervention Team (CIT). This includes the history of community crisis response, changes and additions since 2020, how response, care coordination, and follow-up are managed among the various County departments, and what their future operational needs are, including staffing and resources.

I. Background

A. Police Crisis Intervention Team (CIT) and Crisis Response Efforts

Historically, individuals with mental illness were often institutionalized in state mental health facilities. From the 1950s to 1980s, the nation moved toward deinstitutionalization, assuming newly-developed medication therapies, private mental health facilities, and other community-based supports would be sufficient to meet community needs.[1] Unfortunately, there were never enough community-based facilities, and the unintended results have been unnecessary and sometimes unavoidable criminalization of persons with mental illness, and less-than-ideal treatment and stabilization outcomes. In 1987, in an attempt to more appropriately assist individuals in crisis, Memphis Police Department, along with mental health advocates, developed the Crisis Intervention Team model.[2] Recognized as a best practice, the Memphis Model is used by many police departments across the nation, including MCPD.

MCPD advises that it created its CIT training in 2000, precipitated by a fatality of an individual with severe mental illness on a Crisis Center mobile crisis call in 1998. Then-Chief Moose designated an officer, Joan Logan, to partner with HHS and initiate CIT training for MCPD officers. MCPD/HHS built a strong partnership over the past 23 years, in large part due to the efforts of Officer Logan and Officer Scott Davis, who took over as CIT Coordinator after Officer Logan's retirement. CIT was expanded under a Lieutenant in 2014 to include another full-time officer and a contractual clinician in 2015. This position became a merit position in 2019.

The Department's CIT unit consists of one Sergeant, two full-time officers, one HHS Therapist II (currently vacant), and long/short term temps. Recognizing that one team was insufficient to meet community needs, the Department requires all officers to receive Mental Health First Aid training (eight hours) in the Academy and 40 hours of Crisis Intervention Training (CIT) after completing field training. Officers also have annual online training modules on behavioral health topics and are offered opportunities for advanced training through the Public Safety Training Academy and outside venues. Historically, full-time CIT officers were also crisis negotiators and members of MCPD's peer support team, as well as being certified law enforcement

[1] Jachimowski, K. G., & Cooper, J. A. (2021). *Police response to mental health calls for service: Gatekeepers and street corner psychiatrists*. (Ch. 2)
[2] University of Memphis CIT Center

instructors. Additionally, the Police Department had trained all officers in Mental Health First Aid and had prioritized training as many officers as possible with 40-hour Crisis Intervention Team.

Police have indicated interest in the hiring of more clinicians to create additional CIT teams and have committed to expanding the CIT unit by another two Police Officers.

B. Crisis Center, Mobile Crisis Outreach Team (MCOT), and Expansion of Crisis Now

Crisis Center Background

HHS has operated a Crisis Center and Mobile Crisis Team for more than 20 years. 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. 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.

MCOT History

Toward the end of the 1990s, a memorandum of understanding (MOU) with the Montgomery County Police Department initiated the co-response with police officers. The impetus for the co-response was a felt need to keep MCOT members safe during a crisis intervention. A positive result of the MCOT co-response with police was that most crisis interventions were with individuals presenting at a high acuity level with risk of harm to self and others, thus de-escalating many situations and preventing potential fatalities.

In 2009, the MCOTs became a 24-hour/7-day-a-week operation, and by 2020, the Crisis Center had approximately 24 staff who were eligible to be part of a two-member MCOT, but the Center could deploy only one team at any given time.

In addition, an HHS clinician has functioned as part of a Police Crisis Intervention Team (CIT), as mentioned above. That position is currently vacant. Police have indicated interest in the hiring more clinicians to create additional CIT teams.

Expansion of MCOT Staffing and Teams

The George Floyd incident in the Spring of 2020 created a national movement toward de-coupling law enforcement from mobile crisis response. Council approved a supplemental appropriation in July 2020, along with additional funding in the FY22 budget, to add twelve licensed therapists at the Crisis Center with the intent of increasing the number of MCOTs to a

total of seven. Consultant RI International estimated that the County would need to scale to eight MCOT to have sufficient 24/7/365 coverage.

HHS also received federal grant funds from Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic (CCBHC) program to add eight additional staff, including four licensed therapists and four peer support specialists, to expand the capacity of MCOT teams. The peer support specialist will provide lived experience and knowledge of the community to engage clients on a longer-term basis. HHS hired four peer support specialists last year, and these specialists have started to integrate into MCOTs to be dispatched with licensed therapists.

MCOT Staffing Needs

Recruiting licensed therapists has been a challenge for the Department and other jurisdictions and employers regionally. Council staff understands that to date HHS has hired eight of 16 positions. This has allowed the Crisis Center to have three MCOT teams – one dispatched out of Rockville 24/7 and two other teams in regional satellite locations in Germantown and Silver Spring Monday-Friday 7 am-11 pm.

Council staff understands that the current level of MCOT staffing is insufficient to meet the demand of services or respond to all calls for service. HHS has plans to hire four vacant licensed therapist positions, four grant-funded licensed therapist positions, and four peer support specialists. This level of staffing when filled is anticipated to stand up four-five MCOTs, along with covering increased demand for crisis responses services, including Crisis Center walk-ins, call functions, and stabilization bed support. According to the original consultant report, the County would need eight MCOT teams to meet demand.

Other Crisis Now/Crisis Response Efforts

Since 2020, the County has proactively worked to increase civilian responses to mental health crises and build out a Crisis Now model that effectively stabilizes and connects individuals in crisis with appropriate resources and care. There are multiple components of an effective government-based mental health crisis response which include:

- **Regional Crisis Call Center** that provides quality coordination of crisis care in real-time;
- **Mobile Crisis Team Response** that reaches any person in any community-based location;
- **Creation of a Triage and Dispatch Protocol for MCOTs** that allow a crisis response without police presence when appropriate (see discussion below). The protocol was developed in consultation with Bird Clinic of Eugene, OR, which has run the Crisis Assistance to Reach Out on the Streets (CAHOOTS) program without law enforcement for over 30 years; and

- **Crisis Receiving and Stabilization Facilities:** providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.[3]
    - **Four crisis stabilization beds at the Crisis Center**
    - **Restoration Center project in the FY23-28 CIP** will provide triage, stabilization, and warm hand-off to appropriate services for persons experiencing mental health, substance use disorder, and other types of behavioral health crises over the first 24-72 hour. The facility will divert persons in crisis from emergency room and jails.

- **Leadership Collaborative:** The Leadership Collaborative includes the County departments, hospitals, nonprofit organizations, and the public that are directly involved in crisis care. The group, intended to build an environment of trust and shared commitment, reviews progress on established metrics and targets, assess impact on patient outcomes, and discuss and determine resolution to inter-agency implementation challenges and is meant to build an environment of trust and shared commitment.

II. County Triage and Response Protocols to Behavioral Health Crisis Calls

As noted above, Executive staff and their community partners have worked together to create a new behavioral health call triage and response protocol (attached at ©2). It is designed to prioritize civilian responses to community crisis calls when scene safety permits. The new protocol has enabled HHS Mobile Crisis Outreach Teams (MCOTs) to respond without police in 30-50% of all calls. Police still respond to higher-acuity calls where weapons are present, there is a recent history of violence, or there are other determinants of imminent self-harm or harm to others.

The County implemented its new triage and mobile response protocol on July 25, 2022. It specifies the criteria for two levels of crisis response: (1) civilian clinician response, and (2) a civilian clinician co-response with police. If there is no risk of violence, this will trigger a civilian response. If there is a high risk of violence, the MCOT will continue a co-response with police as it has done for over 20 years.

Civilian response (without police)

- MCOT staff member calls dispatch with client name and address
- A CAD (Computer Assisted Dispatch) is created at Emergency Communications Center (ECC)
- ECC monitors and contacts MCOT every 30 mins to ensure safety
- MCOT ensures that Crisis Center Operations Room is aware of team location
- If team experiences threat/significant risk, team calls police for support or leaves the scene
- When the assessment concludes, team contacts dispatch to remove the CAD
- If team writes an EEP, team contacts dispatch for police to transport client to emergency department

[3] National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, SAMHSA, pg. 12.

Co-response (with police)

- MCOT arrives on scene and calls ECC dispatch non-emergency number to request police support
- Team ensures that Crisis Center Operations Room is aware of their location
- MCOT waits for officers to arrive
- MCOT assesses client
- If an EEP is written, police transport client to the nearest emergency room
- Team notifies Operations room when they leave and either provides the address for next call, or notes if they are returning to the office

Call history to date: According to HHS, preliminary data indicates that over the first five months from August 2022 to December 2022, there were 624 MCOT responses, of which 158 (25.3%) were without police, 314 (50.3%) were with police, and 152 (24.4%) were unknown. Initial experience with the protocol suggests that responses with police continue to predominate, likely because these responses are prioritized due to the higher risk of violence and potential negative outcome of harming self or others. Supervisors are seeking to work with MCOT staff to minimize and eliminate those responses where its "unknown" whether the response was with police or without police.

Response Coordination

Coordination of response changes depending on the circumstances. For example, if an MCOT arrives at the scene of a call and determines there is a higher-threat level at the scene, the team notifies police. The MCOT may also leave the scene if necessary. If MCOTs issue an Emergency Evaluation Petition (EEP), they contact dispatch to request police for a transport.

If Police are dispatched for a call, the officers can request an MCOT, but typically only after they take some actions such as going to the address, making a phone call to the person in crisis, or convincing a supervisor to have an ECC supervisor redispatch the call to MCOT. If police are on the scene of a situation where they see the need for MCOT, they have to call the Crisis Center on their cell phone like anyone else, as there is not a dedicated law enforcement line. Police must explain the entirety of the situation to Crisis Center staff, because the Crisis Center does not have the CAD and does not have access to what call the officer is dealing with. After this step, the officer will be given a time frame for a potential response from MCOT.

