OLO Report 2025 -10 September 9, 2025

Mental Health Crisis Responses in Montgomery County

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Office of Legislative Oversight

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OLO Report 2025-10 Executive Summary September 9, 2025

Mental health crisis responses have evolved over time. A variety of models that aim to provide appropriate responses to the type of mental health crisis an individual faces have emerged. Two major categories of mental crisis response are:

- In-person crisis responses such as mobile crisis teams, law enforcement, and co-responder models; and
- Responses conducted via phone, which include hotlines such as 988 that may offer call, text and/or chat options.

Crisis hotlines were developed to provide anonymous help to individuals experiencing mental health crises. Typically, the caller's issue is resolved over the phone and there is no need to send an in-person response, although follow-up calls are a recommended best practice.

This Office of Legislative Oversight (OLO) report responds to the Council's request to prepare a report that examines similarities and differences in responses and protocols across County call center entities that respond to mental health crisis calls. The County entities highlighted are:

1. The Emergency Call Center (911)
2. 311
3. The Crisis Center
4. 988 and the Montgomery County Crisis Hotline which are administered by EveryMind

County Entities Who Respond to Mental Health Crisis Calls

911. The Emergency Communications Center (ECC) is the public safety answering point (PSAP) for 911 calls placed in the County. They dispatch fire and rescue, emergency medical services, and police in the County. 911 also dispatches the Montgomery County Police Departments' Centralized Crisis Intervention Team (CCIT) which is dedicated to responding to behavioral health emergencies and supporting patrol officers during similar incidents.

The Montgomery County Crisis Center is managed by the Department of Health and Human Services (DHHS). It is open 24 hours a day, 365 days a year. Services are provided by phone or by walk-in. The Crisis Center handles a range of behavioral health and substance use disorder crises and provides full crisis assessments and treatment referrals. The Crisis Center does not provide phone counseling services; instead, its phone lines focus on identifying crisis needs and connecting callers with appropriate resources. Staff are available 24/7 to answer crisis calls in addition to walk-ins and dispatching the Mobile Crisis and Outreach Team (MCOT). MCOT

consists of a licensed mental health professional and a peer recovery specialist who respond in-person to crisis situations.

988 and Montgomery County Crisis Hotline. EveryMind operates both 988 and the Montgomery County Mental Health Crisis Hotline, both available 24/7. Each line focuses on crisis de-escalation and the same team of crisis hotline counselors handles communication for both lines, although not simultaneously.

- **988** is a nationwide hotline that provides immediate and anonymous emotional support via phone calls, text messages, and online chat. EveryMind is the local administrator for 988 and also responds to 988 chat and text messages from across the state of Maryland, in addition to Montgomery County.
- **The Montgomery County Mental Health Crisis Hotline** is a local service with a local phone number. It offers supportive listening, non-crisis support, and connections to local resources like 988, but tailored to the specific needs of county residents. The Hotline provides support exclusively by phone.

311 is the nonemergency line for Montgomery County. It connects callers to County services. The 311 phone line is open Monday through Friday from 7 AM – 7 PM. County residents can also access a chatbot 24/7 through 311's website which connects them to services and can also create service requests online.

The table below summarizes the annual call volume, average answer speed, and the average length of call for the County entities highlighted in this report.

Call Center Entity	Annual Volume (2024)	Average Answer Speed (2024)	Average Length of Call (2024)
911	**848,289** (All calls) **15,040 Calls** Related to Mental Health	10 seconds	2 minutes, 32 seconds
311	**414,524** (All calls) **347** Calls Related to Mental Health	22 seconds	3 minutes, 52 seconds
The Crisis Center (DHHS)*	**41,610** Calls	Not Tracked	Not Tracked
988 (EveryMind)	**39,242** Contacts (15,397 Calls, 16,226 Texts, and 7,619 Chats)	13 seconds (for Call, Text, and Chat)	14 min (Calls) 44 min (Text) 30 min (Chat)
Montgomery County Crisis Hotline (EveryMind)	**18,308** Contacts (17,336 Calls and 972 Texts)	13 Seconds (Calls) (Texts not tracked)	13 min (Calls) (Texts not tracked)

Sources: County Entities

*The Crisis Center does not track the average answer speed and length of call but reported to OLO that callers may wait on hold for up to 15-20 minutes during periods of high call volume.

Overview of Protocols. While protocols differ across all call center entities which operate in the County, all the call center entities determine a caller's "imminent risk" similarly. Imminent risk refers to situations where an individual is in immediate danger of harming themselves or others, has access to means to harm (i.e. weapons), or refuses to ensure their own safety. It is up to the call-takers' discretion to determine the level of imminent risk with some common determining factors shared across the call center entities include:

- Individuals who express active suicidal intent;
- Are in possession of weapon or have indicated they can easily obtain a weapon; and
- Are threatening violence or have a known history of violence.

There are no shared formal protocols across all four call center entities. The ECC, 988, and the Montgomery County Crisis Hotline use accredited protocol systems which are tailored to their respective operational needs. 311 relies on knowledge-based articles created by County agencies, which function as informal protocols and give instructions to call takers on how to respond to calls within a given subject. The Crisis Center follows SAMHSA's National Guidelines for a Behavioral Health Coordinated System of Crisis Care.

Call centers differ on whether the most common response to a mental health crisis is in-person or remote. Data show that most calls to 988 and the Montgomery County Crisis Hotline are resolved over the phone **without police response (98.1% of all calls).** Conversely, calls to the ECC (including 911 and the police non-emergency line) regarding mental health crises typically generate **an in-person police response (98.8% of all calls).** ECC's standing guidance is to dispatch the police when there is any doubt, as doing so guarantees that someone will physically respond. In some cases, the ECC transfers callers to the Crisis Center, but if the Crisis Center cannot respond in a timely fashion, the ECC will dispatch police. While data on police response generated from 311 calls are not available, **less than 1% of all calls (103 calls) in 2024 were transferred to 911.** The Crisis Center **did not** have data on calls transferred to 911.

Periods of Heavy Call Volume. At the time of this report, all the call center entities interviewed for this report informed OLO calls are received in the order they are taken. some strategies specific call centers have employed to handle periods of heavy call volumes are:

- ECC call-takers will pick up additional shifts to provide coverage during high call volume.
- The 311 system is designed to handle seasonal and expected variations in call volume and will provide its call-takers with new information on how to deal with unexpected events on how to respond to requests
- For 988, if there are high call volumes and a call takes longer than 20 seconds to answer, the call is routed to the Prince George's 988 call center or the national 988 backup network center.
- EveryMind can plan for increased staffing ahead of known events or in response to local incidents which may cause heightened community distress but there are no backup phone systems for the Montgomery County Crisis Hotline.

Best Practices from Model and Neighboring Jurisdictions. OLO spoke to staff from the following five jurisdictions: Fairfax County, VA, Albuquerque, NM, Travis County, TX, Anne Arundel County, MD, and Louisville, KY. Staff shared the following lessons learned with OLO:

- Four out of five jurisdictions have a direct transfer line between 911 and their local crisis hotlines, which has facilitated deeper collaboration between the entities;
- Deep collaboration between first responders and other organizations that respond to mental health crises (I.e., non-profits and healthcare centers) is essential so that callers can enter into a continuum of care and get the help they need; and
- Having mental health call-takers and/or a licensed mental health professional working physically in the same building as 911 call takers facilitates deeper communication and makes it easier to transfer callers. Having dedicated mental health workers in the same building also provides them with access to the CAD (computer-aided dispatch system), where they can see what calls are coming through and can better identify calls appropriate for a mental health response.

Recommendations and Discussion Item

OLO offers three recommendations and one discussion item for Council consideration.

Recommendation #1. Explore options to increase the Crisis Center's capacity for taking mental health crisis calls.

Recommendation #2. Increase interoperability across entities that take mental health crisis calls.

Recommendation #3. Improve data collection across County entities that take mental health crisis calls.

Discussion Item #1. The Council could facilitate a community conversation about what type of response is most effective for individuals who have experienced mental health crises and how to build capacity for those programs.

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OLO Report 2025-10

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Introduction

The County Council requested the Office of Legislative Oversight to prepare a report that examines similarities and differences in protocols across County call center entities that respond to mental health crisis calls. Specifically, this report examines established protocols each entity uses when responding to mental health calls, action steps taken during a call, and how each entity responds to times of heavy request volume.

The County entities investigated in this report are as follows: (1) The Emergency Call Center (911), (2) 311, (3) The Crisis Center, and (4) EveryMind administered hotlines which are 988, and The Montgomery County Crisis Hotline. Each entity was interviewed on their established protocols and OLO collected data related to their calls, such as total call volume, average answer speed and length of call, and demographics of caller and reason for call (when available).

The report is organized as follows:

- **Chapter 1 - Mental Health Responses Overview** presents background information on how mental health crisis responses have evolved over time, descriptions of models of response, and best practices for responses.
- **Chapter 2 - County Entities and Responses to Mental Health Crisis Calls** describes how County call center entities operate, their response protocols during periods of high call volume, and how they respond to mental health crisis calls. It also presents data collected from entities on calls, including total number of contacts, answer rate, average call time, and demographic data of callers (when available).
- **Chapter 3 - Mental Health Crisis Response Protocols** examines the protocols used by the County's four main call center entities: EveryMind administered hotlines, 911, the Crisis Center, and 311. It outlines the steps in the triage process and describes possible outcomes based on the triage determination for a reported mental health crisis.
- **Chapter 4 - Best Practices from Model and Neighboring Jurisdictions** summarizes findings from interviews with five outside jurisdictions identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as models for best practices in mental health crisis response.
- **Chapter 5 - Findings, Recommendations, and Discussion Item** summarizes the report's findings and presents recommendations and a discussion item for Council consideration.
- **Chapter 6 - Agency Comments**

OLO staff members Gabriela Monzon-Reynolds and Kaitlyn Simmons conducted this study with assistance from Natalia Carrizosa and Karen Pecoraro. OLO received a high level of cooperation from everyone involved in this study and appreciates the information and insights shared by all. In particular, OLO thanks:

County Government and Organizations

Fariba Kassiri, DCAO
Dr. Earl Stoddard, CAO
Corey Smedley, FRS*
Avital Graves, FRS
Benjamin Kaufman, FRS
Dr. James Bridgers, HHS*
Dorné Hill, HHS
Monica Martin, HHS
Beth Tabachnick, HHS
Marc Yamada, POL*
Kathy Estrada, POL
Tamara Maldonado, POL
David Mcbain, POL
Michael Skidmore, POL
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*Denotes Director or Chief

Outside Jurisdictions

Gerard Bartlett, Albuquerque Police Department (APD)
Jeff Bludworth, APD
Matt Tinney, APD
Brenda Vigil-Gallegos, APD

Jen Corbin, Anne Arundel County Crisis Response System

Christina Manning, Fairfax County

Marisa Malik, Integral Care (Travis County, TX)
Kedra Priest, Integral Care
Nicole Warren, Integral Care

James Polk, Seven Counties (Louisville, KY)
Jean Romano, Seven Counties
Nicole Wiseman, Seven Counties

Glossary

1. **Public Safety Answering Point (PSAP**) – General term for a call center or dispatch center that handles emergency calls and coordinates emergency responses, such as 911. The Emergency Communications Center (ECC) is Montgomery County's PSAP.
2. **Interoperability** – Refers to formal protocols, procedures, or agreements that allow for the transfer of calls from one entity to another (such as 988 to 911 and vice versa).
3. **Georouting** – Refers to technical solutions for directing calls based on a geographic location for the origin of the call without transmitting information about the caller's precise location.
4. **Geolocation** – Identifying the specific, precise location of the caller.
5. **988 –** Originally known as the National Suicide Prevention Lifeline, 988 was established in 2005 with funding from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). It switched to 988 in 2022 for ease of dialing.
6. **311 –** Montgomery County's 311 provides nonemergency government information and services. Individuals can call 311 or chat on the 311 website.
7. **Suicidal Ideation vs. Suicidal Intent** – Suicidal ideation is defined as an individual threatening suicide without the means and opportunity while suicidal intent is defined as an individual is threatening suicide and has the means and opportunity.
8. **Mental Health Crisis** – For the purpose of this report, mental health crisis refers to an individual experiencing one or more of the following: substance abuse, threatening suicide, or experiencing mental distress (find more examples).
9. **Imminent Risk** – Defined as immediate danger of the individual in crisis harming or killing themselves or someone else, now or within the next 24 hours; imminent medical danger from substance use withdrawal; drug overdose or alcohol poisoning; or an individual has already acted with the intent to hurt themselves or someone else's life.
10. **Warm Hand off** – A form of referral to treatment or other services, via transfer of care between service providers through, face-to-face, phone, or video interaction in the presence of the individual being helped.
11. **No wrong door approach –** An approach to mental health services in which individuals seeking help should be able to access services/support from any point of entry within the mental health system without facing unnecessary barriers or delays.
12. **Warmlines –** Refers to peer-operated behavioral health hotlines which can have, phone, chat, and/or text capabilities and provide empathetic listening and peer support to individuals who may be experiencing distress or loneliness.

Chapter 1. Mental Health Responses Overview

Mental health crisis responses have evolved over time. A variety of models that aim to provide appropriate responses to the type of mental health crisis an individual faces have emerged. The two major categories of mental health crisis responses are:

- In-person crisis responses such as a mobile crisis team, law enforcement, and co-responder models; and
- Responses conducted via phone, which include hotlines such as 988 that may offer call, text and/or chat options.

This chapter offers an overview of mental health crisis response models in the U.S., and is organized as follows:

- **Section A** describes early mental health crisis response models on which current models are based;
- **Section B** describes specific categories of mental health response models; and
- **Section C** provides an overview of best practices for mental health crisis response developed by national organizations.

A.. Early Mental Health Crisis Response Models

Los Angeles Suicide Prevention Center.

The first 24 hour crisis hotline in the U.S. was established as a suicide prevention hotline in 1962 in Los Angeles, California. Call-takers focused on building a rapport with callers in assessing their safety, and collaborating to develop an individualized treatment plan, similar to 988's approach today.[1] The call center collected data on anonymous callers' behavioral health issues, demographics, and history of past suicidality and treatment, which was used to integrate research and clinical practices with hotline services. Edwin S. Shneidman, the co-director of the Los Angeles Suicide Prevention Center, the organization that oversaw the hotline, founded the American Association of Suicidology (AAS) in 1968. The AAS became a global hub for suicide prevention research and eventually accredited crisis centers in best practices. Many crisis hotlines today, including 988, are accredited by the AAS.[2]

[1]Draper, John and McKeon, Richard. June, 2024.The Journey Toward 988. A Historical Perspective on Crisis Hotlines in the United States.
[2] American Association of Suicidology. Crisis Center Accreditation Program.

Crisis Assistance Helping Out on the Streets -CAHOOTS

Established in Eugene, Oregon in 1989, this program has shaped approaches for many mobile crisis teams operating today.[3] CAHOOTS responds to requests typically handled by police and Emergency Medical Services (EMS), with a special focus on nonemergency calls regarding mental health crises, homelessness, and substance use disorders. CAHOOTS teams operate in pairs: a crisis intervention worker who is skilled in counseling and de-escalation techniques and a medic who is either a nurse or emergency medical technician (EMT).[4] They are trained to provide crisis intervention, counseling, mediation, information, referrals, transportation to social services, and basic-level emergency medical care.[5]

A medic is included in the team to avoid unnecessary police involvement. For example, in traditional crisis response models, if someone is in a mental health crisis and self-harms, EMS and police typically respond to the scene. In the CAHOOTS model, the team can respond to both the individual's physical and mental health needs, without EMS and police intervention. CAHOOTS staff carry a police radio and are dispatched by 911 and the nonemergency police line in Springfield, Oregon.[6] There is an option to dispatch police and EMS with CAHOOTS if the team believes it is appropriate.[7] However, data from 2019 show CAHOOTS resolved most calls without police intervention. Of the 24,000 calls CAHOOTS responded to, only 311 needed police backup.[8]

Crisis Intervention Teams.

The Crisis Intervention Team (CIT) model focuses on de-escalation during law enforcement encounters with individuals in crisis, particularly if it is behavioral health or disordered substance use related. The first CIT model was developed in Memphis, Tennessee in 1988 when Memphis Police shot and killed Joseph Robinson during a mental health crisis encounter.[9] It was developed through partnerships with the National Alliance on Mental Illness (NAMI), local universities, and mental health providers that develop training for law enforcement.

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[3] Climer, Ben Adam and Gicker, Brenton. January 29, 2021. CAHOOTS: A Model for Prehospital Mental Health Crisis Intervention. Psychiatric Times, Vol 38, Issue 1.
[4] ibid.
[5] Vera Institute. Case Study: CAHOOTS, Eugene Oregon.
[6] As of April 7, 2025, CAHOOTS services are no longer available in Eugene: CAHOOTS® - White Bird Clinic.
[7] Climer, Ben Adam and Gicker, Brenton. January 29, 2021. CAHOOTS: A Model for Prehospital Mental Health Crisis Intervention. Psychiatric Times, Vol 38, Issue 1.
[8] Vera Institute. Case Study: CAHOOTS, Eugene Oregon.
[9] State of California, Commission on Peace Officer Standards and Training. Crisis Intervention Team; Nami Indiana. Veterans and Families - Crisis Intervention Teams.

According to Crisis Intervention Teams International, there are four goals for local CIT programs:

1. To improve safety during law enforcement encounters with people experiencing a mental health crisis, for everyone involved.
2. To increase linkages to effective and timely mental health services for people in mental health crisis.
3. To use law enforcement strategically during crisis situations—such as when there is an imminent threat to safety or a criminal concern—and increase the role of mental health professionals, peer support specialists, and other community support; and
4. To reduce the trauma that people experience during a mental health crisis and thus contribute to their long-term recovery.[10]

B. Types of Responses

The most appropriate type of response to an individual experiencing a mental health crisis depends on the type of risk an individual poses to themselves or others. Generally, "imminent risk," which is defined as immediate risk for the individual in crisis or others near them, would trigger an in-person crisis response. The type of in-person response depends on whether a weapon is present, a history of violence, or if the individual has ingested a substance, or harmed themselves to the extent they need medical services.

Specifically, OLO identified three main types of crisis responses. OLO notes that for some in-person responses, emergency medical services are dispatched alongside these models in cases where an individual needs immediate medical attention.

Law enforcement model – CIT generally consist of one or more officers that receive advance training on de-escalation of crises, active listening, and education surrounding behavioral and mental health crises.[11]

Non-law enforcement model – Many mobile crisis team (MCT) initiatives are designed to prevent unnecessary law-enforcement responses and are equipped to handle a variety of behavioral health crises. If an individual has a weapon present and/or is actively threatening the safety of themselves or others, MCTs may call for police backup.

Crisis hotlines were developed for non in-person responses to provide anonymous help to individuals experiencing mental health crises, including suicidal ideations, acute anxiety and depression. Generally, the caller's issue is resolved over the phone and there is no need to send an in-person response, although follow-up calls are a recommended best practice.

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[10] CIT International. August 2019. Guide to Best Practices in Mental Health Crisis Response.
[11] Nami Indiana. Veterans and Families - Crisis Intervention Teams

Co-response model – Many jurisdictions that employ both CITs and MCTs have coordination between the two. For example, MCTs can be called to a scene where police have already responded, to provide de-escalation and on-site counseling for an individual experiencing a mental health crisis. Conversely, MCTs can call for police back-up if a weapon is brandished or their safety is threatened.

Best practices for these models are discussed in the next section, "Overview of Best Practices from National Organizations."

C. . Overview of Best Practices from National Organizations

Best Practices from Substance Abuse and Mental Health Services Administration (SAMHSA).

SAMHSA is the U.S. Department of Health and Human Services agency that leads public health efforts to advance and improve behavioral health services nationwide. It is also charged with the funding and oversight of 988, formally known as Lifeline.[12]

SAMHSA recently released the 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care, which presents best practices for crisis responses, including crisis hotlines, mobile teams, and coordinated systems of crisis care for behavioral health. The guidelines are built upon three foundational elements that SAMHSA identified as essential within an integrated health care system:

- **Someone to Contact:** Crisis hotlines like 988 and other behavioral health hotlines provide immediate and accessible support.
- **Someone to Respond:** Mobile crisis teams and other services deliver rapid, on-site interventions to de-escalate crises and connect individuals to care and support within their community.
- **A Safe Place for Help:** Crisis Centers that provide emergency and crisis stabilization services along with other support services.[13]

The following best practices outlined in this report follow the foundational elements identified above by SAMHSA.

[12] U.S. Substance Abuse and Mental Health Services Administration. About Us.
[13] U.S. Substance Abuse and Mental Health Services Administration. January 15, 2025. 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care.

Someone to Contact. For crisis hotlines, SAMHSA recommends the following practices:

- Hotlines should be available 24/7, 365 days a year.[14]
- Multiple modes of communication should be available such as texting, calling, and online chatting. Furthermore, having call-takers available 24/7 who can speak multiple languages, along with video-phone capabilities for deaf and hard-of-hearing individuals, improves equity in access.
- Structured suicide risk assessments during a crisis call are recommended. For example, 988 guidelines recommend asking direct questions about current and past suicidal thoughts and ideations like "Are you currently thinking of suicide?" and "Have you thought about suicide in the last X months?"[15]
- When possible, call-takers should perform "warm hand-offs" to connect their callers to local resources that provide consistent and deeper support to the individual. A warm hand-off means staff from both resources will stay on the line together with the individual to ensure both call-takers and individuals are on the same page about the situation and that the individual is not left on hold by themselves during a crisis.
- Hotlines should coordinate with other crisis entities, such as 911 and other crisis hotlines. The goal of these organizations is to help an individual experiencing a crisis by (1) answering their call as fast as possible and (2) connecting them to resources most needed. Sometimes, the resource needed most is 911, especially if the individual has self-harmed or attempted suicide at the time of the call. Formal protocols and consistent collaboration between the entities are essential to fulfilling these goals.
- Providing follow-up calls when necessary. Research shows that follow-up calls can improve outcomes for individuals—especially those experiencing suicidal thoughts or ideation—by increasing treatment engagement, reducing the risk of hospitalization, and decreasing suicidal behaviors.[16] In fact, 988 requires that network centers provide follow up services for all callers who expressed suicidal thoughts within the past 24 hours.[17]

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[14] U.S. Substance Abuse and Mental Health Services Administration. January 15, 2025. 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care.
[15] ibid.
[16] [16] U.S. Substance Abuse and Mental Health Services Administration. January 15, 2025. 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care; Miller, Ivan, et al. June 2017. Suicide Prevention in an Emergency Department Population: The ED-SAFE Study. JAMA Psychiatry; Motto, JA. Winter 1976. Suicide prevention for high-risk persons who refuse treatment. U.S. National Library of Medicine; Stanley, Barbara, et al. July 9, 2015. Brief Intervention and Follow-Up for Suicidal Patients with Repeat Emergency Department Visits Enhances Treatment Engagement. AJPH, Vol. 105 Issue 8; Stanley, Barbara, et al. September 2018. Comparison of the Safety Planning Intervention with Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. JAMA Psychiatry, Vol. 75, No. 9.
[17] 988 Suicide & Crisis Lifeline. May 20, 2023. Crisis Center Guidance: Follow-up with 988 Lifeline Contacts and those Discharged from Emergency Department and Inpatient Setting.

Someone to Respond. Response teams can be law-enforcement, non-law enforcement, or both. For law enforcement responses to mental health crises, CITs are recognized as a best practice by NAMI.[18] CIT International recommends the following practices for local CITs:

- When responding to a crisis, officers should focus on de-escalation and managing the safety of the person in crisis, as well as any family members and bystanders.
- Officers should be aware of and have relationships with community partners, such as MCTs, so they can connect individuals to services quickly while on the scene.
- Officers should also be familiar with key medical terms regarding behavioral health and substance use disorders so they can communicate information effectively to medical staff if the person in crisis is transported to a hospital or other medical institution.
- Officers should engage the individual in crisis with respect and compassion. They should provide explanations for actions such as transportation to a hospital or community mental health facility and offer choices when applicable, such as where they would like to be transported to or if they can go home with a family member or friend.
- Officers should avoid use of restraints and force whenever possible. If an individual is fully cooperative, it is not necessary to handcuff and transport an individual to a hospital or other medical facility. CIT international notes that sometimes receiving centers have policies that require officers to restrain all individuals waiting for care in law enforcement custody and CIT programs should work with these facilities to revise their policies; and
- CIT International stresses that community support and building relationships with other organizations involved in mental health crisis care is essential to creating a strong CIT program. CIT officers should continue to cultivate relationships with community partners to provide the best resources for people in crises.[19]

For non-law enforcement responses, MCTs, such as CAHOOTS, are recognized as a best model to follow by SAMHSA. The following are best practices that SAMHSA recommends local MCTs follow:

- MCTs' responses should be rapid and on demand and able to reach any person in the service area in a timely manner;[20]
- SAMHSA recommends MCT responses should not include law enforcement, unless special circumstances warrant their presence. In that case, it is recommended the response should be led by MCTs, rather than law enforcement (unless a clear public safety risk exists);

[18] National Alliance on Mental Illness (NAMI). Crisis Intervention Team (CIT) Programs.
[19] CIT International. August 2019. Guide to Best Practices in Mental Health Crisis Response.
[20] U.S. Substance Abuse and Mental Health Services Administration. February 14, 2020. National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit Executive Summary.

