Crisis Intervention Team Landscape Analysis
Final Report

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1. Introduction

Crisis Intervention Teams (CIT) are collaborative programs involving law enforcement, emergency responders, behavioral health professionals, and community stakeholders. CIT's goal is to improve how first responders handle situations involving individuals experiencing behavioral health crises—especially when such behaviors are mistaken for criminal or dangerous actions. CIT programs aim to reduce unnecessary incarceration, improve community safety, and ensure individuals receive necessary care.

Key elements and details of CIT programs include:

- Training: Officers receive specialized 40-hour training to better understand and de-escalate mental health crises.
- Community Collaboration: CIT fosters partnerships among law enforcement, healthcare providers, and advocacy groups.
- Alternative Responses: Instead of arrest or hospitalization, officers are trained to connect individuals with appropriate mental health services.
- Origins: The model began in Memphis, Tennessee in 1988 and has since expanded nationwide.

This report centers on the three primary objectives that shaped this research project. Drawing on surveys, interviews, and a scan of national research conducted between July 2024 and June 2025 by faculty and staff at the University of Maryland, Baltimore, School of Social Work (UMB), this report presents key findings on the implementation of CIT programs across the State of Maryland. It also highlights local and national programs demonstrating noteworthy innovations. Please see Appendix A for the meetings UMB attended to support this analysis.

To contextualize these findings, we include data on the number of patrol officers throughout Maryland. While a comprehensive, and current breakdown of sworn officers by county is not readily available from a sole source, we have compiled approximate officer capacity figures from a variety of sources. These estimates offer a general overview of officer capacity across jurisdictions.[1]

Law Enforcement Size	Jurisdiction/Patrol Officer Capacity
2,000+ Officers	• Baltimore City: 2,515
1,000–1,999 Officers	• Prince George's: 1,800 • Montgomery: 1,300 • Baltimore County: 1,100

[1] United States Department of Justice- Office of Justice Programs: Bureau of Justice Statistics. "Census of State and Local Law Enforcement Agencies (CSLLEA), 2018." May 30, 2023. Accessed June 30, 2025. https://www.icpsr.umich.edu/web/NACJD/studies/38771/versions/V1.

500–999 Officers	• Anne Arundel: 850 • Howard: 509
250–499 Officers	• Frederick: 350 • Harford: 297 • Charles: 289
100–249 Officers	• St. Mary's: 171 • Washington: 190 • Wicomico: 190 • Worcester: 150 • Carroll: 150 • Calvert: 150 • Cecil: 120 • Allegany: 100
Under 100 Officers	• Queen Anne's: 90 • Caroline: 80 • Dorchester: 80 • Talbot: 80 • Garrett: 36 • Kent: 35 • Somerset: 21

2. Mapping Maryland's CIT Strengths and Gaps in Infrastructure, Training, and Implementation (Aim #1)

2.1 History and Development of CIT in Maryland

CIT programs in Maryland emerged in response to the growing awareness of the disproportionate contact between individuals with behavioral health conditions—such as serious mental illness, substance use disorders, and intellectual or developmental disabilities—and the criminal justice system. As early as 2016, data revealed that 40% of individuals incarcerated in Maryland jails had a mental health disorder, and more than two-thirds had a substance use disorder.[2] These figures highlighted the pressing need for specialized, community-based crisis response strategies.

CIT was introduced as a proactive approach to improve outcomes for individuals experiencing behavioral health crises by redirecting them from the justice system and connecting them with appropriate care. These programs foster collaboration among law enforcement, mental health professionals, emergency responders, advocates, and community stakeholders to expand non-carceral pathways that emphasize de-escalation, safety, and treatment over incarceration

The momentum for statewide expansion of CIT accelerated following the 2020 Maryland State Summit on Behavioral Health and the Justice System. The summit underscored the need for a centralized body to oversee and evaluate crisis response initiatives. In response, the Maryland

[2] Governor's Office on Crime Control and Prevention. (2016) Substance Use and Mental Health Disorder Gaps and Needs Analysis. https://gocpp.maryland.gov/wp-content/uploads/justice-reinvestment-sa-mh-gaps-needs-20161231.pdf

Behavioral Health and Public Safety Center of Excellence (BHPS-CoE) was established through Section 13-4204 of the Health General Article, enacted in 2021. Shortly thereafter, the Crisis Intervention Team Center of Excellence (CITCE) and the Behavioral Health and Public Safety Center of Excellence (BHPS-CoE) were consolidated under the Governor's Office of Crime Prevention and Policy (GOCPP), forming what is now commonly known as the Centers of Excellence. This integration has strengthened statewide coordination efforts to address behavioral health needs at the intersection of public safety and the justice system.

CIT's evolution in Maryland is closely aligned with the Sequential Intercept Model (SIM), a nationally recognized framework that maps how individuals with behavioral health conditions interact with the criminal justice system. The SIM identifies key junctures, known as intercepts, across the criminal justice system, where targeted interventions can connect individuals to treatment and support services. These intercepts span the continuum from community-based crisis responses, and first encounters with law enforcement to court involvement, incarceration, reentry, and community supervision. CIT plays a critical role at the earliest intercepts, particularly at intercept 0 (community resources) and intercept 1 (first responders).

Today, CIT programs across Maryland continue to grow and adapt with support from the Centers of Excellence, which provides technical assistance, training, and strategic guidance. These efforts promote best practices and help jurisdictions develop tailored crisis response strategies that address their communities' needs.

The following sections outline the key partners and structures driving this work, beginning with GOCPP, including its leadership in CIT strategic planning and coordination of quarterly CIT coordinator meetings. Subsequent sections highlight the contributions of the Maryland Behavioral Health Administration (BHA) and the vital role of county-level CIT coordinators in implementing and sustaining local crisis response systems.

2.2 GOCPP's Role

The Crisis Intervention Team Center of Excellence (CITCE) was established in 2020 under Section 3-522 of the Public Safety Article 2021 within the Governor's Office of Crime Prevention and Policy (GOCPP), formerly known as the Governor's Office of Crime Prevention, Youth, and Victim Services (GOCPYVS[3]). CITCE was created to provide technical assistance for behavioral health crisis intervention and to develop a standardized statewide model.

As previously established, CITCE and BHPS-CoE operate under GOCPP to lead the state's coordinated crisis response framework. Its mandate includes expanding access to treatment, preventing, reducing detention among individuals with behavioral health disorders, and serving as a statewide hub for treatment and diversion of resources.

[3] This name change took effect on January 18, 2024, under the Moore-Miller Administration. Previous and existing documents and agreements that refer to the agency as GOCPYVS remain valid.

Together, these Centers support the statewide coordination and implementation of behavioral health crisis response strategies, including CIT programs, across Maryland.

CIT programming is explicitly listed among the core activities of BHPS-CoE. The BHPS-CoE provides technical assistance and training for CIT, including:

- Curriculum Development: Supporting the creation and refinement of CIT training materials.
- Evidence-Based Practices: Promoting best practices in law enforcement and mental health crisis response.
- Funding Support: Serving as a clearinghouse for identifying and disseminating information about federal and other funding opportunities to sustain CIT programs.

To advance the statewide development, implementation, and monitoring of the CIT model, the Centers of Excellence are partnering with the Maryland Behavioral Health Administration (BHA) to launch a standardized, statewide data collection and analysis initiative. CIT Coordinators will administer Qualtrics surveys developed by GOCPP in collaboration with local jurisdictions. Data will be collected at three intervals (i.e., pre-training, training completion, and six-months post-training) to assess the training impact on both participants and the broader community. Data collection begins on July 1, 2025 (Q1 FY2026), and findings will be displayed on a GOCCP-hosted dashboard with a target launch of October 2025 (Q2 FY2026).

2.2.1 GOCPP Role in Supporting CIT and the Strategic Plan

The following suggestions are drawn from Priority #2 and its associated objectives (2a and 2b) of the Strategic Plan developed by the Maryland Behavioral Health and Public Safety Center of Excellence (BHPS-CoE), housed within GOCPP. This plan was created by the Maryland Crime Research and Innovation Center (MCRIC) at the University of Maryland, College Park, and released in September 2023. It was developed in response to Senate Bill 857 (2021), which established the BHPS-CoE to strengthen coordination between behavioral health services and public safety systems.[4]

Key Strategic Recommendations for CIT Implementation

<u>CIT Coordination</u>

- Host joint training sessions to improve interagency and strengthen team-based crisis response.
- Establish shared policies and procedures to formalize partnerships between law enforcement and behavioral health agencies.

[4] Maryland Crime Research and Innovation Center [MCRIC]. (2023). Behavioral health professional studies: Center of Excellence report [Technical report]. University of Maryland. https://go.umd.edu/BHPS-CoE-Report.

- Convene stakeholders regularly to promote ongoing communication and strategic alignment.

CIT Training

- Offer regular CIT refresher courses and explore innovative approaches to better serve diverse populations and emerging needs.

Coordination with the Behavioral Health Administration

- Interagency collaboration to secure funding to support CIT training, staffing, and related travel expenses.
- Assist local programs in identifying and applying for federal funding such as Substance Abuse and Mental Health Services Administration (SAMHSA's) Mental Health Awareness Training Grants.

Officer Selection & Program Infrastructure

- Maintain an updated list of active CIT officers by jurisdiction for recruitment and collaborative planning.
- Develop and manage an email list for CIT coordinators statewide.
- Facilitate monthly virtual meetings for CIT coordinators to strengthen peer support and foster a statewide learning community.

CIT Training Feedback

- Utilize tools such as Police-Mental Health Collaboration (PMHC) data collection to track key indicators (e.g., training coverage, cultural competency, diversion outcomes, use of force)[5]
- Support jurisdictions in collecting and analyzing implementation and outcomes data
- Provide technical assistance for peer-reviewed and third-party evaluations to support ongoing assessment of CIT program impact.[6]

Connection to GOCPYVS Center of Excellence

- Assess the feasibility of establishing a liaison role between the BHPS-CoE and Justice Reinvestment Act initiatives to enhance interagency communication and expand diversion opportunities for individuals with behavioral health needs

Community Collaboration

- Increase public awareness of CIT programs and available behavioral health resources
- Engage community-based organizations, advocates, and individuals with lived experience to ensure programs are relevant, inclusive, and responsive
- Encourage smaller jurisdictions to partner with neighboring agencies for regional CIT training opportunities

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[5] United States Department of Justice. (n.d.) Measuring performance: Police-Mental Health Collaboration (PMHC) Toolkit. Bureau of Justice Assistance. https://bja.ojp.gov/program/pmhc/measuring-performance

[6] Substance Abuse and Mental Health Service Administration. CIT Best Practices Guide: Methods for Using Data to Inform Practice: A Step-by-Step Guide. (2018) United States Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/sma18-5065.pdf

- Promote phased system development and resource-sharing models to support rural areas

2.3 BHA's Role in Supporting CIT Programs

BHA partners with BHPS-CoE to support and oversee the implementation of CIT programs across Maryland's jurisdictions. BHA allocates funding to strengthen statewide efforts in CIT coordination and training.

Each local behavioral health authority operates under a jurisdiction-specific Scope of Work (SOW), which includes the following activities:

- CIT program coordination, training, outreach, and public education.
- Participation in jurisdiction advisory meetings and CIT Coordinator meetings hosted by GOCPP.
- Engagement with state-level partners, including attendance at meetings and events hosted by the Centers of Excellence.

Training Activities outlined in the SOW

- Delivery of the 40-hour Crisis Intervention Team Model Standard Training Curriculum developed by the Centers of Excellence and adopted by the Police Training and Standards Commission.[7]
- Annual CIT refresher training.
- Administration of pre- and post-training surveys to evaluate knowledge gains and training impact.

State-Level Partnership Responsibilities:

- Participation in quarterly CIT Coordinator meetings.
- Engagement in the annual State Summit on Behavioral Health and the Justice System, which utilizes Sequential Intercept Model (SIM) Mapping Initiative.
- Attendance at Maryland-based CIT conferences and related statewide events.

Monitoring

To assess CIT implementation activity and progress, jurisdictions are required to submit quarterly data to BHA that captures participation levels and activity volume across all SOW components.

In addition, BHA is working in collaboration with GOCPP to develop a centralized database that will support the tracking of training efforts, implementation milestones, and post-training outcomes.

[7] Public Safety Education & Training Center. (April 4, 2025). Police Training and Standards Commission Model Policy Crisis Intervention Team Model Standard Training Curriculum. https://mpctc.dpscs.maryland.gov/pdf/Crisis%20Intervention%20Standard%20Training%20Curriculum.pdf

2.4 Maryland CIT Coordinator Interviews

To enhance understanding of CIT program implementation across Maryland, UMB—in collaboration with GOCPP, MCRIC, and BHA—conducted a comprehensive statewide assessment of CIT programs and efforts.

The initial phase of this assessment involved structured interviews with CIT Coordinators representing all 24 Maryland jurisdictions. These interviews focused on evaluating critical components of each CIT program, including organizational structure, training practices, implementation strategies, funding sources, interagency collaboration, coordinator responsibilities, and technical assistance needs.

Between September 12 and 19, 2024, the UMB team conducted 19 virtual interviews via Zoom. To streamline the process, certain jurisdictions were combined—specifically, the five Mid-Shore counties and the Wicomico/Somerset region. The project was reviewed by the Institutional Review Board (IRB) and classified as Not Human Subjects Research (NHSR), thereby exempting it from IRB oversight.

Each interview lasted approximately one hour and followed a standardized protocol consisting of 27 questions. Responses were categorized into six thematic areas:

1. CIT Coordinator Role
2. CIT Training Specifics
3. Funding
4. Training Feedback and Follow-Up
5. Access to GOCPP Technical Assistance
6. CIT Collaboration and Community Engagement

2.4.1 General Findings of Initial CIT Coordinator Interviews

The following summarizes key themes and observations from interviews with CIT Coordinators across Maryland's 24 jurisdictions:

Areas	Themes & Observations
Staffing	All jurisdictions have designated CIT Coordinators, though their employing agencies vary. Of the jurisdictions contacted, 11 Coordinators are based within Local Behavioral Health Authorities (LBHAs), which are often divisions of local health departments. In other jurisdictions, Coordinators are employed by local crisis providers or law enforcement agencies. While some jurisdictions exhibit strong structural integration between law enforcement and CIT Coordinators, others maintain a more collaborative, partner-based relationship.
Training	All jurisdictions have access to a 40-hour CIT training program aligned with the GOCPP curriculum. In one case, a county participates in sessions hosted by a neighboring jurisdiction. We confirmed that 8 jurisdictions offer CIT-specific refresher courses, and 5 provide complementary or specialized trainings that incorporate CIT-related content—such as de-escalation techniques, recognizing

Areas	Themes & Observations
	hidden mental health conditions, and suicide intervention. Core topics across training programs include de-escalation, mental health and substance use disorders, trauma-informed care, and perspectives from individuals with lived experience. While site visits are commonly part of the curriculum, their use and frequency vary by jurisdiction.
Trainers	Most jurisdictions rely on a lead CIT coordinator supported by local subject matter experts, behavioral health professionals, and peer trainers with lived experience.
Funding	Most CIT programs receive primary funding from BHA, with limited resource sharing across jurisdictions. Some jurisdictions also secure supplemental funding from local governments or agency-specific sources.
Officer Selection and Tracking	Officer selection processes for CIT training vary across jurisdictions. In some areas, officers volunteer for CIT roles, while in others, assignments are made by leadership. Tracking of trained officers is inconsistent: some departments maintain formal databases, others use manual lists, and a few do not track participation at all.
Implementation	All jurisdictions reported active deployment of CIT-trained officers. Implementation models differ—some jurisdictions operate dedicated CIT units, while others embed CIT-trained officers within general patrol operations. The extent of officer engagement and the application of CIT practices vary across departments.
Feedback and Evaluation	Most programs conduct pre- and post-training assessments along with participant satisfaction surveys. However, follow-up coaching is limited. A few jurisdictions provide in-service support or consultation to reinforce skills learned during training.
Technical Assistance	Coordinators expressed a growing need for technical assistance to support effective CIT program implementation and monitoring. Engagement with GOCPP's Centers of Excellence varied by jurisdiction. Several coordinators cited the need for additional support in curriculum development, outcome measurement, and statewide standardization of CIT practices.
Community Collaboration	Nearly all jurisdictions reported collaboration between CIT officers and mobile crisis teams. Many also maintain advisory committees that include representatives from law enforcement, behavioral health agencies, and community-based organizations.
State CIT Conference	Awareness of and participation in the State CIT Conference varied significantly. While some jurisdictions are actively engaged in planning and regularly attending events, others reported limited awareness of upcoming conferences.

The accompanying figure shows the number of law enforcement officers trained in CIT programs across Maryland during State Fiscal Years 2022–2024. These counts exclude non-law enforcement personnel (e.g., EMS, dispatchers). In some cases, the figures are estimates and may include officers from other jurisdictions who attended local training sessions. Accurately calculating the percentage of trained officers within each jurisdiction is challenging due to the lack of publicly available law enforcement payroll data and unclear reporting regarding which types of personnel (e.g., EMS, patrol officers, corrections) are receiving training.

Jurisdiction	SFY22	SFY23	SFY24	Total
Capital Region				
Frederick	127	49	24	200
Montgomery	130	130	130	390
Prince George's County	Unknown*	50	44	94*

Jurisdiction	SFY22	SFY23	SFY24	Total
Central Region				
Anne Arundel	37	34	14	85
Baltimore City	108	64	97	269
Baltimore County	52	20	24	96
Carroll County	16	18	24	58
Harford County	100	91	107	298
Howard	51	35	44	130
Eastern Region				
Cecil	2	2	1	5
Mid-Shore	65	22	18	105
Somerset	7	19	8	34
Wicomico	23	17	22	62
Worcester	20	19	24	63
Southern Region				
Calvert, Charles, St. Mary's	78	101	65	244
Western Region				
Allegany	0	0	0	0
Garrett	0	0	0	0
Washington	0	0	0	0

*Changed CIT training vendor in 2022, SFY22 data not available.

2.4.2 Key Needs Identified through Maryland CIT Coordinator Initial Interviews

The interviews revealed several recurring needs consistently identified by CIT Coordinators across jurisdictions:

Need	Description
Enhanced Tracking and Evaluation	A need for more robust systems to monitor and assess CIT program outcomes, including officer performance, community impact, and long-term effectiveness.
Standardized and Updated Training Curricula	Requests for greater consistency in training content across jurisdictions, along with updates that reflect current best practices and emerging challenges.
Stronger Integration with Behavioral Health and Crisis Systems	Improved coordination between CIT programs and local behavioral health providers, mobile crisis teams, and emergency response infrastructure.
Expanded Peer Learning and Technical Assistance	Increased desire opportunities to share best practices, engage in peer-to-peer learning, and access consistent technical assistance statewide.
Clearer Guidance on GOCPP Center Support	The need for well-defined roles, expectations, and communication channels regarding the support available from the GOCPP BHPS-CoE.

2.4.3 Follow up Survey & Findings from Maryland CIT Coordinators

Follow-up surveys with CIT Coordinators were conducted in February and March 2025 to gather more in-depth information about CIT implementation within each jurisdiction. The survey, administered via Qualtrics and distributed by email, included a series of targeted questions. Both the survey questions and responses are provided below. UMB received responses from 22 counties, including: Howard County, Anne Arundel County, Allegany County, Montgomery County, Frederick County, Baltimore City, Calvert County, Charles County, St. Mary's County (served by a single coordinator), Washington County, Prince George's County, Garrett County, Carroll County, Worcester County, Baltimore County, Somerset County, Harford County, and the five Mid-Shore counties.

Question Areas	Responses
Jurisdiction Strategic Plans, Logic Models or Advisory Boards that Guide CIT implementation and training	• Six counties reported having advisory boards that meet either quarterly or monthly. Additionally, two counties have established steering committees. • In the Mid-Shore region, updates are also shared during the monthly Forensic Workgroup meetings hosted by the Maryland Department of Health's Behavioral Health Administration (MDH BHA). • Calvert County convenes a biweekly Southern Maryland Regional CIT meeting to support coordination and planning. • Wicomico and Somerset counties are developing a CIT curriculum and training program in partnership with the Eastern Shore Criminal Justice Academy. • In Carroll County, the CIT program does not currently align with the county's Sequential Intercept Model map; however, coordinators meet bi-monthly to discuss program goals and priorities.
CIT Implementation Partnerships	• Ten counties reported having some form of crisis response partnership, such as a mobile crisis unit or other intervention model. • Nine counties indicated an existing partnership with the National Alliance on Mental Illness (NAMI), while one county expressed interest in strengthening that relationship.[8] • Twelve counties reported integration or collaboration with community-based mental health and substance use organizations, hospitals, or other local partners. • Baltimore City enables officers to contact 988 to connect individuals with mental health or substance use services. A counselor provides phone-based triage and either offers resources or dispatches a mobile crisis unit. The Baltimore Police Department (BPD) partners with Baltimore Crisis Response, Inc. (BCRI), which conducts on-scene evaluations and transports eligible individuals to its facility. BPD also maintains a co-responder team, available daily from 11 a.m. to 7 p.m., to support crisis response operations. • Frederick County utilizes a mixed-responder model in which local police, mental health professionals, and EMTs jointly respond to 911 calls involving behavioral health crises.

[8] National Alliance on Mental Illness. (February 12, 2025). "Crisis intervention team (CIT) programs." Accessed June 30, 2025. https://www.nami.org/advocacy/crisis-intervention/crisis-intervention-team-cit-programs/.

Question Areas	Responses
CIT-Trained Officers Identified and Dispatched in Jurisdiction	• Dispatch and organizational practices for CIT-trained officers vary across jurisdictions. Approximately half of respondents reported that officer tracking is either not conducted or remains unclear. • Several counties noted that CIT-trained officers are integrated within general patrol units and are not organized as a distinct group. • Baltimore City dispatchers are aware of all CIT officers on duty at the time of a call, and it is mandatory to request a CIT officer for any behavioral health-related call. • Harford County identifies CIT officers by uniform pins and, soon, vehicle stickers. Daily staff schedules highlight CIT-trained personnel, which dispatchers use to assign relevant calls.
CIT-trained officer's role in leading a crisis response	• The role of CIT-trained officers in crisis responses varies across counties. Several jurisdictions assign CIT officers as de-escalation leads during behavioral health incidents. Two counties reported having no formal protocol outlining CIT officer roles, and one county was unsure. • Harford County: CIT-trained officers assist non-CIT personnel in de-escalating situations until the mobile crisis unit arrives. They also participate in the Harford County Crisis Negotiation Team (CNT). • Baltimore County: The county includes CIT-trained officers both within and outside the co-responder unit. Officers in the co-responder unit follow a formal dispatch protocol, while those outside operate under a more informal system. • Baltimore City, Montgomery County, and Allegany County: CIT-trained officers take the lead on behavioral health calls. In Baltimore City, the lead officer on scene is also responsible for incident documentation.
CIT-trained officers and mental health referrals	• In seven counties, CIT-trained officers directly contact 988, mobile crisis units, or other behavioral health resources to assist individuals in need of mental health support. One county reported having no formal referral protocol, while another was unsure. • Harford County: Officers complete a Field Interview Report (FIR) to flag individuals who may require mental health services. The report is submitted to the Crisis Response Unit, which follows up in person or by phone. • Mid-Shore Region: CIT coordinators monitor a central referral email three times daily. Referrals flagged as appropriate are forwarded to the Mobile Crisis Team. Officers may also contact behavioral health resources directly, as needed.

Additionally, CIT Coordinators reported on the types of data they track related to CIT programs as follows:

CIT Impact Questions	Summarized Responses
Enhanced community perception of law enforcement	• Carroll County: During follow-up with individuals referred by CIT-trained officers, respondents are asked about their perceptions of the interaction. • Baltimore City: The Police Department distributes community surveys to assess public perceptions of law enforcement, including responses to behavioral health-related calls. • Harford County: Residents report viewing officers as caring—a crucial factor in reducing stigma and building trust.

CIT Impact Questions	Summarized Responses
	• Other Jurisdictions: About half indicated that this type of information is either not collected or not reported. Among those that do not track community perception, methods and frequency vary.
Fewer arrests and increased jail diversion	• Several respondents reported tracking or enhancing diversion efforts through various mechanisms, including co-responder teams, annual CIT awards programs, feedback from law enforcement agencies, the Emergency Services Crisis Response System (ESCRS), and LEADs teams. • Baltimore City promotes a "least police-involved response" approach for all behavioral health-related calls and emphasizes diversion to appropriate community resources whenever possible. Behavioral Health System Baltimore operates a LEADs program in partnership with the Baltimore Police Department, enabling officers to divert individuals to mental health or substance use services when appropriate.
Improved healthcare referrals and connections to mental health treatment	• In two counties, officers reported being better informed about available county resources, leading to improved referral outcomes. • More than half of respondents did not provide additional details on this topic. • Two counties indicated that referral tracking is supported through mechanisms such as annual CIT awards programs, law enforcement agency feedback, and tools like the MCT Survey, Credible, and the CIT referral email system. • Baltimore County: The co-responder team monitors referrals and service connections both at discharge and throughout each case. • Baltimore City: Behavioral Health System Baltimore (BHSB) employs dedicated staff to collect data and track the field placement of individuals receiving crisis response services, including whether they are successfully connected to ongoing care.
Decreased injuries to both law enforcement and citizens	• Most respondents either did not elaborate or indicated that this information is not currently tracked specifically for CIT officers. However, it was noted that CIT-trained officers are generally perceived as using less physical force. Where data is collected, it is typically maintained by individual law enforcement agencies or through annual CIT awards programs. • Baltimore City: Department policy mandates a Use of Force Assessment for any injuries sustained during behavioral health-related calls.
Reduced crisis response times	• Reduced crisis response times are tracked using a variety of methods, including CAD systems, LBHA call time logs, annual CIT awards programs, law enforcement agency feedback, Credible, and MCT surveys. • Harford County reported a decrease in the time needed to de-escalate crisis situations. • Baltimore City: Behavioral Health System Baltimore (BHSB) monitors response times for all mobile crisis teams to improve operational efficiency and the experience of individuals in crisis.
Increased officer confidence in handling mental health crises	• Officer confidence is measured through pre- and post-tests conducted during the 40-hour CIT training and through assessments by Mobile Crisis Teams (MCTs).

CIT Impact Questions	Summarized Responses
	• Harford County reports that the training has boosted officers' confidence in managing behavioral health calls and contributed to reducing stigma related to law enforcement interactions.
Improved law enforcement perception of individuals with mental illness	• Harford County reported that individuals who have interacted with CIT-trained officers often request them again, citing the officers' understanding and compassionate approach. • Other departments either did not provide additional detail or noted receiving similar feedback through pre- and post-training evaluations or annual CIT awards programs.

2.5 Maryland Law Enforcement Training Academy Interviews

The second phase of the analysis involved interviews with representatives from Maryland's law enforcement training academies to explore how CIT and behavioral health-related curricula are taught, implemented, and reinforced through academy instruction and coaching. These interviews were conducted via Zoom throughout February 2025, with eight of the state's 20 academies responding to interview requests.

A key finding was that several academies have fully integrated CIT training into their cadet curricula and provided detailed insights into their implementation strategies. In contrast, academies that do not include CIT in their formal curriculum reported that such training is typically delivered by external providers. These academies offered perspectives on the effectiveness of those external efforts and outlined the behavioral health topics incorporated within their cadet training programs.

2.5.1 Behavioral Health Training Overview Across Jurisdictions

Behavioral Health Training Curriculum Provided by Maryland's Police Academies

Most jurisdictions provide some form of behavioral health training for entry-level patrol officers, distinct from formal CIT instruction. Common components include:

- De-escalation Techniques: Many academies incorporate scenario-based approaches—such as Integrating Communications, Assessment, and Tactics (ICAT)—to help officers manage high-stress encounters effectively.
- Mental Health First Aid: Officers receive foundational training in identifying and responding to individuals experiencing mental health crises.
- Training on Developmental Disabilities: Providers like Pathfinders for Autism offer guidance on engaging with individuals who have autism or other developmental disabilities.
- Emergency Petition (EP) Procedures: Instruction covers the legal and procedural steps for initiating emergency mental health evaluations.

- Collaboration with Community Partners: Trainings emphasize coordination with crisis services, clinical professionals, and local health departments to promote integrated response strategies.

Variation in CIT Training Across Maryland's Police Academies

The extent to which CIT training is integrated into Maryland's police academies varies widely by jurisdiction. The table below highlights differing approaches to the 40-hour CIT training model:

Element	Details
Use of the 40-Hour CIT Model	CIT Trainings are primarily organized by jurisdiction-specific CIT Coordinators. Twelve counties, including Anne Arundel County and the Eastern Shore, host the 40-hour training within their police academies. Three counties hold training outside of the academy, often in collaboration with community and behavioral health professionals. Some jurisdictions did not indicate a training location, while others send officers to programs hosted by neighboring counties. Training participation may be voluntary, disciplinary, or mandatory, depending on the jurisdiction.
Entry-Level vs. Lateral Officer Training	Entry-level officers consistently receive behavioral health content as part of academy training. However, training for lateral officers varies widely. Some receive foundational instruction, others complete comparative compliance courses, and in certain cases, prior training is reviewed for equivalency. Notably, some academies, such as Southern Maryland and Harford County, do not provide direct behavioral health training for lateral officers.
Tracking and Evaluation	Approaches to tracking CIT-trained officers vary, even among academies not directly involved in delivering CIT instruction. Anne Arundel County, Prince George's County, and the University of Maryland College Park use internal systems or spreadsheets. In contrast, the Department of Public Safety and Correctional Services (DPSCS) and Maryland State Police report challenges with centralized tracking efforts.

Insights from Academy Representatives

Academy representatives shared perspectives on the broader impact of CIT and behavioral health training within their jurisdictions. Many emphasized the importance of specialized units and collaborative relationships with behavioral health systems:

- Anne Arundel, Baltimore County, and Montgomery County have established dedicated CIT units embedded within their law enforcement or crisis response systems, working closely with clinicians and crisis centers.
- Harford County and the Eastern Shore maintain strong partnerships with mobile crisis teams, walk-in centers, and nonprofit behavioral health organizations.

2.5.2 Maryland Academy Improvements to Implementations

Adapted Approaches to CIT Implementation

Several training academies reported innovations in how they implement CIT training, modifying their original practices to better align with the unique needs and cultures of their local communities and law enforcement agencies. Key examples include:

- University of Maryland, College Park (UMCP): The UMCP Training Academy developed and now delivers its own internal CIT training program. This shift stemmed from dissatisfaction with the previous external training provider and a desire for a more tailored, effective curriculum. Academy representatives emphasized the need to balance a focus on officer safety with effective engagement strategies for individuals in crisis.
- Montgomery County: Montgomery County rebranded its CIT initiative as the Crisis Response Team, specifically designed to respond to high-acuity behavioral health calls. This multidisciplinary team includes law enforcement officers, clinicians, and social workers, enabling a more comprehensive and coordinated crisis response.

2.5.3 Maryland Academies: Reported Areas of Improvement

During interviews, academy representatives identified several recurring areas for growth related to behavioral health training and their understanding of CIT-trained patrol officers in the field.

Key themes included:

Themes	Details
Lack of Standardized Refresher Training	Many jurisdictions highlighted the need for consistent follow-up or refresher training to reinforce CIT principles and skills over time.
Limited Use of Data for Evaluation	Few programs systematically track outcomes such as emergency petitions (EPs), arrests, or use-of-force incidents, limiting evaluation capacity.
Gaps in Training for Special Populations	Some jurisdictions are developing modules focused on dementia, autism, and veterans, while others are only beginning to address these areas.
Unsystematized Coordination and Data Sharing	Communication and data sharing among CIT coordinators remain informal and inconsistent, highlighting the need for a more structured statewide approach.

2.6 Aim #1 Observations & Recommendations

Maryland has made considerable progress in building a solid foundation for statewide CIT implementation statewide. Key accomplishments include:

- The designation of CIT Coordinators in every jurisdiction,
- The availability of the 40-hour CIT training curriculum for patrol officers across jurisdictions,
- The establishment of the BHPS-CoE to support and coordinate statewide efforts, and
- Ongoing review of BHA's Scope of Work for FY26.

These foundational elements, in coordination and training, represent some of Maryland's most valuable assets in advancing the effectiveness and reach of CIT initiatives.

Strengthening Maryland CIT: UMB's Recommendations for Sustainable Impact

1. Clarify and Expand the Role and Impact of CIT Coordinators
   - Clearly define and broaden the roles and responsibilities of CIT Coordinators.
   - Track how CIT Coordinators apply their training and leadership in the field.
2. Enhance Regional Implementation Strategies
   - Coordinate training efforts in Garrett and Allegany Counties to improve efficiency.
   - Clarify and define CIT implementation strategies within regional groupings, (e.g., Southern Maryland and the Eastern Shore) to ensure:
     - Individual county goals and community needs are addressed.
     - Unique infrastructure, leadership, and local priorities are incorporated.
3. Expand Community Partnerships
   - Strengthen collaboration between law enforcement and mental health providers, including receiving facilities, to ensure effective behavioral health response pathways for CIT-trained officers.
4. Improve Data Integration and Use
   - Track and analyze CIT applications, particularly related to emergency petitions, including volume and underlying causes.
   - Develop mechanisms for statewide sharing of CIT implementation data to promote peer learning during quarterly CIT Coordinator meetings.
   - Identify key data elements to enable collaborative, data-driven improvements across jurisdictions.
   - Support jurisdictions in setting up systems to collect and manage CIT-related data.
5. Expand Strategic Technical Assistance
   - Provide technical assistance (via BHPS-CoE or UMB) to help jurisdictions:
     - Review the status of BHPS-CoE strategic plan recommendations (implemented and outstanding).
     - Develop strategic plans, logic models, and measurable outcomes.
     - Implement CIT International best practices tailored to local contexts.
6. Bolster State-Level Collaboration and Support
   - Assess progress on the BHPS-CoE Strategic Plan to identify completed and outstanding recommendations.
   - Strengthen interagency coordination between GOCPP and BHA to better align funding, scope of work, and technical assistance with local needs.
   - Increase state funding to support the development and sustainability of CIT infrastructure in jurisdictions.
   - Improve alignment between CIT efforts and BHA's statewide crisis response model and goals.

- Strengthen CIT integration with the Sequential Intercept Model (SIM) in each jurisdiction to support cross-system collaboration and continuity of care.

3. Assessing Maryland's CIT Program Through the Lens of CIT International Standards (Aim #2)

This section evaluates the alignment between CIT training and implementation across Maryland and CIT International's Best Practice Standards, while also highlighting relevant local and national programs. It specifically examines:

- The extent to which Maryland jurisdictions meet CIT International's fidelity expectations,
- The effectiveness of core elements like the 40-hour CIT curriculum,
- Key components that lack full fidelity in implementation, and
- How jurisdictions monitor fidelity, and how these methods compare to CIT International's recommendations.

This analysis highlights both strengths and gaps in Maryland's CIT programs, offering guidance for improved statewide consistency and coordination.

3.1 CIT International Recommended Best Practices

CIT best practices, as outlined in *CIT International's Best Practice Guide for Transforming Community Response to Mental Health Crisis*[9], offer a comprehensive framework to improve the effectiveness, compassion, and coordination of mental health crisis response. The ten core principles presented serve as benchmarks for high-fidelity CIT programs.

Core Principles	Activities
Establish Strong, Sustained Partnerships	• Cross-Sector Collaboration: Engage law enforcement, behavioral health, advocacy groups, hospitals, and social services. • Ongoing Communication: Maintain regular dialogue to share insights and adapt to evolving needs.
Emphasize a Community-Based Approach	• Community Ownership: Involve local leadership and stakeholders in sustainability. • Public Awareness: Educate the public to reduce stigma and encourage early intervention.
Provide Specialized Training for Law Enforcement and Dispatchers	• Comprehensive 40-Hour Training: Cover de-escalation techniques, mental health, and scenario-based learning with diverse input (e.g., clinicians, individuals with lived experience, and family members). • Dispatcher Training: Train dispatchers to recognize behavioral health crises and appropriately route. • Ongoing Education: Offer advanced and refresher courses.

[9] CIT International. (2019, August). CIT International's best practice guide for transforming community response to mental health crisis.

Core Principles	Activities
Develop Clear Policies and Procedures	• Standardized Protocols: Define response, transport, and referral procedures. • Role Clarity: Ensure all participants understand their responsibilities during crisis situations.
Ensure Access to Mental Health Receiving Facilities	• Facility Partnerships: Coordinate with mental health facilities to Collaborate with designated mental health facilities to avoid emergency departments or jails. • Streamlined Transitions: Ensure efficient handoffs between law enforcement and care providers.
Implement Data Collection and Program Evaluation	• Key Metrics Tracking: Monitor outcomes (e.g., resolutions, referrals, use-of-force, response time). • Performance Evaluation: Assess training, protocols, and collaboration. • Transparent Reporting: Share results to guide improvement.
Foster a Culture of Recognition and Accountability	• Acknowledgment of Contributions: Recognize all participants involved. • Feedback Mechanisms: Encourage input to refine program and promote transparency.
Prioritize Safety and De-Escalation Techniques	• De-Escalation Focus: Emphasize communication strategies over force • Trauma-Informed Practices: Train responders to minimize re-traumatization.
Promote Community Outreach and Expansion	• Support for New Programs: Help other communities establish CIT. • Ongoing Outreach: Provide public education and engagement.
Secure Sustainable Funding and Resources	Long-Term Funding Strategies: Advocate for stable financial support. Resource Sharing: Partner across sectors to build and sustain programs.

3.2 CIT Best Practices Identified in Maryland

Interviews and surveys revealed that each jurisdiction in Maryland implements CIT practices based on the unique needs of their local partners and communities. While there is clear statewide commitment to delivering CIT training curricula, the adoption of other recommended best practices varies. Some jurisdictions have begun to incorporate additional components aligned with CIT International's standards, while others remain in earlier stages of implementation or have not yet adopted them. This variation highlights both the flexibility of local implementation and the opportunity for greater consistency and alignment with national best practices.

CIT Best Practices	Evident	Underway Partially*	Not Evident
Strong, Sustained Partnerships		X	
Community-Based Approach		X	
Specialized Training for Law Enforcement and Dispatchers	X		
Clear Policies and Procedures		X	
Access to Mental Health Receiving Facilities			X
Data Collection and Program Evaluation		X	
Culture of Recognition and Accountability		X	

Prioritize Safety and De-Escalation Techniques	X		
Promote Community Outreach and Expansion		X	
Secure Sustainable Funding and Resources		X	

*Underway Partially indicates implementation in some, but not all, jurisdictions.

3.3 CIT International Certification Process and National Sites

In May 2025, UMB met with a CIT International Board Member to gain a deeper understanding of the CIT Certification process. Insights from this conversation, along with information available on the CIT International website,[10] are summarized below. Additionally, the Board Member connected our team with representatives from the State of Virginia to learn more about their robust implementation efforts. These are described in detail in Section 3.5.

3.3.1 CIT International Certification Criteria for Platinum and Gold Programs

CIT International offers a formal certification process for state, regional, and agency-level CIT programs. Certification is awarded at one of four levels—Platinum, Gold, Silver, and Bronze—based on how comprehensively a program has adopted and implemented CIT best practices (*CIT International, n.d.*). Platinum and Gold certifications are granted to regional CIT programs that demonstrate excellence in the following core areas:

Core Area	Description
Comprehensive Training	Certified programs must provide a 40-hour CIT training for law enforcement, covering such topics as mental health, substance use, de-escalation, communication, and officer safety. Trainings are delivered by professionals and individuals with lived experience.
Collaborative Partnerships	Programs must have strong, sustained partnerships with organizations like NAMI, behavioral health agencies, hospitals, and advocacy groups. These collaborations help dismantle silos and support coordinated crisis response systems.
Diversion from the Criminal Justice System	Certified programs prioritize diverting individuals in crisis away from arrest and toward appropriate mental health services.
Community Engagement	Programs engage in public education, outreach, and advocacy to reduce stigma and raise awareness of mental health resources

3.3.2 CIT International Platinum Certification: Anne Arundel County, MD

Among the 20 regional programs awarded Platinum certification, Anne Arundel County in Maryland stands out as a national leader.[11] Notable highlights include:

- Dedicated CIT Unit: Officers are fully integrated within the Crisis System and collaborate closely with Crisis Response Clinicians, both in co-response teams and independently, to assist community members in need.

[10] CIT International. (n.d.) CIT program certification. Retrieved May 20, 2025, from https://www.citinternational.org/CITProgramCertification.
[11] County Office.org. Anne Arundel County Police Department - Millersville, MD. https://www.countyoffice.org/anne-arundel-county-police-department-millersville-md-9a2/.

- Comprehensive Training: All officers receive at least 40 hours of mental health and de-escalation training.
- National First: Anne Arundel became the first major police department in the U.S. to train 100% of officers in Mental Health First Aid.
- Robust Partnerships: Strong collaborations with NAMI and local crisis response providers enhance coordination and service delivery.
- Co-Responder Model: Clinicians and CIT-trained officers jointly respond to calls, ensuring immediate and informed on-scene crisis intervention.
- Imbedded Culture: CIT values are woven into departmental identity, with officers proudly wearing CIT pins.
- Exceeding Standards: The department surpasses the International Association of Chiefs of Police (IACP) benchmark 20% of officers' CIT training.

Additional details, including Anne Arundel's CIT International Certification report, relevant policies and procedures on emergency petitions, mobile crisis teams, and behavioral health protocols, can be found in Appendices B-E. These documents further illustrate the strength and sophistication of the county's CIT coordination and implementation.

3.3.3 CIT International Gold Certification: National Examples

Gold certification is awarded to regional programs that have implemented most CIT best practices and trained at least 20–25% of their officers. These programs demonstrate strong foundational implementation and a commitment to continuous improvement.

Gold-Certified Regions Include:

Location	Highlights
Central Valley, AZ	Grassroots training led by volunteers with lived experience.
Detroit-Wayne, MI	Systemic model emphasizing policy development and research.
Calhoun County, MI	Inclusive training extended to dispatchers and corrections staff.
Trillium Health, NC	Expansive curriculum supported by strong academic partnerships.
Mat-Su Coalition, AK	Rapid expansion featuring mobile crisis teams and EMS-police integration.
St. Joseph County, IN	Emphasis on crisis center coordination and infrastructure development.
Region 7, ID	Multi-agency implementation at the regional level.
Orange County, CA	Specialized training for youth and comprehensive crisis response teams.

Although these programs share core principles, each takes a distinct approach tailored to its local community needs and available resources. According to a CIT International Board Member, the certification process is voluntary and based on self-reported data, reviewed by CIT International. As such, the list of certified programs does not capture all high-performing CIT initiatives statewide.

3.4 Local Leaders in CIT: Spotlight on Maryland Counties

Several Maryland counties are making impressive advancements in CIT initiatives by innovatively tracking behavioral health encounters and expanding support services. Harford County, for instance, collects detailed system-level data (see Appendix F), while St. Mary's and Howard Counties provide coaching following emergency petitions to support individuals in crisis.

Beyond Anne Arundel County—recognized by CIT International for its exemplary CIT programming—both Baltimore and Montgomery Counties have emerged as leaders through robust implementation strategies and innovative approaches. Additional details on these two counties are provided in the sections that follow.

3.4.1 Baltimore County

Affiliated Sante Group (Sante), the crisis services provider for Baltimore County, is funded by the Baltimore County Department of Health and plays a critical role in empowering the Baltimore County Crisis Response System (BCCRS). Through this support, Sante delivers urgent care, mobile crisis services, and in-home interventions to residents across the county. Their mission is focused on expanding access to high-quality mental health services, reducing the stigma surrounding substance use treatment, and prioritizing suicide prevention—particularly among Baltimore County youth.

A key innovation in their approach is a successful partnership with the Baltimore County Police Department. Together, they offer an alternative to traditional law enforcement responses by deploying co-responder teams composed of licensed behavioral health clinicians and specially trained CIT police officers. This collaborative model ensures that behavioral health crises receive appropriate, compassionate, and effective intervention, with direct linkage to community resources.