Council staff understands that MCOTs may not be able to respond to appropriate calls because they are already on a call. Based on the original assessment of service needs, Council staff understands that the County would need approximately five more teams to sufficiently staff and effectively respond as envisioned under the current dispatch protocol. When this happens, MCOTs engage in alternatives, including:

- Offering to speak with a client or family member/concerned party over the phone or arranging for transportation (sometimes via police courtesy transport, if police are on scene and able to do so) for the individual to come into the Crisis Center office, if this is a safe option (the individual would need to be amenable to this).
- Providing consultation to a police officer at the scene on occasions when police are at a scene.

- Making a referral to a homeless outreach team in partnership with Services to End and Prevent Homelessness.

Case Management/Care Coordination

Over the past year, HHS has incorporated the use of peer support specialists, navigators, and case managers (i.e., community service aides) to conduct follow up with clients. MCOTs have always worked closely with County and private providers to facilitate appropriate referrals as needed with such programs as Child Protective Services (CPS), Adult Protective Services (APS), Access to Behavioral Health, residential crisis services, homeless services, and others. Services like DHHS street outreach services play important roles in care coordination, and Mobile Crisis, in turn, supports people in crisis in shelters and permanent supportive housing. The Crisis Center has also always worked closely with law enforcement and Fire and Rescue as needed to coordinate the most appropriate disposition.

Police indicate an interest in having a role in this process as well, to increase community engagement, reduce negative law enforcement interactions, and reduce negative police contacts. Currently, the CIT team is developing and has begun to track those consumers they have previously engaged, and the requests they've received, to follow-up and circle back with the intent of providing wrap-around services to the patient and family. They could assist with the treatment plan approach, including site visits and coordinating transportation if needed.

Mobile Integrated Health Unit (Montgomery County Fire and Rescue): In 2017, MCFRS established its MIH unit [4]to assist community members who initiate many 911 calls and who often have underlying chronic physical and mental health needs.

The MIH team works closely with all six hospitals, MCPD, HHS, non-profit mental health organizations, homeless resources, care managers, community health providers, and others, to identify ongoing patient needs. These efforts are carried out by a social worker, nurse, and paramedic (manager) within MIH. The goal of MIH staff is to connect patients with the next appropriate resources and move on to the next patient. With a larger team, MIH could provide additional care management support, and direct patients to resources immediately from the scene of the 911 call. This includes the ability to divert patients from emergency departments by directing them to mental telehealth support, 988, the Crisis Center, Restoration Center, among others.

Ideal MIH expansion includes additional paramedics, another social worker and a nurse practitioner who can assist with treatment in place, prescription writing, and other such tasks. MIH averages 600+ referrals annually and that number continues to climb. Patients referred to MIH are the most vulnerable, the highest utilizers, and the most complicated out of the 70,000 patients MCFRS transports annually. To make a larger impact on the persistent behavioral health population, MIH needs to connect with people in their moment of crisis, not days or weeks later.

Records Management

HHS uses the NextGen electronic health record (EHR) platform. It is currently upgrading its Behavioral Health Suite. MCFRS and associated partners with the hospitals suggest that the best solution to improve access to client information is to share access to existing databases. They

[4] MCFRS Mobile Integrated Health Unit

suggest there is no reason why there can't be increased access to eJustice, eMeds, and CJAMS/NexGen. In addition, there should be advocacy with CRISP, a hospital-based software, because CRISP staff are working to lift confidentiality restrictions around CFR42. CRISP just added an option to include a patient-signed consent for people to release their mental health history to certain parties, but there is a need to take it a step further and be able to see histories for persons who are resistant to sharing info.

MCPD has indicated the need for a more robust records management software.

III. Other Local Models

As noted above, Anne Arundel's Crisis Response System (CRS)[5] model embeds police officers in the County's privatized Mental Health Agency. The mobile crisis teams (MCTs) were initially designed to respond primarily to calls from police officers and MCTs have police radios to facilitate communication. In addition, they can refer all calls to one of the county's MCTs. The MCT can then be dispatched to assist in stabilizing the individual and connect them to the most appropriate services. the County's population is about 600,000, and during FY17, the MCTs were dispatched 1,912 times. The agency serves the entire county on a 24/7/365 basis. On days when there are sudden surges, the CRS employs contingent part time staff to assist."

HHS has provided a comparison chart (attached at ©14-21) that compares the Montgomery County and Anne Arundel County models.

MCPD has been working with Baltimore County to better understand their current CIT response model. Baltimore County's Behavioral Assessment Unit consists of the Threat Management Team, Mobile Crisis Team, and Critical Incident Support Team. The Unit is staffed by a Lieutenant, Sergeant, Corporal and 15 patrol officers. Baltimore County's MCTs are comprised of one police officer and one clinician, and the department can field eight teams a day, 24 hours a day. County Police contract with a private provider (Affiliated Sante) to employ clinicians.

Their goals are to:

- Create a partnership with mental health and police systems.
- Develop an accessible, coordinated and comprehensive system of psychiatric emergency services.
- Fill service gaps identified in the emergency system.
- Appropriately divert persons who have mental illness from the 911 emergency system and hospital emergency departments.
- Link frequent mental health consumers to the mental health system.
- Reduce police time on calls associated with mental health consumers.
- Increase disposition and treatment options for police officers responding to crisis calls.

[5] Anne Arundel County Mental Health Agency's Crisis Response System

- Increase overall treatment satisfaction for mental health consumers.
- Address the behavioral health needs of consumers in Baltimore County.

Potential Discussion Items

1. What access to data is needed by responding departments and how can data systems and data sharing be improved? What are the barriers to permitting police access to client records?

2. What benefits or challenges would the colocation of MCOT and CIT staff provide? To what extent will colocation support or hinder efforts to move away from a law enforcement approach to crisis response when possible? Are there ways to mitigate the perception of such an approach yet maintain the benefits of colocation? What would be needed to achieve colocation?

3. What crisis response services and staffing are needed to meet County demand? What Departments should be responsible for hiring and supervising these staff?

4. Are there changes to practice or technology/equipment that can improve the communications between County Departments? For example, would the use of police radios be more effective than the use of cell phones and working through dispatch?

5. Are there any changes to current protocols that would improve function of crisis response services? What are the best options if MCOTs are unavailable?

Much progress has been made in boosting the County's crisis response system in recent years; however, HHS, MCPD and MCFRS have indicated the need for increased staffing and programmatic improvements that would increase their collective ability to meet the demand for crisis response services. **The Joint Committee may want to request that the departments jointly develop a comprehensive multi-year plan that assesses the unmet need for services and makes budgetary (operating and capital) and programmatic recommendations to increase service capacity and improve the service integration across departments.**

Answers to Questions for Joint Session Between the Health and Human Services (HHS) and Public Safety (PS) Committees of Montgomery County Council
January 30, 2023

From Vivian Yao, Legislative Associate

Here are some of the things that I anticipate the Joint Committee will want to know:

- **The most up to date triage protocol for mental health crisis requests (assuming it is what you provided in your 1st Q responses) and description of how requests for help are handled, including the step-by-step roles and responsibilities of the participating departments and partners.**

  Most up-to-date triage and dispatch protocol. Following the George Floyd incident in the Spring of 2020, there was a national call for increased involvement of behavioral health personnel in responding to behavioral health crises independent of police. In July 2020, the Montgomery County Council approved a supplemental appropriation of over $500,000 to fund six clinical therapist positions to expand mobile crisis and outreach teams (MCOTS) at the Crisis Center, and to consult with the White Bird Clinic in Eugene, OR, which has run the Crisis Assistance to Reach Out on the Streets (CAHOOTS) program without law enforcement for over 30 years. The mandate for the consultation with the White Bird Clinic was to create a triage and dispatch protocol for MCOTs that would allow them to conduct crisis responses without police presence. After the consultation, a Triage and Dispatch Protocol was created, discussed, and approved by MCGEO staff, and then implemented starting on July 25, 2022. The Common Triage and Dispatch Protocol (see Figure 1) specifies the criteria for two levels of crisis response: (1) civilian response, and (2) co-response with police. If there is no risk of violence, this will trigger a civilian response. If there is a high risk of violence, the MCOT will continue a co-response with police as it has done for over 20 years.

