BALTIMORE CITY COUNCIL
COMMITTEE OF THE WHOLE

Mission Statement

On behalf of the Citizens of Baltimore City, the Public Safety Committee will be responsible for matters concerning public safety, including, but not limited to, emergency preparedness, police services, fire/EMS, & their administrative functions.

The Honorable Zeke Cohen

CHAIR

PUBLIC HEARING

8/27/2025

5:00PM
CLARENCE "DU" BURNS COUNCIL CHAMBERS

LO25-0026

Legislative Oversight – Crisis Response

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Office of Council Services
Nancy Mead – Director
100 Holliday Street, Room 415
Baltimore, MD 21202

COMMITTEE OF THE WHOLE

The Honorable Council President Zeke Cohen
CHAIR

Legislative Oversight Hearing

LO25-0026
Legislative Oversight – Crisis Response

For the purpose of reviewing resources available to respond to individuals experiencing behavioral health crises in Baltimore City, assessing the integration and implementation of specific agencies' responses to such individuals, and determining improvements needed to city agencies' and partners' coordination and response to these crises

BACKGROUND

Baltimore City recently experienced a spate of police involved deaths, several of which were preceded by active mental health crises. And, while these incidents are under active investigation by the Maryland Office of the Attorney General[1] and, accordingly, are not themselves the focus of the Council's hearing, their occurrence in quick succession does highlight potential gaps in the City's crisis response system, warranting an assessment of those potential gaps by the City Council.

On June 17, 2025, well-known arabber, Bilal "BJ" Abdullah Jr. was shot during an encounter with Baltimore Police (BPD).[2]

Just one week later, at about 9:40 PM on June 24, 2025, Dontae Melton approached a marked BPD car and asked officers for help, claiming someone was chasing him.[3] Officers initially responded by requesting a medic to transport Melton to the hospital before detaining Melton to keep him out of the street.[4] At 10:12 PM, with a medic yet to arrive, officers reported that Melton was unconscious, and at 10:27 PM, with a medic still yet to arrive, police transported Melton to the hospital themselves.[5] By early June 26, Melton was dead.[6]

Less than 24 hours after Dontae Melton approached BPD officers for help, police and fire officials responded to two 911 calls reporting a behavioral health crisis at a residence.[7] In just the current calendar year, police have received about 20 previous calls reporting a mental health crisis at the same residence.[8] Upon arrival, officials encountered 70-year-old Pytorcarcha Brooks who was later shot before being pronounced dead at a hospital.[9]

While investigation into each event by the Maryland Office of the Attorney General is ongoing,[10] the incidents left many residents frustrated with the City's crisis response system(s) and the actions of those currently responsible for responding to mental health crises.[11]

Increasing public attention to mental health crises, and the less-than clear approach to responding to those crises, is not unique to Baltimore. In 2020, in response to growing concerns about the state of the nation's mental health, Congress designated 988 as a National Suicide and Crisis Lifeline.[12] Subsequently, Maryland took steps to implement the law at the state level and the state is now home to several call centers hosting trained specialists who can provide resources and assistance to callers experiencing mental health crises.[13] Baltimore City has also taken steps to bolster the state's 988 system.[14] In July 2025, the Board of Estimates approved a five-year $10 million grant for Behavioral Health System Baltimore (BHSB) and its 988 hotline partners.[15]

City services designed to address mental health crises predate recent efforts to reinforce the state's 988 service and stem, in significant part, from the City's 2017 Consent Decree with the Department of Justice. In relevant part, the Agreement requires that the City work to identify gaps in its behavioral health system, recommend solutions, and implement those solutions as appropriate.[16] In addition, the agreement also requires that BPD revise its crisis intervention policies to establish a "least police-involved response," to divert individuals experiencing mental health crises to a behavioral health service whenever the response and diversion are consistent with public safety, and train officers to respond to behavioral health crises.[17]

Since the Consent Decree, the City has taken action to improve BPD's response to behavioral health crises; however, the City's broader behavioral health ecosystem remains fragmented and largely outside of direct City oversight. In 2021, working alongside non-profit actors including BHSB and Baltimore Crisis Response, Inc. (BCRI), the City launched a 911 diversion program to redirect appropriate calls from 911 to mental health professionals via the 988 helpline.[18] However, the diversion rate for 911 calls is low and BPD reports that many eligible calls are not diverted to 988, BHSB, BCRI, or another mobile crisis team, often leaving police as city resident's primary mental health crisis response team.[19]

FISCAL NOTE

City spending on mental health services is primarily allocated through the Baltimore City Health Department's (BCHD's) budget; however, that spending is entwined with spending related to substance abuse disorder.[20] In total, the City budgeted over $9.8 million for BCHD spending related to substance abuse disorder and mental health in fiscal year (FY) 2026.[21] This represents a significant increase from FY 2025 wherein the City budgeted just over $5.2 million, which itself was about a $2 million increase from the FY 2024 spend.[22] The primary driver for the increased budget for this BCHD service is the City's receipt of funds following the settlement of several lawsuits against opioid manufacturers and related pharmaceutical companies.[23] Similarly, the $10 million grant awarded by the Mayor's Office of Recovery Programs to BHSB and 988 partners is allocated from the City's Opioid Restitution Fund.[24]

REPORTING AGENCIES

- Baltimore Police Department
- Baltimore City Fire Department
- Baltimore Crisis Response Inc
- Baltimore City Health Department
- Behavioral Health Systems Baltimore

CITATIONS

[1] Id.; https://www.cbsnews.com/baltimore/news/baltimore-police-body-cam-footage-west-baltimore-arabber-shooting/
[2] https://www.cbsnews.com/baltimore/news/baltimore-police-body-cam-footage-west-baltimore-arabber-shooting/
[3] https://www.thebaltimorebanner.com/community/local-news/dontae-melton-baltimore-police-custody-death-HQHHHJTUKVCCPJCNDX4TSFJCDU/
[4] https://www.thebaltimorebanner.com/community/local-news/dontae-melton-baltimore-police-custody-death-HQHHHJTUKVCCPJCNDX4TSFJCDU/
[5] Id.
[6] Id.
[7] https://www.thebaltimorebanner.com/community/local-news/west-baltimore-police-involved-shooting-DZHVCFUC55H65G4NI2NAL7D5PY/
[8] Id.
[9] https://www.cbsnews.com/baltimore/news/police-response-to-mental-health-crisis-pytorcarcha-brooks-dontae-melton/
[10] Id.; https://www.cbsnews.com/baltimore/news/baltimore-police-body-cam-footage-west-baltimore-arabber-shooting/
[11] https://www.cbsnews.com/baltimore/news/police-response-to-mental-health-crisis-pytorcarcha-brooks-dontae-melton/
[12] https://www.baltimoresun.com/2022/07/18/new-988-national-maryland-suicide-and-crisis-hotline-is-up-and-running/
[13] https://www.baltimoresun.com/2022/07/18/new-988-national-maryland-suicide-and-crisis-hotline-is-up-and-running/
[14] https://www.baltimoresun.com/2025/07/16/baltimore-spending-board-shuffles-10-million-for-mental-health-crisis-hotline/
[15] Id.
[16] https://www.justice.gov/opa/file/925056/dl?inline=
[17] Id.
[18] https://consentdecree.baltimorecity.gov/sites/default/files/behavioral-health-report-0725.pdf
[19] Id.
[20] https://bbmr.baltimorecity.gov/sites/default/files/upload/FY2026%20Agency%20Detail%20Volume%20I.pdf
[21] Id.
[22] Id.
[23] Id.
[24] https://comptroller.baltimorecity.gov/sites/default/files/2025-07-16-AgendaWithTOC%20FINAL%20AGENDA.pdf

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Analysis Date: 8/13/2025

BALTIMORE CITY COUNCIL

COMMITTEE OF THE WHOLE

LO25-0026

Legislative Oversight – Crisis Response

Agency Reports

911/988 Call Diversion

Brandon M. Scott
Mayor

911/988 Diversion

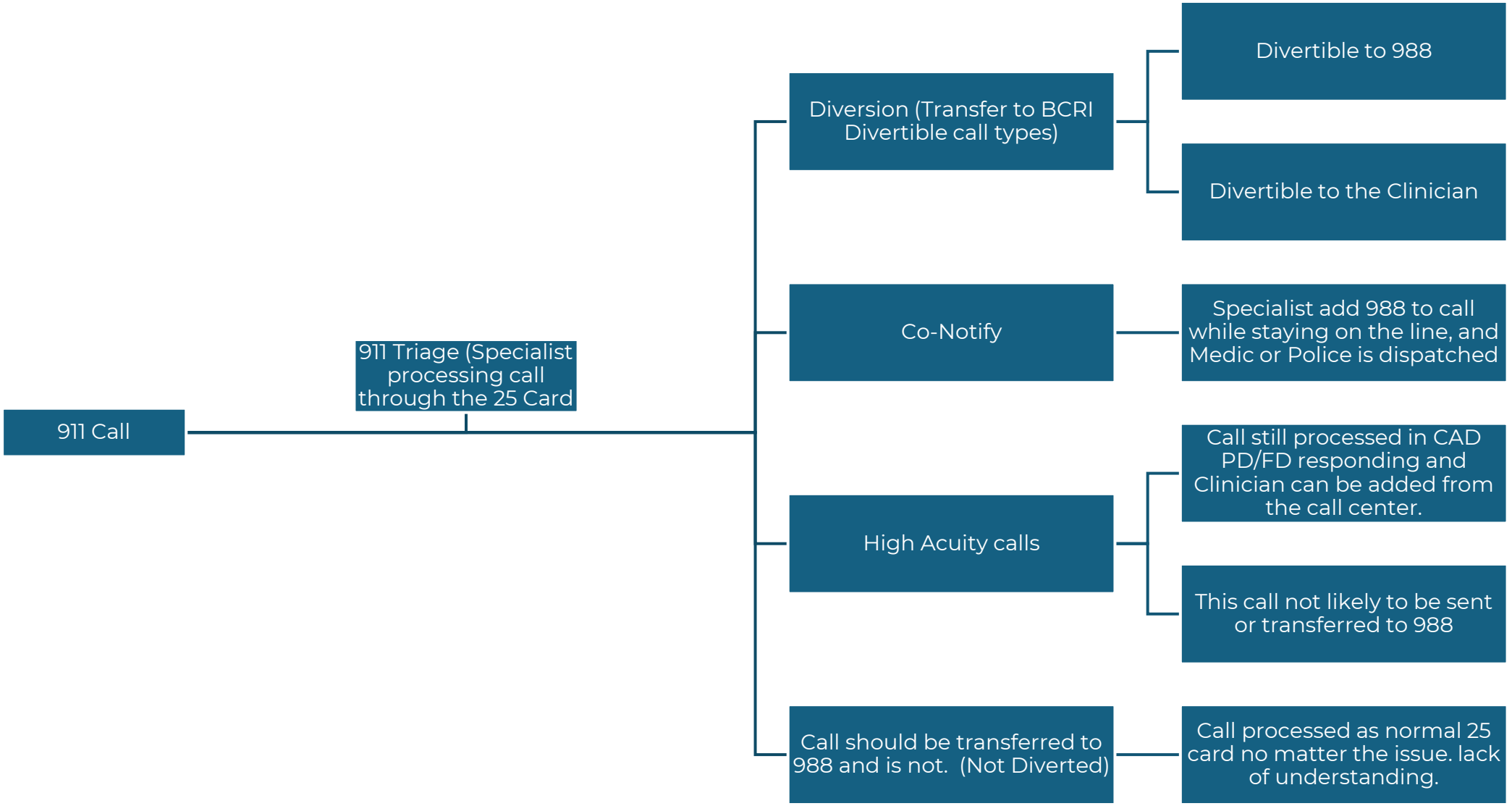
Why We Do Diversion

- Diversion allows us to connect callers experiencing a behavioral health crisis directly with trained clinicians instead of automatically sending police or fire. The goal is to provide the *right response, at the right time*, reducing unnecessary emergency responses while ensuring the caller receives specialized mental health support. It improves outcomes for the community, eases the load on first responders, and ensures individuals in crisis get help that's appropriate to their needs.