- MCTs should be supervised by a licensed behavioral health professional, for multiple reasons. First, a behavioral health professional may be needed to provide a referral or follow-up care for individuals that need further care or stabilization after an MCT visit. Second, a behavioral health professional should provide oversight of non-licensed individuals in the MCT, to ensure they are following clinical best practices;
- Peers with lived experiences that are racially and ethnically representative of their community should be incorporated within the MCT to provide specialized support and shared understanding with individuals in crisis; and
- Utilize real-time GPS technology to coordinate with local crisis call centers that dispatch the MCT.

A Safe Place for Help. In a coordinated system of care, it is essential that a community has places for individuals in crisis to go to for a variety of care. This includes stabilization services, mental health crisis assessments and screenings, and the ability to accept all referrals without turning away individuals in crisis. SAMHSA recommends the following practices for operating facilities that provide crisis receiving and stabilization services:

- The facility should be open 24/7;
- Have a dedicated first responder drop-off area, separate from the walk-in area;
- Have stabilization beds located in the facility or in a nearby partner facility to support individuals who need stabilization services;
- Provide real-time availability of stabilization beds and other services to the local crisis call center hub so call-takers know what services are available for individuals in crisis; and
- Foster relationships with community partners to be able to connect individuals in crisis to ongoing care.[21]

Best Practices from the National Alliance on Mental Illness (NAMI)

NAMI is the nation's largest grassroots mental health organization, dedicated to improving the lives of individuals affected by mental illness and their families. NAMI provides education, support, advocacy, and public awareness to help individuals and families build better lives.

NAMI promotes a comprehensive approach to mental health crisis response by advocating for accessible, community-based services that prioritize person-centered care.[22] This approach

[21] U.S. Substance Abuse and Mental Health Services Administration. February 14, 2020. National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit Executive Summary.

[22] Person centered care is a holistic form of care which focuses on strong provider-patient communication and allows patient's family members, and significant others the ability to create effective care plans together with a doctor.

includes the three core principles outlined in the National Guidelines for Crisis Care: 24/7 crisis call centers, mobile crisis teams, and crisis receiving and stabilization services.

NAMI also promotes the following best practices:

Providing support through 988. NAMI believes that 988 should be an entry point for every person to receive support for immediate crises. 988 should connect people in need to the care, support and resources they need to get well, and stay well throughout and after a crisis.[23]

Prioritizing Mobile Crisis Teams, Over Law Enforcement Response. Mobile crisis teams should be led by mental health staff and offer community-based intervention to individuals in need wherever they are, including home, work, or anywhere in the community.[24]

Implementing Crisis Receiving and Stabilization Services. Crisis receiving and stabilization services should provide safe and calm spaces for crisis observation and stabilization. Crisis stabilization programs should also provide no-wrong-door access to mental health and substance use care, including accepting all walk-ins and ambulance, fire and police drop-offs.[25]

Promoting Trauma-Informed Care. Responders need to provide a calm and secure environment, respect personal space, and ensure that individuals feel physically and psychologically safe from harm.[26]

Offering Support and Resources. These resources will ensure the continuum of services by connecting individuals to ongoing support, including counseling, medication management, and community resources.[27]

Educating and Empowering. NAMI believes that providing resources and training to the public helps individuals, families, and communities better understand and respond to mental health crises and advocate for policies that prioritize mental health services.[28]

Best Practices in Addressing Racial Inequities in Mental Health Crisis Responses and Access to Mental Health Care

Many of the non-law enforcement mental health responses were developed to prevent unnecessary violence inflicted upon individuals experiencing mental health crises, especially Black, Indigenous, and People of Color (BIPOC). Unnecessary law enforcement intervention

[23] National Alliance on Mental Illness, Responding to Crises.
[24] National Alliance on Mental Illness, Crisis Response For Mental Health.
[25] National Alliance on Mental Illness, Responding to Crises.
[26] ibid.
[27] National Alliance on Mental Illness, Navigating a Mental Health Crisis.
[28] ibid.

during behavioral and mental health crises has resulted in the killing of Black and Brown people, including George Floyd in Minneapolis and Marcus-David Peters in Virginia.[29][30]

Law Enforcement and Criminal Justice. Racial disparities in law enforcement are rooted in a legacy of racial injustice, as the earliest policing efforts in the U.S. were slave patrols, which were charged with policing free and enslaved Black people. Today, racial inequities persist in terms of harsher treatment of BIPOC in the criminal justice system, mass incarceration, and higher use of force on BIPOC during a police encounter.[31]

Further, people with mental health illnesses are overrepresented in the criminal justice system and the most recent data available from the Bureau of Justice Statistics show approximately 41% of all state and federal prisoners had a history[32] of mental health illness(es).[33] While data from the study show more White prisoners indicated they had a history of mental health illnesses compared to Black prisoners and Latino prisoners, there is evidence that:

(1) There is inequitable access to mental health services by race and ethnicity and compared to White people, BIPOC are less likely to receive care for mental health illnesses;[34] and
(2) Mental health screening tools used by jails reproduce racial inequities, resulting in fewer Black and Latino people screening positive for mental health illnesses.[35]

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[29] The Marcus Alert in Virginia was developed after a police officer shot and killed Marcus-David Peter and is discussed in further detail in the case study for Fairfax County, VA.
[30] Bazelon Center for Mental Health Law and the Vera Institute for Justice. January 14, 2024. New Federal Guidance for Alternatives to Police for People with Behavioral Health or other Disabilities.
[31] Camp, Nicholas. December 15, 2023. Institutional Interactions and Racial Inequality in Policing: How Everyday Encounters Bridge Individuals, Organizations, and Institutions. Compass Journals; Robinson, Michael. April 7, 2017. Black Bodies on the Ground: Policing Disparities in the African American Community—An Analysis of Newsprint from January 1, 2015, Through December 31, 2015. Journal of Black Studies, volume 48, issue 6.
[32] The study asked people who were incarcerated if they had ever been told "by a mental health professional, such as a psychiatrist or psychologist, that you had (1) manic depression, bipolar disorder, or mania; (2) a depressive disorder; (3) schizophrenia or another psychotic disorder; (4) post-traumatic stress disorder; (5) another anxiety disorder, such as panic disorder or obsessive compulsive disorder; (6) a personality disorder, such as antisocial or borderline personality; or (7) a mental or emotional condition other than those listed above?" Prisoners who answered yes to this question were considered to have a history of a mental health problem.
[33] Maruschak, Laura, et al. June 2021. Indicators of Mental Health Problems Reported by Prisoners: Survey of Prison Inmates, 2016.
[34] Panchal, Namita, et al. May 23, 2024. Racial and Ethnic Disparities in Mental Health Care: Findings from the KFF Survey of Racism, Discrimination and Health.
[35] Prins, Seth, et al. March 15, 2012. Exploring Racial Disparities in The Brief Jail Mental Health Screen. U.S. National Library of Medicine; Vera Institute. July 25, 2019. Racial Disparities In Mental Health and Criminal Justice.

As Black people are more likely to be incarcerated in the U.S. compared to White people, it is essential that responses to mental health crises consider racial inequities in law enforcement and in mental health care.[36]

Mental Health Care. Data demonstrate deep racial inequities in access to mental health care in the U.S., with White adults receiving care at significantly higher rates than Black adults. For adults (18 and over), 2023 data from the National Survey on Drug Use and Health show:

- 15.1% of Black adults report receiving mental health treatment in the past year compared to 27% of White adults;
- 7.7% of Black adults report receiving prescription medication for treating mental health compared to 20.6% of White adults; and
- 56.1% of Black adults who had a major depressive episode in the past year report receiving treatment for depression compared to 68.4% of White adults.[37]

There are also racial inequities in suicides. Between 2018 and 2021, suicide rates of Black individuals aged 10 – 24 years old rose by 37%, the largest proportional increase in this period. 988, a national hotline that helps individuals experiencing a mental health crisis, especially those with suicidal thoughts and intent, has separate hotlines for Spanish-speakers and veterans.[38] However, there is no separate hotline for individuals who would like to seek racially and culturally competent care, which can discourage BIPOC from reaching out and receiving care.[39] These racial inequities show a need for culturally competent care and services for mental health care.

Practices for reducing racial inequities. Best practices for reducing racial inequities in mental health and responses to mental health crises include:

- Minimize reliance on law enforcement by developing behavioral health crisis care systems outside the criminal justice system[40];

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[36] Vera Institute. July 25, 2019. Racial Disparities In Mental Health and Criminal Justice
[37] U.S. Department of Health and Human Services, Office of Minority Health. Mental and Behavioral Health – Black/African Americans.
[38] 988 Helpline. CALL 988 is here to help.
[39] Rice, Alana and Harris, Suzanne. February 2021. Issues of Cultural Competence in Mental Health Care. U.S. National Library of Medicine.
[40] Carrizosa, Natalia. March 9, 2021. Public Safety Responses to Mental Health Situations. OLO Report 2021-04; National Action for Suicide Prevention, Alliance Crisis Services Task Force. Crisis Now, Transforming Services is Within Our Reach.

- Improve collection of demographic data related to individuals reaching out for services, including what help was given and any referrals, disaggregated by race and ethnicity at the local level to show where divides in services may lay[41];
- Crisis systems should center racial justice and equity and be embedded within a holistic, integrated public health care system with high quality, accessible, and equitable services[42];
- Crisis call centers should increase their capacity for language services, including hiring more native speakers of common languages spoken locally[43]; and
- Peers, those who have lived experience of mental health crises, should be centered in crisis response, recovery, and prevention. Efforts should be made to recruit peers that are racially and ethnically representative of the jurisdiction they are working in.[44]

[41] Barksdale, Crystal, et al. May 23, 2022. Innovative Directions to Advance Mental Health Disparities Research. American Journal of Psychiatry, volume 179, number 6.
[42] American Medical Association. February 20, 2024. Embedding Equity in Crisis Preparedness and Response in Health Systems guide.
[43] ibid.
[44] Racial Equity and Social Justice Impact Statement for Bill 43-23; Vasan, Ashwin. Apr 14, 2021. From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response. Fountain House; American Medical Association. February 20, 2024. Embedding Equity in Crisis Preparedness and Response in Health Systems guide.

Chapter 2. County Entities and Responses to Mental Health Crisis Calls

When experiencing a mental health crisis, individuals may reach out to several different entities for help. This study identified four primary call center entities in Montgomery County that people often contact during such crises:

- **EveryMind** - A mental health nonprofit that operates 988 for Montgomery County, along with the Montgomery County Crisis Hotline and the Homeless and Housing Support On-Call Line.
- **Emergency Communications Center (ECC)** – The public safety answering point (PSAP) for 911 calls placed in the County. ECC also answers the 301-279-8000, police non-emergency number.
- **The Crisis Center** – The County's Department of Health and Human Services (HHS) operates the Crisis Center and has both 24/7 walk in and hotline crisis services.
- **311** - Montgomery County's nonemergency number for government information and services.

This chapter provides an overview of each call center entity, including staff training requirements, response protocols during periods of high call volume, and language accessibility services.

This chapter also presents and compares data from each of these entities. As part of its review, OLO requested data for calendar year 2024, including:

- Total numbers of calls, texts, and chats, broken down by reason for contact and demographics of caller;
- Numbers/percentages of calls transferred to another entity;
- Average answer speed; and
- Length of calls.

Not every entity was able to provide all the data requested by OLO. Overall, the demographic data collected is incomplete, and when recorded, it relies on information self-disclosed by the caller.

OLO notes that Maryland 211, which was highlighted in a previous OLO report in 2021 as a resource that County residents use for mental health issues, was not included in this study.[45] OLO was not able to reach a representative of Maryland 211 after numerous emails. Further, when interviewing County entities, staff noted they do not refer individuals to Maryland 211,

[45] Carrizosa, Natalia. March 9, 2021. Public Safety Responses to Mental Health Situations. OLO Report 2021-04.

nor are they included in the Call Center Entity Working Group. As a result, OLO was not able to collect updated data on the number of calls per day for 211.

A. EveryMind (988 and Montgomery County Mental Health Crisis Hotline)

EveryMind operates both 988 and the Montgomery County Mental Health Crisis Hotline, and both services are available 24/7. Each line focuses on crisis de-escalation, and the same team of crisis hotline counselors handles communication to both lines.

988, formerly known as the National Suicide Prevention Lifeline, is a nationwide hotline that provides immediate and anonymous emotional support via phone calls, text messages, and online chat. In Montgomery County, EveryMind serves as the local administrator for 988. It also responds to 988 chat and text messages from across the State of Maryland, not just Montgomery County.[46]

The Montgomery County Mental Health Crisis Hotline is a local service with a local phone number. It offers supportive listening, non-crisis support, and connections to local resources like 988, but tailored to the specific needs of County residents.[47] County residents can reach the hotline by dialing 301-738-2255. The Hotline provides support exclusively by phone. Texting capabilities were discontinued in October 2024, and chat is not available for this line.

Available 24/7?	Call, Text, and/or Chat?	Annual Call, Text, Chat Volume (2024)
Yes, both hotlines are 24/7	988 is capable of call, text, and chat, 24/7 The County hotline only handles calls. Texting capabilities were discontinued in October 2024.	**988:** 39,242 Contacts (15,397 Calls, 16,226 Texts, and 7,619 Chats) **MOCO Crisis Hotline:** 18,308 Contacts (17,336 Calls and 972 Texts)

Protocols and Accreditation

EveryMind is accredited by the American Association of Suicidology (AAS), and its answering protocol is informed by emergency dispatch guidelines provided by AAS. While the protocols

[46] EveryMind. 988 Call, Text & Chat - Reach Out Anonymously for Support
[47] ibid.

are not modeled step-by-step after AAS guidelines, their risk assessment practices are aligned with the standards used by all 988 centers.

Training

The training process for a crisis hotline counselor typically lasts about six weeks, though it may be shortened to five weeks depending on group size. It begins with required modules from Vibrant Emotional Health, the national administrator for 988. These modules cover core skills such as supportive listening, safety planning, and recognizing and assessing suicidal ideation. The training places strong emphasis on repeated practice of these foundational skills.

During the first four days, counselors complete online modules and participate in classroom sessions. Afterward, they are paired with a coach to observe live calls and engage in debriefing discussions. They continue working through online content while reviewing and discussing key concepts with their coach. In the final week and a half to two weeks, counselors begin answering calls themselves, with a coach beside them providing real-time guidance and support as needed.

Training also incorporates a variety of learning methods, including role-playing exercises and the use of an AI simulator that mimics real-time conversations. These approaches help counselors build confidence before interacting with actual callers.

EveryMind tailored their own classroom training materials from core materials provided by Vibrant Emotional Health to meet their specific needs and procedures. For instance, EveryMind created additional modules on mandated reporting, self-care, and mental health basics to better align with their operational context.

Currently, there are no systemic cross-training opportunities between 988 and the other call center entities. However, some collaborative efforts have occurred. For example, EveryMind staff have presented 988 services to 311's staff. Additionally, DHHS and EveryMind co-chair an integrated Crisis Call Centers Workgroup that meets on a bi-monthly basis and includes representation from 311 and the ECC.

Response to High Call Volume Periods

Calls to 988 are routed through Vibrant, the national administrator of the service, where they are queued based on the caller's initial selection. Option 1 connects callers to the Veterans Crisis Line, operated by the Department of Veterans Affairs and Option 2 connects callers to a Spanish-language line. At the time of writing this report, Option 3 which routed callers to a separate center that provided LGBTQ+ specific services was eliminated by the Trump

administration.[48] In Montgomery County, if a caller dials 988 and does not select any of these options, the call is routed through Vibrant and then directed to the local call center if the caller is physically located within the County.

When a call comes into 988, EveryMind's goal is to answer it within 20 seconds. Their current average response time is approximately 13 seconds. If counselors at EveryMind are unavailable, there are two layers of backup. First, the call is routed to Prince George's County 988 call center. If no one is available there, the call is then directed to the national 988 backup network, where it is likely to be answered by a center elsewhere in the country.

Conversely, the 24/7 Crisis Hotline does not have a backup system. EveryMind can increase staffing internally but cannot always respond immediately to unexpected surges. However, they can plan for increased staffing ahead of known events or in response to recent local incidents that may cause heightened community distress.

Counselors also aim to answer Crisis Hotline calls within 20 seconds and the average response time is 13 seconds. If a Crisis Hotline call is not answered, the caller hears a recorded message advising them to call 988 as an alternative. The same process applies to the Homeless Information Line, which is also operated by EveryMind.

EveryMind also prioritizes 988 calls during high-volume periods, as these typically involve higher-risk situations. If the center becomes severely understaffed and receives more 988 calls than local crisis line calls, 988 calls are prioritized to ensure the most urgent needs are addressed first.

Language Accessibility

EveryMind offers language accessibility for both 988 and the Hotline via a language line which is a real time interpretation service with more than two hundred languages. While functional, EveryMind staff and other County employees from call center entities interviewed report that the service can be clunky and is not considered ideal.

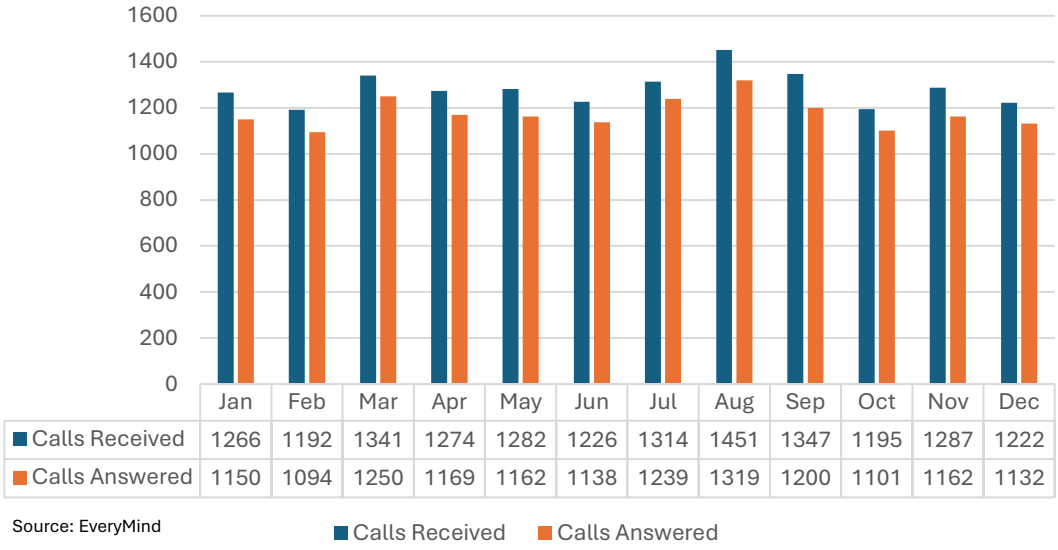
The Spanish-language and video phone services available through 988 are provided outside of EveryMind as part of national subnetworks—specialized groups of centers across the country that handle calls in specific languages or formats. These allow callers to opt into targeted services when contacting 988.

[48] As of July 17, 2025, the 988 Press 3 option for LGBTQ+ specific services is terminated. Trump administration cuts specialized suicide prevention service for LGBTQ+ youth

988 Data

OLO received data from EveryMind on 988. EveryMind notes that because 988 is confidential and anonymous, call-takers only directly ask for age as demographic data. Other data is only tracked when the individual self-discloses, therefore only about 3% of all 988 interactions routed to EveryMind have robust demographic data recorded, including gender, age, race and ethnicity, and military service status. Charts 1, 2, and 3 show the number of calls, texts, and chats received and answered by 988 in 2024.

Chart 1. Number of 988 Calls Received and Answered in 2024

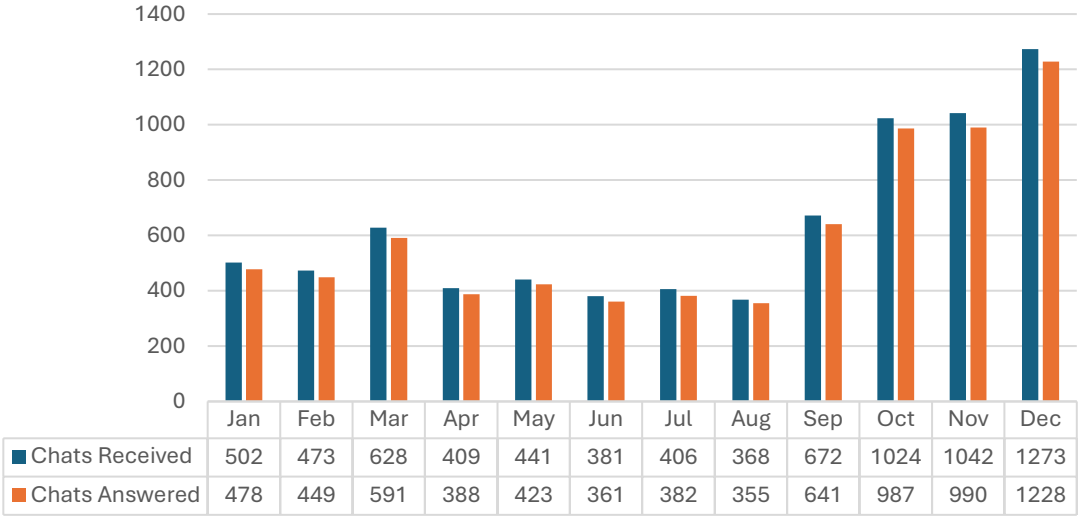


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Calls Received	1266	1192	1341	1274	1282	1226	1314	1451	1347	1195	1287	1222
Calls Answered	1150	1094	1250	1169	1162	1138	1239	1319	1200	1101	1162	1132

Source: EveryMind

The average number of calls answered by 988 counselors per month in 2024 was 1,176. The average answer rate was 92% and, in most months, answer rates were between 90% to 94%, except for September, which had an answer rate of 89%.

Chart 2. Number of 988 Chats Received and Answered in 2024

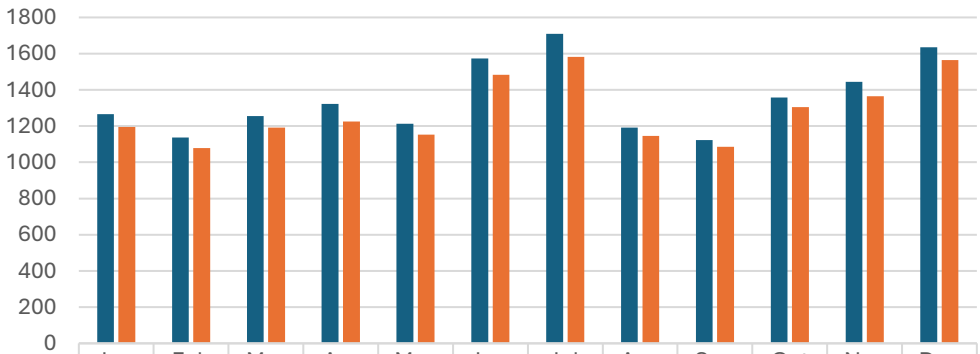


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Chats Received	502	473	628	409	441	381	406	368	672	1024	1042	1273
Chats Answered	478	449	591	388	423	361	382	355	641	987	990	1228

Source: EveryMind

The average number of chats answered by 988 counselors per month in 2024 was 606 and the average answer rate was 95%. From October to December, there was a noticeable spike in chats received. The average for these three months was 1,113 compared to the average chats received from the rest of the year (January – September) which was 476 chats.

