Maryland Office of the Public Defender
Baltimore City District Office and Mental Health Division
Comments on Draft Policies Pertaining to Behavioral Health/Crisis Response
May 2019

The Office of the Public Defender (OPD) provides these comments to the Baltimore Police Department (BPD) on its draft policies addressing the crisis intervention program, draft petitions for emergency evaluation & voluntary admission, and behavioral health crisis dispatch.

The treatment of people who have behavioral health disabilities or are otherwise in crisis is of central importance to the consent decree and the basis for many constitutional violations identified in the DOJ report underlying the decree. These issues are exacerbated by an overreliance on law enforcement to address behavioral health crises and other public health concerns requires BPD to expend significant resources on responding to mattes that would be better addressed by mental health professionals.

We commend BPD for recognizing in its Core Principles that "the least police-involved response necessary for persons with behavioral health disabilities or in crisis consistent with community safety" is needed to promote community and officer safety. OPD urges BPD to further this principle by using its significant political and fiscal influence to advocate for more resources for its mental health partners.

Supporting a robust community mental health system would further BPD's commitment to "creat[e] and maintain[] a culture of service that builds trust and legitimacy in all communities, values the sanctity of human life, and provide for the safety and well-being of all." BPD Mission Statement, Approved by the Monitoring Team 7/6/018. With better funded community partners, BPD can direct its resources where they are most needed. In particular, insufficient funding for the mobile crisis team, which due to lack of funding is unavailable during the all-important overnight period and has just one mobile crisis van for the entire city, is arguably the greatest barrier to an appropriate response to behavioral health calls and a significant public safety issue, resulting in increased deployment of law enforcement resources that can be better utilized elsewhere and potentially escalating situations that are best resolved by a mental health professional.

In addition to supporting community behavioral health services, BPD should engage behavioral health experts in its response team as much as possible. In particular, engaging a behavioral health expert at dispatch would allow for capacity and diagnostic determinations to help inform what level of response is needed and can help guide the appropriate actions.

While we believe that a reduced reliance on law enforcement to respond to behavioral health crises is the most important and effective measure to improve the treatment of people with behavioral health disabilities, we recognize that BPD has little control over the extent of community resources available and, without further funding for its partners, will continue to be the primary responder in most situations. With that in mind, we provide the below

recommendations to the draft policies for the crisis intervention program, behavioral health crisis dispatch, and emergency petitions and voluntary admissions.

I. Provide clearer definitions and legal principles in all three behavioral health policies.

All three draft behavioral health policies have the same core principles and many of the same definitions, which helps provide consistency and continuity across the related policies. However, they lack sufficient definition and discussion about the constitutional and legal standards relating to the treatment of people in a behavioral health crisis. In particular, the standards for civil commitment and the ongoing liberty interest of people with behavioral health disabilities are directly related to police response to a behavioral health crisis and should be incorporated into these policies.

Recommendation 1: Discuss the core principle of Civil Rights consistent with its legal requirements and constitutional framework.

Individuals with a behavioral health disability have the same civil rights as other people, with additional protections for accommodations that may be needed based on their disability. Thus, much like an arrest requires probable cause of crime, involuntary transport to a hospital requires probable cause of dangerousness. See Dent v. Montgomery Cty. Police Dep't, 745 F. Supp. 2d 648, 657 (D. Md. 2010) ("To seize an individual for an emergency medical evaluation, 'an officer must have probable cause to believe that the individual posed a danger to herself or others before involuntarily detaining the individual.'" (quoting S.P. v. City of Takoma Park, MD, 134 F.3d 260, 266 (4th Cir. 1998)).

Even if well intentioned, police responses that limit freedom in order to address overall health, safety, and welfare concerns, without clear and convincing evidence of dangerousness, violates the individual's constitutional rights. O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) ("A finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the 'mentally ill' can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.").

The Core Principle in all three policies

Suggested language: Edit Core Principle 2 as follows:

> Civil Rights. Members who respond to persons with Behavioral Health Disabilities or who are experiencing Crisis shall respect their dignity~~,~~ **and** 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 an emergency evaluation or civil commitment if they present a danger to the life or safety of the individual or of others. MD Health Gen. § 10-602(a).** Members and communications dispatchers shall be trained to increase awareness

of bias in order to minimize the effects of biases on dispatch decisions and responses to calls for service.

