Policy 712

Subject	
CRISIS INTERVENTION PROGRAM	
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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 persons 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 to minimize arrests and law enforcement interactions with persons with Behavioral Health Disabilities or experiencing Crisis;
- Methods for addressing the long-term needs of persons and families in order to provide for the least police-involved response.

The purpose of this policy is to provide directives to avoid the unnecessary involvement of people with criminal justice system.

These directives include:

- deescalating and avoiding escalation when interacting with people with behavioral health disabilities;
- utilizing and referring persons with disabilities to community-based resources;
- exercising discretion to not arrest or press charges for criminal actions when the behavior is related to a person's behavioral health disability.

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 persons 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, persons 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 a person 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 persons who experience Behavioral Health Disabilities; and iv). When needed, provide reasonable modifications to persons with Behavioral Health Disabilities.

Community and Officer Safety. The BPD supports the least police-involved response necessary for 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 persons with Behavioral Health Disabilities or experiencing Crisis, including de-escalating and promoting peaceful resolutions to incidents, and diverting persons 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 a person 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,
- A person'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.

Baltimore City Behavioral Health Collaborative (BCBHC) ─ A group of stakeholders in Baltimore City that work to improve accountability to the people of Baltimore and reduce unnecessary interaction with emergency personnel by ensuring

- a full and comprehensive range of behavioral health services are accessible and high quality,
- city personnel, in particular police, fire and EMS, are just in their interactions with people living with or impacted by mental illness and substance use,
- city policies are collaboratively developed, and
- system efforts across the city are coordinated.

The group includes community members, people with lived experience with mental illness and/or substance use disorder, service providers, institutional leaders and other advocates.

Crisis ─ An incident in which a person 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.

Crisis Intervention ─ The attempt by a member to de-escalate an encounter with a person experiencing Crisis, to return the person to a pre-Crisis level, and divert the person 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 responders to Behavioral Health Disability-related calls for service to which a police response is necessary.

Crisis Response Team (CRT) ─ A unit comprised of CIT officers and licensed Mental Health professionals who respond in pairs to persons in Crisis. The CRT's goal is to peacefully resolve complex situations with the least restrictive techniques, interventions, and resources possible while maintaining the safety and wellbeing of the person or family and others involved in the Crisis, including BPD personnel, and the community.

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

Mobile Crisis Team (MCT) – A team of mental health professionals that may include 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 988 Helpline, 24 hours per day.

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.

988 Helpline – A free and confidential Crisis and suicide hotline available 24/7 to anyone in suicidal crisis or emotional distress. The caller is routed to their nearest Crisis center to receive immediate counseling from trained professionals and local mental health referrals. The lifeline supports people who call for themselves or someone they care about.

DIRECTIVES

Patrol Members

1. When responding as the primary unit to a call for service or on-view incident that appears to involve a person with a Behavioral Health Disability or experiencing a Crisis, non-CIT members shall:

    1.1. Secure the scene, especially with regard to the safety of the member, person in Crisis, and bystanders, if present.

    1.2. Member shall request a CIT officer,

    1.3. Determine if the person in Crisis can be assisted through the 988 Helpline by calling the direct line for law enforcement and EMS personnel as appropriate, (640) 206-1469,

    1.4. Gather all available information to brief the 988 Helpline, CIT officer, CRT or MCT upon arrival, including:

        1.4.1. Observations of the subject's actions, demeanor, and behavior,

        1.4.2. Names(s) of the persons involved, and,

        1.4.3. Interviews of family/friends on scene.

NOTE: CIT officers shall take the lead on the scene of Behavioral Health incidents or persons experiencing Crisis to resolve the situation, but the primary officer maintains all reporting requirements.

2. If a CIT officer or CRT is not available to respond, the assigned officers shall request a supervisor, use verbal and tactical de-escalation outlined in Policy 1107 when time and circumstances permit to attempt to end any imminent danger the person in Crisis poses to themselves or others, and peacefully resolve the incident (See Policy 1107, De-Escalation).

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

3. 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

4. When responding as the primary unit to a call for service or on-view incident that appears to involve a person with a Behavioral Health Disability or experiencing a Crisis, members shall:

    4.1. Take the lead on the scene unless relieved by a supervisor.

    4.2. Secure the scene, especially with regard to the safety of the member, person in Crisis, and bystanders, if present.

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

4.4. Determine if the person in Crisis can be assisted through 988 and take appropriate action.

4.5. The CIT officer shall request a supervisor, seek to de-escalate, and peacefully resolve the incident.

NOTE: CIT officers who are dispatched to an incident involving a person experiencing a Crisis will have 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.