Equally notable is Sante's commitment to data-driven care. Their robust data collection efforts track a wide range of outcomes, including referrals, arrest records, diversions from jail, hospitals, and emergency petitions, as well as service connections at discharge. These metrics are monitored throughout each individual's engagement with law enforcement and crisis services, allowing for continuous quality improvement and impact assessment. See Appendix G for an overview of their comprehensive data collection framework.

According to the Mobile Crisis Team (MCT) report, between July 2023 and May 2024, the MCT responded to 2,433 calls for service, averaging about 203 calls per month. Police departments across the county served as the primary referral source, accounting for more than half of all dispatches (52%). Additional referrals came through 911 dispatch, MCT self-dispatch, 988 or local hotlines, and other sources.

In response to these calls, MCT teams employed a wide range of interventions tailored to the needs of individuals and families involved. Safety planning was the most frequently used intervention,

occurring in 1,426 cases, followed by behavioral health referrals (392), initiation of emergency petitions (348), verbal de-escalation techniques (325), and well-being checks (1,030).

Among the most common presenting issues were situational crises (772 cases), suicide attempts (491), chronic mental illness (332), depression (246), and delusions or hallucinations (271). These concerns speak to the broad scope of behavioral health conditions addressed by the MCT and highlight the team's capacity to manage both acute and chronic psychiatric needs.

Importantly, the data demonstrate significant success in diverting individuals from higher-cost or more punitive systems. Over the reporting period, 369 calls were diverted from emergency rooms, 345 from the initiation of emergency petitions, and 61 from entry into the criminal justice system.

The population served by the MCT reflects the diversity and complexity of behavioral health needs in Baltimore County. Clients ranged from young children to older adults, most being adults aged 22 to 64. Approximately 52% of clients were female, and 42% were male. Insurance data show that many individuals were uninsured or had unknown coverage status (over 1,570 cases), indicating potential barriers to access and a need for continued outreach to vulnerable and underserved groups.

With its focus on co-responder collaboration, systemic diversion from emergency and criminal justice systems (punitive interventions), and data-driven improvement, Baltimore County MCT stands as out as model program for behavioral health crisis response to share statewide and nationally.

3.4.2 Montgomery County

The Montgomery County Police Department (MCPD) CIT program is built on a robust community partnership that includes law enforcement, mental health and addiction professionals, individuals with lived experience, family members and advocates.[12] This innovative, first-responder model delivers police-based crisis intervention training designed to divert individuals from the criminal justice system and connect them to appropriate mental health and medical care. The program also prioritizes the safety of officers and community members in crisis.

All MCPD officers are required to complete CIT training after finishing their field training program. In addition to department-wide implementation, MCPD operates a specialized five-officer Centralized Crisis Intervention Team (CCIT) that responds to behavioral health emergencies and supports patrol officers during such incidents.

The Montgomery County CCIT focuses on education, outreach, follow-up, empowerment, and response for residents affected by mental illness, Autism Spectrum Disorder (ASD), intellectual and developmental disabilities (IDD), Alzheimer's disease, and dementia. CCIT officers respond

[12] Montgomery County, Maryland. "Montgomery County Police Department: About Us Page". https://www.montgomerycountymd.gov/pol/about.html

to a range of critical situations, including mental health crises, traumatic incidents, and the service of Extreme Risk Protective Orders (ERPOs). While patrol officers handle any criminal elements, CCIT officers specialize in behavioral health intervention and de-escalation. When not present at the scene, they remain available for phone consultation and can respond to patrol officers when needed. They primarily operate Monday through Friday during regular business hours, with on-call availability after hours.

To foster trust and reduce stigma, CCIT officers drive unmarked vehicles, wear CIT identification patches, and are differentiated within internal systems. The department is also exploring softer, more approachable uniforms to support community engagement.

This program emerged in response to the growing number of behavioral health-related calls and the increasing population of individuals living with mental illness in Montgomery County. As other community support systems have declined, law enforcement has faced rising demands for crisis response. CCIT officers are trained to apply sound judgment, de-escalation techniques, and appropriate referrals to connect individuals with needed services and support.

Montgomery County Crisis Intervention Response: Operational Structure and Outcomes

MCPD has established well-documented policies that guide patrol officers when responding to or encountering situations exhibiting behaviors consistent with a mental disorder or crisis and follow-up protocols (see Appendices H and I). According to department protocol, CCIT officers are expected to take command of any behavioral health-related call, like how investigators lead major crime scenes. They respond to a wide range of critical incidents, including:

- Suicides in progress,
- Critical incidents at schools,
- Actively violent individuals with mental health conditions,
- Critical missing persons with concerns related to mental health, autism, or IDD, and
- Any behavioral health call requiring specialized intervention.

The CCIT operates within an integrated system that includes strong partnerships with the county's crisis center and the Department of Health and Human Services (HHS). Crisis Center staff are CIT-Trained and coordinate directly with CCIT to ensure a seamless response. To support consistency in response, crisis center staff receive CIT training. Officers are embedded within both the crisis center and HHS facilities, facilitating real-time communication and coordination. An HHS clinician is also co-located with the CCIT unit, to manage high-acuity cases and bridge the gap between public safety and the mental health services. A revised Memorandum of Understanding (MOU) between MCPD and HHS is currently underway and expected to be finalized by the end of 2025.

MCPD's CCIT and broader behavioral health response initiatives manage a significant and sustained volume of calls. Responses often coincide with ERT deployments (barricaded subjects)

or when ERPO's are initiated. A supervisor therapist from HHS, assigned to CCIT unit, documents call data. From January to April 2025, reported activities included:

Total Contacts including calls for service, telephone/email consultations	125 (Jan: 14; Feb; 22; Mar: 47, April: 42)
Police Consultations	36
Community Activity Events/Engagements	6

This local data represents just one component of Montgomery County's behavioral health response system, which also includes MCOT-CIT co-responder units, emergency petition protocols, mobile crisis teams, and specialized investigative responsibilities detailed in Function Code 921 and Function Code 611.

From August 1, 2024, to May 27, 2025, CIT-designated units (call signs CIT10, CIT22, CIT32, CIT42, CIT52, CIT62, and 9C110) responded to 1,411 calls. Key findings include:

- Mental Illness–related calls made up 29.6% of call volume
- Other Miscellaneous Calls: 21%
- Follow-Ups: 16.7%
- Suicide Attempts and Emotionally Disturbed Persons (EDP): Combined 9.6%
- Remaining call types included overdoses, threats, and juvenile complaints

Nearly one-third of all CCIT calls involved mental illness, highlighting the unit's pivotal role in behavioral health crisis response.

In recognition of these efforts, Montgomery County was named the 2025 CIT Response Team of the Year by CIT International and will be honored at the national conference in Anaheim, California, August 11–13, 2025. See Appendix J.

3.5 A National Model for CIT Implementation: Spotlight on Virginia

When asked to identify a national jurisdiction with a strong and sustained history of CIT implementation, a CIT International board member referred UMB to key contacts in Virginia. In response, UMB engaged with the CIT Coordinator at New River Valley Community Services and the Executive Director of the Virginia CIT Coalition. UMB also reviewed a range of Virginia's CIT-related reports, which offered data and detailed documentation of the Commonwealth's almost 30-year journey with CIT, providing valuable insights into its current successes.

Virginia has demonstrated a long-standing commitment to improving the response to individuals experiencing behavioral health crises who come into contact with law enforcement and first responders. Over the past few decades, the Virginia General Assembly has actively invested in CIT programs and transfer-of-custody initiatives that allow law enforcement to disengage when

appropriate, with a particular focus on expanding services and resources in rural areas. Notably, in 2009, legislative efforts aimed to enhance CIT implementation statewide, and in the 2020 Special Session, amendments to the Code of Virginia further advanced the establishment and support of CIT programs.

To promote statewide consistency and sustainability, Virginia established the Virginia CIT Coalition (VACIT)—a body designed to support the growth, development, and integration of CIT programs in alignment with statutory and policy goals. VACIT was established in 2009 to unite the growing number of CIT programs across the Commonwealth. This was a grassroots effort by the local CIT Coordinators. By 2018, this group crafted bylaws, received non-profit status, and created structure around the organization. Participation in VACIT and its regional coalitions is encouraged for all CIT programs in the state. Through this collaboration, Virginia has identified and implemented a core set of essential CIT program elements, including:

1. Community stakeholder collaboration and oversight,
2. Designated CIT Coordinator,
3. A 40-hour CIT core training, certified by the Department of Criminal Justice Services (DCJS), for law enforcement personnel,
4. Train-the-trainer programs to promote local program sustainability,
5. Specialized dispatcher training,
6. Standardized policies and procedures,
7. Therapeutic assessment locations (non-law enforcement facilities) or streamlined procedures for diverting individuals from incarceration,
8. Ongoing data collection to monitor statutory outcomes, and
9. Active participation in VACIT and regional efforts

Virginia's commitment to evaluation and continuous improvement is evident in its clear and actionable pre-/post-training assessments. These assessments measure CIT officers' perceived knowledge, preparedness, and ability before and after CIT training. Officers are asked to rate themselves on topics such as:

- Managing situations involving individuals in crisis
- Understanding of developmental disorders
- Preparedness for engaging individuals expressing suicidal thoughts
- Knowledge of psychiatric medications
- Ability to connect individuals to local resources
- Familiarity with emergency custody and temporary detention processes
- Awareness of local community resources
- Confidence in engaging individuals with substance use disorders
- Ability to de-escalate a person in crisis

(See Appendix K for the full pre-/post-training analysis example)

Virginia has also focused extensive effort on Intercept 1 of the Sequential Intercept Model (SIM), specifically by supporting the development of CIT Assessment Sites—non-criminal justice settings where individuals in behavioral health crisis can be transported by law enforcement for mental health evaluation and service connection. These sites, considered a hallmark of the Commonwealth's CIT success, allow officers to quickly transfer custody of individuals under an Emergency Custody Order (known as Emergency Petitions in Maryland) to a clinical team, enabling officers to promptly return to public safety duties. This model reduces the time officers spend waiting during the assessment process and improves outcomes for individuals in crisis.

As of July 2020, the Virginia Department of Behavioral Health and Developmental Services funds 42 CIT Assessment Sites across the Commonwealth, supporting 33 Community Services Boards. These sites vary in hours of operation (ranging from 12 to 24 hours daily), staffing models (including sworn law enforcement, off-duty officers, and private security), and physical location (many are co-located with medical centers or hospital emergency departments, while a few operate as standalone facilities). Despite operational differences, all assessment sites share a common goal: providing a viable alternative to arrest and supporting Virginia's commitment to behavioral health recovery and diversion from the criminal justice system. Appendices L and M also demonstrate the implementation and data strength of Virginia's CIT program.

3.6 Aim #2 Observations & Recommendations

Initial recommendations from UMB to support Maryland's continued alignment with CIT International Best Practices:

- Leverage Strong CIT Designs and Implementations: Build on the successes of exemplary CIT programs within Maryland and across the U.S. to inform local strategies.
- Establish Clear Infrastructure: Recognize that implementation may vary across jurisdictions, but long-term success requires a defined plan, infrastructure, and sustainable support.
- Provide Technical Assistance Focused on Best Practices: Deliver targeted support—through the CoE and/or UMB—to help jurisdictions develop strategic plans, logic models, and outcome frameworks that reflect CIT International guidance.
- Utilize CIT International Resources: Regularly reference and apply CIT International's materials to strengthen program implementation and maintain fidelity to best practices.
- Facilitate Statewide Learning: Use quarterly CIT Coordinator Meetings to promote cross-jurisdictional data sharing, collaboration, and peer learning. Explore how standardized data collection can advance a coordinated, evidence-driven approach.
- Strengthen Interagency Collaboration: Ensure continued alignment between GOCPP and BHA so that CIT funding, scopes of work, and technical assistance respond effectively to each jurisdiction's unique needs.

4. Maximizing CIT's Role at the Behavioral Health–Criminal Justice Nexus in Maryland (Aim #3)

In this section, we will present outcomes from the data analysis examining the State Emergency Department Database (SEDD) data for the state of Maryland from 2023, with a specific focus on visits related to mental and behavioral health. The SEDD captures information on all emergency department discharges that do not result in hospital admission, representing an indicator of behavioral health crisis demand by the county.

By comparing trends across years and care settings, we would like to understand the evolving burden of mental health conditions on Maryland's healthcare system, identify the most affected populations, and inform strategies for crisis response and inpatient care planning.

Future Analysis: Can CIT Drive Behavioral Health Responses and Divert from Criminal Justice Pathways? UMB SSW recommends developing a plan to assess the impact that CIT can have—or could have—on shifting responses to behavioral health crises away from traditional criminal justice pathways and toward community-based care.

UMB's survey findings indicated growing integration between CIT and Law Enforcement Assisted Diversion (LEAD) programs, a public health–focused approach to addressing low-level offenses often driven by behavioral health challenges such as substance use or mental illness. Instead of arresting individuals, law enforcement officers can divert them to case management and support services.

Emerging LEAD–CIT collaborations have been identified in several Maryland counties, with progress highlighted below:

- Baltimore City: BPD partners with BHSB, which hosts a LEAD program that enables officers to divert individuals when appropriate.
- Calvert County: The LEAD Team lead is expected to collaborate closely with CIT initiatives.
- Harford County: The CIT advisory team includes the head of the LEAD team and is planning to incorporate LEAD into its developing co-responder model.
- Washington County: Local law enforcement maintains a strong relationship with the LEAD team.
- Worcester County: The CIT advisory team includes the head of the LEAD team, demonstrating integrated leadership between the two models.

This assessment plan could address key indicators such as the number and reasons for emergency petitions filed, data on diversion and deflection from the criminal justice system, citizen satisfaction, enhanced community partnerships, and improved linkages to mental health providers.

4.1 Aim #3 Observations & Recommendations

CIT best practices emphasize the need for a strong data infrastructure to evaluate program effectiveness and track the impact of CIT on law enforcement, behavioral health systems, and individuals experiencing behavioral health crises in Maryland. To meet this standard, the state should implement procedures for the routine collection and analysis of CIT-related data across jurisdictions.

At a minimum, Maryland should track:

- The number of officers trained in CIT by jurisdiction
- The number of behavioral health crisis calls involving CIT-trained officers
- The outcomes of those encounters

Key outcome measures should include:

- Emergency petitions
- Emergency department admissions
- Mobile crisis team volume
- Diversion to behavioral health or other health services

Appendix N provides data on emergency department admissions in Maryland for 2023 by behavioral health diagnosis type, both at the state level and by county. There were 91,819 behavioral health-related admissions statewide—equivalent to 1,490 admissions per 100,000 residents—highlighting the significant number of individuals experiencing behavioral health crises.

When paired with routine programmatic data (see Appendix G), this system-level information (Appendix N) creates a powerful opportunity to assess both the reach and effectiveness of CIT programs. Systematic and ongoing data collection is essential to guide program expansion, identify areas for improvement, and demonstrate the value of CIT interventions statewide.

5. Conclusion & Future Direction

To effectively bridge the gap between criminal justice and behavioral health, CIT must serve as more than a training initiative—and form the foundation of a coordinated, community-wide strategy. We recommend that Maryland take decisive steps to embed CIT into a public health framework. This evolution can be guided by state-level leadership through GOCPP and BHA, while still allowing local customization based on partners, resources, and readiness.

With local strategic plans and logic models—and sustained support from evaluation staff at GOCPP, BHA, and researchers at UMB—key focus areas could include:

1. Strengthening partnerships among policymakers, mental health providers, hospitals, and advocacy groups to build seamless crisis response networks.

2. Investing in infrastructure, such as centralized mental health receiving centers and mobile crisis units, to divert individuals from incarceration to appropriate treatment.
3. Implementing data-driven evaluation to track outcomes, identify disparities, and guide continuous improvement.
4. Securing sustainable funding from local, state, and federal sources to ensure long-term viability.
5. Engaging community voices, particularly those with lived experience, to co-create equitable and effective policies.
6. Institutionalizing CIT training across law enforcement agencies to ensure consistent, trauma-informed responses to behavioral health crises.

By embedding CIT efforts within a comprehensive public health and safety framework, and strengthening their implementation across the state, Maryland's investment has the potential to significantly reduce incarceration, enhance mental health outcomes, and build lasting trust between law enforcement and the communities they serve.

6. Appendices

A. Project Related University of Maryland, SSW Meetings (July 1, 2024- June 30, June
B. Anne Arundel County, Crisis Intervention Team, Regional Program Certification Report (2024-2027)
C. Anne Arundel County, Crisis Intervention Team, Index Code 1611.1 (9/11/2020)
D. Anne Arundel County, Mobile Crisis Team, Index Code 1611 (9/11/2020)
E. Anne Arundel County, Emergency Evaluations, Training Bulletin (1/2025)
F. Harford County CIT Report Form (5/16/2025)
G. Baltimore County, Baltimore County Crisis Response System – Mobile Crisis Team Report (6/2024-6/2025)
H. Montgomery County, Follow-Up Instigative Responsibility of Officers (5/6/2025)
I. Montgomery County, Policies and Procedures for Responding to Behavioral Health Emergencies and Persons with an Altered Mental Status (10/27/2022)
J. Montgomery County, Notice CIT Response Team of the Year Award
K. Commonwealth of Virginia, Western Tidewater CIT Pre/Post Analysis
L. Essential Elements of Commonwealth of Virginia Crisis Intervention Team Implementation (Original 9/8/2011, Updated 10/4/2021)
M. Commonwealth of Virginia, CIT Training Data Report (2024)
N. Rate and Count of Behavioral Health Emergency Department Admissions in Maryland
O. References

Crisis Intervention Team Landscape Analysis
Final Report

JUNE 30, 2025

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Table of Contents

1. Introduction

Crisis Intervention Teams (CIT) are collaborative programs involving law enforcement, emergency responders, behavioral health professionals, and community stakeholders. CIT's goal is to improve how first responders handle situations involving individuals experiencing behavioral health crises—especially when such behaviors are mistaken for criminal or dangerous actions. CIT programs aim to reduce unnecessary incarceration, improve community safety, and ensure individuals receive necessary care.

Key elements and details of CIT programs include:

- Training: Officers receive specialized 40-hour training to better understand and de-escalate mental health crises.
- Community Collaboration: CIT fosters partnerships among law enforcement, healthcare providers, and advocacy groups.
- Alternative Responses: Instead of arrest or hospitalization, officers are trained to connect individuals with appropriate mental health services.
- Origins: The model began in Memphis, Tennessee in 1988 and has since expanded nationwide.

This report centers on the three primary objectives that shaped this research project. Drawing on surveys, interviews, and a scan of national research conducted between July 2024 and June 2025 by faculty and staff at the University of Maryland, Baltimore, School of Social Work (UMB), this report presents key findings on the implementation of CIT programs across the State of Maryland. It also highlights local and national programs demonstrating noteworthy innovations. Please see Appendix A for the meetings UMB attended to support this analysis.

To contextualize these findings, we include data on the number of patrol officers throughout Maryland. While a comprehensive, and current breakdown of sworn officers by county is not readily available from a sole source, we have compiled approximate officer capacity figures from a variety of sources. These estimates offer a general overview of officer capacity across jurisdictions.[1]

Law Enforcement Size	Jurisdiction/Patrol Officer Capacity
2,000+ Officers	• Baltimore City: 2,515
1,000–1,999 Officers	• Prince George's: 1,800 • Montgomery: 1,300 • Baltimore County: 1,100

[1] United States Department of Justice- Office of Justice Programs: Bureau of Justice Statistics. "Census of State and Local Law Enforcement Agencies (CSLLEA), 2018." May 30, 2023. Accessed June 30, 2025. https://www.icpsr.umich.edu/web/NACJD/studies/38771/versions/V1.

500–999 Officers	• Anne Arundel: 850 • Howard: 509
250–499 Officers	• Frederick: 350 • Harford: 297 • Charles: 289
100–249 Officers	• St. Mary's: 171 • Washington: 190 • Wicomico: 190 • Worcester: 150 • Carroll: 150 • Calvert: 150 • Cecil: 120 • Allegany: 100
Under 100 Officers	• Queen Anne's: 90 • Caroline: 80 • Dorchester: 80 • Talbot: 80 • Garrett: 36 • Kent: 35 • Somerset: 21

2. Mapping Maryland's CIT Strengths and Gaps in Infrastructure, Training, and Implementation (Aim #1)

2.1 History and Development of CIT in Maryland

CIT programs in Maryland emerged in response to the growing awareness of the disproportionate contact between individuals with behavioral health conditions—such as serious mental illness, substance use disorders, and intellectual or developmental disabilities—and the criminal justice system. As early as 2016, data revealed that 40% of individuals incarcerated in Maryland jails had a mental health disorder, and more than two-thirds had a substance use disorder.[2] These figures highlighted the pressing need for specialized, community-based crisis response strategies.

CIT was introduced as a proactive approach to improve outcomes for individuals experiencing behavioral health crises by redirecting them from the justice system and connecting them with appropriate care. These programs foster collaboration among law enforcement, mental health professionals, emergency responders, advocates, and community stakeholders to expand non-carceral pathways that emphasize de-escalation, safety, and treatment over incarceration

The momentum for statewide expansion of CIT accelerated following the 2020 Maryland State Summit on Behavioral Health and the Justice System. The summit underscored the need for a centralized body to oversee and evaluate crisis response initiatives. In response, the Maryland

[2] Governor's Office on Crime Control and Prevention. (2016) Substance Use and Mental Health Disorder Gaps and Needs Analysis. https://gocpp.maryland.gov/wp-content/uploads/justice-reinvestment-sa-mh-gaps-needs-20161231.pdf

Behavioral Health and Public Safety Center of Excellence (BHPS-CoE) was established through Section 13-4204 of the Health General Article, enacted in 2021. Shortly thereafter, the Crisis Intervention Team Center of Excellence (CITCE) and the Behavioral Health and Public Safety Center of Excellence (BHPS-CoE) were consolidated under the Governor's Office of Crime Prevention and Policy (GOCPP), forming what is now commonly known as the Centers of Excellence. This integration has strengthened statewide coordination efforts to address behavioral health needs at the intersection of public safety and the justice system.

CIT's evolution in Maryland is closely aligned with the Sequential Intercept Model (SIM), a nationally recognized framework that maps how individuals with behavioral health conditions interact with the criminal justice system. The SIM identifies key junctures, known as intercepts, across the criminal justice system, where targeted interventions can connect individuals to treatment and support services. These intercepts span the continuum from community-based crisis responses, and first encounters with law enforcement to court involvement, incarceration, reentry, and community supervision. CIT plays a critical role at the earliest intercepts, particularly at intercept 0 (community resources) and intercept 1 (first responders).

Today, CIT programs across Maryland continue to grow and adapt with support from the Centers of Excellence, which provides technical assistance, training, and strategic guidance. These efforts promote best practices and help jurisdictions develop tailored crisis response strategies that address their communities' needs.

The following sections outline the key partners and structures driving this work, beginning with GOCPP, including its leadership in CIT strategic planning and coordination of quarterly CIT coordinator meetings. Subsequent sections highlight the contributions of the Maryland Behavioral Health Administration (BHA) and the vital role of county-level CIT coordinators in implementing and sustaining local crisis response systems.

2.2 GOCPP's Role

The Crisis Intervention Team Center of Excellence (CITCE) was established in 2020 under Section 3-522 of the Public Safety Article 2021 within the Governor's Office of Crime Prevention and Policy (GOCPP), formerly known as the Governor's Office of Crime Prevention, Youth, and Victim Services (GOCPYVS[3]). CITCE was created to provide technical assistance for behavioral health crisis intervention and to develop a standardized statewide model.

As previously established, CITCE and BHPS-CoE operate under GOCPP to lead the state's coordinated crisis response framework. Its mandate includes expanding access to treatment, preventing, reducing detention among individuals with behavioral health disorders, and serving as a statewide hub for treatment and diversion of resources.

[3] This name change took effect on January 18, 2024, under the Moore-Miller Administration. Previous and existing documents and agreements that refer to the agency as GOCPYVS remain valid.

Together, these Centers support the statewide coordination and implementation of behavioral health crisis response strategies, including CIT programs, across Maryland.

CIT programming is explicitly listed among the core activities of BHPS-CoE. The BHPS-CoE provides technical assistance and training for CIT, including:

- Curriculum Development: Supporting the creation and refinement of CIT training materials.
- Evidence-Based Practices: Promoting best practices in law enforcement and mental health crisis response.
- Funding Support: Serving as a clearinghouse for identifying and disseminating information about federal and other funding opportunities to sustain CIT programs.

To advance the statewide development, implementation, and monitoring of the CIT model, the Centers of Excellence are partnering with the Maryland Behavioral Health Administration (BHA) to launch a standardized, statewide data collection and analysis initiative. CIT Coordinators will administer Qualtrics surveys developed by GOCPP in collaboration with local jurisdictions. Data will be collected at three intervals (i.e., pre-training, training completion, and six-months post-training) to assess the training impact on both participants and the broader community. Data collection begins on July 1, 2025 (Q1 FY2026), and findings will be displayed on a GOCCP-hosted dashboard with a target launch of October 2025 (Q2 FY2026).

2.2.1 GOCPP Role in Supporting CIT and the Strategic Plan

The following suggestions are drawn from Priority #2 and its associated objectives (2a and 2b) of the Strategic Plan developed by the Maryland Behavioral Health and Public Safety Center of Excellence (BHPS-CoE), housed within GOCPP. This plan was created by the Maryland Crime Research and Innovation Center (MCRIC) at the University of Maryland, College Park, and released in September 2023. It was developed in response to Senate Bill 857 (2021), which established the BHPS-CoE to strengthen coordination between behavioral health services and public safety systems.[4]

Key Strategic Recommendations for CIT Implementation

<u>CIT Coordination</u>

- Host joint training sessions to improve interagency and strengthen team-based crisis response.
- Establish shared policies and procedures to formalize partnerships between law enforcement and behavioral health agencies.

[4] Maryland Crime Research and Innovation Center [MCRIC]. (2023). Behavioral health professional studies: Center of Excellence report [Technical report]. University of Maryland. https://go.umd.edu/BHPS-CoE-Report.

- Convene stakeholders regularly to promote ongoing communication and strategic alignment.

CIT Training

- Offer regular CIT refresher courses and explore innovative approaches to better serve diverse populations and emerging needs.

Coordination with the Behavioral Health Administration

- Interagency collaboration to secure funding to support CIT training, staffing, and related travel expenses.
- Assist local programs in identifying and applying for federal funding such as Substance Abuse and Mental Health Services Administration (SAMHSA's) Mental Health Awareness Training Grants.

Officer Selection & Program Infrastructure

- Maintain an updated list of active CIT officers by jurisdiction for recruitment and collaborative planning.
- Develop and manage an email list for CIT coordinators statewide.
- Facilitate monthly virtual meetings for CIT coordinators to strengthen peer support and foster a statewide learning community.

CIT Training Feedback

- Utilize tools such as Police-Mental Health Collaboration (PMHC) data collection to track key indicators (e.g., training coverage, cultural competency, diversion outcomes, use of force)[5]
- Support jurisdictions in collecting and analyzing implementation and outcomes data
- Provide technical assistance for peer-reviewed and third-party evaluations to support ongoing assessment of CIT program impact.[6]

Connection to GOCPYVS Center of Excellence

- Assess the feasibility of establishing a liaison role between the BHPS-CoE and Justice Reinvestment Act initiatives to enhance interagency communication and expand diversion opportunities for individuals with behavioral health needs

Community Collaboration

- Increase public awareness of CIT programs and available behavioral health resources
- Engage community-based organizations, advocates, and individuals with lived experience to ensure programs are relevant, inclusive, and responsive
- Encourage smaller jurisdictions to partner with neighboring agencies for regional CIT training opportunities

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[5] United States Department of Justice. (n.d.) Measuring performance: Police-Mental Health Collaboration (PMHC) Toolkit. Bureau of Justice Assistance. https://bja.ojp.gov/program/pmhc/measuring-performance

[6] Substance Abuse and Mental Health Service Administration. CIT Best Practices Guide: Methods for Using Data to Inform Practice: A Step-by-Step Guide. (2018) United States Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/sma18-5065.pdf

- Promote phased system development and resource-sharing models to support rural areas

2.3 BHA's Role in Supporting CIT Programs

BHA partners with BHPS-CoE to support and oversee the implementation of CIT programs across Maryland's jurisdictions. BHA allocates funding to strengthen statewide efforts in CIT coordination and training.

Each local behavioral health authority operates under a jurisdiction-specific Scope of Work (SOW), which includes the following activities:

- CIT program coordination, training, outreach, and public education.
- Participation in jurisdiction advisory meetings and CIT Coordinator meetings hosted by GOCPP.
- Engagement with state-level partners, including attendance at meetings and events hosted by the Centers of Excellence.

Training Activities outlined in the SOW

- Delivery of the 40-hour Crisis Intervention Team Model Standard Training Curriculum developed by the Centers of Excellence and adopted by the Police Training and Standards Commission.[7]
- Annual CIT refresher training.
- Administration of pre- and post-training surveys to evaluate knowledge gains and training impact.

State-Level Partnership Responsibilities:

- Participation in quarterly CIT Coordinator meetings.
- Engagement in the annual State Summit on Behavioral Health and the Justice System, which utilizes Sequential Intercept Model (SIM) Mapping Initiative.
- Attendance at Maryland-based CIT conferences and related statewide events.

Monitoring

To assess CIT implementation activity and progress, jurisdictions are required to submit quarterly data to BHA that captures participation levels and activity volume across all SOW components.

In addition, BHA is working in collaboration with GOCPP to develop a centralized database that will support the tracking of training efforts, implementation milestones, and post-training outcomes.

[7] Public Safety Education & Training Center. (April 4, 2025). Police Training and Standards Commission Model Policy Crisis Intervention Team Model Standard Training Curriculum. https://mpctc.dpscs.maryland.gov/pdf/Crisis%20Intervention%20Standard%20Training%20Curriculum.pdf

2.4 Maryland CIT Coordinator Interviews

To enhance understanding of CIT program implementation across Maryland, UMB—in collaboration with GOCPP, MCRIC, and BHA—conducted a comprehensive statewide assessment of CIT programs and efforts.

The initial phase of this assessment involved structured interviews with CIT Coordinators representing all 24 Maryland jurisdictions. These interviews focused on evaluating critical components of each CIT program, including organizational structure, training practices, implementation strategies, funding sources, interagency collaboration, coordinator responsibilities, and technical assistance needs.

Between September 12 and 19, 2024, the UMB team conducted 19 virtual interviews via Zoom. To streamline the process, certain jurisdictions were combined—specifically, the five Mid-Shore counties and the Wicomico/Somerset region. The project was reviewed by the Institutional Review Board (IRB) and classified as Not Human Subjects Research (NHSR), thereby exempting it from IRB oversight.

Each interview lasted approximately one hour and followed a standardized protocol consisting of 27 questions. Responses were categorized into six thematic areas:

1. CIT Coordinator Role
2. CIT Training Specifics
3. Funding
4. Training Feedback and Follow-Up
5. Access to GOCPP Technical Assistance
6. CIT Collaboration and Community Engagement

2.4.1 General Findings of Initial CIT Coordinator Interviews

The following summarizes key themes and observations from interviews with CIT Coordinators across Maryland's 24 jurisdictions:

Areas	Themes & Observations
Staffing	All jurisdictions have designated CIT Coordinators, though their employing agencies vary. Of the jurisdictions contacted, 11 Coordinators are based within Local Behavioral Health Authorities (LBHAs), which are often divisions of local health departments. In other jurisdictions, Coordinators are employed by local crisis providers or law enforcement agencies. While some jurisdictions exhibit strong structural integration between law enforcement and CIT Coordinators, others maintain a more collaborative, partner-based relationship.
Training	All jurisdictions have access to a 40-hour CIT training program aligned with the GOCPP curriculum. In one case, a county participates in sessions hosted by a neighboring jurisdiction. We confirmed that 8 jurisdictions offer CIT-specific refresher courses, and 5 provide complementary or specialized trainings that incorporate CIT-related content—such as de-escalation techniques, recognizing

Areas	Themes & Observations
	hidden mental health conditions, and suicide intervention. Core topics across training programs include de-escalation, mental health and substance use disorders, trauma-informed care, and perspectives from individuals with lived experience. While site visits are commonly part of the curriculum, their use and frequency vary by jurisdiction.
Trainers	Most jurisdictions rely on a lead CIT coordinator supported by local subject matter experts, behavioral health professionals, and peer trainers with lived experience.
Funding	Most CIT programs receive primary funding from BHA, with limited resource sharing across jurisdictions. Some jurisdictions also secure supplemental funding from local governments or agency-specific sources.
Officer Selection and Tracking	Officer selection processes for CIT training vary across jurisdictions. In some areas, officers volunteer for CIT roles, while in others, assignments are made by leadership. Tracking of trained officers is inconsistent: some departments maintain formal databases, others use manual lists, and a few do not track participation at all.
Implementation	All jurisdictions reported active deployment of CIT-trained officers. Implementation models differ—some jurisdictions operate dedicated CIT units, while others embed CIT-trained officers within general patrol operations. The extent of officer engagement and the application of CIT practices vary across departments.
Feedback and Evaluation	Most programs conduct pre- and post-training assessments along with participant satisfaction surveys. However, follow-up coaching is limited. A few jurisdictions provide in-service support or consultation to reinforce skills learned during training.
Technical Assistance	Coordinators expressed a growing need for technical assistance to support effective CIT program implementation and monitoring. Engagement with GOCPP's Centers of Excellence varied by jurisdiction. Several coordinators cited the need for additional support in curriculum development, outcome measurement, and statewide standardization of CIT practices.
Community Collaboration	Nearly all jurisdictions reported collaboration between CIT officers and mobile crisis teams. Many also maintain advisory committees that include representatives from law enforcement, behavioral health agencies, and community-based organizations.
State CIT Conference	Awareness of and participation in the State CIT Conference varied significantly. While some jurisdictions are actively engaged in planning and regularly attending events, others reported limited awareness of upcoming conferences.

The accompanying figure shows the number of law enforcement officers trained in CIT programs across Maryland during State Fiscal Years 2022–2024. These counts exclude non-law enforcement personnel (e.g., EMS, dispatchers). In some cases, the figures are estimates and may include officers from other jurisdictions who attended local training sessions. Accurately calculating the percentage of trained officers within each jurisdiction is challenging due to the lack of publicly available law enforcement payroll data and unclear reporting regarding which types of personnel (e.g., EMS, patrol officers, corrections) are receiving training.

Jurisdiction	SFY22	SFY23	SFY24	Total
Capital Region				
Frederick	127	49	24	200
Montgomery	130	130	130	390
Prince George's County	Unknown*	50	44	94*

Jurisdiction	SFY22	SFY23	SFY24	Total
Central Region				
Anne Arundel	37	34	14	85
Baltimore City	108	64	97	269
Baltimore County	52	20	24	96
Carroll County	16	18	24	58
Harford County	100	91	107	298
Howard	51	35	44	130
Eastern Region				
Cecil	2	2	1	5
Mid-Shore	65	22	18	105
Somerset	7	19	8	34
Wicomico	23	17	22	62
Worcester	20	19	24	63
Southern Region				
Calvert, Charles, St. Mary's	78	101	65	244
Western Region				
Allegany	0	0	0	0
Garrett	0	0	0	0
Washington	0	0	0	0

*Changed CIT training vendor in 2022, SFY22 data not available.

2.4.2 Key Needs Identified through Maryland CIT Coordinator Initial Interviews

The interviews revealed several recurring needs consistently identified by CIT Coordinators across jurisdictions:

Need	Description
Enhanced Tracking and Evaluation	A need for more robust systems to monitor and assess CIT program outcomes, including officer performance, community impact, and long-term effectiveness.
Standardized and Updated Training Curricula	Requests for greater consistency in training content across jurisdictions, along with updates that reflect current best practices and emerging challenges.
Stronger Integration with Behavioral Health and Crisis Systems	Improved coordination between CIT programs and local behavioral health providers, mobile crisis teams, and emergency response infrastructure.
Expanded Peer Learning and Technical Assistance	Increased desire opportunities to share best practices, engage in peer-to-peer learning, and access consistent technical assistance statewide.
Clearer Guidance on GOCPP Center Support	The need for well-defined roles, expectations, and communication channels regarding the support available from the GOCPP BHPS-CoE.

2.4.3 Follow up Survey & Findings from Maryland CIT Coordinators

Follow-up surveys with CIT Coordinators were conducted in February and March 2025 to gather more in-depth information about CIT implementation within each jurisdiction. The survey, administered via Qualtrics and distributed by email, included a series of targeted questions. Both the survey questions and responses are provided below. UMB received responses from 22 counties, including: Howard County, Anne Arundel County, Allegany County, Montgomery County, Frederick County, Baltimore City, Calvert County, Charles County, St. Mary's County (served by a single coordinator), Washington County, Prince George's County, Garrett County, Carroll County, Worcester County, Baltimore County, Somerset County, Harford County, and the five Mid-Shore counties.

Question Areas	Responses
Jurisdiction Strategic Plans, Logic Models or Advisory Boards that Guide CIT implementation and training	• Six counties reported having advisory boards that meet either quarterly or monthly. Additionally, two counties have established steering committees. • In the Mid-Shore region, updates are also shared during the monthly Forensic Workgroup meetings hosted by the Maryland Department of Health's Behavioral Health Administration (MDH BHA). • Calvert County convenes a biweekly Southern Maryland Regional CIT meeting to support coordination and planning. • Wicomico and Somerset counties are developing a CIT curriculum and training program in partnership with the Eastern Shore Criminal Justice Academy. • In Carroll County, the CIT program does not currently align with the county's Sequential Intercept Model map; however, coordinators meet bi-monthly to discuss program goals and priorities.
CIT Implementation Partnerships	• Ten counties reported having some form of crisis response partnership, such as a mobile crisis unit or other intervention model. • Nine counties indicated an existing partnership with the National Alliance on Mental Illness (NAMI), while one county expressed interest in strengthening that relationship.[8] • Twelve counties reported integration or collaboration with community-based mental health and substance use organizations, hospitals, or other local partners. • Baltimore City enables officers to contact 988 to connect individuals with mental health or substance use services. A counselor provides phone-based triage and either offers resources or dispatches a mobile crisis unit. The Baltimore Police Department (BPD) partners with Baltimore Crisis Response, Inc. (BCRI), which conducts on-scene evaluations and transports eligible individuals to its facility. BPD also maintains a co-responder team, available daily from 11 a.m. to 7 p.m., to support crisis response operations. • Frederick County utilizes a mixed-responder model in which local police, mental health professionals, and EMTs jointly respond to 911 calls involving behavioral health crises.

[8] National Alliance on Mental Illness. (February 12, 2025). "Crisis intervention team (CIT) programs." Accessed June 30, 2025. https://www.nami.org/advocacy/crisis-intervention/crisis-intervention-team-cit-programs/.

Question Areas	Responses
CIT-Trained Officers Identified and Dispatched in Jurisdiction	• Dispatch and organizational practices for CIT-trained officers vary across jurisdictions. Approximately half of respondents reported that officer tracking is either not conducted or remains unclear. • Several counties noted that CIT-trained officers are integrated within general patrol units and are not organized as a distinct group. • Baltimore City dispatchers are aware of all CIT officers on duty at the time of a call, and it is mandatory to request a CIT officer for any behavioral health-related call. • Harford County identifies CIT officers by uniform pins and, soon, vehicle stickers. Daily staff schedules highlight CIT-trained personnel, which dispatchers use to assign relevant calls.
CIT-trained officer's role in leading a crisis response	• The role of CIT-trained officers in crisis responses varies across counties. Several jurisdictions assign CIT officers as de-escalation leads during behavioral health incidents. Two counties reported having no formal protocol outlining CIT officer roles, and one county was unsure. • Harford County: CIT-trained officers assist non-CIT personnel in de-escalating situations until the mobile crisis unit arrives. They also participate in the Harford County Crisis Negotiation Team (CNT). • Baltimore County: The county includes CIT-trained officers both within and outside the co-responder unit. Officers in the co-responder unit follow a formal dispatch protocol, while those outside operate under a more informal system. • Baltimore City, Montgomery County, and Allegany County: CIT-trained officers take the lead on behavioral health calls. In Baltimore City, the lead officer on scene is also responsible for incident documentation.
CIT-trained officers and mental health referrals	• In seven counties, CIT-trained officers directly contact 988, mobile crisis units, or other behavioral health resources to assist individuals in need of mental health support. One county reported having no formal referral protocol, while another was unsure. • Harford County: Officers complete a Field Interview Report (FIR) to flag individuals who may require mental health services. The report is submitted to the Crisis Response Unit, which follows up in person or by phone. • Mid-Shore Region: CIT coordinators monitor a central referral email three times daily. Referrals flagged as appropriate are forwarded to the Mobile Crisis Team. Officers may also contact behavioral health resources directly, as needed.

Additionally, CIT Coordinators reported on the types of data they track related to CIT programs as follows:

CIT Impact Questions	Summarized Responses
Enhanced community perception of law enforcement	• Carroll County: During follow-up with individuals referred by CIT-trained officers, respondents are asked about their perceptions of the interaction. • Baltimore City: The Police Department distributes community surveys to assess public perceptions of law enforcement, including responses to behavioral health-related calls. • Harford County: Residents report viewing officers as caring—a crucial factor in reducing stigma and building trust.

CIT Impact Questions	Summarized Responses
	• Other Jurisdictions: About half indicated that this type of information is either not collected or not reported. Among those that do not track community perception, methods and frequency vary.
Fewer arrests and increased jail diversion	• Several respondents reported tracking or enhancing diversion efforts through various mechanisms, including co-responder teams, annual CIT awards programs, feedback from law enforcement agencies, the Emergency Services Crisis Response System (ESCRS), and LEADs teams. • Baltimore City promotes a "least police-involved response" approach for all behavioral health-related calls and emphasizes diversion to appropriate community resources whenever possible. Behavioral Health System Baltimore operates a LEADs program in partnership with the Baltimore Police Department, enabling officers to divert individuals to mental health or substance use services when appropriate.
Improved healthcare referrals and connections to mental health treatment	• In two counties, officers reported being better informed about available county resources, leading to improved referral outcomes. • More than half of respondents did not provide additional details on this topic. • Two counties indicated that referral tracking is supported through mechanisms such as annual CIT awards programs, law enforcement agency feedback, and tools like the MCT Survey, Credible, and the CIT referral email system. • Baltimore County: The co-responder team monitors referrals and service connections both at discharge and throughout each case. • Baltimore City: Behavioral Health System Baltimore (BHSB) employs dedicated staff to collect data and track the field placement of individuals receiving crisis response services, including whether they are successfully connected to ongoing care.
Decreased injuries to both law enforcement and citizens	• Most respondents either did not elaborate or indicated that this information is not currently tracked specifically for CIT officers. However, it was noted that CIT-trained officers are generally perceived as using less physical force. Where data is collected, it is typically maintained by individual law enforcement agencies or through annual CIT awards programs. • Baltimore City: Department policy mandates a Use of Force Assessment for any injuries sustained during behavioral health-related calls.
Reduced crisis response times	• Reduced crisis response times are tracked using a variety of methods, including CAD systems, LBHA call time logs, annual CIT awards programs, law enforcement agency feedback, Credible, and MCT surveys. • Harford County reported a decrease in the time needed to de-escalate crisis situations. • Baltimore City: Behavioral Health System Baltimore (BHSB) monitors response times for all mobile crisis teams to improve operational efficiency and the experience of individuals in crisis.
Increased officer confidence in handling mental health crises	• Officer confidence is measured through pre- and post-tests conducted during the 40-hour CIT training and through assessments by Mobile Crisis Teams (MCTs).

CIT Impact Questions	Summarized Responses
	• Harford County reports that the training has boosted officers' confidence in managing behavioral health calls and contributed to reducing stigma related to law enforcement interactions.
Improved law enforcement perception of individuals with mental illness	• Harford County reported that individuals who have interacted with CIT-trained officers often request them again, citing the officers' understanding and compassionate approach. • Other departments either did not provide additional detail or noted receiving similar feedback through pre- and post-training evaluations or annual CIT awards programs.

2.5 Maryland Law Enforcement Training Academy Interviews

The second phase of the analysis involved interviews with representatives from Maryland's law enforcement training academies to explore how CIT and behavioral health-related curricula are taught, implemented, and reinforced through academy instruction and coaching. These interviews were conducted via Zoom throughout February 2025, with eight of the state's 20 academies responding to interview requests.

A key finding was that several academies have fully integrated CIT training into their cadet curricula and provided detailed insights into their implementation strategies. In contrast, academies that do not include CIT in their formal curriculum reported that such training is typically delivered by external providers. These academies offered perspectives on the effectiveness of those external efforts and outlined the behavioral health topics incorporated within their cadet training programs.

2.5.1 Behavioral Health Training Overview Across Jurisdictions

Behavioral Health Training Curriculum Provided by Maryland's Police Academies

Most jurisdictions provide some form of behavioral health training for entry-level patrol officers, distinct from formal CIT instruction. Common components include:

- De-escalation Techniques: Many academies incorporate scenario-based approaches—such as Integrating Communications, Assessment, and Tactics (ICAT)—to help officers manage high-stress encounters effectively.
- Mental Health First Aid: Officers receive foundational training in identifying and responding to individuals experiencing mental health crises.
- Training on Developmental Disabilities: Providers like Pathfinders for Autism offer guidance on engaging with individuals who have autism or other developmental disabilities.
- Emergency Petition (EP) Procedures: Instruction covers the legal and procedural steps for initiating emergency mental health evaluations.

- Collaboration with Community Partners: Trainings emphasize coordination with crisis services, clinical professionals, and local health departments to promote integrated response strategies.

Variation in CIT Training Across Maryland's Police Academies

The extent to which CIT training is integrated into Maryland's police academies varies widely by jurisdiction. The table below highlights differing approaches to the 40-hour CIT training model:

Element	Details
Use of the 40-Hour CIT Model	CIT Trainings are primarily organized by jurisdiction-specific CIT Coordinators. Twelve counties, including Anne Arundel County and the Eastern Shore, host the 40-hour training within their police academies. Three counties hold training outside of the academy, often in collaboration with community and behavioral health professionals. Some jurisdictions did not indicate a training location, while others send officers to programs hosted by neighboring counties. Training participation may be voluntary, disciplinary, or mandatory, depending on the jurisdiction.
Entry-Level vs. Lateral Officer Training	Entry-level officers consistently receive behavioral health content as part of academy training. However, training for lateral officers varies widely. Some receive foundational instruction, others complete comparative compliance courses, and in certain cases, prior training is reviewed for equivalency. Notably, some academies, such as Southern Maryland and Harford County, do not provide direct behavioral health training for lateral officers.
Tracking and Evaluation	Approaches to tracking CIT-trained officers vary, even among academies not directly involved in delivering CIT instruction. Anne Arundel County, Prince George's County, and the University of Maryland College Park use internal systems or spreadsheets. In contrast, the Department of Public Safety and Correctional Services (DPSCS) and Maryland State Police report challenges with centralized tracking efforts.

Insights from Academy Representatives

Academy representatives shared perspectives on the broader impact of CIT and behavioral health training within their jurisdictions. Many emphasized the importance of specialized units and collaborative relationships with behavioral health systems:

- Anne Arundel, Baltimore County, and Montgomery County have established dedicated CIT units embedded within their law enforcement or crisis response systems, working closely with clinicians and crisis centers.
- Harford County and the Eastern Shore maintain strong partnerships with mobile crisis teams, walk-in centers, and nonprofit behavioral health organizations.

2.5.2 Maryland Academy Improvements to Implementations

Adapted Approaches to CIT Implementation

Several training academies reported innovations in how they implement CIT training, modifying their original practices to better align with the unique needs and cultures of their local communities and law enforcement agencies. Key examples include:

- University of Maryland, College Park (UMCP): The UMCP Training Academy developed and now delivers its own internal CIT training program. This shift stemmed from dissatisfaction with the previous external training provider and a desire for a more tailored, effective curriculum. Academy representatives emphasized the need to balance a focus on officer safety with effective engagement strategies for individuals in crisis.
- Montgomery County: Montgomery County rebranded its CIT initiative as the Crisis Response Team, specifically designed to respond to high-acuity behavioral health calls. This multidisciplinary team includes law enforcement officers, clinicians, and social workers, enabling a more comprehensive and coordinated crisis response.

2.5.3 Maryland Academies: Reported Areas of Improvement

During interviews, academy representatives identified several recurring areas for growth related to behavioral health training and their understanding of CIT-trained patrol officers in the field.

Key themes included:

Themes	Details
Lack of Standardized Refresher Training	Many jurisdictions highlighted the need for consistent follow-up or refresher training to reinforce CIT principles and skills over time.
Limited Use of Data for Evaluation	Few programs systematically track outcomes such as emergency petitions (EPs), arrests, or use-of-force incidents, limiting evaluation capacity.
Gaps in Training for Special Populations	Some jurisdictions are developing modules focused on dementia, autism, and veterans, while others are only beginning to address these areas.
Unsystematized Coordination and Data Sharing	Communication and data sharing among CIT coordinators remain informal and inconsistent, highlighting the need for a more structured statewide approach.

2.6 Aim #1 Observations & Recommendations

Maryland has made considerable progress in building a solid foundation for statewide CIT implementation statewide. Key accomplishments include:

- The designation of CIT Coordinators in every jurisdiction,
- The availability of the 40-hour CIT training curriculum for patrol officers across jurisdictions,
- The establishment of the BHPS-CoE to support and coordinate statewide efforts, and
- Ongoing review of BHA's Scope of Work for FY26.

These foundational elements, in coordination and training, represent some of Maryland's most valuable assets in advancing the effectiveness and reach of CIT initiatives.

Strengthening Maryland CIT: UMB's Recommendations for Sustainable Impact

1. Clarify and Expand the Role and Impact of CIT Coordinators
   - Clearly define and broaden the roles and responsibilities of CIT Coordinators.
   - Track how CIT Coordinators apply their training and leadership in the field.
2. Enhance Regional Implementation Strategies
   - Coordinate training efforts in Garrett and Allegany Counties to improve efficiency.
   - Clarify and define CIT implementation strategies within regional groupings, (e.g., Southern Maryland and the Eastern Shore) to ensure:
     - Individual county goals and community needs are addressed.
     - Unique infrastructure, leadership, and local priorities are incorporated.
3. Expand Community Partnerships
   - Strengthen collaboration between law enforcement and mental health providers, including receiving facilities, to ensure effective behavioral health response pathways for CIT-trained officers.
4. Improve Data Integration and Use
   - Track and analyze CIT applications, particularly related to emergency petitions, including volume and underlying causes.
   - Develop mechanisms for statewide sharing of CIT implementation data to promote peer learning during quarterly CIT Coordinator meetings.
   - Identify key data elements to enable collaborative, data-driven improvements across jurisdictions.
   - Support jurisdictions in setting up systems to collect and manage CIT-related data.
5. Expand Strategic Technical Assistance
   - Provide technical assistance (via BHPS-CoE or UMB) to help jurisdictions:
     - Review the status of BHPS-CoE strategic plan recommendations (implemented and outstanding).
     - Develop strategic plans, logic models, and measurable outcomes.
     - Implement CIT International best practices tailored to local contexts.
6. Bolster State-Level Collaboration and Support
   - Assess progress on the BHPS-CoE Strategic Plan to identify completed and outstanding recommendations.
   - Strengthen interagency coordination between GOCPP and BHA to better align funding, scope of work, and technical assistance with local needs.
   - Increase state funding to support the development and sustainability of CIT infrastructure in jurisdictions.
   - Improve alignment between CIT efforts and BHA's statewide crisis response model and goals.

- Strengthen CIT integration with the Sequential Intercept Model (SIM) in each jurisdiction to support cross-system collaboration and continuity of care.

3. Assessing Maryland's CIT Program Through the Lens of CIT International Standards (Aim #2)

This section evaluates the alignment between CIT training and implementation across Maryland and CIT International's Best Practice Standards, while also highlighting relevant local and national programs. It specifically examines:

- The extent to which Maryland jurisdictions meet CIT International's fidelity expectations,
- The effectiveness of core elements like the 40-hour CIT curriculum,
- Key components that lack full fidelity in implementation, and
- How jurisdictions monitor fidelity, and how these methods compare to CIT International's recommendations.

This analysis highlights both strengths and gaps in Maryland's CIT programs, offering guidance for improved statewide consistency and coordination.

3.1 CIT International Recommended Best Practices

CIT best practices, as outlined in *CIT International's Best Practice Guide for Transforming Community Response to Mental Health Crisis*[9], offer a comprehensive framework to improve the effectiveness, compassion, and coordination of mental health crisis response. The ten core principles presented serve as benchmarks for high-fidelity CIT programs.

Core Principles	Activities
Establish Strong, Sustained Partnerships	• Cross-Sector Collaboration: Engage law enforcement, behavioral health, advocacy groups, hospitals, and social services. • Ongoing Communication: Maintain regular dialogue to share insights and adapt to evolving needs.
Emphasize a Community-Based Approach	• Community Ownership: Involve local leadership and stakeholders in sustainability. • Public Awareness: Educate the public to reduce stigma and encourage early intervention.
Provide Specialized Training for Law Enforcement and Dispatchers	• Comprehensive 40-Hour Training: Cover de-escalation techniques, mental health, and scenario-based learning with diverse input (e.g., clinicians, individuals with lived experience, and family members). • Dispatcher Training: Train dispatchers to recognize behavioral health crises and appropriately route. • Ongoing Education: Offer advanced and refresher courses.

[9] CIT International. (2019, August). CIT International's best practice guide for transforming community response to mental health crisis.

Core Principles	Activities
Develop Clear Policies and Procedures	• Standardized Protocols: Define response, transport, and referral procedures. • Role Clarity: Ensure all participants understand their responsibilities during crisis situations.
Ensure Access to Mental Health Receiving Facilities	• Facility Partnerships: Coordinate with mental health facilities to Collaborate with designated mental health facilities to avoid emergency departments or jails. • Streamlined Transitions: Ensure efficient handoffs between law enforcement and care providers.
Implement Data Collection and Program Evaluation	• Key Metrics Tracking: Monitor outcomes (e.g., resolutions, referrals, use-of-force, response time). • Performance Evaluation: Assess training, protocols, and collaboration. • Transparent Reporting: Share results to guide improvement.
Foster a Culture of Recognition and Accountability	• Acknowledgment of Contributions: Recognize all participants involved. • Feedback Mechanisms: Encourage input to refine program and promote transparency.
Prioritize Safety and De-Escalation Techniques	• De-Escalation Focus: Emphasize communication strategies over force • Trauma-Informed Practices: Train responders to minimize re-traumatization.
Promote Community Outreach and Expansion	• Support for New Programs: Help other communities establish CIT. • Ongoing Outreach: Provide public education and engagement.
Secure Sustainable Funding and Resources	Long-Term Funding Strategies: Advocate for stable financial support. Resource Sharing: Partner across sectors to build and sustain programs.

3.2 CIT Best Practices Identified in Maryland

Interviews and surveys revealed that each jurisdiction in Maryland implements CIT practices based on the unique needs of their local partners and communities. While there is clear statewide commitment to delivering CIT training curricula, the adoption of other recommended best practices varies. Some jurisdictions have begun to incorporate additional components aligned with CIT International's standards, while others remain in earlier stages of implementation or have not yet adopted them. This variation highlights both the flexibility of local implementation and the opportunity for greater consistency and alignment with national best practices.

CIT Best Practices	Evident	Underway Partially*	Not Evident
Strong, Sustained Partnerships		X	
Community-Based Approach		X	
Specialized Training for Law Enforcement and Dispatchers	X		
Clear Policies and Procedures		X	
Access to Mental Health Receiving Facilities			X
Data Collection and Program Evaluation		X	
Culture of Recognition and Accountability		X	

Prioritize Safety and De-Escalation Techniques	X		
Promote Community Outreach and Expansion		X	
Secure Sustainable Funding and Resources		X	

*Underway Partially indicates implementation in some, but not all, jurisdictions.

3.3 CIT International Certification Process and National Sites

In May 2025, UMB met with a CIT International Board Member to gain a deeper understanding of the CIT Certification process. Insights from this conversation, along with information available on the CIT International website,[10] are summarized below. Additionally, the Board Member connected our team with representatives from the State of Virginia to learn more about their robust implementation efforts. These are described in detail in Section 3.5.

3.3.1 CIT International Certification Criteria for Platinum and Gold Programs

CIT International offers a formal certification process for state, regional, and agency-level CIT programs. Certification is awarded at one of four levels—Platinum, Gold, Silver, and Bronze—based on how comprehensively a program has adopted and implemented CIT best practices (*CIT International, n.d.*). Platinum and Gold certifications are granted to regional CIT programs that demonstrate excellence in the following core areas:

Core Area	Description
Comprehensive Training	Certified programs must provide a 40-hour CIT training for law enforcement, covering such topics as mental health, substance use, de-escalation, communication, and officer safety. Trainings are delivered by professionals and individuals with lived experience.
Collaborative Partnerships	Programs must have strong, sustained partnerships with organizations like NAMI, behavioral health agencies, hospitals, and advocacy groups. These collaborations help dismantle silos and support coordinated crisis response systems.
Diversion from the Criminal Justice System	Certified programs prioritize diverting individuals in crisis away from arrest and toward appropriate mental health services.
Community Engagement	Programs engage in public education, outreach, and advocacy to reduce stigma and raise awareness of mental health resources

3.3.2 CIT International Platinum Certification: Anne Arundel County, MD

Among the 20 regional programs awarded Platinum certification, Anne Arundel County in Maryland stands out as a national leader.[11] Notable highlights include:

- Dedicated CIT Unit: Officers are fully integrated within the Crisis System and collaborate closely with Crisis Response Clinicians, both in co-response teams and independently, to assist community members in need.

[10] CIT International. (n.d.) CIT program certification. Retrieved May 20, 2025, from https://www.citinternational.org/CITProgramCertification.
[11] County Office.org. Anne Arundel County Police Department - Millersville, MD. https://www.countyoffice.org/anne-arundel-county-police-department-millersville-md-9a2/.

- Comprehensive Training: All officers receive at least 40 hours of mental health and de-escalation training.
- National First: Anne Arundel became the first major police department in the U.S. to train 100% of officers in Mental Health First Aid.
- Robust Partnerships: Strong collaborations with NAMI and local crisis response providers enhance coordination and service delivery.
- Co-Responder Model: Clinicians and CIT-trained officers jointly respond to calls, ensuring immediate and informed on-scene crisis intervention.
- Imbedded Culture: CIT values are woven into departmental identity, with officers proudly wearing CIT pins.
- Exceeding Standards: The department surpasses the International Association of Chiefs of Police (IACP) benchmark 20% of officers' CIT training.

Additional details, including Anne Arundel's CIT International Certification report, relevant policies and procedures on emergency petitions, mobile crisis teams, and behavioral health protocols, can be found in Appendices B-E. These documents further illustrate the strength and sophistication of the county's CIT coordination and implementation.

3.3.3 CIT International Gold Certification: National Examples

Gold certification is awarded to regional programs that have implemented most CIT best practices and trained at least 20–25% of their officers. These programs demonstrate strong foundational implementation and a commitment to continuous improvement.

Gold-Certified Regions Include:

Location	Highlights
Central Valley, AZ	Grassroots training led by volunteers with lived experience.
Detroit-Wayne, MI	Systemic model emphasizing policy development and research.
Calhoun County, MI	Inclusive training extended to dispatchers and corrections staff.
Trillium Health, NC	Expansive curriculum supported by strong academic partnerships.
Mat-Su Coalition, AK	Rapid expansion featuring mobile crisis teams and EMS-police integration.
St. Joseph County, IN	Emphasis on crisis center coordination and infrastructure development.
Region 7, ID	Multi-agency implementation at the regional level.
Orange County, CA	Specialized training for youth and comprehensive crisis response teams.

Although these programs share core principles, each takes a distinct approach tailored to its local community needs and available resources. According to a CIT International Board Member, the certification process is voluntary and based on self-reported data, reviewed by CIT International. As such, the list of certified programs does not capture all high-performing CIT initiatives statewide.

3.4 Local Leaders in CIT: Spotlight on Maryland Counties

Several Maryland counties are making impressive advancements in CIT initiatives by innovatively tracking behavioral health encounters and expanding support services. Harford County, for instance, collects detailed system-level data (see Appendix F), while St. Mary's and Howard Counties provide coaching following emergency petitions to support individuals in crisis.

Beyond Anne Arundel County—recognized by CIT International for its exemplary CIT programming—both Baltimore and Montgomery Counties have emerged as leaders through robust implementation strategies and innovative approaches. Additional details on these two counties are provided in the sections that follow.

3.4.1 Baltimore County

Affiliated Sante Group (Sante), the crisis services provider for Baltimore County, is funded by the Baltimore County Department of Health and plays a critical role in empowering the Baltimore County Crisis Response System (BCCRS). Through this support, Sante delivers urgent care, mobile crisis services, and in-home interventions to residents across the county. Their mission is focused on expanding access to high-quality mental health services, reducing the stigma surrounding substance use treatment, and prioritizing suicide prevention—particularly among Baltimore County youth.

A key innovation in their approach is a successful partnership with the Baltimore County Police Department. Together, they offer an alternative to traditional law enforcement responses by deploying co-responder teams composed of licensed behavioral health clinicians and specially trained CIT police officers. This collaborative model ensures that behavioral health crises receive appropriate, compassionate, and effective intervention, with direct linkage to community resources.

Equally notable is Sante's commitment to data-driven care. Their robust data collection efforts track a wide range of outcomes, including referrals, arrest records, diversions from jail, hospitals, and emergency petitions, as well as service connections at discharge. These metrics are monitored throughout each individual's engagement with law enforcement and crisis services, allowing for continuous quality improvement and impact assessment. See Appendix G for an overview of their comprehensive data collection framework.

According to the Mobile Crisis Team (MCT) report, between July 2023 and May 2024, the MCT responded to 2,433 calls for service, averaging about 203 calls per month. Police departments across the county served as the primary referral source, accounting for more than half of all dispatches (52%). Additional referrals came through 911 dispatch, MCT self-dispatch, 988 or local hotlines, and other sources.

In response to these calls, MCT teams employed a wide range of interventions tailored to the needs of individuals and families involved. Safety planning was the most frequently used intervention,

occurring in 1,426 cases, followed by behavioral health referrals (392), initiation of emergency petitions (348), verbal de-escalation techniques (325), and well-being checks (1,030).

Among the most common presenting issues were situational crises (772 cases), suicide attempts (491), chronic mental illness (332), depression (246), and delusions or hallucinations (271). These concerns speak to the broad scope of behavioral health conditions addressed by the MCT and highlight the team's capacity to manage both acute and chronic psychiatric needs.

Importantly, the data demonstrate significant success in diverting individuals from higher-cost or more punitive systems. Over the reporting period, 369 calls were diverted from emergency rooms, 345 from the initiation of emergency petitions, and 61 from entry into the criminal justice system.

The population served by the MCT reflects the diversity and complexity of behavioral health needs in Baltimore County. Clients ranged from young children to older adults, most being adults aged 22 to 64. Approximately 52% of clients were female, and 42% were male. Insurance data show that many individuals were uninsured or had unknown coverage status (over 1,570 cases), indicating potential barriers to access and a need for continued outreach to vulnerable and underserved groups.

With its focus on co-responder collaboration, systemic diversion from emergency and criminal justice systems (punitive interventions), and data-driven improvement, Baltimore County MCT stands as out as model program for behavioral health crisis response to share statewide and nationally.

3.4.2 Montgomery County

The Montgomery County Police Department (MCPD) CIT program is built on a robust community partnership that includes law enforcement, mental health and addiction professionals, individuals with lived experience, family members and advocates.[12] This innovative, first-responder model delivers police-based crisis intervention training designed to divert individuals from the criminal justice system and connect them to appropriate mental health and medical care. The program also prioritizes the safety of officers and community members in crisis.

All MCPD officers are required to complete CIT training after finishing their field training program. In addition to department-wide implementation, MCPD operates a specialized five-officer Centralized Crisis Intervention Team (CCIT) that responds to behavioral health emergencies and supports patrol officers during such incidents.

The Montgomery County CCIT focuses on education, outreach, follow-up, empowerment, and response for residents affected by mental illness, Autism Spectrum Disorder (ASD), intellectual and developmental disabilities (IDD), Alzheimer's disease, and dementia. CCIT officers respond

[12] Montgomery County, Maryland. "Montgomery County Police Department: About Us Page". https://www.montgomerycountymd.gov/pol/about.html

to a range of critical situations, including mental health crises, traumatic incidents, and the service of Extreme Risk Protective Orders (ERPOs). While patrol officers handle any criminal elements, CCIT officers specialize in behavioral health intervention and de-escalation. When not present at the scene, they remain available for phone consultation and can respond to patrol officers when needed. They primarily operate Monday through Friday during regular business hours, with on-call availability after hours.

To foster trust and reduce stigma, CCIT officers drive unmarked vehicles, wear CIT identification patches, and are differentiated within internal systems. The department is also exploring softer, more approachable uniforms to support community engagement.

This program emerged in response to the growing number of behavioral health-related calls and the increasing population of individuals living with mental illness in Montgomery County. As other community support systems have declined, law enforcement has faced rising demands for crisis response. CCIT officers are trained to apply sound judgment, de-escalation techniques, and appropriate referrals to connect individuals with needed services and support.

Montgomery County Crisis Intervention Response: Operational Structure and Outcomes

MCPD has established well-documented policies that guide patrol officers when responding to or encountering situations exhibiting behaviors consistent with a mental disorder or crisis and follow-up protocols (see Appendices H and I). According to department protocol, CCIT officers are expected to take command of any behavioral health-related call, like how investigators lead major crime scenes. They respond to a wide range of critical incidents, including:

- Suicides in progress,
- Critical incidents at schools,
- Actively violent individuals with mental health conditions,
- Critical missing persons with concerns related to mental health, autism, or IDD, and
- Any behavioral health call requiring specialized intervention.

The CCIT operates within an integrated system that includes strong partnerships with the county's crisis center and the Department of Health and Human Services (HHS). Crisis Center staff are CIT-Trained and coordinate directly with CCIT to ensure a seamless response. To support consistency in response, crisis center staff receive CIT training. Officers are embedded within both the crisis center and HHS facilities, facilitating real-time communication and coordination. An HHS clinician is also co-located with the CCIT unit, to manage high-acuity cases and bridge the gap between public safety and the mental health services. A revised Memorandum of Understanding (MOU) between MCPD and HHS is currently underway and expected to be finalized by the end of 2025.

MCPD's CCIT and broader behavioral health response initiatives manage a significant and sustained volume of calls. Responses often coincide with ERT deployments (barricaded subjects)

or when ERPO's are initiated. A supervisor therapist from HHS, assigned to CCIT unit, documents call data. From January to April 2025, reported activities included:

Total Contacts including calls for service, telephone/email consultations	125 (Jan: 14; Feb; 22; Mar: 47, April: 42)
Police Consultations	36
Community Activity Events/Engagements	6

This local data represents just one component of Montgomery County's behavioral health response system, which also includes MCOT-CIT co-responder units, emergency petition protocols, mobile crisis teams, and specialized investigative responsibilities detailed in Function Code 921 and Function Code 611.

From August 1, 2024, to May 27, 2025, CIT-designated units (call signs CIT10, CIT22, CIT32, CIT42, CIT52, CIT62, and 9C110) responded to 1,411 calls. Key findings include:

- Mental Illness–related calls made up 29.6% of call volume
- Other Miscellaneous Calls: 21%
- Follow-Ups: 16.7%
- Suicide Attempts and Emotionally Disturbed Persons (EDP): Combined 9.6%
- Remaining call types included overdoses, threats, and juvenile complaints

Nearly one-third of all CCIT calls involved mental illness, highlighting the unit's pivotal role in behavioral health crisis response.

In recognition of these efforts, Montgomery County was named the 2025 CIT Response Team of the Year by CIT International and will be honored at the national conference in Anaheim, California, August 11–13, 2025. See Appendix J.

3.5 A National Model for CIT Implementation: Spotlight on Virginia

When asked to identify a national jurisdiction with a strong and sustained history of CIT implementation, a CIT International board member referred UMB to key contacts in Virginia. In response, UMB engaged with the CIT Coordinator at New River Valley Community Services and the Executive Director of the Virginia CIT Coalition. UMB also reviewed a range of Virginia's CIT-related reports, which offered data and detailed documentation of the Commonwealth's almost 30-year journey with CIT, providing valuable insights into its current successes.

Virginia has demonstrated a long-standing commitment to improving the response to individuals experiencing behavioral health crises who come into contact with law enforcement and first responders. Over the past few decades, the Virginia General Assembly has actively invested in CIT programs and transfer-of-custody initiatives that allow law enforcement to disengage when

appropriate, with a particular focus on expanding services and resources in rural areas. Notably, in 2009, legislative efforts aimed to enhance CIT implementation statewide, and in the 2020 Special Session, amendments to the Code of Virginia further advanced the establishment and support of CIT programs.

To promote statewide consistency and sustainability, Virginia established the Virginia CIT Coalition (VACIT)—a body designed to support the growth, development, and integration of CIT programs in alignment with statutory and policy goals. VACIT was established in 2009 to unite the growing number of CIT programs across the Commonwealth. This was a grassroots effort by the local CIT Coordinators. By 2018, this group crafted bylaws, received non-profit status, and created structure around the organization. Participation in VACIT and its regional coalitions is encouraged for all CIT programs in the state. Through this collaboration, Virginia has identified and implemented a core set of essential CIT program elements, including:

1. Community stakeholder collaboration and oversight,
2. Designated CIT Coordinator,
3. A 40-hour CIT core training, certified by the Department of Criminal Justice Services (DCJS), for law enforcement personnel,
4. Train-the-trainer programs to promote local program sustainability,
5. Specialized dispatcher training,
6. Standardized policies and procedures,
7. Therapeutic assessment locations (non-law enforcement facilities) or streamlined procedures for diverting individuals from incarceration,
8. Ongoing data collection to monitor statutory outcomes, and
9. Active participation in VACIT and regional efforts

Virginia's commitment to evaluation and continuous improvement is evident in its clear and actionable pre-/post-training assessments. These assessments measure CIT officers' perceived knowledge, preparedness, and ability before and after CIT training. Officers are asked to rate themselves on topics such as:

- Managing situations involving individuals in crisis
- Understanding of developmental disorders
- Preparedness for engaging individuals expressing suicidal thoughts
- Knowledge of psychiatric medications
- Ability to connect individuals to local resources
- Familiarity with emergency custody and temporary detention processes
- Awareness of local community resources
- Confidence in engaging individuals with substance use disorders
- Ability to de-escalate a person in crisis

(See Appendix K for the full pre-/post-training analysis example)

Virginia has also focused extensive effort on Intercept 1 of the Sequential Intercept Model (SIM), specifically by supporting the development of CIT Assessment Sites—non-criminal justice settings where individuals in behavioral health crisis can be transported by law enforcement for mental health evaluation and service connection. These sites, considered a hallmark of the Commonwealth's CIT success, allow officers to quickly transfer custody of individuals under an Emergency Custody Order (known as Emergency Petitions in Maryland) to a clinical team, enabling officers to promptly return to public safety duties. This model reduces the time officers spend waiting during the assessment process and improves outcomes for individuals in crisis.

As of July 2020, the Virginia Department of Behavioral Health and Developmental Services funds 42 CIT Assessment Sites across the Commonwealth, supporting 33 Community Services Boards. These sites vary in hours of operation (ranging from 12 to 24 hours daily), staffing models (including sworn law enforcement, off-duty officers, and private security), and physical location (many are co-located with medical centers or hospital emergency departments, while a few operate as standalone facilities). Despite operational differences, all assessment sites share a common goal: providing a viable alternative to arrest and supporting Virginia's commitment to behavioral health recovery and diversion from the criminal justice system. Appendices L and M also demonstrate the implementation and data strength of Virginia's CIT program.

3.6 Aim #2 Observations & Recommendations

Initial recommendations from UMB to support Maryland's continued alignment with CIT International Best Practices:

- Leverage Strong CIT Designs and Implementations: Build on the successes of exemplary CIT programs within Maryland and across the U.S. to inform local strategies.
- Establish Clear Infrastructure: Recognize that implementation may vary across jurisdictions, but long-term success requires a defined plan, infrastructure, and sustainable support.
- Provide Technical Assistance Focused on Best Practices: Deliver targeted support—through the CoE and/or UMB—to help jurisdictions develop strategic plans, logic models, and outcome frameworks that reflect CIT International guidance.
- Utilize CIT International Resources: Regularly reference and apply CIT International's materials to strengthen program implementation and maintain fidelity to best practices.
- Facilitate Statewide Learning: Use quarterly CIT Coordinator Meetings to promote cross-jurisdictional data sharing, collaboration, and peer learning. Explore how standardized data collection can advance a coordinated, evidence-driven approach.
- Strengthen Interagency Collaboration: Ensure continued alignment between GOCPP and BHA so that CIT funding, scopes of work, and technical assistance respond effectively to each jurisdiction's unique needs.

4. Maximizing CIT's Role at the Behavioral Health–Criminal Justice Nexus in Maryland (Aim #3)

In this section, we will present outcomes from the data analysis examining the State Emergency Department Database (SEDD) data for the state of Maryland from 2023, with a specific focus on visits related to mental and behavioral health. The SEDD captures information on all emergency department discharges that do not result in hospital admission, representing an indicator of behavioral health crisis demand by the county.

By comparing trends across years and care settings, we would like to understand the evolving burden of mental health conditions on Maryland's healthcare system, identify the most affected populations, and inform strategies for crisis response and inpatient care planning.

Future Analysis: Can CIT Drive Behavioral Health Responses and Divert from Criminal Justice Pathways? UMB SSW recommends developing a plan to assess the impact that CIT can have—or could have—on shifting responses to behavioral health crises away from traditional criminal justice pathways and toward community-based care.

UMB's survey findings indicated growing integration between CIT and Law Enforcement Assisted Diversion (LEAD) programs, a public health–focused approach to addressing low-level offenses often driven by behavioral health challenges such as substance use or mental illness. Instead of arresting individuals, law enforcement officers can divert them to case management and support services.

Emerging LEAD–CIT collaborations have been identified in several Maryland counties, with progress highlighted below:

- Baltimore City: BPD partners with BHSB, which hosts a LEAD program that enables officers to divert individuals when appropriate.
- Calvert County: The LEAD Team lead is expected to collaborate closely with CIT initiatives.
- Harford County: The CIT advisory team includes the head of the LEAD team and is planning to incorporate LEAD into its developing co-responder model.
- Washington County: Local law enforcement maintains a strong relationship with the LEAD team.
- Worcester County: The CIT advisory team includes the head of the LEAD team, demonstrating integrated leadership between the two models.

This assessment plan could address key indicators such as the number and reasons for emergency petitions filed, data on diversion and deflection from the criminal justice system, citizen satisfaction, enhanced community partnerships, and improved linkages to mental health providers.

4.1 Aim #3 Observations & Recommendations

CIT best practices emphasize the need for a strong data infrastructure to evaluate program effectiveness and track the impact of CIT on law enforcement, behavioral health systems, and individuals experiencing behavioral health crises in Maryland. To meet this standard, the state should implement procedures for the routine collection and analysis of CIT-related data across jurisdictions.

At a minimum, Maryland should track:

- The number of officers trained in CIT by jurisdiction
- The number of behavioral health crisis calls involving CIT-trained officers
- The outcomes of those encounters

Key outcome measures should include:

- Emergency petitions
- Emergency department admissions
- Mobile crisis team volume
- Diversion to behavioral health or other health services

Appendix N provides data on emergency department admissions in Maryland for 2023 by behavioral health diagnosis type, both at the state level and by county. There were 91,819 behavioral health-related admissions statewide—equivalent to 1,490 admissions per 100,000 residents—highlighting the significant number of individuals experiencing behavioral health crises.

When paired with routine programmatic data (see Appendix G), this system-level information (Appendix N) creates a powerful opportunity to assess both the reach and effectiveness of CIT programs. Systematic and ongoing data collection is essential to guide program expansion, identify areas for improvement, and demonstrate the value of CIT interventions statewide.

5. Conclusion & Future Direction

To effectively bridge the gap between criminal justice and behavioral health, CIT must serve as more than a training initiative—and form the foundation of a coordinated, community-wide strategy. We recommend that Maryland take decisive steps to embed CIT into a public health framework. This evolution can be guided by state-level leadership through GOCPP and BHA, while still allowing local customization based on partners, resources, and readiness.

With local strategic plans and logic models—and sustained support from evaluation staff at GOCPP, BHA, and researchers at UMB—key focus areas could include:

1. Strengthening partnerships among policymakers, mental health providers, hospitals, and advocacy groups to build seamless crisis response networks.

2. Investing in infrastructure, such as centralized mental health receiving centers and mobile crisis units, to divert individuals from incarceration to appropriate treatment.
3. Implementing data-driven evaluation to track outcomes, identify disparities, and guide continuous improvement.
4. Securing sustainable funding from local, state, and federal sources to ensure long-term viability.
5. Engaging community voices, particularly those with lived experience, to co-create equitable and effective policies.
6. Institutionalizing CIT training across law enforcement agencies to ensure consistent, trauma-informed responses to behavioral health crises.

By embedding CIT efforts within a comprehensive public health and safety framework, and strengthening their implementation across the state, Maryland's investment has the potential to significantly reduce incarceration, enhance mental health outcomes, and build lasting trust between law enforcement and the communities they serve.

6. Appendices

A. Project Related University of Maryland, SSW Meetings (July 1, 2024- June 30, June
B. Anne Arundel County, Crisis Intervention Team, Regional Program Certification Report (2024-2027)
C. Anne Arundel County, Crisis Intervention Team, Index Code 1611.1 (9/11/2020)
D. Anne Arundel County, Mobile Crisis Team, Index Code 1611 (9/11/2020)
E. Anne Arundel County, Emergency Evaluations, Training Bulletin (1/2025)
F. Harford County CIT Report Form (5/16/2025)
G. Baltimore County, Baltimore County Crisis Response System – Mobile Crisis Team Report (6/2024-6/2025)
H. Montgomery County, Follow-Up Instigative Responsibility of Officers (5/6/2025)
I. Montgomery County, Policies and Procedures for Responding to Behavioral Health Emergencies and Persons with an Altered Mental Status (10/27/2022)
J. Montgomery County, Notice CIT Response Team of the Year Award
K. Commonwealth of Virginia, Western Tidewater CIT Pre/Post Analysis
L. Essential Elements of Commonwealth of Virginia Crisis Intervention Team Implementation (Original 9/8/2011, Updated 10/4/2021)
M. Commonwealth of Virginia, CIT Training Data Report (2024)
N. Rate and Count of Behavioral Health Emergency Department Admissions in Maryland
O. References

Crisis Intervention Team Landscape Analysis

Final Report

Appendices

Appendix A

University of Maryland, School of Social Work
Crisis Intervention Landscape Analysis Project – Meeting Schedule

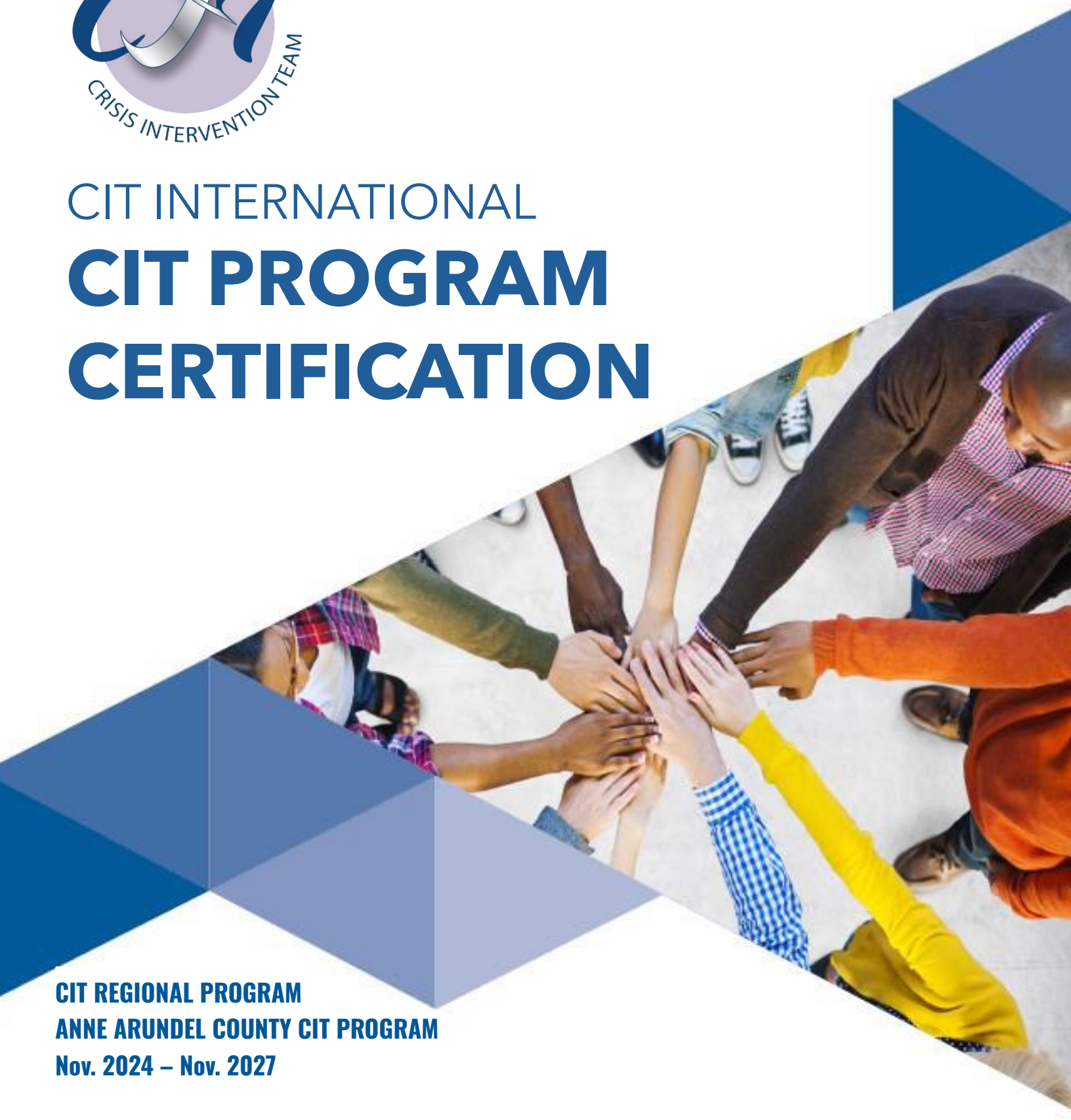
The following is a schedule of project-related meetings. These are in addition to survey interviews with CIT Coordinators and Maryland police training academies.

Meetings	**Dates**
GOCPP CIT Coordinator Meeting	8/4/2024, 11/4/2024, 2/10/2025
CITCE Collaborative Planning Meeting	8/19/2024
UMB/GOCPP/MDH Planning Meetings	7/24/2024, 8/26/2024, 8/29/2024, 10/16/24, 12/2/2024, 1/9/2025, 2/10/2025
CIT International	12/12/2024, 4/8/2025
State of Virginia	5/21/2025
Anne Arundel County	12/16/2024, 2/4/2025
Montgomery County	2/27/2025, 5/27/2025
Baltimore County	9/12/2024

Appendix B

CIT INTERNATIONAL

CIT PROGRAM CERTIFICATION



CIT REGIONAL PROGRAM
ANNE ARUNDEL COUNTY CIT PROGRAM
Nov. 2024 – Nov. 2027

CIT INTERNATIONAL

CIT PROGRAM CERTIFICATION

CIT REGIONAL PROGRAM

ANNE ARUNDEL COUNTY CIT PROGRAM

NOV. 2024 – NOV. 2027

CIT Program Certification: Anne Arundel County CIT Program

CIT International, Inc.
3443 S. State St., #15B
Salt Lake City, UT 84115
https://www.citinternational.org/

ABOUT CIT PROGRAM CERTIFICATION

CIT International provides Crisis Intervention Team (CIT) programs the opportunity to receive certification through a structured assessment and feedback process. There are four levels of certification based on the degree to which a program's application and supporting documentation demonstrate that the program has implemented CIT best practices. CIT best practices are described in the guide, "Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises", which is available online for free download or purchase at https://www.citinternational.org/bestpracticeguide.

Program administrators complete an online application and submit detailed supporting documentation for a team of CIT International evaluators to determine and award the certification level. The certification is valid for three years.

Program certification is awarded based on self-reported data and documents provided by the applicant and is intended to provide an honest assessment of a program's strengths and needs. CIT International is not responsible for incomplete, false, or misleading information.

PROGRAM STRUCTURES

CIT programs apply for certification based on the structure and geographic reach of their program. CIT International recognizes three types of program structures:

- **Agency Program**: A CIT agency program is a community-wide program built around a single police agency that utilizes CIT-trained officers in its community's crisis response system. A CIT agency program may or may not conduct CIT 40-hour trainings, but must have some components of CIT programming.

- **Regional Program**: A CIT regional program is a program of a geographical region. A CIT regional program is responsible for crisis response system development and reform for its region. A CIT regional program conducts CIT 40-hour trainings available to all law enforcement agencies within the region.

- **State/Province Program**: A CIT state/province program is a state or province-wide program. A CIT state/province program is responsible for the development and support of more localized programs, either on a regional or agency level.

CERTIFICATE LEVELS

Programs reviewed through CIT International's certification program will receive a report summarizing strengths of the program, recommendations for improvement, and a final certification level. The certification levels are:

- **Bronze**: A developing program that has met minimum qualifications to be recognized as a CIT program and maintains plans for growth.
- **Silver:** An emerging program that has met many of the best practice criteria of CIT programming.
- **Gold:** An outstanding program that has met most of the best practice criteria of CIT programming.
- **Platinum:** A program that has incorporated the best practices of CIT and is recognized as a leading program. A platinum program may serve as a learning center for other programs worldwide.

EVALUATORS

- Ridg Medford, Board of Directors, CIT International; Oregon Center on Behavioral Health and Justice Integration
- Michele Saunders, LCSW, Events and Programs Coordinator, CIT International
- Yolanda Cruz, Board of Directors, CIT International; California State Council on Developmental Disabilities

APPLICANT DETAILS:
Anne Arundel County CIT Program

The Anne Arundel County CIT Program consists of a coordinating team covering the region of Anne Arundel County, Maryland. The application reports that the population of this region is 590,000 people served by 3 local and 2 state law enforcement agencies, 1 emergency communications center, and 2 correctional facilities.

CONTACT INFORMATION

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(443) 848-2922
www.aacounty.org

EXECUTIVE SUMMARY AND CERTIFICATION

CIT International applauds the Anne Arundel County CIT Program for developing a strong program that incorporates the best practices of CIT across many areas evaluated. Specifically, Anne Arundel County's CIT program is a model for other communities in several capacities, including its:

- multidisciplinary leadership team with a good structure to manage and sustain the CIT program,
- strong integrated crisis response system,
- 40-hour CIT training curriculum for law enforcement as well as training for other disciplines,

The Anne Arundel County CIT program has excelled at development and its commitment to partnerships, crisis response, and the training aspects of CIT programming. The program's Board of Directors through the Anne Arundel County Mental Health Agency can continue to work together to provide attention to adding additional partners, continued efforts to expand CIT programs statewide, and outcomes data collection.

Our evaluation finds that the Anne Arundel County CIT program is in a strong position to grow and sustain the use of best practices. This report includes recommendations to support that growth. Our primary recommendation to all CIT programs is to ensure that all partners are aligned behind a common goal: *ensuring that people in mental health crisis receive a response from mental health services unless a law enforcement response is warranted by public safety*.

Many of our recommendations are designed to support this goal, including:

- increasing the role of your Advocacy CIT Coordinator,
- including emergency medical services on your committee and in your program,
- adding data collection points to assess crisis response outcomes, and
- connecting with other regional CIT programs and advocating for a statewide CIT program.

Overall, the Anne Arundel County CIT program has adopted the best practices for CIT. CIT International commends the program for these accomplishments. It is awarded a certification level of PLATINUM.


CIT INTERNATIONAL
Platinum
PROGRAM
CERTIFICATION
Anne Arundel County
CIT Program
2024 - 2027
NOVEMBER NOVEMBER

EVALUATION AND RECOMMENDATIONS

CONNECTION TO OTHER PROGRAMS

Regionally the connection between agencies within Anne Arundel County is strong and apparent. Officers from Anne Arundel County Police, Maryland Transportation Authority, Annapolis City Police, Crofton Police Department, National Security Agency, Anne Arundel Community College Police, Ft. Meade Provost Marshall's Office and others including Communications Officers, Police Booking Officers, sworn Detention Center Officers, civilians, and chaplains have been voluntarily trained in CIT. All police communications staff within Anne Arundel County Police attended CIT International's Support Training for 911.

Anne Arundel County has a strong regional program that involves multiple law enforcement agencies within its jurisdiction. These agencies coordinate with Mobile Crisis clinicians to active calls for service. There is a CIT Unit with 1 Lieutenant, 1 Sergeant, and 8 officers assigned to the Crisis Response System. Jen Corbin, the Anne Arundel County Mental Health Coordinator, is on multiple committees through the CIT Center of Excellence at the Maryland Governor's Office of Crime Prevention, Youth, and Victim Services and recently presented at the Maryland Police Training Commission to set a state standard for CIT training following the CIT International model. Another committee she is on is to expand CIT into jurisdictions throughout Maryland that are currently without a CIT Program. Lt. Steven Thomas, the CIT Law Enforcement Coordinator, was co-chair of Governor Wes Moore's public safety transition team in 2023 to encourage other jurisdictions to follow CIT International's model of CIT training and Best Practices. In 2023 Lt. Thomas also assisted Maryland State Senator Sara Ellfreth with legislation to create a fund to pay for mental health training for police officers. The legislation passed unanimously in both chambers of the legislature and was signed into law by Governor Moore.

RECOMMENDATIONS:

- CIT International applauds the connections the Anne Arundel CIT Program has developed with the agencies operating within its county. CIT International commends the Anne Arundel County CIT Coordinators for taking on leadership roles in expanding CIT programs and best practices throughout Maryland and recommends building on these efforts to grow and sustain CIT Programs across more counties in the future.

- CIT International recommends the Anne Arundel CIT Program explore the steps it could take to advocate not only for the implementation of additional regional programs, but also for a statewide CIT program. For example, it could work with other regional programs to create a statewide program directory, host regular statewide calls to troubleshoot program challenges, create a statewide website or newsletter, organize a statewide conference, or organize statewide training events.

PARTNERSHIPS AND MULTIDISCIPLINARY CIT COMMITTEE OVERSIGHT

The Anne Arundel County CIT Unit is part of the Crisis Response System, which is governed by a Board of Directors through the Anne Arundel County Mental Health Agency. Board members include individuals with lived experience, their family members, community providers, members of law enforcement, the public school system, local hospitals, community and government officials. Per the bylaws, the Board of Directors is only required to meet annually, but it meets monthly and keeps detailed meeting minutes.

RECOMMENDATIONS:

- CIT International congratulates the Anne Arundel CIT Program for its diversity of partnerships represented on the multidisciplinary Board of Directors through the Anne Arundel County Mental Health Agency. CIT International recommends considering the expansion of this committee to also include representatives from emergency communication centers (911 centers), veterans services, housing, emergency medical personnel, and judicial services.
- While mental health advocates are included on the committee, the Board of Directors could benefit from inviting additional advocates to join the leadership team. For example, peer support, housing advocates, veterans, intellectual/developmental disability advocates, and substance use disorder advocates from the community could add valuable perspectives to the Board's work.

INTEGRATED CRISIS RESPONSE SYSTEM

Anne Arundel has a very robust integrated crisis response system. Components of their crisis response system they noted include a Warmline, Mobile Crisis Teams, Hospital Diversion, Jail Diversion, Care Coordination, Safe Stations, Crisis Beds, Urgent Care, and the CIT Unit. They do offer both law enforcement and non-law enforcement response as well as coordinated response. Approximately 70% of crisis response involves a non-law enforcement mobile crisis response team.

SELECTION OF LAW ENFORCEMENT TRAINING

CIT trainings in Anne Arundel County are held quarterly. In alignment with best practices, CIT training is not mandatory and there is a screening process to determine suitability to attend the training. An 8-hour in-service/refresher course is offered annually. All Anne Arundel Police Department sworn officers are trained in Mental Health First Aid. An 8-hour de-escalation training is offered for everyone at the academy level and as an in-service training.

RECOMMENDATIONS:

- The minimum time of service requirement to attend a 40-Hour CIT class in Anne Arundel is off of field training and probation with independent patrol service. CIT International recommends that the Anne Arundel County CIT Program advise law enforcement agencies that officers participating in the 40-hour CIT training should be experienced officers who apply for the program.

40-HOUR CIT TRAINING

The Anne Arundel County CIT training is offered in accordance with an impressive variety of best practices, including:

- holding the training in a single one-week period,
- limiting the size of attendees to a manageable and effective size (25),
- advocating for trainees to be self-selected,
- the training is not mandatory,
- individuals with lived experience provide some of the instruction,
- site visits are included,
- scenario-based training is included.
- a written test, and formal scoring on the practical exams, is part of the CIT initial and yearly recertification training.

TRAINING FOR OTHER DISCIPLINES

CIT International applauds the Anne Arundel CIT Program for offering a variety of trainings for other disciplines outside of law enforcement. An 8-hour Mental Health First Aid (MHFA) is offered for emergency communications personnel and behavioral health staff. This training includes role play. Approximately 10% of participants in the 40-hour CIT course are non-law enforcement individuals with a connection to the crisis response system.

MHFA is provided to community groups including, but not limited to the NAACP, schools, judiciary personnel, fire department personnel, other police departments and church groups. Participants in the 40-hour CIT classes have included fire department personnel, dispatch, detention center, local hospital security and public defenders.

RECOMMENDATIONS:

- CIT International recommends including emergency medical personnel in the MHFA training.

CIT PROGRAM COORDINATION

The Anne Arundel CIT Program has a Law Enforcement CIT Coordinator, a Mental Health CIT Coordinator, and an Advocacy CIT Coordinator. The Law Enforcement CIT Coordinator has completed the Coordinator Certification Course through CIT International. The Law Enforcement CIT Coordinator is partnered with the mental health CIT clinician, and has been on the Anne Arundel County NAMI Board of Directors since 2017.

RECOMMENDATIONS:

- CIT International recommends that the Anne Arundel County CIT Program work towards a balanced leadership team composed of a mental health coordinator, a law enforcement coordinator, and an advocacy coordinator, which reflects the structure of the coordinating teams. While the application indicates that these roles exist, the role of the Advocacy CIT Coordinator in working with the other coordinators on system improvement and program management is unclear. As a regional program, it is important to coordinate among all partners and represent all perspectives. In addition, although we do not believe this is the case in Anne Arundel, we advise all programs that a program disproportionally managed by one partner for long periods can inadvertently shut out the perspectives of other partners.

POLICY AND DIVERSION

CIT International commends The Anne Arundel CIT Program for having all Detention Center Officers and 6 civilian police booking officers assigned to the central booking facility CIT-trained. The Jail Diversion Program includes a clinician who attends bail review hearings, and provides resources and assistance to the individual who is generally released on pre-trial.

Anne Arundel indicated that there are examples of written policy directing the utilization of CIT officers. Anne Arundel County Police Index Code 1611.1 Crisis Intervention Team (CIT) states the definition of a CIT officer, section 2 describes the purpose of CIT, and section 4 provides protocols for the utilization and responsibilities of CIT officers on the scene of a mental health crisis. While CIT programs are known for CIT-trained officers, successful programs not only focus on improving the crisis response system, advocating for needed services, and strengthening partnerships across the community but also create policy to guide and direct the individuals involved in providing crisis response services.

The Anne Arundel Police Department Communications Section has “Standard Operating Procedure (SOP) COMM 0815 Callers in Crisis” which, among other details, outlines the responsibilities of emergency communications to identify if a caller is suffering an active mental health crisis, and if so, to triage the call to identify the appropriate resources

available for the caller. This SOP also states that mental health calls that do not require a police response may be conferenced in with 988 or the Anne Arundel County Mobile Crisis Hotline (aka the Warmline).

DATA COLLECTION AND QUALITY IMPROVEMENT

CIT International commends the Anne Arundel County CIT Program on its robust and detailed tracking of data to understand the demand for crisis response services, who is initiating the response, and who is responding. Every emergency petition that is written and/or served by officers is reviewed by a Hospital Diversion Specialist for follow-up with the individual and/or their family. Currently, there is no mechanism to provide feedback to the mental health care system and CIT officers, and some outcomes data is lacking.

RECOMMENDATIONS:

- CIT International recommends that the Anne Arundel County CIT Program measure additional data points such as response time, use of force, call disposition, and recidivism to better understand the outcomes of crisis response encounters.[1]
- CIT International recommends that the Anne Arundel CIT Program ensures they are creating regular feedback mechanisms for agency programs to focus on the impact they are making. These could be occasional meetings with local law enforcement, mental health, and advocates to review encounter data from their jurisdiction and discuss opportunities for improvement and change. This can be a morale booster so that CIT officers can see the successes of their work. Sometimes data reveal a need to adjust the staffing of CIT officers, increase access to a specific service, provide training to a group of professionals, increase public awareness, or other steps that increase the program's effectiveness.[2]

  If a meeting with every local jurisdiction is not possible, the regional program can provide a data report to each jurisdiction and then host a general meeting to discuss how local programs can use the data for local improvement.

- If data collection reveals a need to support some individuals with higher needs, the program should consider starting a complex case team. This team would bring together behavioral health and criminal justice stakeholders and advocates to problem-solve around the needs of individuals who experience frequent crises, have frequent involvement with the justice system, and don't seem to be getting the right support.[3]

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[1] For further information about which data to collect and how to use it for problem-solving, review the section "Plan for Program Monitoring" in CIT International's best practice guide, *Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises*, pages 107-111.

[2] For further discussion of conducting these feedback meetings, please review CIT International's best practice guide, Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises, pages 109-111.

[3] To learn more about complex case teams, including protecting privacy when sharing health information, please review CIT International's best practice guide, *Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises*, pages 175-179.

PROGRAM SUSTAINABILITY

The Anne Arundel County CIT Program has developed several measures to ensure the program's sustainability. They hold monthly Board of Director meetings to maintain the momentum of their program. They utilize websites, newsletters, and Facebook to communicate about their program's updates, information, and successes. The website is robust and vibrant. CIT officers, those assigned to the CIT Unit, as well as Crisis Response Clinicians routinely receive Police Department commendation awards. The program also utilizes the Anne Arundel County NAMI annual awards dinner to recognize officers and clinicians for outstanding service. CIT International applauds the Anne Arundel County CIT Program for these measures.

FINANCIAL SUSTAINABILITY

CIT International congratulates the Anne Arundel County CIT Program for its efforts to ensure the program's financial sustainability. The program is funded through the Maryland State Behavioral Health Federal Block Grant (37%), the Maryland State Behavioral Health SOP Grant (19%), a variety of grants through the Anne Arundel County Department of Health, the Annapolis Police Department CIT Grant, and the Anne Arundel County Police Department Mobile Crisis Team Grant. The application indicated, "As these are essential services of the state and county, adequate funding has been approved to sustain them for at least the next two years." The Board of Directors has a budget committee.

https://www.citinternational.org/

CIT International, Inc. is a nonprofit membership organization whose primary purpose is to facilitate understanding, development, and implementation of Crisis Intervention Team (CIT) programs throughout the U.S. and worldwide in order to promote and support collaborative efforts to create and sustain more effective interactions among law enforcement, mental health care providers, individuals with mental illnesses, their families, and communities and to reduce the stigma of mental illness.

Appendix C

CRISIS INTERVENTION TEAM (CIT)

INDEX CODE: 1611.1
EFFECTIVE DATE: 09-11-20

Contents:

I. DEFINITIONS

Anne Arundel County Crisis Response System – Part of the Anne Arundel County Mental Health Agency, Crisis Response, is a comprehensive system of care to provide assistance to consumers with mental health issues, when they are in crisis and in pre-crisis. There are numerous components to the system including but not limited to: Warmline. Mobile Crisis Teams, Mobile Treatment, Hospital Diversion, Jail Diversion, In-Home Intervention Teams, Transportation, Emergency Departments, Residential Crisis Services, Crisis Intervention Teams, Urgent Care, Safe Stations and Care Coordination.

Crisis Intervention Team (CIT) ***Unit - The unit consists of teams of one Anne Arundel County police officer and one Anne Arundel County Crisis Response Clinician. The officer is trained in the 40-hour Memphis Model of CIT Training, as well as both Individual in Crisis and Group Crisis Intervention through ICISF (International Critical Incident Stress Foundation). The CIT Unit conducts follow-up for consumers with mental health issues referred to them and responds to traumatic events within the community. The CIT Unit is housed at Anne Arundel County Crisis Response and is part of the larger Crisis Response System.***

CIT Law Enforcement Coordinator - Anne Arundel County Police Officer holding the rank of Sergeant or above (or as designated by the Chief), who is responsible for all administrative, planning, training, coordinating, and selection of the officers for the Crisis Intervention Team.

Behavioral Health Coordinator - Anne Arundel County Mental Health Agency (AACMHA) employee who is responsible for overseeing the clinical coordination for the client and selection of the clinician who will be assigned to the Crisis Intervention Team.

CIT Officer - A member of the Anne Arundel County Police Department who has completed 40 hours of ***the Memphis Model of CIT Training***. ***The officer does not have to be assigned to the CIT Unit. It is expected that CIT Officers will routinely use their training, knowledge and skills to assist mental health consumers and developmentally delayed adults. CIT Officers are a link to Mobile Crisis Teams, the CIT Unit and community resources.***

CIT Clinician - An employee of the Anne Arundel County Mental Health Agency who is a licensed clinician.

Consumer - A person with a mental health issue.

Crisis Intervention Training - A specialized course of instruction which provides training to law enforcement officers on responding to ***and assisting consumers with mental health issues, individuals with developmental disabilities, and those with substance use addiction. The training is based on the 40-hour Memphis Model CIT training.***

II. PURPOSE

CIT is a culture of helping, as part of the Department's community policing model, integrating mental health throughout the police department by utilizing the strengths of Anne Arundel County Crisis Response. CIT trained officers are expected to use their training whenever possible in the course of their duties.

CIT officers should respond to calls for service to utilize their training and passion to help when they recognize the issue is caused by substance abuse or a mental health concern. CIT officers will assist persons and families in crisis, in the community, and attempt to restore them to a pre-crisis level. CIT officers will refer the person or family to the MCT, the CIT Unit or a community resource for follow-up.

The Crisis Intervention Team (CIT) ***Unit*** is an ***integration*** between police and mental health professionals to help redirect individuals with mental ***health issues*** from the judicial system to the health care system. The target population is ***consumers*** with ***mental*** health issues who would benefit from mental health ***and/or substance abuse*** intervention or linkage to additional community resources. ***The community policing goal is prevention. When the consumer is linked to appropriate community resources, they are then supported and less likely to be involved in inappropriate or criminal behavior.***

Outcomes of CIT interventions include:

A. ***Providing safer interactions between*** officer***s*** and ***consumers.***
B. Redirecting clients with mental ***health issues*** from the judicial system to the health care system.
C. Improve outcomes of police interactions with people with mental ***health issues.***
D. Reducing the number of repeat calls for service for persons with mental ***health issues.***
E. ***Improve community quality of life by reducing incidents in which someone with mental health issues commits criminal acts.***
F. ***Reduce incarceration of consumers.***
G. ***Reduce recidivism by adult and juvenile consumers with mental health issues.***

III. REQUESTS FOR THE CRISIS INTERVENTION TEAM

A. Types of Calls

Generally, the CIT Unit provides follow-up to mental health consumers, those with developmental disabilities, and substance abuse addiction based on referrals.

Referrals can be for the following situations:

1. Repeat callers to 911 who are identified ***as mental health consumers***.
2. ***Consumers*** who are identified as high utilizers of the public mental health system.
3. Persons with known mental ***health issues*** disconnected from services and causing concern in the community.
4. Suicidal attempts and completions.
5. Runaways ***and missing persons (working in conjunction with investigators) who are missing due to mental health issues.***
6. ***Mental health consumers*** at high risk of becoming involved in the judicial system.
7. Provide resources and support to families and victims of traumatic events.
8. Death notification for traumatic events such as murders, suicides, and major accidents.
9. ***Suspects whose crimes are due to their mental health issues***
10. ***Follow-up to emergency petitions where the consumer is also charged with a crime.***
11. ***Mental Health Consumers who are at high risk of becoming involved in the judicial system.***
12. ***Homelessness.***
13. ***Consumers whose perceived victimization is due to their delusional thinking.***
14. ***Victims who are victims due to their mental health issues.***

15. Schools needing assistance with students and/or families with mental health issues and in crisis when a parent cannot be located to give parental permission for a Mobile Crisis Team.

16. To assist a mental health consumer, which due to the consumer's history of violence or substance abuse, it would not be safe for a Mobile Crisis Team to respond.

17. Follow-up on Juvenile Citations in which the behavior is due to a mental health issue. Referrals can be from patrol, specialized units, or the juvenile/witness program director.

18. Safe Station clients attempting to obtain substance abuse treatment with a criminal history, which is creating a roadblock into obtaining treatment.

19. Working in conjunction with HSI for assessment and follow-up from threat complaints.

20. As the CIT Unit is part of the Anne Arundel County Police Department, it is also a part of Anne Arundel County Crisis Response System. There are times that a client may receive assistance from other parts of Crisis Response and the CIT Unit is asked to provide assistance. Requests for assistance and referrals can come from any part of the Crisis Response System including but not limited to: Operations, Mobile Crisis Teams, Hospital Diversion, Jail Diversion, and Care Coordination.

21. Consumers and their family members can call into the 24/7 Crisis Response Warmline for assistance.

B. Request for Service

In most calls for service, patrol officers should first call for a Mobile Crisis Team for assistance. Exceptions are active barricades, active shooters, or any other extreme call, in which a CIT Unit officer can provide assistance that a Mobile Crisis Team cannot provide. If there is a question between a Mobile Crisis Team or a CIT Unit responding, the officer or supervisor should call the Warmline (410-768-5522) and speak with a CIT member.

IV. SCENE OPERATIONS

A. Based on the advanced level of mental health training, the first arriving CIT Officer on scene of a mental health crisis will assume command of the scene***, regardless of post assignment***. The CIT Officer will have control over a crisis scene involving a person in mental health crisis, unless relieved by a supervisor ***or a CIT Unit Officer.***

B. Responsibilities at the scene for the CIT Officer and clinician are to coordinate other personnel to effectively bring about a safe and appropriate disposition. The goal is to establish, develop and implement safe, proactive and preventive methods of containing emotionally explosive situations that could lead to violence.

The CIT Officer is responsible for their safety, their clinician partner's safety, the consumer's safety, as well as the safety of a Mobile Crisis Team when they are on scene.

C. The CIT Clinician will not place hands on or intervene physically with members of the community. In situations where physical intervention is required, the CIT Officer will respond appropriately and request additional police resources as needed. If an officer is in imminent danger and requests assistance verbally or nonverbally, the CIT Clinician may provide assistance.

D. CIT members are trained in scene safety and are required to follow CIT safety procedures while in the field.

E. CIT members will not leave the scene until the situation is stabilized and a disposition is determined.

F. Possible dispositions include:

1. Stabilization with a crisis plan
2. Referral to next day service
3. Referral to long term service
4. Transport to a program or shelter
5. Transport to the Emergency Room voluntarily
6. Contact with provider involved in client's treatment
7. Placement in a crisis bed
8. Placement in emergency shelter
9. Emergency Petition

V. SPECIAL SITUATIONS

A. Hostage negotiations may be supported under the direction of the Special Operations Division if a request for assistance is made. CIT may be used to assist the Conflict Negotiations Team during barricade/hostage negotiation incidents.

B. Death notification***, community*** and bystander assistance at traumatic events will be ***coordinated by the CIT Unit following the practices and procedures of CISM (Critical Incident Stress Management) from ICISF (International Critical Incident Stress Foundation)***.

C. Additional support to family or bystanders may be offered at the scene of a suicide or death.

D. Coordination of service will occur with Domestic Violence, ***Social Services***, Adult and Child Protective Service, Department of Disability Services, Juvenile ***Services***, Geriatric Services, ***the Public Defender's Office, the States Attorney's Office, Anne Arundel County Schools,*** and other community agencies.

VI. PROPONENT UNIT: Bureau of Patrol.

VII. CANCELLATION: ***This directive cancels Index Code 1611.1, dated 08-28-14.***

Appendix D

MOBILE CRISIS TEAM

INDEX CODE: 1611
EFFECTIVE DATE: 09-11-20

Contents:

I. PURPOSE

The Police Department and Anne Arundel County Crisis Response are in partnership to integrate law enforcement and mental health services to assist anyone with a mental health issue who is in crisis or pre-crisis. The Mobile Crisis Team (MCT) supports the work of the police officer who encounters persons and families in crisis in the community. Assistance is offered at the scene to persons with ***a*** mental ***health issue*** and to those experiencing situational crises. The target population is people who would benefit from mental health intervention or linkage to additional community resources. Outcomes of MCT interventions include:

A. Freeing officer time for police duties
B. Appropriate use of emergency rooms and emergency evaluation procedures
C. More immediate stabilization of interpersonal and family crises
D. Service to teens and children
E. Linkage of persons with mental illness into appropriate resources
F. Crisis counseling for members of the community at the scene of a traumatic incident

II. AUTHORITY

The MCT acts as a support to the police and will be permitted to:

A. Operate within the county from a vehicle that circulates among the districts and is recognized as the mobile crisis vehicle.
B. Participate in ride-alongs with police officers for training purposes.
C. Attend roll calls.
D. Maintain a mailbox at each station.
E. Keep officers informed of the disposition of each case as permitted by law.
F. Communicate on authorized police radio channels.

III. REQUESTS FOR THE MOBILE CRISIS TEAM

A. Types of Calls

The following are typical situations which can benefit from MCT assistance:

1. Suicidal thoughts ***or ideation with or*** without attempt.
2. Strange or bizarre behavior
3. Family and domestic violence involving multiple members.

4. Child and adolescent issues.
5. Runaways.
6. Questionable need for Adult or Child Protective Services
7. Geriatric issues with unknown needs for service.
8. Homeless with mental health issues.
9. Completed suicides.
10. Traumatic Incidents- Any call involving death or when death is eminent.
11. Unattended deaths
12. Death notifications
13. Someone seeking assistance or linkage to services with mental health or substance abuse.
14. School calls for students in crisis with parent permission for MCT to assist the child.
15. When an officer is unsure if an emergency petition is appropriate or if the officer believes the clinical expertise of the MCT will be helpful in completing an emergency petition.

Types of calls that are not appropriate include:

1. A person who has a weapon or is immediately involved in a violent or assaultive ***behavior***.
2. A person who is required by law or policy to be arrested.

B. How to Request

The decision to request support from the MCT remains with the officer at the scene ***or a supervisor***. The safety of the situation should be stabilized before the team is called to enter the scene. The officer should notify Communications of the request for the MCT and will be advised of potential arrival time. ***If it is believed that the MCT may be helpful, the MCT should be requested. If there is a question of willingness to receive assistance from the MCT, have the MCT respond and the person can refuse services from MCT upon their arrival. If there is a question of appropriateness of MCT responding the officer should call the Warmline (410-768-5522) and request to speak with MCT.***

IV. COMMUNICATIONS

A. Request for the MCT will be made to communications by radio.

B. The MCT will monitor the radio when not involved in a call and will keep themselves available for potential dispatches.

C. The MCT will not arrive at the site until the request is made, but may place themselves within the geographic area and notify dispatch of their availability.

D. After arrival at the scene, the officer will use radio communication to notify the MCT of the appropriate place and time to enter the scene.

E. Determinations of priorities for intervention will be made by the MCT using input from Communications and the officer at the scene.

F. The MCT will be trained and responsible for appropriate use of radio communications.

G. Face to face communications should be attempted at roll call or after the disposition of the case when possible.

H. Copies of police reports or notes about past and potential mental health situations can be ***forwarded to CIT supervision for MCT follow-up***.

I. The MCT will relay the disposition of every case to the responding officer within guidelines of confidentiality.

J. There are situations when the MCT responds to calls without police due to Warmline dispatches or while conducting follow-up to previous calls for service, which do not require police assistance. In those situations, the MCT will notify communications by radio of their location.

V. SCENE OPERATIONS

A. Responsibilities at the scene for the officer include remaining at the scene until the MCT has determined a disposition or determined that further assistance is not needed. ***The Officer must remain at the scene until the MCT tells the officer they can clear.***

B. Responsibilities at the scene for the MCT include ***de***-escalation of emotional situations, assessments, brief mental status evaluations for suspected emotional disorders, crisis intervention, and linkage to services.

C. MCT members do not place hands on or intervene physically with members of the community. In situations where physical intervention is required, the officer ***will*** stay on the scene.

D. MCT members are trained in scene safety and are required to follow MCT safety procedures while in the field.

E. MCT members do not leave the scene until the situation is stabilized and a disposition is determined. ***The*** MCT should call officers to return to the scene if the situation deteriorates.

F. Possible dispositions include:

1. Stabilization with a crisis plan
2. Referral to next day service
3. Referral to long term service
4. Set up for urgent care appointments
5. Transport to the Emergency Room
6. Arrest
7. Placement in a crisis bed
8. Placement in emergency shelter
9. Referral for family members or bystanders

VI. ADDITIONAL RESOURCES

In addition to the MCT, the Crisis Response System will offer other services including:

A. ***Referrals to c***risis beds for adults and children
B. Transportation to and from mental health appointments
C. Urgent care appointments
D. ***Provide resources for e***mergency shelter for those with mental health needs.
E. Support and coordination of services by phone.
F. Stabilization visits
G. Crisis case management
H. Hospital Diversion
I. Jail Diversion
J. Safe Stations
K. Care Coordination

VII. SPECIAL SITUATIONS

A. Hostage negotiations will be supported under the direction of the Special Operations Division if request for assistance is made.

B. Death notification***, community,*** and bystander assistance at traumatic events will be supported when chaplains are unable to respond or need additional resources.

C. Additional support to family or bystanders may be offered at the scene of a suicide**,** death***, or any other traumatic incident.***

D. Coordination of service will occur with Domestic Violence, ***Social Services,*** Adult and Child Protective Services, Juvenile ***Services***, Geriatric Services, ***the Public Defender's Office, the State's Attorney's Office, the Anne Arundel County Schools,*** and other community agencies.

VIII. PROPONENT UNIT: Bureau of Patrol.

IX. CANCELLATION: This directive cancels Index Code 1611, dated ***08-28-14***.

Appendix E

Anne Arundel County Police Department
Training Division

Training Bulletin # 2024-015

December 2024

Emergency Petitions

Emergency Petitions are Legal Documents for the District Court of Maryland

- An Emergency Petition allows a Police Officer to take an individual into custody and transport them to the closest Emergency Room for an evaluation.
- At the emergency room the individual loses their right to refuse service for an evaluation.
- Court ordered Emergency Petitions are valid for 5 days.
- Officer written Emergency Petitions should be based on current information and/or a current assessment
- Emergency Petitions for a missing person should not be written until the person is located.
- If there is a question if someone should be taken to the hospital on an Emergency Petition a mobile crisis team should be consulted and/or respond and assess the person. **When in doubt call Mobile Crisis to respond to the scene.**

Legal Standard, Senate Bill 273 (2003):

"Suspected to have a mental disorder, presents a danger to the life or safety of individual or other, must observe the individual in question or their behavior, **Emergency Petition can be based on examination, observation or other pertinent information**." Pertinent information can be from a **third party**.

Behavior includes:

- A clear disruption in mental functioning, however, does not include intellectual disability, unless the individual presents bizarre, aggressive or self-injurious behavior and/or a co-occurring mental disorder.
- The individual will display either passive or active actions.
- Passive actions may consist of self-neglect; including starvation and dehydration, not taking necessary medications to maintain health, purposely dressing improperly for the weather without regard to safety, and not recognizing and responding to common dangers in everyday life.
- Active actions are behaviors which in itself presents a danger to life or safety of the individual or others.

Danger:

- Determine if they or someone else in "harm's way" due to the behavior and/or their inaction.

Poor Judgement can be used to a show mental disorder or dangerousness:

- Responsive behaviors to hallucinations or delusions
- Risk taking and/or exaggerated abilities without considering consequences
- Inappropriate public self-exposure or touching of others
- Refusing shelter during inclement weather

Index Code 1830
Section X Custody
If an individual with mental health issues is taken into custody, officers will make a reasonable effort to use the least restraint possible **(minimally handcuffed per Index Code 2003)** to protect the arrestee from self-injury, while taking all necessary precautions.

There are times a Mobile Crisis Team will request someone be transported to the hospital who does not meet Emergency Petition criteria. The person would have to agree to voluntarily seek mental health treatment. The Mobile Crisis Team will follow the transporting officer in their own vehicle and accompany the person into the emergency room. In these situations, the person should **not be handcuffed**, as they are not in custody. **If there is a question or concern about safety, the officer should discuss the concern with the Mobile Crisis Team, so they can re-evaluate if an Emergency Petition should be completed**.

Completing an Emergency Petition:

- The Emergency Petition must be legible and **completely** filled out.
- The evaluee's complete name, address, date of birth and all descriptors should be included.
- Every line of the Emergency Petition **should** have information or N/A.
- In line 3 when possible identify a family member or friend who can give additional information and background on the person's diagnosis, history and behavior. The hospital can contact them for additional information.
- **In line 9 of the Emergency Petition, the Behavior must be specific, descriptive, and detailed to include:**
    1. Quotes i.e., "I want to die", "I have nothing to live for"
    2. Statement of current problems and issues
    3. Statement of helplessness and hopelessness
    4. Details concerning self-care (not eating or bathing)
    5. Declining shelter in extreme inclement weather.
    6. Erratic behavior, responding to hallucinations/delusions
    7. Not slept in days or extremely limited sleep in days.
    8. Describe specific suicidal behavior in detail.
- **In line 10 of the Emergency Petition, why they are a danger to themselves or others must be described**. **It must be explained how the behavior in line 9 makes them a danger to themselves and/or others.**
- Line 10 should also include **Mental Health History**:
    1. Statement regarding previous hospitalizations and/or diagnosis
    2. Statement regarding previous suicide attempts, reckless behaviors, inabilities to care for self and previous calls for service.
    - Further, in Line 10, if they have a **plan** to commit suicide, it should be specifically described, as well as their ability (**means**) to carry out the plan.
    - Line 10 should include **lack of support** in all areas including social, emotional, vocational, and medical. If they do not have any family or friends for support, it should be clearly noted in the petition.
    - Information in line 9 frequently needs to be repeated in line 10.

It is obvious that all the necessary information will not fit on the lines of the Emergency Petition. Therefore you must either write on the back or attach the additional information to the Emergency Petition.

- **Errors in completing an Emergency Petition will result in the individual being**

immediately discharged. Errors may include:

- Not properly describing the specific behaviors or documenting why the behaviors are dangerous.
- Not signing the Emergency Petition; must be an original signature
- Not filling in all of the necessary sections of the Emergency Petition

An incident report must be completed and a copy of the Emergency Petition must be uploaded into **an incident/offense report.**

Whenever a health care or mental health professional completes an Emergency Petition under HG 10-622 an officer **must** sign the petition. The original Emergency Petition (with original signatures) must be left with hospital staff. **In these incidents Officers should complete an incident/offense report and should include a copy of the Emergency Petition with the report**. This is a one-time opportunity for the police department to record the health care or mental health professional's documentation without violating HIPPA. This information can be extremely valuable in future interactions.

Crisis Intervention Team Report

Appendix F

Subject Details

Subject:

Disposition of Subject:

If Other (Disposition):

Diverted From:

Equipment/Technique:

Mobile Crisis Team Utilized:

Complainant Details

Complainant:

Relationship to Subject:

If Other (Relationship):

Anonymous: ☐

Crisis Intervention Details

Living Arrangements:

Prior Mental Health Hospitalization:

If Other (Living Arrangement):

Prior Mental Health Treatment:

Current Mental Health Treatment:

Currently Taking Medication for Mental Illness:

Prescribed Medications:

Subject Transported By

Officer:

Ambulance (Company, Unit #):

Subject Transported To

Detention Facility:

Hospital:

If Other (Detention Facility):

If Other (Hospital):

Subject Weapons Details

Subject Used Weapons: ☐

Subject Used Force: ☐

If Yes, Type (Weapons):

If Yes, Type (Force):

Did You Observe Any of the Following?

Nothing unusual observed: ☐

Absurd, illogical thinking, talking: ☐

Bizarre behavior/appearance: ☐

Hearing voices/hallucinating: ☐

Anxious/excited: ☐

Paranoia or suspiciousness: ☐

Violent behavior: ☐

Severe depression, mood: ☐

Suicidal talk: ☐

Signs of intoxication/drug use: ☐

Suicidal gesture(s): ☐

Aggressive/threatening behavior or speech: ☐

CAD Hazard (explain in narrative): ☐

Possible intellectual & developmental disability: ☐

CIT Officer Information

CIT Officer:

Date:

Additional Information

Forwarded to Mobile Crisis ☐

Assisting Other Agency:

Appendix G

SANTÉ AFFILIATED SANTÉ GROUP

BALTIMORE COUNTY CRISIS RESPONSE SYSTEM

July 2023-June 2024

Mobile Crisis Team Report

	1st Quarter				2nd Quarter				3rd Quarter				4th Quarter				FY24	YTD
	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total	Apr	May	Jun	Total	Total	Avg
Number of Calls for Service	240	221	192	**653**	216	174	182	**572**	146	195	238	**579**	215	247	167	**629**	**2433**	***202.75***
Dispatch By:																		
911 Dispatch	88	66	30	**184**	33	28	46	**107**	46	62	83	**191**	53	85	53	**191**	**673**	***56.08***
Fire	0	2	8	**10**	2	1	1	**4**	2	1	3	**6**	0	2	1	**3**	**23**	***1.92***
GBRICs Call Center	0	0	0	**0**	0	0	0		0	0	0	**0**	0	0	0			***0.00***
IHIT	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	***0.00***
MCT	11	9	8	**28**	5	8	6	**19**	3	6	15	**24**	8	9	7	**24**	**95**	***7.92***
OPS	24	25	24	**73**	31	26	29	**86**	21	16	29	**66**	47	35	25	**107**	**332**	***27.67***
Police PCT/Dept	116	118	117	**351**	141	108	99	**348**	70	104	104	**278**	103	110	78	**291**	**1268**	***105.67***
Other	1	1	5	**7**	4	3	1	**8**	4	6	4	**14**	4	6	3	**13**	**42**	***3.50***
Type of Dispatch:																		
New Dispatch	191	166	153	**510**	164	142	138	**444**	119	151	183	**453**	167	191	132	**490**	**1897**	***158.08***
Follow-up Dispatch	49	55	39	**143**	52	32	44	**128**	27	44	55	**126**	48	56	35	**139**	**536**	***44.67***
*Total # Telehealth Visits New	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	**1**	***0.08***
*Total # Telehealth Visits F/U	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	***0.00***
MCT Consultation:																		
Unknown Consumer											12	**12**	11	11	4	**26**	**38**	***9.50***
Prior Consumer											16	**16**	10	10	12	**32**	**48**	***12.00***
Dispatch Area:																		
Pct 6	22	21	19	**62**	23	18	27	**68**	16	17	27	**60**	28	32	10	**70**	**260**	***21.67***
Pct 8	20	20	15	**55**	20	14	19	**53**	11	22	17	**50**	13	21	17	**51**	**209**	***17.42***
Eastside Pct 9	24	17	21	**62**	26	18	18	**62**	10	22	32	**64**	20	27	17	**64**	**252**	***21.00***
Pct 11	33	27	26	**86**	21	16	19	**56**	22	15	22	**59**	24	28	21	**73**	**274**	***22.83***
Pct 12	20	31	25	**76**	31	18	16	**65**	13	23	24	**60**	21	30	24	**75**	**276**	***23.00***
Pct 1	17	17	17	**51**	17	14	12	**43**	8	13	13	**34**	7	17	15	**39**	**167**	***13.92***
Pct 2	48	25	18	**91**	25	19	18	**62**	17	20	33	**70**	26	20	17	**63**	**286**	***23.83***
Westside Pct 3	15	13	12	**40**	10	8	13	**31**	12	16	20	**48**	25	17	9	**51**	**170**	***14.17***
Pct 4	15	24	18	**57**	20	30	19	**69**	22	31	23	**76**	33	18	21	**72**	**274**	***22.83***
Pct 7	26	26	21	**73**	23	19	21	**63**	15	16	27	**58**	18	37	16	**71**	**265**	***22.08***
Other	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**	***0.00***
Shift: 6AM-2PM	23	15	23	**61**	30	7	13	**50**	8	18	16	**42**	21	21	13	**55**	**208**	***17.33***
7AM-3PM	62	52	52	**166**	55	43	44	**142**	42	49	73	**164**	41	66	48	**155**	**627**	***52.25***
2PM-10PM	25	24	23	**72**	33	31	38	**102**	19	28	40	**87**	45	35	24	**104**	**365**	***30.42***
3PM-11PM	72	67	48	**187**	39	43	35	**117**	37	49	43	**129**	51	53	35	**139**	**572**	***47.67***
5PM-1AM	20	26	20	**66**	23	26	24	**73**	20	24	37	**81**	38	32	25	**95**	**315**	***26.25***
11PM-7AM	38	37	26	**101**	36	24	28	**88**	20	27	29	**76**	19	40	22	**81**	**346**	***28.83***
For Each Call:				**Avg**				**Avg**				**Avg**				**Avg**		
Mean Response Time (min)	16	16	16	**16.0**	17	17	18	**17.3**	17	20	17	**18.00**	19	18	19	**18.6667**	**16.0**	***17.50***
Mean Total Time Spent (min)	74	72	82	**76.0**	75	78	77	**76.7**	76	73	77	**75.3333**	81	78	47	**68.67**	**76.0**	***74.17***
Mean Total Travel Distance (mile)	8	8	8	**8.0**	9	8	9	**8.7**	9	9	9	**9.0**	9	10	10	**9.67**	**8.0**	***8.83***
Gender of Client:				**Total**				**Total**				**Total**				**Total**		
Female	134	111	103	**348**	129	111	98	**338**	82	104	122	**308**	114	120	93	**327**	**1321**	***110.08***
Male	104	106	87	**297**	84	59	82	**225**	62	85	114	**261**	99	124	71	**294**	**1077**	***89.75***
Unknown	1	1	0	**2**	1	3	0	**4**	1	2	0	**3**	1	0	1	**2**	**11**	***0.92***
Other	1	3	2	**6**	2	1	2	**5**	1	4	2	**7**	1	3	1	**5**	**23**	***1.92***
Insurance Type per Client:																		
Medicaid	30	17	21	**68**	24	27	32	**83**	25	28	31	**84**	37	34	20	**91**	**326**	***27.17***
Medicare	7	11	9	**27**	14	9	8	**31**	12	18	15	**45**	8	16	10	**34**	**137**	***11.42***
Private	18	29	23	**70**	20	20	22	**62**	17	15	30	**62**	23	35	22	**80**	**274**	***22.83***
Other	2	2	3	**7**	0	1	1	**2**	5	2	2	**9**	6	2	0	**8**	**26**	***2.17***
Uninsured	12	4	9	**25**	7	1	3	**11**	6	5	10	**21**	4	7	5	**16**	**73**	***6.08***
Unknown	168	150	126	**444**	147	115	116	**378**	81	126	146	**353**	135	150	110	**395**	**1570**	***130.83***
Military	3	8	1	**12**	4	1	0	**5**	0	1	4	**5**	2	3	0	**5**	**27**	***2.25***
Client Age:																		
Child (1-12 years)	11	9	11	**31**	11	13	5	**29**	7	10	11	**28**	16	11	3	**30**	**118**	***9.83***
Teenager (13-17 years)	25	28	19	**72**	34	23	12	**69**	20	22	32	**74**	28	29	24	**81**	**296**	***24.67***
Transitional Adult (18-21 years)	17	28	16	**61**	22	14	13	**49**	5	26	21	**52**	19	21	8	**48**	**210**	***17.50***
Adult (22-64 years)	157	131	122	**410**	123	103	124	**350**	84	115	144	**343**	127	149	108	**384**	**1487**	***123.92***
Elderly (65+ years)	26	23	16	**65**	24	16	24	**64**	24	17	20	**61**	20	27	19	**66**	**256**	***21.33***
Unknown	4	2	8	**14**	2	5	4	**11**	6	5	10	**21**	5	10	5	**20**	**66**	***5.50***

Additional Descriptive Stats:	**240**	**Aug**	**Sep**	**Total**	**Oct**	**Nov**	**Dec**	**Total**	**Jan**	**Feb**	**Mar**	**Total**	**Apr**	**May**	**Jun**	**Total**	**Total**	***240.00***
Mean age of client	37	35	36	**36**	35	34	41	**37**	39	36	35	**110**	34	38	37	**109**	**36**	***36.42***
Minimum age of client	6	8	7	**7**	5	7	7	**6**	7	5	9	**21**	7	6	12	**25**	**7**	***7.17***
Maximum Age of client	90	91	92	**91**	92	87	93	**91**	82	80	90	**252**	84	92	98	**274**	**91**	***89.25***
Call Location:																		
Community	46	35	39	**120**	37	37	36	**110**	16	20	34	**70**	28	53	29	**110**	**410**	***34.17***
Court/Jail	2	0	4	**6**	3	2	2	**7**	0	3	0	**3**	4	1	0	**5**	**21**	***1.75***
Hospital	4	1	2	**7**	0	0	1	**1**	1	2	3	**6**	4	1	3	**8**	**22**	***1.83***
Office	1	2	0	**3**	2	0	1	**3**	0	2	4	**6**	0	0	1	**1**	**13**	***1.08***
Other	4	2	3	**9**	5	5	3	**13**	8	3	11	**22**	13	12	5	**30**	**74**	***6.17***
Provider	3	0	0	**3**	0	0	1	**1**	0	1	0	**1**	3	0	1	**4**	**9**	***0.75***
Residence	174	177	141	**492**	162	125	135	**422**	117	159	175	**451**	157	174	126	**457**	**1822**	***151.83***
School	2	2	3	**7**	5	4	1	**10**	2	5	10	**17**	5	6	1	**12**	**46**	***3.83***
Workplace	4	2	0	**6**	2	1	2	**5**	2	0	1	**3**	1	0	1	**2**	**16**	***1.33***
Drugs	11	5	10	**26**	9	2	4	**15**	4	6	7	**17**	11	11	13	**35**	**93**	***7.75***
Alcohol	21	22	20	**63**	22	15	17	**54**	10	18	25	**53**	19	14	20	**53**	**223**	***18.58***
Focal Issues: (3 per call)																		
Adult Abuse/Neglect	1	0	0	**1**	1	0	0	**1**	1	0	2	**3**	0	4	0	**4**	**2**	***0.75***
Anxiety	9	14	14	**37**	6	5	5	**16**	5	9	3	**17**	7	11	6	**24**	**60**	***7.83***
Autism Spectrum SX/BX	6	3	7	**16**	5	10	8	**23**	6	7	7	**20**	8	8	5	**21**	**80**	***6.67***
Child Abuse/Neglect	1	1	0	**2**	1	0	1	**2**	0	0	2	**2**	1	1	1	**3**	**9**	***0.75***
Child with Significant Illness	0	0	1	**1**	0	0	0	**0**	1	0	0	**1**	1	0	0	**1**	**3**	***0.25***
Child/Adolescent Behavior	16	20	20	**56**	26	19	10	**55**	15	20	27	**62**	22	21	14	**57**	**230**	***19.17***
Chronic Mental Illness	48	19	24	**91**	28	23	22	**73**	19	25	36	**80**	24	37	27	**88**	**332**	***27.67***
Community Resources	22	20	23	**65**	29	17	19	**65**	15	17	19	**51**	17	26	12	**55**	**236**	***19.67***
Confusion/Dementia	4	2	2	**8**	2	5	9	**16**	5	3	6	**14**	3	3	6	**12**	**50**	***4.17***
Co-occuring Disorder/Concerns	0	0	1	**1**	1	1	0	**2**	0	0	0	**0**	0	0	0	**0**	**3**	***0.25***
Death By Suicide	3	3	4	**10**	7	4	10	**21**	3	3	6	**12**	6	3	6	**15**	**58**	***4.83***
Death Other Than Suicide	25	16	17	**58**	11	15	15	**41**	12	11	16	**39**	21	19	9	**49**	**187**	***15.58***
Delusional/Hallucinations	25	26	22	**73**	24	14	14	**52**	25	24	36	**85**	22	23	16	**61**	**271**	***22.58***
Depression	32	26	17	**75**	19	22	13	**54**	14	15	23	**52**	20	25	20	**65**	**246**	***20.50***
Developmental Disability	3	6	3	**12**	4	4	2	**10**	6	1	3	**10**	5	3	2	**10**	**42**	***3.50***
Domestic Violence	1	2	2	**5**	4	3	3	**10**	2	3	3	**8**	3	1	2	**6**	**29**	***2.42***
Emergency Petition	16	15	15	**46**	15	10	8	**33**	5	15	25	**45**	11	21	9	**41**	**165**	***13.75***
Family Conflict	32	29	25	**86**	25	23	17	**65**	21	26	23	**70**	29	35	29	**93**	**314**	***26.17***
Family Support/IVC Assistance	1	1	0	**2**	2	0	0	**2**	0	1	1	**2**	0	0	2	**2**	**8**	***0.67***
Fatal Accident	0	0	0	**0**	0	0	0	**0**	1	0	0	**1**	5	0	0	**5**	**6**	***0.50***
Financial	1	3	1	**5**	3	2	1	**6**	0	2	1	**3**	0	3	2	**5**	**19**	***1.58***
Homeless	2	7	7	**16**	2	4	4	**10**	2	6	7	**15**	2	7	6	**15**	**56**	***4.67***
Homicidal Ideation	7	7	3	**17**	2	5	5	**12**	0	3	3	**6**	4	5	4	**13**	**48**	***4.00***
Legal	2	0	1	**3**	2	1	0	**3**	0	1	0	**1**	0	2	0	**2**	**9**	***0.75***
Mania	4	8	3	**15**	7	9	2	**18**	2	6	4	**12**	6	8	5	**19**	**64**	***5.33***
Marital/Significant Other Conflict	10	7	2	**19**	7	7	5	**19**	4	10	9	**23**	3	10	7	**20**	**81**	***6.75***
Medical Issue Primary	9	2	8	**19**	6	5	3	**14**	4	4	0	**8**	4	5	5	**14**	**55**	***4.58***
Mood Disorder	8	8	3	**19**	5	3	5	**13**	3	6	6	**15**	3	12	2	**17**	**64**	***5.33***
Non-suicidal Self Injurious Behavior	4	7	1	**12**	5	3	1	**9**	6	0	2	**8**	4	3	2	**9**	**38**	***3.17***
Other	39	26	26	**91**	25	28	33	**86**	18	25	26	**69**	27	38	24	**89**	**335**	***27.92***
Police/CIT (Main Contact)	0	1	1	**2**	3	1	3	**7**	1	0	1	**2**	1	0	0	**1**	**12**	***1.00***
Psychotic	2	8	5	**15**	3	0	2	**5**	5	1	2	**8**	2	2	0	**4**	**32**	***2.67***
PTSD	11	6	11	**28**	8	1	13	**22**	2	6	19	**27**	4	13	10	**27**	**104**	***8.67***
Runaway/Wandering	1	0	1	**2**	0	0	0	**0**	1	1	0	**2**	1	3	3	**7**	**11**	***0.92***
Sexual Assault	0	3	1	**4**	1	0	0	**1**	0	1	0	**1**	0	0	0	**0**	**6**	***0.50***
Situational Crisis	74	75	52	**201**	57	49	54	**160**	46	72	69	**187**	70	88	66	**224**	**772**	***64.33***
Substance Use	25	18	14	**57**	15	8	17	**40**	7	18	16	**41**	14	18	14	**46**	**184**	***15.33***
Suicidal Ideation	4	8	4	**16**	6	5	4	**15**	1	5	6	**12**	3	8	0	**11**	**54**	***4.50***
Suicide Attempt	40	41	32	**113**	46	43	38	**127**	28	37	48	**113**	54	48	36	**138**	**491**	***40.92***
Traumatic Brain Injury (TBI)	1	1	0	**2**	0	0	0	**0**	0	1	0	**1**	1	0	0	**1**	**4**	***0.33***
Unemployed	0	0	0	**0**	1	0	0	**1**	0	1	0	**1**	0	0	0	**0**	**2**	***0.17***
Violence	6	2	6	**14**	3	1	4	**8**	2	3	3	**8**	3	5	3	**11**	**41**	***3.42***

Diagnostic Category:	**Jul**	**Aug**	**Sep**	**Total**	**Oct**	**Nov**	**Dec**	**Total**	**Jan**	**Feb**	**Mar**	**Total**	**Apr**	**May**	**Jun**	**Total**	**Total**	***Avg***
Anxiety Disorder	5	17	13	**35**	15	5	6	**26**	9	9	2	**20**	6	9	6	**21**	**102**	***8.50***
Bipolar/Related Disorder	20	28	19	**67**	34	27	25	**86**	17	22	30	**69**	27	34	14	**75**	**297**	***24.75***
Depressive Disorder	38	35	23	**96**	41	29	22	**92**	26	22	46	**94**	31	31	20	**82**	**364**	***30.33***
Diagnosis due to Medical Condition	2	0	5	**7**	0	1	0	**1**	0	1	0	**1**	1	1	0	**2**	**11**	***0.92***
Disruptive/Impulse/Conduct Disorder	12	15	13	**40**	14	14	7	**35**	9	18	20	**47**	15	17	7	**39**	**161**	***13.42***
Dissociative Disorder	1	0	0	**1**	1	0	0	**1**	2	0	0	**2**	0	0	0	**0**	**4**	***0.33***
Not Applicable	31	23	28	**82**	25	36	34	**95**	28	24	26	**78**	36	42	23	**101**	**356**	***29.67***
Neurocognitive Disorder	4	3	4	**11**	4	5	5	**14**	5	7	9	**21**	5	5	5	**15**	**61**	***5.08***
Neurodevelopmental Disorder	11	10	10	**31**	11	9	12	**32**	8	12	11	**31**	11	15	8	**34**	**128**	***10.67***
Other	4	4	0	**8**	2	1	0	**3**	0	2	2	**4**	3	3	2	**8**	**23**	***1.92***
Personality Disorder	4	2	1	**7**	1	4	1	**6**	0	4	3	**7**	2	2	1	**5**	**25**	***2.08***
Schizophrenia/Psychotic Disorder	43	31	27	**101**	14	11	22	**47**	11	30	37	**78**	21	28	23	**72**	**298**	***24.83***
Substance/Addictive Disorder	16	12	9	**37**	12	9	11	**32**	4	13	13	**30**	5	11	10	**26**	**125**	***10.42***
Trauma/PTSD	4	12	6	**22**	3	3	5	**11**	8	3	6	**17**	7	7	4	**18**	**68**	***5.67***
Undetermined	45	29	34	**108**	39	20	32	**91**	19	28	33	**80**	45	42	44	**131**	**410**	***34.17***
Intervention Used:																		
Assist with EP	8	3	2	**13**	5	11	9	**25**	6	4	8	**18**	10	6	2	**18**	**74**	***6.17***
BH Referral	48	62	50	**160**	39	41	20	**100**	20	28	20	**68**	17	27	20	**64**	**392**	***32.67***
CIST Call	22	20	25	**67**	15	15	23	**53**	10	13	18	**41**	25	21	17	**63**	**224**	***18.67***
Client Education	85	85	75	**245**	83	62	56	**201**	44	49	61	**154**	64	62	47	**173**	**773**	***64.42***
Client Refused Services	8	16	6	**30**	11	7	7	**25**	6	10	5	**21**	8	7	4	**19**	**95**	***7.92***
Client Unavailable	1	5	2	**8**	5	4	5	**14**	4	6	3	**13**	4	4	5	**13**	**48**	***4.00***
Contact EMT	6	3	3	**12**	5	5	2	**12**	4	5	4	**13**	3	6	1	**10**	**47**	***3.92***
Contact Law Enforcement	1	0	0	**1**	2	4	0	**6**	2	0	0	**2**	1	3	1	**5**	**14**	***1.17***
Contacted APS	2	0	0	**2**	0	0	1	**1**	1	0	0	**1**	1	3	1	**5**	**9**	***0.75***
Contacted CPS	3	3	3	**9**	0	0	0	**0**	0	0	2	**2**	1	3	2	**6**	**17**	***1.42***
Crisis Bed Placement	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	0	1	1	**2**	**3**	***0.25***
Emergency Petition by MCT	39	32	26	**97**	22	22	21	**65**	12	27	50	**89**	33	42	22	**97**	**348**	***29.00***
Escort to Hospital	23	17	23	**63**	21	18	17	**56**	21	21	20	**62**	23	19	14	**56**	**237**	***19.75***
Family Education	68	62	50	**180**	62	46	35	**143**	31	40	44	**115**	58	40	35	**133**	**571**	***47.58***
Grief Support	26	16	25	**67**	18	15	23	**56**	14	13	13	**40**	20	20	13	**53**	**216**	***18.00***
Non-BH Referral	22	17	16	**55**	24	12	6	**42**	5	13	3	**21**	1	6	2	**9**	**127**	***10.58***
Physical Intervention	0	1	0	**1**	2	3	0	**5**	1	0	2	**3**	0	0	0	**0**	**9**	***0.75***
Safety Plan	150	142	118	**410**	138	105	100	**343**	89	116	127	**332**	115	139	87	**341**	**1426**	***118.83***
School/Provider/Etc Education	3	0	3	**6**	0	2	0	**2**	1	1	1	**3**	0	0	0	**0**	**11**	***0.92***
Stable upon MCT arrival	25	41	42	**108**	39	34	31	**104**	24	42	49	**115**	40	52	28	**120**	**447**	***37.25***
Transport to Hospital	28	26	9	**63**	20	16	10	**46**	6	17	34	**57**	20	30	22	**72**	**238**	***19.83***
Verbal De-escalation	34	34	25	**93**	21	24	26	**71**	22	32	29	**83**	22	38	18	**78**	**325**	***27.08***
Voluntary ER	19	14	11	**44**	30	17	14	**61**	9	7	10	**26**	13	13	17	**43**	**174**	***14.50***
Well-being Check	71	65	76	**212**	72	58	71	**201**	57	87	119	**263**	112	148	94	**354**	**1030**	***85.83***
Other	11	10	9	**30**	15	17	11	**43**	9	13	10	**32**	7	14	7	**28**	**133**	***11.08***
Calls Diverted from ER:																		
Yes	38	46	29	**113**	36	32	27	**95**	27	26	27	**80**	26	33	22	**81**	**369**	***30.75***
No	66	53	41	**160**	57	48	39	**144**	32	46	78	**156**	59	66	45	**170**	**630**	***52.50***
N/A	136	122	122	**380**	123	94	116	**333**	87	123	133	**343**	130	148	100	**378**	**1434**	***119.50***
Calls Diverted from the Criminal Justice System:																		
Yes	10	11	7	**28**	7	2	6	**15**	4	2	4	**10**	1	5	2	**8**	**61**	***5.08***
No	3	3	3	**9**	5	1	0	**6**	2	6	3	**11**	1	2	1	**4**	**30**	***2.50***
N/A	227	207	182	**616**	204	171	176	**551**	140	187	231	**558**	213	240	164	**617**	**2342**	***195.17***
Calls Diverted from Emergency Petition:																		
Yes	39	37	19	**95**	45	33	26	**104**	26	25	24	**75**	23	27	21	**71**	**345**	***28.75***
No	38	36	29	**103**	26	27	26	**79**	18	32	58	**108**	43	48	23	**114**	**404**	***33.67***
N/A	163	148	144	**455**	145	114	130	**389**	102	138	156	**396**	149	172	123	**444**	**1684**	***140.33***

Appendix H

MONTGOMERY COUNTY, MARYLAND
DEPARTMENT OF POLICE

FOLLOW-UP INVESTIGATIVE RESPONSIBILITY

DIRECTIVE NO:	EFFECTIVE DATE:
FC 0611	**May 6, 2025**
CANCELS: FC 0611, dated March 15, 2021	**ACCREDITATION STANDARDS:** CALEA Standards: *6th Edition,* 1.2.1, 1.2.4, 1.2.5, 26.2.1, 26.3.2, 41.2.4, 41.2.5, 41.2.6, 41.2.7, 42.2.1, 43.1.1, 43.1.5, 44.1.1, 46.1.10, 81.2.5, 82.2.1, 82.2.2, and 83.1.1
PROPONENT UNIT: Investigative Service Bureau, Patrol Services Bureau, **Community Engagement Division**, and the Internal Affairs Division	**AUTHORITY:** **Marc R. Yamada, Chief of Police**

If a provision of a regulation, departmental directive, rule, or procedure conflicts with a provision of the contract, the contract prevails except where the contract provision conflicts with State law or the Police Collective Bargaining Law. (FOP Contract, Article 61).

I. POLICY

The department's policy is to provide guidelines for investigators' responses, efficiently use staff, ensure investigation continuity for specific crimes, and provide investigative support for patrol officers.

II. NOTIFICATION GUIDELINES

A. The arresting officer or supervisor will immediately notify the appropriate investigative section in all situations involving the arrest of an individual for:

1. Homicide
2. Robbery
3. Rape (first or second-degree) or third-degree sex offense
4. Kidnapping
5. First-degree assault that **involves intimate partners**
6. Hate crimes/bias incidents involving an underlying crime delineated in this directive

7. **Sex/Human Trafficking**
8. Gang-related crimes
9. **Motor Vehicle Theft**
10. Any attempt of the above

B. During the responsible investigative unit's scheduled work hours, the primary officer will call the investigative unit's office to contact an available **investigator**. If no **investigator** is in the office or available by phone, the Public Safety Communications Center (PSCC) will assist in contacting an **investigator**.

C. After-hours **investigator** notifications will be made to the appropriate investigative unit by the PSCC supervisor. All notifications will be made in compliance with the established notification procedures.

D. Any officer who makes an arrest and believes that criminal intelligence can be gained by interrogating the defendant should transport the defendant to the district station. The officer must ensure that the appropriate investigative section is notified for timely consultation with the arresting officer.

III. PATROL SERVICES BUREAU (PSB) RESPONSIBILITIES AND NOTIFICATIONS

A. **Patrol Officers**

1. Responsibility for follow-up investigations lies with the initial responding officer, except for those offenses specifically delineated in this directive or accepted by any investigative unit. Officers will complete all incident reports before the end of the tour of duty unless a supervisor authorizes an exception.

2. Officers will be responsible for conducting and completing the investigation of crimes not assigned to an investigative unit, except when the following conditions exist:

   a. The offense appears to be a part of a pattern of such offenses.

   b. Follow-up is required in widely separated locations outside the geographic boundaries of the district in which the offense occurred.

   c. A misdemeanor offense that is sufficiently serious to warrant the assistance of specialized **investigators**.

   d. Any case in which a departmental employee is the subject of the investigation.

3. Officers will **respond to and preliminarily investigate all hate crimes and bias incidents. The Criminal Investigations Division (CID) conducts the follow-up investigation of all hate crimes except those delineated to other Investigative Services Bureau (ISB) divisions under this directive**. If a hate/bias incident occurs in conjunction with a crime delineated in this directive, it will be the investigative responsibility of the division/section/unit listed in this directive. [i.e., **1st-degree sex**

assault hate crime (Special Victims Investigation Division-SVID), kidnapping hate crime (Major Crimes Division-MCD/Robbery)].

a. All hate/bias incidents, criminal and non-criminal, require a written incident report, and **all hate crimes require** a follow-up investigation.

b. No incident should be characterized as a prank if it manifests evidence of prejudice towards a protective class defined by Maryland law. The victim's belief/perception that the crime is a hate-motivated incident is sufficient evidence to classify an event as hate-motivated.

c. When documenting any incident in which bias is present (i.e., a swastika spray painted in a public facility; **a noose being displayed**, racial slurs used during a reported aggressive driving incident; antisemitic flyers are distributed throughout a neighborhood; a foreign national flag is burned, etc.), officers should select a bias data value from the list provided in E-Justice when completing the incident report. The incident report, **photos of the event**, and any supplemental reports should be forwarded to pol.hatecrimes@montgomerycountymd.gov by the end of the officer's shift. **Photos need to be uploaded to the department's digital evidence platform**.

Note: This distribution group address includes the MCPD Chief, the Public Information Office (PIO), and the Community Engagement Division (CED).

d. Shift supervisors will be immediately notified of all verified incidents and will immediately notify the district/duty commander. The district/duty commander will ensure that the Patrol Services Bureau (PSB) Chief, Director/Community Engagement Division (CED), and the Public Information ~~Division~~ Office (PIO) receive timely notification of any hate/bias incident.

4. **Response to Threats of School Violence or School Threat Assessments**
Officers will be responsible for responding to and conducting the preliminary investigation of any school threats during school closures (inclement weather, school holidays) and non-school hours (outside 0700-1500, Monday-Friday) or when a Community Engagement Officer (CEO) is unavailable. The CED Behavioral Analysis and Administrative Unit (BAAU) will be notified and responsible for follow-up coordination.

5. All notifications will be made in compliance with the procedures established in this directive.

B. **Patrol Investigative Unit (PIU)**
The Patrol Investigative Units (PIU) are resources that are assigned investigations at the discretion of the district commander. PIU **investigators** primarily investigate misdemeanor offenses that may be a part of trends, patterns, and series occurring within their district of assignment.

C. **Patrol Supervisors**
Patrol supervisors are responsible for the following:

1. Ensuring that a thorough preliminary investigation is conducted before any notification or referral.
2. Assigning follow-up investigations to patrol officers using the department's Records Management System (RMS).

3. Ensuring the appropriate investigative unit is notified in accordance with this directive.

4. Notifying the PSCC whenever specific investigative assistance is required outside business hours.

5. Ensure officers complete all incident reports before the end of their tour of duty and that the report is approved and assigned to the appropriate patrol or investigative unit unless a patrol supervisor authorizes an exception. If an exception is authorized, and the incident report is not complete by the end of the officer's tour of duty, the supervisor will notify the follow-up investigative unit of the delay.

IV. RESPONSE BY INVESTIGATIVE SECTIONS/UNITS

A. The decision to have **investigators** respond is based on several criteria:

1. The complexity of the case
2. The seriousness of the incident (i.e., injuries sustained by the victim)
3. The solvability **of the case**
4. The availability of staff
5. Work priorities

B. Follow-Up Investigations

The follow-up investigation is an extension of the preliminary investigation. The purpose of the follow-up is to facilitate successful case closure. The identification of additional victims/witnesses, recovery of stolen property, and the identification and arrest of the perpetrator characterize successful case closure. **Investigators** from the Criminal Investigations Division (CID), Major Crimes Division (MCD), Special Investigations Division (SID), Special Victims Investigation Division (SVID), **Community Engagement Division (CED)**, and Internal Affairs Division (IAD) shall be responsible for conducting follow-up investigations pursuant to the guidance in the directive.

V. FIELD SERVICES BUREAU (FSB) RESPONSIBILITIES AND NOTIFICATIONS

A. **Community Engagement Division (CED) Responsibilities and Notifications**

1. **Community Engagement Section (CES) Responsibilities**

Community Engagement Officers (CEOs) will respond to and conduct the preliminary investigation of any school threats during regular school hours (0700-1500, Monday through Friday). PSB District Patrol Officers will be responsible for responding to and conducting the preliminary investigation of any school threats during school closures (inclement weather, school holidays) and non-school hours

(outside 0700-1500, Monday through Friday) or when a Community Engagement Officer (CEO) is unavailable. The Behavioral Assessment & Administrative Unit (BAAU) will coordinate follow-up if necessary.
Note: In the event the threat of school violence or school threat assessment is complex (e.g., Extreme Risk Protection Order (ERPO), search warrant, cell phone ping, surveillance, etc.), the CEO or District Patrol Officer shall contact CED/BAAU, who will conduct the investigation. CED/BAAU will collaborate with the appropriate ISB division on a case-by-case basis.

2. **Crisis Response Support Section (CRSS) Responsibilities**

Note: While the majority of sworn officers on the MCPD have received at least forty (40) hours of Crisis Intervention Team (CIT) training, this section of the Function Code refers specifically to the centralized Crisis Intervention Team (CIT), which falls under the Crisis Response Support Section (CRSS) within the Community Engagement Division (CED).

a. **Crisis Intervention Team (CIT) Responsibilities**
CIT has been established to address the complexities of mental health consumers and calls-for-service (CFS) within Montgomery County. CIT officers are an advanced resource with the skills to handle more complex calls-for-service. CIT is the primary assigned investigative unit for any Extreme Risk Protection Order (ERPO), except those handled by SVID.

b. **CIT Notification and Follow-Up Responsibilities**
An on-duty or after-hours on-call CIT officer will be notified and will respond, if necessary, as a resource to assist with the following:

i. **Non-fatal felonious assaults requiring medical attention, committed by mental health consumers when the victim has sustained a serious or a life-threatening injury (where surgery and hospital admittance are likely), but death is not deemed imminent.**
ii. **Modified and full Emergency Response Team (ERT) callouts involving mental health consumers.**
iii. **Any complex call for service regarding mental health/ autism, intellectual or developmental disability (IDD), where a supervisor believes a CIT officer could provide information that would help achieve a positive outcome.**

3. **Behavioral Assessment and Administrative Unit (BAAU)**

a. **Behavioral Assessment and Administrative Unit Responsibilities**
BAAU has been established to coordinate and formulate threat reduction, mitigation, site management, and security strategies for situations that may not rise to the level of criminal charges but may still pose an extremely high risk of violence.

i. **BAAU will conduct and, if necessary, respond to threat assessments and threat assessment investigations.**
ii. **BAAU is responsible for disseminating all information related to hate/bias incidents in the county.**

b. **<u>BAAU Notification and Follow-Up Responsibilities</u>**
BAAU will be notified and will be the primary assigned investigative unit in the follow-up investigation of the following types of incidents:

i. **Threat assessment investigations when the incident becomes complex and requires enhanced investigative tools (e.g., ERPO, search warrant, ping, surveillance, etc.).**
ii. **Threats of mass school violence to Montgomery County Public Schools (MCPS), private schools and colleges.**
iii. **Threats against Police Officers, County Employees, and County Officials.**
iv. **Workplace / Religious Institution Violence/ Mass Violence Threats.**
v. **Threat assessments for bias/hate incidents, where the suspect's actions Pose a danger to the public. CID will conduct the hate crime criminal Investigation.**
vi. **Non-Domestic Stalking Cases with significant concerns for the victim's safety.**
vii. **Persons with serious mental illness who pose a significant danger to the community or law enforcement.**
viii. **Bomb threats in coordination with Fire Rescue's FEI component.**
ix. **Miscellaneous cases in which a threat assessment is requested but falls outside the normal parameters of the Crisis Response Support Section (CRSS)/BAAU will be considered case-by-case and require the supervisor's approval before team involvement. The primary investigative responsibility will remain with the requesting unit.**

B. Traffic Operations Division (TOD)

1. **<u>Collision Reconstruction Unit (CRU) Responsibilities and Notifications</u>**

a. **<u>CRU Responsibilities</u>**
CRU is responsible for the investigation of all fatal traffic collisions and critical injury motor vehicle collisions involving police officers, dignitaries, or public officials.

<u>Note</u>: In cases where a police-involved incident results in the death of a civilian or injuries that are likely to result in the death of a civilian, Maryland's Independent Investigations Division (IID) will be notified and assume responsibility of the investigation (refer to IB 22-01).

b. **<u>CRU Notifications and Response</u>**
CRU will be immediately notified and <u>will</u> respond to the following:

i. **Traffic collisions where death is confirmed.**

ii. All critical injury motor vehicle collisions that involve any police officer, dignitary, or public official, whether or not a county-owned motor vehicle is involved.

c. **CRU will be immediately notified and <u>may</u> respond to:**
   i. When a victim expires within thirty (30) days of a motor vehicle collision that was previously reported as non-fatal (refer to Function Code (FC) 1021 – Motor Vehicle Collisions).
   ii. Motor vehicle collisions where the Montgomery County Fire and Rescue Services (MCFRS) incident commander indicates death is imminent or expected (refer to FC 1021 - Motor Vehicle Collisions).
   iii. Upon confirmation of a life-threatening collision where alcohol or drugs are suspected (refer to FC 0515 -Traffic Offenses Involving Alcohol/Drugs).
   iv. A sufficiently serious collision warrants a CRU investigator's assistance (refer to FC 1021 - Motor Vehicle Collisions).
   v. Upon the request of another investigative unit where the forensic mapping capabilities of the CRU would enhance the investigation.

d. **Only the CRU supervisor will make or coordinate requests for Decentralized CRU (D-CRU) investigators; D-CRU officers will not be directly requested without the CRU supervisor's prior approval.**

VI. CRIMINAL INVESTIGATIONS DIVISION (CID) - RESPONSIBILITIES, NOTIFICATIONS AND RESPONSES

A. **<u>CID - District Investigative Sections Responsibilities</u>**
The CID District Investigative Sections are responsible for investigating the following crimes:

1. Residential and commercial burglaries, **including those** burglaries involving county-owned properties (including attempts), **and the theft of firearms, except when** the crime is suspected of having been committed by a current or former intimate or romantic partner. **<u>Note</u>: FIU will have investigative responsibility for commercial burglaries from firearm dealers/gun stores, including attempts.**

2. **Non-fatal felonious** assaults where the victim has sustained a **serious** injury **requiring medical attention or during which a firearm was pointed. Includes but not limited to stabbings, malicious wounding, and blunt force trauma.**

3. All non-commercial robberies, **and delivery service driver robberies (e.g., Amazon, United Parcel Service (UPS), Federal Express (FedEx), etc.) when the driver is robbed of a package being delivered to a resident,** including food delivery robberies and attempts.

4. Missing Persons/Critical Missing Persons when no foul play is suspected. If the district investigator determines foul play, the detective will immediately consult with the Major Crimes Division (MCD) and facilitate the transition to Major Crimes.

a. If the missing person, 18 years of age or older, has not been located or returned within 72 hours of the CID detective's investigative follow-up, the case will be transferred/assigned to the Major Crimes Division (refer to FC 0617 - Missing Persons Adult/Children).

b. The MCP **Form** 630 (Missing Persons Supplement) must be completed before the Missing Persons/Cold Case Unit accepts the case.

5. Felony theft (value at least $10,000).

6. **All** hate crimes involving any crimes except those delineated to other ISB divisions.

7. Intentional firearm shootings or evidence of a firearm shooting (e.g., shell casings, bullet holes, etc.).

8. All other criminal offenses that require follow-up investigations and are not within the area of investigative responsibility of patrol or other specialized units.

B. **CID - District Investigative Sections Notifications and Response**
CID District Investigative Sections will be immediately notified and will respond to the following:

1. **Non-fatal felonious** assaults where the victim has sustained **a serious or** life-threatening injury **requiring medical attention. (Includes but is not limited to stabbings, malicious wounding, and blunt force trauma.)**

2. Arrests for robberies and attempts.

3. Arrests for burglaries and attempts **(except 4th degree burglary)**

4. Critical missing adults (refer to FC 0617 - Missing Persons Adult/Children) if requested by the Managed Search Operations Team (MSOT).

5. Any case where detective supervisors and scene supervisors agree that a response would enhance the investigation.

Note: A completed incident report is sufficient notification for all other incidents, which is the follow-up responsibility of CID.

C. **CID - Financial Crimes Section Responsibilities**
At the discretion of the Financial Crimes Supervisor, the CID Financial Crimes Section is responsible for the follow-up investigation of:

1. Forgery/uttering
2. Confidence games
3. Embezzlement
4. Counterfeiting of checks/credit cards

5. Financial exploitation of the elderly
6. Identity theft

VII. INVESTIGATIVE SERVICES BUREAU (ISB) - INTERNAL AFFAIRS DIVISION (IAD)

A. **Internal Affairs Division Responsibilities**
IAD is responsible for investigating allegations of violations of departmental rules by any Department of Police employee. IAD will handle the administrative investigation and procedures related to the administrative investigation of the following:

1. Criminal allegations against any Department of Police employee. The Chief of Police or a designee will assign follow-up investigations of criminal allegations against Department of Police employees to an investigative unit sergeant or a sworn executive staff member.

2. Use of force complaints.

3. Allegations of racial, sexual, or ethnic discrimination or harassment.

4. The operation of a motor vehicle while under the influence of alcohol or drugs.

5. The operation of a county vehicle involved in a fatal motor vehicle collision.

6. The alleged violation of any departmental directive or county, state, or federal law.

7. Any other complaint/situation designated by the Chief of Police or a designee.

B. **Internal Affairs Division Notifications and Response**
IAD investigators will be immediately notified and may respond to the following events:

1. All firearm discharges involving authorized on-duty and off-duty weapons (except range practice and humane destruction of non-domestic animals).

2. Any range practice or destruction of an animal incident resulting in injury.

3. Any incident resulting in death or serious injury requiring the immediate hospitalization of a person in police custody.
4. Any incident where a department employee is a party to a domestic dispute or domestic violence incident.

5. Any incident involving a department employee as a suspect in a criminal complaint.

6. Any incident where a department employee is arrested, issued a criminal citation, or a civil citation involving possessing a controlled, dangerous substance.

7. Any other event or situation that may be deemed necessary by an executive officer after

consultation with the Director of IAD or a designee.

VIII. INVESTIGATIVE SERVICES BUREAU (ISB) - MAJOR CRIMES DIVISION (MCD): RESPONSIBILITIES, NOTIFICATIONS, AND RESPONSES

A. MCD - Homicide Section

1. MCD - Homicide Section Responsibilities

MCD - Homicide Section investigates all deaths, critical assaults when death is highly likely or imminent, solicitation/conspiring to murder, life-threatening injuries as a result of police action, and police shootings, etc.

Note: The Independent Investigations Division (IID) investigates all police-involved incidents that result in the death of an individual or injuries that are likely to result in the death of an individual occurring in the State of Maryland. MCD will be immediately notified and will notify the IID.

2. MCD - Homicide Section Notifications and Response

MCD - Homicide Section will be immediately notified and will respond to the following:

a. All deaths, except for traffic-related deaths and those where natural causes are apparent.

Note: Notification will be made, and **investigators** may respond to incidents where death is determined to be from natural causes.

b. Critical assaults, **accidental or self-inflicted injuries** when death is highly likely or imminent.

c. Any missing person investigation where foul play is learned during the investigation. The incident will be jointly investigated by the Missing Persons / Cold Case Section and the Homicide Section.

d. All intentional firearm discharges (to include discharges at domestic animals) by employees, regardless of whether any injury results, except for authorized range practice or the destruction of dangerous or injured animals.

e. Any accidental firearm discharges **by an MCPD officer** that result in any injury to **another or self**.

f. Solicitation/conspire to murder.

g. All incidents where any Montgomery County Department of Police, Fire **and** Rescue Services (MCFRS), **or Department of Corrections** (MCDOC) employee sustains a life-threatening bodily injury as the result of a criminal incident.

h. All incidents involving serious injuries (non-life threatening) to a police officer as a result of a criminal incident. For this guidance, the duty/district commander will confer with the Director of the Major Crimes Division.

i. All incidents where an individual sustains life-threatening injury resulting from police action, on-duty and off-duty. **MCD will also contact the Maryland Independent Investigations Division (IID).**

3. MCD – Forensic Investigator (FI) Notifications

a. In every instance in which there is a death of a person outside of a medical facility, a forensic investigator (FI) will be contacted for authority to direct the disposition of the body. Medical facilities will notify the forensic investigator of the deaths of persons in their care.

b. **Always consult a Homicide Section investigator/supervisor before contacting the on-call FI.**

c. To contact a forensic investigator, officers will call the Public Safety Communications Center **(PSCC)**, which will then contact the on-call FI.

d. When officers are advised of deaths at medical facilities that are the result of injuries for which the deceased was being treated or deaths of infants, the officer should ensure that the forensic investigator and Homicide Section have been notified. If in doubt as to the proper course of action, officers should contact an investigator from the Homicide Section.

B. **MCD - Robbery Section**

1. MCD - Robbery Section Responsibilities

MCD - Robbery Section is responsible for investigating all commercial proceeds robberies (except food delivery robberies and attempts), carjackings, home invasion robberies, adult kidnappings, all kidnappings with ransom, and felony thefts by a group of offenders who enter a retail establishment to steal goods and items that appear to be part of a criminal trend.

2. MCD - Robbery Section Notifications and Response

a. MCD - Robbery investigators shall be immediately notified. They will respond to arrests, crimes, or attempts to commit the following unless, after conferring with an on-scene supervisor, it is determined that an on-scene response will not enhance the investigation.

i. Bank robberies.
ii. Home invasion robberies.
iii. Home invasion first-degree assaults
iv. All commercial and commercial proceeds robberies that result in serious personal injury.

v. Carjacking robberies.
vi. All kidnappings **(unless intimate partner)** where the victim is 18 years or older.
vi. All kidnappings, regardless of age, involving ransom.
viii. All robberies or felony thefts by a group of offenders who enter a retail establishment to steal goods and items **that appear part of a criminal trend** (i.e., blitz attack/flash mob/ takeover/intimidation).

Note: The Robbery Section will assume investigative responsibility if and when a trend of robberies or felony retail thefts by a group of offenders involves a criminal enterprise that exceeds CID/PIU resources or when it warrants the assistance of the Robbery Section.

b. MCD Robbery investigators shall be immediately notified and may respond to arrests, crimes, or attempts to commit the following:

i. Commercial and commercial-proceed-robberies cases, **to include deliveries to a business (commercial product delivery)**.

Note: For residential robberies and residential service delivery robberies, refer to Section VI.A.3.

ii. Shoplifting cases when accompanied by an assault resulting in serious injury **or during which a weapon was displayed or used.**

C. **MCD - Fugitive Unit**
The Fugitive Unit will handle extradition procedures and investigative activity regarding the fugitive governor's and rendition warrants.

D. **MCD - Missing Persons/Cold Case Section**
Missing Person / Cold Case Investigators shall be responsible for:

1. Any open adult missing person investigation after CID has completed a full investigation for at least 72 hours.

2. Any homicide that has been previously investigated but remains open.

3. Any serial rape investigation that has been previously investigated but remains open.

4. Any suspected human remains burial site or skeletal scatter.

5. The Missing Persons/Cold Case Section and the Homicide Section will jointly investigate any missing person investigation where foul play is learned during the investigation.

E. **MCD - Auto Crimes Enforcement Section (ACES)**

1. MCD - Auto Crimes Enforcement Section Responsibilities
ACES Investigators will be responsible for the follow-up investigation of the following crimes:

a. Motor Vehicle Theft (including attempts);

b. Exportation and trafficking of stolen vehicles;

c. Illegal chop shops;

d. Fraudulent automobile dealer incidents;

e. Vehicle insurance fraud;

f. Selling of stolen vehicles to scrap yards;

g. Forged vehicle documents;

h. Replated automobile VINs;

Note: While the theft of individual motor vehicle parts (ex., airbags, catalytic converters, etc.) will remain at the district level, ACES will assume investigative responsibility if and when a trend is identified that involves a criminal enterprise that exceeds PIU resources.

2. MCD - Auto Crimes Enforcement Section Notifications and Response
ACES Investigators will be immediately notified and may respond to arrests for motor vehicle theft or attempted motor vehicle theft.

IX. INVESTIGATIVE SERVICES BUREAU (ISB) - SPECIAL INVESTIGATIONS DIVISION (SID): RESPONSIBILITIES, NOTIFICATIONS, AND RESPONSES

A. SID Criminal Street Gang Unit (CSGU)

1. SID - CSGU Responsibilities
The SID Criminal Street Gang Unit is responsible for **investigating** organized street crime (or "gang crime"), identifying organized street crime members, and identifying trends.

2. SID - CSGU Notifications and Response

a. Whenever a known/suspected organized street crime member is arrested or is the victim in an active criminal investigation, the officer shall immediately notify an on-duty/on-call CSGU detective via the **PSCC.** Notifications should occur before clearing the scene or transporting the arrested individual to the CPU.

b. If an officer contacts known/suspected organized street crime member(s) where no arrest occurs, the officer will request an on-duty CSGU detective via **PSCC**. If no on-duty CSGU detective is available, a notification will be sent via email to the CSGU detective assigned to the district of occurrence. The following are some examples of these scenarios: traffic stops, field interviews, runaways, and missing persons where there is suspected gang association, assaults, etc.

c. Supervisors will **ensure** all incidents involving confirmed/suspected organized street crime members or organized street crime-related criminal activity (including graffiti)

are documented. When an incident report is written, "Gang-Related" should be placed at the beginning of the narrative. The approving supervisor will ensure that "GANG" is selected as a 2nd group notification to route a notification to the CSGU. **The approving supervisor will also notify the CSGU gang supervisor via email.**

d. The CSGU shall be immediately notified and may respond to any incident of possible extortion and blackmail involving known or suspected organized street crime members.

B. **SID - Vice and Intelligence Unit (V&I)**

1. **SID - V&I Responsibilities**
V&I **investigators** will be responsible for the follow-up investigation of the following crimes:

a. Illegal gambling and gaming devices.

b. Human trafficking, prostitution, and related offenses.

c. Sale, manufacture, or distribution of pornographic material.

d. Corruption of public officials.

e. Sensitive investigations as assigned by the Director, SID.

2. **SID - V&I Notifications and Response**
During scheduled hours, V&I will be immediately notified and may respond to crimes or arrests involving any terrorist-related incident, credible information regarding terror activity, or any arrest that may impact or have credible information affecting homeland security.

C. **SID - Drug Enforcement Section (DES)**

1. **SID - DES Responsibilities**
The Drug Investigative Unit is responsible for:

a. Parcel interdiction, which includes the interception of suspicious packages containing large amounts of illicit drugs and then conducting controlled deliveries.

b. Conducts interdiction activities at local hotels/motels, bus stations, Maryland Area Regional Commuter (MARC) Train Stations, and storage facilities;

c. Targeting street-level to mid-level CDS traffickers. Emphasis is on undercover drug purchases, controlled buys, buy-bust operations, the execution of narcotic-related search warrants, surveillance, and on-view arrests of Controlled Dangerous Substance (CDS) violators, and;

d. Coordinates CDS complaints at the district level.

2. **The Major Offender/ Conspiracy Unit is responsible for disrupting major drug trafficking organizations and targets sources of supply and assets of major narcotics traffickers. The unit also assists outside agencies with narcotic investigations within the county.**

3. **SID - DES Notifications and Response**

   a. **The Drug Enforcement Section will be immediately notified and shall respond to incidents involving:**

      i. **Quantity of CDS and derivatives indicative of high-level distribution.**
      ii. **Cannabis over 50 pounds or edibles, waxes, etc., consistent with high-level distribution.**
      iii. Statements of suspects indicating knowledge of the distribution of controlled dangerous substance activities of others.
      iv. Large amounts of US currency under circumstances indicative of the distribution of controlled, dangerous substances or unexplained circumstances.
      v. Indoor or outdoor growth **of more than ten (10) cannabis plants and evidence of a sophisticated growing operation.** A copy of all incident reports from cannabis plant seizures will be forwarded to the Drug Interdiction Unit at SID.
      vi. The **PSCC** supervisor will make after-hours notifications.

D. **SID - Firearms Investigative Unit (FIU)**

1. **SID - FIU Responsibilities**
   SID Firearms Investigative Unit (FIU) is responsible for commercial burglaries from firearm dealers/gun stores, including attempts. The FIU conducts Federal Firearms License (FFL) investigations involving prohibited persons and threat assessment investigations involving images of firearms in which there is no specific threat (social media posting). FIU will be responsible for the release of firearms. Refer to FC 0640-Investigations of Firearms Violations.

2. **SID - FIU Notifications and Response**

   a. **FIU investigators will be immediately notified of all arrests for firearm offenses when the arrestee is a prohibited person (refer to FC 0640 - Investigations of Firearms Violations). A copy of the incident report will be forwarded for all other arrests by the end of the officer's tour of duty. FIU may respond depending on the case's circumstances and if an investigator's response would enhance the case.**

   b. **FIU will assist, if tasked or needed to assist in the investigation of all firearms-related investigations. In cases of commercial burglaries and attempts involving firearms, CID will take the lead, except for those burglaries and attempts specifically targeting firearm dealers/gun stores (FIU will be primary).**

E. **SID - Pharmaceutical Unit (PU)**

1. **SID - PU Responsibilities**
PU **investigators** will be responsible for the follow-up investigation of the following:

a. Prescription Fraud and Forgery **incidents** in Montgomery County, Maryland.

b. Doctor Shopping (involves the use of deception and manipulation to encourage a doctor to prescribe drugs for illicit use or sale) in Montgomery County, Maryland.

c. Questionable prescribing practices of physicians and health care facilities in Montgomery County, Maryland.

d. Questionable distribution practices of pharmaceutical dispensaries in Montgomery County, Maryland.

2. **SID - PU Notifications and Response**

a. PU **investigators** shall be notified and may respond to reports of or arrests for prescription forgery/fraud, doctor shopping, or theft of prescription pads.

b. PU **investigators** will be immediately notified and may respond to:

i. Arrests of subject(s) at a pharmacy attempting to obtain a prescription by fraud.
ii. Arrests of subject(s) in possession of forged prescriptions.

F. **SID - Overdose Investigative Unit (OIU)**

1. **SID - Overdose Investigative Unit Responsibilities**
The Overdose Investigative Unit is responsible for the investigation of all suspected fatal opioid overdoses and non-fatal overdoses deemed high priority. OIU will conduct independent investigations on fentanyl dealers identified during overdose investigations but where the facts do not allow prosecution.

2. **SID - Overdose Investigative Unit Notifications and Response**
The Overdose Investigative Unit will be notified of and shall respond to all suspected opioid overdoses, both fatal and non-fatal.

X. INVESTIGATIVE SERVICES BUREAU (ISB) - SPECIAL VICTIM'S INVESTIGATIONS DIVISION (SVID): RESPONSIBILITIES, NOTIFICATIONS, AND RESPONSES

A. **SVID - Child Abuse/Sexual Assault (CA/SA) Unit**

1. **SVID - Child Abuse/Sexual Assault Unit Responsibilities**
SVID Child Abuse/Sexual Assault Unit investigates the following:

a. 1st Degree Child Abuse, 2nd Degree Child abuse (when part of a pattern, refer to Section X.A.2.a), and the sexual abuse of children.

b. All first and second-degree rapes or third-degree sex offenses, including attempts and sexual abuse where the victim is under 18 years of age and the suspect is known.

c. Investigates fourth-degree sex offenses when the suspect is known, where the incident is part of a pattern of such offenses, or follow-up is required in widely separated locations outside the geographic boundaries of the district in which the offense occurred.

2. SVID - Child Abuse/Sexual Assault Unit Notifications and Response
SVID Child Abuse/Sexual investigators will be immediately notified and may respond to the following:

a. All first and second-degree rapes or third-degree sex offenses, **including attempts**, and sexual abuse where the victim is under 18 years of age and the suspect is known.

b. All incidents involving first-degree child abuse (i.e., incidents involving severe physical injury requiring hospitalization).

c. Second-degree child abuse (i.e., incidents involving a physical injury that does not require hospital treatment) where there is a pattern of abuse and or/further investigative follow-up is warranted as determined by the notified Child Abuse/Sex Assault Unit investigator.

d. Sexual abuse of a minor where:

i. The suspect is known.
ii. Time, circumstances, and the minor's age may require a forensic interview by Child Protective Services.
iii. Second-degree child abuse is co-occurring.

B. **SVID - Missing Children/Runaway Unit**

1. SVID - Missing Children/Runaway Unit Responsibilities
SVID - Missing Children/Runaway Unit will be responsible for the investigation of missing children, runaways, kidnappings, and parental abductions.

2. SVID - Missing Children/Runaway Unit Notifications and Response

a. **Investigators** will be immediately notified and will respond to kidnappings, **including attempts** of victims under 18 years of age, except in cases involving ransom and homicide**. (refer to MD. Criminal Law Code §3-502)**

b. **Investigators** will be immediately notified and may respond to parental abductions of a juvenile.

c. **Investigators will be immediately notified and may respond to missing at-risk children (Refer to FC 0617 - Missing Persons Adults/Children for the definition of "at risk" and other requirements).**

d. **Investigators will be immediately notified and may respond to incidents when a subject takes a substantial step to lure or entice a juvenile verbally or physically.**

e. **The Missing Children/Runaway Unit Supervisor will coordinate and activate the Maryland Amber Alert Plan and confirm that all the criteria have been met before contacting the Maryland State Police (MSP).**

f. **For specific procedures, required criteria, and additional information, refer to the Maryland Amber Plan Memorandum of Understanding (MOU) and FC 0617 Missing Persons Adults/Children, Section XI: Maryland Amber Plan and Silver Alert Program.**

C. **SVID - Child Exploitation Unit (CEU)**

1. **SVID-Child Exploitation Unit Responsibilities**
   SVID-Child Exploitation Unit investigates the following:

   a. Internet crimes against children (including Child Sexual Abuse Material (CSAM) and Child Exploitation Material (CSEM);

   b. Child pornography; and

   c. Sextortion cases where the victim is under 18 years of age.

2. **SVID - Child Exploitation Unit Notifications and Response**
   The CEU will be notified of and may respond to the following:

   a. **All cases involving Child Sex Abuse Material (CSAM), Child Sexual Exploitation Material (CSEM), or child pornography.**

   b. **Sextortion cases where the victim is under 18 years of age.**

D. **SVID - Sex Offender Registry Unit (SORU)**

1. **SVID - Sex Offender Registry Unit**
   SORU will be responsible for managing the County's sex offender registry and investigating violations of the sex offender registry laws.

2. **SVID - Sex Offender Registry Unit (SORU) Responsibilities**

   a. The Sex Offender Registry Unit (SORU) investigators will handle all registrations of sex offenders who work, attend school, or live in Montgomery County, Maryland.

b. SORU investigators follow up and will obtain warrants for sex offender registry violations when necessary.

c. **Should an officer identify that a suspicious person, suspect, or arrestee is on the sex offender registry, the officer should forward all documentation to SORU at** SOR@montgomerycountymd.gov

E. **SVID - Sex Assault Unit (SAU)**

1. **SVID - Sex Assault Unit Responsibilities**
SVID Sexual Assault Unit investigates the following:

a. All rapes and third-degree sex offenses (including attempts) where the victim is 18 years or older;

b. Fourth-degree sex offenses or indecent exposures when the victim(s) are under 18 years old, AND the suspect is unknown. These incidents must be part of a pattern of such offenses or when follow-up is required in widely separated locations outside the geographic boundaries of the district in which the offense occurred.

c. All rapes and third-degree sex offenses (including attempts) where the victim is under 18 years old when the suspect is unknown;

d. Fourth-degree sex offenses or indecent exposures when the victim(s) are 18 years or older. These incidents must be part of a pattern of such offenses or when follow-up is required in widely separated locations outside the geographic boundaries of the district in which the offense occurred.

2. **SVID - Sex Assault Unit Notifications and Response**
SVID-SAU will be immediately notified of and may respond to:

a. All first and second-degree rapes, or third-degree sex offenses, including attempts, where the victim is 18 years of age or older.

b. All rapes and third-degree sex offenses (including attempts) where the victim is under 18 years old when the suspect is unknown;

Note: In cases where there is no arrest, the investigator will determine if the incident meets the Physical Evidence Recovery Kit (PERK) guidelines (refer to FC 0616 – Investigation of Rapes and Sex Offenses).

F. **SVID - Domestic Violence/Elder Abuse Unit (DV/EAU)**

1. **For this directive, intimate partner violence is defined as those incidents between:**

a. A current or former spouse

b. An individual who has a child in common with the abuser, whether or not they reside together.

c. An individual who is dating or has dated the abuser.

Note: This does not include non-intimate cohabitants

2. **SVID - Domestic Violence/Elder Abuse Unit Responsibilities**
SVID - Domestic Violence/Elder Abuse Unit investigates:

a. **Cases of intimate partner violence when the victim sustains a serious injury (including all cases of strangulation), where the pair have multiple prior incidents, and/or burglaries where the perpetrator is a current or former intimate partner;**

b. **Kidnappings perpetrated by an intimate partner;**

c. **Incidents requiring Extreme Risk Protection Orders (ERPO) as the result of intimate partner violence;**

d. **All cases of elder, vulnerable, or institutional abuse resulting in an arrest or serious injury (including strangulation).**

3. **SVID - Domestic Violence/Elder Abuse Unit Notifications and Response**
The DV/EAU will be immediately notified and may respond to:

a. All intimate partner violence incidents where the victim has sustained serious injury, including all cases of strangulation, whether hospitalization occurs or not.

b. **All reports for domestic or intimate partner violence where a police officer, regardless** of the agency of affiliation, is the suspect or the victim.

c. All **intimate partner** violence incidents involving simple assault where the victim/suspect has multiple prior incidents.

d. **Intimate partner stalking victims.**

e. Any burglary with clear evidence that the perpetrator is a current or former intimate partner.

f. **An incident requiring an** Extreme Risk Protective Order (ERPO) **as the result of intimate partner violence.**

g. All incidents of elder, vulnerable, or institutional abuse (refer to FC 0672) that result in an arrest or serious injury (including strangulation), whether hospitalization occurs or not.

XI. RELEASE AUTHORIZATION FORM (MCP Form 208)

A. In a criminal investigation, the MCP **Form** 208, "Release Authorization Form," may be used when the facts of the case are not in dispute, the victim requests that the police take no further action, and the request is being made freely and voluntarily. If there is any indication that the complainant's reluctance to proceed with the investigation is due to fear of, or coercion/duress by, the suspect, the officer/investigator will continue the investigation and will not allow an MCP **Form** 208 to be signed.

Note: In instances where cases are closed by exception due to an uncooperative victim, investigators will document this in the supplement report.

B. The MCP **Form** 208 will not be used if an investigation determines the original complaint was false or baseless. If an original incident report has already been written, a supplement report will be submitted using the same clearance, closing the case as "Unfounded."

C. The MCP **Form** 208 will **not** be used in the following cases:

1. Rape
2. Sexual Assault
3. Domestic Violence
4. Child Abuse
5. Child Neglect
6. Hate Crimes

D. The investigating officer's supervisor must review each MCP Form 208 to ensure the appropriateness of the release authorization. **The original MCP Form 208 should remain in the case file, and a copy should be attached to the report.**

Appendix I

RESPONDING TO BEHAVIORAL HEALTH EMERGENCIES AND PERSONS WITH AN ALTERED MENTAL STATUS

FC No.: 921
Date: 10-27-22

If a provision of a regulation, departmental directive, rule, or procedure conflicts with a provision of the contract, the contract prevails except where the contract provision conflicts with State law or the Police Collective Bargaining Law. (FOP Contract, Article 61)

Contents:

I. Purpose

This directive provides guidance to officers when responding to or encountering situations involving persons displaying behaviors consistent with a mental disorder or crisis.

II. Policy

The department's policy is to provide a comprehensive response to individuals who display symptoms of a mental disorder. Under Maryland law, police officers, duly licensed physicians, certified psychologists, ***licensed clinical social workers, licensed clinical professional counselors, clinical psychiatric/ mental health nurses, psychiatric nurse practitioners, licensed clinical marriage and family therapists, health officers or designees of a health office*** can seek emergency evaluation of individuals whom they feel meet the established criteria. When an officer suspects an individual suffers a mental disorder and presents a danger to the life and safety of the individual or others, the officer will take the individual into custody and complete the Petition for Emergency Evaluation (and the accompanying procedures) as

outlined in this directive. The petition for the emergency evaluation may be based on examination, observation, or other information that is pertinent to the factors giving rise to the petition.

III. Definitions:

For purposes of this directive, the following terms have the meanings indicated.

A. Clinical Assessment Triage Services (CATS): Assigned to Montgomery County Detention Center (MCDC), responsible for conducting mental health assessment during the intake process.

B. Consumer: An individual who receives mental health services (public or private) and/or suffers from a mental disorder and/or a developmental/intellectual/cognitive disability.

C. Emergency Evaluation Petition (EEP): An EEP is a process by which an individual suspected of having a mental disorder, who presents a danger to the life and safety of themselves or others, is evaluated by a mental health professional in a clinical setting.

D. Emergency Facility: A facility that the Maryland Department of Health designates, in writing, as an emergency facility. Emergency facility includes a licensed general hospital that has an emergency room.

E. Emergency Facility Personnel: A physician, physician assistant, nurse practitioner or other advanced practice professional employed or under contract with the emergency facility.

F. Evaluee: An individual for whom an emergency evaluation (petition) is sought or made.

G. Hospital Warrant: In accordance with Maryland Code, Health-General Article 12-120, a warrant issued by the court where a determination that probable cause exists that the named defendant has violated a conditional release under Title 12 of the Health-General Article.

H. Mental Disorder: A diagnosable condition that affects a person's thinking, emotional state and behavior. Disrupts the person's ability to work, carry out daily activities and engage in satisfying relationships.

I. Mental Health Professional: Physician, psychologist, clinical social worker, licensed clinical professional counselor, clinical nurse specialist, psychiatric nurse practitioner or their designee operating as part of a Mobile Crisis Team.

J. Mobile Crisis Outreach Team: A Department of Health and Human Services (HHS) team made up of mental health professionals who help adults and children having a mental health crisis.

K. Petitioner: Peace officer, mental health professional or an interested person (citizen). Judicial review is required for interested persons' petition.

IV. Crisis Intervention Team (CIT)

A. The Crisis Intervention Team (CIT) consists of officers trained in ***managing*** the consumer ***and techniques used to effectively de-escalate crisis incidents involving persons with an altered mental state***.

B. Employees ***that have not received crisis intervention training and*** are interested in becoming a CIT ***trained, should notify their supervisor of their interest in the training program. CIT training dates are posted via the PSTA scheduling software system.***

C. ***Training***
Employees (both sworn and non-sworn) receive 40 hours of instruction on mental ***health disorders*** and techniques used to effectively de-escalate crisis incidents involving consumers. Upon completion of the 40 hours of training, the employees will become certified as CIT members. CIT members will be awarded a CIT insignia to be worn above their nametags.

D. ***Officers that are CIT certified*** will be identified in the CAD with a ***special skill designator,*** so they can be dispatched when requested to handle complicated mental ***health*** calls for service. The CIT officer will respond to the scene when requested by the ***supervisor***, beat officer or officer assigned to the call. If there are no trained CIT officers available in a specific district, an adjoining district CIT officer and that officer's supervisor will be notified of the need for the CIT officer to respond.

E. Once the CIT officer is on the scene of a mental ***health*** call, the CIT officer becomes the primary officer. This does not relieve the first officer on the scene of a hostage, barricade, or life-threatening situation from activating the Emergency Response Team as directed in FC 950, "Emergency Response to Hostage, Barricade, and All Life-Threatening Situations," if such activation is tactically necessary.

F. The CIT officer will determine:
1. If the consumer is in need of an Emergency Evaluation Petition.
2. If ***a HHS*** Mobile Crisis ***Outreach*** Team needs to respond to assist.
3. If the consumer needs to be charged criminally or diverted to mental health services. (Refer to section ***VI and Appendix A***)
4. If the consumer does not require immediate medical or mental health attention and can be referred to resources available during normal business hours ***(e.g. Crisis Center, group home, other mental health professional).***

G. The CIT officer will complete:
1. An MCP 922, "***Mental Health Consumer*** Report" and forward it to the ***Crisis Response Support Section (CRSS)***.
2. All other required reports ***and applicable paperwork***.

H. The Crisis Intervention Team Coordinator is ***a designated centralized team member*** assigned to ***the Crisis Response Support Section, Community Engagement Division*** and can be contacted at (240) 773-5057 or by fax at ***(240) 773- 5045. After hours CIT requests can be made via ECC.***

V. Interactions with Consumers

A. ***Symptoms***
Some symptoms of an altered mental state include, but are not limited to:
1. ***Disorientation***
2. ***Loss of memory regarding their identity, time, or place.***
3. ***Displaying inappropriate or impulsive behavior.***
4. ***Hallucinations (auditory or visual) or feelings of persecution.***
5. ***Paranoia***
6. ***Talking to themselves, such as responding to auditory hallucinations.***
7. ***Describing unrealistic, abnormal, and/or delusional physical symptoms or thoughts.***

B. ***De-Escalation***
In accordance with officer safety techniques, steps that can be taken to de-escalate a situation involving a person suspected of having a mental disorder include, but are not limited to:
1. ***When possible, turn off emergency lights and sirens.***
2. ***Disperse crowds.***

3. ***Assume a non-threatening manner when approaching the individual.***
4. ***Communicate with the individual in a calm fashion.***
5. ***Always be truthful when dealing with an individual with a mental disorder; if the person becomes aware of deception, they may withdraw in distrust or retaliate in anger.***

VI. *Interviews/Arrest Alternatives for Consumers*

A. *Interviews*

If an officer suspects that a person to be interviewed has a mental disorder, special precautions must be taken to ensure that any statements made are voluntary and credible. Efforts should be made to gather information about the person's mental condition from credible sources such as witnesses and family members or reports of forensic analysis. Officers shall corroborate the individual's statements with information obtained from these sources.

B. *Arrest Alternatives*

When dealing with a consumer, who has committed non-violent, minor violations, an officer should consider either:

1. ***Initiating an EEP instead of filing criminal charges, or***
2. ***Pre-booking diversion alternative to arrest***

Note: If criminal charges have been filed and the officer believes that mental health treatment is necessary, the officer may initiate an EEP in addition to the criminal charges. Officers shall articulate the totality of the circumstances that led to the arrest or petition in their incident report.

C. Pre-Booking Diversion (Appendix A)

Pre-booking diversions will be completed at ***the Central Processing Unit*** (CPU). ***While in transit to CPU, officers will have the CPU booking officer/supervisor contact CATS (Clinical Assessment and Triage Services) to have the consumer evaluated. If the CATS staff is not available,*** while they are in transit to CPU with the consumer, ***the*** officers will request ECC to notify the Crisis Center. Crisis Center staff will meet the officer at CPU to conduct the pre-booking diversion assessment.

VII. Petition Procedure

A. Citizen Petitioners

1. ***Any interested person*** who has reason to believe a person is suffering from a mental disorder and presents a danger to the life and safety of the individual or others may complete a petition for the emergency evaluation of that person. Judicial review is required when a citizen is the petitioner.
2. If the court is open:
   a. The petitioner will present the petition to a judge of the District Court for immediate review.
   b. Upon determining that probable cause exists to detain the subject named in the petition, the judge will sign the order and direct the Sheriff***'s Office*** to take the subject into custody and transport the subject to an emergency facility.
   c. If the judge determines the petition does not establish probable cause, the judge will order no further action.
3. If the District Court is closed:
   a. The petitioner will request a petition application from the nearest available District Court Commissioner.
   b. The Commissioner will take appropriate action to provide for review of the petition by the on-call judge.
   c. If the judge signs the order, the commissioner will contact the Sheriff***'s Office*** for service of the ***order***. If the Sheriff***'s Office*** is not available, the commissioner will contact MCP***D*** for service of the petition.

d. The life of the judge's order is five days.

B. Departmental Responsibilities in Serving Petitions Obtained by Citizens

1. The petitioner ***may*** respond with the petition to the district where the petition is to be served.
2. The primary concern is the welfare of the evaluee and other citizens. Supervisors will not delay service of a petition arbitrarily. If all officers are already assigned to non-emergency calls, supervisors should reassign officers to ensure that the petition is served as soon as possible. Delay of service is appropriate when:
   a. The evaluee (or others) would not be endangered due to the delay, or
   b. Other factors necessitate a delay (e.g. higher priority calls, no officers available, etc.).
3. A minimum of two officers will be assigned to serve the petition. One of the officers should be the same sex as the person named in the petition whenever practical.
4. Officers serving a petition will notify ECC of their status.
5. The supervisor responsible for overseeing service of the petition will ensure that:
   a. The petition is completed and signed.
   b. The MCP ***922*** is completed.
   c. The individual named in the petition is placed in custody as soon as possible.
   d. The individual is transported to the closest designated emergency facility for evaluation (Holy Cross ***Silver Spring or Germantown***, ***Medsta***r Montgomery ***Medical Center***, Shady Grove Adventist, Suburban, or Adventist ***White Oak Medical Center***).
6. If officers locate the evaluee, two officers will take the evaluee into custody and transport the evaluee to the nearest ***emergency facility*** utilizing a single vehicle. ***Officers must notify the emergency facility they are in transit with an emergency petition.*** Officers will request that the dispatcher have the station call the ***emergency facility*** and advise them ***MCPD is*** bringing in a***n evaluee*** for an emergency evaluation and request that hospital security meet them in the emergency room. ***Officers should also advise whether the evaluee is cooperative or uncooperative***.
7. If officers assigned to serve a petition are unable to locate the evaluee, ***the officers will notify their supervisor***. The supervisor will determine whether additional attempts at service will be made by the police or if the petition should be returned to the Sheriff's Office ***Domestic Violence (DV) Section***.
8. If the supervisor determines that additional attempts at service ***are not possible or feasible, the supervisor will designate an officer to contact the Montgomery County Sheriff's Office DV Section at 240-777-7016 (24-hours) and transport the original petition to the Sheriff's DV section located at 600 Jefferson Plaza suite #500 (Family Justice Center) in Rockville. The Sheriff's Office will record MCPD's attempted service of the petition until it is either served or expires (5 days).***
9. If a person named in a petition is subsequently located (e.g., if a family member finds the person and notifies the Sheriff's Office), and the petition is at the Sheriff's Office, the Sheriff's Office will ***verify the petition and*** contact ECC to request ***MCPD*** serve the petition when a Sheriff's Office supervisor has determined that:
   a. The Sheriff's ***DV Section*** is out of service,
   b. The Sheriff's Office has no other personnel available to serve the petition, and
   c. Delaying the service would endanger the evaluee or others.
10. ***In the event MCPD serves the petition, the Sheriff's Office will ensure the transfer of the original petition to the officer who has the evaulee in protective custody as soon as possible.***

C. Responsibilities of Police Officers as Petitioners

1. If a police officer has probable cause to believe that a person has a mental disorder and the person presents a danger to the life or safety of the individual or of others, the officer will take the subject into custody and transport the subject to the nearest designated emergency facility ***within the state***. The petition may be based on examination, observation, or ***other*** information ***obtained that is*** pertinent to the factors giving rise to the petition ***(Maryland Code, Health–General Article § 10-622)***. NOTE: The police officer does NOT have to observe the behavior.
2. ***Officers must notify the emergency facility they are in transit with an emergency petition. Officers will request that the dispatcher have the station call the emergency facility and advise them MCPD***

is bringing in an evaluee for an emergency evaluation and request that hospital security meet them in the emergency room. Officers should also advise whether the evaluee is cooperative or uncooperative.

3. Once at the ***emergency facility***, officers will complete side 1 of the CC/DC 13, "Petition for Emergency Evaluation," (Appendix ***B***) and the top half of the CC/DC 14, "Additional Certification by Peace Officer." (Appendix ***C***). Both forms will be presented to the ***charge nurse*** of the emergency room at the hospital. Officers completing the forms must sign their names and write their titles (e.g., Police Officer III), ID numbers, ***and e-mail*** next to their names ***in block 11 of the petition (CC/DC 13) in the event the emergency facility personnel need to contact the officer for additional information or to request the officer attend an administrative law hearing if the consumer is admitted involuntarily.***
4. Officers will take immediate action to prevent harm to all persons. Police officers are not civilly or criminally liable for completing a Petition for Emergency Evaluation or for taking a person into custody for an evaluation when it is done in good faith. As with a physician, certified psychologist, health officer, or designee of the Health Officer, no prior judicial review is required.
5. ***Officers will complete the incident report and forward form MCP 922 along with copies of the petition and incident report via inter-office mail to the Crisis Response Support Section. Officers should scan all appropriate paperwork related to the incident (petition, MCP 922, notes, etc.) into their incident report.***

D. Crisis Center/Mobile Crisis ***Outreach*** Team Staff as Petitioners

1. The staff of the Montgomery County Crisis Center, which includes ~~the~~ Mobile Crisis ***Outreach*** Teams ***(MC-43, MC-44, and MC-45)***, are ***licensed clinicians credentialed to initiate emergency petitions***. Emergency Evaluation Petitions signed by the Crisis Center staff either at the Crisis Center or on-site in the community do not require prior judicial review. The address and phone number for the Crisis Center are:

   1301 Piccard Drive
   Rockville, MD 20850
   (240) 777-4000 ***(24 Hours)***
2. Upon the completion and signing of a petition for emergency evaluation in accordance with all legal criteria and requirements, the Crisis Center staff will contact ECC to request assistance for service of the petition.
3. ECC will dispatch the Sheriff's ***DV Section***. If the Sheriff's ***DV Section*** is unavailable, ECC will advise a supervisor in the district where the petition is to be served. ***The supervisor will assign a minimum of two officers to serve the petition. The supervisor will assign at least one officer of the same sex as the person named in the petition whenever practical. When presented with a petition for service, officers will complete the bottom half of the CC/DC 14 ("certifications by other persons qualified under HG 10-622 and peace officer").***
4. ***Officers must notify the emergency facility they are in transit with an emergency petition. Officers will request that the dispatcher have the station call the emergency facility and advise them MCPD is bringing in an evaluee for an emergency evaluation and request that hospital security meet them in the emergency room. Officers should also advise whether the evaluee is cooperative or uncooperative.*** Officers will document the transport on the ***MCP 922***. ***Officers will complete and forward the MCP 922 along with a copy of the petition via interoffice mail to Crisis Response and Support Section (CRSS) HQ 3rd Floor.***

E. Other Assistance Requested by the Mobile Crisis ***Outreach*** Team

If ***a*** Mobile Crisis ***Outreach*** Team requests police assistance for any reason other than actual petition service (e.g., back-up/security to interview a potential evaluee, etc.), the police will provide assistance as appropriate.

F. ***Other Assistance Requested at Emergency Facilities***

In instances where an emergency facility requests police assistance for a person with a mental disorder, officers will meet with the emergency facility personnel and provide the appropriate support.

1. ***In cases where an evaluee is at the emergency facility but has not been admitted and not under the care of emergency facility personnel (e.g. parking lot, waiting room and reception desk), officers will respond and may petition the evaluee at the emergency facility.***
2. ***In cases where the evaluee has been admitted within the emergency facility and is under the care of emergency facility personnel, officers will advise the emergency facility personnel complete the DHMH Form 34 (Application for involuntary admission) and DHMH Form 2 (Physician Certificate) for involuntary admission.***

VIII. Procedure While at the Emergency Facility

A. The emergency facility must accept the individual for evaluation upon a properly executed petition ***(EMTALA – Emergency Medical Treatment Active Labor Act).***

B. Officers will give emergency room staff all pertinent information about the evaluee including the identity and location of the evaluee's relatives, if known ***and document the information in block 3 of the CC/DC 13 (petition).***

C. The officers will leave the ***emergency facility*** and return to normal duty unless the patient is violent and the ***emergency facility personnel*** requests that the officers remain. If the request is made, the officers will advise their supervisor of the request.

D. The officers must remain at the ***emergency facility*** until their supervisor has responded to the ***emergency facility personnel's*** request. If the evaluee is violent, the supervisor will direct the officers to remain at the hospital. When officers are requested to remain at the ***emergency facility***, it is the responsibility of the attending physician to examine the evaluee as promptly as possible ***(MD Code, Health General Article 10-620).***

E. An evaluee must be examined within 6 hours after being transported to the emergency facility and may not be detained for longer than 30 hours from the time of arrival at the ***emergency facility (MD Code, Health General Article 10-620).***

F. If the examining physician certifies the evaluee, the physician shall place the evaluee in an appropriate facility. Once a physician has placed an evaluee, the physician will contact the private ambulance company which is under contract with the ***emergency facility***. The private ambulance service will transport persons certified for commitment ***to a specialty referral center***.

G. ***For all officer-initiated petitions,*** whether the evaluee is certified or not, officers will complete the appropriate ***incident*** report (2942 - Mental Illness) ***and an MCP 922 (Mental Health Consumer Report).***

IX. Transporting Aggressive Patients with a Mental *Disorder*

The transporting of patients with ***a*** mental ***disorder*** requires officers to exercise caution to avoid possible injury to themselves or the evaluee. Officers will use their own judgment to determine the most appropriate method of restraint. Officers should consider ankle cuffs, and waist chains (in addition to handcuffs) based on their assessment of the evaluee. In situations where the transporting officer deems the patient "aggressive," the following procedures apply:

1. Request an ***ALS (Advanced Life Support)*** ambulance via ECC.
2. Assist Fire/Rescue personnel with the application of appropriate restraints (e.g., tie-down stretcher, restraints, etc.).
3. One police officer will ride inside the ambulance, and a second officer will follow behind in a cruiser.

4. Officers will document the transport on the ***MCP 922***. ***Officers will forward the MCP 922 along with the incident report and petition (if applicable) via interoffice mail to the Crisis Response and Support Section***

X. ***Police Service of Hospital Warrants***

Pursuant to 3-101(e) of the Criminal Procedure Article, Annotated Code of MD, a hospital warrant authorizes any law enforcement officer in the state to apprehend the individual and transport the individual to the designated facility specified in the hospital warrant. The individual is not presented to the court prior to transport to the designated healthcare facility. The facility listed in the warrant will be a state psychiatric hospital or designated healthcare facility. The individual is not taken to a detention center prior to transport to the designated healthcare facility/hospital.

XI. Warrant Arrests of Suicidal/*Persons with an Altered Mental State*

A. Occasionally, Officers will come across persons who, upon being arrested on a warrant, will present suicidal thoughts or symptoms of a mental disorder. For the purposes of this directive, the following definitions will apply to persons who are arrested and processed at the Central Processing Unit (CPU):

Injury: A medical condition that requires an arrestee to have immediate medical treatment, such as broken bones, severe lacerations and/or medical conditions that medical staff at CPU are unable to care for/stabilize without additional medical support (e.g. re-setting of bones, stitching, acute overdose of alcohol/drugs).

Illness: A medical condition that requires long-term medical treatment that medical staff at CPU can manage and/or treat via regular medical appointments off-site or with on-site medical equipment and support (ex. HIV, mental health disorder, COPD).

B. If upon being taken into custody for a warrant, it is determined that the arrestee has injuries that would require immediate medical treatment, then the officer will request evaluation and transport by Fire/Rescue personnel. An officer will maintain custody of the arrestee until medically cleared through the hospital upon discharge, the officer will take possession of all medical release discharge documents and present the arrestee along with discharge paperwork to the CPU staff for processing. Any and all injuries will be documented via an incident report, supplement and CPU 513. If possible, officers should take photographs of injuries.

C. If, when taken into custody for a warrant, the arrestee expresses suicidal thoughts, ideations, signs, or symptoms of a mental health disorder, the arrestee will be transported to CPU for processing. Officers will notify CPU staff of the arrestee's suicidal gestures/altered mental state upon arrival to CPU. Once the arrestee is seen by the district court commissioner and booked in, CPU staff will coordinate transportation to the Crisis Intervention Unit (CIU) at the Montgomery County Correctional Facility (MCCF) for Mental Health treatment/stabilization. If the arrestee is seen by the commissioner and released on their own recognizance, CPU staff will make every effort to have the arrestee seen by the CPU Clinical Assessment and Triage Services (CATS) team. CATS personnel will complete an evaluation for emergency petition (CC-DC 13,14) if required, and request police respond to transport the individual to an emergency facility. It is important to realize the individual in this case is no longer in criminal custody and the petition should be served in routine fashion. Any suicidal gestures or symptoms of a mental disorder that an arrestee in custody presents should be documented in the event report, supplement and/or the CPU 513.

D. If an emergency petition is presented to an officer and the individual has a warrant, the emergency petition will take precedent and the individual will be transported to the emergency facility and a

hospital guard detail will be initiated in accordance with FC 812 (Prisoner Guard Detail at Hospitals) until the arrestee is medically stable/cleared after which the warrant will be served, and the arrestee will be taken to the CPU. The officer will take possession of all medical release discharge documents and present the arrestee along with discharge paperwork to the CPU staff for processing.

XII. Documentation and Reporting

A. Officer/Civilian Initiated Petitions

The officer will complete an incident report and MCP 922. The clearance code (2942*) will be used for all officer-initiated petitions and petitions obtained by citizens, this will allow the Crisis Response and Support Section (CRSS) to track all related mental health police calls. Officers will forward copies of the emergency petition and the MCP 922 (if applicable) to CRSS, Community Resources Bureau.

B. MCP 922

An MCP 922 (Mental Health Consumer Report) will be used by officers to document contacts with consumers. The MCP 922 is a means for the CRSS to document mental health contacts with the police when incident reports are not required. Officers will forward the MCP 922 to the CRSS, Community Resources Bureau.

C. Transports

The EEP Service/Transport clearance code (2950*) will be used when an officer receives an emergency petition from mental health professionals identified in Section I of this directive and is only for transporting the evaluee to an emergency facility for evaluation. This clearance would be applicable when transporting from locations such as the Crisis Center, mental health clinics and/or treatment centers. Officers utilizing this clearance code will complete an MCP 922 and forward copies of the emergency petition and MCP 922 to CRSS, Community Resources Bureau.

XIII. Resolution of Issues Between the County Police and the Sheriff's Office

Problems arising related to this directive will be resolved ***via the director of the Crisis Response and Support Section, CIT Coordinator, Community Resources Bureau Chief, or designee.***

XIV. CALEA Standards: 1.2.1, 41.2.7, 70.2.1, 70.3.1, 70.3.2, 74.2.1, 74.3.1, 81.2.4

XV. Proponent Unit: ***Crisis Response and Support Section***

XVI. Cancellation

This directive cancels Function Code 921, effective date ***06-10-2005, Information Bulletin 14-01 and Training Bulletin 07-03***

Marcus G. Jones
Chief of Police

Appendix J

CIT INTERNATIONAL, INC.

Improving Crisis Response Systems

CIT International
3443 S State St. #15B
Salt Lake City, UT 84115
888-738-2484 (CITI)
www.CITInternational.org

May 16, 2025

Dear Sergeant Michael Skidmore,

Congratulations! We are pleased to inform you that you and the other members of Montgomery County CIT have been selected for the 2025 CIT Response Team of the Year Award. We will be presenting you with this award at the CIT International Conference in Anaheim, California, August 11-13, 2025.

The Conference registration for one member of the team is complimentary. To register, use the following link: https://www.citinternational.org/event-5943112. Select the ticket type that says, Special Ticket and when asked, enter the code CitCAFREE25 (this is case sensitive).

Attached is a press release that you can share with your local media. Please forward the headshots of your team to Darren.Ivey@citinternational.org before Friday, May 23, 2025. We will use this to recognize you and the team on our social media platforms as well as other ways at the Conference.

Thank you for your exemplary service, and many contributions to your local community. Once again, Congratulations! We look forward to seeing you in Anaheim.

Jeanette

Jeanette Borunda, CIT International
Awards Committee Chair

Appendix K

Western Tidewater CIT Pre/Post Analysis

Summary/Highlights:

- Perceived knowledge, preparedness, and abilities across all questions increased between the survey prior to the CIT training and the post-survey.
- Responses indicated that respondents' perceived ability to manage a situation with a person in crisis yielded the smallest increase (23%).
- The largest increase was seen in familiarity with local community resources (45%), followed by ability to connect persons in crisis to resources (41%), indicating a potential strength of the CIT training as officers' education in community resources.

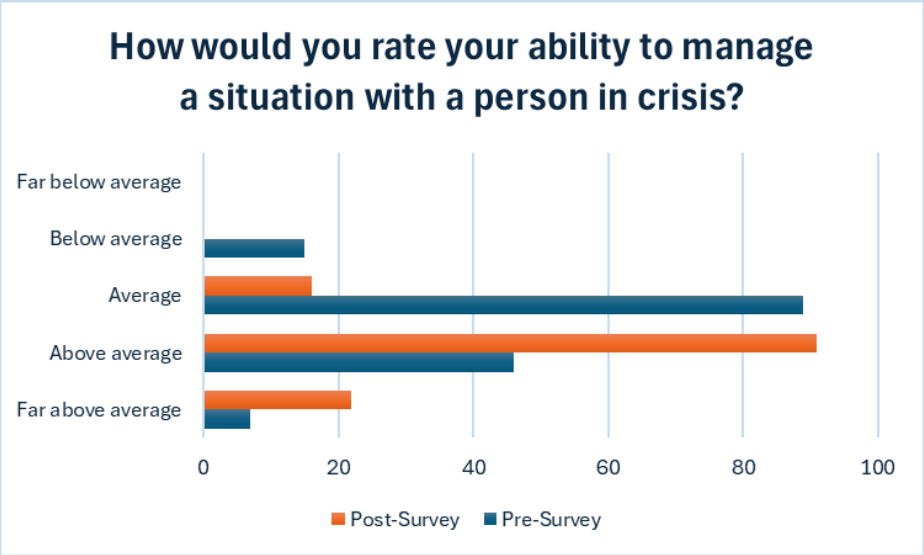
Demographics:

- The respondents' number of years spent in their profession ranged from <1 year to 39 years, with the average of all responses falling around 7.8 years.
- The professional makeup of the class included mostly law enforcement officials (55.3%), followed by corrections officials (18.7%), behavioral health providers (11.4%), and Fire/EMS (10.6%), with communications/dispatch making up 4.1% of the class.

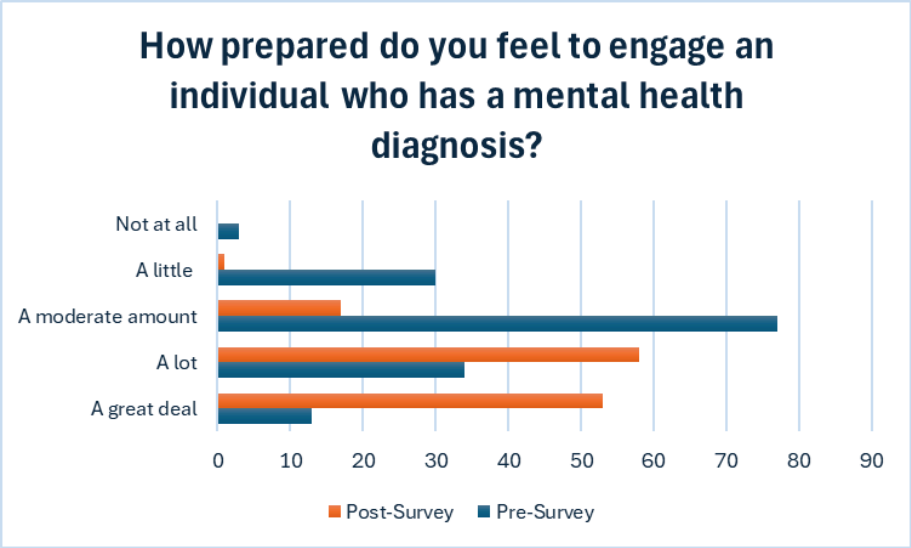
Survey Analysis:

Crisis Management:

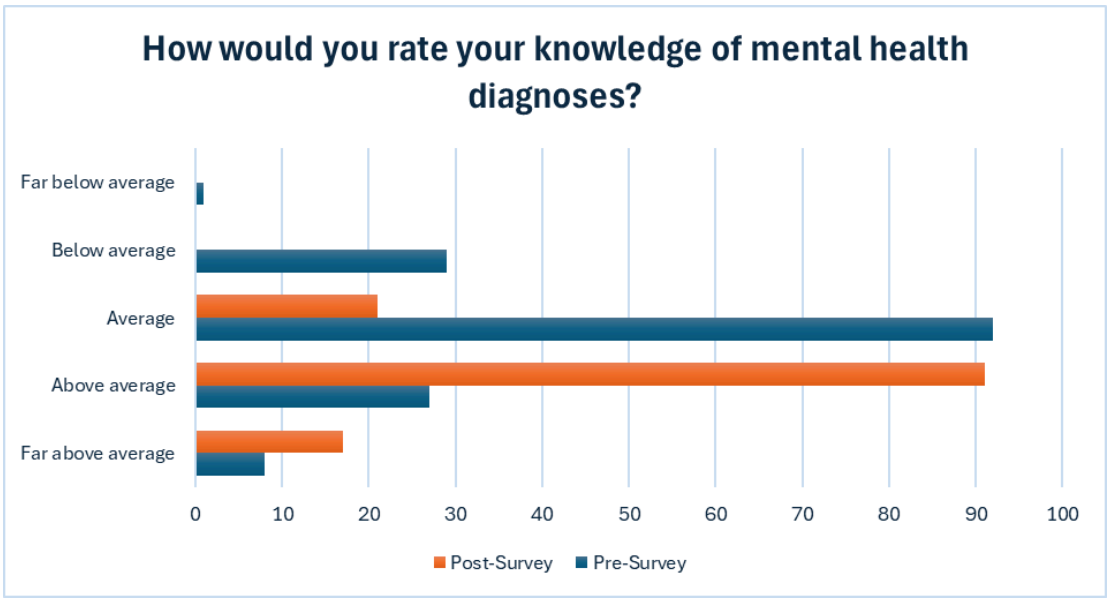
In response to the question, "How would you rate your ability to manage a situation with a person in crisis?" officers' responses averaged 3.29 on a 5-point scale, with the most common response being "average" in the pre-training survey. Responses rose with an average of 4.05 on the post-training survey (with the most common response being "above average"), indicating a **23% increase in their perceived ability to manage a citation with a person in crisis**. This is the **smallest** increase seen in any single question among these respondents.



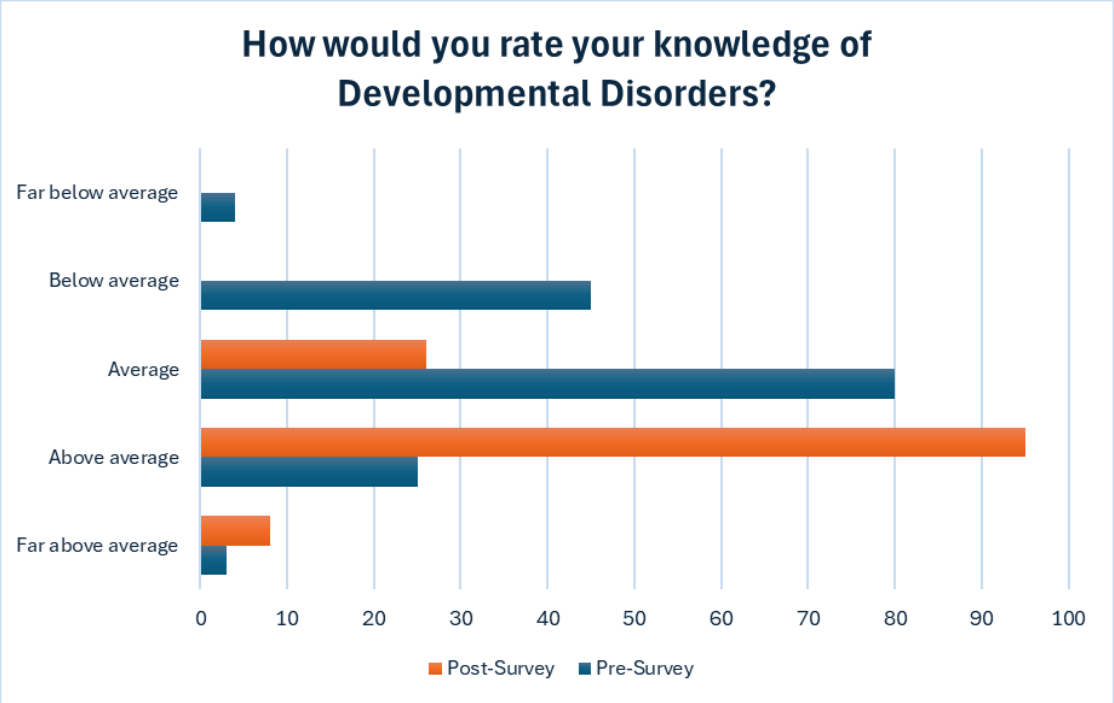
Preparedness (Engaging with PMH):
In response to the question, "How prepared do you feel to engage an individual who has a mental health diagnosis?" respondents' answers rose an average of 3.15 on a 5-point scale in the pre-training survey to a 4.26 upon taking the post-training survey, resulting in a **35% increase in perceived preparedness** to engage with persons with mental health diagnoses.



Knowledge:
Officers' responses to "How would you rate your knowledge of mental health diagnoses?" yielded an average of 3.08 on a 5-point scale, with the most common answer being "average" in the pre-training survey. Upon taking the post-training survey, respondents averaged 3.97, with the most common response of "above average," indicating a **29% increase in perceived knowledge of mental health diagnoses**.

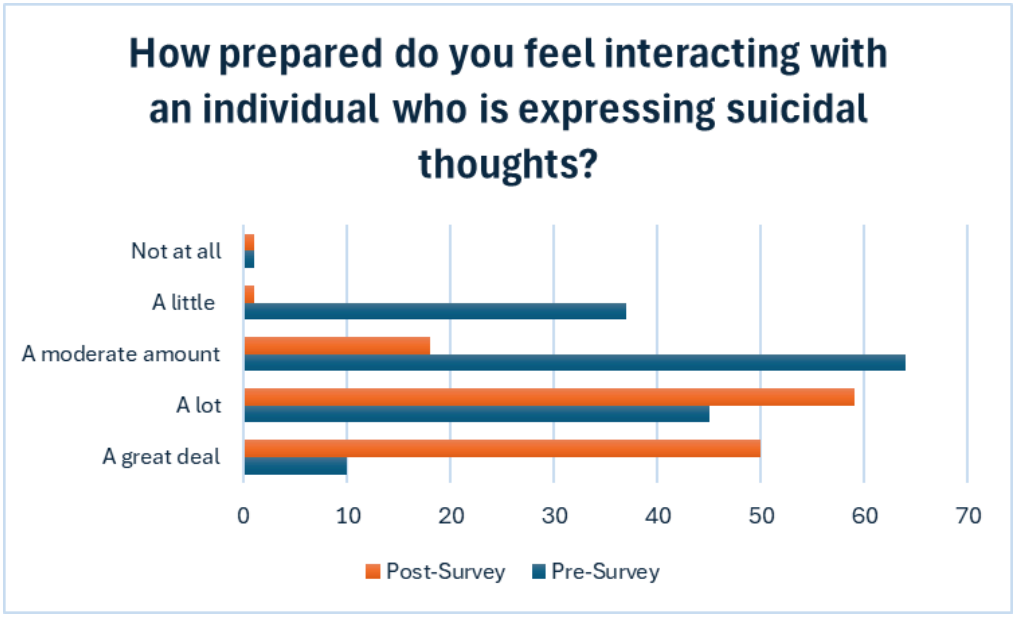


The question “How would you rate your knowledge of Developmental Disorders?” averaged 2.86 on a 5-point scale in the pre-training survey, and 3.86 in the post-training survey. **This indicates a 35% increase in perceived knowledge of Developmental Disorders.**

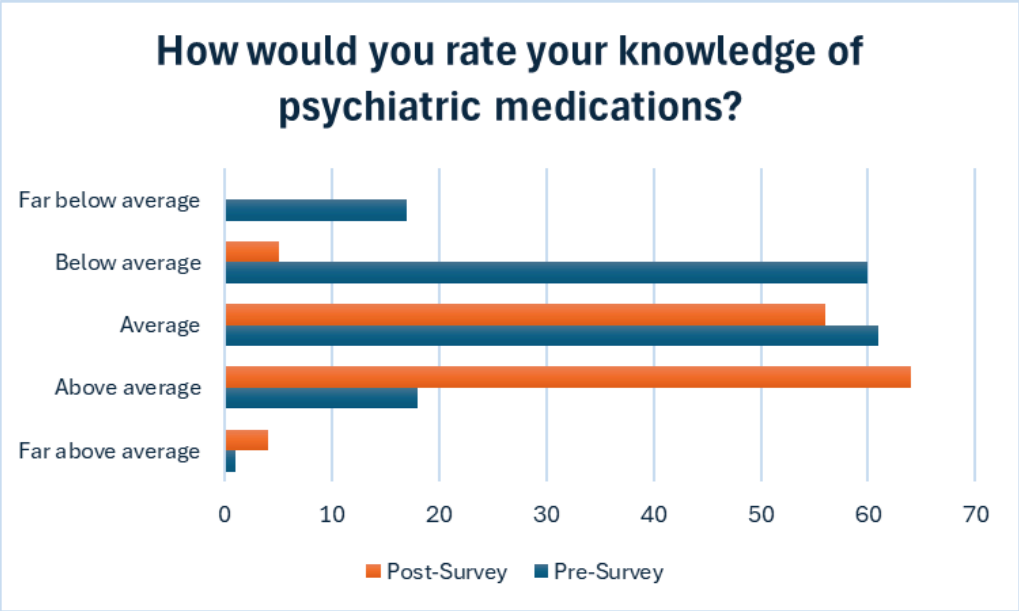


Preparedness (Suicidal Thoughts):

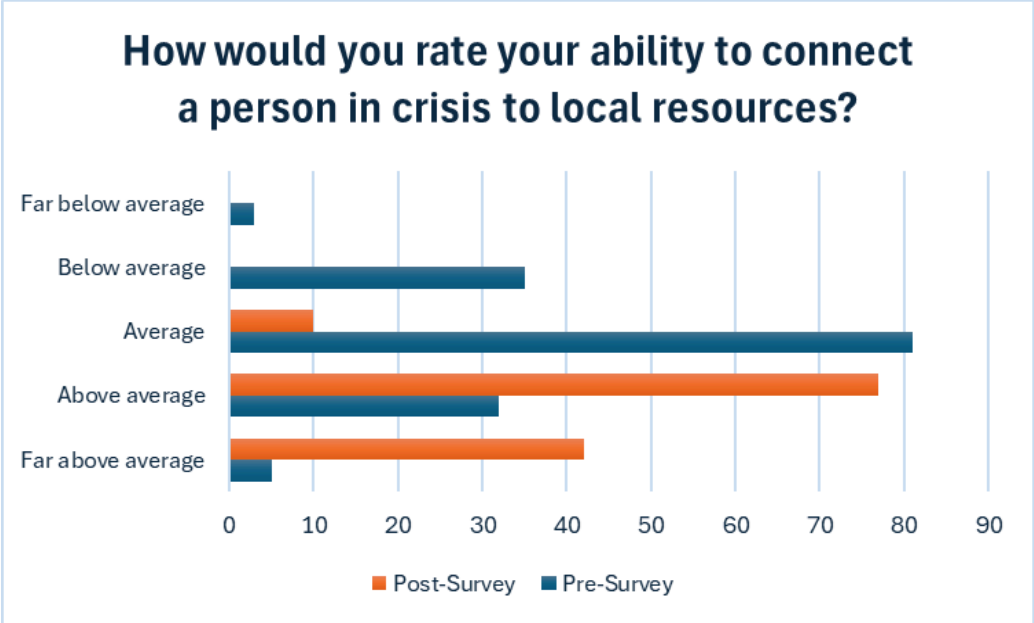
Responses to the question “How prepared do you feel interacting with an individual who is expressing suicidal thoughts?” yielded an average of 3.17 on a 5-point scale, with a most common response of “a moderate amount” in the pre-training survey. Following the training, responses increased to an average of 4.21, indicating a **33% increase of perceived preparedness in interacting with an individual who is expressing suicidal thoughts**.



Knowledge (Medications):
In response to the question, "How would you rate your knowledge of psychiatric medications?" respondents averaged 2.53 on a 5-point scale in the pre-training survey, and 3.52 in the post-training survey, **indicating a 39% increase in perceived knowledge of psychiatric medications among respondents**.

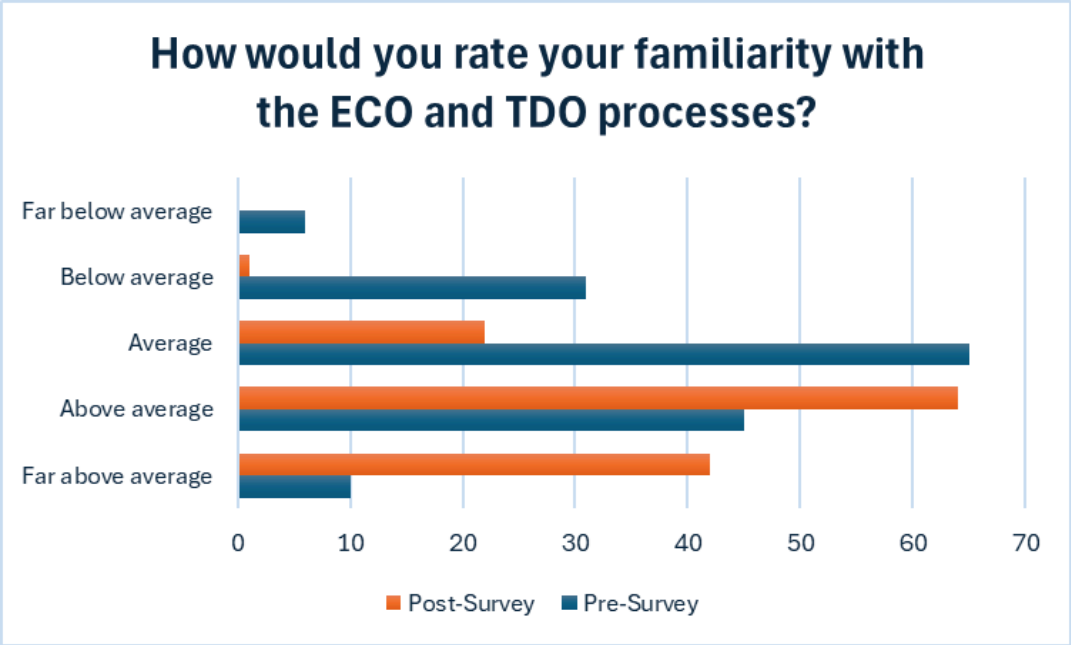


Connecting to Resources:
The question "How would you rate your ability to connect a person in crisis to local resources?" resulted in an average of 3.01 on a 5-point scale among respondents in the pre-training survey, increasing to 4.25 in the post-training survey. This indicates a **41% increase in perceived ability to connect persons in crisis to local resources**.



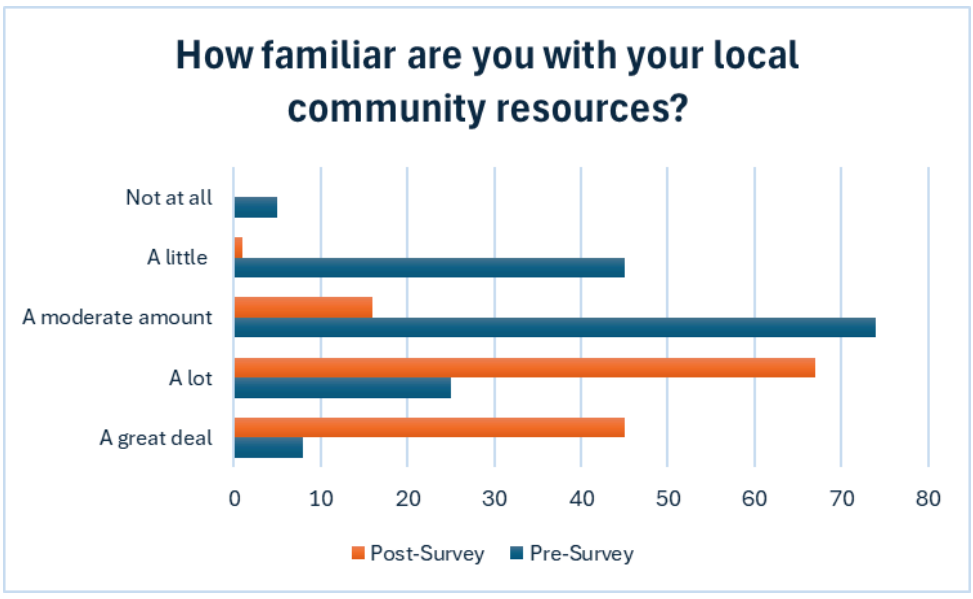
ECO/TDO:

Responses to the question "How would you rate your familiarity with the emergency custody order (ECO) and temporary detention order (TDO) processes?" resulted in an average of 3.14 on a 5-point scale in the pre-training survey, rising to a 4.14 in the post-training survey. **This represents a 32% increase in familiarity with ECO and TDO processes among respondents**.



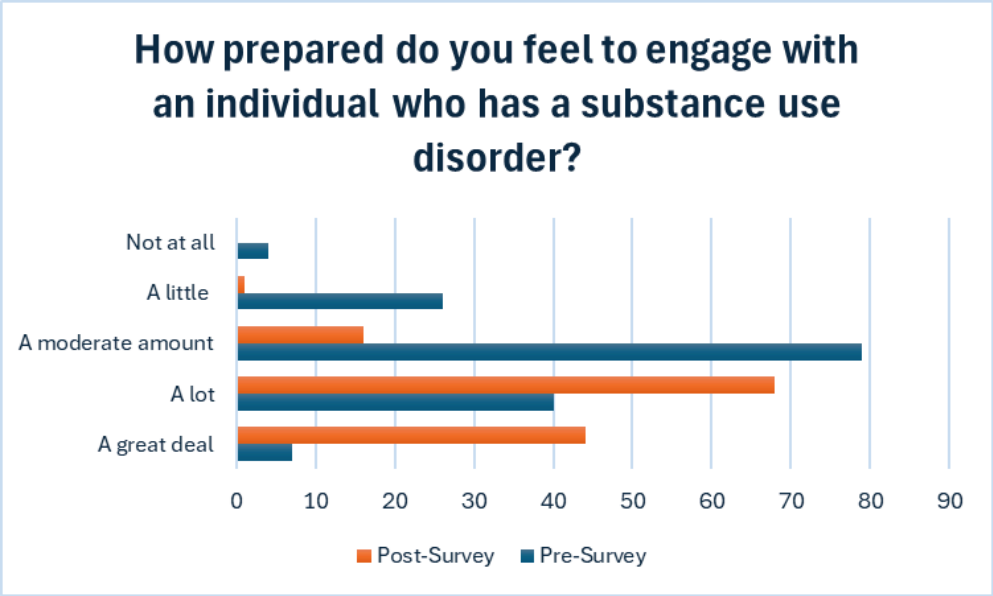
Familiarity with Resources:

Responses to the question "How familiar are you with your local community resources?" averaged 2.91 on a 5-point scale in the pre-training survey, increasing to 4.21 out of 5 in the post-training survey. This represents a **45% increase in familiarity with local community resources**—the largest increase seen in among these respondents to a single question between pre and post surveys.



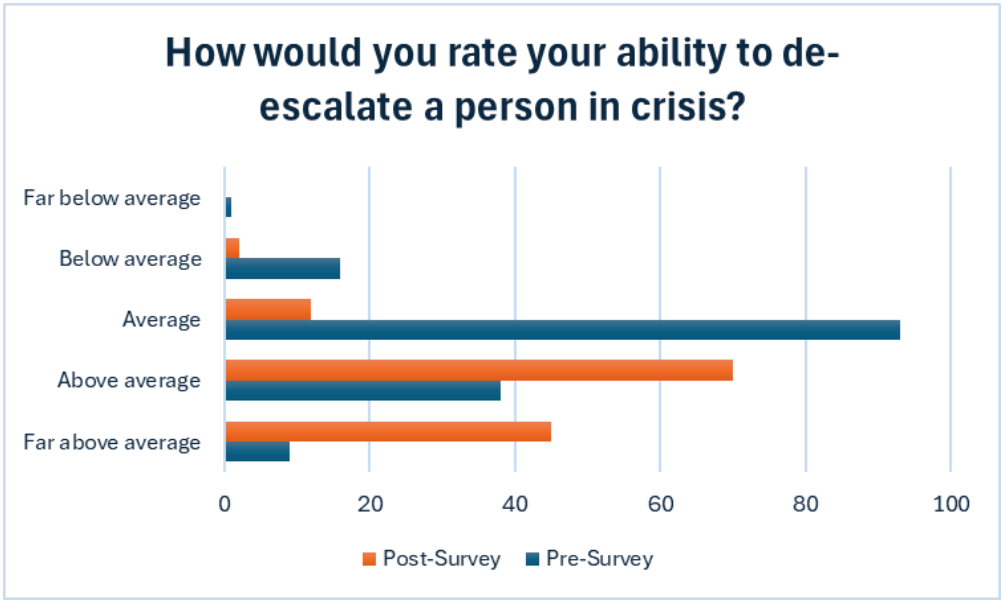
Substance Use:

The question, "How prepared do you feel to engage with an individual who has a substance use disorder?" showed an average of 3.13 on a 5-point scale in the pre-training survey, with the most common response being "a moderate amount," compared to an average 4.20 out of 5 in the post-training survey, with the most common response shifting to "a lot". This is a **34% increase in perceived preparedness in engaging with individuals who have substance use disorders**.



De-Escalation:

Responses to the question, "How would you rate your ability to de-escalate a person in crisis?" averaged 3.24 on a 5-point scale in the pre-training survey, with "average" being the most common response. This increased to an average of 4.22 in the post-training survey, with "above average" as the most common response. **This represents a 30% increase in perceived ability to practice de-escalation with a person in crisis.**



Appendix L

Essential Elements for the Commonwealth of Virginia

Crisis Intervention Team Programs (CIT)

CIT Program Development Guidance
Virginia CIT Coalition
September 8, 2011 (Updated November 4, 2021)

Introduction: The CIT Concept

Crisis Intervention Teams (CIT) are programs that bring together local stakeholders, including law enforcement officers and other first responders, emergency communication officers, behavioral health treatment providers, consumers of behavioral health services and others (such as hospitals, emergency medical care facilities, non-law enforcement first responders, and family advocates). The goal is to improve the response to persons experiencing behavioral health crises who come into contact with law enforcement and other first responders. Such individuals may come to the attention of first responders due to actions or behaviors that are misinterpreted as criminal in nature, inappropriate, dangerous or violent. Additionally, law enforcement officers routinely interact with individuals with behavioral health disorders as a result of Virginia's civil commitment process. In many of these situations, it is necessary to help such individuals access behavioral health treatment, or place such persons in custody and seek either behavioral health treatment referral or incarceration for criminal acts.

Effective CIT programs enhance community collaboration, develop a stable infrastructure and provide training to improve criminal justice and behavioral health system response to individuals with behavioral health issues. The CIT model was originally developed in 1988 by the Memphis, Tennessee Police Department, and has subsequently spread throughout the country. Through the development of a widely representative stakeholders' task force, Memphis created a program to provide specialized training for a select cadre of patrol officers, as well as training all police dispatchers, and established a therapeutic treatment site as an alternative to incarceration. The 40-hour training enabled officers to more effectively communicate with and understand the particular needs of individuals with mental illness. In so doing, officers were able to reduce the potential for misunderstanding and enhance their ability to de-escalate situations involving persons with mental illness. Additionally, with education about treatment options and access to a therapeutic assessment site, officers were able to connect individuals with needed treatment, in lieu of incarceration or hospitalization, consistent with the needs of public safety and addressing the underlying issue of mental illness.

Legislative Initiative for CIT in Virginia

The 2009 Virginia General Assembly, through Senate Bill 1294, amended Sections 9.1-102, 187, 188, 189 and 190 of the *Code of Virginia* to direct the Department of Criminal Justice Services in conjunction with the Department of Behavioral Health and Developmental Services to "…support the establishment of crisis intervention team programs in areas throughout the Commonwealth." The Code was further amended during the 2020 Special Session of the Virginia General Assembly. It also established numerous criteria for the departments to use in implementing its provisions. The code sections that relate to CIT programs throughout the Commonwealth are:

§9.1-102. Powers and Duties of the Board and the Department of Criminal Justice Services

> The Department, under the direction of the Board, which shall be the policy-making body for carrying out the duties and powers hereunder, shall have the power and duty to: … 47. Assess

and report, in accordance with §9.1-190, the crisis intervention team programs established pursuant to §9.1-187.

§ 9.1-187. Establishment of crisis intervention team programs

A. By January 1, 2010, the Department of Criminal Justice Services and the Department of Behavioral Health and Developmental Services, utilizing such federal or state funding as may be available for this purpose, shall support the development and establishment of crisis intervention team programs in areas throughout the Commonwealth. Areas may be composed of any combination of one or more counties, cities, towns, or colleges or universities contained therein that may have law-enforcement officers as defined in § 9.1-101, or campus police officers appointed pursuant to the provisions of Chapter 17 (§ 23-232 et seq.) of Title 23. The crisis intervention teams shall assist law-enforcement officers in responding to crisis situations involving persons with mental illness, substance abuse problems, or both. The goals of the crisis intervention team programs shall be:

1. Providing immediate response by specially trained law-enforcement officers;
2. Reducing the amount of time officers spend out of service awaiting assessment and disposition;
3. Affording persons with mental illness, substance abuse problems, or both, a sense of dignity in crisis situations;
4. Reducing the likelihood of physical confrontation;
5. Decreasing arrests and use of force;
6. Identifying underserved populations with mental illness, substance abuse problems, or both, and linking them to appropriate care;
7. Providing support and assistance for mental health treatment professionals;
8. Decreasing the use of arrest and detention of persons experiencing mental health and/or substance abuse crises by providing better access to timely treatment;
9. Providing a therapeutic location or protocol for officers to bring individuals in crisis for assessment that is not a law-enforcement or jail facility;
10. Increasing public recognition and appreciation for the mental health needs of a community;
11. Decreasing injuries to law-enforcement officers during crisis events;
12. Reducing inappropriate arrests of individuals with mental illness in crisis situations;
13. Decreasing the need for mental health treatment in jail.

B. The Department, in collaboration with the Department of Behavioral Health and Developmental Services, shall establish criteria for the development of crisis intervention teams that shall include assessment of the effectiveness of the area's plan for community involvement, training, and therapeutic response alternatives and a determination of whether law-enforcement officers have effective agreements with mental health care providers and all other community stakeholders.

C. By November 1, 2009, the Department, and the Department of Behavioral Health and Developmental Services, shall submit to the Joint Commission on Health Care a report outlining the status of the crisis intervention team programs, including copies of any requests for proposals and the criteria developed for such areas.

§ 9.1-188. Crisis intervention team training

The Department, in consultation with the Department of Behavioral Health and Developmental Services, the Department for Aging and Rehabilitative Services, and law- enforcement, brain injury, and mental health stakeholders, shall develop a crisis intervention training program divided into the following three categories: (i) a module of principles-based training to be included as part of the compulsory minimum training standards subsequent to employment for all law-enforcement officers, (ii) a module of principles-based training to be included as part of the basic training of and recertification requirements for law-enforcement officers, and (iii) a comprehensive advanced training course for all persons involved in the crisis intervention team programs. Every locality shall establish or be part of a crisis intervention team program in accordance with the provisions of this article.

The curriculum for the basic training and recertification modules and the comprehensive advanced training course shall be approved for Department-certified in-service training credits for law-enforcement officers. All law enforcement officers involved in a crisis intervention team program shall complete the comprehensive advanced training course in accordance with clause (iii). The comprehensive advanced training course's curriculum developed in accordance with clause (ii) shall include a module on brain injury as part of the four hours of mandatory training in legal issues.

§ 9.1-189. Crisis intervention team protocol

Each crisis intervention team shall develop a protocol that permits law-enforcement officers to release a person with mental illness, substance abuse problems, or both, whom they encounter in crisis situations from their custody when the crisis intervention team has determined the person is sufficiently stable and to refer him for emergency treatment services.

§ 9.1-190. Crisis intervention team program assessment

The Department, and the Department of Behavioral Health and Developmental Services, shall assess and report on the impact and effectiveness of the crisis intervention team programs in meeting the program goals. The assessment shall include, but not be limited to, consideration of the number of incidents, injuries to the parties involved, successes and problems encountered, the overall operation of the crisis intervention team programs, and recommendations for improvement of the program. The Department, and the Department of Behavioral Health and

Developmental Services, shall submit a report to the Joint Commission on Health Care by November 15, 2009, 2010, and 2011.

§ 2.2-213.5 Dissemination of information about specialized training to prevent and minimize mental health crisis.

The Secretary of Health and Human Resources and the Secretary of Public Safety and Homeland Security shall encourage the dissemination of information about specialized training in evidence-based strategies to prevent and minimize mental health crises in all jurisdictions. This information shall be disseminated to, but not limited to, law-enforcement personnel, other first responders, hospital emergency department personnel, school personnel, and other interested parties, to the extent possible. These strategies shall include (i) crisis intervention team (CIT) training for law-enforcement personnel and other first responders as designated by the community CIT task force and (ii) mental health first aid training for other first responders, hospital emergency department personnel, school personnel, and other interested parties. The Secretary of Health and Human Resources and the Secretary of Public Safety and Homeland Security shall encourage adherence to the models of training and achievement of programmatic goals and standards. The goals for CIT training shall include (i) training participants to recognize the signs and symptoms of behavioral health disorders; (ii) teaching participants the skills necessary to de-escalate crisis situations and how to support individuals in crisis; (iii) educating participants about community based resources available to individuals in crisis; and (iv) enhancing participants' ability to communicate with health systems about the nature of the crisis to include rules regarding confidentiality and protected health information. The goals for mental health first aid training shall be to teach the public (to include first responders, school personnel, and other interested parties) how to recognize symptoms of mental health problems, how to offer and provide initial help, and how to guide a person toward appropriate treatments and other supportive help.

Program Description for CIT in Virginia

At its core, CIT provides 1) law enforcement-based crisis intervention training for assisting individuals with a mental illness; 2) a forum to promote effective problem-solving regarding interaction between the criminal justice and behavioral health care system; and 3) improved community-based solutions to enhance access to services for individuals with a mental illness. Successful CIT programs improve first responder and consumer safety, and appropriately redirect individuals with mental illness from the criminal justice system to the health care system.

Essential Elements for Virginia's CIT Programs

DCJS and DBHDS strongly encourage CIT programs adhere to a limited number of uniform requirements, referred to as the "Essential Elements of VACIT", to assure that the basic structure of all CIT programs is consistent throughout the state. The departments created the Virginia CIT Coalition (VACIT) to support

the growth and development in all aspects of CIT programs as well as fully and effectively integrate CIT's statutory and policy goals in CIT programs throughout the Commonwealth. Participation in VACIT is encouraged for all programs, through participation in their Regional CIT Coalition.

While supporting the growth and development of CIT programs across the Commonwealth, the VACIT encourages programs to become self-sufficient and sustainable to the fullest extent possible. Mutual support among programs, through regional coalitions and other means, is encouraged but each program should strive to meet their respective ongoing needs for stakeholder engagement, CIT training, assessment site and other field operations, with internal and locally cultivated resources specific to that catchment area's program. Programs should strive to develop and maintain a local cadre of instructors through a self-directed instructor development program. Over-reliance on instructors from other programs, in the near-term, prohibits the long-term sustainability of a community's CIT program.

Each autonomous program and its stakeholder group should determine its respective personnel, financial and other resource commitments necessary for program sustainability. All stakeholders should demonstrate investment in the program infrastructure. Some of these commitments may include cost-sharing for positions (e.g., CIT Coordinator), space for training, cost of law enforcement overtime and sharing or pooling of equipment/supplies necessary for training or community outreach events. Sustainability is best demonstrated by utilization of memorandums of agreement. These agreements are particularly helpful as key team members may rotate out of CIT leadership positions into other duties and it is beneficial to have these agreements in place for the arrival of new CIT leaders.

DBHDS, DCJS and the VACIT leadership and coalition members worked together to establish these essential elements for the development and operation of CIT programs:

1. Community stakeholder collaboration and oversight;
2. CIT Coordinator;
3. 40 hour DCJS-certified CIT core training for law enforcement personnel;
4. Train-the-trainer classes for CIT program sustainability;
5. Dispatcher training;
6. Policies and procedures;
7. Therapeutic assessment location (not a law enforcement or jail facility), or procedures, to streamline access to services in lieu of incarceration (when appropriate);
8. Collection of data to monitor statutory outcome measures; and
9. Active participation in VACIT and regional efforts.

These elements are central to the success of CIT programs and the achievement of CIT program goals. What follows are the recommended essential elements and a brief description of the necessary components of each element.

1. Community Stakeholder Collaboration and Oversight

Central to the formation and ongoing success of Crisis Intervention Team programs is the creation of fully integrated, collaborative community partnerships. At a minimum these partnerships need to include representatives from:

- *Law Enforcement* – local police departments, sheriffs' offices, campus police departments, other relevant law enforcement agencies and other first responders.
- *Behavioral Health* – local community services boards, educators and private providers within the behavioral health treatment and provider community.
- *Community* – dynamic community involvement should reflect the composition of the local community, with particular emphasis on the inclusion of persons with mental illness. Historically, consumer advocacy organizations (such as the National Alliance on Mental Illness or Mental Health America) are highly involved in the development of CIT programs. However, some communities within the Commonwealth do not have operating consumer advocacy organizations. Therefore, at a minimum, all CIT programs should have a strategy for consumer and family member involvement, and, where possible, should also include consumer advocacy organizations. Involvement of all other appropriate community partners is highly suggested, to include but not limited to: fire and rescue, emergency medical services, correctional officers, judges, magistrates, special justices, attorneys, emergency department directors, psychiatric hospitals, local human rights organizations, etc.

A community oversight committee of critical community partners and stakeholders is essential in order to guide the initial planning and implementation of a CIT program and to provide ongoing oversight of the program's continued operation and sustainability, including critical incident review, funding and community outreach and education. These committees have taken a variety of names across the Commonwealth, including oversight committee, advisory committee, task force, etc.

2. CIT Coordinator

Each CIT program requires a designated individual or individuals to serve as CIT Coordinator(s) in order to manage the various training and program elements, including day-to-day logistics of inter-departmental communication, data collection and management, scheduling trainings and working with the community oversight committee.

The existence of both the CIT Coordinator(s) and a community task force are considered critical to the achievement of program goals and objectives. CIT programs bring together professionals from behavioral health treatment, criminal justice and public safety, and consumers and community members in a new and unique partnership. This requires close coordination, collaboration, problem-solving, and negotiation. Without at least one person tasked with facilitating this process and a local task force of the key stakeholders to work out details, reach consensus on local policies and procedures and provide ongoing program review and adjustments, CIT programs are significantly challenged.

The ideal candidate for the position of CIT Coordinator will possess a basic understanding of the issues confronting law enforcement and emergency services and should have pre-existing relationships and connections to the law enforcement and behavioral health communities.

3. 40 Hour CIT Core Training for Law Enforcement Personnel

Community stakeholders and law enforcement have debated what makes a CIT Program a "true" Crisis Intervention Team Program. Different regions have different issues which require flexibility to develop a diverse and regionally effective version of the CIT program model. Just as Virginia has adapted the Memphis Model to its laws and needs, so, too, have rural and urban localities made additional adaptations to suit their needs. These are the central tenets of the training which must be maintained.

The following are minimum standards, although programs are strongly encouraged to exceed and expand these to enhance the scope or depth of their individual programs.

a. 40 Consecutive Hours

A basic requirement of the CIT Core training program is 40 consecutive hours of classroom training delivered over five days. Breaking the training up into blocks with a lapse of time in between interferes with the CIT training's goals, namely, to build program cohesion, and to instill in students a deeper awareness of the needs of individuals with mental illness and the capacity to utilize and integrate their newly developed skills.

b. Class Size

Class size will vary from locality to locality in regard to the maximum number of students that can be provided with effective instruction and sufficient opportunity to engage in role play exercises. Experience across Virginia demonstrates that a class size of 20-25 is ideal, and it is not recommended to exceed a class size of 30 students. Programs should always keep in mind that a larger class size can constrain students from obtaining the maximum functionality of role play exercises and participation in discussion.

c. Didactic Component

Didactic CIT training must include modules on Basic Mental Health Diagnoses or Clinical States, Basics of Substance Abuse and the Medical Model, Basics of Intellectual and Developmental Disabilities, Psychiatric Medications, Verbal De-escalation and/or Crisis Intervention Skills, Suicidality, Legal Issues (e.g., liability, CIT Code provisions, etc.) and Civil Commitment, Overview of Special Populations, and Cultural Diversity. Other topics such as Adolescent Issues, Veterans Issues, and Geriatric Issues, or other region specific or topical areas should be added by programs as needed, and as long as the basic core curriculum is provided. Required module length may vary from program to program, however, based on statutory requirements, Legal Issues and Civil Commitment must total four hours in length.

In 2017, VACIT developed a Core CIT Training curriculum that includes a Lesson Plan and Training Aides. The VACIT curriculum, annually approved by DCJS, includes the required training modules mentioned above, as well as role play scenarios, and only covers 30 hours, or 75%, of the training's content. The other 10 hours of training content is elective and localities may include those modules that address the needs of their specific communities. When applying for training credit through DCJS or a local criminal justice training academy, programs must submit a lesson plan, training aides and instructor biographies.

d. Experiential Component

An important goal of CIT training is to increase sensitivity and awareness through direct experience. The Memphis Model utilizes the second day of the 40 hour training for site visits and other interaction with consumers to provide a personalized perspective not otherwise achievable. Virginia's model will mirror this approach. Site visits shall be conducted in person unless weather and/or facility restrictions necessitate this portion of the training be virtual. Training modules must include consumer and family presentations and virtual experience programs such as Hearing Voices Curriculum by Pat Deegan and the National Empowerment Center (preferred). This portion of the curriculum and its timing greatly enhance the overall experience of the 40-hour training.

e. Practical Component

Role Play within CIT seeks to build upon the foundation of didactic and experiential information provided earlier in the training week. Role play within CIT will in all cases begin with an overview of 'The Four Coaching Plays' of CIT. These are the essential tools for developing de-escalation and relationship building skills. Role play exercises are to be integrated into the training over each of the program's final three days with each day increasing in intensity and difficulty. This ensures practical knowledge and skill building lessons are turned into useable abilities for the CIT student. The role plays are to be utilized both as a practical experience for the responders involved and as a learning opportunity for the rest of the class by their observation and feedback in each of the exercises. Additionally, each role play must utilize a specially trained feedback panel. The feedback panel must include at least one law enforcement officer or first responder and one behavioral health representative and may also include consumer representatives when feasible to provide appropriate feedback and foster growth of the officer's confidence and abilities. Role players should be law enforcement officers, other first responders and any CIT program stakeholders using scenarios that will be created from real life experiences and NOT utilize students or professional actors. Any parties involved in role play scenarios shall have completed the CIT train the trainer course.

Prior to role play exercises, students will be asked to secure any weapons that may be in their possession. The use of live firearms and other lethal weapons is not permitted in the training environment or during role play exercises. Use of inert (training) weapons by students during role play exercises shall be at the discretion of each training program. Also, students are not permitted to go "hands on" (use physical force/defensive tactics) during role play exercises.

Should a student feel that the circumstances of the exercise require them to use force, they will be instructed to raise their hand and indicate how they would proceed if the scenario were real. There are plenty of valid arguments for the use of weapons and defensive tactics during role play exercises. However, the focus of CIT training and role play exercises is for law enforcement personnel to develop and utilize communication skills. Furthermore, the use of force and lethal weapons in the classroom pose potential safety concerns.

f. Presentation Order

As noted above, the flow and order of the training units is significant. Therefore, all 40 hour core CIT trainings will follow these guidelines for the placement and timing of specific units:

Monday

- Introduction to CIT
- Basic Mental Health Diagnoses (Clinical States)
- Hearing Voices Curriculum Practical Exercise

Tuesday

- Site Visits

Wednesday

- Basic Crisis Intervention Skills & The Four Coaching Plays (must take place immediately before Basic Role Play Exercises)
- Basic Role Play Exercises

Thursday

- Intermediate Role Play Exercises

Friday

- Advanced Role Play Exercises

g. Training Attire

Law enforcement and other first responders are strongly encouraged to wear civilian clothes throughout the duration of the training, with “business casual” as the general standard. However, it is understood that officers may have to be uniformed on occasion because of a court appearance or other obligations.

A table which lays out the Model 2017 VACIT Core Training Agenda can be found in Appendix B. Additional information about the VACIT Core CIT Training curriculum can be found on the organization's website (www.virginiacit.org).

4. CIT Train the Trainer Training (TTT)

Just as Crisis Intervention Team Core Training has basic elements, so does CIT Train the Trainer Training (TTT). TTT develops the local 40 hour training faculty to enhance their capacity and expertise to provide the 40 hour CIT training consistently for their team. CIT TTT ensures uniformity among trainers involved with creating and participating in CIT Role Play, developing effective presentation and proficient feedback skills for students. Subject Matter Experts instructing clinically-focused didactic modules are not required to take a TTT course as there is a line between didactic classroom instruction and the practical methodology of CIT skill building. However, behavioral health instructors who are involved in the 40 hour role play training component are to participate in the TTT course. Officer instructors need special attention to ensure they understand and emulate the proper CIT role play model. Behavioral health instructors engaging in role play likewise require special attention to ensure that their message carries the proper tone, being neither too clinical nor too simplistic, for the trainees. It is important to note that while a student taking the CIT TTT class will be adequately prepared to assist with a 40 hour Core CIT Training, it will require ongoing observation, assistance and tutoring with TTT veteran instructors before that student is a veteran instructor and sufficiently prepared to teach a TTT class.

The CIT TTT is a 20 consecutive hour program, provided over two and a half days, for no more than 18 students at a time. Individualized attention is critical, hence the smaller class size. The first day consists of classroom instruction on CIT fundamentals of theory, public presentation, and methodology required to instruct CIT Core students. Elements that are required include CIT theory from a process perspective, public speaking, effective role play, feedback skills and 'The Four Coaching Plays.'

The second and third day will focus on CIT role play development and implementation. Students will develop, plan and perform scenarios developed under instructor supervision. Student developed scenarios will gradually increase in complexity to better prepare the class to teaching in a full CIT Core class. Instructors will act as mock students to ensure that participants are exposed to a wide variety of potential situations and problems.

Prerequisite for the TTT is successful completion of the CIT 40 hour core training to ensure that officers have the message and foundational skills that the TTT will further develop and build upon. It is strongly recommended that students have a solid experience base after completing the training and becoming a CIT Officer before attending the CIT TTT.

5. CIT Dispatcher Training

Dispatcher training is an important piece of CIT that ensures trained officers on duty are properly utilized in the community. Dispatcher training in Virginia is minimally a four hour course whose key elements include basic CIT concepts, Clinical States, Experiential Exercises and Role Play. Role plays for dispatchers must provide for no visual contact between dispatcher trainee and subject. Some CIT

programs in Virginia offer CIT Dispatcher training as six, eight or sixteen hours. A longer, more intensive training program is advantageous and more desirable. It should be noted that CIT Dispatcher training of four hours is viewed as an absolute minimum that may be built upon. Four hours to instruct 10 students is adequate where four hours to instruct 20 is not. A larger class will require more time and coordination of these efforts should be made accordingly. (Sample eight hour schedule provided in Appendix C, with a target student capacity range 15 to 20)

6. Policies and Procedures

Policies and procedures are a necessary component of CIT. They provide a set of local guidelines that direct the actions of law enforcement and other first responders, dispatch and behavioral health providers. Due to the large number of stakeholders in CIT, it is important that these guidelines be designed by all agencies and individuals affected.

Each CIT program or law enforcement agency will develop their own policies regarding the size of their CIT-trained patrol division. The number of trained CIT officers available to each shift must be adequate to meet the crisis response needs of the community. Experience suggests that a successful CIT program will, at a minimum, have trained 20—25% of the agency's patrol division, which will likely result in 24/7 CIT officer coverage. There are differences that exist between large urban communities and small rural communities. Smaller agencies may need to train a higher percentage of officers to attain optimal coverage. The ultimate goal is to have an adequate number of patrol officers trained in order to ensure that CIT-trained officers are available at all times. Ideally, 100% of dispatchers should be trained to appropriately elicit sufficient information to identify and respond to a behavioral health-related crisis.

While the Memphis Model of CIT advocates for a model where officers volunteer and apply for the opportunity to become a CIT Officer, reflective of the suggested minimum or 20-25% being trained. In this approach, individuals who have an interest and desire to receive the training would be interviewed, approved by a supervisor, and selected based on experience. It is also understood, under this model, that policies and procedures would be put into place which would specify those whom are CIT-trained on each shift, be dispatched and designated as the lead officer or responder on scene in mental health crises. The VACIT supports the Memphis Model of CIT but recognizes that each agency, in collaboration with their designated CIT program, is responsible for formulating their own policies and procedures as it relates to numbers trained and guidelines to direct the actions of the first responders. For more information about the perceived concerns regarding the training of 100% of law enforcement personnel, CIT International has developed some position papers on the topic (www.citinternational.org/Position-Papers). In some instances, the training of 100% of law enforcement personnel without other necessary CIT components has resulted in Consent Decrees from the U.S. Department of Justice (http://www.portlandoregon.gov/police/62044).

It is also important for each agency, in collaboration with their designated CIT program, to formulate polices and procedures regarding those students who, once in the midst of the CIT 40-hour course, may exhibit behavior that is not in alignment with the CIT values and mindset. As CIT is not intended to correct a first responder who may not have a well-developed set of interpersonal skills, policies and

procedures should be supportive of actions being taken which will uphold the integrity of the CIT programs.

Crisis Intervention Team agencies may see the value in training a high percentage of a patrol staff in complementary behavioral health awareness or skills-based training such as the evidenced-based practice Mental Health First Aid training program disseminated by the National Council for Behavioral Health. This approach offers agencies the opportunity to augment the training received in a law enforcement basic school, delivering core content in a concise, time limited format which is less taxing when staffing personnel training.

Within the law enforcement community, policies are needed in order to provide guidelines regarding how to safely and respectfully transport consumers and how to develop supportive program infrastructure through a system of partnerships and inter-agency agreements. Policies must be in place to address the actions of both emergency dispatchers and patrol officers. Emergency dispatcher policies should clearly define and describe the role of dispatchers in the CIT program, which is to identify and dispatch the nearest available CIT Officer to respond to the crisis. Additionally, it is recommended that the responding CIT Officer leads the intervention, regardless of rank, except under unique or complicated circumstances that dictate otherwise. Policies and procedures that maximize the CIT Officer's discretion are critical. CIT Officers should be allowed to integrate their wide range of law enforcement training when handling CIT calls. Please note that CIT provides de-escalation training and should not replace other trainings or policies with which agencies train their staff when responding to calls for service in the community. CIT and verbal de-escalation may not be appropriate to all interventions encountered by law enforcement and other first responders. Personnel should always follow their agency's policy.

Within the behavioral health community, policies must accommodate consumers in the least restrictive setting and allow for a wide range of inpatient and outpatient referral sources. Barriers that prevent officers from accessing immediate behavioral health care for an individual should be examined and processes put in place to reduce or eliminate the amount of time officers spend off the road when involved in a behavioral health call.

7. Therapeutic Assessment Location or Procedures to Streamline Access to Services

While the statewide model for CIT is currently built upon the Memphis CIT model, which includes the utilization of a therapeutic assessment center, each community must assess their available resources, context, and the practicality or reality of operating a fully functioning receiving facility. Each locality or program at a minimum must develop a diversion mechanism or protocol that is an agreement-based process incorporating the community's strengths, resources and needs, in order to divert individuals into community care and treatment while also reducing officer involved time.

A therapeutic treatment alternative may consist of an actual physical location to which persons experiencing a behavioral health crisis may be taken for emergency treatment or stabilization, or it may consist of some other set of alternative means for providing appropriate interventions to individuals in crisis. Sometimes, it is a combination of the two. CIT programs are discouraged from utilizing criminal

justice facilities, such as a police department or sheriff's office, for assessing or triaging the treatment needs of behavioral health clients, absent a significant threat to public safety or incarceration on criminal charges, or when other mitigating circumstances dictate.

The ideal for a CIT program is to have a physical location that is *not* a jail or criminal lock-up always available to which an officer can deliver a person in crisis and turn over custody to someone trained to assist that person. This releases the officer to return to other duties and provides the treatment options needed by the consumer. A person for whom a therapeutic, community-based alternative is not appropriate due to the nature of the crime charged, may well need behavioral health treatment and care provisions at the jail to which he or she is taken. Under those circumstances, effective utilization of de-escalation skills by a CIT officer is likely to reduce the difficulties which a jail might encounter.

The following six components represent the ideal elements which are necessary to achieve the most successful type of triage/assessment site:

- 24/7 availability of the assessment site for law enforcement to use as an access point for services as an alternative to incarceration;
- 24/7 availability of emergency services personnel who can determine clinical status and assess treatment needs for the individual;
- 24/7 availability of on-site trained security to support the site by accepting transfer of the individual and to provide for the safety of all persons involved;
- 24/7 access to medical screening for individuals in crisis;
- 24/7 access to dispositional options including psychiatric beds available to accept voluntary individuals and those under behavioral health detention orders, crisis stabilization units, detox, and other community-based services; and
- 24/7 availability of peer support for individuals awaiting evaluation or transportation to dispositional options during the site's operational hours.

As of July 2020, the Department of Behavioral Health and Developmental Services provides funding for 42 assessment sites across the Commonwealth of Virginia. Each assessment site is unique in terms of its hours of operation, staffing and location. While the ideal standard is a site that operates 24/7, numerous programs operate sites on a 12 or 16 hour model, 7 days a week. In terms of security staffing, most sites utilize sworn law enforcement officials, either as a duty or off-duty assignment. A small number of sites use private security officers. Most assessment sites are co-located on a medical center campus or within a hospital emergency department, although a few are standalone facilities. Despite the variation in hours, staffing and location, every CIT assessment provides an alternative to arrest for law enforcement officials and supports the Commonwealth of Virginia's commitment to the principles of recovery.

8. Data Collection

Data collection is critical to measuring the progress and impact of CIT programs. It is made difficult by many factors, including the diversity of local data gathering systems and sharing capacities. Each locality has a great deal of autonomy in the design and functioning of their law enforcement and public safety agencies. This has led to development of localized communications and management information

systems that are not required to be uniform and consistent from one locality to the next. While all incidents handled by law enforcement officers are typically reported and captured in some data bank, the elements of an incident which may identify it as involving a person with mental illness are not always known or identifiable. Without a CIT program in place in a community, it is believed that many incidents that typically lead to arrest and injuries may have resulted from contact with persons experiencing a behavioral health crisis for which responding officers were not well trained or prepared to handle with alternatives to physical arrest. Identifying such incidents and emphasizing alternative resolutions is critical to measuring the success of a CIT program.

In Virginia, CIT programs are encouraged to collect the following core data elements for all law enforcement interventions that involve an individual in crisis: 1) how CIT Officers are dispatched to such calls (i.e., call type); 2) how long a CIT Officer remains involved in the call (time in service); 3) the number of injuries involved, if any; 4) the final disposition of the intervention.

Additionally, CIT programs that receive funding for an assessment site are required to provide data to the Department of Health and Developmental Services on a quarterly basis. For each individual who is assessed at the site, in addition to the core data elements above, program must report the following data:

1. Date and Time
    a. Arrival at Assessment Site
    b. Transfer of Custody Occurs
    c. Departure from Assessment Site
2. Referral Information
    a. Referral Source
    b. Field Disposition and Location
    c. Primary Officer Agency
    d. No Transfer Explanation, if applicable
    e. ECO Type, if applicable
    f. Alternative to Arrest
3. Outcome
    a. Clinical Disposition
    b. Agency Transporting TDO, if applicable
    c. Receiving Hospital, if applicable
    d. Length of Transport

The Department of Behavioral Health and Developmental Services uses this data to monitor each program and to report the overall program's success to the General Assembly.

9. Active participation in VACIT and Regional efforts

The VACIT is a board of individuals who were elected by representatives selected by CIT programs within the five regions. It is intended that the regional CIT coalitions be a conduit of information to and from

the VACIT. For this reason, it is considered essential for representatives from each CIT program in the Commonwealth participate in the regional meetings and communications. While it would be preferred for the Coordinators of each program be involved and in attendance, when that is not possible, it is expected that an active and influential representative from each CIT program make every effort to participate. More details regarding the structure and function of the VACIT can be found in the By-laws on the virginiacit.org website.

Recommended optional components of CIT programs in Virginia

1. CIT for jail staff and corrections personnel
2. CIT for non-law enforcement first responders and behavioral health treatment personnel
3. CIT Refreshers/Recertification
4. CIT Advanced and In-service Training Courses
5. Specialized CIT response unit
6. Self-review of CIT program on regular basis
7. Awards and recognition

These elements are suggestions for CIT programs to consider as ways to broaden their programs and the intended purpose of improving first responder interactions and outcomes for individuals in crisis. What follows are these suggested elements and a brief description of each.

1. Crisis Intervention training for jail staff and correctional officers: While CIT was originally created as a law enforcement based first responder program, there is a large population of incarcerated persons with mental illness in Virginia jails who are not appropriate for jail diversion through CIT. Utilization of the 40-hour core CIT training curriculum for jail staff and correctional officers can have a positive impact for local jails. CIT training and utilization of de-escalation techniques for local jail personnel may diminish the risk of injuries to consumers and jail staff as well as reducing the incidence of persons receiving additional charges as a result of symptomatic behaviors. Programs may choose to include jail staff and correctional officers in their 40-hour core CIT trainings. This is a worthwhile use of resources while developing and furthering a working partnership amongst agencies.
2. Crisis Intervention training for non-law enforcement first responders (i.e., Fire/EMS) and behavioral health treatment personnel: Elements of CIT may easily be applied to other first responders dealing with consumers in the community. While CIT is primarily designed for law enforcement, Virginia should continue to offer training to these other groups to enhance the effectiveness and safety of all public service persons and the public. Programs may choose to include non-law enforcement first responders and behavioral health treatment personnel in their 40-hour core CIT trainings. This is a worthwhile use of resources while developing and strengthening a working partnership amongst agencies. Programs could also consider including additional partnering agencies such as: Magistrates, Assessment site Nurses, Probation and Parole, etc.
3. CIT Refreshers or Recertification should be considered by established programs. The refresher course should re-emphasize the use of the CIT skills, renew familiarity with relevant legal codes,

understanding of updated policies and procedures, and an awareness of area resources. (Refer to a sample curriculum in Appendix D)

4. Advanced and In-service Training Courses for all CIT-Trained Personnel is encouraged in order to provide further training and awareness on relevant topics. Advanced trainings should provide more in-depth exploration of topics which are covered in the 40-hour training week or additional topics which may be relevant.
5. A specialized CIT Co-Response Unit is suggestive of select CIT-trained first responders from law enforcement, fire/EMS, behavioral health, and other relevant community agencies who collaborate a coordinated response. This coordinated effort engages individuals who may be high-end users of 9-1-1 services. Additionally, co-response units are used to connect individuals with resources and support in order to avoid reaching a point of crisis that may warrant an emergency custody order or other involuntary measures. Often co-response units are utilized to augment CIT programs through the provision of follow-up crisis care or ongoing crisis management.
6. Self-Review of Each CIT Program on an annual basis is strongly encouraged by the VACIT. A sample review form (Appendix E) which was adapted from a tool developed by the Florida CIT Coalition, will allow for programs to self-monitor and be reminded to maintain those elements deemed valuable by the VACIT.
7. Awards and Recognition are strongly encouraged by the VACIT as well as the Memphis Model of CIT. Each program should explore ways to provide recognition to those in their community (partnering agencies, individual responders, community groups, stakeholders, etc.) who are demonstrating the skills and mindset of CIT.

APPENDIX A: Model 2017 VACIT Core CIT Training Agenda

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8:00 am	**Unit 1** Introduction to CIT & Basic Mental Health Concepts *Sugg: Law Enforcement Faculty and Mental Health Professional/ Emergency Services Clinician*	**Unit 7** Site Visits	OPEN	**Unit 11** Suicide Intervention Skills *MH Professional*	OPEN
8:30 am					
9:00 am			OPEN		**Unit 15** Professional Liability & Legal Issues *Sugg: Commonwealth Attorney.*
9:30 am	**Unit 2** Introduction to Clinical States *Mental Health Professional/Emergency Services Clinician*				
10:00 am			OPEN	**Unit 12** Verbal De-Escalation Techniques *Law Enforcement Faculty and Mental Health Professional/ Emergency Services Clinician*	OPEN
10:30 am					
M11:00 am			OPEN		
11:30 am	**Unit 3** Psychotropic Medications *MH Professional*			Lunch *(on your own).*	
12:00 pm	Lunch *(on your own)*		Lunch (*on your own)*		Lunch (*provided)*
12:30 pm				**Unit 13** Civil Commitment Procedures & Related Issues *Sugg: Head Magistrate and Special Justice*	**Unit 16** Advanced Role Play Exercises *CIT Faculty*
1:00 pm	**Unit 4** "Hearing Voices" Audio Exercise *Sugg: Law Enforcement Faculty and Mental Health Professional/Emergency Services Clinician*				
1:30 pm			**Unit 9** Basic Crisis Intervention Skills *Law Enforcement Faculty and Mental Health Professional/ Emergency Services Clinician*		
2:00 pm	OPEN			**Unit 14** Intermediate Role Play Exercises *CIT Faculty*	
2:30 pm		**Unit 8** Site Visit Review *Sugg: Law Enforcement Faculty and Mental Health Professional*	**Unit 9 (cont)** Four Coaching Plays *CIT Faculty*		
3:00 pm	**Unit 5** Dual Diagnosis (Mental Health & Substance Abuse) *MH Professional*		**Unit 10** Basic Role Play Exercises *CIT Faculty*		
3:30 pm		OPEN			
4:00 pm	**Unit 6** Peer/Family/Consumer Perspectives				
4:30 pm					
5:00 pm					

APPENDIX B:

Model CIT Train the Trainer (Instructor School) Agenda

DAY ONE

0900-1000 Developing a Self-Sustaining CIT Program

1000-1015 BREAK

1015-1200 Public Speaking

1200-1300 LUNCH

1300-1400 Role Play Presentation

1400-1415 BREAK

1415-1515 Role Play Presentation (Cont'd)

1515-1530 BREAK

1530-1700 Four Coaching Plays Presentation

DAY TWO

0800-0900 Creating Role Play Scenarios in Mentored Workgroups

0900-0915 BREAK

0915-1015 Role Play Development in Mentored Workgroups (Cont'd)

1015-1030 BREAK

1030-1200 Role Play Implementation and Practice

1200-1300 LUNCH

1300-1445 Role Play Implementation and Practice

1445-1500 BREAK

1500-1700 Role Play Implementation and Practice

DAY THREE

0800-1100 Role Play Implementation and Practice

1100-1130 BREAK

1130-1230 Debrief with New Faculty

APPENDIX C:

Model Emergency Communications Officer CIT Training Agenda

8:00 AM	Welcome/Awareness of Mental Health Issues
9:00 AM	Introduction to Clinical States
11:00 AM	Emergency Custody Orders/ Temporary Detention Orders
12:00 PM	Lunch
	(Video- Beyond Silence)
1:00 PM	Hearing Voices
2:00 PM	Four Coaching Plays & Verbal De-Escalation
3:00 PM	Scenarios
5:00 PM	Certificates & Adjourn

APPENDIX D:

Model CIT Refresher Course Agenda

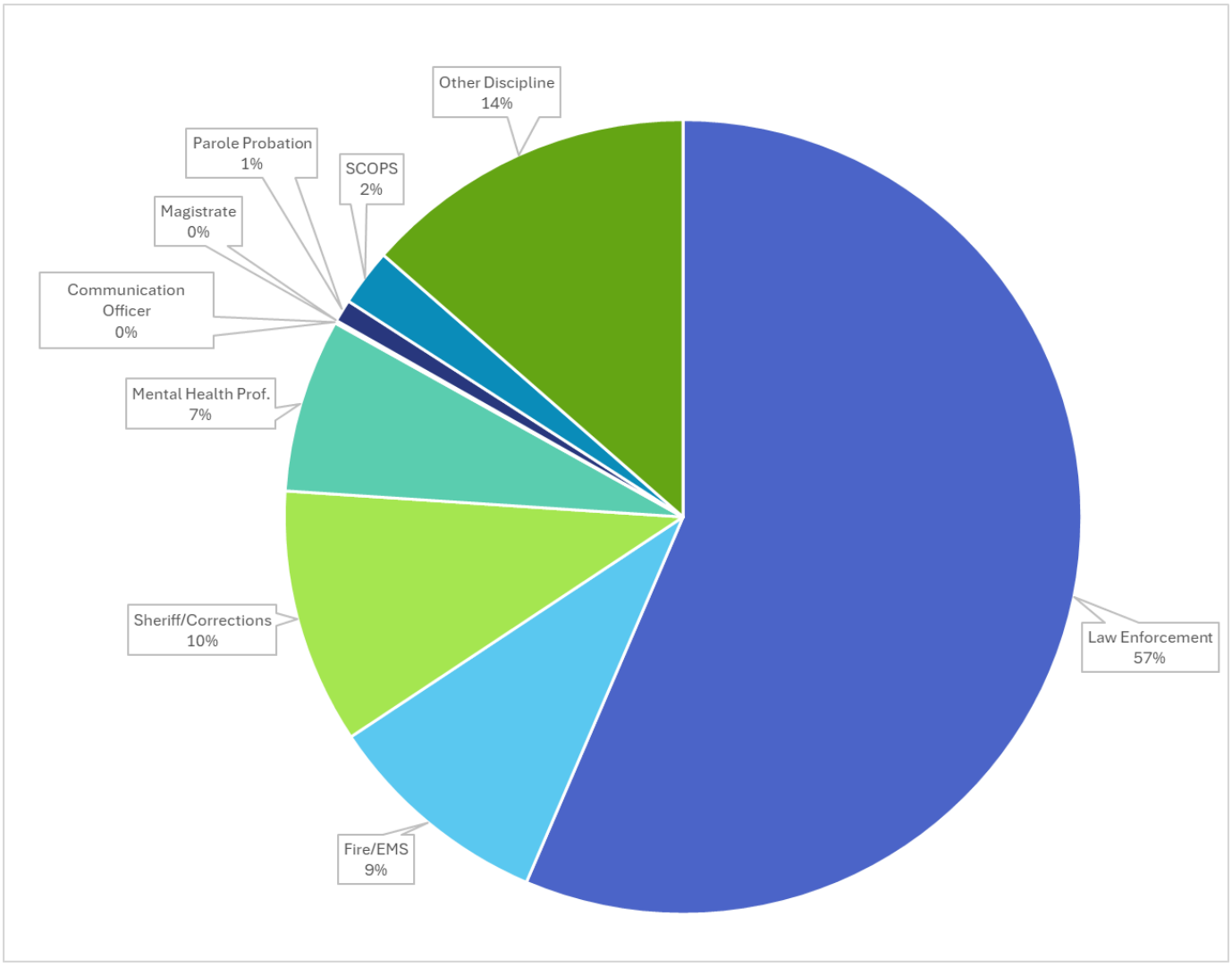
Time	**Topic**	**Presenter/required staff**
8-9 Unit 1	BRIEF reminder/intro of CIT program/initiatives Current Issues (i.e., regarding policies and procedures, assessment site, data collection, specific challenges relevant to region) Review of Coaching plays	Lead instructors/Cadre
9 – 11 Unit 2	Legal update (review relevant code, changes in code) Legal panel (questions related to issues, changes, case studies)	Attorney Attorney, magistrate, rep from each agency
11-12:00 Unit 3	Specialty topic of choice	Subject matter expert related to topic to be covered

Appendix M

Virginia CIT Coalition 2024 Training Data Report

Across the state of Virginia, in 2024, 132 CIT training courses were held. This equates to 5,280 hours of training offered around the state. A total of 2,453 professionals were trained, with a majority coming from law enforcement (56.5%), followed by other disciplines not listed (13.5%). Figure 1 illustrates the rate of professionals trained across the state by discipline. Professionals from the Sheriff's Office or corrections (10.4%), Fire/EMS (9.2%), and mental health professionals (7.6%) were also common across the trainings held. Those working as SCOPS (2.3%), in parole/probation (0.9%), communications officers (0.1%), and magistrates (0.04%) were less prominent. There were 284 dispatchers trained in 2024 as well.

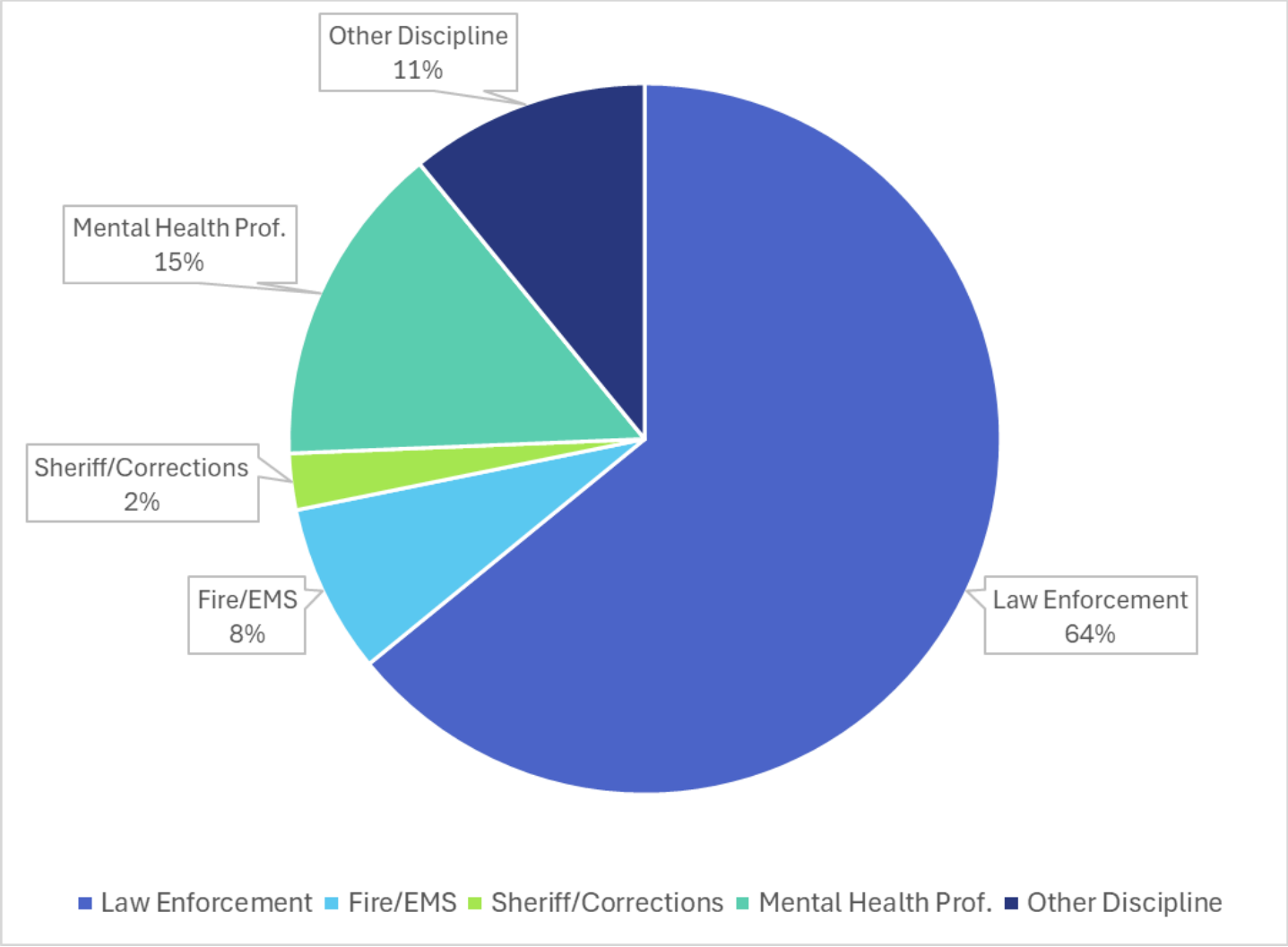
Figure 1. Virginia CIT Trained Professionals in 2024 by Discipline



"Train the Trainer" Trainings

There were 23 "train the trainer" courses held across the state in 2024. Most of the 156 professionals that took part in these trainings work in law enforcement (64.1%) or are mental health professionals (14.7%). Figure 2 illustrates the breakdown of the disciplines among the professionals who took part in these "train the trainer" courses. Fire/EMS (7.7%) and other disciplines (10.9%) are also common backgrounds for CIT trainers. Those who work in the Sheriff's Office or in corrections were less prevalent among these trainings (2.6%).

Figure 2. Virginia Train the Trainer Professionals in 2024 by Discipline



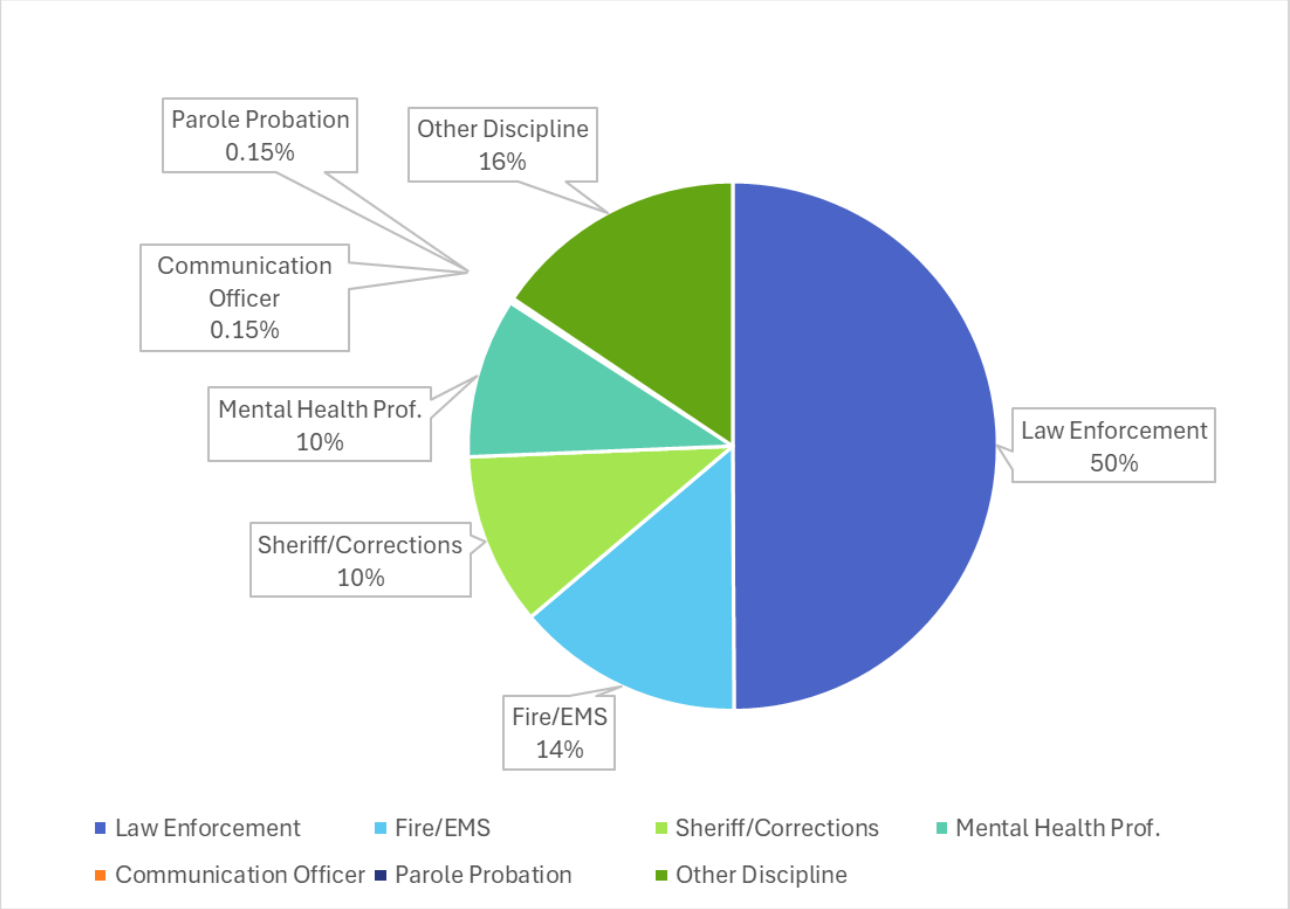
Region 1

Region 1 includes the following departments:

- Alleghany Highlands
- Thomas Jefferson Area
- Northwestern
- Rappahannock Rapidan
- Lynchburg/Central Virginia
- Rockbridge/Bath
- Rockingham Harrisonburg
- Crossroads CIT
- Blue Ridge
- Rappahannock Area

Region 1 had the second highest number of CIT trainings across the state, when compared to the other 4 regions of Virginia. In 2024, across the 10 departments in this region, 31 CIT trainings were held and 477 professionals were trained. Figure 3 illustrates the number of professionals trained in region 1 over the course of 2024 by their discipline. There were no magistrates or SCOPS trained in region 1, so these labels were excluded. Law enforcement officers were the most common professionals seen in these trainings (50%), followed by those working in another discipline (15.6%)

Figure 3. Region 1 CIT Trained Professionals in 2024 by Discipline



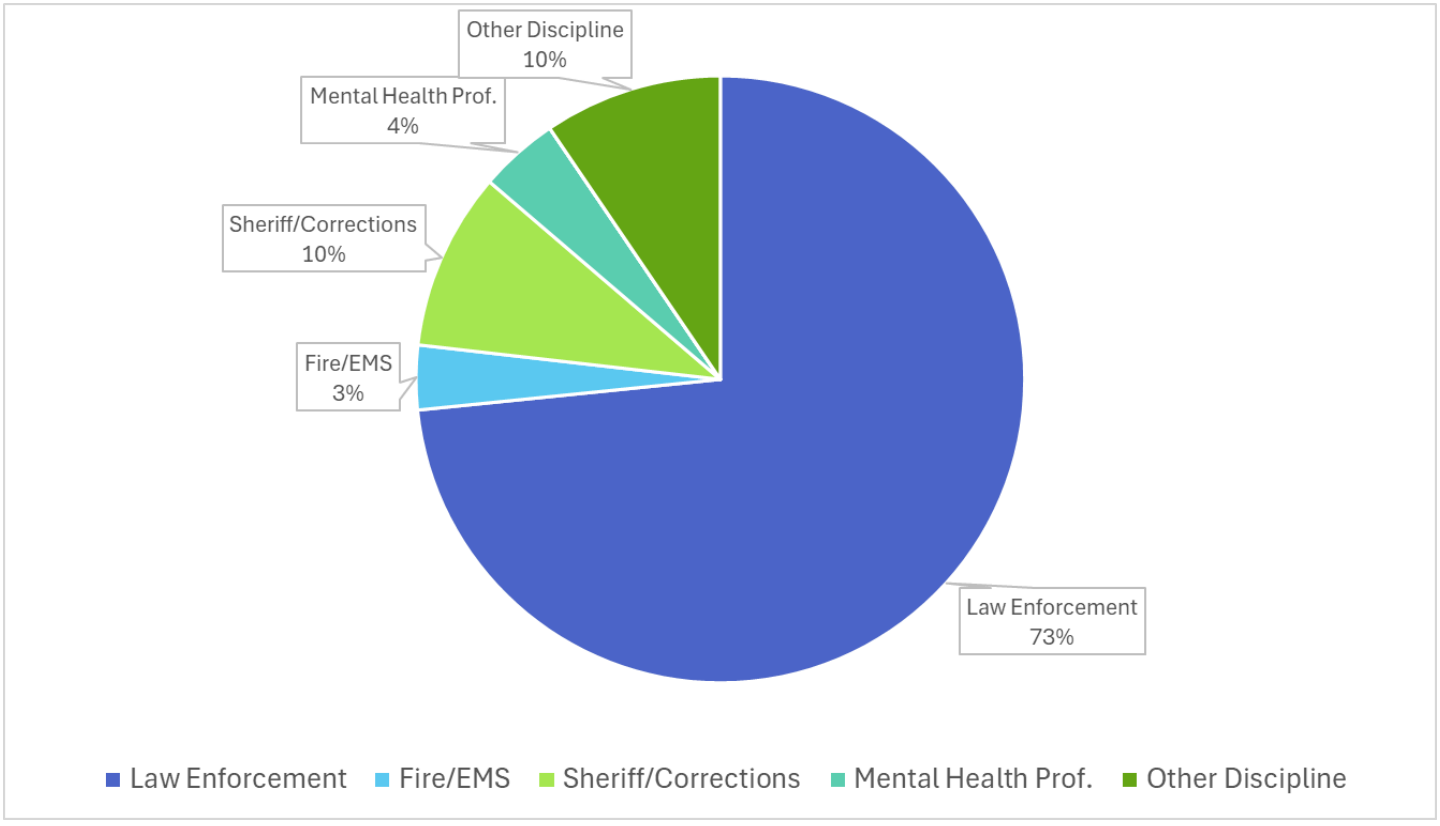
Region 2

Region 2 includes the following departments:

- Fairfax
- Alexandria
- Arlington
- Greater Prince William
- Loudoun

Region 2 had the fourth highest number of CIT trainings across the state, when compared to the other 4 regions of Virginia. In 2024, across the 5 departments in this region, 23 CIT trainings were held and 496 professionals were trained. While the fourth highest number of trainings were held across this region, they had the third-highest number of professionals trained. Figure 4 illustrates the rate of professionals trained in region 2 over the course of 2024 by their discipline. There were no communications officers, magistrates, or parole/probation officers trained in region 2, so these labels were excluded. Law enforcement officers were the most common professionals seen in these trainings (73.4%), followed by those working with the Sheriff's Office and/or in corrections (9.5%).

Figure 4. Region 2 CIT Trained Professionals in 2024 by Discipline



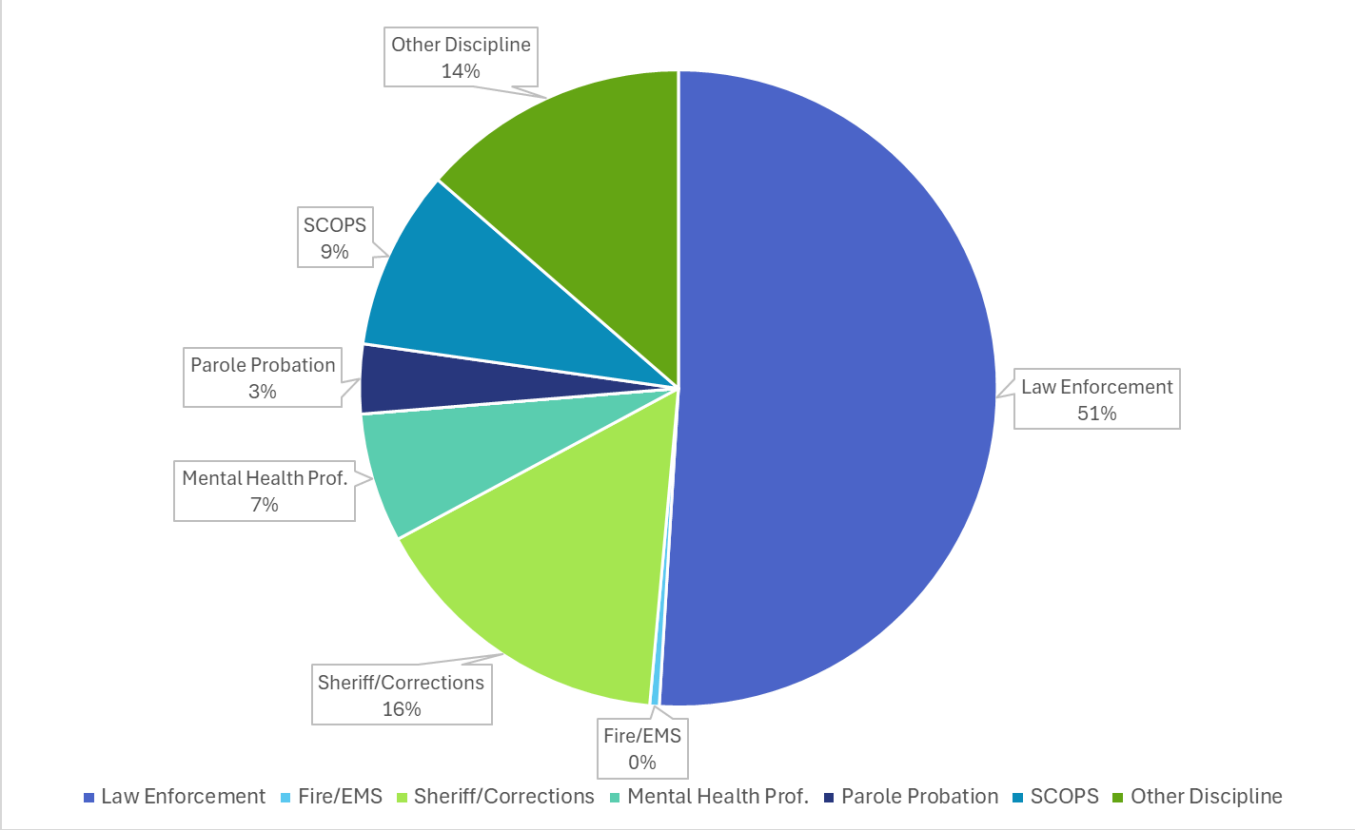
Region 3

Region 3 includes the following departments:

- New River Valley
- Danville-Pittsylvania
- Southside
- Mount Rogers
- Highlands
- Piedmont
- Roanoke Valley
- PD 1
- Cumberland Mountain

Region 3 had the highest number of CIT trainings across the state, compared to the other 4 regions of Virginia. In 2024, across the nine departments in this region, 35 CIT trainings were held and 624 professionals were trained. Figure 5 illustrates the rate of professionals trained in region 3 over the course of 2024 by their discipline. No communications officers or magistrates were trained in region 3, so these labels were excluded. Law enforcement officers were the most common professionals seen in these trainings (50.1%), followed by those working with the Sheriff's Office and/or in corrections (15.7%).

Figure 5. Region 3 CIT Trained Professionals by Discipline



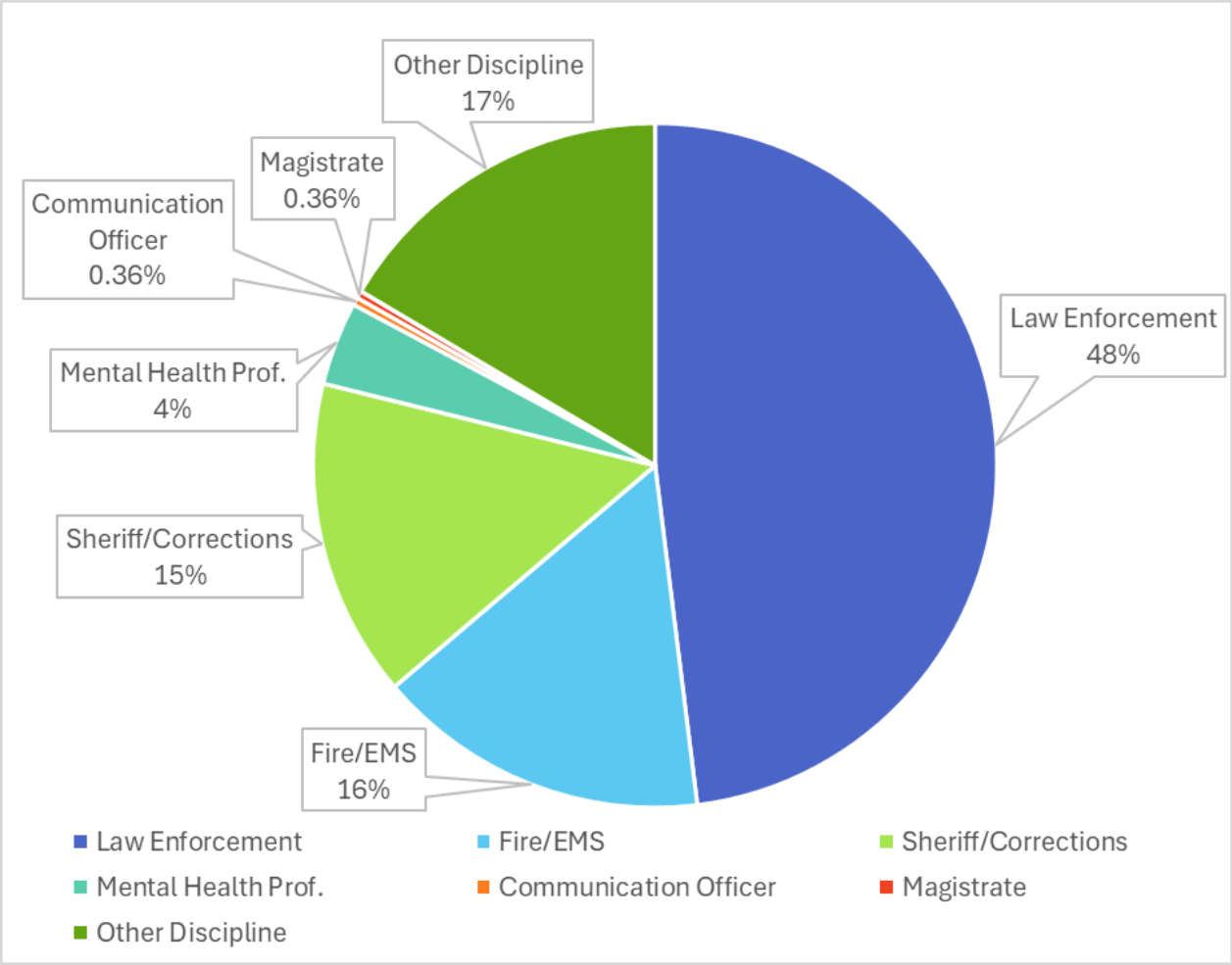
Region 4

Region 4 includes the following departments:

- Richmond
- South Central Virginia
- Chesterfield
- Hanover
- Henrico
- Virginia's Heartland

Region 4 had the lowest number of CIT trainings held across the state, compared to the other 4 regions of Virginia. In 2024, across the six departments in this region, 13 CIT trainings were held and 279 professionals were trained. Figure 6 illustrates the rate of professionals trained in region 4 over the course of 2024 by their discipline. No SCOPS or parole/probation officers were trained in region 4, so these labels were excluded. Law enforcement officers were the most common professionals seen in these trainings (48%), followed by those working in another discipline (16.5%).

Figure 6. Region 4 CIT Trained Professionals by Discipline



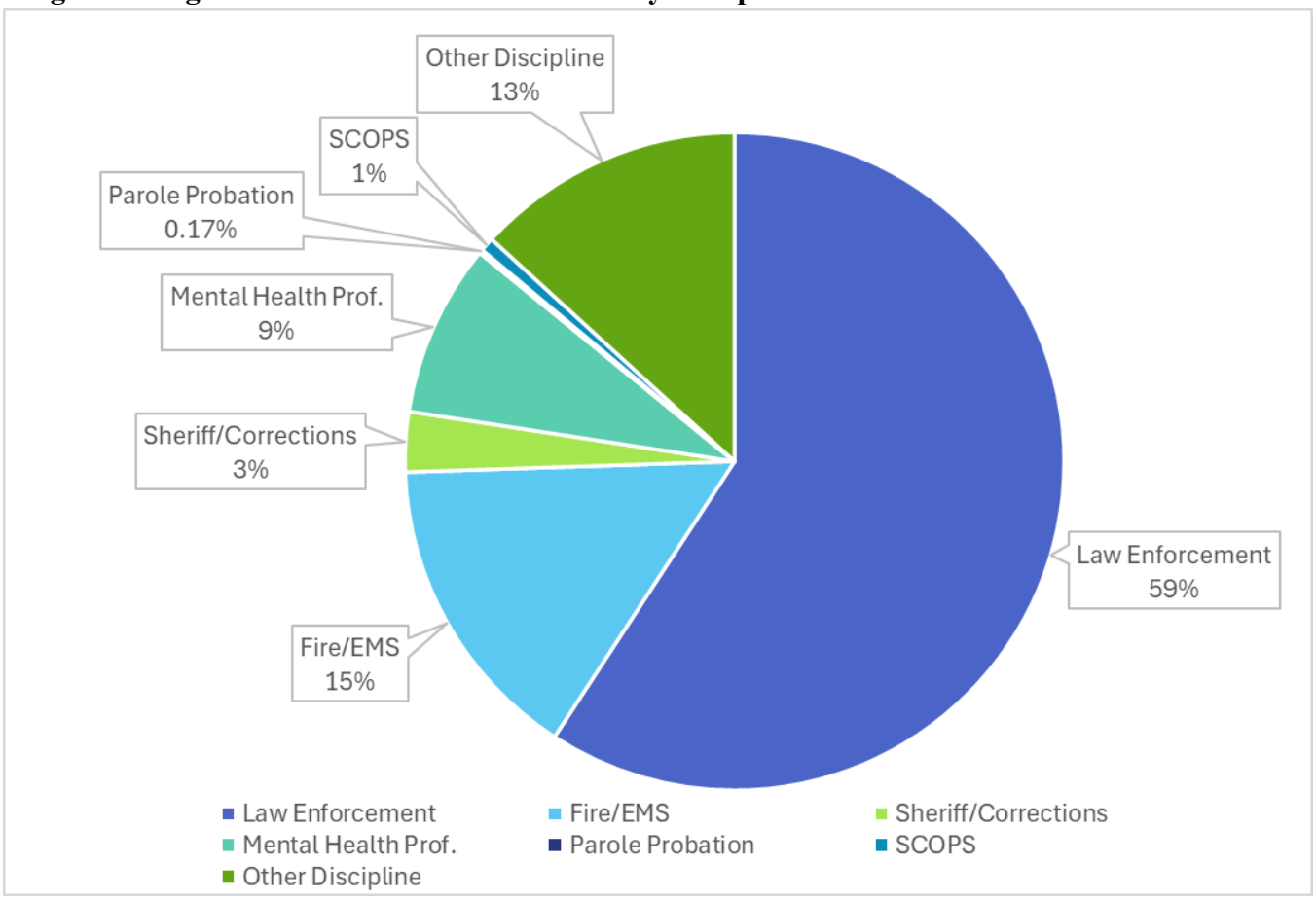
Region 5

Region 5 includes the following departments:

- Colonial
- Chesapeake
- Virginia Beach
- Western Tidewater
- Middle Peninsula Northern Neck
- Hampton-Newport News
- Norfolk
- Eastern Shore
- Portsmouth

Region 5 had the third highest number of CIT trainings held across the state, compared to the other 4 regions of Virginia. In 2024, across the 10 departments in this region, 30 CIT trainings were held and 577 professionals were trained. Figure 7 illustrates the rate of professionals trained in region 5 over the course of 2024 by their discipline. No communication officers or magistrates were trained in region 5, so these labels were excluded. Law enforcement officers were the most common professionals seen in these trainings (59.%), followed by Fire/EMS (15.3%).

Figure 7. Region 5 CIT Trained Professionals by Discipline



Appendix N

SEDD Database Documentation: Healthcare Cost and Utilization Project

Count of Emergency Admissions in Maryland by Primary Diagnosis

	Population	Psychosis	Depression	Bipolar	Anxiety	Trauma	Self-harm	Developmental	Alcohol	Opioid	Cannabis	Sedative	Stimulant	Any Behavioral Disorder
Maryland	6163981	9064	10353	4955	9840	3722	8642	1203	21522	8817	2634	515	2313	91819
Allegany	67266	83	162	49	109	50	147	12	181	167	32	14	27	1176
Anne Arundel	593347	549	856	347	890	225	1039	97	2013	618	214	58	164	7664
Baltimore County	845986	1192	1379	874	1357	629	892	280	2561	1193	393	79	244	12072
Baltimore City	569107	2448	1529	1010	1298	792	1749	183	4088	3516	469	102	671	19794
Calvert	94559	54	160	49	219	72	116	18	267	66	47	6	24	1178
Caroline	33427	25	67	29	58	24	69	14	99	31	4	1	13	474
Carroll	175472	92	333	130	326	58	122	49	465	118	51	18	29	1903
Cecil	104870	61	109	41	174	45	103	9	276	142	32	11	29	1155
Charles	170111	187	266	80	206	117	153	23	361	87	76	12	24	1775
Dorchester	32583	52	134	34	114	49	58	16	156	83	26	6	30	838
Frederick	287540	163	400	148	393	143	558	54	918	136	76	15	78	3439
Garrett	28588	21	43	13	87	16	46	5	49	14	8	1	9	351
Harford	263815	287	627	198	319	95	189	32	702	210	71	40	48	3093
Howard	335366	255	519	251	302	76	177	67	604	143	77	20	37	2758
Kent	19295	30	61	22	49	21	24	16	102	21	8		10	408
Montgomery	1053067	1206	1175	588	1232	244	897	128	2827	465	338	35	138	10018
Prince George's	946980	865	707	349	831	235	744	64	1750	344	287	28	112	6859
Queen Anne's	51720	22	63	21	111	23	65	6	130	37	11	5	7	536
Somerset	24608	30	93	20	78	15	29	4	97	27	23	4	19	494
St. Mary's	114783	77	180	41	178	181	180	18	314	90	25	5	20	1427
Talbot	37814	20	54	16	71	22	41	10	131	26	17	3	16	464
Washington	155257	134	198	91	249	230	256	32	528	344	43	14	129	2546
Wicomico	104486	163	399	151	348	82	128	13	320	150	75	7	71	2147
Worchester	53934	29	158	36	143	25	51	9	211	45	23	8	20	823

SEDD Database Documentation: Healthcare Cost and Utilization Project

Rate of Emergency Admissions in Maryland by Primary Diagnosis per 100,000 population

	Population	Psychosis	Depression	Bipolar	Anxiety	Trauma	Self-harm	Developmental	Alcohol	Opioid	Cannabis	Sedative	Stimulant	Any Behavioral Disorder
Maryland	6163981	147	168	80	160	60	140	20	349	143	43	8	38	1490
Allegany	67266	123	241	73	162	74	219	18	269	248	48	21	40	1748
Anne Arundel	593347	93	144	58	150	38	175	16	339	104	36	10	28	1292
Baltimore County	845986	141	163	103	160	74	105	33	303	141	46	9	29	1427
Baltimore City	569107	430	269	177	228	139	307	32	718	618	82	18	118	3478
Calvert	94559	57	169	52	232	76	123	19	282	70	50	6	25	1246
Caroline	33427	75	200	87	174	72	206	42	296	93	12	3	39	1418
Carroll	175472	52	190	74	186	33	70	28	265	67	29	10	17	1085
Cecil	104870	58	104	39	166	43	98	9	263	135	31	10	28	1101
Charles	170111	110	156	47	121	69	90	14	212	51	45	7	14	1043
Dorchester	32583	160	411	104	350	150	178	49	479	255	80	18	92	2572
Frederick	287540	57	139	51	137	50	194	19	319	47	26	5	27	1196
Garrett	28588	73	150	45	304	56	161	17	171	49	28	3	31	1228
Harford	263815	109	238	75	121	36	72	12	266	80	27	15	18	1172
Howard	335366	76	155	75	90	23	53	20	180	43	23	6	11	822
Kent	19295	155	316	114	254	109	124	83	529	109	41	0	52	2115
Montgomery	1053067	115	112	56	117	23	85	12	268	44	32	3	13	951
Prince George's	946980	91	75	37	88	25	79	7	185	36	30	3	12	724
Queen Anne's	51720	43	122	41	215	44	126	12	251	72	21	10	14	1036
Somerset	24608	122	378	81	317	61	118	16	394	110	93	16	77	2007
St. Mary's	114783	67	157	36	155	158	157	16	274	78	22	4	17	1243
Talbot	37814	53	143	42	188	58	108	26	346	69	45	8	42	1227
Washington	155257	86	128	59	160	148	165	21	340	222	28	9	83	1640
Wicomico	104486	156	382	145	333	78	123	12	306	144	72	7	68	2055
Worchester	53934	54	293	67	265	46	95	17	391	83	43	15	37	1526

Appendix O

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