Recommendation 2: Provide examples of appropriate de-escalation techniques in the core principle of De-Escalation.

De-Escalation is a central concept throughout the behavioral health response policies. While Policy 1107 (De-Escalation) is referenced, the behavioral health and crisis response policies should reiterate the key points that related to interactions with people with behavioral health disabilities or crisis.

Suggestions language: Amend the De-Escalation Core Principle as follows:

> **Common de-escalation techniques for responding to people with behavioral health disabilities include, but are not limited to:**
>
> - **Communication techniques to calm an agitated subject and promote rational decision making:**
> - **Decreasing the exposure to the potential threat by moving to a safer position;**
> - **Slowing down the pace of the incident;**
> - **Applying the critical thinking framework**
>
> **During encounters with persons experiencing behavioral health disorders or in crisis, members will employ developmentally-appropriate, trauma-informed tactics including, but not limited to, using a calm and natural demeanor, and avoiding threatening language.**

Recommendation 3: In the Behavioral Health Disabilities definition, provide guidance on the direct observations of a member that support a finding of a behavioral health disability.

BPD members are not clinicians with the expertise and ability to diagnose disabilities. Nonetheless, their observations will often guide their actions and conclusions. Training will be crucial to ensuring that members rely on observations in an appropriate manner. The policy should spell out the types of observations that may appropriately support the conclusion of a behavioral health disability and which do not.

Form 320, Item 25 provides a list of observed behaviors that might support a conclusion that the person has a disability. The policy definitions should reinforce these criteria and further make note of biases that are not appropriate for determining that a disability exists.

Suggested language: Amend the Behavioral Health Disabilities definition as follows:

> …A person may be suspected of experiencing a Behavioral Health Disability or experiencing Crisis through a number of factors including:
>
> . . .

- A member's direct observation **of 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 toward others.**

Recommendation 4: Include a definition of dangerousness.

As noted above, dangerousness is a critical factor to determine whether a person may be civilly committed, and thus, whether the person may be detained and transported for an emergency evaluation. Md. Health Gen. § 10-622(a). Because this concept is central to permissible police action, dangerousness should be defined and discussed within the behavioral health policies.

Suggested language: Add to the Definitions sections:

> **Dangerousness - An imminent risk of harm to self or others. Transport to a psychiatric emergency facility requires probable cause that the person is a danger to oneself or others.**

II. Policy 712 – Crisis Intervention

Recommendation 1: Clarify the courses of action available after the scene has been stabilized.

The Crisis Intervention Program policy provides a useful chart of options available once the scene is stabilized that rightly emphasizes de-escalation and referrals, which are more appropriate than an emergency petition or arrest in the majority of circumstances. However, components of this chart should be revised to more clearly focus on the behavior underlying the nature of the call and require de-escalation in all circumstances.

"Indication of a Behavioral Health Disability" (the second nature of a call listed) should be incorporated into the categories just above ("harmless behavior which appears related to an illness, disorder, or disability") and below ("indication of urgent behavioral health needs to crisis"), depending on the surrounding circumstances. Police activity should be responding to behaviors and events, which may be harmless, urgent or dangerous. An additional category relying exclusively on indication of a disability, without an accompanying action underlying the call, wrongly suggests that member activity based solely on someone's status as a person with a disability is appropriate.

Moreover, the distinction of criminal and non-criminal behavior suggests that de-escalation is only appropriate for calls based solely on non-criminal behavior, rather than being the first step in a continuum of responses for all calls, even when criminal behavior is present. Rather than separate out criminal and non-criminal behavior, providing the courses of actions within each category as a list would be clearer and more accurately reflect the escalating responses available.

Finally, the indication of an urgent behavioral health crisis, without any presentation of dangerousness, is not an appropriate grounds for involuntary hospitalization. Therefore, the appropriate response is not to transport to a hospital but to provide with resources. If the person seeks hospitalization, for reasons discussed under Policy 713, the member should still either seek an emergency petition or utilize the Crisis Information & Referral Line (CI&R), rather than seek a voluntary hospitalization for someone who may lack the capacity to consent.