Chart 3. Number of 988 Texts Received and Answered in 2024

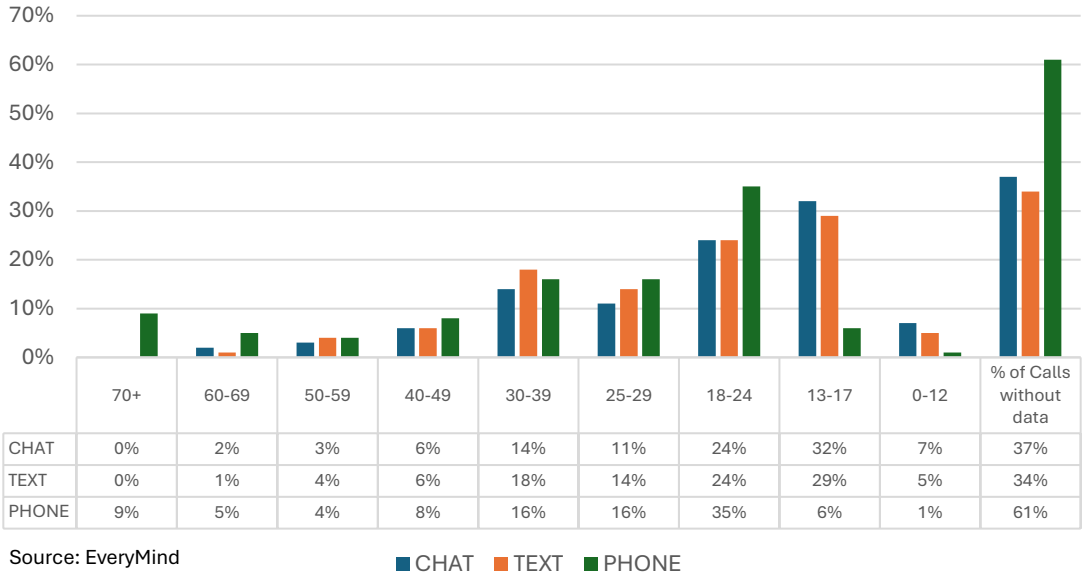


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Texts Received	1266	1136	1256	1322	1212	1574	1709	1192	1122	1358	1444	1635
Texts Answered	1196	1078	1192	1226	1152	1484	1583	1146	1086	1305	1364	1565

Source: EveryMind

The average number of texts answered by 988 counselors per month in 2024 was 1,352 and the average answer rate was 95%. The month with the highest volume of texts received was July with 1,709 texts. Of all the ways to reach 988 in 2024, text messages made up the highest volume of contacting 988.

Chart 4. 988 Self-Disclosure Rates by Age in 2024

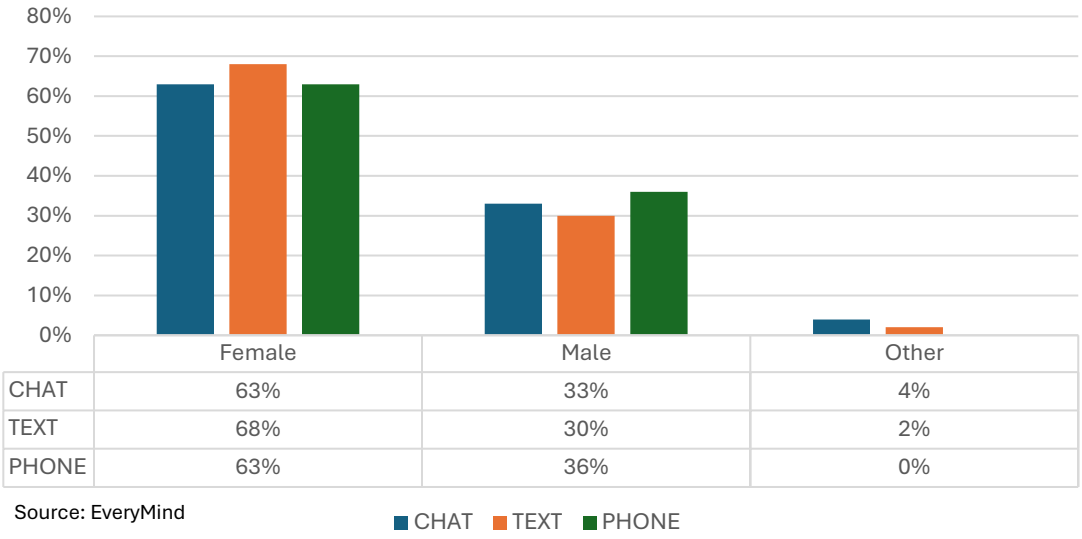


	70+	60-69	50-59	40-49	30-39	25-29	18-24	13-17	0-12	% of Calls without data
CHAT	0%	2%	3%	6%	14%	11%	24%	32%	7%	37%
TEXT	0%	1%	4%	6%	18%	14%	24%	29%	5%	34%
PHONE	9%	5%	4%	8%	16%	16%	35%	6%	1%	61%

Source: EveryMind

Percentages in the "unknown" category were calculated using all contacts from calendar year 2024 as the denominator. This shows the proportion of contacts for which no data was available for that category. In contrast, percentages for all other categories reflect only those contacts where individuals self-disclosed demographic information—contacts without any demographic data are excluded from these calculations. Percentages may not add up to 100% and OLO reported the percentages as presented by EveryMind.

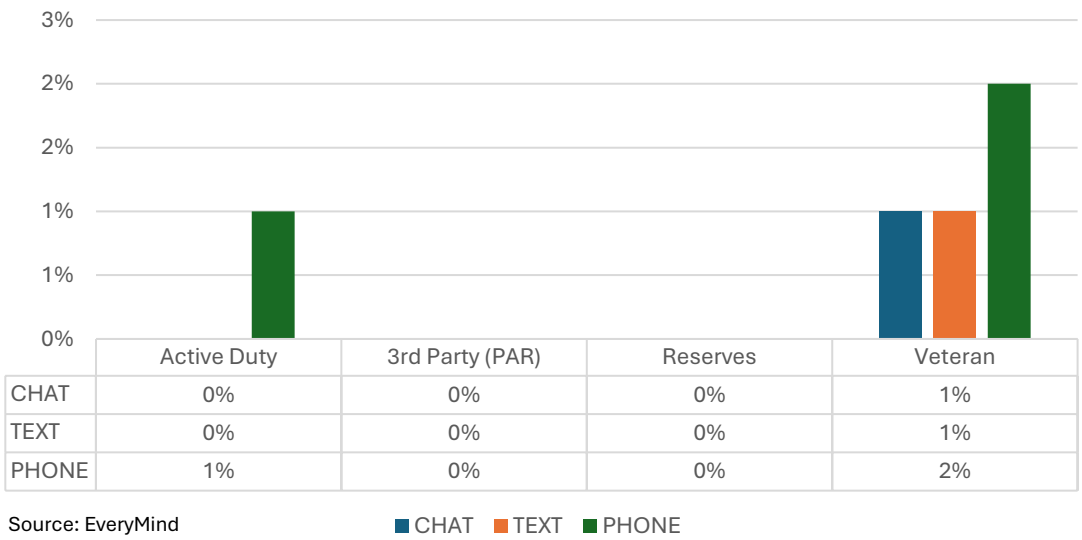
Chart 5. 988 Self-Disclosure Rates by Gender in 2024



	Female	Male	Other
CHAT	63%	33%	4%
TEXT	68%	30%	2%
PHONE	63%	36%	0%

Source: EveryMind

Chart 6. 988 Self-Disclosure Rates by Military Status in 2024



	Active Duty	3rd Party (PAR)	Reserves	Veteran
CHAT	0%	0%	0%	1%
TEXT	0%	0%	0%	1%
PHONE	1%	0%	0%	2%

Source: EveryMind

Data shows the demographic categories that were disclosed most often were age and military service. 988 counselors only ask for age, and callers are not required to provide it. Other data are tracked if a caller decides to self-disclose, such as race and ethnicity and gender. In 2024, about 55% of individuals who contacted 988 chose to disclose their age, 36% disclosed their gender, and 56% disclosed their military status. The least frequently disclosed demographic

category was race and ethnicity, with only 3% of callers providing that information. Due to the small sample size, race and ethnicity data is not presented in this report.

Of the callers who did choose to self-disclose information on their demographics:

- Most callers fell within the 18-24 age range **(27%)** and 13-17 age range **(13%)**. The age range represented least was the 60-69 age range **(2%)** and 70+ **(3%).**
- Most callers identified as women **(65%)** and only **34%** of callers identified as men. **2%** of callers identified as other.
- **98%** of callers did not have any military status and only **1%** of callers were veterans. This might be due to having a separate veteran's crisis hotline that callers may select when dialing 988.

Below lists the multiple reasons why callers contacted 988 in 2024. OLO notes that calls, texts, and chats can be associated with multiple issues, and the categories are self-reported. As a result, they may not fully capture the range of concerns the individuals were experiencing. However, the five most common reasons for contacting 988 in 2024 were:

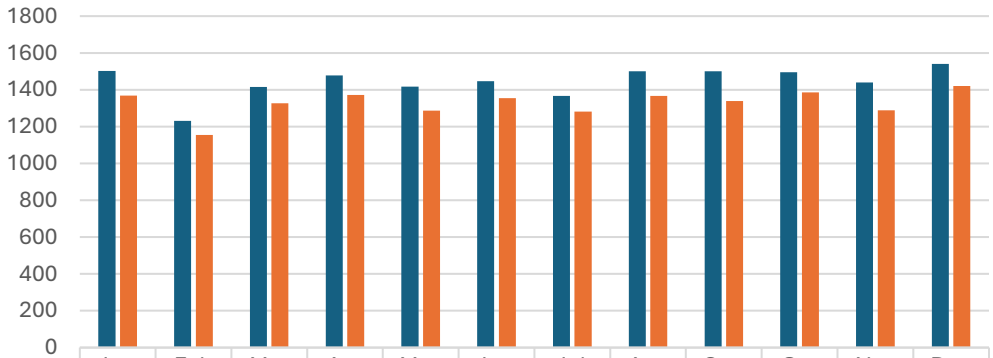
- **Family/Other Relationship** – 10,546
- **Other** – 5,060
- **Depression** – 4,211
- **Anxiety** – 2,919
- **Self-Harm** – 2,148

The sixth most common reason for contacting 988 was on behalf of another person (third-party visitor). 2,125 callers reached out to 988 due to concern for another person in their life, such as a relative, partner, or friend.

Montgomery County Crisis Hotline Data

OLO received data from EveryMind on the Montgomery County Crisis Hotline. Chart 8 and 9 shows the number of calls and texts received and answered by EveryMind in 2024.

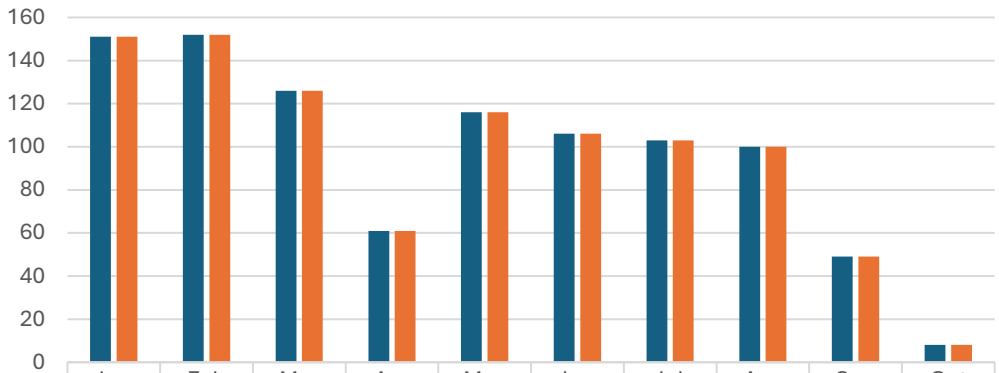
Chart 8. Number of Calls Received and Answered by the Crisis Hotline Line in 2024



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Calls Received	1502	1231	1416	1478	1417	1447	1367	1501	1501	1496	1439	1541
Calls Answered	1369	1154	1327	1372	1286	1355	1281	1366	1339	1385	1289	1421

Source: EveryMind

Chart 9. Number of Texts Received and Answered by the Crisis Hotline in 2024*

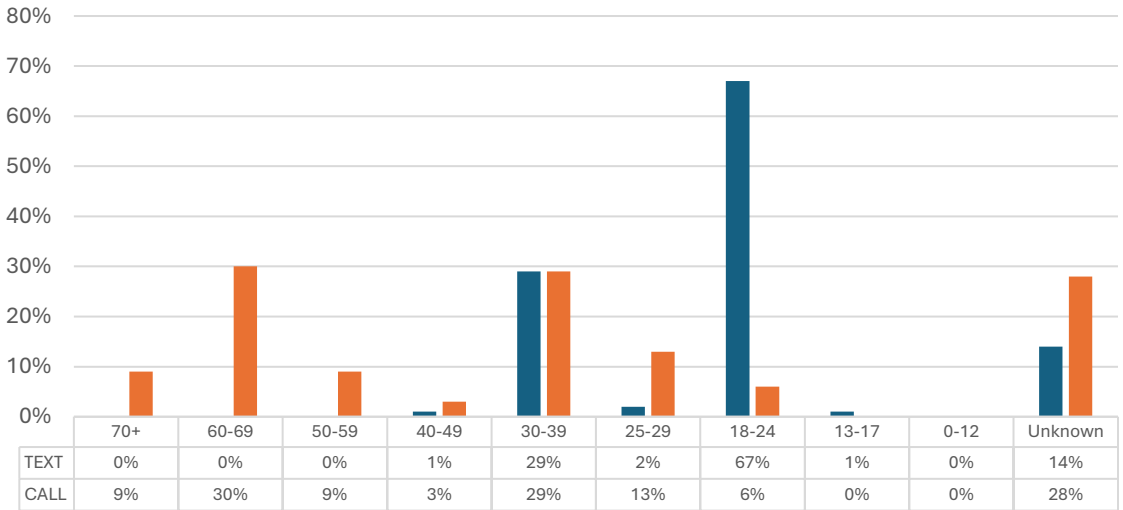


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Texts Received	151	152	126	61	116	106	103	100	49	8
Texts Answered	151	152	126	61	116	106	103	100	49	8

Source: EveryMind

The data shows the majority of outreach to the Montgomery County Crisis Hotline comes from phone calls rather than texts. The average number of calls per month answered for 2024 was 1,328. The average number of texts per month answered was 97.[49]

Chart 10. Crisis Hotline Self-Disclosure Rates by Age (2024)



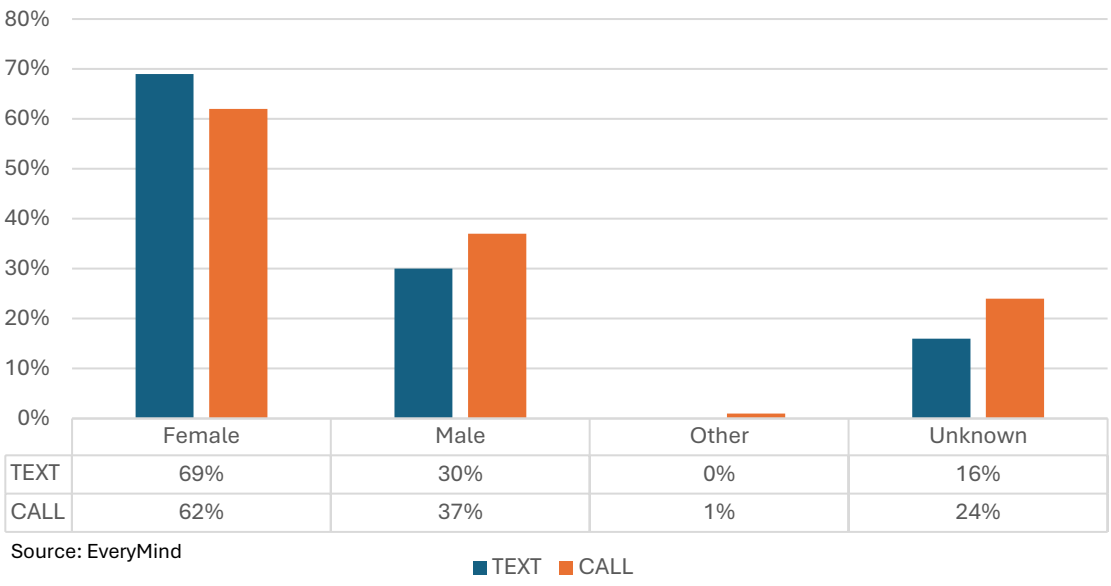
	70+	60-69	50-59	40-49	30-39	25-29	18-24	13-17	0-12	Unknown
TEXT	0%	0%	0%	1%	29%	2%	67%	1%	0%	14%
CALL	9%	30%	9%	3%	29%	13%	6%	0%	0%	28%

Source: EveryMind

[49] This average is for January – October as text data for November and December were unavailable.

The Montgomery County Crisis Hotline received 1,939 more **calls** than 988. Conversely, 988 received 15,254 more **texts** than the Montgomery County Crisis Hotline.

Chart 11. Crisis Line Self-Disclosure Rates by Gender (2024)



	Female	Male	Other	Unknown
TEXT	69%	30%	0%	16%
CALL	62%	37%	1%	24%

Source: EveryMind

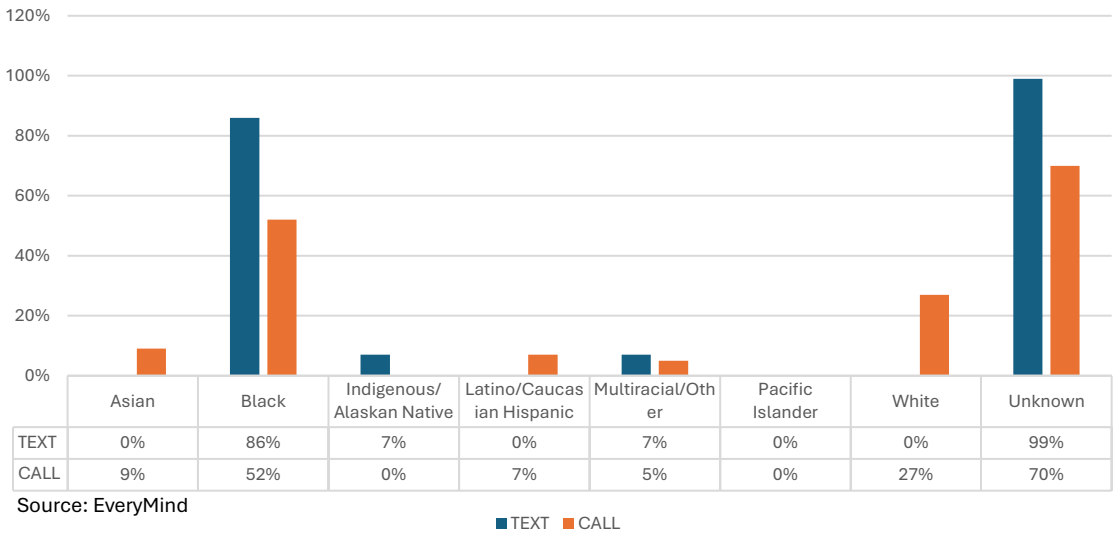
Like 988, callers are not required to disclose their demographic information, although they may choose to. The Crisis Hotline counselors only solicit information on the age of the caller. Other demographic data is tracked if callers choose to self-disclose. Disclosure rates are higher compared to 988: 74% of all individuals who reached out to the crisis hotline disclosed their age and 77% of all individuals disclosed their gender. Race and ethnicity information was still the least disclosed category but approximately 11% of individuals who reached out to the crisis hotline disclosed this compared to 3% of 988 callers.

Of the callers who self-disclosed demographic data:

- Most callers fell within the 30-39 age range **(29%)** and 60-69 age range **(27%).** Only **3%** of callers fell within the 40-49 age range. Notably, far less callers were within the 18-24 age range **(13%)** and 13-17 age range **(<1%)** compared to 988 callers.
- Most callers identified as women **(63%)** and only **37%** of callers identified as men. **1%** of callers identified as other.
- Most callers were Black **(53%). 25%** of callers were White, **8%** of callers were Asian, **7%** of callers were Latino, and **7%** of callers were multiracial. OLO notes only 11% of all callers self-disclosed their race so this is likely not representative of all callers.

- **98%** of callers did not have any military status and only **1%** of callers were veterans.

Chart 12. Crisis Line Self-Disclosure Rates by Race/Ethnicity (2024)



	Asian	Black	Indigenous/ Alaskan Native	Latino/Caucasian Hispanic	Multiracial/Other	Pacific Islander	White	Unknown
TEXT	0%	86%	7%	0%	7%	0%	0%	99%
CALL	9%	52%	0%	7%	5%	0%	27%	70%

Source: EveryMind

Chart 13. Crisis Line Self-Disclosure by Military Status (2024)

	Active Duty	3rd party (PAR)	Reserves	Veteran	Unknown
TEXT	0%	0%	0%	0%	12%
CALL	1%	0%	0%	1%	24%

Source: EveryMind

OLO notes calls and texts can be categorized into multiple issues. Further, these categories are self-reported, so it does not encompass the entirety of issues individuals face. However, the five most common reasons for contacting 988 in 2024 were:

- **Family/Other Relationship** – 5,844
- **Other** – 3,482
- **Anxiety –** 1,623
- **Job/Career –** 1,594
- **Depression –** 1,227

Combined Data for Both 988 and the Montgomery County Crisis Hotline

EveryMind also shared call, text, and chat data for fiscal years 2024 and 2025[50]. For FY24 (from July 1, 2023, to June 30, 2024), the combined number of hotline contacts answered was 54,874. Preliminary FY25 data showed the combined number of hotline contacts answered was 58,748. This includes all calls, chats, and texts from both 988 and the Montgomery County Hotline. Data shows that FY25 has nearly 4,000 more contacts compared to FY24, with two months remaining in the fiscal year at the time the data report was received by OLO.

Other combined data points collected are as follows for calendar year 2024:

- **Average number of Full-Time Call-takers on any Given Shift** – 38.8 to 43.3
- **Average Answer Speed**:
    - 988 Calls – 13 Seconds
    - Hotline Calls – 13 Seconds
    - 988 Chat – 13 Seconds
    - 988 Text[51] – 13 Seconds
- **Average Length of Call, Chats, and Texts:**
    - 988 Calls: 14 minutes
    - Hotline Calls: 13 minutes
    - 988 Chat: 30 minutes
    - 988 Text: 44 minutes
- **Percent of Calls Resolved Over Phone by 988 and the Crisis Center (No transfer to 911 or other entity needed):**
    - Calls – 98.1%
    - Chats - 98.2%
    - Texts – 98.4%

[50] Data for FY25 was shared before the end of the fiscal year (June 30). OLO received the data from EveryMind in late April.
[51] For both 988 text and chat answering speed data, that is for EveryMind's center specifically. The Maryland chat and text queue average speed to answer is 68 seconds across the three centers in the state.

- **Number and Percent of Calls, Chats, and Texts Transferred to 911:**
    - Calls - 119 (0.1%)
    - Chats – 89 (1%)
    - Texts – 118 (0.7%)
- **Number and Percent of Calls, Chats, and Texts Transferred to the Crisis Center:**
    - Calls - 462 (1.5%)
    - Chats – 43 (0.6%)
    - Texts – 134 (0.9%)

B. Montgomery County Crisis Center

The Montgomery County Crisis Center is managed by the Department of Health and Human Services (DHHS). It is open 24 hours a day, 365 days a year. Services are provided by phone or in person with no appointment needed. The Crisis Center handles a range of behavioral health and substance use disorder crises and provides full crisis assessments and treatment referrals. There are four crisis beds which can be used as an alternative to hospitalization.

The Crisis Center does not provide phone counseling services; instead, its phone lines focus on identifying crisis needs and connecting callers with appropriate resources. The staff includes licensed mental health professionals and peer recovery specialists who are available 24/7 to answer crisis calls. Intake staff also handle walk-ins and dispatch the Mobile Crisis and Outreach Team (MCOT). Additionally, the Crisis Center handles after-hours calls for several critical services, including Child Protective Services, Adult Protective Services, and trauma-related services.

Available 24/7?	Call, Text, and/or Chat?	Annual Call Volume (2024)
Yes	Call	41,610 Calls

Mobile Crisis and Outreach Team -MCOT-

Administered through HHS's Crisis Center, MCOTs consist of a licensed mental health professional and a peer recovery specialist who respond together. The mobile crisis staff wear plain clothes, do not have access to computer-aided dispatch (CAD) or sirens, and rely on de-escalation techniques and rapport-building skills to engage with their clients.

The team has access to police radios as a safety measure to request backup if needed. There are several types of situations for which mobile crisis teams are dispatched:

- A caller requests the mobile crisis team;
- Someone calls the Crisis Center and indicates they are contemplating suicide or self-harm but do not indicate they have a weapon or an immediate plan, the MCOT would respond to that situation alone;
- A concerned third party, such as a friend or family member, calls the Crisis Center and indicates they are worried about the well-being of an individual; or
- First responders request the presence of MCOT for aid in de-escalation of a situation.