Why We Use the 25 Card (IAED)

- The IAED 25 Card is the standard protocol for handling psychiatric, abnormal behavior, and suicide-related calls. It gives our specialists a structured, consistent framework for triaging these sensitive calls. By using the 25 Card, we can:
  - Ask the right questions in the right order.
  - Determine the severity of the situation.
  - Decide whether the call can be diverted, co-notified, or needs an immediate police/fire response.
  - This ensures we're not relying on guesswork, but instead following an internationally recognized, evidence-based system that supports both caller safety and operational consistency.

911/988 Diversion/Clinician Call Flow Chart



911/988 Diversion/Clinician Call Flow Chart

Explanation (for your understanding):
Start: Every call begins with a 911 specialist using the 25 Card to triage.
Diversion: If it's the right type of call, it can be diverted to 988 or a clinician.
Co-Notify: Sometimes both 911 and 988 stay involved — 988 clinician is looped in while 911 still dispatches services.
High Acuity Calls: If it's serious (violent, life-threatening, etc.), it stays in CAD and goes to police/fire, with clinician support added if possible.
Missed Transfers: Sometimes calls that should go to 988 don't, and they end up being handled as standard 25 Card cases.

911 Diversion
Call Type Explanation

	EMD V14
Call Types	Diversion or Co-Notify
25O01 Non-Suicidal and alert (Hist. Mental Health Conditions)	Diversion
25O02 Suicidal Ideations and alert (Hist. Mental Health Conditions)	Diversion
25A01 Non-Suicidal and Alert	Diversion
25A02 Suicide Ideation and alert	Diversion
25A03 (Suicidal Ideations) Ingestion of Medication/Substances	Co-Notify
25B01 Serious Hemorrhage	FD response / BPD Response
25B02 Non-Serious or Minor Hemorrhage	FD response / BPD Response
25B03 Intending Suicide	Diversion
25B04 Jumper (Threatening)	FD response/ BPD response (Co-Notify Optional)
25B05 Near Hanging, Strangulation or Suffocation	FD response / BPD response (Co-Notify Optional)
25B06 Unknown status / Other Codes not applicable	Diversion
25C01 Altered LOC (Hist. Mental Health Condition)	Diversion
25C02 Altered LOC (Unknown Hist. Ment. Health Cond.)	Use 26CARD Sick Person to Process call
25C03 Altered LOC (Ingestion of Medications/Substances)	FD response (Co-Notify)
25C04 Altered LOC (Sud. Chang. In Behavior/Personality)	FD response (Co-Notify)
25D01 Arrest	FD response / BPD response
25D02 Unconscious	FD response / BPD response
25D03 Not alert	FD response / BPD response
25D04 DANGEROUS Hemorrhage	FD response / BPD response
25D05 Near Hanging, Strangulation or Suffocation	FD response / BPD response
25D06 Jumped Now	FD response / BPD response

All Children 12 years and older can be diverted. C Suffix = Co-Notification to BCRI.

Double check the suffixes V- Violent, W-Weapons, B-Violent & Weapons (PD Added to Call), **C-Crisis Team/Alternative Response (BCRI/Diversion), D-Crisis Team/Alternative Response w/Violence or Weapons (BPD Response), T-Threatening Self-Immolation (BPD Response)

911 Diversion Call Type Explanation

Explanation (for your understanding):

Diversion vs. Co-Notify:

- Diversion = call can be fully handed off to 988/BCRI.
- Co-Notify = 911 still dispatches police/fire but adds a clinician to the call.

Examples of Diversion Calls:

- 25O01: Non-suicidal, alert, with mental health history.
- 25O02: Suicidal ideations, alert, with mental health history.
- 25A01–25A02: Non-suicidal/alert or suicidal/alert.

Examples of Co-Notify/Not Divertible:

- 25A03: Suicidal ideations with ingestion of meds/substances (clinician added, but FD still responds).
- 25B04–25B05: Jumper or near hanging (requires FD/BPD).
- Serious emergencies (arrest, unconscious, hemorrhage) — must remain with FD/BPD.

Special Notes:

- **C Suffix** = co-notify to BCRI.
- **V, W, B, D, T Suffixes** = violent/weapons/self-immolation → must stay with BPD.
- Children 12+ years = eligible for diversion.

BCFD EMS

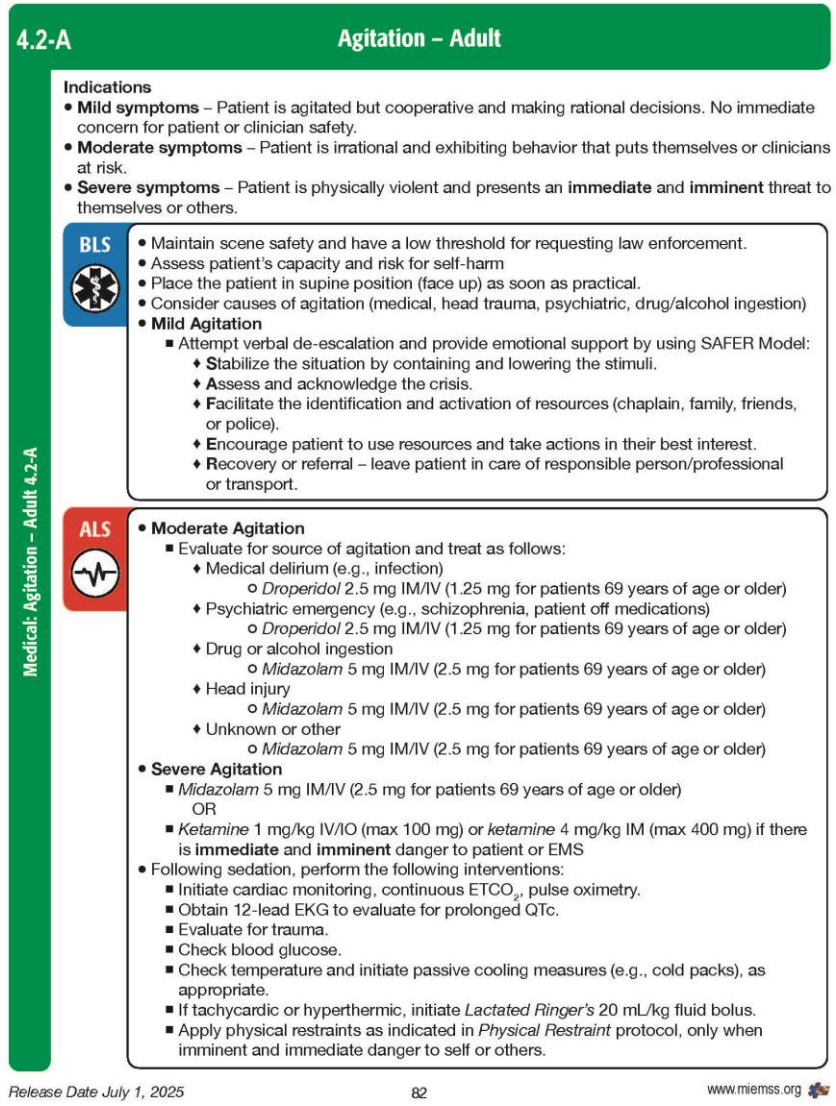
Assistant Chief James Matz

Role

- First medical contact for individuals in crisis
- 24/7 citywide coverage
- Initial stabilization of medical conditions (e.g., overdose, injury, altered mental status)
- Support for scene safety alongside BPD and crisis response teams
- Bridge to behavioral health and social service resources

MMP – Agitation Protocol

- **Safety first**
- **Rule out medical causes**
- **Standardized patient assessment: vital signs, airway/breathing/circulation, mental status**
- **Physical exam to identify concurrent medical issues**



4.2-A Agitation – Adult

Medical: Agitation – Adult 4.2-A

Indications

- **Mild symptoms** – Patient is agitated but cooperative and making rational decisions. No immediate concern for patient or clinician safety.
- **Moderate symptoms** – Patient is irrational and exhibiting behavior that puts themselves or clinicians at risk.
- **Severe symptoms** – Patient is physically violent and presents an **immediate** and **imminent** threat to themselves or others.

BLS

- Maintain scene safety and have a low threshold for requesting law enforcement.
- Assess patient's capacity and risk for self-harm
- Place the patient in supine position (face up) as soon as practical.
- Consider causes of agitation (medical, head trauma, psychiatric, drug/alcohol ingestion)
- **Mild Agitation**
  - Attempt verbal de-escalation and provide emotional support by using SAFER Model:
    - **S**tabilize the situation by containing and lowering the stimuli.
    - **A**ssess and acknowledge the crisis.
    - **F**acilitate the identification and activation of resources (chaplain, family, friends, or police).
    - **E**ncourage patient to use resources and take actions in their best interest.
    - **R**ecovery or referral – leave patient in care of responsible person/professional or transport.

ALS

- **Moderate Agitation**
  - Evaluate for source of agitation and treat as follows:
    - Medical delirium (e.g., infection)
      - *Droperidol* 2.5 mg IM/IV (1.25 mg for patients 69 years of age or older)
    - Psychiatric emergency (e.g., schizophrenia, patient off medications)
      - *Droperidol* 2.5 mg IM/IV (1.25 mg for patients 69 years of age or older)
    - Drug or alcohol ingestion
      - *Midazolam* 5 mg IM/IV (2.5 mg for patients 69 years of age or older)
    - Head injury
      - *Midazolam* 5 mg IM/IV (2.5 mg for patients 69 years of age or older)
    - Unknown or other
      - *Midazolam* 5 mg IM/IV (2.5 mg for patients 69 years of age or older)
- **Severe Agitation**
  - *Midazolam* 5 mg IM/IV (2.5 mg for patients 69 years of age or older)
    OR
  - *Ketamine* 1 mg/kg IV/IO (max 100 mg) or *ketamine* 4 mg/kg IM (max 400 mg) if there is **immediate** and **imminent** danger to patient or EMS
- Following sedation, perform the following interventions:
  - Initiate cardiac monitoring, continuous $ETCO_2$, pulse oximetry.
  - Obtain 12-lead EKG to evaluate for prolonged QTc.
  - Evaluate for trauma.
  - Check blood glucose.
  - Check temperature and initiate passive cooling measures (e.g., cold packs), as appropriate.
  - If tachycardic or hyperthermic, initiate *Lactated Ringer's* 20 mL/kg fluid bolus.
  - Apply physical restraints as indicated in *Physical Restraint* protocol, only when imminent and immediate danger to self or others.