Suggested language: Revise the chart as follows:

Nature of Call	~~**Non-Criminal Behavior**~~ **Courses of Action**	~~**Criminal Behavior**~~
Harmless behavior which appears related to an illness, disorder, or disability.	1. Do not intervene, or members may refer the individual to the appropriate resources or services (e.g., BCRI, Mobile Crisis Team, Crisis Information & Referral Line 410-433-5175). . 2. Issue citizen contact receipt. Provide a print out with contact information for obtaining community-based services.	~~Issue citizen contact receipt. Provide a print out with contact information for obtaining community-based services.~~
~~Indication of a Behavioral Health Disability.~~	~~1. Take steps to de-escalate and ensure the individual is connected to the appropriate services.~~	~~Refer the individual to the appropriate services (e.g., LEAD), document the crime on Form 320, and issue a citizen contact receipt.~~
Indication of urgent Behavioral Health needs or Crisis.	**1.** Take steps to de-escalate and resolve using CIT, CRT, behavioral health resources, and least restrictive alternatives. **2. Refer the individual to the appropriate services (e.g., LEAD, CI&R Line), document incident on Form 320, and issue a citizen contact receipt.**	~~Transport to the closest designated psychiatric emergency facility, document incident on Form 320, miscellaneous report, and issue citizen contact receipt.~~

The individual presents a danger to the life or safety to themselves or others, and the individual is unable or unwilling to be admitted voluntarily.	**1.** Take steps to de-escalate and resolve using CIT, CRT, and behavioral health resources. **2.** 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 on Form 320, miscellaneous report, and issue citizen contact receipt.	~~Emergency Petition and involuntary transport to the closest psychiatric emergency facility, document incident on Form 320, 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.	**1.** Emergency Petition and transport to the closest designated psychiatric emergency facility, document incident on Form 320, miscellaneous report, and citizen contact receipt. Coordinate with appropriate services as possible. **2. 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 States Attorney.**	~~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 States Attorney.~~

Recommendation 2: Upon request by OPD, with letter of representation, provide Form 320 and other relevant materials without a subpoena.

Form 320 states that it is not to be released outside of BPD, and individuals who are admitted after an emergency evaluation generally lack the capacity to consent to the release of

information. As a result, our Mental Health Division attorneys, who represent individuals in civil commitment and not criminally responsible (NCR) proceedings, generally need to obtain a subpoena in order to access this information. In part due to the inability to secure consent, and the recognition of the individuals' attorney as a personal representative, a petitioner's attorney is within the exceptions to HIPAA and is authorized by law to obtain medical information without a release form. MD Health Gen. § 4-306. Requiring a subpoena prevents timely access to this important information sufficiently in advance of the hearing.

Suggested language: Add to the Reporting Requirements:

> **4. Provide the evaluee's attorney with a copy of Form 320, when requested by counsel with a letter of representation provided. Disclosure to the evaluee's legal representative does not violate HIPAA. MD Health Gen. § 4-306.**

Recommendation 3: Include implicit bias in the required training for CIT officers and CRT members.

Interactions with people with a behavioral health disability or crisis are often escalated due to implicit bias. Race, gender, size, age and language ability often impact presumed levels of dangerousness and competency. The specialized training provided to CIT officers and CRT members should include dedicated modules on implicit bias and its impact on behavioral health calls.

Suggested language: Under Required Action, Training and Selection of Personnel add to both CIT Officers ¶4 and CRT ¶ 3:

> **Implicit bias and its impact on responding to individuals with a Behavioral Health Disability or Crisis**

Recommendation 4: Require CIT Officers and CRT Members to establish a base level of competency for the materials covered in the specialized.

Members relied upon for crisis response need to not just participate in additional training but establish a mastery of the information provided. Qualification for these specialized positions should require passage of an exam covering the basic materials provided.

Suggested language: Under Required Action, Training and Selection of Personnel provide a new CIT Officers ¶5 (then renumbering current ¶¶ 5,6) and CRT ¶ 4 (renumbering current ¶¶ 4,5):

> **Establish understanding of the information provided in the enhanced training by obtaining a score of at least 70% on the training exam.**

Recommendation 5: Gather and collect data on the number of calls in which CIT Officers and/or the CRT were requested and dispatched.