Protocols

The Crisis Center follows SAMHSA's National Guidelines for a Behavioral Health Coordinated System of Crisis Care and its foundational elements: someone to contact, someone to respond and a safe place for help.

Additionally, MCOT uses an internally developed triage protocol modeled after the CAHOOTS program from Eugene, Oregon. This protocol provides the steps for MCOT's triage and dispatch for behavioral health crisis (see appendix A).

Training

The Crisis Center's essential staff includes 63% masters-level licensed therapists and 27% peer recovery specialists. Most Crisis Center clinicians have obtained clinical licensure, which means they have completed the post-graduate requirements necessary to be able to independently diagnose and treat. The Crisis Center also employs masters-level clinicians with graduate degrees who are working towards independent clinical licensure and conduct their assessments under appropriate clinical supervision.

The Crisis Center staff offer trainings throughout the County specific to their subject matter expertise, including guidance on initiating Emergency Evaluation Petitions.[52] Many of these training courses are offered in collaboration with the County's Office of Human Resources via HHS' Center for Continuous Learning.

Since the Crisis Center does not provide phone counseling services, there are no licensing or specialized training requirements for their intake staff.[53] However, the Crisis Center provides

[52] An emergency evaluation is a way to get a person who presents a danger to themselves or others to an emergency room to be examined. If the court orders an emergency evaluation, the person will be taken to the nearest emergency facility by a law enforcement officer. An emergency room physician will then determine if the person qualifies for involuntary admission to a psychiatric facility.

[53] While there are not licensing or training requirements for intake staff, all Crisis Center staff are either master's or doctoral level licensed mental health professionals or certified peer recovery specialists/allies, all of which have received a high level of professional training in counseling and communication techniques.

training during orientation to all staff on proper protocols for answering crisis phone calls. These protocols are periodically reviewed during staff meetings and individual and group supervision.

As with 988, there are no systemic cross-training opportunities between the Crisis Center and the other call center entities. However, Crisis Center staff complete the 40-hour CIT training at the earliest available opportunity after being hired. Despite the lack of formal cross-training systems, there have been some collaborative training efforts. For example, the Crisis Center provided 311 staff with training on phone-based de-escalation techniques in response to an increase in distressed callers related to global events. Additionally, Crisis Center staff partnered with 988 to deliver safety-related training for both supervisors and call-takers.

Response to Periods of High Service Demand

The Crisis Center does not have dedicated call-takers. Staff are assigned to different functions, such as MCOT and Residential Crisis beds but there are no staff that are only dedicated to answering incoming calls. Monday through Friday, there are 11-15 staff for each shift which allows 6-10 staff to be assigned to MCOT. This leaves a minimum of 5 staff in the office to answer phone calls, attend to Residential Crisis Services (RCS) clients, and walk-in clients.[54] Although the Crisis Center has requested additional call-takers, the request has not been approved. This has led to an "all hands on deck" approach, where all available staff, including supervisors, answer phones during periods of high call volume.

As a result, callers may wait on hold for 15 to 20 minutes.[55] While on hold, callers hear a repeated recording instructing them to hold until someone is available to answer the call. There is no backup number or message that instructs callers to dial another number.

The Crisis Center requested an upgraded phone system to help reduce wait times. The goal with this system is to establish a triage system where calls from police, fire and rescue, or individuals who are suicidal, homicidal, or in immediate distress will be prioritized and moved ahead of callers with non-crisis-related issues. Currently, some callers are routed incorrectly, including individuals who should be contacting 311 instead. Although the County Executive designated the phone system upgrade as a critical project three years ago, it has not yet been implemented. The Crisis Center is now aiming to have the new system in place by early July of next year.

[54] During overnight shifts, the Crisis Center has a minimum of 2 staff in the office if an MCOT team is dispatched.

[55] Staff feedback.

As for in-person response capacity, the County has approved increased staffing, and there are now five MCOTs during times of highest call-volume. The goal is to expand to seven teams to meet growing demand and reduce wait times.[56] At the time of the study, the Crisis Center was in the process of filling sixteen positions, either newly created or vacant due to retirements and staff departures. Their goal is to have all seven MCOTs operational by September 2025.

Language Accessibility

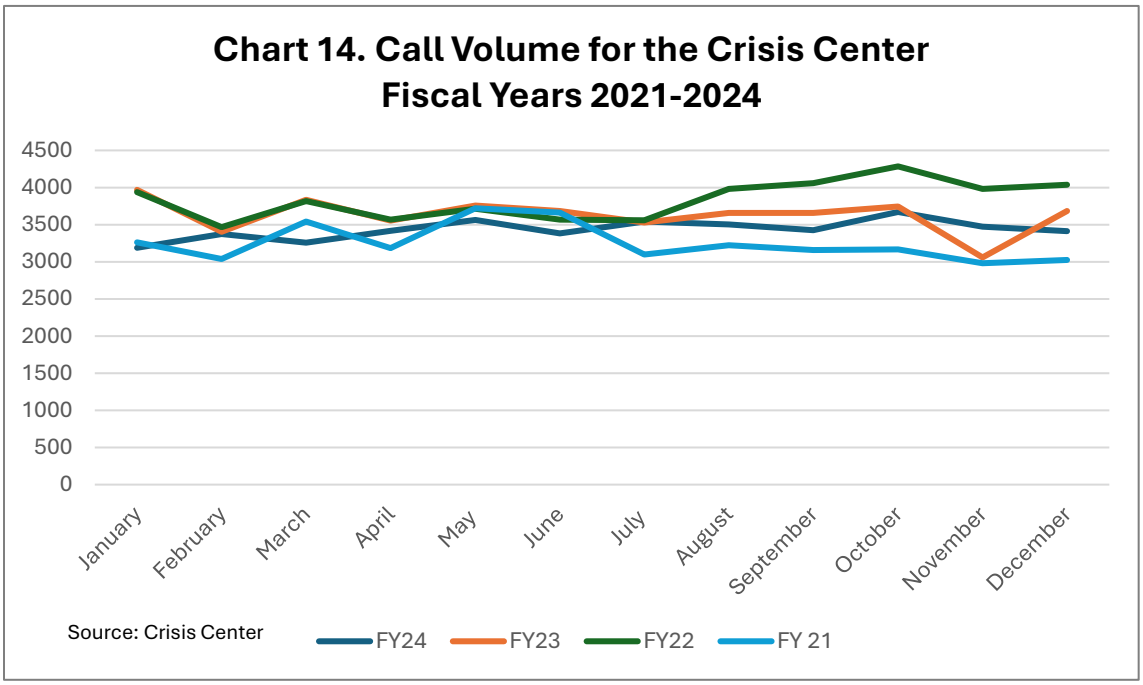
The Crisis Center has ten merit staff members and five PRN who can assist with Spanish interpretation and translation. Counseling services are available in Spanish, with the goal of having a Spanish-speaking therapist on every shift. In addition to Spanish, their staff includes speakers of other languages such as Mandarin, Farsi, Korean, Arabic and French.

To support communication with clients who speak other languages, staff also have access to a language line. When a bilingual staff member is not available, English-speaking staff use the language line to communicate with non-English-speaking clients. Additionally, the Center has a contract to provide American Sign Language (ASL) interpretation services via tablet when an ASL interpreter is not available in person.

Data on Call Volume and MCOT Dispatches

The Crisis Center provided OLO with data on call volume and number of MCOT dispatches for recent fiscal years. The Crisis Center noted that they do not capture data on the demographics of callers nor the content or length of the phone calls. Currently, their phone systems do not automatically track data on the content and acuity of each call. Staff are hopeful they will have the ability to capture more detailed data once the phone system upgrade is completed later this year.

[56] According to the July 2022 assessment performed by Effective Law Enforcement for All Inc., MCPD noted that MCOT's were understaffed and routinely unavailable.



According to data, FY22 had the highest call volume in the period from FY21 to FY24. Data for the entire FY25 was not available at the time of the report. On average across the period from FY21 – FY24, the monthly average calls per month is 3,399.

May, October, and March have the most average calls per month across the FY21 – FY24 period with 3,690, 3,668, and 3,623 monthly calls respectively.

Table 1. MCOT Dispatches

Month	FY24	FY25	Average
January	131	198	165
February	207	252	230
March	192	277	**235**
April	205	233	219
May	200	Pending	--
June	205	Pending	--
July	149	190	170
August	143	183	163
September	131	242	187
October	115	248	182
November	141	224	183
December	164	234	199
Total	**1983**	**2281**	**2132**

Source: Crisis Center

Data for MCOT dispatches was provided for FY24 and FY25. Across the period for FY24-25, March had the highest monthly average with 235 dispatches. In FY24-25, the monthly dispatch average was 194.

Despite FY25 incomplete data collection at the time of this report, dispatches have gone up 15% since FY24.

C. 911 (Emergency Communications Center -ECC-)

ECC is the only public safety answering point for receiving 911 calls in the County and operates 24/7. They are a tri-accredited 911 center, one of only about twenty nationwide. They dispatch fire and rescue, emergency medical services, and police in the County.

The County offers text-to-911, as an alternative to calls. OLO notes that 911 Emergency Communications Specialists (PSECS) do not answer text or calls at the same time, but all of them are trained to answer texts and calls. ECC's PSECS also answer all incoming calls on the 301-279-8000 non-emergency number.

Available 24/7?	Call, Text, and/or Chat?	Annual Call Volume (2024)
Yes	Call and Text	848,289 (All calls) 15,040 Calls Related to Mental Health

Protocols and Accreditation

ECC is accredited through the International Academy of Emergency Dispatch. As part of this accreditation, ECC uses three protocols[57]:

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

The protocols include a scripted set of questions for PSECS to follow. Based on the caller's responses, the call may be routed in different directions, depending on how the situation unfolds.

Protocol 41: Caller in Crisis. Recently, the academy introduced a new EMD protocol called Protocol 41: Caller in Crisis which is intended for use with a suicidal 1st party caller. One of its key benefits is the addition of an emotional control tool which provides call-takers with sample statements to help calm callers, manage the conversation, and fill in any gaps. Although the protocol has been introduced in Maryland and a significant portion of the County's ECC staff have completed training, no 911 centers are currently using it. While the emotional control tool itself appears to enhance call taking, it is only available within Protocol 41 which otherwise introduces several complexities and limitations to the overall call taking process. Protocol 41 will not be implemented with this initial release however the County awaits future improvements to the EMD software.

Training

ECC's training program for PSECS lasts twelve months, with the possibility of extension to eighteen months. The first phase of training covers state-mandated foundational instruction,

[57] Carrizosa, Natalia. March 9, 2021. Public Safety Responses to Mental Health Situations. OLO Report 2021-04.

including emergency telecommunications. This portion takes place in a classroom setting at the ECC and lasts twelve weeks. During this phase, trainees receive specialized instruction in three core protocols along with County-specific guidance on how to handle various types of incidents—such as animal-related issues, domestic disputes, theft complaints, and others—each with its own set of protocols.

After completing the classroom portion, trainees are assigned to a communications training officer and begin on-the-job training for eighteen weeks. During this time, they shadow the training officer and continue developing their skills in real-time situations.

At the end of the eighteen weeks, they undergo a hands-on evaluation to assess their readiness before moving on to the next phase. Trainees must meet specific benchmarks successfully to advance through the program.

As with the other call center entities, there are no cross-training opportunities. However, in 2022 all ECC staff participated in CIT Support Training for 911. Since then, all new employees participate in the training during their early training phases.

Response to High Call Volume Periods

The ECC is staffed by 86 PSECS with 26 PSECS in training in various phases. PSECS work in twelve-hour shifts for the most part, with some eight-hour and ten-hour occasional shifts providing enough coverage for high call volume periods. They also have a backup center they use when their primary center is not operational.

Additionally, callers that live within the city limits of Takoma Park, City of Rockville, or Chevy Chase Village, can call those local police departments directly. However, if the call requires medical assistance, the call is routed back to the ECC.

Language Accessibility

ECC uses a language line service for interpretation. In addition, they have several staff members who are certified in other languages including Spanish, French, Korean, and Vietnamese. When those employees are on duty and a call is received in their language, they can conduct the call in the caller's language.

For the hearing-impaired community, ECC is still required to have a phone system that provides Telecommunications Device for the Deaf (TDD) equipment. TDD is an older, landline-based method that functions as a text-based communication system, allowing users to type messages that are displayed on the receiving device. However, most callers now use cell phones to text or connect via video relay making this system obsolete.

Data on Mental Health Related Calls Received by ECC (911) in 2024

OLO received calendar year 2024 data from ECC. OLO notes ECC does not track demographics of callers. The following data is the combined annual total for 2024. 911 can accept both calls and texts and the data represents both modes of communication.

- **Number of Calls:** 848,289
- **Number of Calls Received Related to Mental Health Crises:** Approximately 15,040
- **% of Mental Health Related Calls by Reason for Contact[58]:**
  - Mental/Behavioral Health – 13,755
  - Suicidal – 1,285
- **Average Speed to Answer:** 10 seconds
- **Average Length:** 2 minutes, 32 seconds
- **Calls that Need Language Services:** 23,201
- **% of Calls Resolved Over Phone by ECC without Sending Services[59]:** Approximately 9,751
- **% of Calls Transferred to 988, Crisis Center, or other Mental Health Crisis Entity:** 72 calls Conferenced, Referred, or Transferred

[58] For this data, it is an approximation as it depends on the caller's self-report and the call-taker's discretion. Not all calls related to mental health may be accounted for.

[59] According to 911 staff, "This number includes repetitive calls with mental health issues who may call rambling but not actually hold a conversation and/or unwilling (not able to process or do not stay on the line) to take info regarding 988 and Crisis Center Services".

D. 311

Available 24/7?	Call, Text, and/or Chat?	Annual Call Volume (2024)
No, Available Monday – Friday 7 AM – 7 PM	Call and chatbot available through the website	414,524

311 is Montgomery County's nonemergency line that connects callers to County services. The phone line is open Monday through Friday, from 7 AM to 7 PM. Residents can also submit service requests online, for example, for bulk trash pickup, pothole repair, or tree inspection and pruning—or use the 311 chatbot on the County's website to access services.

Monty – 311's AI Chatbot

Monty is 311's AI Chatbot which is powered by ChatGPT and is multi-lingual. Monty is designed to answer non-emergency questions and provide information about County services. Monty cannot respond to emergencies; if someone requests help with a mental health crisis via chat, it will advise the individual to contact 911 for emergencies. Monty is trained using information from 311's KBAs and is trained to answer routine service questions such as "When is early voting?, "How do I order a new recycle bin?" and "Where is the closest library to me?." Monty is available 24/7 on any device with an internet browser.

Knowledge Based Articles

To respond effectively to mental health crisis calls, 311 customer service representatives (CSRs) use knowledge-based articles (KBAs) in the Siebel system to determine the appropriate response and connect the caller with the appropriate resources.[60] 311's CSRs focus on disseminating information, rather than providing in-depth counseling services.

Over the past couple of years, 311 has partnered with the other three call center entities in the County to standardize response protocols for mental health crises. 311 has also trained their CSRs to help them identify a mental health emergency. CSRs are trained on what a mental health emergency might look or sound like as oftentimes, callers do not outright say "I'm having

[60] Siebel is the customer relationship management application used by 311 to track and manage their service interactions with customers.

a mental health crisis", but more often, they will say they are feeling anxious, need therapy, or are so overwhelmed they struggle to vocalize what they need.

Response to High Call Volume Periods

The 311 system is designed to handle seasonal and expected variations, so their answering protocols do not change during heavy request times. However, when unexpected events occur, they will usually update or enhance specific KBAs to address the situation. This is when the Relationship Manager collaborates with the departmental point of contact to ensure CSRs have the most up-to-date information. Because CSRs are not permitted to improvise or provide information that is not pre-approved, all communication must be based on existing KBAs.

Data on Mental Health Crisis Calls

311 shared the following data with OLO for calendar year 2024. 311 presented data on calls where there is a request for service. Data from the chatbot was not included. OLO also notes that demographic data is not collected by 311.

- **Number of Calls:** 414,524 calls
- **Number of Calls Related to Mental Health Crises:** 347 (where the attached solution contained "Mental Health")
- **Average Answer Speed:** 22 seconds
- **Average Length of Call:** 232 seconds (3 minutes, 52 seconds)
- **Percent of Calls that Need Language Services:** <1%
- **% of Calls Transferred to 988, Crisis Center, or Other Mental Health Crisis Entity:** <1% (333 Calls Transferred or Referred)
- **% of Calls Transferred to 911:** <1% (103 calls transferred in CY24)

E. Centralized Crisis Intervention Team

The Montgomery County Police Department (MCPD) has a specialized Centralized Crisis Intervention Team (CCIT) dedicated to responding to behavioral health emergencies and supporting patrol officers during such incidents. Housed within the Community Engagement Division, CCIT focuses on education, outreach, follow-up, empowerment, and response for residents affected by mental illness, Autism Spectrum Disorder, intellectual and developmental disabilities (IDD), Alzheimer's disease, and dementia. CCIT officers are trained in de-escalation and behavioral health intervention and respond to a wide range of critical situations, including mental health crises, traumatic incidents, and the service of Extreme Risk Protective Orders (ERPOs). When not physically present at a behavioral health call, CCIT officers are available by phone for consultation and can respond in person when needed. They primarily operate

Monday through Friday during regular business hours, with on-call availability outside those times.[61]

CCIT includes one sergeant, one supervisor therapist, and five officers who are assigned to the following districts: Bethesda, Wheaton, Silver Spring, Germantown, and Gaithersburg.[62] The supervisor therapist is an HHS employee who is located within police headquarters and works with CCIT officers in a co-response model. In certain situations, the supervising therapist will accompany an officer to the scene and provide follow-up for the CCIT unit.

MCPD also has officers who have completed the 40-hour Crisis Intervention Training (CIT) but are not part of the specialized CCIT response. MCPD estimates that over 75% of officers are CIT certified.

Protocols

Typically, CCIT is dispatched to suicide attempts in progress and to situations where an individual in behavioral health crisis is violent. CCIT teams can be dispatched by:

- 911 PSECS;
- Other officers to provide de-escalation and crisis intervention support during calls; or
- CCIT officers themselves, as they monitor incoming calls and identify a potential behavioral health crisis.

The CCIT team works closely with MCOT, with both teams able to request each other's support on specific calls. For example, if someone is barricaded in their home, CCIT will automatically contact MCOT and share relevant information. MCOT then determines whether the situation involves a potential mental health component and, if so, they will respond.

CCIT officers also scan incoming calls and flag those where the individual expresses a desire to speak with a clinician. The officer may reach out directly to the individual and offer to connect them with a clinician instead of sending police. If the individual agrees, the officer will then contact the Crisis Center to have MCOT respond, and police will not be dispatched unless requested.

CCIT officers drive unmarked vehicles, wear CIT identification patches, and are marked differently in internal systems. The department is also working toward issuing uniforms with a softer, more approachable appearance to further reduce stigma and support engagement.

[61] CCIT's review for Maryland's Governor's Office of Crime Prevention. 2025

[62] While they are assigned to these districts, they are not restricted to those areas and may be dispatched elsewhere in the County.

Training

All officers in MCPD receive training in mental health first aid (MHFA) and over 75% of officers are CIT certified. CCIT officers must also be certified as general instructors in the State of Maryland and receive additional training such as Integrating Communications, Assessment, and Tactics training, which is a de-escalation model developed by the Police Executive Research Forum.

Presently, the eight-hour MHFA training and the 40-hour CIT post field training is held at the academy. The department offers four classes per year, each with up to 40 participants. There are no CIT or MHFA retraining requirements for existing officers.

Response to Periods of High Service Demand

The CCIT's primary responsibilities are evenly split between providing training and conducting follow-up on referrals from patrol officers. Currently, the CCIT does provide initial responses to calls involving individuals experiencing a behavioral health crisis.[63] Since only five officers are assigned to CCIT, the team relies on patrol officers to respond to behavioral health crisis calls when they are unavailable. CCIT prioritizes responding to suicides in progress, incidents involving violent mechanisms of injury (MO), and other in-progress calls where they can assist with de-escalation.

There is no standardized roster of CIT-certified officers on patrol. Without such a roster, 911 PSECS cannot identify which patrol officers are CIT-certified. As a result, there is no practical way to prioritize dispatching a specialized CIT patrol officer. However, according to MCPD, all officers will soon have a designation in the CAD system, allowing 911 operators to identify which officers possess specific skills.

F. Comparison of Call Volume and Response Times Across Call Center Entities

OLO was able to compare call volume and average answer speed across all call center entities. Other data points, such as demographics and reason for calling were not available across all entities so they cannot be compared. However, these data points are presented in this chapter for each individual entity, when available.

[63] Effective Law Enforcement for All, Inc. October 2022. Review of the Montgomery County, MD Police Department.

Table 2 below compares data that was collected for 2024 across all call center entities interviewed for the report.

Table 2. Call Volume and Average Answer Speed Across Call Center Entities in 2024

Call Center Entity	Annual Volume (2024)	Average Answer Speed (2024)	Average Length of Call (2024)
988 (EveryMind)	39,242 Contacts* (15,397 Calls, 16,226 Texts, and 7,619 Chats)	13 seconds (for Call, Text, and Chat)	Calls – 14 minutes Text – 44 minutes Chat – 30 minutes
Montgomery County Crisis Hotline (EveryMind)	18,308 Contacts* (17,336 Calls and 972 Texts)	13 Seconds (Calls) (Texts not tracked)	13 minutes (Calls) (Texts not tracked)
The Crisis Center (DHHS)	41,610 Calls	NA	NA
911	848,289 (All calls) 15,040 Calls Related to Mental Health	10 seconds	2 minutes, 32 seconds
311	414,524 (All calls) 347 Calls Related to Mental Health	22 seconds	3 minutes, 52 seconds

*Denotes calls, texts, and chats received, not answered
Source: Various County Entities

The data shows for overall call volume, 911 has the most calls. However, approximately 2% of these calls are recorded as related to mental health. 911 also has the quickest average answer speed and shortest average call length.

For call center entities that only focus on mental health crises, the Crisis Center has the highest volume of calls with 41,610 calls. 988 has the next highest volume with 39,242 contacts which includes calls, texts, and chats. The County Crisis Hotline has the least amount of volume with 18,308 contacts which include phone and chat. 988 and the County Crisis Hotline have the same average answer speed, 13 seconds and similar average lengths of calls (13 and 14 minutes respectively). 988 text and chat take more than twice as long to resolve compared to calls, with the average text conversation lasting 44 minutes and the average chat conversation lasting 30 minutes.

The next table shows the average volume for County Mental Health Crisis Resources for 2021, which was collected for OLO Report 2021-4, *Public Safety Responses to Mental Health*

Situations and compares it to the average volume in 2024, calculated from data collected for this report.

Table 3. Comparison of Average Volume for County Mental Health Crisis Resources (2021 vs. 2024)

Resource	Average Volume (2021)	Average Volume (2024)
Montgomery County Crisis Center	104 calls per day	114 calls per day
MCOT	40 responses per month	165 responses per month*
Montgomery County Crisis Hotline (EveryMind)	44 calls and 9 texts per day	47 calls and 3 texts per day**
MC311	3 calls per day	Less than 1 call per day*** (347 calls per year)

*This average represents FY24, as data was not provided for CY24.
** This average represents the number of calls received, rather than answered.
***This average represents the number of calls coded as mental health related.
Source: Various County Agencies and OLO Report 2021-4

For all other entities besides MCOT, the average call volume did not change significantly when comparing 2021 to 2024 data. For MCOT, the average monthly response went up from 40 responses in 2021 to 165 responses per month in 2024, approximately a 313% increase.

Chapter 3. Mental Health Crisis Response Protocols

Call center entities in Montgomery County use response protocols to guide their actions when an individual reports a mental health crisis. State law also requires that every public safety answering point uses standards-based protocols to respond to callers.

This chapter examines the protocols used by the County's four main call center entities: 988, 911, the Crisis Center, and 311. Each section outlines the steps in the triage process and describes the possible outcomes based on the triage determination for a reported mental health crisis.

A. State Law Requirements

The Emergency Communications Center (ECC) is the Public Safety Answering Point (PSAP) for 911 calls in Montgomery County. Section § 1-304.1. of the Annotated Code of Maryland establishes that each PSAP should employ standards-based protocols for the processing of 911 requests for emergency assistance.

