November 1, 2019

By electronic mail and
By first class mail

BPD Monitoring Team
c/o Kenneth Thompson
Venable LLP
750 East Pratt Street, Suite 900
Baltimore, Maryland 21202

Re: Comments on Baltimore Public Health System Gap Analysis

Dear BPD Monitoring Team:

The Bazelon Center for Mental Health Law and Disability Rights Maryland submit the following comments on the "Baltimore Public Behavioral Health System Gap Analysis" conducted by Human Services Research International (HSRI) and published on the Baltimore Police Department's website on October 1, 2019.[1]

The Bazelon Center for Mental Health Law is a national public interest organization founded in 1972 to advance the rights of individuals with mental disabilities. The Center advocates for laws and policies that provide people with behavioral health disabilities the opportunities they need to participate fully in their communities. Its litigation and policy advocacy is based largely on the Americans with Disabilities Act's guarantees of non-discrimination and reasonable accommodation. The Center has long worked to promote the diversion of people with behavioral health disabilities from the criminal justice system and for safer police practices.

Disability Rights Maryland (DRM) is the state's federally designated protection and advocacy organization for persons with disabilities. We have long been concerned about the experience of Baltimore City residents with behavioral health disabilities as they interact with members of the police. DRM advocates for the use of diversion policies that reduce interaction of persons with

[1] Human Servs. Research Int'l (HSRI), *Baltimore Public Behavioral Health System Gap Analysis* (Oct. 2019) [hereinafter Gap Analysis], https://www.baltimorepolice.org/baltimore-public-health-system-gap-analysis.

behavioral health disabilities in crisis with the police whenever possible, and for the implementation of crisis response techniques that can help prevent situations that lead to over-reliance on incarceration, unnecessary institutionalization, and unreasonable use of force. We advocate for a crisis response system that works to connect people in crisis to voluntary behavioral health services, and thereby decrease inappropriate criminal justice involvement for people with disabilities.

The behavioral health system gap analysis is a requirement of the Consent Decree between the United States of America, the Baltimore Police Department (BPD), and the Mayor and City Council of Baltimore ("City of Baltimore" or "the City").[2] The Decree states BPD's commitment to "responding to individuals with Behavioral Health Disabilities and those in crisis in a manner that respects individuals' civil rights and contributes to their overall health and welfare." *Id.* ¶ 96.[3] Among the Decree's objectives are to "prevent situations that could lead to unreasonable use of force, promote connection of people with Behavioral Health Disabilities or in crisis to the behavioral health system, and decrease inappropriate criminal justice involvement for people with Behavioral Health Disabilities or in crisis." *Id.*

The Decree follows the U.S. Department of Justice's findings that the BPD engaged in a pattern or practice of illegal conduct including, among other things, "using enforcement strategies that produce severe and unjustified disparities in the rates of Stops, Searches and Arrests of African Americans." *Id.* ¶ 4; *see also* U.S. Dep't of Justice, Civil Rights Division, Investigation of the Baltimore City Police Department 3, *passim* (Aug. 10, 2016) [hereinafter Findings Letter]. The Department found that the BPD disproportionately stops, searches, and arrests Black Baltimoreans at remarkably pronounced rates. Findings Letter at 7 (noting that "[i]n each of BPD's nine police districts, African Americans accounted for a greater share of BPD"s stops than the population living in the district" and that "African Americans accounted for 95 percent of the 410 individuals BPD stopped at least 10 times"); see also id. at 3-4 (noting public perception that there are "two Baltimores," one wealthy and largely white, the second impoverished and largely Black, with the latter experiencing "unjustified stops, searches, and arrests, as well as excessive force"). Given this and other evidence, it is all but certain that people of color with behavioral health disabilities living in Baltimore have been among the individuals most vulnerable to illegal conduct and resulting trauma and other harms.[4]

---

[2] Consent Decree, *United States of America v. Police Dep't of Baltimore City, et al.*, No. 1:17-cv-00099-JKB, ¶ 97 (D. Md. Jan. 12, 2017) [hereinafter Decree].

[3] The Decree defines "Behavioral Health Disabilities" as "[d]isabilities associated with substance-related disorders, addictive disorders, and mental disorders." Decree ¶ 511.d.

[4] *Cf.* Gap Analysis at 38 (noting that in fiscal year 2018 "Black or African American" people make up 62.8% of Baltimore's population, but constituted 77.2% of the population of recipients of behavioral health services through the city's public behavioral health system); *see also* Leah Pope, *Racial Disparities in Mental Health and Criminal Justice*, Vera Inst. of Justice (Jul. 24, 2019) (collecting studies, stating that in 2016 black people were 2.17 times more likely to be arrested as white people, and 3.5 times more likely to be incarcerated in jail, and that more than 25% of people in jail had "serious psychological distress"), https://www.vera.org/blog/racial-disparities-in-mental-health-and-criminal-justice; Jordan E. DeVylder et al., JAMA Network

The Consent Decree resolves the claims alleged in the United States' federal complaint, including that the BPD uses unreasonable force against individuals with behavioral health disabilities – again, in Baltimore predominantly people of color with such disabilities – and that it fails to make reasonable accommodations in its interactions with such individuals, in violation of the Americans with Disabilities Act (ADA). Complaint ¶¶ 41(d), (e), 75-80. The ADA protects people with disabilities from discrimination on the basis of disability. 42 U.S.C. § 12132. The ADA's implementing regulation requires state and local governments, including the City of Baltimore and the BPD, to make reasonable modifications to policies, practices, and procedures as needed to avoid disability discrimination. 28 U.S.C. § 35.130(b)(7).