While the policy accounts for circumstances in which CIT or CRT are unavailable, it does not encourage or address determining the extent of need and any gaps in current services. The frequency with which CIT or CRT dispatch is requested and the extent to which these requests are met should be reviewed and factored into recruitment, training, operations and oversight.

Suggested language: Add the following to the Required Action for the Crisis Intervention Coordinator:

> **4.6 The number of calls where a CIT officer or the CRT was requested, and the percentage of those calls where a CIT officer or the CRT were dispatched and able to respond.**

III. Policy 713 – Petitions for Emergency Evaluation & Voluntary Admission

Recommendation 1: Do not encourage officers to seek consent for a voluntary evaluation; require either an emergency petition or a referral from the CI&R line.

Not all behavioral health crises require services as intensive as hospitalization, and even if the person seeks psychiatric assistance, they should be directed toward the appropriate level of care. Rather than over-rely upon the limited resources of hospital emergency rooms, members should be encouraged to make fuller use of the CI&R line for voluntary treatment needs.

Beyond general resource efficiency, voluntary admission to the hospital in lieu of an emergency petition may actually deny hospital services to those most in need. A person in crisis or otherwise suffering from a behavioral health condition may lack capacity to consent. If an individual transported to the hospital for a voluntary admission is later determined to lack capacity, an Administrative Law Judge might release the patient due to a procedural error in the admission process. See COMAR 10.21.01.09 (G) (3) (a)-(c). As BPD members lack the clinical expertise to determine capacity to consent, they should presume that consent it not possible when responding to a behavioral health crisis.

Rather than seek consent for a voluntary admission, members should be required to either seek an emergency petition to transport to the hospital (based on probable cause of a mental disorder and dangerousness), or utilize the CI&R line to make an appropriate referral that will withstand legal challenges.

Suggested language: In the Directive, Emergency Petition Based on Personal Observation section, remove ¶1 (asking the individual to seek a voluntary evaluation and, with consent, transporting to nearest DPEF).

In the General Section, prior to the Directives, add the following provision:

> **If an individual consents to a voluntary evaluation and treatment, contact the CI&R Line to obtain a proper referral. Note that if the individual consents to services**

through the CI&R Line, the member should not prepare a Petition for Emergency Evaluation package.

Recommendation 2: Provide petitioner's counsel with documents prior the involuntary civil commitment hearing.

Individuals who are involuntarily admitted to a psychiatric facility are entitled to an involuntary admission (IVA) hearing within 10 days of their admission. OPD's Mental Health Division is charged with representing individuals at these hearings, but is rarely provided with timely access to sufficient information. As noted above (Recommendation 2, Policy 712), HIPAA protections for medical information (such as what may be included in Form 320) do not apply to legal counsel. All information pertaining to the circumstances underlying the person's commitment, including any interaction with the police resulting in transport to the hospital, is necessary discovery for these proceedings. Within 48 hours of an emergency petition, OPD should be provided with all relevant documentation, including: Form 320, Juvenile custody report form 83/11 (if applicable), 911 call, CAD, body-worn camera video, miscellaneous incident reports, and the emergency petition.

Suggested language: Within the Required actions for supervisors, include:

4. Within 48 hours of an emergency evaluation, forward to OPD's Mental Health Division documentation related to the petition, including but not limited to, any of the following materials: Form 320, Juvenile custody report form 83/11, 911 call, CAD, body-worn camera video, miscellaneous incident reports, and the emergency petition.

Recommendation 3: Note that a government agency (i.e. DSS) cannot voluntary admit a child under age 16.

While, as the policy notes, a minor under the age of 16 years of age can be admitted voluntarily upon the consent of a parent or guardian, Maryland regulations require that the parent or guardian not be a representative of a state agency. COMAR 10.21.01.07. In accordance with this limitation, the policy should make clear that children in foster care cannot be transported for a voluntarily evaluation. Children in state custody will always require an emergency petition to be transported to a designated psychiatric emergency facility.

Suggested language: Add a note after Interaction with Youth ¶ 4:

NOTE: A government agency, such as the Department of Social Services, cannot seek voluntary admission for a child in its custody. Thus, a minor in foster care may only be admitted to a psychiatric emergency facility via an Emergency Petition.