Standards-based protocols ensure consistent and reliable call processing and data handling. These protocols, developed by organizations including the National Emergency Number Association (NENA), Association of Public-Safety Communications Officials International (APCO), and the Federal Communications Commission (FCC), provide a framework for call handling procedures, data entry, and equipment standards.

As described in Chapter 2, in Montgomery County, 911 utilizes a protocol system developed by the International Academy of Emergency Dispatch. Although 988 and the Crisis Center are not considered PSAPs, they have also developed triage protocols tailored to their respective operational needs. In contrast, 311 relies on knowledge-based articles created by County agencies, which function as informal protocols. OLO notes that there is no shared triage protocol across all four call center entities.

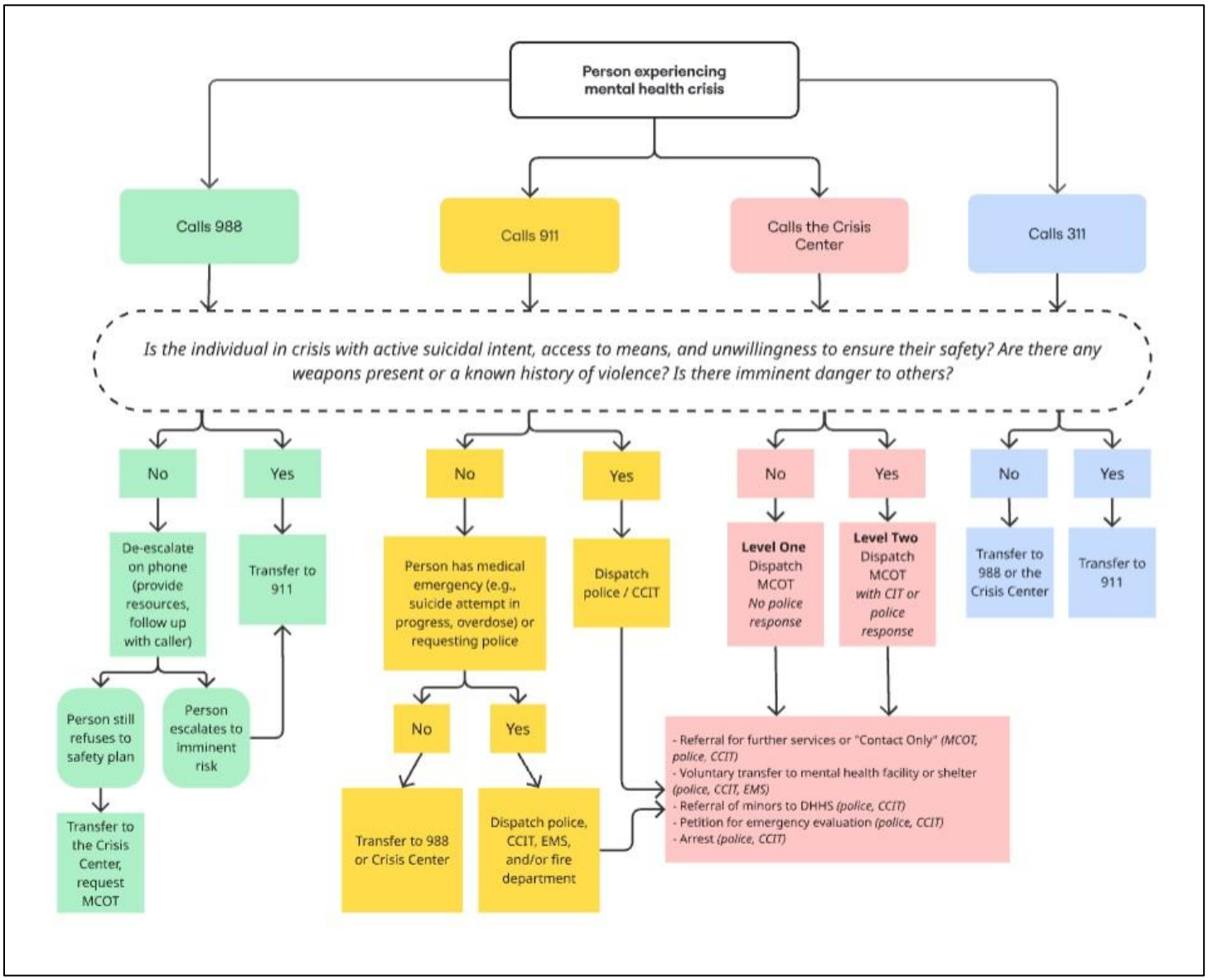
B. Call Center Entities and Triage Pathways for Mental Health Crisis Calls

Each call center entity has a distinct but coordinated approach to assessing risk, determining appropriate responses, and connecting individuals to support. Understanding how these systems interact, and the protocols each follows, provides insight into the County's overall strategy for responding to behavioral health emergencies with both care and public safety in mind.

Chart 15 illustrates the four call center entities a person may call when experiencing a mental health crisis. The Montgomery County Crisis Hotline and the non-emergency police number are

integrated into the triage pathways for 988 and 911, respectively. This section provides a detailed explanation of each step in the process. The information presented is based on interviews with representatives from the different call center entities and reviews of their triage protocols.

Chart 15. Crisis Response Flowchart for Call Center Entities in Montgomery County



Mental Health Crisis Calls Received by 988

Because 988 services are anonymous and confidential, except in cases of imminent risk or mandated reporting, the counselor's first task when answering a call is to assess the level of risk. They begin by determining whether the caller is experiencing suicidal thoughts and whether they have taken any steps to harm themselves. After this, the counselor evaluates the caller's intent and likelihood of acting on their thoughts by asking questions such as:

- Do you have a plan?
- Do you have a timeline?
- Do you have access to the means to carry it out?

Counselors also assess other potential risks and protective factors such as the caller's overall mental well-being, the strength of their family and social relationships, connections to their community, whether they are in a safe environment, and if there are others nearby who can offer support.

Although 988 counselors follow risk assessment protocols, they engage the caller in a conversational manner. Their goal is to build rapport and trust with the caller to obtain key pieces of information and assess the caller's needs and safety. A key focus throughout the call is to de-escalate the caller if they are experiencing heightened mental health symptoms.

As the conversation unfolds, the counselor determines whether an in-person response is necessary. If the person is determined to be at imminent risk, meaning they are in immediate danger of harming themselves or others, express active suicidal intent, have access to means, refuse to ensure their own safety, possess weapons, or have a known history of violence, the counselor will initiate a warm transfer to 911. During this process, the 988 counselor remains on the line to briefly relay relevant details to the 911 dispatcher before completing the transfer. Calls in which the caller refuses to engage in safety planning are generally transferred to the Crisis Center unless the imminent risk is escalated. In those situations, callers are generally transferred to 911.

In some cases, an individual may disclose signs of imminent risk and then abruptly end the call, chat, or text. When this occurs, the 988 team attempts to reestablish contact if the interaction was via phone or text. They also notify local law enforcement and share whatever limited information is available, in case police can locate the individual by pinging their phone number.

Because 988 counselors do not have a direct line to 911 or the Crisis Center, they must manually dial the number when initiating a transfer to either entity.

According to EveryMind, approximately 98% of interactions do not involve imminent risk. In these cases, resolving the call typically involves one or more of the following steps:

- **The counselor works collaboratively with the caller to create a personalized safety plan.** This plan may keep an individual safe until a scheduled appointment with a mental health provider is available or until a support person, such as a family member, returns.

- **The counselor determines whether the caller needs to be connected to additional services**, such as in-person counseling, assistance with basic needs, or other community resources. If so, the 988 counselors will warm-transfer the call to the Crisis Center along with the relevant details. The Crisis Center then decides whether to dispatch MCOT to assess the situation and provide appropriate support.

- **Scheduling a follow-up call with the caller.** 988 counselors offer follow-up calls to anyone who has expressed active suicidal thoughts within the past 24 hours or several days. These follow-ups are scheduled at a time chosen by the caller and serve to check in, offer continued support, and encourage follow-through on the steps discussed during the initial conversation.

OLO notes that the same process applies to callers that reach out via the Montgomery County Mental Health Crisis Hotline. However, the Hotline primarily handles lower-risk, supportive listening calls, and the nature of these calls tends to differ. Approximately 90% of calls to the Hotline are assessed as low or moderate risk.

Mental Health Crisis Calls Received by 911

When a call comes into 911, a PSECS (911 Emergency Communications Specialist) answers the call. The PSECS requests the caller's name, address and phone number, along with the nature of the incident as described by the caller. Using the initial information from the caller, the PSECS identifies whether the call is a behavioral health call and then begins using the emergency police and medical dispatch protocols. The protocol is read word for word, and the responses are recorded in the CAD system.

Depending upon the nature of the incident, mental health crisis calls can receive the following forms of dispatch or assistance:

- Police only response (MCPD);
- Medical only response (MCFRS);
- Police and medical response; or
- Referral for further services (the Crisis Center or 988).

All incoming calls on the non-emergency number are routed to the ECC and answered by the same PSECS who handle 911 calls. A mental health crisis call received on the non-emergency line is not transferred to 911, since both lines are staffed by the same personnel. The PSECs process and handle the call in the same manner as they would if it had come through the 911line.

Montgomery County Police Department (MCPD) Response

When police are dispatched to respond to a mental health situation, the nature of their response depends on several factors: whether the individual has been accused of a crime, the nature of any alleged offenses, or whether the individual has been deemed at imminent risk. ECC's definition of "imminent risk" aligns with that of 988, referring to situations where an individual is in immediate danger of harming themselves or others, has access to means, refuses to ensure their own safety, or possesses weapons. Police may also be dispatched if specifically requested by the caller. Police responses in these situations may include:[64]

- **"Contact only"**. Officers provide the individual and/or their family with information about community resources to meet the individual's behavioral health needs;

- **Referrals/voluntary transport to facilities**. Officers provide voluntary referrals and/or transportation to facilities such as shelters or the Crisis Center;

- **Referral of minors to DHHS**. Officers may refer minors who are first-time offenders and charged with a misdemeanor to the Juvenile Justice Services program within DHHS. This voluntary program serves as an alternative to formal involvement with the Maryland Department of Juvenile Services (DJS). Eligible youth referred to the program receive behavioral health assessments and drug screenings, followed by treatment recommendations based on their needs.

- **Petition for emergency evaluation**. Officers may determine an individual meets the criteria for a petition for emergency evaluation and may transport them to the nearest emergency department. Additionally, officers may be dispatched to serve petitions initiated by Crisis Center staff, healthcare professionals, or private individuals when Sheriff's deputies are unavailable.

- **Arrest.** If the alleged criminal offense is serious, or if the individual is accused of a minor criminal offense and the officer determines the individual is not mentally ill, the officer will process the individual into the criminal justice system.

[64] Carrizosa, Natalia. March 9, 2021. Public Safety Responses to Mental Health Situations. OLO Report 2021-04.

For complicated mental health situations, officers that respond may request assistance through the ECC, CCIT and/or MCOT. CCIT can also respond to mental health situations that occur while they are in the vicinity ("on-view" responses).

Montgomery County Fire Rescue Service (MCFRS) Response

When responding alongside police, MCFRS takes the lead if the situation appears to be primarily medical in nature. If the situation is potentially dangerous, the police take the lead and MCFRS stages away from the scene until the police advise that the scene is safe.

For patient encounters, MCFRS follows the Maryland Medical Protocols for Emergency Medical Services*****. According to the General Patient Care section, patient encounters include:

- Scene arrival and size-up
- Patient approach
- Initial assessment
- History and physical exam/assessment
- Treatment
- Communications
- Reassessment
- Disposition / Transfer of care[65]

Referral for Further Services

If the PSECS determines that the individual in crisis is not at imminent risk, is willing to speak with someone, or is actively seeking help for mental health concerns, they may refer the individual to either the Crisis Center or 988 for additional support. However, ECC has traditionally directed most mental health-related calls to the Crisis Center. While 988 is working with ECC to develop protocols and encourage the diversion of appropriate calls, 911 calls are not yet being redirected to 988.

When transferring to the Crisis Center, the PSECS initiates a warm handoff. This involves the PSECS staying on the line to briefly share relevant details with the Crisis Center before completing the transfer. Once the transfer is complete, ECC's involvement ends. The PSECS then creates a "file only" record in the system to document the call and how it was handled.

[65] Maryland Institute for Emergency Medical Services Systems, "The Maryland Medical Protocols for Emergency Medical Services", July 1, 2025.

ECC staff noted that ambiguity can arise when PSECS try to assess whether a physical response is needed, particularly in gray-area situations where suicidal thoughts are present, but no immediate threat or means are reported. In these cases, PSECS often default to dispatching the police as it provides reassurance that someone will respond in person. If a caller is referred to the Crisis Center and placed on hold for an extended period, and the call returns to the PSECS, they will typically dispatch the police as well.

Although ECC tries to provide their CSRs with as much training and tools as possible, their standing guidance is to dispatch the police when there is any doubt, as doing so guarantees that someone will physically respond and help.

Mental Health Crisis Calls Received by the Crisis Center

When a call comes in through the Crisis Center's main line (240-777-4000) requesting MCOT, the call-taker completes a referral form that includes questions to assess the situation such as:

- Are there weapons in the home?
- Is the person acting aggressively?
- Are they threatening themselves or others?
- Do they have a weapon in their hand?
- What is the composition of the household?
- Are there pets?
- Is there a history of mental health issues?
- Do they take medications?
- Have they ever taken medications?

The call-taker also checks the caller's electronic health records, if available, to better understand their history and recent events. This allows them to assess how the individual has responded to past referrals, diagnoses, or treatments.

Since their phone system doesn't automatically capture or save contact information, call-takers manually write down the caller's phone number and details during the conversation. This ensures they have a way to reconnect if the call is disconnected or if the caller chooses not to share additional identifying information.

Like 988, the call-taker works to determine if the caller is at imminent risk. Indicators of imminent risk are like those used by 988 and 911: the caller is in immediate danger of harming themselves or others, expresses active suicidal intent, has access to means, refuses to ensure their own safety, possesses weapons, or has a known history of violence. Based on this

information, the call-taker determines the appropriate response level, either dispatching MCOT without police involvement (Level One) or with police involvement (Level Two).[66]

Table 4 outlines the two priority levels, their associated risk indicators, and the appropriate response for each.

Table 4. Crisis Center Triage and Dispatch Protocol Response Levels for Behavioral Health Crisis

Response Level	Time	Risk Indicator	Response
Level One - *No police response*	Calls between 7am-11pm	MCOT will respond to calls that **do not** involve: • Weapons • Current violence • Threats of aggression • Recent history of violence (within last 12 months), • Evidence of active self-injury • Means of harm • Imminent danger to others	• MCOT calls dispatch with client name and address. • Information from the call is entered into the Computer-Aided Dispatch (CAD) system. ECC monitors and contacts MCOT every 20 minutes to ensure safety. • MCOT ensures the 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 assessment concludes, team contacts dispatch to remove the CAD. • If team writes an Emergency Evaluation Petition (EEP), team contacts dispatch for police to transport client to emergency department.
Level Two – *Police response*	Optional for calls between 7am-11pm Mandatory between 11pm-7am	MCOT and police will respond to calls that **involve**: • Weapons • Current violence • Threats of aggression • Recent history of violence (within the last 12 months), • Evidence of active self-injury • Means of harm • Imminent danger to others	• MCOT arrives on scene and calls ECC dispatch non-emergency number to request police support. • Team ensures Crisis Center Ops Room is aware of their location. • MCOT assesses client; if an EEP is written, police transport client to nearest emergency room. • MCOT notifies Ops Room when they leave and either takes the address for next call or notes if they are returning to the office.

[66] See the Crisis Center's Triage Dispatch Protocol of Behavioral Health Crisis, appendix A.

Level One Responses

The Crisis Center will dispatch MCOT without police presence for calls that do not pose an imminent threat—that is, when there are no weapons involved, no current violence or threats of aggression, no recent history of violence (within the past 12 months), and no evidence of active self-injury, access to means of harm, or imminent danger to others. From 7 a.m. to 11 p.m. MCOT has the option to bring police along. However, from 11 p.m. to 7 a.m., police are required to accompany them on mobile calls.[67] Nighttime conditions—reduced visibility and fewer people around—present additional risks, so police presence during these hours helps ensure everyone's safety.

Level Two responses

The Crisis Center will dispatch MCOT to mental health incidents where there are some concerns such as reports suggesting possible weapons or other immediate risks, though details remain unclear. Upon arriving at the scene, MCOT will evaluate the situation and contact ECC's non-emergency line to request police support if needed. However, if the presence of a weapon or threat is certain, the Crisis Center will route the call directly to 911 for immediate police dispatch and offer MCOT's assistance.

As with Level One responses, MCOT has the option to request police accompaniment for calls received between 7 a.m. and 11 p.m. However, for calls that come in between 11 p.m. and 7 a.m., police presence is required.

Referral for Further Services

The Crisis Center focuses on crisis assessments and referrals when necessary but does not provide phone counseling services If a caller's primary request is for a supportive/active listening line, the caller will be referred to 988.

The Crisis Center also connects callers with community resources and conducts routine follow-ups for individuals seen by MCOT, as this is built into their process. However, follow-ups for walk-in clients are not considered routine. They are handled on a case-by-case basis, depending on the individual's needs. In some situations, a therapist may follow up for clinical reasons. For example, if the person is waiting for an appointment or if the therapist wants to ensure a smooth transition of care, a follow-up will be conducted. In other cases, follow-up may not be necessary.

[67] This is due to a union agreement for County employees.

Mental Health Crisis Calls Received by 311

When a call comes into 311, part of their initial greeting message instructs the caller to hang up and dial 911 if the situation is an emergency. This is followed by several prompts. If the caller chooses to speak with a CSR, the call is routed to the next available CSR, who will determine the nature of the inquiry based on the conversation.

If the caller expresses concerns related to mental health, the CSR uses information from the conversation to search the system for relevant keywords and locate the appropriate KBA. Once the CSR finds the relevant KBA, they verify the topic and follow the associated instructions. For example, if a caller mentions the word "suicide" during the call, the CSR immediately searches for the appropriate KBA using this word. In this case, the KBA states:

"If threats of suicide with means (immediate access to carry out the act, for example, a plan in place, caller has a gun, knife, pills/medications, etc.) in progress, transfer to 911. For thoughts of suicide and no means to carry out, transfer to 988."

In this scenario, the KBA directs the CSR to determine, based on the information provided by the caller, whether the situation involves a "threat of suicide with means" or "thoughts of suicide without means." If it is a threat of suicide with means, the KBA instructs the CSR to perform a warm transfer to 911. Conversely, if the situation involves thoughts of suicide without means, the CSR is directed to warm transfer the call to 988.

For a warm transfer, CSRs are instructed to stay on the line, identify themselves, and inform the receiving party they are transferring a caller. They provide the caller's name, phone number, location (if known), and any other relevant details. CSRs are instructed to warm transfer the call even if the caller refuses to provide this information.

When transferring to 988, CSRs use their 1-800 number, as they do not have a direct line to 988. However, they do have a direct line for transferring calls to 911.

There are several KBAs within the Siebel system that can be used during a mental health crisis. OLO compiled a list of the most common KBAs related to mental health crises. Table 5 summarizes these KBAs, including their descriptions and specific instructions for CSRs on how to handle these calls:

Table 5. Siebel Knowledge Based Articles Related to Mental Health Crisis

Topic	KBA Description:	CSR Instructions:
988 Lifeline	• Mental health support, from supportive listening to crisis intervention. This includes suicidal thoughts, anxiety, depression, substance use, or psychosis.	1. Direct caller to dial 988, text or chat. 2. Caller can also be warm transferred to 988. 3. Provide the Crisis Center number as an additional resource.
Montgomery County Crisis Center	• Mental health support when someone is a danger to themselves or others, needs urgent assistance, or if there are concerns involving students, children, or workplace mental health.	1. Warm transfer the call to the Crisis Center. 2. If the Crisis Center line is unavailable, warm transfer to 988. 3. For medical emergencies, warm transfer to 911. 4. Provide additional resources if needed.
Suicide	• Threats of suicide with means (e.g., the caller has immediate access to a method, such as a plan, gun, knife, or medications). • Callers experiencing suicidal thoughts but with no means to act on them.	1. For threats of suicide with means, warm transfer call to 911. 2. For suicidal thoughts but no means, warm transfer call to 988.
Mobile Crisis Team Requests	• Crisis evaluations, hospital assessments facilitation, stabilization and recommendation of appropriate treatment and resources.	1. Warm transfer the call to the Crisis Center.
Mental Health Crisis	• Non-emergency referrals or requests for mental health or substance use treatment for adults or minors (up to age 17).	1. If request is for an adult, refer to Adult Behavioral Health Services. 2. If request is for a minor child in need of substance abuse services, refer to Child and Adolescent Assessment Services.
Anxiety, Depression, Panic	• Mental health support, from supportive listening to crisis intervention. This includes suicidal thoughts, anxiety, depression, substance use, or psychosis.	1. Direct caller to dial 988, text or chat. 2. Caller can also be warm transferred to 988. 3. Provide the Crisis Center number as an additional resource.
Drug Overdose	• Ingest of toxic substance.	1. Warm transfer call to 911.
Drug Addiction	• Non-emergency referrals or requests for mental health or substance use treatment for adults or minors (up to age 17).	1. If request is for an adult, refer to Adult Behavioral Health Services. 2. Caller may also be referred to Harm Reduction Services or the Methadone clinic. 3. If request is for a minor child in need of substance abuse services, refer to Child and Adolescent Assessment Services.

Mental Health Crisis Texts and Chats

Three of Montgomery County's call center entities (311, 911, and 988) offer either text or chat capabilities in addition to standard voice call services.

911 provides texting as an alternative to voice calls. When someone sends a text to 911, the first response typically asks whether the individual can make a voice call. If they can, they are encouraged to do so, as voice calls are generally faster and more effective for emergency response. However, in situations where texting is safer, or more comfortable (such as domestic violence scenarios) operators will continue to communicate via text.

All 911 PSECS are trained to handle both calls and texts; however, they can only engage with one mode at a time. This ensures that full attention is given to each interaction, especially since emergencies can escalate quickly.

311 offers chat functionality through its AI-powered virtual assistant, Monty. Monty is guided by the existing KBAs, which are regularly updated to ensure the information it provides is accurate and current. If a mental health-related query comes through the chat, Monty retrieves relevant content from the appropriate KBA. To maintain the quality of information, 311 collaborates with external partners to update KBAs with any new or relevant data.

988 supports both text and chat options, allowing users to engage in the way that feels most comfortable to them. While the core protocol remains the same across all platforms, the flow of text and chat conversations tends to differ. Text and chat interactions are typically longer than voice calls due to natural delays in typing and response. For context, a typical voice call lasts around 14 minutes, while text or chat sessions may average 30 - 44 minutes.

Most 988 counselors are cross trained to handle phone, chat, and text conversations. However, they can only engage in one conversation at a time, due to the potential for a low-risk exchange to escalate rapidly. For instance, a counselor may be finishing a chat session before making themselves available for a new one, but they cannot take a call while actively engaged in a chat or text.

988's protocol also includes follow-up messaging. If a texter becomes inactive, the counselor sends an initial idle prompt five minutes after the texter's last message, informing them that the session will be ended if there is no response within the next five minutes. If there is still no response within those five minutes, the session is closed.

Chapter 4. Best Practices from Model and Neighboring Jurisdictions

OLO spoke with five outside jurisdictions that have been identified by literature from academic journals and SAMHSA as modeling best practices in mental health crisis response. Their responses along with literature highlighting their crisis response model(s) are summarized below.

All jurisdictions OLO spoke to highlight the importance of collaboration and shared formal protocols between different call center entities. Examples OLO heard were:

- Almost all jurisdictions highlighted the importance of interoperability between their 911 call centers and mental health crisis call centers, meaning there is a direct line for transfer and shared formal protocols between the call centers. Almost all jurisdictions we spoke to have a direct transfer line between 911 and their local crisis hotlines, which has facilitated deeper collaboration between the entities;
- Deep collaboration with non-profits and healthcare centers in the jurisdiction so that callers can enter in a continuum of care and not fall through the cracks. It is important for everyone involved in crisis response – crisis hotline call-takers, first responders, and MCTs, to know what resources there are in the County and to have a relationship with staff, so individuals experiencing a mental health crisis can get the care they need quickly;
- Internal education about how each call center functions and internal meetings with call center employees to build trust and confidence when a caller should be transferred to another entity, such as from 911 to 988. Jurisdictions reported that once they established better relationships between the call center entities, 911 operators were much more likely to transfer calls related to mental health to a local crisis hotline; and
- Having mental health call-takers and/or a licensed mental health professional working physically in the same building as 911 -facilitates deeper communication and makes it easier for transferring callers. Having dedicated mental health workers in the same building also provides them with access to CAD, where they can see what calls are coming through and can identify calls where they have the expertise to respond.