4.6. Attempt to determine:

4.6.1. The nature and severity of the Crisis situation;

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

4.6.3. The potential for rapid change in behavior; and

4.6.4. Whether the person 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.

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

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

4.7.2. Past incidents involving injury or harm to the person or others;

4.7.3. Previous incidents involving suicide risk;

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

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

4.7.6. Information about the person, 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 person, factors that may have precipitated the crisis, as well as examples of strategies that have proven effective with the person in the past;

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

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

4.7.9. 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.

4.8. Gather all available information to brief CRT, MCT or additional personnel upon arrival.

4.9. 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.	Members may refer the person to the appropriate resources or services (e.g., requesting a MCT by using the direct line for law enforcement and EMS personnel). Complete Incident Report including Behavioral Health form and provide Baltimore Police Contact Card.	
Indication of urgent Behavioral Health needs or Crisis.	Take steps to de-escalate and resolve by calling for behavioral health resources, including MCT, CIT, CRT. Complete Incident Report including Behavioral Health form and provide Baltimore Police Contact Card.	Take steps to de-escalate and resolve by calling for behavioral health resources, including MCT, CIT, CRT, and LEAD. Complete Incident Report including Behavioral Health form and provide Baltimore Police Contact Card.
The person presents a danger to the life and safety of themselves or others, and the person 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, complete Incident Report including Behavioral Health form.	Take steps to de-escalate when feasible, Emergency Petition and involuntary transport to the closest psychiatric emergency facility, complete Incident Report including Behavioral Health form.
Escalation of harmful or symptomatic behavior	Take steps to de-escalate when feasible, Emergency	Take steps to de-escalate when feasible, and depending

where there is no available, less-restrictive form of intervention that is consistent with the welfare and safety of the person.	Petition and transport to the closest designated psychiatric emergency facility, complete Incident Report including Behavioral Health form. Coordinate with appropriate services as possible.	on severity of criminal offense and officer's discretion, arrest the person. Coordinate with Forensic Alternative Services Team (FAST) and mental health court Assistant State's Attorney. Complete Incident Report including Behavioral Health form.

4.9.1. Exercise 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 persons 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 prefers the least-intrusive response based on the totality of the circumstances;

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

4.10. If emergency evaluation is required, take the person into custody in the least restrictive manner appropriate and ensure the person is transported to the closest or most appropriate 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 and Policy 713, Petitions for Emergency Evaluation & Voluntary Admission.

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

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

Crisis Response Team

5. The CRT is available to respond to calls for service that relate to a person who may have a Behavioral Health Disability between 1100 and 1900 and may be used as a resource to assist patrol, CIT, and other BPD members in their interactions with people with Behavioral Health Disabilities.

6. The behavioral health professional is responsible to final disposition of CFS to which CRT responds and members are directed to defer to their professional judgment on CFS to which they respond.

Supervisors

7. To support the mission of the BPD and the CIT program, which includes providing the least police-involved response necessary, supervisors shall:

    7.1. Seek the input of CIT personnel and other resources on the scene (e.g., MCT) regarding strategies for resolving the Crisis, where it is reasonable for them to do so.

    7.2. 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.

    7.3. Ensure the appropriate reports (i.e., Behavioral Health Report and Incident Report) are completed and forwarded to the appropriate locations.

    7.4. Identify and encourage members under their supervision across all shifts and districts who are qualified to apply to be CIT officers.

Reporting Requirements

8. All members shall complete an Incident Report and the Behavioral Health Form in Axon Records for **all** calls for service that involved a person with a behavioral health-related disability, including by not limited to, the following incident type:

    8.1. **28** – Suicide Attempt;

    8.2. **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).

9. The Behavioral Health Report shall include a statement that the officer believes the person evidences a Behavioral Health Disability or is in Crisis, 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.

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.

REQUIRED ACTION

Training and Selection of Personnel

CIT Officers

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

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

    10.2. Have completed at least one (1) year of service beyond field training. Complete a written application package to include:

        10.2.1. Supervisory recommendations,

        10.2.2. Use of force history,

        10.2.3. Disciplinary record and complaint history; and

    10.3. Complete an in-person interview.

    10.4. 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:

        10.4.1. How to conduct a field evaluation to decide the most appropriate treatment or service (e.g., Emergency Petition, referral to Behavioral Health Crisis Services such as the 988 Helpline or MCT, or provide resource information);

        10.4.2. Suicide intervention;

        10.4.3. Mental health and intellectual and developmental disability diagnoses;

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

        10.4.5. The effects of substance misuse;

        10.4.6. Perspectives of persons with disabilities and their family members;

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

        10.4.8. The rights of persons with disabilities;

        10.4.9. Civil commitment criteria;

        10.4.10. Crisis de-escalation;

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

10.4.12. Scenario-based exercises.

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

Crisis Response Team (CRT)

11. In addition to all the above, members shall:

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

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

Crisis Intervention Coordinator

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

12.1. Facilitate communication between BPD, members of the behavioral health provider community, and maintain the effectiveness of the BPD Crisis Intervention Program.