As the U.S. Department of Justice's findings letter indicates, the BPD's and the City's failures to implement nondiscriminatory policies, practices, and procedures also implicate the ADA regulation's "integration mandate," which requires public entities to administer programs and services to people with disabilities in the most integrated setting appropriate to their needs. U.S. Dep't of Justice, Civil Rights Division, Investigation of the Baltimore City Police Department (Aug. 10, 2016), at 110 (citing 28 C.F.R. § 35.130(d) and *Olmstead v. L.C.*, 527 U.S. 581 (1999)). The Department has stated that government support of "criminal justice entities to coordinate with, and divert to, community-based services" may be required to prevent the unnecessary institutionalization of people with disabilities, in violation of the ADA.[5] A consensus exists that public entities have an obligation to address the deficits in their systems that put individuals with behavioral health disabilities at risk of contact with law enforcement and criminal systems, and becoming unnecessarily incarcerated.[6]

The gap analysis was intended to identify gaps in Baltimore's behavioral health service system, including problems with the quantity and quality of services available through the system, and

---

Open, *Association of Exposure to Police Violence With Prevalence of Mental Health Symptoms Among Urban Residents in the United States* 8 (Nov. 21, 2018) (finding that police violence exposures were commonly reported among adult residents of Baltimore and New York City; communities of color and LGBTQIA+ communities were disproportionately affected, and exposures were associated with greater odds of current psychological distress and concurrent (12-month) suicidal ideation, suicide attempts, and psychotic experiences), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2715611.

[5] U.S. Dep't of Justice, Civil Rights Division, *Examples and Resources to Support Criminal Justice Entities in Compliance with Title II of the Americans with Disabilities Act* (2017), https://www.ada.gov/cjta.html. Citing the Department's guidance, advocates have noted that "jails and prisons are institutions and that they are a type of segregated setting." *See* Technical Assistance Collaborative, *Olmstead at 20: Using the Vision of Olmstead to Decriminalize Mental Illness* 7 (Sept. 2019) [hereinafter *Olmstead* at 20], http://www.tacinc.org/media/90807/olmstead-at-twenty_09-04-2018.pdf.

[6] *See Olmstead* at 20, *supra* note 5, at 8.

unmet needs "that lead to preventable criminal justice involvement." Decree ¶ 97. The City is to "assist with implementation of the recommendations as appropriate." *Id.*

In general, we believe that the gap analysis' recommendations are sound overall, if somewhat unspecific, and that implementation of them is necessary so that the City of Baltimore and the BPD may comply with their ADA obligations, including to prevent unnecessary law enforcement involvement with Baltimore residents with behavioral health disabilities and unnecessary institutionalization of this population.

It is imperative, however, that any effort to implement the gap analysis' recommendations include "service users and family members . . . who are reflective of the diversity of Baltimore City." Gap Analysis at 98. We agree with the Gap Analysis that support needs to be provided to promote the involvement of Baltimore residents, including people of color with disabilities, with lived experience in the criminal and behavioral health systems, such as financial support for time spent doing planning, implementation, and monitoring work, and that meetings must be held at accessible times in accessible places. *Id.* The City, CPIC, and other stakeholders working in this effort should consider whether implicit bias training is needed, so that implementation decisions (including decisions about which providers provide more culturally-competent and bias-free services) are as free from bias as possible. This is needed to ensure that the communities the BPD and behavioral health system serve fully participate and have meaningful input into the implementation effort – which is really the only way to it can be successful.

Below we offer the following global and more specific comments on the gap analysis:

1. Baltimore's behavioral health crisis response system should be expanded and improved, with a goal of vastly reducing BPD involvement in behavioral health crisis calls.

We completely agree with the gap analysis' recommendation that Baltimore's behavioral health crisis response system be expanded and improved. The BPD exists to ensure public safety by addressing those engaged in criminal activities. This mission should not include BPD attempting to provide behavioral health services to Baltimore residents or using law enforcement responses to individuals needing mental health services – especially to those whose behaviors appear to others to constitute a crisis, but is not in fact criminal behavior. BPD officers should not be called to respond to incidents in which an individual is reported to be in a behavioral health crisis; instead, this should be the province of Baltimore's behavioral health crisis response system.