A. Fairfax County, Virginia

Population	Type of Model	Model Established
1,160,925	Formal Coordination between 911 and 988	2023

Since 2023, Fairfax County's 911 and 988 call centers work closely together and have formal agreements with each other to respond to mental health crises. As there is no 311 in Fairfax County, many non-emergency calls come into their 911 call center. To best serve those having a mental health crisis where the caller does not need police intervention, protocols were put in place to transfer callers to 988. Before 911 completes the transfer, they conduct a risk assessment of the caller to determine if there is "imminent risk", meaning does the individual have the means and/or will to hurt themselves or others around them. The information in this case study comes from a direct interview OLO conducted with Fairfax County staff and a report from the RAND corporation published in 2024.[68]

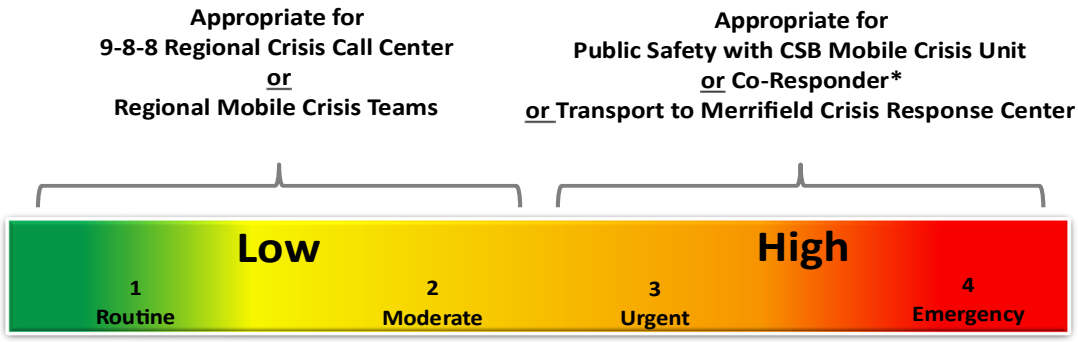
How is a mental health crisis identified? According to staff, a key component of Fairfax's model is the use of a common language shared among 911 and 988 personnel, including first responders such as police, emergency services personnel, and call-takers. This common language is the triage framework, which was established by the Marcus Alert legislation passed by Virginia's state senate.[69] Fairfax County is an early implementer of the system as the legislation requires all jurisdictions in the state to be compliant by 2028.[70]

[68] Brooks Holliday, Stephanie, et al. March 20, 2024. The Road to 988/911 Interoperability: Three Case Studies on Call Transfer, Colocation, and Community Response. RAND Corporation.
[69] Virginia Department of Behavioral Health and Developmental Services (DBHDS). The Marcus-David Peters Act.
[70] ibid.

Marcus Alert

The Marcus Alert is named after Marcus-David Peters, a young Black biology teacher who was killed by Richmond police in 2018 during a mental health crisis. Marcus Alert enhances services for people experiencing a crisis related to behavioral health, which includes mental health, substance use, or developmental disabilities through coordination between 911 and regional crisis call centers. For example, mental health crisis calls where the individual is not at imminent risk will likely be diverted to 988 or another crisis call center and will not get a law enforcement response, unless the situation escalates (I.E., self-harm, weapon present and accessible). The goal of the Marcus Alert system is to provide a behavioral health response to behavioral health emergencies.

Within this framework, there are four levels which correspond to the severity of a situation. The following graphic and table visualize and explain the criteria for each level.



*Co-Responder Team is **only** available within the Fairfax County Police Department jurisdictional boundaries.

LOW	HIGH	HIGH
Level 1 (Routine) to Level 2 (Moderate)	Level 3 (Urgent)	Level 4 (Emergency)
• Difficulty or inability to cope • Suicidal thought with no plan or direct access to means (includes desires to harm oneself or not be alive with no plan or means or opportunity to carry out) • An altered mental state with no safety or medical concerns, and not currently under the influence of substances • Minor self-injurious behavioral that does not need medical attention • A caregiver requesting assistance due to current non-violent behaviors • A known individual with non-violent mental health history • A willingness and ability by the individual to participate in their own care or safety	• Active aggression • Active psychosis (may include significant delusions and/or hallucinations, disorganized thinking and speech, disconnection from reality) • Homicidal thoughts with no active behaviors or intent • Active self-injurious behavior with medical risk • Suicidal thoughts with plan & access to lethal means	• Immediate threat to life • Active suicide attempt or overdose • Active assault on others with ability to harm • Weapon present and accessible

Source: Fairfax County Presentation shared by staff

Staff are trained in this framework and are able to quickly determine if a scenario falls in the routine, moderate, urgent, or emergency category and can quickly communicate to first responders and other call-takers.[71] Due to this system, staff report that during heavy request volumes, it has helped with creating some efficiency in the system, as calls deemed a Level 1 or 2 now can be diverted to 988 or another crisis hotline, rather than dispatching police or emergency medical services.

During the interview with OLO, staff shared that everyone involved in emergency response can quickly set the scene of a call by referring to it as a Level 1, 2, 3, or 4. This communicates a lot of the context of the call in a concise manner and helps responders know if they are needed at the scene.[72] Generally, Level 1 and 2 are appropriate for 988 or the Fairfax-Falls Church Community Services Board mobile crisis unit[73] to respond to and Level 3 and 4 are appropriate for law

[71] Interview with Fairfax County.
[72] Interview with Fairfax County
[73] The mobile crisis unit is a program through the Fairfax-Falls Church Community Services Board and provides on-scene evaluation, treatment, and crisis intervention in the County. They specialize in mental health emergencies and work closely with the police and fire and rescue department to arrange responses.

enforcement response, the mobile crisis unit, or a co-responder unit[74] with both law enforcement and a clinician in the same car.

Further, there is a large focus on determining imminent risk – meaning if an individual presents an immediate risk to themselves or others. As shown in the previous table describing the framework, imminent risk is defined by the Marcus Alert as Level 3 and 4 and includes scenarios such as active aggression or psychosis, suicidal thoughts with a plan and access to lethal means, active assault, or weapon present and accessible. Scenarios deemed to be at imminent risk generally require law enforcement to be present, although MCTs (non-law enforcement) can co-respond with law enforcement to help de-escalate an individual in a crisis.

Coordination of System

Staff interviewed by Fairfax County cited the following as key to the success of their coordination and cooperation between 988 and 911:

- The passing of the Marcus Alert system in Virginia, which created a common framework for Fairfax County employees involved in mental health crisis support and emergency responses to use.
- Biweekly stakeholder meetings that included 988 and 911 staff, along with other entities in mental health services and emergency services, which established a level of trust and coordination between everyone involved in mental health crisis responses. The meetings also worked to establish a common definition of imminent risk across all entities.
- Fairfax focused on creating a culture shift at both the response and community level. As Fairfax does not have 311 or 211, residents were used to calling 911 for everything. Concerted efforts to increase residents' awareness of 988 and its purpose were conducted.
- In the paperwork for emergency responders, there is a section that denotes if the situation was related to a mental health crisis or other behavioral health issue. This helps ensure data collection for behavioral health crises so patterns can be studied.

[74] Co-responder team is only available within the Fairfax County Police Department's jurisdictional boundaries.

Prior to the implementation of the Marcus Alert system in Fairfax, there were many meetings between 988 and 911 staff, including police and other emergency responders, to develop a system that works for everyone. Some concerns raised at these meetings, which were talked through to find solutions include:

- **What if 911 transfers an individual to 988 and then the situation becomes dangerous (I.e., requires police intervention)?** – 911 has a direct line to 988 and with a press of a button, they can transfer a caller to 988 and conduct a warm handoff to set expectations on both sides for the call. 911 will also share basic information with 988 before hanging up and 988 has a direct line back to 911. This helped ease concerns 911 staff had about what would happen if a call escalated after being transferred to 988.
- **911 call-takers only know what is heard on the phone and cannot rule out anything and are conditioned to send police and fire for almost all scenarios to ensure safety.** – Talks between 911 and 988 helped to build trust in 988's ability to resolve most mental health crises over the phone. Further, there were frequent callers into 911 who just wanted to speak to someone, which turned out to be a good fit for 988. This helped 911 call-takers to reduce call volume loads and be ready for emergencies. Further, stakeholder meetings, which included 911 and 988 staff, helped establish a common definition for imminent risk, which helped build confidence in transferring calls.

Training

911 call-takers undergo a training process that meets industry standards and the Virginia Department of Criminal Justice Services that includes a ten week training course and twelve weeks of on the job training. However, there is only one day of training related to callers with suicidality in the ten week training course.

988 staff receive six weeks of training, followed by on-the-job training, which is approved by Vibrant. Staff note they look for staff who are competent in dealing with mental health crises and that those with personal experience can sometimes be more effective than someone with an educational background related to mental health.

When the Marcus Alert process started in Fairfax County, both 988 and 911 call-takers received training on the transfer process from 911 to 988 and vice versa as well as when a transfer is appropriate. 911 call-takers also received training on 988 to better understand what they do. There was also cross-training between law enforcement, the MCT, and co-responder teams whom the 911 and 988 call-takers interact with and are part of the continuum of care of mental health services in Fairfax County.

Other Unique Features

The planning process for the implementation of the Marcus Alert System was led by the Fairfax-Falls Church Community Services Board (CSB), which is the behavioral health authority for the region and the administrator for Fairfax's 988 line. One of the key facilitators did not come from a public safety nor a clinical background, so they serviced as an "honest broker" when difficult discussions such as logistical, cultural and philosophical differences arose. For example, the RAND report cited staff across law enforcement, crisis services, and behavioral health services, had varying levels of risk tolerance when it came to a caller exhibiting signs of a mental health crisis. Creating a definition for imminent risk with specific scenarios collaboratively in these meetings was key to establishing strong collaboration between all entities involved.

B. Albuquerque, New Mexico

Population	Type of Model(s)	Model Established
560,274	Crisis Intervention Team, Co-responder model, Informal coordination with community mental health service providers	1997 (Crisis Intervention Team established)

The Albuquerque Police Department (APD) has a division dedicated to mental health crisis interventions, called the Crisis Intervention Division. Within this division, there are three branches:

- **Follow up Detectives –** This unit is responsible for conducting follow-up visits with individuals affected by and/or who are experiencing behavioral health crises. They focus on connecting individuals with community resources and reducing their interactions with emergency services, both law enforcement and medical.
- **Crisis Intervention Unit Coordinators –** This unit includes supervising staff who are stationed at the Emergency Communications Center (ECC) and reviews calls and makes decisions on what team to send – non-law enforcement, co-responder, or the crisis intervention team which is only law enforcement.
- **Mobile Crisis Team –** This is a co-response team which consists of an officer and an independently licensed clinician from a partner agency, named Albuquerque Community Safety Department (ACS). Generally, they are dispatched when an individual is both exhibiting signs of a mental health crisis and violent behavior. This includes suicide threats with access to means, individuals armed with a weapon threating others,

suicide attempts in high-risk situations (such as jumping from a building), or individuals making "bizarre and threatening statements".

In addition, there is a psychiatrist who is a full time employee of APD. Their duties include assisting with training in the CIT program, providing clinical guidance, consulting on cases, and conducting home visits with detectives and clinicians. They also partner with community stakeholders and conduct outreach to educate community members and partners about the program.

The information in this case study comes from an interview with OLO and Albuquerque Crisis Intervention Team staff, websites for the Crisis Intervention Branch and Albuquerque Community Safety, and some peer-reviewed studies that featured the Albuquerque model.[75] The case study differs from the others in which it focuses more on in-person crisis response rather than call-center entities, however it does describe coordination between the systems.

How is a mental health crisis identified? 911 call-takers use a call matrix to determine the type of emergency. It includes guidance on how to classify a call as a mental health crisis. For example, if the caller discloses they are having suicidal thoughts or another type of mental health crisis, such as a panic attack, the call is flagged immediately. Call-takers also have guidelines for questions that can identify if the situation is related to mental health. Flagged calls related to a behavioral health crisis, including substance use disorders that do not pose a threat to the caller or others, are routed to ACS for response. However, if the individual is armed and poses a threat to themselves or others, it's routed to the police.

Albuquerque's 311 call-takers have a similar matrix, however they typically forward mental health calls to ACS unless there is a threat of violence in which case they forward to 911.

Coordination of System

New Mexico differs from other states in which it does not have a government or country-run mental health program. Instead, mental health treatment is provided by independent organizations. When someone calls in to either a non-emergency number (their 311) or 911 and exhibiting signs of a behavioral health crisis, the city provides one of two responses:

[75] Rosenbaum, Nils, et al. June 1, 2017. Collaboration to Reduce Tragedy and Improve Outcomes: Law Enforcement, Psychiatry, and People Living With Mental Illness. The American Journal of Psychiatry; City of Albuquerque. Crisis Intervention; Albuquerque Police Department. September 12, 2014. Crisis Intervention Division, Related SOP(s) Form(s), Other Resource(s), and Rescinded Special Order(s).

- The call is forwarded to the Albuquerque Community Safety Department which is a non-law enforcement team who acts independently of APD and staffed by non-licensed caseworkers but provides social work-related services; or
- Either a Mobile Crisis Team is dispatched, which consists of a uniformed officer in a marked vehicle with a licensed clinician or a Crisis Intervention Team is dispatched, which is usually two law enforcement officers.

Additionally, a sergeant within the Crisis Intervention Division also goes through referrals received by CIT via "non-first level emergency calls" related to mental health (about 400 to 500 a month) and disseminates them to community partners. These community partners help individuals receive the care and services needed.

There are no formal agreements between ACS and APD, although they do collaborate informally. Staff note the relationship between the organizations increased when APD brought in a full-time psychiatrist. The psychiatrist helped bridge the gap between the organizations, whereas before ACS was cautious about collaborating and sharing information with APD.

Further, there is no direct line between 988 and 911. A call-taker from either side must call directly and stay on the line with the individual until the call is answered. This presents a challenge as it increases the time call-takers for both 988 and 911 are placed on hold with the caller during a warm transfer.

Training and Staffing

Every Albuquerque officer is required to undergo CIT training and uniformed officers have an additional enhanced CIT program they must go through. The additional CIT training is a 40-hour class in the academy and there is an 80-hour course where different crisis scenarios are covered. The enhanced CIT program is an additional eight hours of training and focuses on barricaded individuals, engagement, disengagement, and non-engagement.

911 call-takers are required to take 20 hours of mental health first aid training, which includes scenarios based on actual calls that were recorded for training purposes.

APD staff shared with OLO some staffing data which include:

- There are four fully equipped Mobile Crisis Teams. APD notes that maintaining full staffing has been a long-standing challenge on both clinician and officer departments;
- Out of 885 sworn APD officers, 200+ Uniformed Officers[76] are fully certified Crisis Intervention Team (CIT) officers.[77]

[76] Interview with APD
[77] Albuquerque News. May 1, 2024. Albuquerque Police Department seeing increase in recruits.

Other Unique Features

One feature unique to APD is that their full time psychiatrist, in collaboration with the city government, conducts a comprehensive data analysis each year that reviews CAD systems, police reports, and other behavioral health indicators over time.

The data helps APD identify:

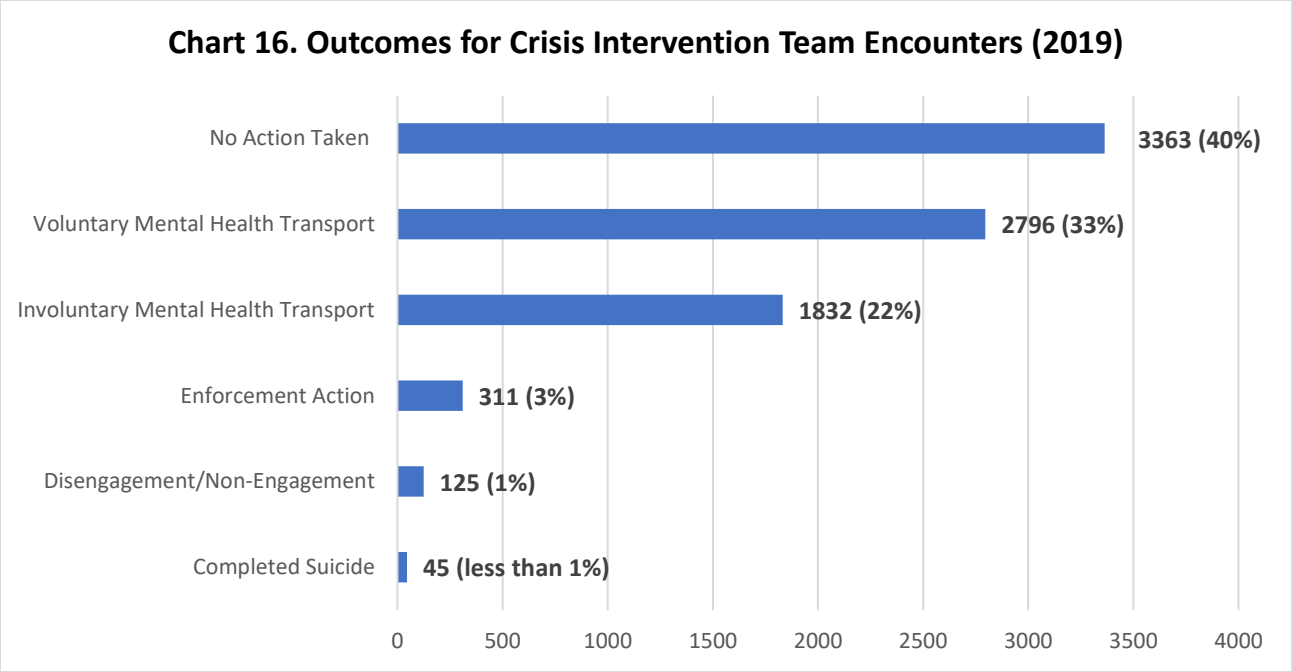
- Time periods when there are high volume requests related to behavioral health; and
- How that matches when officers with the highest amount of CIT training are on call.

APD staff also noted having a clinician present as part of the team is beneficial for many reasons:

- Community partners that provide mental health services are more willing to speak and work with APD;
- When officers transport an individual experiencing a crisis to the hospital, the clinician can communicate directly with doctors and nurses and provide a clinical context on that person; and
- Clinicians can complete Certificates of Evaluation[78] for individuals upon hospital admission, to inform treatment decisions and connect individuals with ongoing support and resources after they are discharged.

Finally, staff note the lack of government-run mental health programs make it difficult for non-governmental organizations to provide mental health services for individuals. Only non-profits offer mental health services, however, due to funding issues, many programs do not last long, and it can be difficult to find services. To help address this issue, a Mental Health Response Advisory Committee was formed and includes community members, local providers of mental health services, law enforcement, and other organizations. The committee provides input on policies and training for ACS and APD staff and each year, they update a resource card which has information on mental health services. These cards are given to officers, who can distribute them to the community. APD staff note they rely heavily on ACS to connect individuals to resources and facilitate virtual intakes for mental health services.

[78] A Certificate of Evaluation is issued when an individual is not safe to remain in the community and needs to be admitted to the hospital to be evaluated. The hospital generally develops a medication management plan or helps stabilize individuals, depending on their needs.



Source: Albuquerque Police Department

The chart shows most outcomes for CIT encounters have no action taken (40%) with the second most common outcome being voluntary mental health transport (33%). For enforcement action, which made up 3% of all encounters, the following actions were recorded:

- **Arrest** – 217 (70%)
- **Summons** – 65 (21%)
- **Verbal Warning** – 23 (7%)
- **Citation** – 6 (2%)

C. Travis County (Austin), Texas

Population	Type of Model(s)	Model Established
1,334,961	Formal Collaboration between 911 and 988, 911 Integration Team	2019

Integral Care, a nonprofit organization in Travis County, Texas, supervises both a 24/7 local helpline and regional 988 call center. Their call-takers are dually trained to answer calls from both numbers, like EveryMind in Montgomery County. Integral Care covers over seventy counties in Texas, including Travis County. There is a backup center located within Texas that can take 988 calls in times of high volume.

Integral Care formally collaborates with 911 through their "911 integration staff." Integration staff work physically inside the 911 call center and their goal is to intervene earlier in the crisis system to prevent police responses when possible. Staff describe the integration team as a safety net for the 911 call center as they can intervene "higher up stream" than 988 and determine whether the caller is better supported over the phone or if a MCT is needed.

How is a mental health crisis identified? Travis County's 911 call center answers every call with "Do you need police, fire, EMS, or mental health?" If the caller requests police or mental health services, the call-taker will ask a few screening questions to assess whether there is imminent risk for the person or community. If there is no immediate danger, the call is transferred to a crisis clinician, who is part of the 911 integration staff.

Compared to 911 operators, the 911 integration staff are better suited to determine what response is necessary for an individual caller. Responses include support over the phone, connecting to resources, and dispatching MCTs.

Coordination of System

The 911 integration team works physically inside the 911 operation center to promote collaboration and is staffed 24/7. Staff note 911 operators can walk over to the integration team staff and consult with them and vice versa. Generally, crisis clinicians in the 911 integration team take calls in two ways: (1) a live transfer where a call is directly handed off to a clinician; or (2) the caller is informed of the transfer, or the call is placed in the queue and answered when a clinician is available.

Crisis clinicians also have access to the CAD system, which allows them to check on welfare calls assigned to the police and review if there is a mental health component to the call. If the call meets criteria, they can reach out to the individual directly and if they make contact, they can then assess whether it is more appropriate to provide support over the phone or dispatch a mobile team.

There are two mobile teams – the Mobile Crisis Outreach Team (MCOT) and the Expanded Mobile Crisis Outreach Team (EMCOT). MCOT was established in 2006 and provides face-to-face clinical assessments for individuals who need more support after calling the 24/7 helpline. EMCOT was established in 2013 and is a co-responder model that dispatches with first responders and provides specialized support during mental crises. They can be dispatched in two ways: when first responders identify a mental health crisis that does not include a medical emergency or public safety threat; or the 911 integration staff dispatch directly before first responders arrive on the scene. In the latter case, the goal is to relieve public responders within 10-15 minutes and clinicians remain on-site for as long as it takes to provide care to the individual.

Additionally, when clinicians determine a need for an in-person response from the MCT, they assess the appropriate level of urgency. Responses can be classified as routine (within 24 hours), urgent (within eight hours), or immediate (within an hour). This decision is based on factors such as risk level and the individual's ability to follow a safety plan. Once determined, the clinician informs the caller of the estimated response time.

Training and Staffing

Both the local 24/7 helpline and 988 are administered by Integral. Integral operators are trained through Vibrant, which is used by many 988 centers. Their operators are accredited by the American Association of Suicidology (AAS). The training generally lasts about eight to ten weeks – starting with online training modules that include recorded and live calls that trainees listen in on and ending with the "practicum" stage where they take live calls with a supervisor available for support.

911 call center clinicians do not have any accreditation, but they use evidence-based training such as the Columbia Suicide Severity Index and Barbara Stanley's Safety Planning. Their training lasts about two to three months which includes front-end training, observation, shadowing other clinicians, and listening in on calls. They also receive CAD training which teaches them how to use the system and what information can or cannot be shared due to privacy regulations.

Currently, there are 19 full-time employees for the integration team. Staff note they recently added five more positions, one of which is a new supervisor position whose main responsibility is reviewing CAD data for calls that are suitable for the team to take.

Other Unique Features

Staff described the queue processes for 988, the local mental health crisis hotline and the 911 integration staff located in the 911 call center:

- 988 calls can only remain in the queue for sixty seconds. If the call is not answered within that time, it moves to the backup queue and one of the backup centers located in Texas will pick up the call.
- The local mental health crisis hotline remains in a queue until a staff member becomes available. They are answered in the order they arrive and are not prioritized based on urgency of the situation.
- 911 calls are not answered initially by integration staff and transferred by 911 operators. The time it takes to pick up depends on the volume of calls. Integration staff provide support and conduct screenings. The average length of a call is 10 to 11

minutes. Staff note that frequent callers may receive shorter, more focused conversations in times of heavy request volumes.

D. Anne Arundel County, Maryland

Population	Type of Model	Model Established
594,582	**No Wrong Door/ Person – Centered Care**	**2015**

Anne Arundel County's mental health services model focuses on a "no wrong door" model. This means that no matter the point of entry into the system, whether it's calling 911, the county's warmline, or going in person to an emergency room or county-run crises services, the individual seeking help will not be turned away. However, they may be connected to more appropriate services in the county's continuum of care, based on what they need. The county's warmline is part of this system, operates 24/7, 365 days a year, and answers calls for mental health issues and provides resources for individuals who need food, housing, or health care services. Staff note the warmline "needs to know a little about a lot of things" to be able to connect residents to the resources they need.