Refusal Protocol

- **Deescalate & assess**
- **Behavioral health screening for risk to self/others**
- **Medical clearance per Maryland EMS Protocols before transport**

(4) Secondary survey – directed by the chief complaint
  (a) Medical calls – exam of lungs, heart, abdomen, and extremities. Blood glucose testing for patients with Diabetes Mellitus. Neurological exam for altered consciousness, syncope, or possible stroke.
  (b) Trauma calls – for patients meeting criteria in the Maryland Medical Protocols Trauma Decision Tree recommending transport to a Trauma Center: exam of neck and spine, neurological exam, palpation and auscultation of affected body regions (chest, abdomen, pelvis, extremities).

(5) Capability to make medical decisions (complete questions 1 through 4 on the Patient-Initiated Refusal of EMS form):
  (a) Disorientation to person, place, time, situation
  (b) Evidence of altered level of consciousness resulting from head trauma, medical illness, intoxication, or other cause
  (c) Evidence of impaired judgment from alcohol or drug ingestion
  (d) Language communication barriers were removed by assuring "language line" translation when indicated
  (e) The patient understands the nature of the illness

D. Following the assessment, complete items 5 through 9 on the Patient-Initiated Refusal of EMS Form, noting the presence of conditions that may place the patient at higher risk of hidden illness/injury or of worse potential outcome.

E. Management

(1) Patients at the scene of an emergency who meet criteria to allow self-determination shall be allowed to make decisions regarding their medical care, including refusal of evaluation, treatment, or transport. These criteria include:
  (a) Medical capacity to make decisions – the ability to understand and discuss the nature and consequences of the medical care decision
  (b) Adult (18 years of age or greater)
  (c) Those patients who have not reached their 18th birthday and are:
    (i) Married, **OR**
    (ii) Parent of a child, **OR**
    (iii) Requesting:
      a. Treatment for drug abuse or for alcoholism,
      b. Treatment for STI or for contraception,
      c. Treatment of injuries from alleged rape or sexual offense, **OR**
      d. Treatment for pregnancy-related conditions
    (iv) Living separate and apart from the minor's parent, parents, or guardian, whether with or without consent of the minor's parent, parents, or guardian, and is self-supporting, regardless of the source of the minor's income.
  (d) A patient who has been evaluated by EMS clinicians as having 'no' answers to questions 1, 2, 3a, 3b, and 4 on the Patient-Initiated Refusal of EMS

Refusal Protocol

Section One:
When encountering a patient who is attempting to refuse EMS treatment or transport, assess their condition and record whether the patient screening reveals any lack of medical decision-making capability (1, 2, 3a, 3b, and 4) or high risk criteria (5–8):

1. Disoriented to: Person? ❑ yes ❑ no
   Place? ❑ yes ❑ no
   Time? ❑ yes ❑ no
   Situation? ❑ yes ❑ no
2. Altered level of consciousness? ❑ yes ❑ no
3. Alcohol or drug ingestion by history or exam AND:
   a. Slurred speech? ❑ yes ❑ no
   b. Unsteady gait? ❑ yes ❑ no
4. Patient does not understand the nature of illness and potential for bad outcome? ❑ yes ❑ no

4A. **Judgment impaired by** severe illness or injury? ❑ yes ❑ no

If yes, transport

5. Abnormal vital signs
   For Adults
   Pulse greater than 120 or less than 60? ❑ yes ❑ no
   Systolic BP less than 90? ❑ yes ❑ no
   Respirations greater than 30 or less than 10? ❑ yes ❑ no
   For minor/pediatric patients
   Age inappropriate HR or ❑ yes ❑ no
   Age inappropriate RR or ❑ yes ❑ no
   Age inappropriate BP ❑ yes ❑ no
6. Serious chief complaint (chest pain, SOB, syncope) ❑ yes ❑ no
7. Head Injury with history of loss of consciousness? ❑ yes ❑ no
8. Significant MOI or high suspicion of injury ❑ yes ❑ no
9. For minor/pediatric patients: ALTE, significant past medical history, or suspected intentional injury ❑ yes ❑ no

If yes, consult

10. Clinician impression is that the patient requires hospital evaluation ❑ yes ❑ no

Section Two:
For clinicians: Following your evaluation, document information and care below:

1. Did you perform an assessment (including exam) on this patient? ❑ yes ❑ no
   If yes to #1, skip to #3
2. If unable to examine, did you attempt vital signs? ❑ yes ❑ no

Fire Department - MOP

MOP 809-3

MANUAL OF PROCEDURE DETAIL PROCEDURE	SECTION EMERGENCY MEDICAL SERVICES
	SUBJECT PATIENT CARE- MANAGING COMBATIVE PATIENTS AND BEHAVORIAL HEALTH RESPONSES

PURPOSE

The goal of this document is to give direction to both the Baltimore City Fire Department (BCFD) and Baltimore City Police Department (BPD) regarding the proper handling of a patient with behavioral health complaints and who don't have the capacity to refuse medical care encountered in the prehospital setting.

DEFINITIONS

Emergency Petition (EP): A petition for the emergent evaluation of an individual who is believed to **a**) have a mental disorder and **b**) pose a significant danger to the life and safety of the individual or others.

Emergency Petitioner: The person initiating the EP process against an individual. In the state of Maryland, healthcare providers (excluding EMS providers), peace officers or any interested party can initiate the EP process.

Capacity: Capacity describes a person's ability to a make a decision. In a medical context, capacity refers to the ability to utilize information about an illness and proposed treatment options to make a choice that is congruent with one's own values and preferences.

Situations where patients lack capacity

Situations where patients inherently lack capacity to refuse medical care include, but are not limited to:

1) Cases of altered mental status
2) Cases with obvious intoxication with alcohol or illicit substances
3) Cases with obvious head trauma or concern for traumatic injury to the head
4) Cases where the patient is hypoglycemic

Restraint

As mentioned above, EPs and lack of capacity cases often are carried out without the consent of the patient. In cases where patients are actively resisting efforts at treatment and transport, the restraint and administration of medication may be necessary. While BCFD personnel are responsible for the proper selection and administration of medication, it is the policy of the BCFD that personnel may not physically restrain a patient in the absence of a medical or safety imperative. Thus, if the determination is made that physical restraint is necessary for the safety of the patient and personnel, BPD officers will be expected to assist by providing restraint only when indicated. Restraint, as always, should be discontinued as soon as it is safe to do so.

- **Capacity describes a person's ability to a make a decision. In a medical context, capacity refers to the ability to utilize information about an illness and proposed treatment options to make a choice that is congruent with one's own values and preferences.**

Coordination

- Integration with BPD Crisis Intervention Teams (CIT)
- Coordination with Baltimore Crisis Response, Inc. (BCRI)
- Notification to BCHD Access Line for follow-up services
- Real-time consultation with medical control for complex cases
- Shared protocols for safe transfers between EMS and behavioral health providers

Challenges

- High call volume with repeat utilizers
- Limited capacity in crisis stabilization facilities
- Extended hospital offload times for psychiatric patients
- Safety risks for patients and providers during volatile situations
- Gaps in follow-up care after initial EMS contact

Emerging Trends

- Increase in co-occurring medical + behavioral health crises
- More youth behavioral health calls
- Greater demand for non-hospital crisis resources
- Pilot programs for EMS–mental health co-response models
- Use of telehealth for real-time psychiatric consultation

Brandon M. Scott
Mayor

Thank You

BALTIMORE CITY HEALTH DEPARTMENT

LO25-0026 - Legislative Oversight - Crisis Response

August 27, 2025

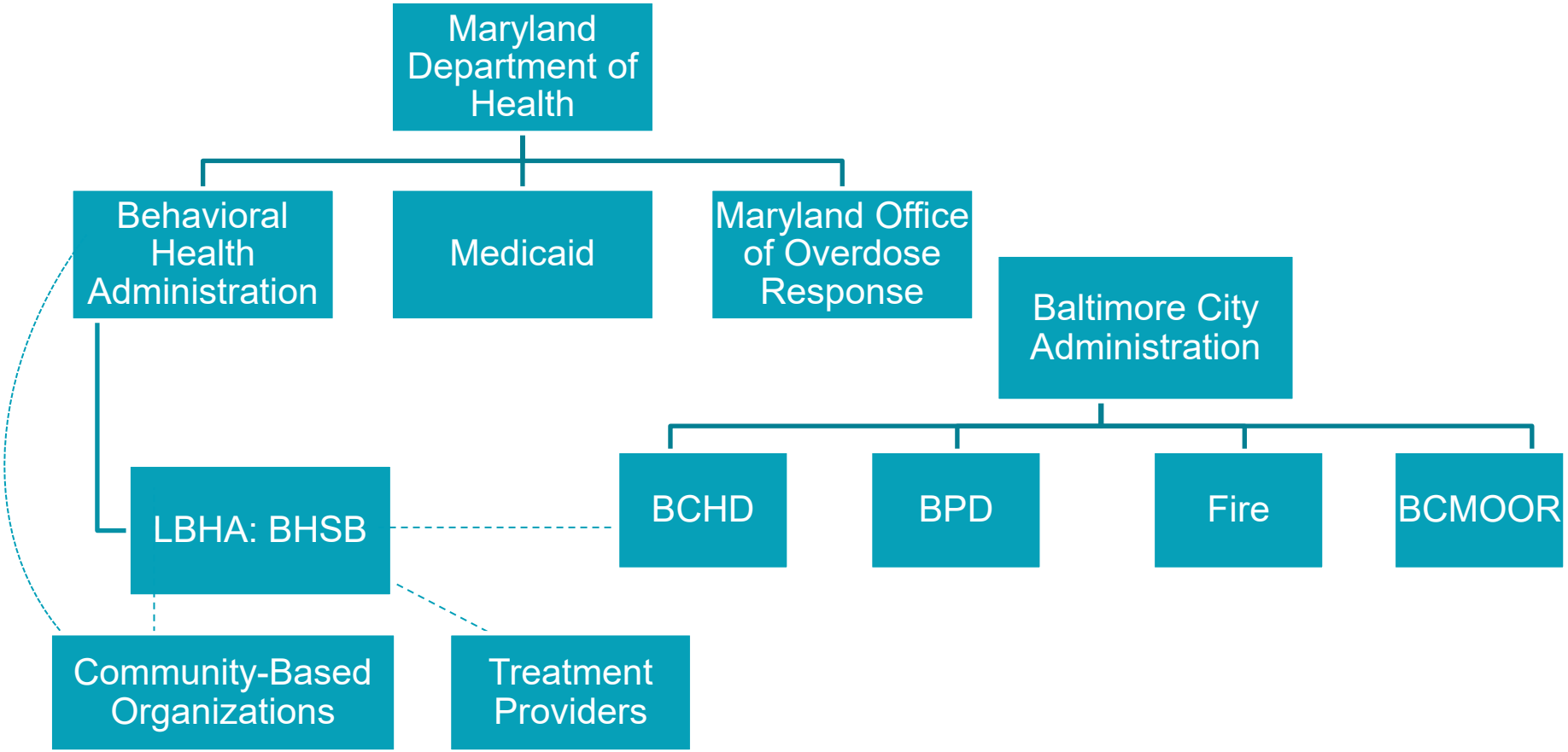
Brandon M. Scott
Mayor, Baltimore City
Michelle Taylor, MD, DrPH, MPA
Acting Commissioner of Health, Baltimore City