As the gap analysis indicates, there is a severe disparity between the capacity of the crisis response system and the need for non-BPD response to behavioral health calls. We understand that non-BPD mobile crisis response services exist but are not available on a 24/7 basis in Baltimore.[7] As a result, even where a call is referred to a mobile crisis team for response, the

[7] *See* Behavioral Health System Baltimore (BHSB), *Baltimore City's Behavioral Health Crisis Response System: Plan to Strengthen and Expand the System* 21 (June 2019) [hereinafter BHSB Crisis Plan], https://www.bhsbaltimore.org/wp-content/uploads/2019/06/BHSB-Behavioral-Health-Crisis-System-Plan-Final.pdf.

team may respond hours later or even days later.[8] By contrast, following an ADA settlement agreement with the United States, the State of Georgia instituted a statewide mobile crisis system that requires a response to all calls within an hour.[9] We believe that mobile crisis teams, working in tandem with other crisis services available through the behavioral health system, are by far preferable as a response to crises than are law enforcement responses. Studies show that both persons with disabilities and law enforcement prefer the response of mobile crisis teams to police involvement and find them more effective.[10] However, they must be timely (at least within an hour) and available on a 24/7 basis to be a meaningful alternative to a BPD response.

We also suspect that there are far too few community-based residential crisis "beds," sometimes referred to as community crisis apartments or mental health respite facilities, in Baltimore.[11] To have an effective crisis response system, Baltimore must have resources *other than the BPD* to respond to behavioral health calls, and somewhere other than its jail or emergency rooms to take individuals who need urgent assistance.[12] Peers (trained specialists with "lived experience" in

---

[8] Gap Analysis at 72. It is also a problem that mobile crisis teams cannot perform assessments for linkage to community-based services while with an individual in the community, but rather require individuals to go to an office for such assessments. *Id.* at 73. We are aware that this has happened in other communities, with the result that people who need services are not engaged and seemingly disappear – until the next crisis.

[9] *See* Settlement Agreement, *United States v. State of Georgia*, Civil Action No. 1:10-CV-249-CAP (Oct. 19, 2010), at part III.B.2.b.v, https://www.ada.gov/olmstead/documents/georgia_settle.pdf.

[10] *See, e.g.*, Roger Scott, *Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction*, 51 Psychiatric Servs. 9, 1153-6 (Sept. 2000).

[11] *See* Gap Analysis at 56; BHSB Crisis Plan, *supra* note 7, at 12 (noting only one 21-bed community-based residential crisis unit in Baltimore).

[12] Other communities, including San Antonio and Portland, have invested in 24/7 crisis outpatient facilities, including short-term crisis residential beds, as an alternative to transport to a police or sheriff's station for processing, or to an emergency room. *See* Melissa Vega, New Crisis Stabilization Unit Opens in San Antonio, News4 San Antonio (Jul. 16, 2018), https://news4sanantonio.com/news/local/new-crisis-stabilization-unit-opens-in-san-antonio-07-17-2018; Settlement Agreement, *United States of America v. City of Portland*, Case No. 3:12-cv-02265-SI, at ¶¶ 91-96 (Dec. 17, 2012) (describing Portland's Addictions and Behavioral Health Unit (ABHU)), https://www.justice.gov/sites/default/files/crt/legacy/2013/11/13/ppb_proposedsettle_12-17-12.pdf. Such facilities must be able to take immediate responsibility for individuals who present themselves at the facility, to be seen as a meaningful alternative to the station or the emergency room by law enforcement officers. *See Olmstead* at 20, *supra* note 5, at 10-11 (describing "crisis drop-off centers" that are open 24/7 and have a "no refusal" policy).

Baltimore's behavioral health system) should be included in all of these components of the crisis service system – employed on mobile crisis teams and staffing crisis stabilization units.[13]

We also agree with the recommendation that there be an expansion of mid-level outreach and engagement services, also involving peers, that connect people in public spaces with housing and services. We know that people with behavioral health issues may behave in public in ways that others find odd or strange but do not threaten harm. A number of communities have established effective outreach teams, staffed by paid employees or volunteers, which help meet the immediate needs of persons engaging in unusual behaviors on the street, and also help engage these individuals in considering participation in other, longer-term behavioral health services.[14] Baltimore should expand whatever mid-level outreach and engagement teams currently exist.[15]

As the behavioral health system develops crisis response and mid-level outreach capacity, the BPD should end its Homeless Outreach Team (HOT) program. We agree with DRM's comments on an earlier draft of the Gap Analysis: many of the outreach functions performed by HOT are also performed by other, peer-led programs that already exist in Baltimore, but that are currently underfunded.[16] Having BPD officers provide outreach and service linkage functions that are already available in the behavioral health system does not further the Decree's objective of "decreas[ing] inappropriate criminal justice involvement for people with Behavioral Health Disabilities or in crisis." Decree ¶ 96. Ideally, the expertise of persons working on the HOT team, and other resources dedicated to the team, can be used to support similar initiatives in the behavioral health system.