How is a mental health crisis identified? To assess imminent risk, warmline operators conduct a "lethality assessment" over the phone using the Columbia Suicide Risk Scale. Some questions they ask callers include:

- Are you at risk of suicide?
- Do you wish you could go to sleep and not wake up?
- In the past month, have you had a plan to kill yourself?
- Have you taken steps to attempt suicide?

The warmline does not offer 24/7 text support, but they do have a mobile phone where family members can send copies of chat conversations to assist with emergency response. This phone is only monitored periodically.

Further the warmline classifies calls as either hot or warm:

- Hot calls are categorized as those involving suicidal ideation and intent, risk of violence, or other mental health crises such as psychosis; and
- Warms calls include crises, such as food insecurity, housing instability, and other situations that are crises where the individual is not at imminent risk of harm to themselves or others.

Coordination of System

Many crisis services are housed within the same building which includes the warmline, Crisis Intervention Team officers, mobile crisis team, and walk-in crises services. About 3 to 4 Anne Arundel CIT police officers are physically working at any given time in the building where the warmline operators are.

There are two main points of coordination between officers and the warmline and 911 and the warmline:

- Warmline operators are in constant communication with CIT officers co-located in the building. Through the officers, they have access to CAD. They are also able to directly dispatch officers if available.
- 911 can transfer directly into the warmline. Staff gave the example that individuals who call 911 and just want to chat, need medication, or exhibiting signs of a mental health crisis without a serious threat of violence, they will transfer to the warmline. Warmline staff can transfer back however if they need law enforcement aid, they will locate an officer in the building.

Further, warmline staff prioritize calls from county entities for dispatching MCTs in the following way:

- **Priority 1:** Police Radio Calls
- **Priority 2:** Hospitals and County agencies
- **Priority 3:** Individual from community requesting intervention/crisis services

Their team assesses needs and provides appropriate referrals. If someone requires services outside their home or is experiencing homelessness, the MCT – which is made up of two clinicians - is typically dispatched to assess the individual and connect them with support services. However, the MCT possesses a police radio which serves two purposes: (1) ability to call for law enforcement; or (2) pick up police calls where they may be of service.

Warmline and other county crises agencies collaborate with two county programs that accept referrals. Additionally, they have memorandums of agreement with various providers, allowing them to secure appointments within 24, 48, or 72 hours, depending on availability. There are two crisis beds available throughout the county.

Further, there is consistent collaboration and communication with medical providers. Every Thursday, county staff meet with representatives from two hospitals and an urgent care provider to discuss trends in the emergency room (ER), assess how county services are working, and address any challenges that arise. Once a month, staff also meet with hospital security

officers to discuss safety risks related to bringing people into the hospital and discuss other ways to deepen their working relationships.

Between all the entities involved in county crises services, there are regular meetings to review data to see where there is friction and/or overload in the system and how to rectify that. Staff note the warmline has been around since 1999 but was not embedded in the continuum of care until about 10 years ago.

Staff note that they do not have a regional call center for 988 located in the county, therefore they do not promote 988. They feel in-county services are better at matching individuals with the resources they need. 988 will transfer calls to the warmline if they identify an individual is located in Anne Arundel and may need specialized services.

Training

Warmline operators are ASIST (Applied Suicide Intervention Skills Training) certified. Everyone in crisis services, which warmline operators are part of, also undergo Critical Incident Stress Management (CISM) training at some point.

Further, each department involved in the no-wrong door approach has its own dedicated training sessions, which include call monitoring and hands-on learning. During training, new staff members observe and listen to calls, which follows a structured training progression. They are only cleared to answer calls independently once they have completed the required training.

Anne Arundel officers who work closely with crises services are Mental Health First Aid certified, with county-wide certification rates at 28% currently. Additionally, over 20% of officers have completed crisis prevention training, amounting to approximately 220 trained officers.

Other Unique Features

Anne Arundel County has programs that are focused on getting individuals into the continuum of care for mental health and other services. As mentioned before, they use a no-wrong door approach where no matter where an individual contacts the system, there is coordination and cooperation between all programs and partners to connect them to the service(s) best suited to their needs. The diagram below illustrates some of the points of entry for the county.

Further, there are three unique programs staff shared with OLO that aim at reducing the burden on the 911 system by targeting behavioral health crises in Anne Arundel County:

- **Safe Stations –** The county has designated 41 fire stations as "Safe Station" locations which provide stabilization services for individuals. There are transportation services available to bring individuals to safe stations if needed.
- **Jail Diversion Program –** This program is aimed at individuals with substance abuse programs. A clinician is stationed at the jail every morning to test for substances. Anyone who tests positive is interviewed by the clinician and if they are willing to join the program, a plan is presented at their pre-trial. The plan allows individuals to work on recovery while on release and includes follow-ups with a care coordinator.

- **Hospital Diversion Program –** County employees track every Emergency Petition[79] (EP) that is ordered by the court and reported by police. A county clinician calls the hospital the following day after an EP(s) is issued to check if the individual is still there. The program works with hospital clinicians to identify individuals in need of services and ensures no one is missed.

E. Louisville, Kentucky

Population	Type of Model	Model Established
622,981	**Crisis Call Diversion Program – De-escalation**	**2022 (Pilot Established)**

Louisville's 911 Center, MetroSafe, works with Seven Counties, a local nonprofit that provides mental health services, to administer the Crisis Call Diversion Program (CCDP). The program's crisis triage workers (CTW) work inside the 911 operation center. Seven Counties has a MCT that is deployed from a separate location.

How is a mental health crisis identified? When an individual calls in with what appears to be a mental health crisis, the process is as follows:

- 911 call-takers will ask a few initial questions to determine the appropriate emergency response, which could involve the police, fire department, EMS, or mental health services.
- If the call is related to mental health and does not pose immediate risk to the caller or others[80], the call-taker will transfer the call to the Deflection Crisis Triage Worker (CTW) team. OLO notes the caller must be sixteen or older to be transferred.

[79] An emergency evaluation is a way to get a person who presents a danger to themselves or others to an emergency room to be examined. If the court orders an emergency evaluation, the person will be taken to the nearest emergency facility by a law enforcement officer. An emergency room physician will then determine if the person qualifies for involuntary admission to a psychiatric facility.

[80] Ineligible situations include active rescue or an active threat with a weapon. Staff note that someone can be transferred if they possess a weapon but are not actively threatening anyone with it. Further, an individual cannot be transferred if they have harmed themselves to the extent they need emergency medical services. However, the CTW can work with individuals who are intoxicated, if they are able to make decisions and communicate.

- The CTW team functions similar to a crisis hotline and focuses on de-escalation, providing emotional support and stabilization, creating a safety plan and problem solving with the person in crisis.[81]
- If the CTW determines a face-to-face response would be beneficial, they initiate a mobile response.
- Mobile responders, trained in mental health crisis intervention, meet the person where they are to further de-escalate and assess the situation and, if appropriate, connect the individual to services needed. Responders have the option of transporting the person to a community resource, such as a shelter.

Coordination of System

Deflection staff cite that having access to CAD was essential to their work**.** They evaluated other models across the country when developing their pilot program and concluded they needed a 911 center where police, fire, and EMS were all housed together. Physically being in the same room fosters easier communication as there can be both in-person conversations and/or quick phone calls. Having access to CAD, they can read a description of the caller's situation and consult a colleague if it makes sense to transfer the call to the deflection team. Staff noted that sometimes calls marked as low priority can end up in a queue, especially in times of high call volume. The deflection team can help with queue management by picking up calls that can be handled by de-escalation.

Another successful practice is related to how calls are transferred from the 911 call-taker to the deflection team. Originally, the 911 call-taker would ask if the caller wanted to speak with the deflection team. This was deemed ineffective, partly due to limited public awareness of what the deflection team could offer. Now, 911 call-takers have criteria for which calls qualify for the deflection team and those calls are automatically routed. The caller still has the option to decline speaking with the team once they are routed, in which case they will be returned to the call-taker or placed in queue for police or EMS response. Staff note throughout this deflection process, there is ongoing communication among all hubs involved (I.e., the call-takers, EMS, police and fire, and deflection team). Since the change to automatic routing, the number of refused deflection calls has decreased significantly, and the team rarely needs to send calls back to 911.

Staff also note having the deflection team located within the 911 call center can provide mental health support to call-takers as well. They cited during a recent mass shooting in Louisville,

[81] Staff note they differ from 988 and operate independently. The main difference is 988 is staffed by licensed clinicians and it is a treatment service while the diversion program focuses on triage: "creating stability in the moment and identifying next steps in a crisis."

Seven Counties was able to conduct a debrief with some call-takers after the shooting which helped immensely.

Training and Staffing Levels

Staff come from a broad range of experiences and educational backgrounds, and all are highly skilled in de-escalation techniques. Some staff are working towards becoming clinicians, some lived experience, and several staff members either obtained or in the process of obtaining peer support certification. Crisis de-escalation is the primary focus of the deflection team, and they hire specifically for that skill. For that reason, staff come from diverse backgrounds such as former law enforcement, paramedics, hospital workers, correctional facilities, schools, and community homes. The team is made up of individuals from various ages and across different neighborhoods, which was intentionally prioritized to ensure a diverse and well-rounded group that reflects Louisville.

To train the deflection team for the pilot program, they had employees shadow existing teams within Seven Counties that have already engaged with the community, such as their homeless outreach group. This helped them gain experience in community engagement and interact with constituents who may need deflection services at some point. They also rode along with police officers and continue to attend meetings with police to build visibility and rapport. As the program expands, the deflection team has started training with EMS to better understand how to respond to individuals in a mental health crisis.

The Crisis Diversion team has thirty-six full-time and six part-time employees. For any given shift, generally there are two to three crisis triage workers, a couple of MCTs (usually made up of two or three members) and a team lead which oversees operations. The mobile crisis response team is also administered by Seven Counties and some crisis triage workers are both on the deflection team and mobile crisis response team.

Other Unique Features

The Crisis Deflection Team came about after multiple individuals experiencing mental health crises were killed by law enforcement officers. Due to this, Seven Counties sought to develop a program to help individuals experiencing mental health crises to access resources they need without law enforcement intervention. They approached MetroSafe 911 with launching an initiative aimed at this and it sparked the start of a planning process, which included community groups, universities, and the Kentucky Department of Labor and Health. The planning process helped develop what model they wanted to create – a co-responder model or alternative model – and ultimately, the alternative responder model was the best fit for Louisville. The vision was to create a model that includes police, fire, EMS, and deflection

services, acknowledging that sometimes complex situations require multiple responders, but those best equipped for de-escalation should take the lead in mental health crises.

Within that planning process, the triage protocols were developed by gathering information on best practices from a variety of sources. The University of Louisville partnered with them to conduct a study to examine alterative response models in other areas and this was used to build their own approach. Staff note one of the programs studied which aligns the closest with Louisville's model is Austin, where they visited several times.

Chapter 5. Findings, Recommendations, and Discussion Item

A variety of mental health crisis response models operated by different entities exist in Montgomery County. An individual may get a different response based on how they reach out for assistance. For example, calling 911 is more likely to get an in-person and law-enforcement response compared to a crisis hotline, which is more likely to resolve the crisis over the phone.

The County Council requested this Office of Legislative (OLO) report to gather information on the nature of the response an individual would get depending on which crisis response entity they call. This report examines and reports on the protocols each entity uses when responding to mental health crisis calls. It also compares and contrasts protocols and response data among the different entities.

A. Findings

This section presents OLO's findings, which include insights from national mental health responses, outside jurisdictions, local data and findings from interviews with County call center entities.

Overview of Mental Health Responses

Finding #1. OLO identified three main types of crisis response: law enforcement model, non-law enforcement model, and co-response model.

The most appropriate type of response to an individual experiencing a mental health crisis depends on the type of risk an individual poses to themselves or others. Generally, "imminent risk" which is defined as immediate risk for the individual in crisis or others near them would constitute an in-person crisis response. The type of in-person response depends on if there is a weapon present, a history of violence, or if the individual has ingested something or harmed themselves to the extent they need medical services.

OLO identified the following three main types of crisis response:

Law enforcement model. Crisis Intervention Teams (CITs) are based on a model developed in Memphis, Tennessee in 1988. CITs generally consist of one or more officers that receive advance training on de-escalation of crises, active listening, and education surrounding behavioral and mental health crises.

Non-law enforcement models. Mobile crisis teams (MCTs) provide non-law enforcement responses to mental health crises. Many MCTs are modeled after Crisis Assistance Helping Out on the Streets (CAHOOTS), which was formed in Eugene, Oregon in 1989. If an individual has a

weapon present and/or is actively threatening the safety of themselves or others, MCTs may call for police backup.

Crisis hotlines offer anonymous, phone-based help to individuals experiencing mental health crises, including suicidal ideations and acute anxiety and depression. The first 24-hour crisis hotline in the U.S. was established in Los Angeles in 1962. Generally, the caller's issue is resolved over the phone and there is no need to send an in-person response, although follow-up calls are a recommended best practice.

Co-response model. Many jurisdictions that employ both CITs and MCTs have coordination between the two. For example, MCTs can be called to a scene where police have already provided de-escalation and on-site counseling for an individual experiencing a mental health crisis. Conversely, MCTs can call for police back-up if a weapon is brandished or their safety is threatened.

Finding #2. Black, Indigenous and People of Color (BIPOC) disproportionately experience violence from law enforcement during mental health crises and access mental health care at lower rates than White people. Experts recommend several strategies to close racial gaps in responses to mental health crises.

Many of the non-law enforcement mental health responses were developed to prevent unnecessary violence inflicted upon individuals experiencing mental health crises, especially for BIPOC. Unnecessary law enforcement intervention during behavioral and mental health crises has resulted in the killing of Black and Brown people by police, including George Floyd in Minneapolis, Minnesota and Marcus-David Peters in Richmond, Virginia.

Racial disparities in law enforcement are rooted in a legacy of racial injustice, as the earliest policing efforts in the U.S. were slave patrols, which were charged with policing free and enslaved Black people. Today, racial inequities persist in terms of harsher treatment of BIPOC in the criminal justice system, mass incarceration, and higher use of force on BIPOC during a police encounter

Additionally, data from the National Survey on Drug Abuse and Health show that Black adults receive mental health care at substantially lower rates than White adults. For example, in 2023, 15% of Black adults reported receiving mental health treatment in the past year compared to 27% of White adults.

These racial disparities show a need for culturally competent care and services for mental health care. Best practices for closing gaps in racial disparities in mental health and responses to mental health crises include:

- Minimizing reliance on law enforcement by developing behavioral health crisis care systems outside the criminal justice system;
- Improve collection of demographic data related to individuals reaching out for services, including what help was given and any referrals, disaggregated by race and ethnicity at the local level to show where gaps in services may lay;
- Crisis systems should center racial justice and equity and be embedded within a holistic, integrated public health care system with high quality, accessible, and equitable services;
- Crisis call centers should increase their capacity for language services, including hiring more native speakers of common languages spoken locally; and
- Peers, those who have lived experience of mental health crises, should be centered in crisis response, recovery, and prevention. Efforts should be made to recruit peers that are racially and ethnically representative of the jurisdiction they are working in.

County Entities

OLO interviewed four primary call centers which take mental health crisis related calls: the Emergency Communications Center (ECC), 311, The Crisis Center, and EveryMind which operates 988 and Montgomery County Crisis Hotline. The following findings reflect what OLO learned from interviews with these call centers.

Finding #3. Each call center entity has their own strategies to contend with periods of heavy request volumes. However, across all call centers, calls are handled in the order they are taken.

All County call centers interviewed for this report informed OLO that calls are received in the order they are taken. Currently, there is no prioritization of calls. However, some call center entities do have backup call centers and other strategies in place to deal with periods of heavy request volumes.

ECC. The ECC operates 911 and the police non-emergency line. It is staffed by 86 emergency communications specialists (PSECS), with 26 PSECS are currently in training. PSECS generally work twelve hour shifts but will work eight and ten hour shifts to provide coverage during high call volume periods. An alternative ECC center is used when their primary center is not operational.

311. Individuals call 311 to request nonemergency government services and information. Answering protocols do not change during heavy request times as the 311 system is designed to handle seasonal and expected variations in call volume. However, when unexpected events have occurred in the County, 311 has provided its customer service representatives with

information, via "knowledge base articles," on how to respond to requests regarding those specific events.

Crisis Center. The County's 24-hour Crisis Center provides free crisis services, including assessments and referrals, via telephone and in person at the Crisis Center and via Mobile Crisis Teams. The Crisis Center does not have a backup call center, nor does its phone line have a message that instructs callers to dial another number when someone calls into the Crisis Center's hotline. There are no dedicated call-takers so callers may wait on hold for up to 20 minutes. OLO notes the Crisis Center requested an upgraded phone system to reduce wait times by establishing a triage system where calls from police, fire and rescue, or individuals who are suicidal, homicidal, or in immediate distress will be prioritized and moved ahead of callers with non-crisis-related issues. At the time of writing this report, the Crisis Center aimed to have the new system in place by July 2025.

EveryMind. EveryMind operates two crisis hotlines: 988, and the Montgomery County Hotline. The 988 Suicide & Crisis Lifeline is a national system. When callers dial 988, they are first asked if they want to connect to: (1) the Veterans Crisis Line or (2) the Spanish-language line; both of which are handled by a separate center outside the County. If a caller within Montgomery County dials 988 and does not select any of these options, the call is routed to the 988 center in Montgomery County operated by EveryMind. However, in times of high call volumes (if a call takes longer than 20 seconds to answer), the call can be routed to Prince George's County's 988 call center or the national 988 backup network center.

The Montgomery County Crisis Hotline does not have a backup system. EveryMind can plan for increased staffing ahead of known events or in response to local incidents which may cause heightened community distress, but there are no backup phone systems.

Finding #4. Across the County call center entities, imminent risk is defined similarly. However, determining what type of response is needed for a mental health crisis can be challenging for call-takers.

All call center entities determine a caller's "imminent risk." Generally, imminent risk refers to situations where an individual is in immediate danger of harming themselves or others, has access and means to harm (i.e. weapons), or refuses to ensure their own safety. Callers will not explicitly say they are at imminent risk and instead, it is up to the call-taker to determine the level of imminent risk.

Some factors used in this decision-making include:

- Individuals who express active suicidal intent;
- Are in possession of a weapon or have indicated they can easily obtain a weapon; and

- Are threatening violence or have a known history of violence.

Determining whether a physical response is warranted can be challenging for call-takers, particularly in ambiguous cases, such as when a person expresses suicidal thoughts but does not present an immediate threat or disclose a means. While call center entities provide training and guidelines, the responsibility for deciding whether to escalate the situation to an imminent danger response ultimately lies with the call-takers.

Data show that most calls to 988 and the Montgomery County Crisis Hotline are resolved without police involvement (98.1% of all calls). Generally, if a weapon is present, County call center entities will choose to dispatch police.

Conversely, calls to the ECC (including 911 and the police non-emergency line) regarding mental health crises typically generate an in-person police response (98.8% of all calls). ECC's standing guidance is to dispatch the police when there is any doubt, as doing so guarantees someone will physically respond. In some cases, the ECC transfers callers to the Crisis Center, but if the Crisis Center cannot respond in a timely fashion, the ECC will also dispatch police.

Finding #5. Currently, the ECC diverts mental health calls that do not require a police response to the Crisis Center. However, the Crisis Center does not have dedicated call-takers for its hotline, and protocols are not yet in place to divert calls from the ECC to 988.

Both 311 and the ECC have traditionally directed mental health-related calls to the Crisis Center when appropriate. However, the Crisis Center does not have dedicated call-takers. Monday through Friday, there are 11-15 staff for each shift which allows 6-10 staff to be assigned to MCOT. This leaves a minimum of 5 staff in the office to answer phone calls, attend to Residential Crisis Services (RCS) clients, and walk-in clients. As a result, callers may wait on hold for 15 to 20 minutes. Additionally, there is no backup number or message that instructs callers to dial another number. While EveryMind is working with ECC to develop protocols and encourage the diversion of appropriate calls, 911 calls are not yet being redirected to 988 consistently.

Finding #6. There are no shared formal protocols, nor systematic cross-training opportunities across the four call center entities that operate in Montgomery County.

There is no shared triage protocol across all four call center entities. The ECC utilizes a protocol system developed by the International Academy of Emergency Dispatch. EveryMind and the Crisis Center have developed triage protocols tailored to their respective operational needs. 311 relies on knowledge-based articles created by County agencies, which function as informal protocols.

While there is a workgroup that works to coordinate efforts between the call center entities, training across groups is done in an ad-hoc manner. However, outside jurisdictions interviewed for this report cite that cross-training can significantly improve coordination and communication, enhance service continuity, support holistic responses, and promote consistency in service delivery. Shared training fosters a common language, approach, and philosophy of care, resulting in more consistent and effective support for those seeking help.

Finding #7. The average annual volume, answer speed, and length of calls in 2024 varied across County call center entities.

OLO collected data from 988, Montgomery County Crisis Hotline, The Crisis Center, 911, and 311 to compare call volume, average answer speed, and average length of call. The table below shows data collected for 2024 across all call center entities interviewed for the report.

Call Center Entity	Annual Volume (2024)	Average Answer Speed (2024)	Average Length of Call (2024)
988 (EveryMind)	39,242 Contacts* (15,397 Calls, 16,226 Texts, and 7,619 Chats)	13 seconds (for Call, Text, and Chat)	Calls – 14 minutes Text – 44 minutes Chat – 30 minutes
Montgomery County Crisis Hotline (EveryMind)	18,308 Contacts* (17,336 Calls and 972 Texts)	13 Seconds (Calls) (Texts not tracked)	13 minutes (Calls) (Texts not tracked)
The Crisis Center (DHHS)	41,610 Calls	NA	NA
911	848,289 (All calls to 911) 15,040 Calls Related to Mental Health	10 seconds	2 minutes, 32 seconds
311	414,524 (All calls) 347 Calls Related to Mental Health	22 seconds	3 minutes, 52 seconds

*Denotes calls, texts, and chats received, not answered
Source: Various County Entities

The data show for overall call volume, 911 has the most calls. However, approximately 2% of these calls are recorded as related to mental health. 911 also has the quickest average answer speed and shortest average call length.

For call center entities that only focus on mental health crises, The Crisis Center has the highest volume of calls at 41,610. 988 has the next highest volume at 39,242 contacts although this includes calls, texts, and chats. The County Crisis Hotline has the least amount of volume with 18,308 contacts which include phone and chat. 988 and the County Crisis Hotline have the same average answer speed, 13 seconds and similar average lengths of calls (13 and 14 minutes respectively). 988 text and chat take more than twice as long to resolve compared to calls, with the average text conversation lasting 44 minutes and the average chat conversation lasting 30 minutes.

OLO also notes that while the Crisis Center does not track the average answer speed nor average length of call, staff report it can take up to 15-20 minutes to answer the phone. This is because their staff handle multiple roles: dispatching the MCT, checking in walk-in clinics, and answering calls. There is no dedicated call-taker on any given shift.

Finding #8. EveryMind was the only call center entity interviewed that collected demographic data, such as age, race, ethnicity, and gender. However, as this data is only collected if the caller offers the information, they did not collect this data for most of their calls.

EveryMind runs both 988 and the Montgomery County Crisis Hotline.

For 988, the demographic categories that were disclosed most often was age and military service. 988 call-takers only solicit demographic information, and it is not required for callers to self-disclose. In 2024, about 55% of all individuals who reached out to 988 disclosed their age, 36% disclosed their gender, and 56% disclosed their military status. The least disclosed demographic category was race and ethnicity as only 3% of callers self-disclosed. Of callers who did choose to self-disclose information on their demographics (with the exception of race and ethnicity as the sample size was too small):

- Most callers fell within the 18-24 age range **(27%)** and the 13-17 age range **(13%)**. The age range represented the least was the 60-69 age range **(2%)** and 70+ **(3%).**
- Most callers identified as women **(65%)** and only **34%** of callers identified as men. **2%** of callers identified as other.
- **98%** callers did not have any military status and only **1%** of callers were veterans. OLO notes there is a separate veteran's crisis hotline that callers may select when dialing 988.