@Bmore_Healthy
BaltimoreHealth
health.baltimorecity.gov

Agenda

- Baltimore City's behavioral health ecosystem
- BCHD's participation in behavioral health crisis response
- Our new Division of Public Behavioral Health

Baltimore City's Behavioral Health Ecosystem



Brandon M. Scott
Mayor, Baltimore City
Michelle Taylor, MD, DrPH, MPA
Acting Commissioner of Health, Baltimore City

BALTIMORE CITY HEALTH DEPARTMENT

BCHD's Participation in Behavioral Health Crisis Response

Overdose Spike Alerts

EMS sends non-fatal overdose data to BCHD daily

BCHD epidemiologists create daily cluster report

BCHD sends reports to approved organizations

Organizations use alerts to inform their outreach and activities

Behavioral Health Collaborative

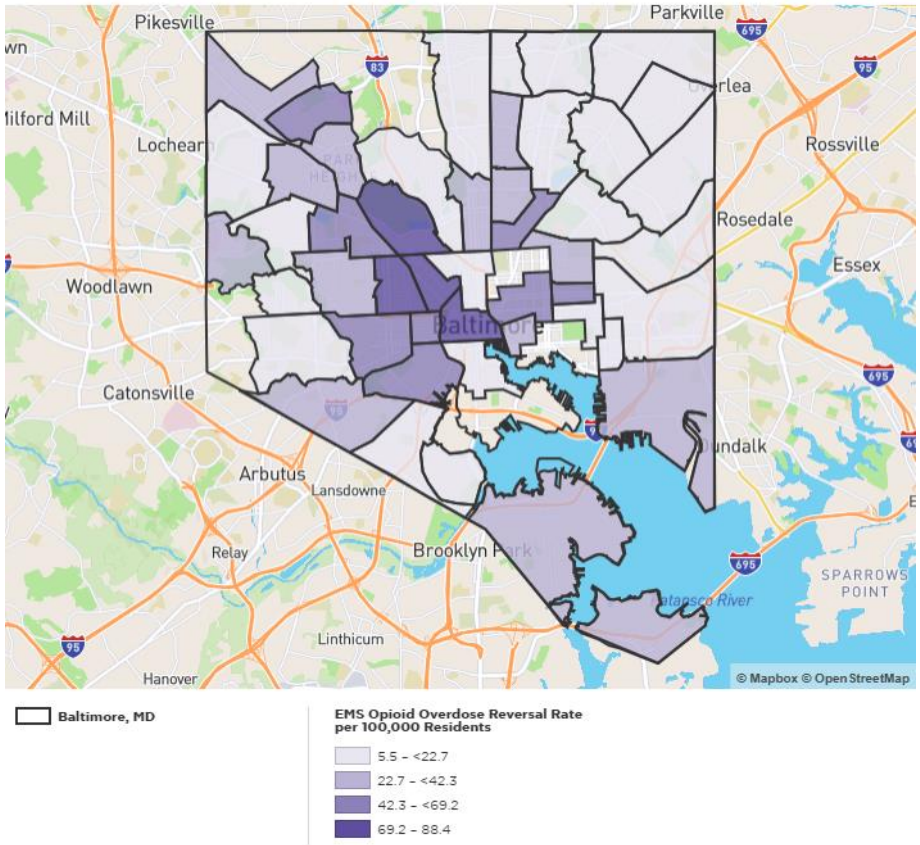
Sentinel Event Review

Brandon M. Scott
Mayor, Baltimore City
Michelle Taylor, MD, DrPH, MPA
Acting Commissioner of Health, Baltimore City

BALTIMORE CITY HEALTH DEPARTMENT

EMS Overdose Reversals

Rate of Naloxone Opioid Overdose Reversals Reported by EMS by Community Statistical Area (CSA), Baltimore City, January 2024 - May 2025 *

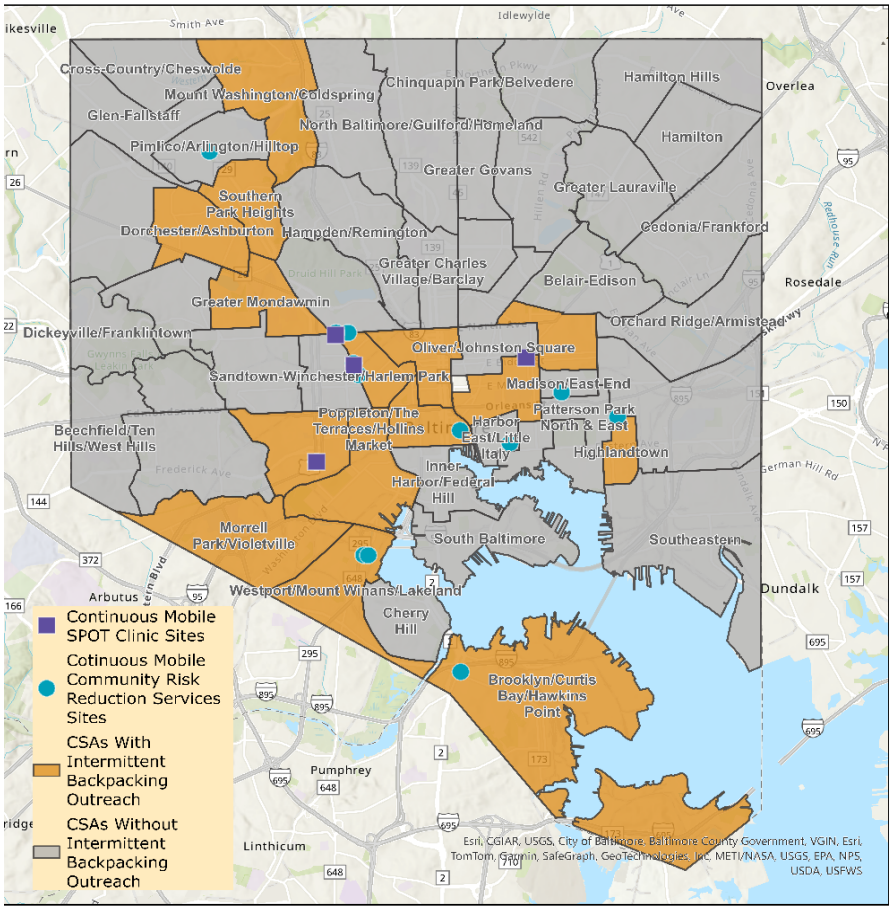


Data source: BCFD EMS. Map created on 6/24/25.

Missing CSAs are suppressed due to low counts of overdose reversals.

BCHD Naloxone Distribution & Training

Baltimore City Health Department Overdose Prevention Outreach Map by Community Statistical Area as of 8/21/25



Community Statistical Areas (CSAs) are geographical boundaries used to approximate neighborhoods in Baltimore City. Map created by the Baltimore City Health Department on 8/21/2025.

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Michelle Taylor, MD, DrPH, MPA
Acting Commissioner of Health, Baltimore City

BALTIMORE CITY HEALTH DEPARTMENT

Our New Division of Public Behavioral Health

Our current behavioral health programs & services

Training & education

Data & strategy

Harm reduction

Improving treatment

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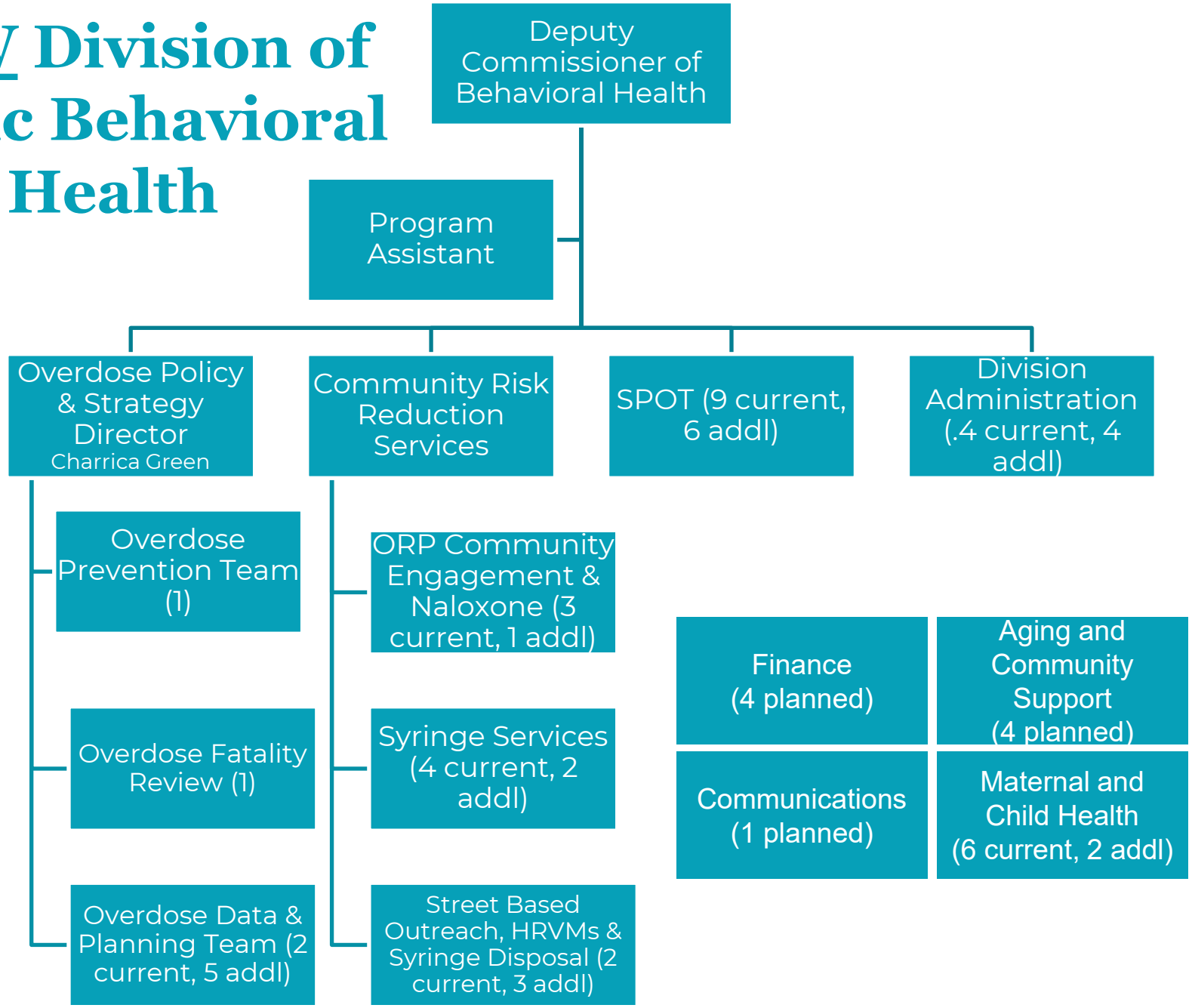
Acting Commissioner of Health, Baltimore City

BALTIMORE CITY HEALTH DEPARTMENT

NEW Division of Public Behavioral Health



Next Steps for the Division

Align with Needs Assessment and Strategic Plan

Finalize implementation plan for the ORF

Recruit and **hire** staff and transition to new division

Address **sustain**ability

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BALTIMORE CITY HEALTH DEPARTMENT

Thank you for your time.
Questions?