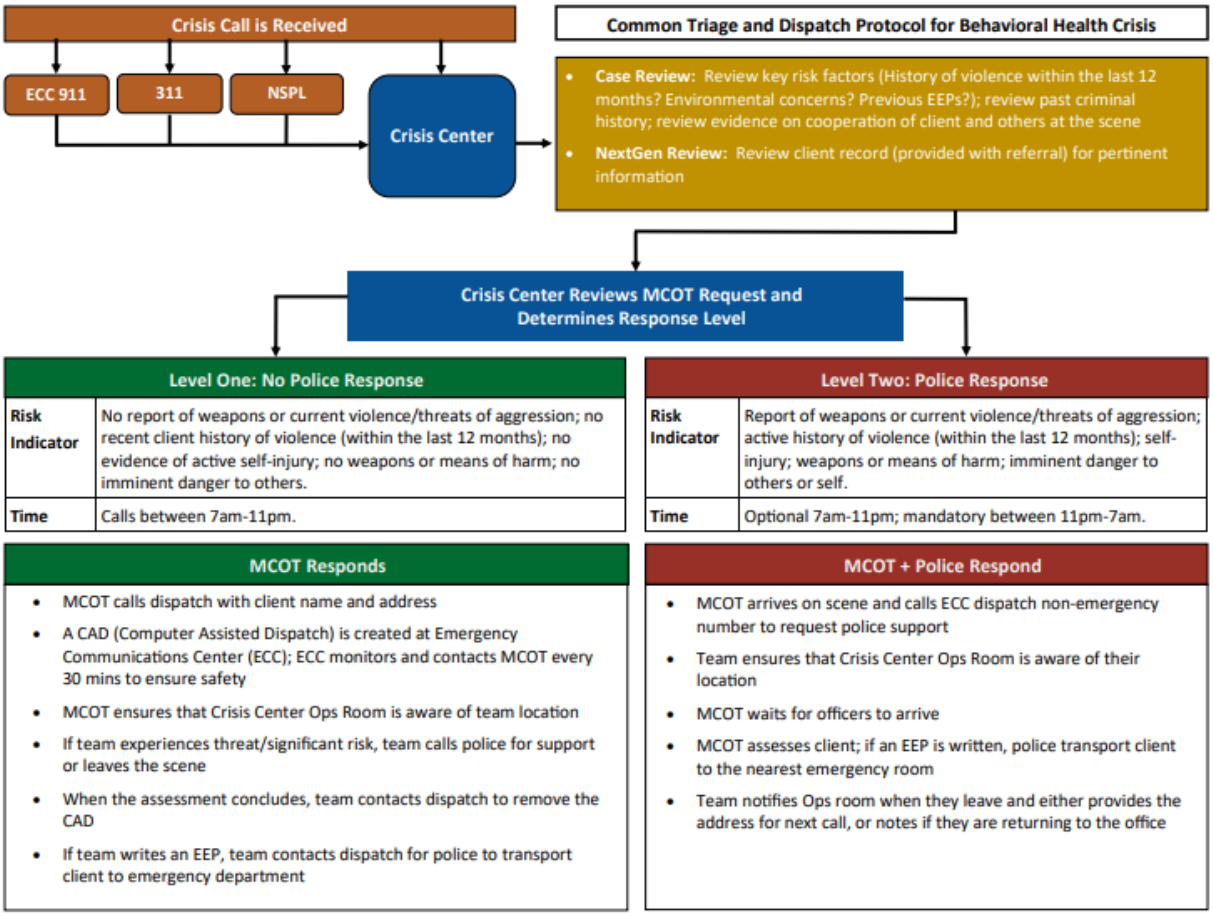
  Description of how requests for help are handled, including the step-by-step roles and responsibilities of the participating departments and partners. The following are the MCOT procedures for the civilian response without police and the co-response with police (also see procedures in Figure 1):

  - ***Civilian response (without police)***
    - MCOT staff member calls dispatch with client name and address
    - A CAD (Computer Assisted Dispatch) is created at Emergency Communications Center (ECC)
    - ECC monitors and contacts MCOT every 30 mins to ensure safety
    - MCOT ensures that Crisis Center Operations Room is aware of team location
    - If team experiences threat/significant risk, team calls police for support or leaves the scene
    - When the assessment concludes, team contacts dispatch to remove the CAD

- If team writes an EEP, team contacts dispatch for police to transport client to emergency department

- ***Co-response (with police)***
  - MCOT arrives on scene and calls ECC dispatch non-emergency number to request police support
  - Team ensures that Crisis Center Operations Room is aware of their location
  - MCOT waits for officers to arrive
  - MCOT assesses client
  - If an EEP is written, police transport client to the nearest emergency room
  - Team notifies Operations room when they leave and either provides the address for next call, or notes if they are returning to the office

Figure 1. Common Triage and Dispatch Protocol for Behavioral Health Crisis



- **Update on how triage protocol has been implemented and instances when Crisis Center has not been able to field crisis calls.** This question has two components and will be answered accordingly.

Update on how triage protocol has been implemented. The Common Triage and Dispatch Protocol was implemented on July 25, 2022, after completing conversations

with MCGEO staff. These conversations were necessary to address safety concerns, training classes, and a police communication protocol if a response without police escalated to a dangerous situation after the MCOT arrived at the scene. Preliminary data indicates that over the first five months from August 2022 to December 2022, there were 624 MCOT responses, of which 158 (25.3%) were without police, 314 (50.3%) were with police, and 152 (24.4%) were unknown. Initial experience with the protocol suggests that responses with police continue to predominate, likely because these responses are prioritized due to the higher risk of violence and potential negative outcome of harming self or others. Supervisors are seeking to work with MCOT staff to minimize and eliminate those responses where its "unknown" whether the response was with police or without police.

Instances when Crisis Center has not been able to field crisis calls. MCOT staff try to respond to all calls for service. However, there are times when demand outpaces the ability of staff to field the crisis center calls. When this happens, MCOT staff will perform alternative actions which may include:

- Offering to speak with a client or family member/concerned party over the phone or arranging for transportation (sometimes via police courtesy transport, if police are on scene and able to do so) for the individual to come into the Crisis Center office, if this is a safe option (the individual would need to be amenable to this).
- Providing consultation to a police officer at the scene on occasions when police are at a scene.
- Making a referral to a homeless outreach team in partnership with Services to End and Prevent Homelessness.

- **Service data on the number of requests referral sources (911, 311, 988, walk ins), responses to requests (MCOT civilian response, CIT request/dispatch, etc.) and disposition (EEP, etc.) Do you track how often MCOT is requested but not available or wait times?** This question consists of several components. Each component is addressed below.

  Service data on the number of requests referral sources (911, 311, 988). As an example of requests for MCOTs that partnering call centers generated, below are totals of requests per call center for the three most recent months (i.e., October to December 2022:

  - 988 for MCOT: 117
  - 911 for MCOT: 44
  - 311 to Crisis Center: 78
  - Total: 239

  These requests show both the need for MCOTs and the importance of understanding the role that each of the partnering call centers play. These call centers make their requests to Crisis Center Hotline (240-777-4000) call takers. For the last two years, the directors of these three call centers together with leadership staff at the Crisis Center Hotline have convened every six weeks through an Integrated Crisis Call Centers

Workgroup to collaborate with each other, strategize, compile data, develop protocols, engage in cross training, and more. In the absence of one regional crisis call center, this collaboration has been critical for building the crisis response model in Montgomery County.

Service data on the number of requests referral sources (walk ins). Crisis Center therapists provided walk-in services to people who arrived in-person at the Crisis Center as follows over the last three fiscal years (FYs):

FY20 (mostly pre-pandemic year):	4,669
FY21 (pandemic year):	3,730
FY22 (transition to post-pandemic):	5,869

Crisis Center therapists currently perform walk-in, MCOT, and Residential Crisis Services (RCS) duties, as needed. During the pandemic, there were fewer walk-ins than during pre-pandemic times.

Responses to requests (MCOT civilian response, CIT request/dispatch, etc.) and disposition (EEP, etc.). As indicated above, the MCOT civilian response compared to a co-response with police from August to December 2022 was as follows:

Civilian response (without police):	158 (25.3%)
Co-response (with police):	315 (50.3%)
Unknown:	152 (25.4%)
Total	624 (100%)

MCOT requests from the Montgomery County Police Department (MCPD) come predominantly from police officers on patrol who are dispatched to the scene of a behavioral health crisis. Many of these patrol officers have had a 40-hour CIT training and are familiar with the Crisis Center MCOTs due to a long-standing 20-year history of co-response. The MCOT requests also come from 911 warm handoffs as indicated above. Currently, CIT team requests occur occasionally, but with an expected expansion of the CIT, requests for an MCOT co-response will likely increase.

At the present time, data on emergency evaluation petition (EEP) conducted by an MCOT is not reported. This information is expected to be reported in the future.

Do you track how often MCOT is requested but not available or wait times? Currently, data on how often an MCOT is requested and not available is not tracked. But these data will be useful to collect in the future. Wait times are also not tracked currently. Wait time is impacted by volume of MCOT requests, complexity of cases, travel time to and from calls, among other such factors. MCOTs seek to be available and responsive as quickly as possible.

- **Please identify any barriers to (optimal) service delivery, needs to address barriers and priorities for services expansion.** The following are lists of barriers and priorities.

Barriers. Barriers to service delivery include, but are not limited to,

- **Lack of licensed behavioral health therapists available for crisis response.** These professionals include social workers, psychologists, counselors, and substance use specialists with Master's Degrees and professional licenses who have training and experience in crisis response. A blog post in the Real Time Report indicated that "[t]here are an estimated 700,000 social workers in the United States as of 2018. The total number of jobs is expected to grow 11 percent over the next decade, significantly faster than the overall job market's growth." In a highly racial and ethnic diverse county, therapists from communities of color and immigrant groups will need to be prioritized.
- **Capacity of Mobile Crisis Outreach Teams.** Right now, there are 3 MCOTs available during the day and evening shifts, Monday to Friday.
- **Capacity of stabilization services.** With a proposed Restoration Center to be built by 2026, 45 recliners and beds will be created for short-term stabilization services.
- **Difficulty recruiting hospital behavioral health staff.** Nexus Montgomery hospitals are facing difficulty recruiting and high turnover, especially in the emergency departments (EDs), partially due to increases in violence against health care providers and staff. Nexus is convening a monthly workgroup to address workplace violence, including acts of violence committed by BH/non-BH patients, family members and other visitors.
- **Lack of medical staffing at Central Processing Unit (CPU).** Montgomery County Police Department (MCPD) officers currently bring people with suspected behavioral health conditions who have been arrested straight to hospital EDs for medical clearance. Currently, there are no staff in the CPU able to conduct medical clearances as is desired by the hospitals.
- **High behavioral health utilization.** Avital Graves, director of the Mobile Integrated Health (MIH) Unit of Montgomery County Fire and Rescue Services (MCFRS) currently leads a monthly workgroup to address individual behavioral health high utilizer cases among Nexus hospital staff, MCPD and community-based partner organizations (e.g., Sheppard Pratt, Cornerstone). High utilizers are defined as individuals who engage with the county's crisis system four or more times per month, including ED visits and calling 911. Reducing preventable/inappropriate behavioral health utilization among the highest utilizers remains a top priority for all stakeholders, as this relatively small number of patients place a disproportionate burden on hospital EDs and first responders.
- **Extremely limited resources for behavioral health patients with autism, intellectual and developmental disabilities (IDD).** First responders and hospitals are encountering more behavioral health patients, including children and adolescents, with autism and/or IDD. These patients' needs cannot be met in the ED, where they end up "boarded" for weeks or months, waiting for an inpatient bed opening. When a patient is finally able to access an inpatient bed, stays are

short and services are usually limited to medication management, without necessary behavioral interventions.

- **Side-by-side comparison between Anne Arundel County Crisis Services and Montgomery County system, including services offered, entities providing services, service delivery protocols, challenges, opportunities, limitations, etc. Speaking specifically to the possibility of co-location of services and care coordination would be of interest.** Please refer to the chart Appendix A.

From Susan Farag, Legislative Associate

1) **Please provide a brief synopsis of the history of the Mobile Crisis Teams, including the recent modification/expansion of the MCOT response model, including the development of the new triage and dispatch protocol. Please provide the most up-to-date call/dispatch protocol you have, outlining where you receive calls from (e.g., Everymind 988, Crisis Center, 911, Police on patrol/CIT, 311(?), walk ins, etc.), who assesses them for appropriate dispatch, and what elements determine the type of response.**
    - **What % of dispatches are MCOT teams without police?**
    - **What % of dispatches are MCOT teams with police?**
    - **What % of dispatches are MCOT teams alone, who later request police presence?**
    - **What % of dispatches are police requesting MCOT assistance?**

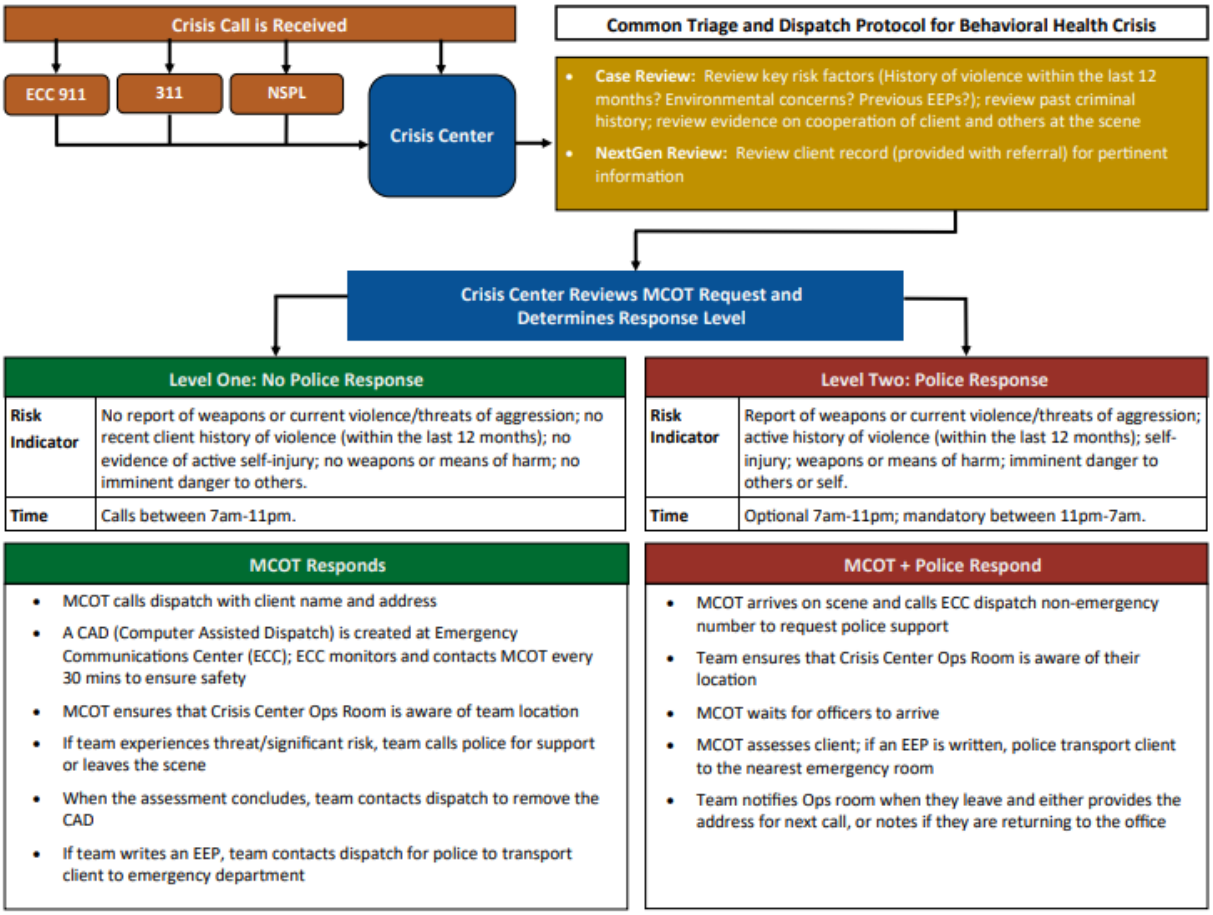
Below is a response to each of the components of this question.

Please provide a brief synopsis of the history of the Mobile Crisis Teams, including the recent modification/expansion of the MCOT response model, including the development of the new triage and dispatch protocol. The history of MCOTs in Montgomery County is relatively long.

- MCOTs were established in the early 1990s.
- Toward the end of the 1990s, a memorandum of understanding (MOU) with the Montgomery County Police Department initiated the co-response with police officers.
- The impetus for this co-response was a felt need to keep MCOT members safe during a crisis intervention.
- A positive result of the MCOT co-response with police was that most crisis interventions were with individuals presenting at a high acuity level with risk of harm to self and others, thus de-escalating many situations and preventing potential fatalities.
- In 2009, the MCOTs became a 24-hour/7-day-a-week operation.
- By 2020, the Crisis Center had approximately 24 staff who were eligible to be part of a two-member MCOT, but they could deploy only one team at any given time.
- The George Floyd incident in the Spring of 2020 created a national movement toward de-coupling law enforcement from mobile crisis response.
- By July of 2020, the Montgomery County Council approved a supplemental appropriation of over $500,000 to hire six more licensed therapists at the Crisis Center with the intent of increasing the number of MCOTs available to be dispatched.

- The supplemental appropriation also funded a consultation with the White Bird Clinic of Eugene, OR, which has run the Crisis Assistance to Reach Out on the Streets (CAHOOTS) program without law enforcement for over 30 years.
- The mandate for the consultation with the White Bird Clinic was to create a triage and dispatch protocol for MCOTs that would allow them to conduct crisis responses without police presence.
- After the consultation, a Common Triage and Dispatch Protocol was created, discussed, and approved by MCGEO staff, and then implemented starting on July 25, 2022.
- The Common Triage and Dispatch Protocol (see Figure 1) specifies the criteria for two levels of crisis response: (1) civilian response, and (2) co-response with police.
- If there is no risk of violence, this will trigger a civilian response.
- If there is a high risk of violence, the MCOT will continue a co-response with police as it has done for over 20 years.
- In the Spring and Summer of 2022, the Crisis Center hired four peer support specialists to join the MCOTs and to provide lived experience and knowledge of the community which will allow the MCOTs to engage with clients on a longer-term basis.
- In January 2023, peer support specialists have started to integrate into an MCOT and be dispatched with a licensed therapist.

Figure 1. Common Triage and Dispatch Protocol for Behavioral Health Crisis



Please provide the most up-to-date call/dispatch protocol you have, outlining where you receive calls from (e.g., Everymind 988, Crisis Center, 911, Police on patrol/CIT, 311(?), walk ins, etc.), who assesses them for appropriate dispatch, and what elements determine the type of response. The following are the MCOT procedures for the civilian response without police and the co-response with police (also see procedures in Figure 1):

- ***Civilian response (without police)***
  - MCOT staff member calls dispatch with client name and address
  - A CAD (Computer Assisted Dispatch) is created at Emergency Communications Center (ECC)
  - ECC monitors and contacts MCOT every 30 mins to ensure safety
  - MCOT ensures that Crisis Center Operations Room is aware of team location
  - If team experiences threat/significant risk, team calls police for support or leaves the scene
  - When the assessment concludes, team contacts dispatch to remove the CAD
  - If team writes an EEP, team contacts dispatch for police to transport client to emergency department

- ***Co-response (with police)***
    - MCOT arrives on scene and calls ECC dispatch non-emergency number to request police support
    - Team ensures that Crisis Center Operations Room is aware of their location
    - MCOT waits for officers to arrive
    - MCOT assesses client
    - If an EEP is written, police transport client to the nearest emergency room
    - Team notifies Operations room when they leave and either provides the address for next call, or notes if they are returning to the office

As an example of requests for MCOTs that partnering call centers (i.e., 988, 911, 311) generated, below are totals of requests per call center for the three most recent months (i.e., October to December 2022:

- 988 for MCOT: 117
- 911 for MCOT: 44
- 311 to Crisis Center: 78
- Total: 239

These requests show both the need for MCOTs and the importance of understanding the role that each of the partnering call centers play. These call centers make their requests to Crisis Center Hotline (240-777-4000) call takers. For the last two years, the directors of these three call centers together with leadership staff at the Crisis Center Hotline have convened every six weeks through an Integrated Crisis Call Centers Workgroup to collaborate with each other, strategize, compile data, develop protocols, engage in cross training, and more.

MCOT requests from the Montgomery County Police Department (MCPD) come predominantly from police officers on patrol who are dispatched to the scene of a behavioral health crisis. Many of these patrol officers have had a 40-hour CIT training and are familiar with the Crisis Center MCOTs due to a long-standing 20-year history of co-response. The MCOT requests also come from 911 warm handoffs as indicated above. Currently, CIT team requests occur occasionally, but with an expected expansion of the CIT, requests for an MCOT co-response will likely increase.

Crisis Center therapists provided walk-in services to people who arrived in-person at the Crisis Center as follows over the last three fiscal years (FYs):

FY20 (mostly pre-pandemic year): 4,669
FY21 (pandemic year): 3,730
FY22 (transition to post-pandemic): 5,869

During the pandemic, there were less walk-ins than during pre-pandemic times. There is also evidence that MCOT responses increased dramatically during the pandemic, suggesting that therapists had more time for MCOT responses and were not tied as

much to responding to walk-ins. To clarify, Crisis Center therapists currently perform walk-in, MCOT, and Residential Crisis Services (RCS) duties, as needed.