For the Montgomery County Crisis Hotline, disclosure rates are higher compared to 988 and 74% of all individuals who reached out to the crisis hotline disclosed their age. 77% of all individuals disclosed their gender. 77% of all individuals also disclosed their military status. Race and ethnicity information was still the least disclosed category but approximately 11% of

individuals who reached out to the crisis hotline disclosed this, compared to 3% of 988 callers. Of callers who self-disclosed demographic data:

- Most callers fell within the 30-39 age range **(29%)** and 60-69 age range **(27%).** Only **3%** of callers fell within the 40-49 age range. Notably, far less callers were within the 18-24 age range **(13%)** and 13-17 age range **(>1%)** compared to 988 callers.
- Most callers identified as women **(63%)** and only **37%** of callers identified as men. **1%** of callers identified as other.
- Most callers were Black **(53%). 25%** of callers were White, **8%** of callers were Asian, **7%** of callers were Latino, and **7%** of callers were multiracial.
- **98%** of callers did not have any military status and only **1%** of callers were veterans.

Finding #9. For call center entities that do not solely take mental health crisis calls: 911 and 311, the number of calls recorded as related to mental health crises was relatively low.

OLO received data from 311 and 911 on calls related to mental health crises. The call count is an approximation based on the initial call's information. If a first responder was dispatched to the call in-person and found it to be related to mental health, that would not be recorded in this count.

Of the 848,289 calls received by 911 in 2024, approximately 15,040 (2%) of these calls were related to mental health. Of those 15,040 calls, 13,755 calls were related to mental and behavioral health and 1,285 were related to suicide, such as suicidal ideations and attempted suicide. Only 72 calls were either conferenced, referred or transferred to 988, the Crisis Center, or another mental health crisis entity.

Of the 414,524 calls received by 311 in 2024, approximately 347 calls (>1%) were related to mental health. Of those, 333 calls were transferred or referred to 988, the Crisis Center, or other mental health crisis entity.

Finding #10. The County call center entities have different modes of communication – call, text, and chat. All call center entities, except for 311, are open 24/7.

The table below shows each call center's mode of communication. 988 is the only entity that offers call, text, and chat. OLO notes that operators across all entities are trained to answer all modes of communication but will only focus on responding to a single mode of communication at a time. For example, an operator will finish a text conversation before going to answer a new call, text, or chat.

Call Center or Hotline	Call, Text, and/or Chat?
988	Call, text, and chat
Montgomery County Crisis Hotline	Call and text
The Crisis Center	Call
911	Call and text
311	Call and Chatbot (available on 311 website)

All entities, besides 311, are open 24/7. 311 is available Monday – Friday from 7 AM to 7 PM. The 311 chatbot, which is powered by ChatGPT is multi-lingual, available 24/7 and can be used on any device that can connect to the internet.

Further, all call center entities use language-line, a live interpretation service, for individuals who call in and cannot communicate in English. There are some call-takers that speak languages other than English, with the majority speaking Spanish.

Finding #11. In Montgomery County, there are two dedicated teams that respond to mental health crises: the Mobile Crisis Team and the Crisis Intervention Team.

Administered through HHS's Crisis Center, the Mobile Crisis Outreach Team (MCOT) is staffed by licensed mental health professionals and responds in two-person teams. From 7 AM to 11 PM, MCOT has the option to bring police along on calls, depending on the situation. From 11 PM to 7 AM, it is required by MCGEO for MCOT to accompany police due to increased risks associated with nighttime conditions like reduced visibility and decreased public presence. During the day and evening hours, there are 3-5 MCOT teams functioning, which will be expanded to 7 MCOT teams in September.

MCOT is dispatched by the Crisis Center. The team has access to police radios to collect information about the case they're dispatched to and request back up if needed. The team wears plain clothes, does not have access to CAD or sirens, and uses de-escalation techniques and rapport-building skills to engage with their clients. MCOTs generally respond without law-enforcement presence when there is no indication of weapons present at the scene or if there is no history of violence with the individual they are responding to.

The Centralized Crisis Intervention Team (CCIT) is housed within the Community Engagement Division of the Montgomery County Police Department. The officers in this team have advanced training in de-escalation and mental health crises. OLO notes the CCIT team only works Monday through Friday.

The CCIT team includes one sergeant, one supervisor therapist, and five officers who are assigned to the following districts: Bethesda, Wheaton, Silver Spring, Germantown, and Gaithersburg. The supervisor therapist is an HHS employee who is located within police headquarters and works with CIT officers in a co-response model. In certain situations, the supervising therapist will accompany an officer to the scene and provide follow-up for the CCIT unit.

Further, CCIT officers receive enhanced training related to CIT and de-escalation. While all officers in MCPD receive training in mental health first aid (MHFA) and over 75% of officers are CIT certified, there are no CIT or MHFA retraining requirements for existing officers. In comparison, CCIT officers must also be certified as general instructors in the State of Maryland and receive additional training such as Integrating Communications, Assessment, and Tactics training, which is a de-escalation model developed by the Police Executive Research Forum. Up to date training ensures officers are properly equipped to provide specialized support for mental health crises.

The CCIT team also works closely with MCOT. CCIT officers may request them on specific calls and vice versa. For example, when someone is barricaded in their home, the CCIT will automatically contact MCOT. CCIT will provide relevant information to help MCOT determine if the situation has a mental health component, in which case they will respond.[82]

Outside Jurisdictions

Finding #12. OLO spoke with staff from five jurisdictions considered by experts to be models in mental health crisis response. Staff from all jurisdictions highlighted the importance of collaboration and shared formal protocols between the various local call center entities.

OLO spoke to staff from the following five jurisdictions: Fairfax County, VA, Albuquerque, NM, Travis County, TX, Anne Arundel County, MD, and Louisville, KY. Staff shared the following lessons learned with OLO:

- Almost all jurisdictions highlighted the importance of interoperability between their 911 call centers and mental health crisis call centers, meaning there is a direct line for

[82] HHS informed OLO that a co-response pilot between MCOT and CCIT was recently created.

transfer and shared formal protocols between the call centers. Four out of five jurisdictions have a direct transfer line between 911 and their local crisis hotlines, which has facilitated deeper collaboration between the entities.

- Deep collaboration with non-profits and healthcare centers in the jurisdiction is essential so that callers can enter a continuum of care and not fall through the cracks. It is important for everyone involved in crisis response – crisis hotline call-takers, first responders, and mobile crisis teams, to know what resources are available and have a relationship with staff, so individuals experiencing a mental health crisis can get the care they need quickly.

- Staff noted the importance of internal education, how each call center functions and meetings with call-takers from other call centers to build trust and confidence in transfer protocols (e.g. transfers from 911 to 988). Jurisdictions reported that once they established better relationships between the call center entities, 911 operators were much more likely to transfer calls related to mental health to a local crisis hotline.

- Having mental health call-takers and/or a licensed mental health professional working physically in the same building as 911 call-takers facilitate deeper communication which makes it easier to transfer calls. Having dedicated mental health workers in the same building also provides them access to the CAD (computer-aided dispatch system), where they can see what calls are coming through and can better identify calls appropriate for a mental health response.

B. Recommendations

OLO offers the following recommendations and one discussion item for Council Consideration.

Recommendation #1 Explore options to increase the Crisis Center's capacity for taking mental health crisis calls.

The Crisis Center is a 24/7 hub for the community in receiving help during mental health crises. It takes calls related to mental health crises through their hotline in addition to walk-in services. The Crisis Center also has stabilization resources, the Mobile Crisis Team, and other services.

Staff working at the Crisis Center are assigned to functions during each shift, such as MCOT, Residential Crisis beds, and other functions. All other available staff respond to calls, walk-ins, and other queries. As such, there are no staff dedicated to only answering incoming calls and this can result in long wait times for callers – sometimes up to 20 minutes. This long wait can be detrimental to someone experiencing a crisis.

OLO heard from other entities, such as ECC and 311. They refer most callers experiencing a mental health crisis that do not need a police response to the Crisis Center's hotline. Yet, the Crisis Center does not currently have sufficient capacity to function effectively as the main point of contact for those experiencing a mental health crisis.

Some recommendations for addressing the limited capacity:

- Increase Crisis Center staff allocations to allow for some staff to be dedicated call-takers.
- Upgrade the hotline's phone lines so calls can be answered remotely.
- Encourage County entities to distribute calls amongst other hotlines besides the Crisis Center, such as 988 and the Montgomery County Crisis Hotline.

Recommendation #2 Increase interoperability across entities that take mental health crisis calls.

Across all outside jurisdictions OLO interviewed for this report, the importance of interoperability was highlighted, meaning there is a direct line for transfer and shared formal protocols between the call centers. Almost all jurisdictions OLO spoke to have a direct transfer line between 911 and their local crisis hotlines, which has facilitated deeper collaboration between the entities. Further, jurisdictions noted that interoperability was the result of years of collaboration, building trust, and coordinating efforts between the entities.

911, 311, EveryMind, and the Crisis Center are part of the Integrated Crisis Call Center Workgroup, which focuses on building coordination and relationships with the entities and their employees. However, despite coordinating efforts, there are no direct lines between County entities that receive mental health crisis calls.

Providing the Integrated Crisis Call Center Workgroup with the resources necessary to develop direct lines and shared formal protocols between entities could be a good strategy for increasing interoperability.

Recommendation #3 Improve data collection across County entities that take mental health crisis calls.

Data collection across County entities that take mental health crisis calls is limited, especially with regards to demographic information. SAMHSA recommends robust data collection for mental health crisis hotlines to better understand which populations are calling. This information can help tailor services to be culturally competent and age-appropriate, as well as guide expansion based on the most common reasons for reaching out (e.g., suicidal ideation, depression, anxiety). SAMHSA specifically recommends that demographics of the caller,

including age range, gender, race, and ethnicity, should be collected if the caller is willing to provide information and if it is appropriate to inquire.

Across the County entities that OLO interviewed for this report: the ECC, 311, EveryMind (which operates 988 and the Montgomery County Crisis Hotline), and the Crisis Center, EveryMind collected the most data. However, only about 2% of EveryMind calls in 2024 had robust demographic data available. The other call center entities did not collect any demographic data.

The Council could consider requesting that demographic data be collected and reported by County entities whenever possible to determine how to best serve County residents who use these services. The Crisis Center could be a good candidate for collecting this data as it may be more difficult to collect robust demographic data from 911 emergency calls. However, systems would need to be updated to allow the Crisis Center to collect these data.

Discussion Item #1 The Council could facilitate a community conversation about what type of response is most effective for individuals who have experienced mental health crises and how to build capacity for these programs.

OLO identified three main types of responses to mental health crises which are a law enforcement model, non-law enforcement model, and co-response model. Within Montgomery County, the following entities fall within these three models:

- **Law enforcement:** Montgomery County Police Department's Centralized Crisis Intervention Team
- **Non-Law Enforcement:** The Crisis Center, 988, Montgomery County Mental Health Crisis Hotline, and MCOT (between the hours of 7 AM – 11 PM)
- **Co-Response Model:** MCOT (must respond with a police officer between the hours of 11 PM – 7 AM or if there is significant risk such as presence of weapons, current or recent history of violence, or threats of aggression)

There are constraints associated with these programs and entities including:

- At the time of this report, there are five Mobile Crisis Outreach Teams available during peak call times. MCOT's goal is to expand to seven teams to meet growing demand, reduce wait times and have the teams operational by September 2025.
- Only five officers are assigned to the Montgomery County Police Department's Crisis Intervention Team and assigned to five districts in the County: Bethesda, Wheaton, Silver Spring, Germantown and Gaithersburg. OLO notes that although they are assigned to these districts, they are not restricted to those areas.
- Research has shown younger people prefer chat and texting options over phone calls. While 988 has text and chat capabilities, the Crisis Center can only take phone calls for

their hotline and the Montgomery County Crisis Hotline discontinued their text services in October 2024.

The Council could facilitate a series of community conversations with residents to determine which responses are most effective and safe for individuals who have experienced mental health crises in the County. Input gathered from these series could be used to build capacity for County programs related to mental health crises.

OFFICE OF THE COUNTY EXECUTIVE

Marc Elrich
County Executive

Richard S. Madaleno
Chief Administrative Officer

MEMORANDUM

August 29, 2025

TO: Chris Cihlar, Director
Office of Legislative Oversight

FROM: Richard S. Madaleno, Chief Administrative Officer

SUBJECT: Draft OLO Report 2025-10: *Mental Health Crisis Responses in Montgomery County*

Thank you for the opportunity to comment on the Office of Legislative Oversight's (OLO) Draft Report 2025-10: *Mental Health Crisis Responses in Montgomery County*.

As you are aware, the response to behavioral health crises has been a priority of the County Executive. We have made significant investments in recent years to enhance the County's capacity for mobile crisis response while also expanding multiple programs and initiatives aimed at preventing mental health crises.

We are pleased that, starting in September, the Montgomery County Crisis Center will have the capability to dispatch up to seven Mobile Crisis and Outreach Teams (MCOTs) simultaneously across the County during peak call hours. This is more than double the capacity the Crisis Center had two years ago, with a maximum of three MCOT teams available to dispatch at that time. This expansion is a testament to our commitment to providing timely and effective crisis intervention.

Moreover, the ongoing collaboration between the Montgomery County Department of Health and Human Services (DHHS) and Montgomery County Police Department (MCPD) has been instrumental in addressing crisis response. In 2024, we added a new DHHS Supervisory Therapist position to the MCPD Crisis Intervention Team and recently launched a co-response pilot. This initiative assigns additional DHHS staff, including clinicians and peer specialists, to MCPD during peak volume shifts, further strengthening our crisis response efforts. Additionally, the Crisis Center maintains established valuable partnerships with the cities of Rockville and Takoma Park, providing dedicated clinicians to assist municipal officers with behavioral health

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calls. And since the spring of 2024, Montgomery County Fire and Rescue Services (MCFRS) has successfully facilitated Emergency Medical Services (EMS) transport for residents experiencing behavioral health crisis to the Crisis Stabilization Unit, which DHHS opened in 2023. This formal partnership has effectively diverted 136 EMS drop-offs of patients in behavioral health crisis from area emergency rooms to date, ensuring residents receive more appropriate and specialized support during their time of need.

In the fall of 2024, DHHS reconstituted and expanded the former "Crisis Now" workgroups into a Behavioral Health Coordinated System of Crisis Care effort. With pivotal support from the Primary Care Coalition, our Behavioral Health Crisis Leadership Collaborative is now co-chaired by DHHS and Adventist Healthcare, with representation from other area hospitals, MCPD, Department of Correction and Rehabilitation (DOCR), MCFRS, community advocates, Community-Based Organizations (CBOs), and others. Workgroup co-chairs from DHHS, MCFRS, and EveryMind further engage participation from a diverse array of additional public and private partners and representatives with lived experience in advancing our efforts.

We greatly appreciate the Office of Legislative Oversight's attention to this critical issue and look forward to continuing our work to enhance behavioral health crisis responses in Montgomery County.

The draft report includes the following recommendations.

Recommendation #1: **Explore options to increase the Crisis Center's capacity for taking mental health crisis calls.**

CAO Response: We agree with this recommendation, with the clarification that increased capacity is needed to improve the Crisis Center's ability to provide immediate or timely response to all calls that it fields. As noted in the report, the Crisis Center also handles after-hours calls and walk-ins for several critical DHHS services (Child Protective Services, Adult Protective Services, Services to End and Prevent Homelessness, emergency shelter needs for those experiencing intimate partner violence or human trafficking, etc.). As such, increased capacity and updated technology are needed to quickly triage and field all incoming calls for any of these needs, ultimately improving response time critical interventions for behavioral health crisis calls and MCOT dispatches.

Recommendation #2: **Increase interoperability across entities that take mental health crisis calls.**

CAO Response: We agree with this recommendation. This is precisely what the Integrated Crisis Call Centers Workgroup of the Behavioral Health Coordinated Systems of Crisis Care effort has been focused on, per the Substance Abuse and Mental Health Services Administrations (SAMHSA) 2025 National Behavioral Health Crisis Care Guidance (specifically the Someone to Contact: 988 Lifeline and Other Behavioral Health Lines section). With a renewed composition and co-leadership (DHHS and EveryMind) as of fall of 2024, this workgroup has coordinated

efforts between the call center entities (988, the Crisis Center, Emergency Communications Center, 311) and MCFRS' Mobile Integrated Health Team. As noted in the report, this workgroup has also conducted initial cross-training with participants. Utilizing state-recommended exercises to increase awareness of each call center's response and triage protocols, this work group has laid the groundwork needed to take interoperability to the next level. We appreciate OLO's affirmation that outside jurisdictions interviewed for this report cited this cross-training can "significantly improve coordination and communication, enhance service continuity, support holistic responses, and promote consistency in service delivery," and that "Shared training fosters a common language, approach, and philosophy of care, resulting in more consistent and effective support for those seeking help." The Integrated Crisis Call Centers Workgroup deemed these goals to be primary in maximizing county residents' experience with behavioral health crises response in the short-term, while also building relationships across the call center entities and employees required for the future development of direct lines and shared formal protocols.

Recommendation #3: **Improve data collection across County entities that take mental health crisis calls.**

CAO Response: We agree with this recommendation. This will also require the Department of Technology and Enterprise Business Solutions (TEBS) support and County investment, to ensure we leverage the most updated technology for data extraction, consolidation and visualization without increasing the administrative burden on the multiple call centers.

Discussion Item #1: **The Council could facilitate a community conversation about what type of response is most effective for individuals who have experienced mental health crises and how to build capacity for those programs.**

CAO Response: We are always eager to engage with and support community conversations, as ongoing learning and exchange with our residents is paramount in ensuring our local efforts are meeting, and evolving with, our community's needs. We are also fortunate to benefit from SAMSHA's recent issuance this year of the updated national guidelines, which were developed with the input of a multitude of subject matter experts and collaborators with experiential knowledge, including many with lived experience. DHHS has a consulting agreement with one of the experts that contributed to these guidelines and is also fortunate to have representatives from the Intellectual and Developmental Disabilities (IDD) community and the National Alliance for the Mentally Ill engaged in the Behavioral Health Coordinated Systems of Crisis Care workgroups, along with first responders and nonprofit partners.

We know from the research and from the expertise and input of these various entities that there is no one most effective response for all individuals who have experienced behavioral health crises. This is why a health-led multi-pronged and multi-modal crisis continuum delivers the best outcomes, when these parts (988/crisis lines, mobile crisis teams, and crisis stabilization facilities) are tightly coordinated and available 24/7. We understand that continuing to build capacity for this coordinated response requires braided financing, integrated crisis operations and

data measurement, completion of planned crisis stabilization expansion projects such as the Diversion Center, building the behavioral health workforce, and deepened partnerships.

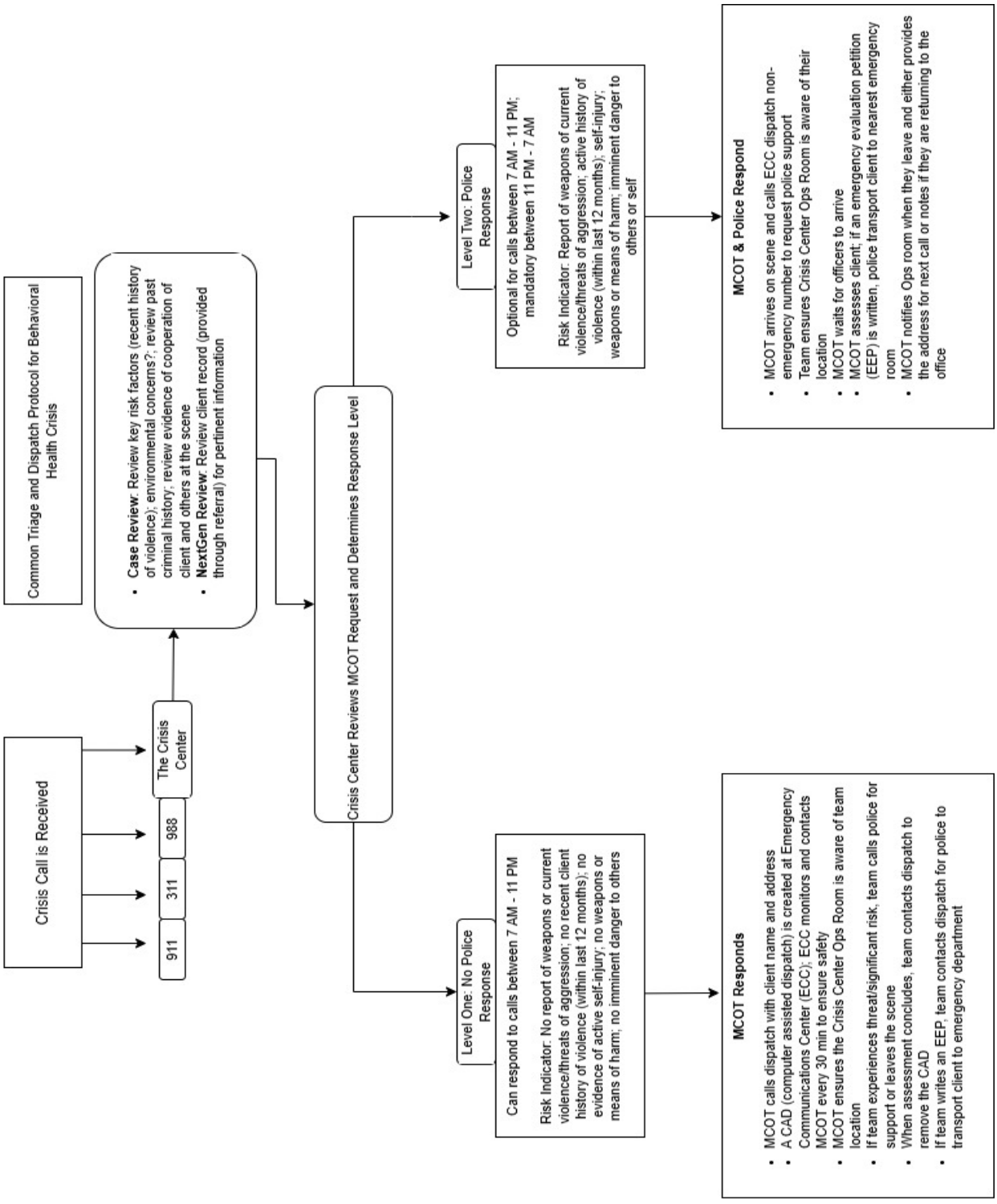
In closing, we thank you for the opportunity to affirm that Montgomery County is committed to a health-first, mobile-first system that resolves most crises in the community, uses police only when safety requires it, and offers stabilization settings plus proactive follow-up.

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

RM/mm

cc: Fariba Kassiri, Deputy Chief Administrative Officer, Office of the County Executive
Earl Stoddard, Assistant Chief Administrative Officer, Office of the County Executive
Tricia Swanson, Director of Strategic Partnerships, Office of the County Executive
Dr. James Bridgers, Director, Montgomery County Department of Health and Human Services
Gail Roper, Director, Department of Technology and Enterprise Business Solutions
Corey Smedley, Fire Chief, Montgomery County Fire and Rescue Services
Marc Yamada, Police Chief, Montgomery County Police Department
Karen Randolph, Chief Operating Officer, Department of Technology and Enterprise Business Solutions
Victoria Lewis, MC311 Director, Department of Technology and Enterprise Business Solutions
Monica Martin, Chief of Behavioral Health and Crisis Services, Montgomery County Department of Health and Human Services

Appendix A


Crisis Call is Received
911
311
988
The Crisis Center
Common Triage and Dispatch Protocol for Behavioral Health Crisis
Case Review: Review key risk factors (recent history of violence); environmental concerns?; review past criminal history; review evidence of cooperation of client and others at the scene
NextGen Review: Review client record (provided through referral) for pertinent information
Crisis Center Reviews MCOT Request and Determines Response Level
Level One: No Police Response
Can respond to calls between 7 AM - 11 PM
Risk Indicator: No report of weapons or current violence/threats of aggression; no recent client history of violence (within last 12 months); no evidence of active self-injury; no weapons or means of harm; no imminent danger to others
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 min to ensure safety
MCOT ensures the 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 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
Level Two: Police Response
Optional for calls between 7 AM - 11 PM; mandatory between 11 PM - 7 AM
Risk Indicator: Report of weapons of current violence/threats of aggression; active history of violence (within last 12 months); self-injury; weapons or means of harm; imminent danger to others or self
MCOT & Police Respond
MCOT arrives on scene and calls ECC dispatch non-emergency number to request police support
Team ensures Crisis Center Ops Room is aware of their location
MCOT waits for officers to arrive
MCOT assesses client; if an emergency evaluation petition (EEP) is written, police transport client to nearest emergency room
MCOT notifies Ops room when they leave and either provides the address for next call or notes if they are returning to the office