Brandon M. Scott
Mayor, Baltimore City
Michelle Taylor, MD, DrPH, MPA
Acting Commissioner of Health, Baltimore City

BALTIMORE CITY HEALTH DEPARTMENT

Appendix

Baltimore City Behavioral Health Ecosystem

Mayor's Office of Overdose Response (BCMOOR)

Coordinates the activities of City agencies, chairs the Mayor's Overdose Cabinet, chairs the Restitution Advisory Board.

Behavioral Health System Baltimore (BHSB)

Nonprofit local behavioral health authority for Baltimore City. Manages the city's public behavioral health system, administers state and federal funding, provider accountability.

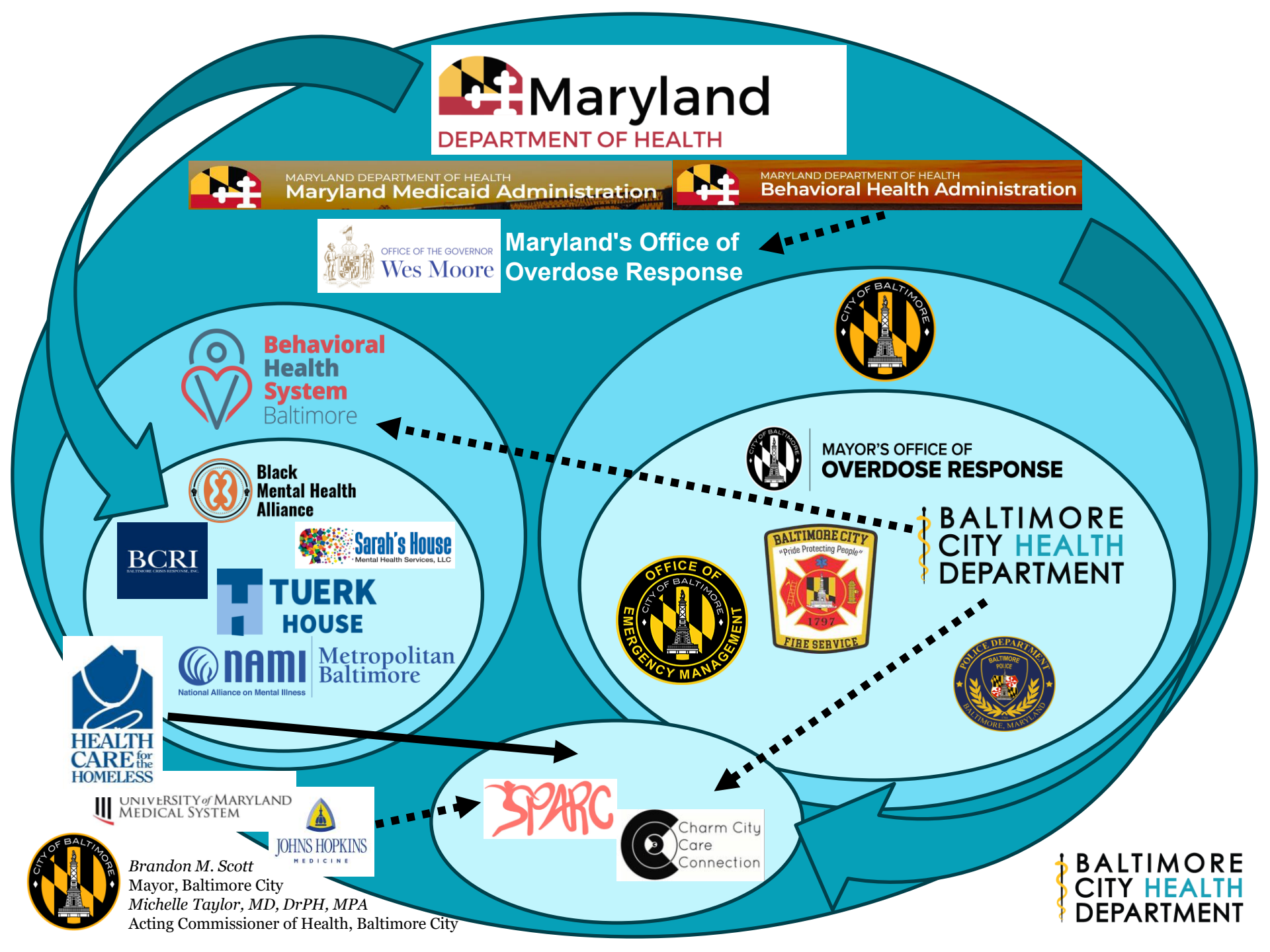
City Agencies

Baltimore City Health Department provides overdose prevention, harm reduction, and treatment services; Baltimore City Fire Department operates the population health initiative, conducting outreach and referrals.

Community Providers

Independent of City government. Include community-based organizations, public and private clinics, and hospitals.

The State: Sets regulations; responsible for licensure, oversight, & funding


Maryland
DEPARTMENT OF HEALTH
MARYLAND DEPARTMENT OF HEALTH
Maryland Medicaid Administration
MARYLAND DEPARTMENT OF HEALTH
Behavioral Health Administration
OFFICE OF THE GOVERNOR
Wes Moore
Maryland's Office of Overdose Response
Behavioral Health System Baltimore
Black Mental Health Alliance
BCRI
Sarah's House
Mental Health Services, LLC
TUERK HOUSE
NAMI
National Alliance on Mental Illness
Metropolitan Baltimore
HEALTH CARE for the HOMELESS
UNIVERSITY of MARYLAND MEDICAL SYSTEM
JOHNS HOPKINS MEDICINE
SPARC
Charm City Care Connection
CITY OF BALTIMORE
MAYOR'S OFFICE OF OVERDOSE RESPONSE
BALTIMORE CITY HEALTH DEPARTMENT
OFFICE OF CITY OF BALTIMORE EMERGENCY MANAGEMENT
BALTIMORE CITY "Pride Protecting People" 1797 FIRE SERVICE
POLICE DEPARTMENT BALTIMORE POLICE BALTIMORE, MARYLAND
CITY OF BALTIMORE
Brandon M. Scott
Mayor, Baltimore City
Michelle Taylor, MD, DrPH, MPA
Acting Commissioner of Health, Baltimore City
BALTIMORE CITY HEALTH DEPARTMENT

Baltimore City's Behavioral Health Crisis Response System

Administrative coordinator	Behavioral Health System Baltimore (Local Behavioral Health Authority)
988 operators	Baltimore Crisis Response, Inc. (BCRI), Sante, Grassroots
Mobile crisis responders	BCRI, Sante

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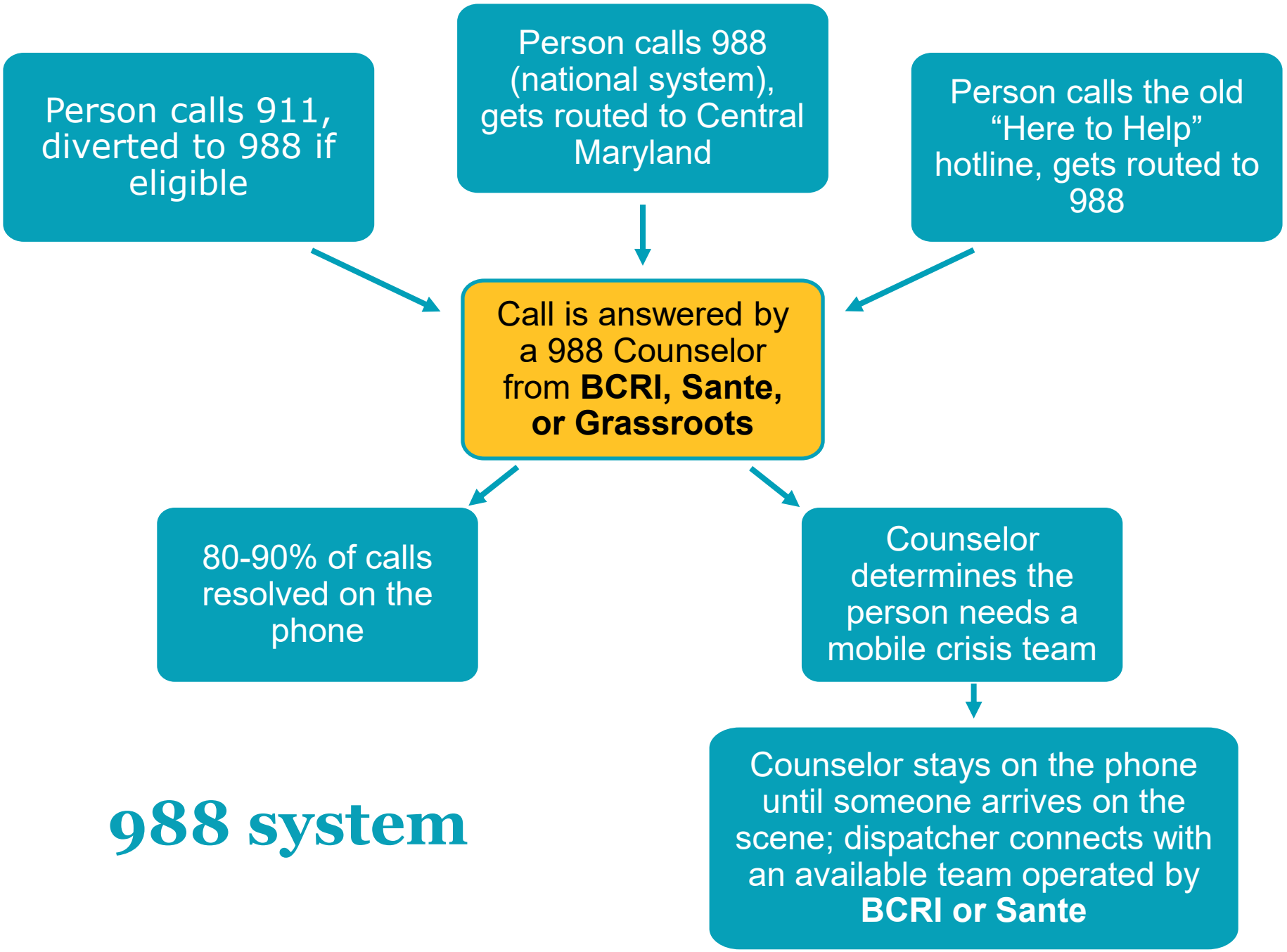
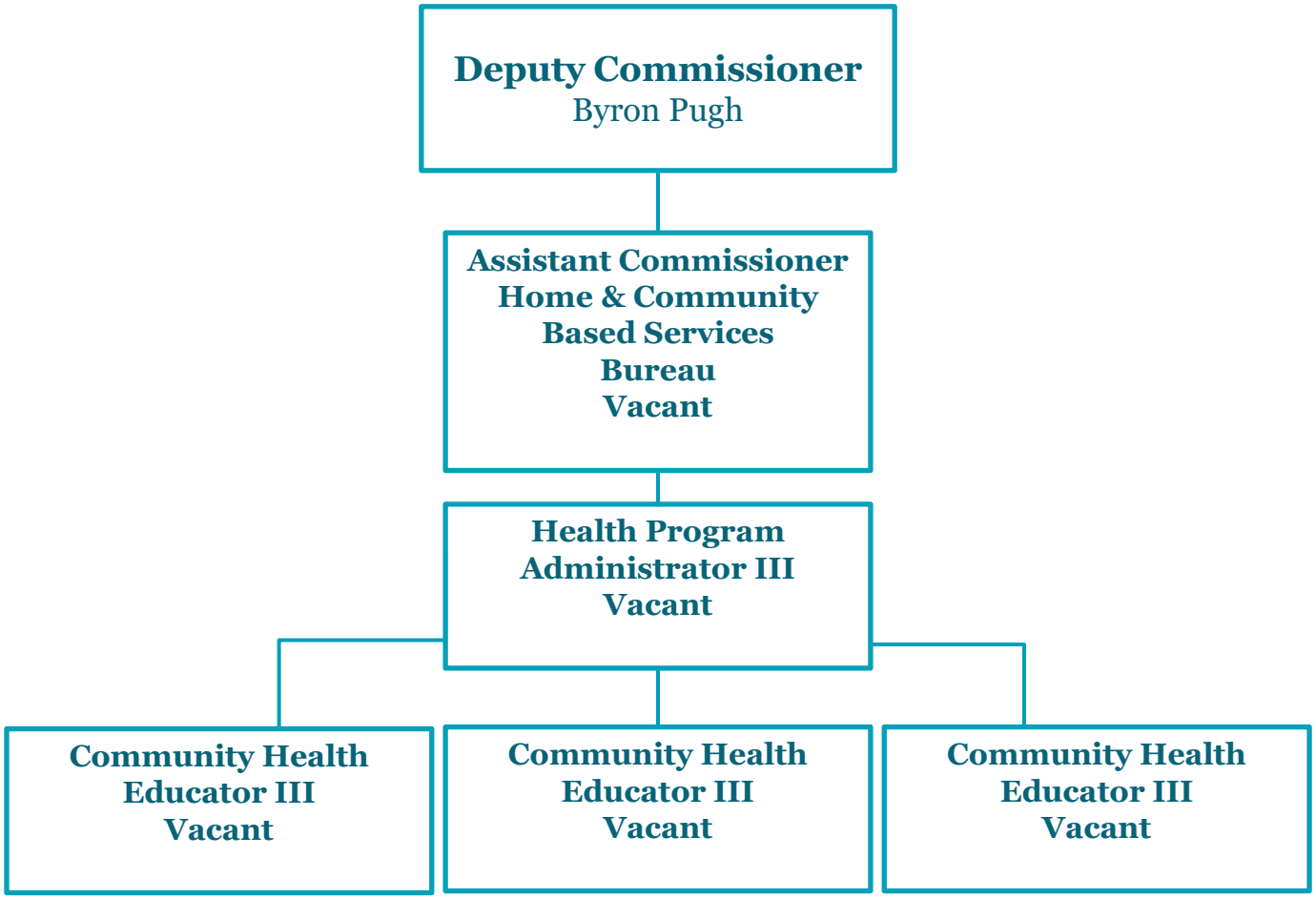
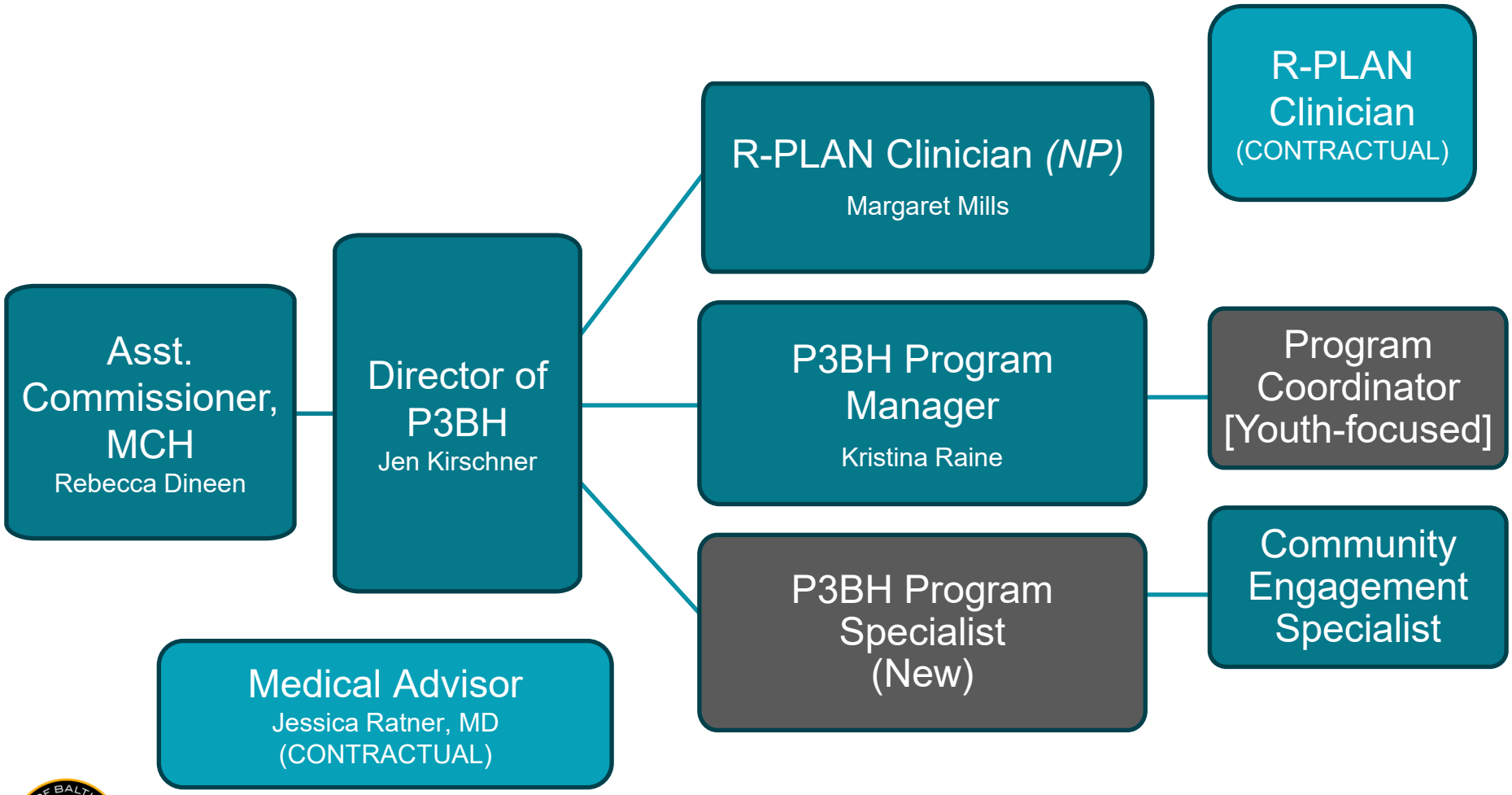
BALTIMORE CITY HEALTH DEPARTMENT


Person calls 911, diverted to 988 if eligible
Person calls 988 (national system), gets routed to Central Maryland
Person calls the old "Here to Help" hotline, gets routed to 988
Call is answered by a 988 Counselor from **BCRI, Sante, or Grassroots**
80-90% of calls resolved on the phone
Counselor determines the person needs a mobile crisis team
Counselor stays on the phone until someone arrives on the scene; dispatcher connects with an available team operated by **BCRI or Sante**

988 system


Deputy Commissioner
Byron Pugh
Assistant Commissioner
Home & Community
Based Services
Bureau
Vacant
Health Program
Administrator III
Vacant
Community Health
Educator III
Vacant
Community Health
Educator III
Vacant
Community Health
Educator III
Vacant

New Prenatal – 3 (P3) Behavioral Health Program within Maternal & Child Health



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BALTIMORE CITY HEALTH DEPARTMENT

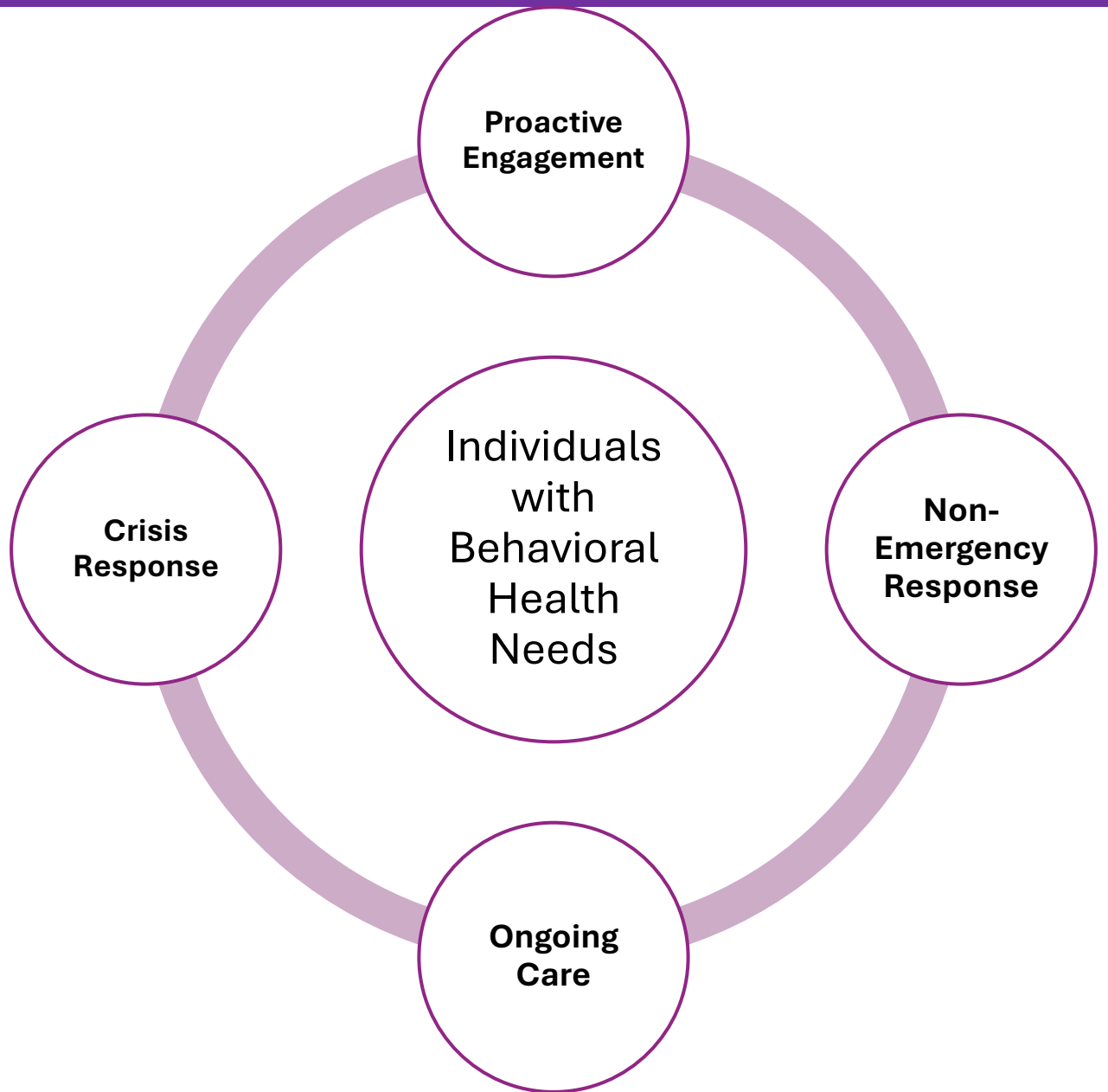
LO25-0026 Crisis Response:

Behavioral Health Support System & ORF

August 28, 2025

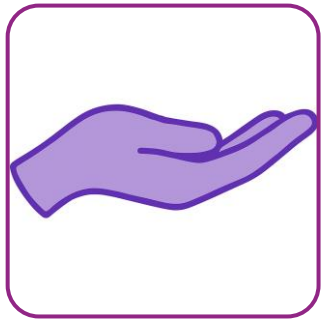
MAYOR'S OFFICE OF
OVERDOSE
RESPONSE

Behavioral Health Support Ecosystem



MAYOR'S OFFICE OF
OVERDOSE RESPONSE

Opioid Restitution Fund Grantees



Proactive Engagement

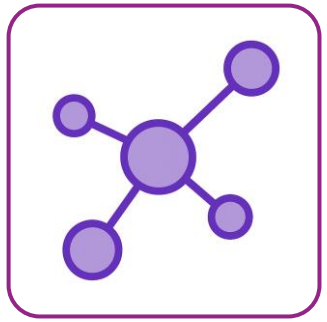
- Outreach
- Referral to Resources
- Charm City Care Connection
- Bmore POWER

Non-Emergent Response

- Timely response when requested
- Connection to services
- 24/7 Outreach
- BCORE

Crisis Response

- Emergency behavioral health and health needs
- Maryland Coalition of Families



Follow Up

- Ensure service connections made
- Providers

Ensuring coordination and collaboration with other grantees and City agencies

MAYOR'S OFFICE OF OVERDOSE RESPONSE

24/7 Outreach - $15 million

- Aligns with Paragraph 97 of the Consent Decree

- Ensures the right response to every call for assistance and identifies people in need of help earlier and reduces unnecessary use of emergency services

- Built on successful national models and SAMHSA's Crisis Now model which includes three guiding pillars:

  Someone to Call – a centralized, easy-to-remember number to call for help.
  A Person to Respond – specialized teams available 24/7 for proactive engagement and urgent, non-emergency response.
  A Place to Go – safe spaces for respite, stabilization, and connection to long-term services.

MAYOR'S OFFICE OF
OVERDOSE
RESPONSE

BCORE- $10 million

- Baltimore Comprehensive Overdose Response to End the Epidemic
- Partnership between University of Maryland Baltimore, Johns Hopkins School of Medicine, Baltimore City Fire Department, and People Encouraging People (PEP)
- Goal: expand access to treatment and create low-barrier care and supports to improve treatment success
    1. **Telemedicine Line** – Immediate access to medication to treat opioid use disorder
    2. **Emergency Department Excellence** - improves and standardizes OUD care across 11 emergency departments in the City
    3. **GOLDIE** – a software platform to facilitate connections to care across clinical, social service, and non-traditional care settings
    4. **BCFD Population Health** - extend the reach of overdose co-response and proactive community engagement
    5. **Community Connection Teams** – mobile outreach and case management teams provide long term supportive care of varying length and intensity on the street and at community locations citywide.

BPD BEHAVIORAL HEALTH POLICIES 713 & 715

- **Policy 713: Petitions for Emergency Evaluation & Voluntary Admission**
  - Ensures that emergency petitions and voluntary admissions handled by the BPD:
    - Minimize unnecessary police involvement
    - Prioritize de-escalation and community resources
    - Protect civil rights and safety of the evaluee
    - Use clear, documented procedures for petitions, service, and transport

- **Policy 715: Behavioral Health Crisis Dispatch**
  - Ensures that all calls involving behavioral health crises are handled through:
    - Careful 911 intake and, if eligible, diversion to 988
    - Prioritization of specialized crisis-training for all BPD dispatchers, 911 Call Specialists, and supervisors
    - Use of community and behavioral health resources whenever possible, and
    - Ongoing evaluation and improvement through collaboration with the city's behavioral health system

BPD BEHAVIORAL HEALTH TRAINING

CRISIS RESPONSE TEAM

40 hrs. Specialization training + advanced training; co-responds with Licensed Clinician to acute BH and Emergency Petition scenes

CIT CERTIFIED PATROL OFFICER

40 hrs. Specialization training, annual 8 hrs. refresher training

ALL 911 SPECIALISTS AND POLICE DISPATCHERS

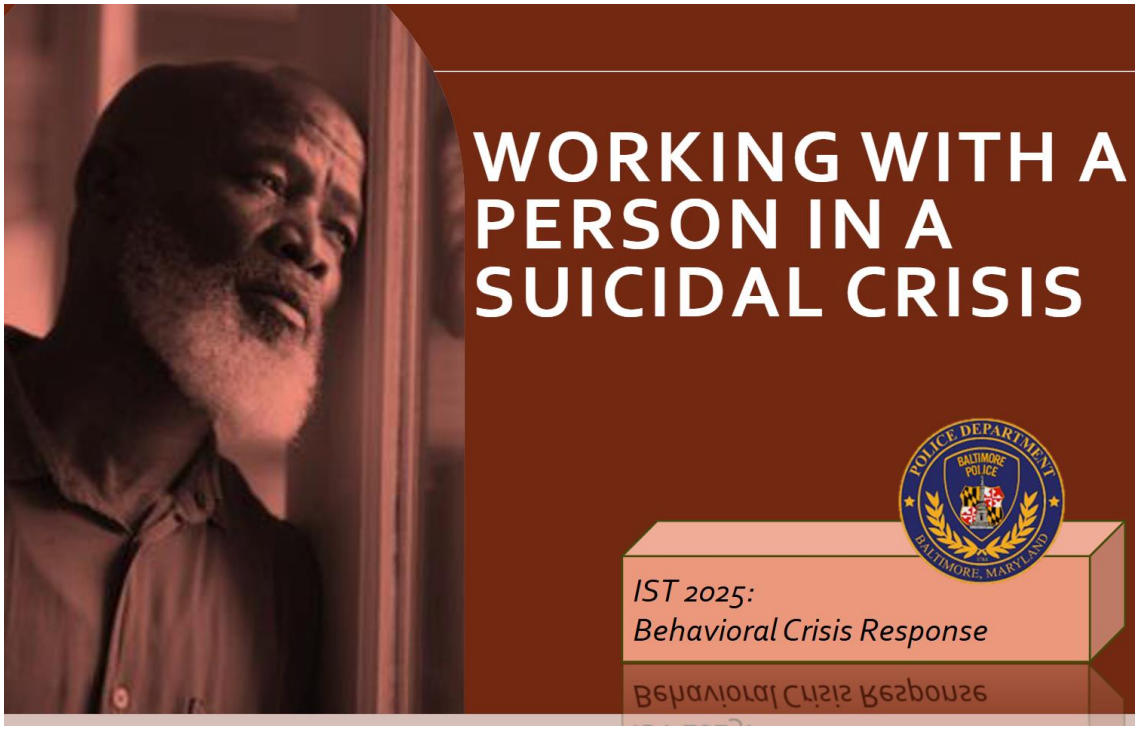
8 hrs. in-service Behavioral Health Awareness training

