SSJC Opposes Bill 43-23, CIT Crisis Intervention Team Established

Bill 43-23 would cement the County's reliance on law enforcement for crisis response by codifying into law the CIT program (co-response by a police officer and a mental health clinician in one vehicle) and creating an advisory committee weighted toward criminal justice. This would set the stage for even greater use of force with people experiencing a mental health or substance use crisis. We are particularly concerned for BIPOC persons, whose lives and well-being would be disproportionately threatened.

Passage of 43-23 would represent a giant leap backward, undermining years of progress toward a crisis response system that promised to provide civilian-led trauma-responsive care to any resident in need. While the current MCOT program is not meeting expectations, it is still preferable to the proposed CIT program.

Since Montgomery County police killed Robert White, an unarmed Black man with a mental health condition, in 2018, SSJC has worked with elected leaders and mental health experts to develop a consensus around a model featuring Mobile Crisis Outreach Teams (MCOTs), each staffed by a clinician and a peer support specialist. Mobile crisis teams are one of three essential elements of the national Crisis Now standard established by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

In May 2022 the County Department of HHS introduced a protocol that would have a joint response of an MCOT and police when the Crisis Center determines a behavioral health crisis involves a significant risk of harm. The County selected that MCOT model because of its effectiveness in delivering exceptional care while reducing unnecessary contact between police and the person in crisis.

If Bill 43-23 passes, when 9-1-1 perceives a behavioral health crisis to involve a significant risk of harm, the protocol would send a CIT co-response (police officer + clinician in one vehicle) instead of sending an MCOT in joint response with police. (See Appendix below for graphic illustration and more detail about these response types.)

We are not alone in our criticism of the CIT co-response approach. In Crisis Now, a publication of the National Association of State Mental Health Program Directors, the article The Misunderstanding of the Crisis Intervention Team Program (5/24/22), quotes the former head of CIT International, who highlights many of the points we make below:

> "While certainly better than a police-only response, the embedded co-responder model is costly, and it's not as beneficial as other approaches like mobile crisis services. Police departments with embedded co-response either have dedicated officers waiting for mental health crisis calls or clinicians riding along with officers responding to unrelated calls. 'The problem,' notes Bruno, 'is that the same amount of dollars are going toward building multiple programs and systems, and this type of co-response isn't the most effective or cost-efficient approach.' ....For example, co-dispatch of a mobile crisis team and CIT-trained officers allows both resources to be used jointly when required but otherwise function independently. 'That way, mental health assets aren't riding with a cop all day,' he says, 'or a cop isn't standing around while a clinician provides mental health support.'"

SSJC opposes Bill 43-23 for the following reasons:

This bill would undercut the still-fledgling MCOT program. While we are not satisfied with current MCOT program performance, we believe it can work with proper oversight, staffing, and commitment from the County. The Executive's proposed budget will expand the MCOT program, and allow for teams to be placed around the county, requiring a significant increase in the number of mental health clinicians. The County found it difficult to hire and retain mental health clinicians for the existing three teams, and this bill would create unnecessary competition for a limited pool of mental health professionals.

MCOTs offer substantial benefits over a CIT co-response. When police response is needed, they should be responding jointly with MCOTs, not as part of a CIT co-response team as the bill would have them do. Mobile crisis programs across the country have shown that when properly staffed, trained, and operationalized, teams of health professionals and peer support specialists, namely MCOTs, provide better, more compassionate care, and prevent harmful, even deadly, interactions with law enforcement. Even the national Crisis Now standard that the County has committed to, includes MCOTs, not a CIT co-response.

- **The state's Community-based Mobile Crisis Response system will reimburse for MCOT responses but not for CIT co-responses.** As explained in the November 28, 2023, Maryland state town hall meeting, the state's behavioral health and Medicaid crisis response funding will cover an MCOT response by either a peer and clinician (or 2 peers with a telehealth clinician), but will not reimburse for a clinician in a CIT co-response. Thus dispatch of a CIT co-response will deprive the County of Medicaid and state money.
- **A CIT co-response would unnecessarily tie up law enforcement and clinician resources, while not providing the benefits of peer presence.** In a joint MCOT and police response, the MCOT can stay afterwards and provide support to bystanders and those involved, allowing the police to leave and avoiding tying up police unnecessarily, while ensuring adequate care is provided. And MCOTs will develop a rapport with people which will be helpful in needed follow-up visits (made without need for police presence), and which can help avoid or de-escalate future crises.