---

[13] Gap Analysis at 106; BHSB Crisis Plan, *supra* note 7, at 21-23.

[14] *See, e.g.*, Portland Street Medicine, *Who We Are?* (last visited Oct. 28, 2019) (describing "coalition of volunteer medical providers, social workers, care managers, and lay people" who "deliver high quality reliable care and build trust through empathy and continuity" to homeless individuals), https://www.portlandstreetmedicine.org/who-we-are.

[15] We note as an effective practice agencies that provide both ACT and outreach teams, to facilitate interagency handoffs of clients who may be engaged in services by the agency's outreach team and then later served by the same agency's ACT team, which may even include some of the same staff. *See* Pathways to Housing DC, *Our Programs* (last visited Oct. 28, 2019) (describing programs including "Housing First" (ACT/housing) teams and "Homeless Street Outreach" teams), https://pathwaystohousingdc.org.

[16] *See* Letter to Members of Gaps Analysis Subcommittee from David A. Prater, Disability Rights Maryland (Sept. 19, 2019) [hereinafter Prater Letter], at 5 (citing Mayor's Office of Human Services, *Homeless Service Program* (describing *The Journey Home*, Baltimore City's plan on homelessness), https://human-services.baltimorecity.gov/homeless-services (last visited Oct. 31, 2019)).

2. Baltimore's behavioral health system must be expanded and improved so that residents can access effective community-based services, including permanent supported housing, that have been shown to reduce behavioral health crisis calls and criminal system involvement.

The gap analysis recommends that certain essential services in Baltimore's behavioral health system be increased and enhanced, including Assertive Community Treatment (ACT) teams, intensive case management, permanent supported housing, crisis response services, supported employment, peer supports, and medication-assisted treatment (MAT). We agree that these services are essential components of a functioning community-based behavioral health system. Baltimore must have these services, in sufficient quality and quantity, in order to effectively divert people with behavioral health disabilities from contact with law enforcement and needless incarceration.[17]

One key "service" is permanent supported housing. Permanent supported housing leads to more housing stability, improvement in behavioral health symptoms, reduced hospitalization, and increased satisfaction with quality of life when compared to other types of housing for people with behavioral health disabilities.[18] If Baltimore created a robust system that ensured housing

[17] *See, e.g.*, Bazelon Center for Mental Health Law, *Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration* (Sept. 2019) [hereinafter Diversion to What?] (describing "essential and effective community services that should be part of every community's mental health system," including ACT, supported housing, mobile crisis services, supported employment, and peer support services, each of which has been shown to decrease criminal system involvement among persons receiving the services); U.S. Dep't of Health & Hum. Servs., Substance Abuse and Mental Health Servs. Admin. (SAMHSA), *A Bridge to the Possible: Principles of Community-based Behavioral Health Services for Justice-Involved Individuals: A Research-Based Guide* (2019) [hereinafter A Bridge to the Possible], at 21 (listing medication-assisted treatment as an example of an evidence-based practice for treatment of substance use disorders by individuals involved with criminal systems), https://store.samhsa.gov/system/files/sma19-5097.pdf.

[18] *See* Bazelon Center for Mental Health Law, *Supportive Housing: The Most Integrated and Effective Housing for People with Mental Disabilities* 1 (2017) (citing E. Sally Rogers et al., *Systematic Review of Supported Housing Literature 1993-2008,* Center for Psych. Rehab. (2009)), http://www.bazelon.org/wp-content/uploads/2017/04/supportive-housing-fact-sheet.pdf. At several points the gap analysis refers to efforts in Baltimore to increase "transitional" or "step-down" housing programs. Gap Analysis at 54, 56, 62, 108. We disagree with this focus. Virtually all people with behavioral health disabilities can transition and maintain recovery successfully in permanent supported housing, with individualized supports of adequate intensity such as ACT, case management, crisis response, supported employment, and peer supports. Studies have shown that providing immediate, permanent housing leads to more long-term housing stability when compared to other forms of housing, including those conditioned on treatment. *See, e.g.*, Sam Tsemberis & Ronda F. Eisenberg, *Pathways to Housing: Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities*, Psych. Servs. 51:4 (2000); Martha R. Burt & Jacquelin Anderson, Corp. for Supportive Hous., *AB2034 Program*

for residents experiencing behavioral health issues, this would significantly reduce the number of behavioral health "crisis" calls to which either BPD officers or mobile crisis teams respond. It is also needed so that Baltimore can transition individuals with behavioral health disabilities from its jail to community-based supports in the community that have been shown to prevent recidivism.[19]

Peer support services, provided by trained specialists with "lived experience" in the behavioral health system, should be a critical component of Baltimore's system going forward. Peer specialists may perform a variety of tasks, including helping individuals transition from a corrections or other institutional setting to the community, stay connected to providers, maintain or develop social relationships, and participate in community activities.[20] Studies indicate that incorporating peer support services into the behavioral health system divert individuals with behavioral health disabilities from hospitalization, involuntary treatment, and jail.[21] We agree with the gap analysis' recommendation that peer support services be strengthened in Baltimore (as crisis responders but also employed on ACT teams that respond to clients in crisis and in supported housing and supported employment programs), and believe such efforts should be encouraged by Behavioral Health System Baltimore (BHSB) and the State of Maryland,

---

Experiences in Housing Homeless People with Serious Mental Illness 3 (Dec. 2005), https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2011/12/Report_AB20341.pdf.

[19] Based on our experience in other jurisdictions, we believe that Baltimore may want to generously estimate the need for ACT teams, which provide 24/7 support to clients, including crisis support, as its system changes to enhance early intervention to support youth and adults with behavioral health needs before they require more intensive supports. In so doing, Baltimore may wish to consider making forensic ACT (FACT) teams available to individuals with criminal system involvement. One study indicates that persons receiving FACT over the course of a year spent significantly fewer days in jail than similar participants not receiving FACT (21.5 vs. 43.5) and were less likely to incur new convictions. J. Steven Lamberti et al., *Forensic Assertive Community Treatment: Preventing Incarceration of Adults with Severe Mental Illness*, 55 Psychiatric Services 11, 1285-1293, 1289 (2004).

[20] Diversion to What?, *supra* note 17, at 11.

[21] *See, e.g.*, New York Ass'n of Psychiatric Rehabilitation Servs., Inc., *Peer Bridger Project* (last visited Oct. 28, 2019) (participants in a "peer bridger" program for persons discharged from psychiatric hospitals experienced 71% fewer hospitalizations), https://www.nyaprs.org/peer-bridger; Sue Bergeson, OptumHealth, *Cost Effectiveness of Using Peers as Providers* 2 (2011) (Pierce County, Washington, reduced involuntary psychiatric hospitalizations for individual in behavioral health crises by 32% using peer support services), http://www.fredla.org/wp-content/uploads/2016/01/Cost_Effectiveness_of_Using_Peers_as_Providers.pdf; Nat'l Ass'n of Counties, *Supporting People with Mental Illnesses in the Community* (2018) (37% of participants receiving peer support through a peer-run 23-hour crisis program were diverted from jail over first several months of program), https://www.naco.org/sites/default/files/documents/SAMHSA%20Case%20Study%20Louisville-Jefferson%20Final.pdf.

including through implementing certification and enhancing provider Medicaid reimbursement rates for such services.[22]

The gap analysis would be more useful if it was more specific to Baltimore. Because the gap analysis failed to do so, Baltimore should consult with its mental health experts and other community stakeholders, including persons with lived experience, to estimate how many more ACT teams, crisis response teams, crisis stabilization units, and permanent supported housing units Baltimore needs.[23] If HSRI lacks the data to make such estimates, its report should indicate what data it needs and the City should prioritize and mandate such data collection. However, in our experience, law enforcement officials, hospitals, and community providers often have significant knowledge about how many individuals have frequent contacts with law enforcement, cycle through jails or emergency rooms, or who are high service utilizers. Given HSRI's many interviews with key stakeholders, we expect that HSRI either has this information, or can direct the CPIC and BHSB as to how to get it, and can estimate the unmet need within the system. As such, we strongly recommend the City begin with HSRI to collect this information.

Having a credible estimate of the need for housing and services among Baltimore residents will be particularly important as the City and stakeholders develop the resources to meet this need. Although the parties are responsible for Decree implementation, in our experience developing the resources needed to satisfy ADA obligations has generally meant garnering support from state behavioral health, housing, and Medicaid agencies, and from the state legislature, which can appropriate funds for use in developing a housing voucher program, for example, or for use in funding additional or different services. (State housing resources are a necessary supplement to federal programs in every jurisdiction that has made a dent in meeting supported housing needs, including because of the disqualification from eligibility for federal housing vouchers for people with criminal histories, and because the HUD definition of who is "chronically homeless" is too restrictive for persons who actually need supported housing.) State officials who can support whatever policy changes or additional appropriations may be needed must be at the table going forward; otherwise, we fear that the gap analysis' many helpful recommendations will not be implemented. This includes representatives of the Commission to Study Mental and Behavioral Health in Maryland, chaired by Lieutenant Governor Boyd K. Rutherford, and the Maryland Departments of Health, Human Services, and Housing & Community Development.

Further, the gap analysis notes the 2014 recommendation of the Continuity of Care Advisory Panel (CCAP) that an outpatient civil commitment program be implemented in Maryland,[24] but

---

[22] *See* Gap Analysis at 29 (noting that efforts to pursue Medicaid reimbursement for peer support services are already underway).

[23] We note that the gap analysis refers to CrisisNow as a resource for estimating need for certain crisis services. Gap Analysis at 109; *see also id.* at 107 ("Researchers have developed formulas for estimating the appropriate number of ACT slots for a given population."). The gap analysis itself will be more valuable to stakeholders who will advocate for these and other services if it includes more specific estimates of need.