- ***What % of dispatches are MCOT teams without police?***
- ***What % of dispatches are MCOT teams with police?***
- ***What % of dispatches are MCOT teams alone, who later request police presence?***
- ***What % of dispatches are police requesting MCOT assistance?***

As indicated above, the MCOT civilian response from August to December 2022 compared to the co-response with police was as follows:

Civilian response (without police):	158 (25.3%)
Co-response (with police):	315 (50.3%)
Unknown:	152 (25.4%)
Total	624 (100%)

Due to the newness of data collection on the civilian response, at this time there is no information on how many MCOTS conducting a civilian response will later request police presence. There is also no precise information on how many of the MCOT co-responses with police were requested by police, but this is expected to be a significant number.

2) **Please provide a brief overview of any planned expansion of current MCOT services.** Plans over the next two years are to expand the MCOTs at the Crisis Center by hiring for the following positions that are currently being advertised:
   - Hire licensed therapists for 4 vacant merit positions
   - Hire another 4 licensed therapists for merit-term (grant funded) positions
   - Hire 4 peer support specialists for merit-term positions.
   - These 16 new hires will allow MCOTs to respond with 4 to 5 teams on day and evening shifts, Monday to Fridays

3) **For those subsequent requests for police presence, what are the reasons given? (e.g. newly determined threat of harm, need to EEP?).** As stated, an escalation in the client's behavior, such that it might pose a risk to those on scene, or the determination that a client meets criteria for an Emergency Evaluation Petition would be the primary reasons police would be requested to respond to a scene after initially responding without law enforcement.

4) **If police determine an MCOT team is more appropriate than police intervention, how do police contact the Crisis Center to request an MCOT team?** Police contact the Crisis Center's crisis phone line (i.e., 240-777-4000) to request a mobile crisis response. These requests are prioritized and responded to as quickly as possible because experience has shown that calls from police officers are often the ones involving clients at the highest levels of acuity in need of de-escalation and trauma-informed care.

5) **Do MCOT teams carry police radios? If not, what is the primary method of communication between MCOT and police?** Yes, all teams are currently equipped with one radio, which is used for any emergency communications. Mobile crisis requests are received through the Crisis Center Operations Room phone lines. MCOT teams have cell phones for routine communications.

6) **What is the current staffing for MCOT teams, hours/shifts, and locations across the County?** The Crisis Center is currently funded for one 24/7 team dispatched out of primary office in Rockville and two teams located in regional satellite locations in Germantown and Silver Spring. These two satellite locations are staffed Monday-Friday, 7am-11pm.

7) **Please provide data on number of calls handled by MCOT teams.** The increased MCOT responses over the last three fiscal years (FYs) indicates the important role that MCOTs have played during the pandemic.

FY20 (mostly pre-pandemic year):	397
FY21 (pandemic year):	796
FY22 (transition to post-pandemic):	930

8) **Please provide data on MCOT call dispositions.** The Crisis Center does not have a report on MCOT call dispositions, primarily due to challenges with accessing information from the current electronic health record system. However, staff will try to resolve this situation soon. Having said this, dispositions may include the following:
   - de-escalation
   - behavioral health assessment
   - emergency evaluation petition (EEP)
   - referral to an appropriate service in the behavioral health provider community

9) **How long does an average call take?** On average, a mobile crisis response takes 90-120 minutes. This varies considerably around the client's clinical presentation and other situational factors such as number of people involved, timeframe for police response, need for language interpretation, among others.

10) **If all MCOT teams are busy, what are average wait times for availability?** The Crisis Center does not keep specific data on wait times. Wait time can be impacted by volume of MCOT requests, complexity of cases, travel time to and from calls, and so forth. MCOT requests are responded to as quickly as possible.

11) **If MCOT teams are not available, how are calls handled? Dispatched to CIT, CIT-trained police, available police on patrol?** How requests are handled may be determined by acuity or circumstances of the request. Higher acuity cases that represent a high risk for violence may be referred to patrol officers for immediate response. Patrol officers are often CIT trained. Lower acuity cases where immediate safety concerns are not present may be held and responded to as soon as MCOT is available. These decisions are made in communication with the requestor.

12) **Please identify any barriers to MCOT service delivery, what resources are needed to address those barriers, and your priorities for services expansion.** Recruitment/hiring of skilled licensed mental health professionals. Hiring has been impeded by nationwide clinician shortage, higher salaries/hiring incentives in competing jurisdictions, and increased availability of telework in other programs. The Crisis Center continues efforts to work with human resources (HR) personnel to aggressively recruit qualified applicants, as well as expanding partnerships with

local universities in an effort to recruit master's level interns who may be interested in pursuing career opportunities in government service.

13) **In terms of client records management, what system(s) are used?** NextGen is the electronic health record (EHR) platform used at the Department of Health and Human Services (DHHS). It is currently upgrading its Behavioral Health Suite.

14) **How are care coordination and follow-up addressed (by HHS, Police, Fire, and others) to maximize the ability of clients to access and maintain appropriate treatment?** Over the past year, DHHS has incorporated the use of peer support specialists, navigators, and case managers (i.e., community service aides) to conduct follow up to clients. MCOTs have always worked closely with County and private providers to facilitate appropriate referrals as needed with such programs as Child Protective Services (CPS), Adult Protective Services (APS), Access to Behavioral Health, residential crisis services, homeless services, and others. The Crisis Center has also always worked closely with law enforcement and fire and rescue services as needed to coordinate most appropriate disposition.

    In addition, Montgomery County Fire and Rescue Services (MCFRS) engages the Mobile Integrated Health (MIH) team to introduce a follow-up aspect to the typical episodic emergent care. MIH works closely with all six hospitals, MCPD, DHHS, non-profit mental health organizations, homeless resources, care managers, community health providers, and others, to identify ongoing patient needs. These efforts are carried out by a social worker, nurse, and manager (i.e., paramedic) within MIH. The goal of MIH staff is to connect patients with the next appropriate resources and move on to the next patient.

15) **Please provide a brief history of the Police CIT unit, where it stands now, and its plans moving forward?** MCPD began its CIT training program in 2000, precipitated by a fatality of an individual with severe mental illness on a Crisis Center mobile crisis call in 1998. Then-Chief Moose designated an officer, Joan Logan, to partner with DHHS and initiate CIT training for MCPD officers. MCPD/DHHS built a strong partnership over the past 22-23 years, in large part due to the efforts of Officer Logan and Officer Scott Davis, who took over as CIT Coordinator after Officer Logan's retirement. CIT was expanded in 2014 to include another full-time officer and a contractual clinician in 2015. This position became a merit position in 2019. CIT has historically facilitated 4-6 40-hour training sessions for County/local officers, as well as providing advanced trainings, consultation to LE and other professionals, and assisting with evaluations.

16) **What is the current staffing for CIT?** One sergeant, two full-time officers, one DHHS Therapist II (currently vacant), and long/short term temps.

17) **What types of crisis training do police receive? Do CIT unit members receive any additional specialized training?** Officers receive 8 hours of Mental Health First Aid training in the Academy and 40 hours of Crisis Intervention Training (CIT) after completing field training. Officers also have annual online training modules on behavioral health topics and are offered opportunities for advanced training through the PSTA and outside venues. Historically, full-time CIT officers were also crisis negotiators and members of MCPD's peer support team, as well as being certified LE instructors.

18) **Please provide data on number of calls handled by the CIT unit.**
MCPD to respond.

19) **Please provide data on number of requests for MCOT teams.**
Currently, data on how often an MCOT is requested is not tracked. However, partnering call centers generated totals of requests per call center for the three most recent months (i.e., October to December 2022:

988 for MCOT:	117
911 for MCOT:	44
311 to Crisis Center:	78
Total:	239

20) **Please identify any barriers to CIT service delivery, what resources are needed to address those barriers, and your priorities for services expansion.**
MCPD to respond.

21) **In terms of client records management, what system(s) are used by Police? Do these systems integrate with DHHS systems?**
MCPD to respond.

22) **Anne Arundel County's Crisis Response System is markedly different from ours -- their mental health services are managed by a public/private agency, and a variety of their policies and procedures may not easily be replicated here. However, it would be helpful to better understand whether certain aspects of their model, such as physical co-location of Police CIT and MCOTs, shared data systems, and shared care coordination may be beneficial to the County. Please be ready to discuss whether these types of changes may be helpful in augmenting responses to both low acuity and higher acuity crisis calls. Please be ready to discuss any foreseeable drawbacks as well.** See Appendix A for a chart with the comparison between Anne Arundel County's and Montgomery County's crisis responses.

Appendix A

Behavioral Health Crisis Response in Anne Arundel and Montgomery Counties: Comparison Chart

Comparison Criteria	Anne Arundel County	Montgomery County
Crisis response system	• Provides services to the community through 24-hour warmline call center, Mobile Crisis Teams, Crisis Intervention Teams (police in crisis building), Care Coordination, Hospital Diversion, Jail Diversion, Safe Station (SUD), and transportation • Non-profit organization is lead agency • Coordinates with all other County Departments, School, and the Judicial systems	• Provides services at the Crisis Center that include Mobile Crisis and Outreach Teams (MCOTs), walk-in crisis intervention services four Residential Crisis Services (RCS) beds, and transitional psychiatry • Coordinates with programs in the same building that include Abused Persons Program (APP), Victims of Sexual Assault Program (VASAP), Services to End and Prevent Homelessness (SEPH), Child Welfare Services (CWS), among others • The MCOT co-response with police has been implemented in collaboration with the Montgomery County Police Department (MCPD) for over 20 years • The County's Department of Health and Human Services is the lead agency • Outputs in FY22 include: o 45,981 calls to the Crisis Center Hotline o 930 MCOT responses o 5,869 walk-in crisis interventions o 78 Critical Incident Stress Management responses o Over 1,000 students and families referred from schools for assessments
24/7/365 crisis call center	• "Community Warmline" receives calls 24 hrs/7 days per week • Community Warmline staff intervene with callers who are experiencing a mental health and/or substance use disorder emergency • Warmline staff also answer calls from police, call takers at 911, 988 Lifeline, 211, Anne Arundel County Public	• Crisis Center Hotline (240-777-4000) receives calls 24 hrs/7 days per week (over 45,000 calls in FY22). • Call takers answer calls for service from individuals experiencing a mental health or substance use crisis, neighbors of individuals in crisis, police, call takers at 911 Emergency Community Center (ECC), 988 Lifeline, 311 county information, Montgomery County

	Schools, hospital staff, EMTs, and homeless services and shelter staff • Community Warmline staff also coordinates calls with police and fire and rescue, and community agencies requesting information about behavioral health crises • Non-emergency calls are handled by staff & provides the caller with information, support, and referrals • Warmline staff is available after hours and when other county departments are closed to triage and support social needs	Public Schools, hospital staff, EMTs, homeless services, homeless shelter staff, among others, and coordinates a crisis response with them. • Call takers also answer calls for service for APP, VASAP, trauma services, individual homeless service requests, and after hours calls for Child Welfare Services (CWS), Adult Protective Services (APS), and Public Health (PH). • Non-emergency calls are handled by staff who provide the caller with information, support and referrals
Crisis call centers collaboration (e.g., crisis hotline, 988, 911, 311)	• Warmline staff also answer calls from police, 911 operators, 988 Lifeline and 211 which are transferred to the Warmline • 911 operators are trained to triage and transfer calls as needed	• Planning and implementation workgroup with representatives of the Crisis Center Hotline, 988, 911, and 311 has met regularly every six weeks over the last two years • Outcomes of these workgroup meetings include trainings with call takers, grants, warm hand offs, protocols for appropriate triage and dispatch of MCOTs, visuals for informing the public, communication procedures, among others
`Mobile crisis teams	• **Composition.** Mobile crisis teams (MCT) consist of two-member teams that include an independently licensed clinician and a graduate level licensed clinician • MCT is available 24/7/365 • MCT is on police radio so can be directly dispatched by patrol or through the Crisis warmline • MCT can dispatch with police or without police (overnight MCT always dispatches with an officer due to safety) • MCT can respond to calls initiated by a call to the warmline if there is no risk of violence	• **Composition.** Mobile crisis and outreach teams (MCOTs) consist of two-member teams that include a licensed clinician and a non-licensed clinician • **Staffing.** The Crisis Center has 30 licensed clinicians. It also has non-licensed clinicians and peer support specialists. • **Times available.** MCOTs are active 24/7/365 • **Multiple locations.** Since summer of 2022, they are in three locations: Downcounty (Silver Spring, Upcounty (Germantown), and Midcounty (Rockville). The mid-county location is open 24 hours/7 days a week. • **MCOT capacity.** Up to three MCOTs can be deployed during day and evening shifts, Monday to Friday. • **Co-response with police and civilian response.** All MCOT responses were conducted with police presence for over 20 years until July 25, 2022, at which time a new triage and dispatch protocol was established and approved by union employees that allows some MCOTs to deploy without police presence if there is no risk of violence.

		• **Peer support specialists.** A new MCOT team that pairs a licensed clinician with a peer support specialist began to deploy in January 2023.
Stabilization services	• **Stabilization services** – AA Crisis Response works with providers in the community who run the stabilization services (Due to the geography of the county this is more advantageous than one large facility-transportation limited) • AA County utilizes 2 stabilization centers for placement for mental health, SUD and diversion from hospitals and jail	• A new Restoration Center facility is being planned, designed and built with $17M in Maryland legislated dollars, with estimated opening in 2026. It will include 25 recliners, and 20 beds, for sobering, stabilization and diversion from hospitals and jails. • A 24/7 low-acuity stabilization room with four recliners is being developed at the Crisis Center with SAMHSA grant funding.
Follow-up and referrals to continuum of care	• AA Crisis Response has a unit of care coordinator who do all follow up on calls completed by MCT and CIT • Care Coordinators help with benefits, gaining ID, Birth Certificates and SSN cards • Care Coordinators help get their clients set up follow up appointments and help be taking them to their appointments is transportation is a barrier • Care Coordinators review care with individuals to reduce additional issues (support for adhering to court appearances if transportation is needed, rent/eviction notices, medication ran out etc)	• MCOT, walk-in, and RCS staff at the Crisis Center implement robust discharge plans • Longer term navigation and care coordination procedures are beginning to be implemented at the Crisis Center with SAMHSA funding • (See also the answer to "Partnerships with continuum of care providers" below)
Involvement with police	• **Co-response** – CIT is a co-responder model in which the officer and clinician ride together in an unmarked police car to calls. • **Co-location** – CIT officers and CIT clinicians are located together at the Crisis Response office and always respond together • **Staffing** – CIT consist of a Lieutenant, Sergeant, and 8 officers • All officers in AA County Police Department are trained **in Mental Health First Aide** • **40-hour CIT Training-** AA County runs four 40-hour CIT trainings a year to	• **Co-response.** MCOT co-response with police has occurred for over 20 years and continues. Co-response is defined as a call by police or MCOT to connect each other and coordinate to arrive together at a crisis scene. Currently, MCOT and police staff are re-examining the co-response with goal of improving it co-location practices and response times. • **Co-location.** A licensed clinician is embedded within the Crisis Intervention Team (CIT) for at least the last 5 years. The clinician position is currently vacant. ***Care coordination*** with police on specific cases occurs intensively. • **40-hour CIT training.** MCOT and CIT staff have collaborated for over five years in training

	include site visits, guest speakers on behavioral health topics, role playing and de-escalation training • **CIT** a key component of responses to the school system, esp if parents cannot be located. Allows for intervention in a timely manner so that teachers etc, can continue with their work/permits minimal disruption and best outcomes for the student	police, human service clinicians, peer support specialists and more. Currently, this training is mandated for all police recruits.
Involvement of fire and rescue services	• **Safe Station program –** 24/7/365 access for the community to access SUD treatment by coming to any fire or police station for help. Fire then dispatches out a clinician from crisis to assess and place individual • **Mobile Crisis & CIT** respond to any fires that cause loss of life or where the home is uninhabitable to assist with supporting the family with resources. This is coordinated with the Red Cross • Follow up care is transferred to the most appropriate unit of the CRS after stabilization	• **Collaboration on planning, advisory, and implementation workgroups.** The involvement of Montgomery County Fire and Rescue Services (MCFRS) personnel and volunteers has been multi-faceted over the last several years, especially in collaborative workgroups such as the following: ○ **Leadership Collaborative.** The chief of MCFRS is integral to this "high level" workgroup that also includes the director of the Department of Health and Human Services (DHHS), the chief of the Montgomery County Police Department (MCPD), leaders from the six hospitals in Montgomery County, chairs of two behavioral health county-wide committees and councils, among others. This workgroup troubleshoots high level police and practice activities in crisis response such as developing a stabilization facility (Restoration Center) and creating measures for documenting progress toward building the community-wide crisis response. Meets quarterly. ○ **High utilizers workgroup (direct service).** The director of the Mobile Integrated Health (MIH) unit at MCFRS moderates this group that identifies and strategizes on assisting individuals who are high utilizers of emergency rooms, Crisis Center, police officer contact, and more. The workgroup consists of partnering staff from hospitals, non-profit sector, police, and county government. It's a subgroup of Nexus Montgomery, an organization that brings together the six hospitals. ○ **Integrated Crisis Call Centers Workgroup.** MCFRS staff participate in this workgroup

		consisting of partners from 911, 988, 311, Crisis Center Hotline, DHHS, MCFRS, and MCPD and whose mission is to guide implementation of collaborative activities such as protocols, trainings, data sharing, warm hand offs to Crisis Center Hotline and each other, among others. Meets every six weeks. ○ **Crisis and Outreach Teams Workgroup.** MCFRS staff also participates in this workgroup consisting of MCOT management staff, and managers of homeless outreach teams, ACT teams, STEER teams (for peer involvement in substance use crisis interventions). It also includes staff from DHHS and MCPD. The mission of this workgroup is to resolve issues relating to the implementation of behavioral health crisis outreach teams. Meets every six weeks. ○ **Stabilization Services Workgroup.** MCFRS also provides input in this workgroup consisting of staff representatives from DHHS, MCPD, Department of General Services (DGS), Office of Management and Budget (OMB), MCPD, and others. The mission of this workgroup is to provide guidance and advice on the creation of facilities for short-term (i.e., 1 to 72 hours) stabilization of individuals in a mental or substance use crisis. Meets every six weeks. • **Upcoming opportunity.** MCFRS and Crisis Center staff are currently determining criteria for dropping off EMT clients at the Crisis Center as an alternative to emergency room drop offs. Police for many years have been dropping off individuals in crisis at the Crisis Center.
Coordination with harm reduction efforts	• Harm reduction efforts are done through the Safe Station program and in partnership with the Health Department • Some coordination with Detention facilities for individuals who are discharged abruptly from the DC	• **Activities.** Harm reduction staff have been active distributing Narcan kits across many partners including police stations, fire and rescue stations, libraries, schools and other locations. They have also conducted numerous trainings and have engaged in numerous public education campaigns. They continue to seek additional ways to combat overdose deaths. • **Opioid Intervention Team (OIT).** Key partners that include staff from District Attorney, police, fire and rescue services, schools, DHHS, community members, and more, meet monthly