12.2. Complete 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.

12.3. Collect data on the suspected Behavioral Health Disability or Crisis status of persons 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.

12.4. Report quarterly to the BCBHC regarding calls for service that involve possible Behavioral Health Disabilities or people in crisis, including:

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

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

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

12.4.4. Whether force was used, the type of force used; and

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

12.5. Work with Education and Training Section (E&T) and BCBHC to develop, deliver, and update CIT training as needed.

12.6. Identify, develop, and maintain partnerships with program stakeholders and serve as a point of contact for advocates and persons with Behavioral Health Disabilities and their families, caregivers, professionals, and others associated with the mental health and intellectual and developmental disability community.

12.7. Serve as the point of contact for addressing concerns of stakeholders and community members regarding BPD Crisis Intervention services, including address specific calls for services and identify and implement any changes in protocol or training of personnel to improve future responses.

12.8. Maintain a current roster of all CIT-certified officers.

12.9. Disseminate a provider list on community-based behavioral health resources for purposes of diversion.

12.10. Ensure the selection of appropriate candidates for designation as CIT officers.

12.11. Ensure CIT officer capacity is sufficient to respond, at all times of the day and in all districts, to persons in Crisis and with Behavioral Health Disabilities.

12.12. Oversee the development and implementation of a selection process for CIT officers.

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

12.14. Review CIT policy and procedure annually and suggesting revisions as needed.

12.15. Prepare an annual report for the Police Commissioner and BCBHC, on the development and implementation of a "Crisis Intervention Plan" that details the following:

12.15.1. 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;

12.15.2. 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;

12.15.3. Relationships with other members of BCBHC;

12.15.4. Barriers to effective service delivery; and

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

12.16. Review outcome data to:

12.16.1. Recognize officers deserving commendation;

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

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

12.16.4. Assist with CIT training curriculum changes; and

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

BCBHC

13. The Collaborative shall assist in the development and implementation of the Crisis Intervention Program. The BCBHC will meet regularly and work collectively to:

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

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

13.3. Assist in developing policies and procedures for the disposition or referral of persons to community resources.

13.4. Assist in developing and maintain a list of service providers and resources for BPD members and Dispatch for referral purposes.

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

13.6. Seek to expand the membership of BCBHC where appropriate.

Education and Training (E&T) Section

14. The Commander of E&T shall:

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

14.2. 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.

14.3. 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 persons with Behavioral Health Disabilities, and scenario-based de-escalation skills training.

14.4. 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.

14.5. 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

REFERENCED 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

Rescind 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.

APPENDIX A: Designated Psychiatric Emergency Facilities

Baltimore City	
Grace Medical Center 2000 W. Baltimore Street Baltimore, MD 21223 (410) 362-3000	Johns Hopkins Bayview Medical Center 4940 Eastern Avenue Baltimore, MD 21224 (410) 550-0100
Johns Hopkins Hospital & Health System 600 N. Wolfe Street Baltimore, MD 21287 (410) 955-5964	MedStar Union Memorial Hospital 201 E. University Parkway Baltimore, MD 21218 (410) 554-2000
Sinai Hospital of Baltimore *(Lifebridge Health)* 2401 W. Belvedere Avenue Baltimore, MD 21215 (410) 601-5461	University of Maryland Medical Center 22 S. Greene Street Baltimore, MD 21201 (410) 328-1219
UMD Medical Center Midtown Campus 827 Linden Avenue Baltimore, MD 21201 (410) 225-8100	

APPENDIX B: Additional Community Resources

Baltimore Crisis Response, Inc.: 988 Helpline	9-8-8 or (410) 433-5255 Direct line for law enforcement & EMS personnel: (640) 206-1469
Mental Health & Substance Use: Information and Treatment Line	(410) 433 5175
Homeless Veterans Hotline	1–877–424–3838
211 MD at UWCM: 24 Hour Information and Referral Hotline	211 (from a local phone) 1–800–492-0618