[24] Gap Analysis at 16-17.

it does not recommend that such a program be developed as part of Baltimore's behavioral health system. There is no evidence that mandating outpatient services through a court order has any additional benefit.[25]There is, on the other hand, ample evidence that the services that are identified in the gap analysis and recommendations (such as ACT, permanent supported housing, and mobile crisis services), provided on a voluntary basis, can bring tremendous improvements in outcomes including reduced hospitalizations, reduced arrests, greater housing stability, and reduced symptoms.

As Baltimore's behavioral health system improves and expands, including expanding its capacity to provide ACT and other case management services, the BPD should reduce and eventually end its Law Enforcement Assisted Diversion (LEAD) pilot program, which also provides case management and linkage services. We have heard BPD representatives describe the LEAD program as a "stopgap" while more robust, community-based services, including case management, are developed. A principle goal of implementation of the gap analysis' recommendations should be to completely eliminate the need for BPD involvement in coordinating and providing services to persons with behavioral health disabilities. That should be the function of the public behavioral health system. In the short term, BPD officers should end the practice of "social contact referrals" to LEAD, whereby (as we understand it) officers stop persons who are not suspected of criminal activity and refer them to LEAD.[26] Officers should be directed to refer individuals who appear to need behavioral health services to crisis teams, outreach teams, or other service providers, without actually approaching the individual in need (and BPD must provide a protocol and training for how this will work). In the longer term, we hope that the expertise of those working in the LEAD program, and other program resources, can be used to strengthen similar services in Baltimore's behavioral health system. We expect that the implementation of the gap analysis will determine when and how LEAD will be shrunk, as progress is made in developing case management and other long-term services in the behavioral health system.

3. To be effective, Baltimore's behavioral health services must be culturally competent, non-discriminatory, and result in improved life outcomes. The system must seek and meaningfully include input from the community in achieving these goals.

The gap analysis identifies the cultural competence of the services provided through Baltimore's public behavioral health systems as a key impediment to the effectiveness of the services. Specifically, the report cites concerns about services provided to Spanish-speaking residents or members of the LGBTQIA communities. We echo these concerns and also add our concern that

[25] *See* National Coalition for Mental Health Recovery, *Involuntary Outpatient Commitment: Myths and Facts* 1 (Apr. 3, 2014), https://www.ncmhr.org/downloads/NCMHR-Fact-Sheet-on-Involuntary-Outpatient-Commitment-4.3.14.pdf; Michael Rowe, Ph.D., *Alternatives to Outpatient Commitment*, 41 J. Amer. Acad. of Psych. & the Law 332 (2013), https://pdfs.semanticscholar.org/46ed/ffc4ecf0ec32a854f7dda1d5c1e734f48515.pdf.

[26] *See* Prater Letter, *supra* note 16, at 3-5 (noting that 75% of BPD's LEAD cases result from "social contact referrals" of persons from Baltimore's downtown business district, the majority of whom are persons of color).

provider staff may be insensitive to the challenges faced by residents of Baltimore's historically poor, predominantly Black western and eastern neighborhoods.[27] Providers must take steps to ensure that staff understand the cultural norms and socio-economic challenges of these communities, including by training with community members with lived experience. Services must be delivered in a way that acknowledges the various traumas residents of these neighborhoods have experienced – as well as those experienced by provider staff – while advancing a person-centered, recovery-focused approach to providing services.

Staff should also be trained in how to avoid both implicit and explicit bias in providing supports to people of color, people with mental health impairments, individuals with substance use histories, homeless people, and others. Studies show that biases about persons of color, drug users, and homeless people are as likely to be found among staff at social service agencies as they are to be found anywhere else, including in criminal settings.[28] As the gap analysis notes, "attitudes about drug use have led to resistance to safe consumption sites and other harm-

---

[27] *See*, *e.g.*, National Alliance on Mental Illness (NAMI), *African American Mental Health* (last visited Oct. 31, 2019) ("Conscious or unconscious bias from providers and lack of cultural competence result in misdiagnosis and poorer quality of care for African Americans."), https://www.nami.org/find-support/diverse-communities/african-americans; Black Mental Health Allicance, *History & Overview* (last visited Oct. 31, 2019) (despite progress, "specialized professional development and continuing education are still needed to give cultural insight to mental health practitioners and other professionals who serve Black families and communities of color" in Baltimore), https://blackmentalhealth.com/history-and-overview/.