		to report, strategize and advise. Number of overdose deaths, Narcan Kit distribution, STEER program activities, and other information for Montgomery County is tracked through various databases including federal (CDC), state (MDH), police, EMT, and medical databases to get the most accurate current counts and information. • **Outcomes.** Overdose deaths in Montgomery County increased from 2.6 per 100,000 in 2010 to 13.9 in 2020. During this same period, the Maryland State rates increased from 10.4 in 2010 to 44.2 in 2020. These rates continue to increase locally, statewide, and nationally, especially due to the wide distribution of fentanyl, a potent and easy-to-acquire synthetic opioid that contributes to most overdose deaths. • **Addressing overdose deaths among youth.** There is currently high concern for penetration of the fentanyl market among youth. Montgomery County Public Schools (MCPS) with support from DHHS harm reduction efforts are addressing education and training of students and parents.
Engagement with community	• Participate in Sound of Silence which is an education program in the county that does assemblies at schools and events in the community • CIT and MCT provide community debriefing after traumatic events • Multiple trainings and participation in most health fairs and community events	• **Partner and community workgroups.** Several partner and community workgroups as outlined in the "involvement of fire and rescue services" have met regularly (about every six weeks or more as needed) to strategize, advise, and provide feedback on the implementation of the Crisis Now model in Montgomery County. • **Community Forum on the Restoration Center.** A community forum to inform both a neighborhood group (i.e., Seven Locks Alliance) and the entire Montgomery County community about plans for the Restoration Center was held on October 6, 2022. County agency leaders provided information about the need for stabilizing people in behavioral health crises as an alternative to placing them in overcrowded emergency rooms or charging them and placing them in jail. Future community forums are planned to invite the community to provide feedback on the design and implementation of the facility. • **Engagement with community advocacy groups.** DHHS, police and other county agency

		staff staff have met multiple times over the last two years with community advocate groups such as the Silver Spring Justice Coalition (SSJC) who are concerned with social justice and equity. They have also met regularly with advocates concerned with lack of crisis services for individuals with developmental disabilities and on the autism spectrum. These advocate groups have provided invaluable input in the development of appropriate and effective crisis response services.
Partnerships with continuum of care providers	• **AA County Partnerships** – meet weekly with both AA County hospital emergency room mental health supervisors. Meet monthly with school system to discuss high risk school cases, meet monthly with stabilization providers, monthly with health department. Work closely with Dept of Social Services for homeless and other disadvantaged populations including but not limited to foster children, homeless children etc. Work with the local management board for continued follow-up for families.	• **Crisis Center community partnerships.** For about 40 years, the Crisis Center has established effective partnerships with community providers who serve as referral destinations for persons in crisis. Some referral destinations are for persons with high acuity needs and may include referral to a crisis bed for stabilization, a residential facility for recovery, an assertive community treatment (ACT), or on occasion to higher level intervention in an emergency room. For those at medium to low acuity levels, they may be referred to psychiatric rehabilitation programs (PRP), case management services, outpatient mental health clinic (OMHC) for adults or children, substance use services, and a host of other behavioral health services. In some instances, referrals may include non-behavioral health services such as housing, food security, income and other such social determinants of health (SDOH). All these services exist in Montgomery County in both the public and non-profit sectors. In some instances, referrals to child protective services, services to end and prevent homelessness, trauma services, victims of abuse, crime, and domestic violence, and public health services, senior behavioral health services, among many other programs under the DHHS may also occur. Public sector services serve as a safety net for the uninsured or underinsured and are delivered through Behavioral Health and Crisis Services (BHCS) of DHHS. • **Nexus Montgomery Behavioral Health Workgroup.** This workgroup is convened by the Primary Care Coalition on behalf of Nexus Montgomery, a collaboration with six hospitals.

		The workgroup includes public and private sector providers, and has proven to be an excellent vehicle for troubleshooting, information, strategic planning, and policy monitoring.
Data systems	• **Co-response –** officers have signed confidentiality agreements and put notes in the electronic medical record when on a call for service • Police computer systems are run separately in the building than CRS systems. • CRS uses and electronic medical record that allows for information sharing in real time between shifts for safety and best outcomes for individuals	• **DHHS crisis data systems.** Most MCOT-related data is entered and reported through NextGen, the electronic health record system for DHHS. In addition, counts of calls, MCOT responses, RCS bed days, walk-in responses, and detailed assessments with students referred from schools are recorded. • **Police data systems.** Due to legal restrictions, police information is only accessible to police officers. However, during MCOT co-responses with police, data is used to keep crisis situations safe. MCOT members also alert police officers of the behavioral health conditions of clients in crisis within HIPAA confidentiality limits. • **Emergency communication (911) data system.** Provides information on number of behavioral health-related police interventions and warm-handoffs to MCOTS. • **Other data systems such as 988 and 311.** Warm hand off data is shared with MCOTs and with 911. • **Coordination among data systems.** There are legal restrictions on joining and sharing DHHS and police data. DHHS behavioral health staff have partial access to statewide medical data system called CRISP. Over the last two years, behavioral health staff have been working with UniteUs platform to use UniteUs as a tool that will facilitate referrals from DHHS behavioral health staff to community providers.

Montgomery County Council
Public Safety Meeting 1/30/2023
Question/Answer Document

I am sending some questions for your departments, to prepare for the joint work session on January 30. Could you provide responses by January 23? Please let me know if you have questions. Thanks!

0) Please provide a brief synopsis of the history of the Mobile Crisis Teams, including the recent modification/expansion of the MCOT response model, including the development of the new triage and dispatch protocol. Please provide the most up-to-date call/dispatch protocol you have, outlining where you receive calls from (e.g. Everymind 988, Crisis Center, 911, Police on patrol/CIT, 311(?), walk ins, etc.), who assesses them for appropriate dispatch, and what elements determine the type of response.
    a. What % of dispatches are MCOT teams without police?
    b. What % of dispatches are MCOT teams with police?
    c. What % of dispatches are MCOT teams alone, who later request police presence?
    d. What % of dispatches are police requesting MCOT assistance?

This number is hard to produce for two reasons. First, oftentimes police officers request assistance from the crisis center or mental health providers via cell phone and not through ECC. Secondly, searching the CAD will provide a limited number, but this search is labor intensive because it requires searching keywords.

1) Please provide a brief overview of any planned expansion of current MCOT services.
2) For those subsequent requests for police presence, what are the reasons given? (e.g. newly determined threat of harm, need to EEP?)
3) If police determine an MCOT team is more appropriate than police intervention, how do police contact the Crisis Center to request an MCOT team?

The officers can request an MCOT but typically only after they take some actions such as going to the address, making a phone call to the person in crisis, or convincing a supervisor to have an ECC supervisor redispatch the call to MCOT. If PD is on the scene of a situation where they see the need for MCOT they have to call the crisis center on their cell phone like anyone else as there is not a dedicated LE line. They will explain the entirety of the situation because the crisis center doesn't have the CAD and doesn't have access to what call the officer is dealing with. After this step the officer will be given a time frame for a potential response from MCOT.

4) Do MCOT teams carry police radios? If not, what is the primary method of communication between MCOT and police?
5) What is the current staffing for MCOT teams, hours/shifts, and locations across the County?
6) Please provide data on number of calls handled by MCOT teams.
7) Please provide data on MCOT call dispositions.
8) How long does an average call take?

9) If all MCOT teams are busy, what are average wait times for availability?
10) If MCOT teams are not available, how are calls handled? Dispatched to CIT, CIT-trained police, available police on patrol?
11) Please identify any barriers to MCOT service delivery, what resources are needed to address those barriers, and your priorities for services expansion.
12) In terms of client records management, what system(s) are used?
13) How are care coordination and follow-up addressed (by HHS, Police, Fire, and others) to maximize the ability of clients to access and maintain appropriate treatment?

The PD should play a part in this process to increase community engagement, reduce negative law enforcement interactions, and reduce negative police contacts. Currently, the CIT team is developing and has begun to track those consumers they've contacted and the requests they've received as a way to followup and circle back with the intent of providing wrap around services to the patient and family. Our role will be to assist with the treatment plan approach which means performing site visits and coordinating transportation if needed.

14) Please provide a brief history of the Police CIT unit, where it stands now, and its plans moving forward?

The CIT program began with one officer in 2001. The focus was on providing training to patrol officers in CIT and helping outline the basic elements of a CIT program. Further, the role was to establish connections with HHS, help with policies and procedures, and get the CIT school up and running.

During this phase, an LCSW began working with the small CIT unit. The clinician was eventually embedded into the department. That role was created to help with training, review, and provide guidance on completing emergency evaluation petitions (EEP) and on acute cases.

The program's second phase did not deviate far from its original inception. The first officer to hold the position passed the torch, and the replacement continued with the established procedures and mission. However, this second officer began to help patrol in real-time cases in addition to training increasingly. The department added one officer to the program in 2014.

The structure and use of CIT remained unchanged from 2001 until March 2022. At this time, Sergeant Chad Matthews arrived in the role of CIT supervisor. Having been a road supervisor for over four years at the time he took the position, he saw the need to provide a better product to the patrol officers, detectives, and, more importantly, to the citizens in crisis. Observing and evaluating the gaps in services and the fractured connections, the Sgt began a monthly meeting of community stakeholders, calling it Crisis Stat. The first Crisis Stat meeting was held in May 2022 and paved the way for establishing broken relationships, connecting partners, and learning how to serve our mentally ill population better.

The Sgt also established connections with neighboring jurisdictions to observe and understand their programs. These relationships were vital in framing out how to revamp and update the MCPDs CIT program. The ten thousand-foot view of the vision for the team looks similar in

size and scope to a hybrid model of the Baltimore County Police Department's Behavioral Assessment Unit (BAU) and Anne Arundel County's CIT program.

These models use several teams of Co-Responders (defined as One CIT officer and One social worker). Each unit is expected to be in the field during the majority of their shift and responsible for answering 911 calls involving a significant mental health component. This model provides a timely response to the person in crisis. The Co-Responder units focus on providing safety for the patient while quickly connecting them to the appropriate services.

These teams also have a group of dedicated officers who research and triage threats of potentially criminal behavior and other concerns. These requests come from police officers, executives, community members, to name a few. Their Threat Management Team (TMT) receives extensive training in behavioral analysis to provide as clear a picture as possible for the CIT teams.

15) What is the current staffing for CIT?

As of today, one sergeant and two officers and in less than two months it will have two sergeants and four officers. Additionally, Officer Laurie Reyes (Autism/IDD) is assigned to under the CRSS umbrella along with a few officers who help on an ad hoc basis.