- **The Peer Support Specialists who staff MCOTs are essential to effective crisis response**. The presence of a peer signals to the person in crisis that the response team is civilian-led, making the presence of police – if they must be there – less frightening. Mental health professionals, including peers, are equipped to de-escalate in ways armed law enforcement officers simply cannot, offering their care and insights to the person in distress. We must use MCOTs not only as an alternative to police response in situations deemed safe enough for them to show up first to the scene, but as an additional resource that can make a crucial difference, even and especially in potentially dangerous situations.
- **MCPD data shows that police have been increasing their incidents of use of force each year**, particularly when dealing with people with mental or behavioral health crises. BIPOC people and those with mental illness and other disabilities are disproportionately the victims of police use of force in our county. Thus many are profoundly reluctant to call for crisis intervention because they don't want police to respond, and police are often sent instead of a requested MCOT. Someone may be triggered by the presence of armed police (regardless of their uniform). Jurisdictions with MCOT-type response programs demonstrate that people in crisis are less likely to react or resist if an MCOT team that includes peer support specialists is in the lead, allowing the team to resolve the crisis in a non-coercive manner.
- **MCOT mental health experts should take the lead in responding**, even in the limited number of crises that require a police officer when someone is in imminent danger. MCOTs improve the likelihood of de-escalation, an appropriate trauma-informed response, and a positive outcome.
- **The bill's standard for a CIT co-response is vague.** As we have heard repeatedly from victims of police force, 9-1-1 dispatchers and police are inclined to interpret almost any threat as an "acute incident … where there is a significant risk of harm to the individual in crisis or to someone else…." For police officers far too many situations look like a significant danger when they aren't. While we are not satisfied with the existing 9-1-1 protocols, which send police to a mental health crisis instead of an MCOT or joint response, this bill is not the answer.
- **MCOT response times could be significantly improved** by the expansion of MCOT teams as expected. The bill's sponsor touts the speed of police cars, but CIT co-response isn't likely to be as fast as regular police response, and with the expansion of MCOTs, MCOT response times will be faster. Additionally, MCOT response times can be reduced using strategies used in other jurisdictions such as: strategic placement of teams (some use vans staged at hot spots), MCOT direct monitoring of dispatch calls, and having a clinician on staff at 9-1-1 dispatch to more quickly identify need for MCOT response.

The composition of the bill's Advisory Committee is inappropriate and its focus and power are too broad. The bill's advisory committee does not adequately represent the needs or perspective of people with mental health issues or members of communities disproportionately affected by police and the police use of force. Nor does it adequately represent the views of those with mental health crisis expertise. The proposed committee's

disproportionate membership would have an emphasis on criminal justice, rather than mental health and community-oriented solutions. Moreover, the bill would give excessive power to advise the Council and Executive on the County's overall crisis response, rather than be limited to the CIT teams. The committee would create yet more bureaucracy and less flexibility when responding to a broad range of 9-1-1 calls that warrant a response from an MCOT. In short, the entire advisory committee proposal is ill-conceived.

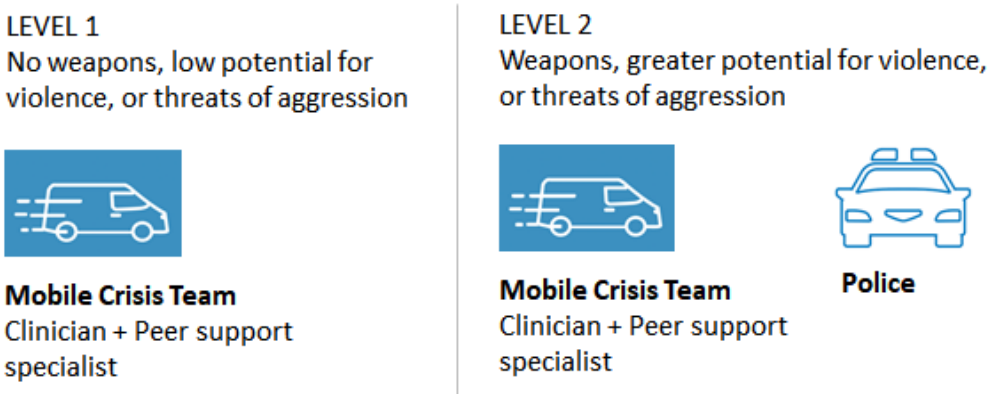
Any reliance on recommendations from the CIT Center of Excellence is premature. The bill requires that the CIT co-response "team will follow the guidance provided by the Crisis Intervention Team Center of Excellence at the State level in implementing, delivering, and enhancing crisis intervention services in the county." The state center has not yet even released requirements for CIT co-response, so the county should not agree to their guidance before knowing what they will advise. Deferring to a state center that focuses on CIT responses instead of the coordinated response including MCOTs is inappropriate. That center does not adequately reflect the needs or priorities of Montgomery County and our citizens, including the flexibility in considering what programs we have chosen to implement. We have more than enough expertise in our county to develop and expand appropriate mental health crisis responses.

The County needs to focus on fully implementing the MCOT system as originally planned and provide executive oversight on that collaborative model. This is not the time for the Council to emphasize a separate system and create a separate bureaucracy that is not part of a comprehensive mental health continuum of care response system. To do so will create more problems than it will solve and is likely to confuse and alienate residents at risk.

Appendix: Introduced MCOT response vs CIT co-response

Protocol as introduced with MCOT joint response with police

The protocol that the county HHS introduced in May 2022 has the Crisis Center sort crises into two levels. Level 1 allows MCOT-only response when there is no risk. Level 2 allows MCOTs to have police accompany them in a joint response, when a behavioral health crisis involves a "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." The following depicts part of the introduced protocol:



Refer to the official HHS document for details.

Protocol from bill with CIT co-response team

If Bill 43-23 passes, the protocol would still have MCOT only response for Level 1. However, it would have 9-1-1 decide if a Level 2 response is needed, which would result in a CIT co-response (police officer + clinician team), instead of a MCOT in joint response with police, when there is a behavioral health crisis that is perceived by 9-1-1 to involve a significant risk of harm. The bill's protocol is depicted as follows: