Policy 712

Subject	
CRISIS INTERVENTION PROGRAM	
Date Published	Page
DRAFT 6 October 2022	

By Order of the Police Commissioner

POLICY

The Baltimore Police Department (BPD) will implement a first-responder model of Crisis Intervention as a component of Baltimore City's Behavioral Health and Crisis Response Systems. The department will identify:

- Strategies for de-escalating crises and connecting individuals to community resources that provide appropriate service;
- Appropriate use of hospital emergency services only after less restrictive alternatives have been considered;
- Opportunities for diversion from the criminal justice system;
- Methods for addressing the long-term needs of individuals and families in order to provide for the least police-involved response.

The purpose of this policy is to provide guidance and expectations for members to adequately respond to persons experiencing Behavioral Health Disabilities or in Crisis.

CORE PRINCIPLES

Community Planning and Implementation. The BPD is an important component of the Baltimore Crisis response system by effectively responding to and de-escalating incidents that pose an imminent danger to community safety, and diverting individuals to community resources that provide appropriate services. The BPD maintains a collaborative relationship with the behavioral health care system, people with lived experience, and advocacy groups in order to develop, implement, and evaluate a comprehensive Crisis response system that allows for the least police-involved response for persons in Crisis consistent with community safety.

Civil Rights. Members who respond to persons with Behavioral Health Disabilities or who are experiencing Crisis shall respect their dignity, civil rights, and contribute to their overall health, safety, and welfare. Even in Crisis, individuals with Behavioral Health Disabilities retain their constitutional rights, including their rights to liberty and due process. Consistent with these rights and Maryland law, a member may only detain and/or transport an individual for emergency evaluation or civil commitment if they present a danger to the life and safety of themselves or others (MD Health Gen. § 10 602 a).

Members and communications dispatchers shall be trained to i). Understand the value to society of persons with disabilities residing in the community; ii). Understand the need to avoid assumptions, stereotyping, and discrimination against persons with disabilities; iii). Increase awareness of bias as it relates to interactions with individuals who experience Behavioral Health Disabilities; and iv). Provide reasonable modifications to individuals with Behavioral Health Disabilities as needed.

Community and Officer Safety. The BPD supports the least police-involved response necessary for

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persons with Behavioral Health Disabilities or in Crisis consistent with community safety. BPD will ensure that members have the training and resources to appropriately respond to individuals with Behavioral Health Disabilities or experiencing Crisis, including de-escalating and promoting peaceful resolutions to incidents, and diverting individuals to community resources that provide stabilizing services.

De-Escalation. Members shall use de-escalation techniques and tactics to attempt peaceful resolution of an incident without resorting to the need for force (See Policy 1107, *De-Escalation)*. While members are not expected to diagnose mental or emotional conditions, they are expected to recognize behaviors that are indicative of persons with Behavioral Health Disabilities. Common de-escalation techniques for responding to people with Behavioral Health Disabilities include, but are not limited to:

- Time: Slowing down the pace of an incident.
- Distance: Maximizing space to increase reaction time.
- Cover: Moving to a safer position to decrease exposure to a potential threat.
- Communication: Interacting with an individual in order to promote rational decision-making.
- Continuous assessment and application of the critical decision-making model.

Sanctity of Human Life. Members shall make every effort to preserve human life in all situations.

DEFINITIONS

Behavioral Health Disability — Primarily refers to any Mental Illness and/or Substance Use Disorder but also may be used to describe any disabling condition that impacts a person's ability to self-regulate their thinking, mood, or behavior, including intellectual and developmental disabilities, autism spectrum disorders, and dementia. A person may be suspected of experiencing a Behavioral Health Disability through a number of factors including:

- Self-Report,
- Information provided to dispatch or members directly by witnesses or informants,
- An individual's previous interaction(s) with the BPD, or
- A member's direct observation including, but not limited to, behaviors consistent with psychiatric diagnoses, such as disorientation/confusion, unusual behavior/appearance (neglect of self-care), hearing voices/hallucinating, anxiety/excitement/agitation, depressed mood, crying, paranoia or suspicion, self-harm, and/or threatening violence towards others.

NOTE: The terms "disability" and "disorder" are often used interchangeably. In this context, the preferred term is disability.

Collaborative Planning and Implementation Committee (CPIC) — A group of individuals and organizations representing a wide range of disciplines and perspectives who develop, implement, and evaluate a comprehensive Crisis response system for Baltimore City that allows for the least police-involved response for people with Behavioral Health Disabilities or experiencing Crisis consistent with community safety while improving outcomes. The CPIC oversees the BPD Crisis Intervention Program.

Crisis — An incident in which an individual experiences or displays intense feelings of personal distress (e.g., anxiety, depression, anger, fear, panic, hopelessness) that they are unable to address with their ordinary coping strategies and that may cause disruptions in thinking (e.g., visual or auditory hallucinations, delusions, cognitive impairment). Crisis can result from Mental Illness, a Substance Use Disorder, an intellectual or developmental disability, a personal Crisis, or the effects of drugs or alcohol.

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Crisis Intervention — The attempt by a member to de-escalate an encounter with an individual experiencing Crisis, to return the individual to a pre-Crisis level, and divert the individual to community resources when appropriate.

Crisis Intervention Team (CIT) Officers — Patrol officers who volunteer to undergo a selection process and receive 40 hours of specialized training in order to serve as primary responders to Behavioral Health Disability-related calls for service to which a police response is necessary.

Crisis Response Team (CRT) — A specialized unit comprised of certified officers and licensed Mental Health professionals who respond in pairs to persons in Crisis and highly complex and/or emotionally heightened situations.

Mental Illness — A health condition that significantly impairs a person's thinking, mood, or behavior and may affect his or her ability to effectively address individual, interpersonal, and social challenges.

Mobile Crisis Team – A team of mental health professionals including psychiatrists, social workers, peers, and nurses who can be dispatched to any Baltimore City location to provide immediate assessment, intervention, and treatment. The Mobile Crisis Team may be contacted via the 9-8-8 Helpline, 24 hours per day. Behavioral health professionals are available by phone 24 hours per day and are available to respond in-person between the hours of 0700 and midnight.

Substance Use Disorder – A mental health disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications.

GENERAL

The goals of the BPD and the Crisis Intervention Program are to:

1. Reduce the inappropriate involvement of individuals with Behavioral Health Disabilities or in Crisis with the criminal justice system.

2. Equip members with methods to safely and appropriately interact with persons with Behavioral Health Disabilities or experiencing Crisis to improve the safety of members, individuals with Behavioral Health Disabilities or in Crisis and their families, and others within the community.

3. De-escalate Crises to achieve peaceful resolutions to incidents and eliminate the unreasonable, unnecessary, and/or disproportional uses of force against individuals with Behavioral Health Disabilities or in Crisis.

4. Minimize arrests and law enforcement interactions with individuals with Behavioral Health Disabilities or experiencing Crisis.

5. Collaborate with CPIC in the development, implementation, and evaluation of the Department's Crisis Intervention Program as it integrates with a citywide crisis response system providing for the least police-involved response for persons with Behavioral Health Disabilities or in Crisis consistent with community safety.

6. Assist individuals and their families to obtain voluntary stabilizing support.

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Crisis Response Program

BPD has committed to responding to persons with Behavioral Health Disabilities and/or experiencing Crisis with the following resources:

7. **Crisis Intervention Team (CIT) Officers** – Specially trained and certified volunteer patrol officers who are dispatched to respond to calls for service for persons in Crisis with the objective of diverting them from the criminal justice system.

8. **Crisis Response Team (CRT)** – A specialized unit comprised of certified officers and licensed Mental Health professionals who respond in pairs to persons in Crisis. The CRT serves as backup support to members and to assist in peacefully resolving complex situations with the least restrictive techniques, interventions, and resources possible while maintaining the safety and wellbeing of the individual or family and others involved in the Crisis, BPD personnel, and the community. Examples of CRT officer on-scene duties include - but are not limited to - scene security, supporting the licensed mental health professional in developing a rapport with the individual or family, providing information to the mental health professional of past encounters with the individual or family when available, and interacting with family members or interested persons to obtain additional information about those in Crisis.

DIRECTIVES

Patrol Members

When responding as the primary unit to a call for service or on-view incident that appears to involve an individual with a Behavioral Health Disability or experiencing a Crisis, members will perform the following:

9. The first responding member, if not a CIT officer, is responsible for:

   9.1. Securing the scene, especially with regard to the safety of the member, individual in Crisis, and bystanders, if present.

   9.2. Determine if the circumstances require the response of a CIT officer or CRT, and notify dispatch in case a CIT officer has not already been dispatched to the scene.

   9.3. Gather all available information to brief the CIT officer or CRT upon arrival, including:

      9.3.1. Observations of the subject’s actions, demeanor, and behavior,

      9.3.2. Names(s) of the individuals involved, and

      9.3.3. Interviews of family/friends on scene.

NOTE: CIT officers shall act as primary officer on the scene of Behavioral Health incidents or persons experiencing Crisis.

10. If a CIT officer or CRT is not available to respond, the assigned officers shall request a supervisor, seek to de-escalate, and peacefully resolve the incident (See Policy 1107, *De-*

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Escalation).

11. Members may refer to the guidelines on pp. 6 and 7 of this Policy in determining the disposition of the call for service.

12. Members shall be trained in and employ trauma-informed strategies.

13. For interactions with youth or children experiencing Crisis, members shall employ trauma-informed, developmentally appropriate tactics including – but not limited to – using a calm and natural demeanor and avoiding threatening language (See **Children and Youth** in Policy 1115, *Use of Force*).

CIT Officers

When responding as the primary unit to a call for service or on-view incident that appears to involve an individual with Behavioral Health Disability or experiencing a Crisis, members will perform the following:

14. Assume primary responsibility for the scene unless relieved by a supervisor.

15. Secure the scene, especially with regard to the safety of the officer, person in Crisis, and bystanders.

16. Request back-up unit(s) and a supervisor to respond as necessary.

NOTE: CIT officers who are dispatched to an incident involving an individual experiencing a Crisis will have primary responsibility for the scene **unless** a supervisor has assumed responsibility, in which instance a supervisor shall seek input from a CIT officer regarding strategies and tactics for response when reasonable.

17. Attempt to determine:

    17.1. The nature and severity of the Crisis situation;

    17.2. Whether the presence of a Behavioral Health Disability may be impacting the person's perception, thoughts, or behavior;

    17.3. The potential for rapid change in behavior; and

    17.4. Whether the individual presents a potential physical danger to himself/herself or others.

NOTE: If the incident is determined to be a hostage/barricade situation, member actions shall be guided by Policy 702, *Hostage/Barricade/Sniper Incidents* and the appropriate resources shall respond and act as primary unit on the scene.

18. If responding to an incident in progress, members shall attempt to obtain additional information about the individual in Crisis prior to making contact with them. This information may include:

    18.1. Past occurrences of this or other Crisis-related situations;

    18.2. Past incidents involving injury or harm to the individual or others;

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18.3. Previous incidents involving suicide risk;

18.4. Medications or substances, including failure to take medication or substance withdrawal;

18.5. Indications of substance use and/or Substance Use Disorder;

18.6. Information about the individual, family, or support system that may aid in de-escalating the Crisis and lead to effective resolution. This may include: preferences, strengths, and interests of the individual, as well as examples of strategies that have proven effective with the individual in the past;

18.7. Contact information for relatives, friends, or neighbors available to assist officers;

18.8. Contact information for physicians, treatment professionals, or peer supporters who have worked with the individual and may be of assistance to members.

18.9. Information from any of the available sources listed above that might assist in effectively assessing and resolving the situation and bring it to peaceful resolution using the least-intrusive measures.

19. Use verbal and tactical de-escalation set forth in Policy 1107 when time and circumstances permit in order to attempt to end any imminent danger the person in Crisis poses to themselves or others.

20. Determine the most appropriate course of action for the individual involved, including a determination of whether the circumstances require the response of CRT, Behavioral Health Crisis Services such as the Crisis Information & Referral (CIR) Line or a Mobile Crisis Team, or additional services up to and including physicians, treatment professionals, and/or peer supporters, and inform dispatch.

21. Gather all available information to brief CRT, Behavioral Health Crisis Service, or additional personnel upon arrival.

22. Once sufficient information has been collected and the scene has been stabilized, members have several options when selecting an appropriate disposition for the call for service. Members may elect a course of action consistent with the below table:

Nature of Call	Non-Criminal Behavior	Suspected Criminal Behavior
Harmless behavior which appears related to an illness, disorder, or disability.	Do not intervene, or members may refer the individual to the appropriate resources or services (e.g., BCRI, Mobile 9-8-8 Helpline).	Issue citizen contact receipt. Provide a print out with contact information for obtaining community-based services.
Indication of urgent Behavioral Health needs or Crisis.	Take steps to de-escalate and resolve using community-based behavioral health resources (e.g., BCRI, Mobile Crisis Team, 9-8-8 Helpline).	Take steps to de-escalate and resolve using behavioral health resources (e.g., CIT, CRT, 9-8-8 Helpline, and LEAD). Document incident in Axon Records, miscellaneous report, and issue citizen contact receipt.

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The individual presents a danger to the life and safety of themselves or others, and the individual is unable or unwilling to be admitted voluntarily.	Take steps to de-escalate and resolve using CIT, CRT, and behavioral health resources. If risk remains after all options available are implemented and all conditions for Emergency Petition are met, complete Emergency Petition and involuntary transport to the closest designated psychiatric emergency facility, document incident in Axon Records, miscellaneous report, and issue citizen contact receipt.	Take steps to de-escalate when feasible, Emergency Petition and involuntary transport to the closest psychiatric emergency facility, document incident in Axon Records, miscellaneous report, and issue citizen contact receipt.
Escalation of harmful or symptomatic behavior where there is no available, less-restrictive form of intervention that is consistent with the welfare and safety of the individual.	Take steps to de-escalate when feasible, Emergency Petition and transport to the closest designated psychiatric emergency facility, document incident in Axon Records, miscellaneous report, and citizen contact receipt. Coordinate with appropriate services as possible.	Take steps to de-escalate when feasible, and depending on severity of criminal offense and officer's discretion, arrest the individual. Coordinate with Forensic Alternative Services Team (FAST) and mental health court Assistant State's Attorney.

22.1. Exercising the discretion to not arrest is particularly appropriate in situations where the person's behavior is related to a Behavioral Health Disability, Mental Illness, Substance Use Disorder (including alcohol and prescription drugs), cognitive impairment, or Developmental Disability. Officers' discretion should be guided by the goal of diverting individuals with Behavioral Health Disabilities, Mental Illness, or developmental disabilities from criminal justice involvement, when appropriate, given the nature and seriousness of the incident. The BPD has a preference for the least-intrusive response based on the totality of the circumstances.

22.2. For all incidents involving persons with Behavioral Health Disabilities or experiencing Crisis, members shall complete a Behavioral Health Report in Axon Records (Appendix A).

23. If emergency evaluation is required, take the person into custody and ensure the individual is transported to the closest or <u>most appropriate</u> designated psychiatric emergency facility (i.e., the hospital where the person in Crisis is most frequently treated or is under the care of a physician), See Appendix B, Designated Psychiatric Emergency Facilities.

24. Ensure that the persons in custody are transported, along with medications, in keeping with Policy 1114, *Persons in Police Custody,* and Policy 503, *Transportation of Passengers in Departmental Vehicles.*

25. Follow the guidelines listed in Policy 824, *Body Worn Cameras*, when wearing a BWC inside a Mental Health or Medical Facility.

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Crisis Response Team

The BPD's CRT is comprised of sworn officers with enhanced training and multiple years of experience responding to calls for service related to Behavioral Health Disabilities or Crisis, and licensed mental health professionals who work together in teams. The CRT is available to respond to calls for service between 1100 and 1900. The CRT is responsible for:

26. Responding to the following calls for service (and others as requested):

    26.1. Suicide attempts;

    26.2. Serious incidents involving persons with a Behavioral Health Disability or in Crisis;

    26.3. Unexplained, strange, or bizarre behavior (e.g., a person wandering in traffic or standing on the roof of a building), including those incidents in which the person may be under the influence of drugs and/or alcohol;

    26.4. Service of Emergency Petitions in which the person in Crisis has a known Mental Health Disability or Mental Illness combined with a history of violence; and

    26.5. Repeat 911 callers who are identified with unmet, recurring behavioral health needs.

27. Assuming control of the scene involving the individual in Crisis upon arrival unless relieved by a supervisor under exigent circumstances.

28. Determining strategies for peacefully resolving the incident. The CRT utilizes advanced de-escalation and Crisis Intervention strategies along with the behavioral health resources available towards the goal of resolving the crisis using the least restrictive alternatives.

29. Supporting additional units to de-escalate and promote a peaceful resolution in situations that require SWAT or other specialized units.

30. Responding to incidents when requested in which the Hostage Negotiation Team responds. The role of the CRT in these instances is to provide on-scene access to any available health history and act as a resource to the Incident Commander.

31. Offering referrals to behavioral health and or other social services to address the needs of the individual or family.

32. Transporting an individual to a designated psychiatric emergency facility or additional services in order to allow the primary officer on scene to stay in-service.

Supervisors

In order to support the mission of the BPD and the CIT program, supervisors shall:

33. Indicate on the daily run down which officers are CIT officers.

34. Seek the input of CIT personnel regarding strategies for resolving the Crisis, where it is reasonable for them to do so.

35. Respond to behavioral health calls when requested by members to assist in resolving Crisis situations, conducting appropriate investigations, and providing referrals to behavioral health services.
36. Ensure the appropriate reports (i.e., Behavioral Health Report and Miscellaneous Incident Report) are completed and forwarded to the appropriate locations.

37. Certify that appropriate reports containing confidential mental health and/or medical information, as required by law, are properly secured so that only law enforcement personnel have access to the reports and confidential material as needed.

38. Identify and encourage members under their supervision across all shifts and districts who are qualified to serve as CIT officers.

Reporting Requirements

39. All members shall complete an Incident Report and the Behavioral Health Form in Axon Records for **all** behavioral health-related calls for service of the following incident type:

    39.1. **28** – Suicide Attempt;

    39.2. **85** – Behavioral Health Crisis;

NOTE: Calls with an incident type of 28 or 85 must be coded either **XY** (report written, domestic-related) or **XN** (report written, not domestic-related). An **oral code** may not be given unless the call is unfounded, the complainant cannot be located, or the incident type is changed and the new incident type does not have a behavioral health component (e.g., the incident is a dispute among neighbors and neither party appears to have a Behavioral Health Disability).

    39.3. The Behavioral Health Report shall include a statement that the officer believes the person evidences a Behavioral Health Disability based on specific behavior, overt acts, attempts, or threats that were observed by or reliably reported to the officer.

NOTE**:** Officers are not required to complete a Behavioral Health Report solely because they observe someone they believe is under the influence of a controlled dangerous substance. Indications of a Crisis or Behavioral Health Disability should also be present.

40. Complete a Miscellaneous Incident Report, when necessary, in addition to the Behavioral Health Report (e.g., Destruction of Property or Common Assault).

NOTE**:** Write “CIT Officer” or “CRT Officer,” as applicable, at the beginning of any Statement of Probable Cause in which a defendant is believed to have a Behavioral Health Disability and is charged with a criminal offense.

41. E-mail all Behavioral Health Reports and any related Incident Reports by the end of the tour of duty to CIT@baltimorepolice.org.

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REQUIRED ACTION

Training and Selection of Personnel

CIT Officers

CIT officers are assigned to patrol districts and maintain their standard patrol duties except when called to a Crisis event. In order to be selected as a CIT officer, members shall:

42. Volunteer to be certified and serve as a CIT officer.

43. Have completed at least one (1) year of service beyond field training.

44. Complete a written application package to include:

    44.1. Supervisory recommendations,

    44.2. Use of force history,

    44.3. Complaint history, and

    44.4. Disciplinary file.

45. Volunteer to attend 40 hours of enhanced CIT training separate and distinct from general behavioral and de-escalation training for all BPD patrol members. This training includes:

    45.1. How to conduct a field evaluation in order to determine the most appropriate treatment or service (e.g., Emergency Petition, referral to Behavioral Health Crisis Services such as the Crisis Information and Referral (CIR) Line or Mobile Crisis Team, or provide resource information);

    45.2. Suicide intervention;

    45.3. Community mental health and intellectual and developmental disability resources;

    45.4. Mental health and intellectual and developmental disability diagnoses;

    45.5. The effects of substance misuse;

    45.6. Perspectives of individuals with disabilities and their family members;

    45.7. Implicit bias and its impact on responding to individuals with a Behavioral Health Disability or Crisis;

    45.8. The rights of persons with disabilities;

    45.9. Civil commitment criteria;

    45.10. Crisis de-escalation;

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45.11. On-site visits to mental health, substance use, and intellectual and developmental disability community programs, and interaction with individuals with behavioral health disabilities; and

45.12. Scenario-based exercises.

46. Complete an in-person interview.

47. Receive eight (8) hours of annual in-service Crisis Intervention training to maintain expertise and skills.

Crisis Response Team (CRT)

CRT members are specially trained BPD members working with licensed mental health professionals who work in pairs to support the work of members who encounter individuals and persons in Crisis. Assistance is offered by CRT at the scene. In order to be selected as a CRT officer, members shall:

48. Complete at least two (2) years of patrol experience as a BPD officer following field training;

49. Complete an in-depth assessment to include:

49.1. Examination of a written application;

49.2. Supervisory recommendations;

49.3. Use of force history;

49.4. Disciplinary record and complaint history; and

50. Volunteer to attend 40 hours of enhanced CIT training separate and distinct from general behavioral health awareness training for all BPD patrol members. This training includes:

50.1. How to conduct a field evaluation in order to decide the most appropriate treatment or service (e.g., Emergency Petition, referral to Behavioral Health Crisis Services such as the Crisis Information and Referral (CIR) Line or Mobile Crisis Team, or provide resource information);

50.2. Suicide intervention;

50.3. Community mental health and intellectual and developmental disability resources;

50.4. Mental health and intellectual and developmental disability diagnoses;

50.5. The effects of substance misuse;

50.6. Perspectives of individuals with behavioral health disabilities and their family members;

50.7. The rights of persons with Behavioral Health Disabilities;

50.8. Civil commitment criteria;

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50.9. Crisis de-escalation;

50.10. On-site visits to mental health, substance use, and intellectual and developmental disability community programs, and interaction with individuals with Behavioral Health Disabilities; and

50.11. Scenario-based exercises.

51. In-person interview with a panel comprised of representatives from BPD, Behavioral Health Systems Baltimore (BHSB), and other members of CPIC.

52. Receive eight (8) hours of annual in-service Crisis Intervention training to maintain expertise and skills.

Crisis Intervention Coordinator

The BPD shall designate a member at the rank of sergeant or above to act as Crisis Intervention Coordinator. The Coordinator shall be responsible for:

53. Facilitating communication between BPD, members of the behavioral health provider community, and maintaining the effectiveness of the BPD Crisis Intervention Program.

54. Completing at least eight (8) hours of training on the role and duties of the Crisis Intervention Coordinator in addition to the CIT training the Coordinator has already received at the Academy and during CIT officer certification.

55. Collecting data on the suspected Behavioral Health Disability or Crisis status of individuals subject to law enforcement actions including stops, searches, arrests (to include type of offense and probable cause), use of force, injuries, and in-custody deaths;

56. Reporting quarterly to the CPIC regarding calls for service that involve possible Behavioral Health Disabilities or people in crisis, including:

56.1. The number of calls where a CIT officer or CRT was requested and dispatched;

56.2. The nature of the Crisis, and the extent to which individuals previously interacted with BPD;

56.3. The disposition of those calls, including whether referred to community services, an emergency room, emergency petition, or arrest;

56.4. Whether force was used and the type of force used; and

56.5. The steps taken, if any, to de-escalate the interaction.

57. Working with Education and Training Section (E&T) and CPIC to develop, deliver, and update CIT training as needed;

58. Identifying, developing, and maintaining partnerships with program stakeholders and serving as a point of contact for advocates and individuals with Behavioral Health Disabilities and their

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families, caregivers, professionals, and others associated with the mental health and intellectual and developmental disability community;

59. Serving as the point of contact for addressing concerns of stakeholders and community members regarding BPD Crisis Intervention services, including addressing specific calls for services and identifying and implementing any needed changes in protocol or training of personnel to improve future responses.

60. Maintaining a current roster of all CIT-certified officers;

61. Disseminating a provider list maintained by CPIC that lists community-based behavioral health resources for purposes of diversion.

62. Ensuring the selection of appropriate candidates for designation as CIT officers;

63. Ensuring CIT officer capacity is sufficient to respond, at all times of the day and in all districts, to individuals in Crisis and with Behavioral Health Disabilities;

64. Overseeing the development and implementation of a selection process for CIT officers;

65. Scheduling training for all CIT and CRT personnel (other than Recruit training), including the 40-hour CIT course and annual refresher training;

66. Reviewing CIT policy and procedure annually and suggesting revisions as needed;

67. Preparing an annual report for the Police Commissioner and CPIC, via official channels, addressing the development and implementation of a "Crisis Intervention Plan" that details the following issues:

    67.1. An analysis and assessment of Crisis Intervention incidents to determine whether BPD has a sufficient number of CIT-certified and CRT officers, whether it is deploying those officers effectively throughout the Department, and whether CIT officers, call-takers, and dispatchers are appropriately responding to people in Crisis;

    67.2. Calls for service data, Behavioral Health Reports written, dispositions of incidents, uses of force on behavioral health-related calls for service, and indications of de-escalation techniques;

    67.3. Relationships with other members of CPIC;

    67.4. Barriers to effective service delivery; and

    67.5. Recommendations for improving the Department's response to persons in Crisis and with Behavioral Health Disabilities.

68. Review outcome data to:

    68.1. Recognize officers deserving commendation;

    68.2. Develop new response strategies for repeat calls for service;

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68.3. Identify training needs or officers that require additional training;

68.4. Assist with CIT training curriculum changes; and

68.5. Identify and address other issues that hinder or may improve Crisis and Behavioral Health Disability response.

Collaborative Planning and Implementation Committee (CPIC)

The Committee shall direct the development and implementation of the Crisis Intervention Program. The CPIC will meet regularly and work collectively to:

69. Identify and implement, as appropriate, strategies to reduce the number of individuals with Behavioral Health Disabilities or persons in Crisis who have unnecessary encounters with law enforcement.

70. Continuously evaluate the overall Crisis Intervention Program, study national models, and make recommendations on modifications to the design in order to have the least police-involved response necessary.

71. Develop policies and procedures for the disposition or referral of individuals to community resources.

72. Develop and maintain a list of service providers and resources for BPD members and Dispatch for referral purposes.

73. Enhance community connections with advocates and mental health professionals and provide a seamless system of care for people in Crisis and with Behavioral Health Disabilities.

74. Seek to expand the membership of CPIC where appropriate.

Education and Training (E&T) Section

The Commander of E&T shall:

75. Work in partnership with CPIC and the Crisis Intervention Coordinator to develop and deliver all Crisis Intervention Program training requirements.

76. Develop and implement a behavioral health training curriculum that provides **all** recruits at least 16 hours of training in the Academy and veteran officers at least eight (8) hours of annual in-service training on how to respond to behavioral health-related calls for service in accordance with departmental policy. Training will reflect changes in policy, law, and developments in best practices.

77. Certify all CIT and CRT supervisors and officers by delivering the 40-hour Crisis Intervention Program course separate and distinct from Academy and in-service training for all members prior to members being assigned to CIT/CRT duties. This training shall include not only lecture-based instruction, but also on-site visitation and exposure to Mental Health providers, interaction with individuals with Behavioral Health Disabilities, and scenario-based de-escalation skills training.

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78. Certify as CIT personnel 30% of patrol supervisors and officers across all districts and shifts, providing sufficient training opportunities to maintain this percentage as personnel transfer and promote to new assignments.

79. Provide a minimum of eight (8) hours of behavioral health in-service training each year to all CIT and CRT officers. Crisis Intervention training shall emphasize Mental Health-related topics, developmental disabilities, Crisis resolution skills, de-escalation training, and access to community-based services.

APPENDICES

A. Designated Psychiatric Emergency Facilities
B. Additional Community Resources

ASSOCIATED POLICIES

Policy 503, *Transportation of Passengers in Departmental Vehicles*
Policy 702, *Hostage/Barricade/Sniper Incidents*
Policy 713, *Petitions for Emergency Evaluations & Voluntary Admission*
Policy 824, *Body Worn Cameras*
Policy 1107, *De-Escalation*
Policy 1114, *Persons in Police Custody*
Policy 1115, *Use of Force*

RESCISSION

Remove and destroy/recycle Policy 712, *Crisis Intervention Program* dated 29 June 2021.

COMMUNICATION OF POLICY

This policy is effective on the date listed herein. Each employee is responsible for complying with the contents of this policy.

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APPENDIX A

Designated Psychiatric Emergency Facilities

Baltimore City	
Grace Medical Center 2000 W. Baltimore Street Baltimore, MD 21223 (410) 362-3000	Johns Hopkins Hospital & Health System 600 N. Wolfe Street Baltimore, MD 21287 (410) 955-5964
Johns Hopkins Bayview Medical Center 4940 Eastern Avenue Baltimore, MD 21224 (410) 550-0100	UMD Medical Center Midtown Campus 827 Linden Avenue Baltimore, MD 21201 (410) 225-8100
Sinai Hospital of Baltimore *(Lifebridge Health)* 2401 W. Belvedere Avenue Baltimore, MD 21215 (410) 601-5461	MedStar Union Memorial Hospital 201 E. University Parkway Baltimore, MD 21218 (410) 554-2000
University of Maryland Medical Center 22 S. Greene Street Baltimore, MD 21201 (410) 328-1219	MedStar Good Samaritan Hospital 5601 Loch Raven Blvd. Baltimore, MD 21239 (443) 444-8000
Greater Baltimore Medical Center (GBMC) 6701 N Charles St. Towson, MD (Baltimore County) (443) 849-2000	

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APPENDIX B

Additional Community Resources

Resource	Contact
Baltimore Crisis Response, Inc.: 988 Helpline	9-8-8
Mental Health & Substance Use: Information and Treatment Line	410–637–1900
Homeless Veterans Hotline	1–877–424–3838
National Suicide Lifeline	1–800–784–2433 or 1–800–273–8255
211 MD at UWCM: 24 Hour Information and Referral Hotline	211 (from a local phone) 1–800–492-0618

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