16) What types of crisis training do police receive? Do CIT unit members receive any additional specialized training?

MCP provides a minimum of an eight-hour mental health first aid training to all officers. Also, approximately 75-80% of the department has been to the 40-hour Crisis Intervention Team (CIT) training.

The CRSS/CIT team members attend the annual CIT International Conference as part of learning best practices and current procedures. The Sergeant for the team will be attending the Federal Law Enforcement Training Center (FLETC) Mental Health Crisis Instructor Training Program at the end of February.

17) Please provide data on number of calls handled by the CIT unit. = ***81 calls (see attachment) (This information is from ECC)***

18) Please provide data on number of requests for MCOT teams. = ***This one can't be determined. ECC looked at the comments with the words "crisis center" and "MCOT". The comments vary and pertain to the phone number provided, the caller taking the involved party to the crisis center, etc. ECC put this in place this year to indicate a modified circumstance of MCOT when they are responding for an Evaluation – to date there have been 4 incidents. (This information is from ECC)***

Behavioral Health System for Montgomery County: Its Emerging Crisis Response Model

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Challenge: Increase in behavioral health crisis responses

1. The pandemic exacerbated the need for a robust emergency response to behavioral health crises in Montgomery County (MC), Maryland. The following are examples of increased crisis responses.
    1. In calendar year 2021 the 24/7 Mobile Crisis and Outreach Team (MCOT) at the Department of Health and Human Services (DHHS) reported 979 behavioral health crisis responses, a 98% increase form 495 in 2020.
    2. In calendar year 2021, the Montgomery County Fire and Rescue Services (MCFRS) reported a 28% increase in emergency medical technician (EMT) responses to behavioral health crises from 10,471 in 2020 to 13,377 in 2021.

Challenges: Gap in crisis response and stabilization services

- **Crisis response.** Insufficient number of mobile crisis and outreach teams that RI International estimated Montgomery County needs. Eight teams are needed, but there are currently three that can be dispatched on day and evening shifts, Monday to Friday.

- **Stabilization services.** Lack of short-term (i.e., 24-72 hour) specialized behavioral health facilities to stabilize individuals who experience a behavioral health crisis incident such as a suicide attempt, a drug overdose, or a psychiatric episode with a risk for harming self or others.

Opportunities: Behavioral health crisis response

What is the Crisis Now model?

- It's a public health response to people experiencing a behavioral health crisis.
- The model includes:
  (1) Integrated crisis call centers (toward a regional "air traffic control" model)
  (2) Mobile crisis and outreach teams
  (3) Stabilization facilities
  (4) Crisis care follow up

Opportunities: Behavioral health crisis response

Crisis Now model: Goals and essential features

(1) Divert people experiencing a behavioral health crisis from landing in jail or in a hospital emergency room

(2) Respond equitably

(3) Engage the community

(4) Promote wellbeing and achieve public safety

Essential features of Crisis Now incorporate the best practices of CAHOOTS and Asante models: Civilian response, use of peers with lived experience

Opportunities: Behavioral health crisis response

Integrated call centers: What is being done now?

- A Crisis Call Center Integration Workgroup consisting of representatives from four crisis call centers including Emergency Communications Center 911, Crisis Center Hotline, 988 Suicide and Crisis Lifeline, and Montgomery County 311 have convened every six weeks since December 2020 for advising on collaborative policies and practices, training, funding, data sharing, among others.
- Goal: To increase efficiencies in call for services, dispatch and deployment of MCOTs.

Opportunities: Behavioral health crisis response

Integrated crisis call centers: Warm Handoffs to Crisis Center Hotline for MCOT response, October to December, 2022

988 for MCOT:	117
911 for MCOT:	44
311 to Crisis Center:	78
Total:	239

Opportunities: Behavioral health crisis response (expansion)

MCOT Civilian and Co-Response with Police

- Started to implement the Common Triage and Dispatch Protocol (next slide) on July 25, 2022
  - from August to December 2022, number and percent of MCOT responses were as follows:
    - Civilian response (without police): 158 (25.3%)
    - Co-response (with police): 315 (50.3%)
    - Unknown: 152 (25.4%)
    - Total 624 (100%)
- Current composition of MCOT team: Two therapist clinicians, one licensed

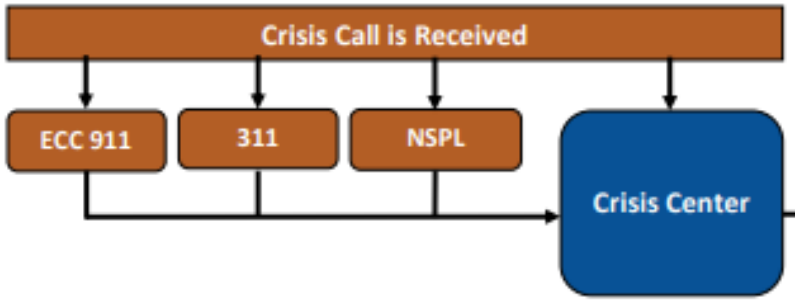
Opportunities: Behavioral health crisis response (expansion)

- **Future of civilian response:**
  - Add a peer support specialist (with lived experience): For short- and long-term engagement
  - Create a mobile response and stabilization services (MRSS) team with two family peer support specialists: For responding to crises among children and youth
- **Future of co-response with police:**
  - Dispatch therapist and police officer together: For increased communication, faster response time, co-sharing of clinical and public safety data

Opportunities: Behavioral health crisis response (expansion)

Common Triage and Dispatch Protocol: Criteria for determining whether a response should be "civilian" or "co-response" with police, and procedures for response

(next slide)



Common Triage and Dispatch Protocol for Behavioral Health Crisis

- **Case Review:** Review key risk factors (History of violence within the last 12 months? Environmental concerns? Previous EEPs?); review past criminal history; review evidence on cooperation of client and others at the scene
- **NextGen Review:** Review client record (provided with referral) for pertinent information

Crisis Center Reviews MCOT Request and Determines Response Level

Level One: No Police Response	
Risk Indicator	No report of weapons or current violence/threats of aggression; no recent client history of violence (within the last 12 months); no evidence of active self-injury; no weapons or means of harm; no imminent danger to others.
Time	Calls between 7am-11pm.

Level Two: Police Response	
Risk Indicator	Report of weapons or current violence/threats of aggression; active history of violence (within the last 12 months); self-injury; weapons or means of harm; imminent danger to others or self.
Time	Optional 7am-11pm; mandatory between 11pm-7am.

MCOT Responds

- MCOT calls dispatch with client name and address
- A CAD (Computer Assisted Dispatch) is created at Emergency Communications Center (ECC); ECC monitors and contacts MCOT every 30 mins to ensure safety
- MCOT ensures that Crisis Center Ops Room is aware of team location
- If team experiences threat/significant risk, team calls police for support or leaves the scene
- When the assessment concludes, team contacts dispatch to remove the CAD
- If team writes an EEP, team contacts dispatch for police to transport client to emergency department

MCOT + Police Respond

- MCOT arrives on scene and calls ECC dispatch non-emergency number to request police support
- Team ensures that Crisis Center Ops Room is aware of their location
- MCOT waits for officers to arrive
- MCOT assesses client; if an EEP is written, police transport client to the nearest emergency room
- Team notifies Ops room when they leave and either provides the address for next call, or notes if they are returning to the office

Opportunities: Behavioral health crisis response (coordination)

Mobile Crisis and Outreach Teams (MCOT): What is being done now?

- ***Coordinating with Services to End and Prevent Homelessness (SEPH) outreach teams.*** There is 1 FTE Outreach Coordinator who oversees coordinated strategy with at least 14 outreach-related staff.
- ***Coordinating with Police Department Crisis Intervention Team (CIT).*** 1 therapist (vacant), 2 FTE officers dedicated to behavioral health crisis response.
  - Future: (1) Strengthen CIT training, and (2) build CIT co-response with behavioral health therapists
- ***Coordinating with Fire and Rescue Services Mobile Integrated Health (MIH) team.*** 1 FTE social worker, 2 FTE paramedics
  - Future: Establish "safe houses" in fire and rescue stations, especially for increased harm reduction efforts to prevent overdose deaths

Opportunities: Behavioral health crisis response

Stabilization Facilities: What is being done now?

- ***Convening a Stabilization Workgroup***. Staff from the Department of Health and Human Services, Police Department, Fire and Rescue Services, and hospitals partner to advise and strategize on stabilization services.
- ***Constructing a Restoration Center***. Public and private partners are developing architectural design and capital budget, and seeking funding, for construction of a facility to stabilize persons in a behavioral health crisis over the first 24-72 hours with goal to divert them from emergency rooms and jail, and to re-integrate inmates with behavioral health needs into the community
- ***Creating a stabilization room at Crisis Center***. The County has received a two-year SAMHSA grant to renovate a room and hire staff for a 4-recliner stabilization room.

Opportunities: Behavioral health crisis response

Crisis Care Follow Up: What is being done now?

- Walk ins are referred to least restrictive, community-based, culturally competent programs of the continuum of care
- Walk ins served at the Crisis Center, FY20-FY22:
  - FY20 (mostly pre-pandemic year): 4,669
  - FY21 (pandemic year): 3,730
  - FY22 (transition to post-pandemic): 5,869
  - Three-year total: 14,268
- Future:
  - (1) Add navigators, care coordinators, case managers to Crisis Center staff for care coordination, referrals, and follow up with SAMHSA grant funds
  - (2) Build a robust continuum of care to prevent recycling through the crisis response model: Increase in residential crisis and residential long-term beds, outpatient services, case management, respite care, among others

The dream revisited

A new public health approach for building a behavioral health crisis response includes:

1. Responding rapidly and effectively to crises
2. De-escalating situations at risk for harm of self and others
3. Responding to persons in crisis at highest acuity levels for preventing fatality including overdose death and suicide
4. Making crisis response accessible, equitable, culturally and linguistically appropriate for a highly diverse population
5. Promoting wellbeing and public safety