[28] *See*, *e.g.*, Benjamin Le Cook et al., *Assessing Racial/Ethnic Disparities in Treatment across Episodes of Mental Health Care*, 49 Health Servs. Res. 206 (2013) (Blacks and Latinx individuals had lower adequacy of care than white individuals), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3844061/; Yumiko Aratani & Janice Cooper, *Racial and Ethnic Disparities in the Continuation of Community-Based Children's Mental Health Services*, 39 Journal of Behavioral Health Servs. Res. 116 (2012) (non-English speaking children of color less likely to continue receiving services than were English-speaking white children), https://www.researchgate.net/publication/51792097_Racial_and_Ethnic_Disparities_in_the_Continuation_of_Community-Based_Children's_Mental_Health_Services ; Lyndonna Marrast, et al., *Racial and Ethnic Disparities in Mental Health Care for Children and Young Adults: A National Study*, 46 Int'l Journal of Health Servs. 810 (2016) (Black and Latinx children received less outpatient mental health care than white children did), https://journals.sagepub.com/doi/abs/10.1177/0020731416662736 ; Ana Balsa, et al., *Testing for Statistical Discrimination in Health Care*, 40 Health Servs. Res. 227 (2005) (people of color less likely to have depression diagnosed than were white people; evidence found that race affects medical care decisions), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361135/; Seth Prins, et al., *Exploring Racial Disparities in the Brief Jail Mental Health Screen*, 39 Crim. Justice Behav. 635 (2012) (Black and Latinx individuals less likely to be screened positive for mental health issues; Black and Latinx individuals were 50% less likely than whites to have been hospitalized or to be taking psychiatric medications), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4768817/ .

reduction strategies, such as needle exchange programs or even access to peer support services."[29] Regular training to help eradicate these biases is a must. Incorporating peers into services, including ACT and crisis response teams and as part of supported employment services, should help.

The gap analysis suggests a concern with the effectiveness of certain community-based services offered through Baltimore's public behavioral health system, such as Psychiatric Rehabilitation Program (PRP) services, which are used by more individuals than ever before.[30] The effectiveness of services in the system, and the outcomes experienced by persons using the services, should be continuously monitored through a robust quality improvement system. Whether this is the province of the Maryland Department of Health and its Behavioral Health Administration, or Behavioral Health Systems Baltimore (BHSB), expectations for service quality should be set and regularly measured. Contracts with providers should include incentives for good performance, as measured by improved outcomes, and indicate how performance deficits will be penalized.

4. <u>All BPD officers should receive crisis intervention team (CIT) training, but resources for such training should not be taken away from those needed for expansion and improvement of the behavioral health system</u>.

We agree with the recommendation that CIT training should be ongoing and provided to all BPD officers, whether they become official CIT-response officers or not. Even after Baltimore's behavioral health system is expanded and enhanced, BPD officers will in their normal course of duty be called to respond to incidents involving people with behavioral health disabilities or who are in crisis. This happens even when 911 dispatchers have been fully trained on when and how to refer behavioral health calls to non-BPD crisis response teams (including ACT teams), and even when the dispatchers have information about the names of individuals likely to be involved in such calls, or the street addresses where such incidents may more often take place. (For this reason, we support the recommendation that 211 and crisis hotlines continue to be developed and vigorously promoted as an alternative to 911 for behavioral health crisis calls.) Although at least one empirical study found no statistically significant evidence that CITs have a beneficial effect on either arrests of individuals with mental disorders or on police safety,[31] a more recent study

[29] Gap Analysis at 50.

[30] *Id.* at 3, 40. The gap analysis indicates that some PRP services are provided in day treatment and residential settings. *Id.* at 30. We note that many jurisdictions are moving away from providing PRP services in group home or segregated day settings, and are more likely to provide the skills training and other services associated with PRPs in integrated settings, including in supported employment or education. We encourage the parties to consider, as part of their implementation efforts, whether in the future PRP services should be provided in integrated settings to improve their effectiveness.

[31] *See* Sema A. Taheri, *Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis*, 27 Crim. Just. Pol. Rev. 76 (2016),

found evidence that CIT training contributes to improvements in knowledge and attitudes with respect to behavioral health issues, and some evidence of reduced use of force in encounters with individuals with behavioral health disabilities.[32] All BPD officers would be better prepared to handle whatever calls involving behavioral health crises they may respond to, with CIT training that focuses on, in addition to de-escalation techniques, awareness of behavioral health issues, promoting relationships with service providers, and implicit and explicit bias-reduction instruction.

In the interest of building a robust community-based behavioral health system that meets the needs of all Baltimore residents, including those with behavioral health disabilities, however, resources to provide CIT training to BPD officers should not come from the same budget as those resources needed to provide effective services, including permanent supported housing, to individuals who need them. To be clear, *any* BPD officer's appearance in a behavioral crisis situation, whether the officer is CIT trained or not, may exacerbate the trauma associated with behavioral health "crises." We assume these resources come from different sources – that, for example, expansion and enhancements of permanent supported housing and community-based services are a function of state regulation and legislation, including appropriations. But if this is not the case we strongly believe that expansion of both crisis response and longer-term services is the City's top priority—over CIT training for BPD officers—because expansion and creation of these services would greatly reduce the possibility of the inappropriate interactions of BPD officers with people with behavioral health disabilities.

We also offer the following additional comments on specific aspects of the gap analysis:

- It is unclear to us whether the gap analysis included enough information from Baltimore residents with lived experience in the behavioral health system. Gap Analysis at 22-23 (describing seven "key informant focus groups"). In general, we believe it critical for any systems change effort to include and meaningfully respond to the concerns of members of the community the system serves. In this case that means listening to people with behavioral health disabilities themselves. Also, as noted above the effort to implement the recommendations must include persons with disabilities themselves, at every level and phase of the process.[33]

---

https://pdfs.semanticscholar.org/1ba4/b9f49e5948d8d0741de81f070b4b28c9ce2f.pdf?_ga=2.110150597.1545302355.1572631211-1683049900.1572631211.

[32] *See* Amy C. Watson et al., *The Crisis Intervention Team (CIT) Model: An Evidence-Based Policing Practice?*, 35 Behavioral Sci. L. 431 (2017), https://onlinelibrary.wiley.com/doi/abs/10.1002/bsl.2304; *see also* Michael T. Compton et al., *Police Officers' Volunteering for (Rather than Being Assigned to) Crisis Intervention Team (CIT) Training: Evidence for a Beneficial Self-Selection Effect*, 35 Behavioral Sci. L. 470 (2017), https://www.semanticscholar.org/paper/Police-officers'-volunteering-for-(rather-than-to)-Compton-Bakeman/17c2c21a558b14bc2f592a1c6449f65b6c55358b.

[33] We also believe it a significant problem that HSRI could not obtain individual level outcomes measurement data in time for publication of the gap analysis, which would have provided more

- As the gap analysis suggests, it is a problem that "the majority of mental health and SUD services cannot be billed on the same day." Gap Analysis at 43. This is a problem for the Maryland Departments of Health and Human Services, Maryland's mental health and Medicaid agencies, to address. Similarly, the Departments should address whether targeted case management services can be made available for individuals with psychiatric disabilities who also have a primary diagnosis of a substance use disorder, *id.* at 54,[34] and whether inter-agency service coordination, now "largely a grant funded service," can be made Medicaid reimbursable. *Id.* at 81.

- The gap analysis notes "challenges with information sharing and barriers to collaboration" due to the Health Insurance Portability and Accountability Act (HIPAA). Gap Analysis at 51. In communities where we work we often hear concerns about whether HIPAA compliance prevents the sharing of information among agencies serving people with behavioral health disabilities, including providers but also law enforcement, jails, and schools. Engaging people in understanding the value to them of such information sharing is key. Some communities are exploring global releases and memoranda of understanding among the agencies providing services in the community as a means of facilitating lawful and helpful information sharing.

- The gap analysis notes that under the now-defunct "Second Chance" pilot program, community providers began delivering services to individuals at the Baltimore jail for roughly four months before discharge, which provided for "a therapeutic relationship to be formed that was then continued upon release." Gap Analysis at 57. We note that this model, in which service providers either track clients who are incarcerated, or connect with individuals with behavioral health disabilities through pre-discharge service planning, have been successful at effectively engaging such individuals in community-based services following transition from jail or prison. As it implements the gap analysis' recommendations, the BHSB, the City, the State, and other stakeholders should consider how such a program can be reinstituted in Baltimore.[35]

- The gap analysis focuses appropriately on recommendations addressing workforce development issues. Gap Analysis at 111-112. There is a need nationwide to continue to

---

granular data for use in estimating trends among the population of persons receiving services from Baltimore's system. This data needs to be made available to the implementation effort going forward.

[34] *Cf. Olmstead* at 20, *supra* note 5, at 9 ("Fragmented mental health and substance abuse treatment systems fail to provide fully integrated care for such persons, further exacerbating both conditions and elevating the risk for arrest and incarceration.").

[35] *See* A Bridge to the Possible, *supra* note 17, at 16 ("For individuals in jails or prisons, case management should ideally begin before release and continue throughout the transition to the community.").

develop a cadre of qualified provider staff to work in community-based settings. In our experience in communities seeking to meet their ADA integration obligations by rebalancing their behavioral health systems, this has usually required the participation of state mental health and Medicaid agencies, which can set rates that include premiums to attract qualified staff to community-based providers, provide training on effective practices to provider staff, and work with state universities on long-term training and workforce development strategies.

The Bazelon Center and Disability Rights Maryland appreciate the opportunity to comment upon the Baltimore public behavioral health system gap analysis. We hope the gap analysis will result in the expenditure of resources to implement its recommendations, which should significantly reduce the number of inappropriate interactions between law enforcement personnel and Baltimore residents with behavioral health disabilities, in so doing better protecting the civil rights of this population. In our view, compliance with the Consent Decree requires implementation of the recommendations.

Please feel free to contact Lewis Bossing, Senior Staff Attorney, at lewisb@bazelon.org or (202) 467-5730 x1307 with any questions about these comments.

Sincerely,

/s/
Jennifer Mathis
Director of Policy and Legal Advocacy
Bazelon Center for Mental Health Law

Lewis Bossing
Senior Staff Attorney
Bazelon Center for Mental Health Law

David A. Prater
Managing Attorney
Disability Rights Maryland