ALL BPD OFFICERS

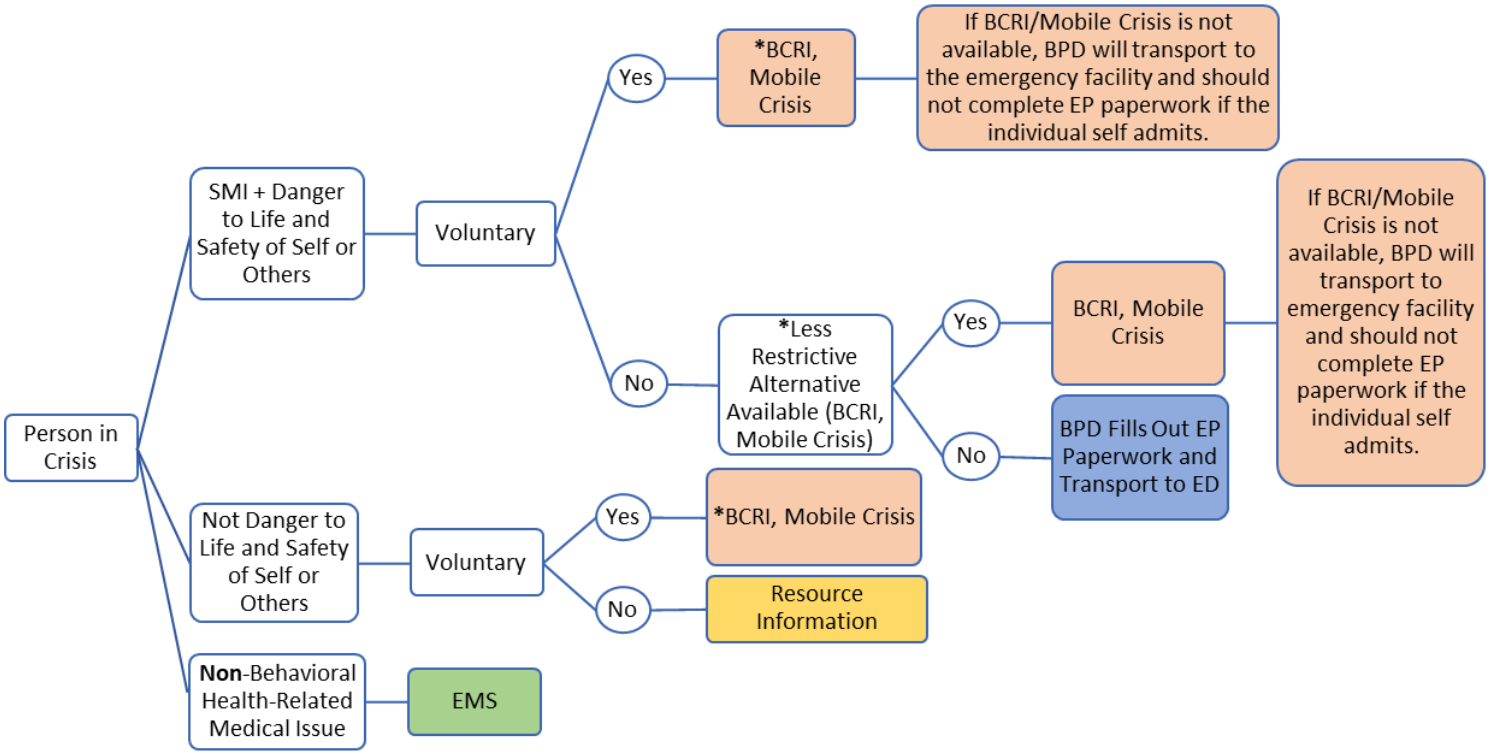
24 hrs. entry-level Behavioral Health Awareness Training; 8 hrs. annual in-service Behavioral Health Awareness training

BPD BEHAVIORAL HEALTH TRAINING

- 24% of BPD patrol officers are CIT certified
- 6 CIT classes for 2025 have been scheduled.
- Almost 60% of BPD members have completed the annual BH training for 2025



FLOW CHART: WHO RESPONDS TO PEOPLE WITH SMI EXPERIENCING CRISES



* The BPD member has the discretion to contact BCFD to request an EMS transport for a person who, in the member's judgment, consistent with the principles of this policy, would be better served by non-BPD transport. For instance, in cases where the person has co-existing medical issues requiring emergent intervention or has preexisting conditions that would prohibit police or MCT from transporting safely, EMS transport may be more appropriate. For someone with a history of trauma or other mental health concerns associated with police contact, an EMS transport may help de-escalate the situation, making this transport a reasonable accommodation to the needs of a person with a disability.

BPD DATA

FIGURE 1: BEHAVIORAL HEALTH CALL VOLUME BY AGENCY JULY 2020 - DEC 2024

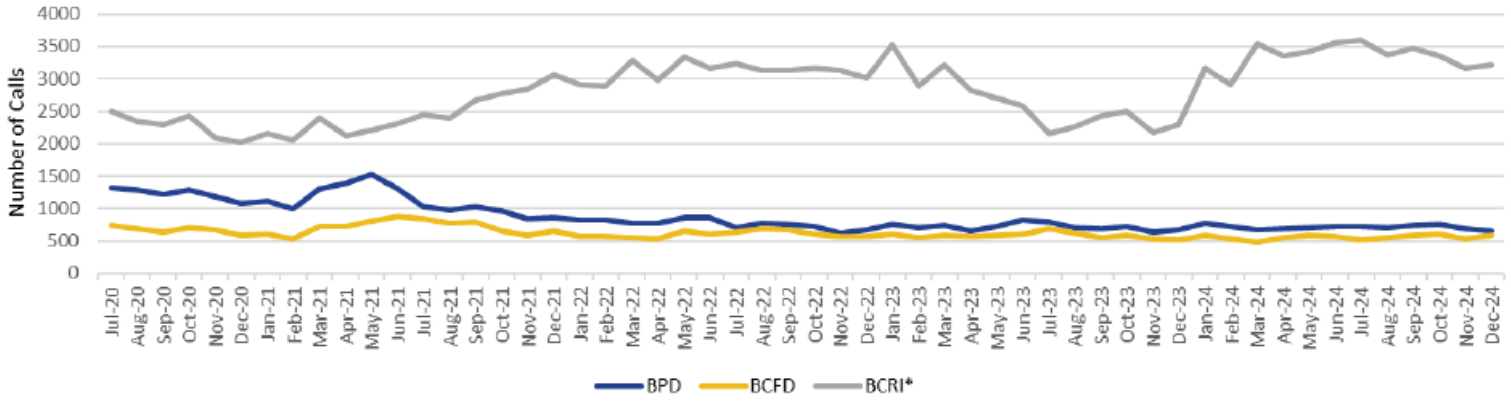


TABLE 6: USE OF FORCE INCIDENTS ASSOCIATED WITH BEHAVIORAL HEALTH CALLS FOR SERVICE

Month	Level 1	Level 2	Level 3	Q3-Q4 Total
July	6	3	0	9
August	4	5	0	9
September	6	1	1	8
October	5	3	0	8
November	1	2	0	3
December	2	1	0	3
Q3-Q4 Total	**24**	**15**	**1**	**40**

BPD ACCOUNTABILITY LANDSCAPE

- BPD BH Interaction Audits
- BPD Audits
- BPD Annual Use of Force Reports
- BCBHC Data Subcommittee Reports
- BPD Performance Review Board
- BPD Special Investigation Response Team (SIRT)

BALTIMORE CITY BEHAVIORAL HEALTH COLLABORATIVE DATA SUBCOMMITTEE BIANNUAL REPORT

Jul 1, 2024 – Dec 31, 2024

June 25, 2025

BALTIMORE CRISIS RESPONSE, INC.

BEHAVIORAL HEALTH CRISIS RESPONSE TRIAGE MATRIX

The Central Maryland 988 Triage Matrix is designed to ensure fairness, improve efficiency, and unify crisis response across the region—shifting from ad-hoc, judgment-based dispatching to a structured, coordinated, and outcome-focused system. It's a foundational step toward building a crisis response system that’s equitable, responsive, and sustainable.

988 call center counselors use the Central Maryland 988 Triage Matrix as a decision-support tool to determine the most appropriate response for a person in crisis.

THE CENTRAL MARYLAND 988 TRIAGE MATRIX PLAYS A CRUCIAL ROLE IN ENHANCING BEHAVIORAL HEALTH CRISIS RESPONSE BY STANDARDIZING AND STREAMLINING HOW CRISIS CALLS ARE ASSESSED AND ROUTED ACROSS THE REGION.

Benefit	What It Enables
Standardized decisions	Consistent assessment of crisis needs across jurisdictions
Equitable access	Uniform criteria prevent bias in resource allocation
Efficient resource use	Smart allocation of mobile crisis teams to those who need them most
Part of a coordinated system	Integrates with bed registry, outpatient referrals, follow-ups

How does the counselor use the matrix?

1. Gather Information through structured questions
2. Match situation to the Matrix Criteria

Tier	Description	Action
Level 1 – Phone Support	Low risk, caller stabilized with de-escalation	Continue phone support and refer to outpatient
Level 2 – Mobile Crisis Dispatch	Moderate risk, unsafe but no imminent danger	Dispatch Mobile Crisis Team (MCT)
Level 3 – Co-Responder / EMS	High risk, imminent danger, violence, or severe medical needs	Activate law enforcement/EMS + MCT if possible

CAPACITY & RESPONSE TIMES

- Using data to more strategically dispatch teams.
  - Heat-mapping to determine best dispatch locations
  - Identifying trends to host training & education sessions and connections-clinics.
- Increasing frequency & number of follow-ups.
  - Mobile response & 988
- Utilizing remote clinical support when appropriate.
- Through a partnership with Maryland Coalition of Families, adding a Family Support Specialist to mobile response.
- Revising matrix to better support 3rd party callers.
- Staggering & overlapping shifts to maximize coverage during peak times.
- Establishing career-pipelines with local schools through internships.
- Regular job fairs hosted by Mayor's Office of Employment & Development.

Baltimore City Behavioral Health Crisis Response System

Presented to Baltimore City Council
August 27, 2025

Behavioral Health System Baltimore

BHSB'S CORE FUNCTIONS

Advocacy & Planning

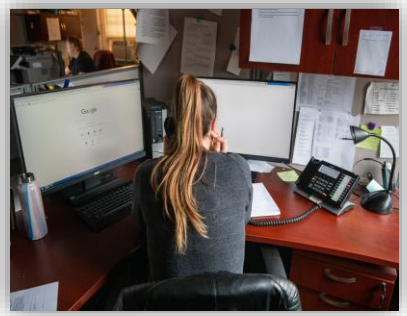
Local Partnerships

System Management

Managing Public Funds

Public Education

Crisis Response:
Anyone, Anywhere, Anytime



Someone to call

Someone to respond

Somewhere to go

Crisis System Infrastructure – Someone to Call

988 Helpline for immediate counseling and connection to resources
24/7. Regional. Answers 4,000+ calls a month. Makes 1,400+ follow-up/care coordination calls to 600+ people per month. 54% of incoming calls from people in Baltimore City. 91% of calls resolved on the phone.

115 counselors and 6 dispatchers answering 988 calls
Average call answer time = 23 seconds. Call answer rate = 90%. One of the highest in the country. Maryland based network for back up calls.

Maximized staffing
Regional structure addresses workforce challenges. Baltimore Crisis Response, Inc, (BCRI) is the lead entity & contracts with Affiliated Sante Group and Grassroots.

Open Access scheduling for same/next day outpatient appointments for lower-acuity callers
25+ connections to open access appointments from 988 per month

Bed registry for community-based 24/7 crisis beds

Offers real-time connection to immediate mental health and substance use treatment for people experiencing a crisis.

Crisis System Infrastructure – Someone to Call

Diversion from 911 to 988
Eight CAD codes are eligible for diversion to 988 for callers ages 12 and up. 2 clinicians housed in Baltimore City 911 call center to identify & facilitate diversion opportunities. Multistakeholder QA process to guide implementation.

Community engagement and outreach
Support culture change to increase awareness and use of the 988 helpline as an alternative to calling 911 or using the ED. Community shaped marketing.

CALL988 Campaign

Paid marketing to increase awareness and use of the 988 Helpline. Community informed campaign.

Community Ambassadors Program
Trusted people in communities spreading the word about 988

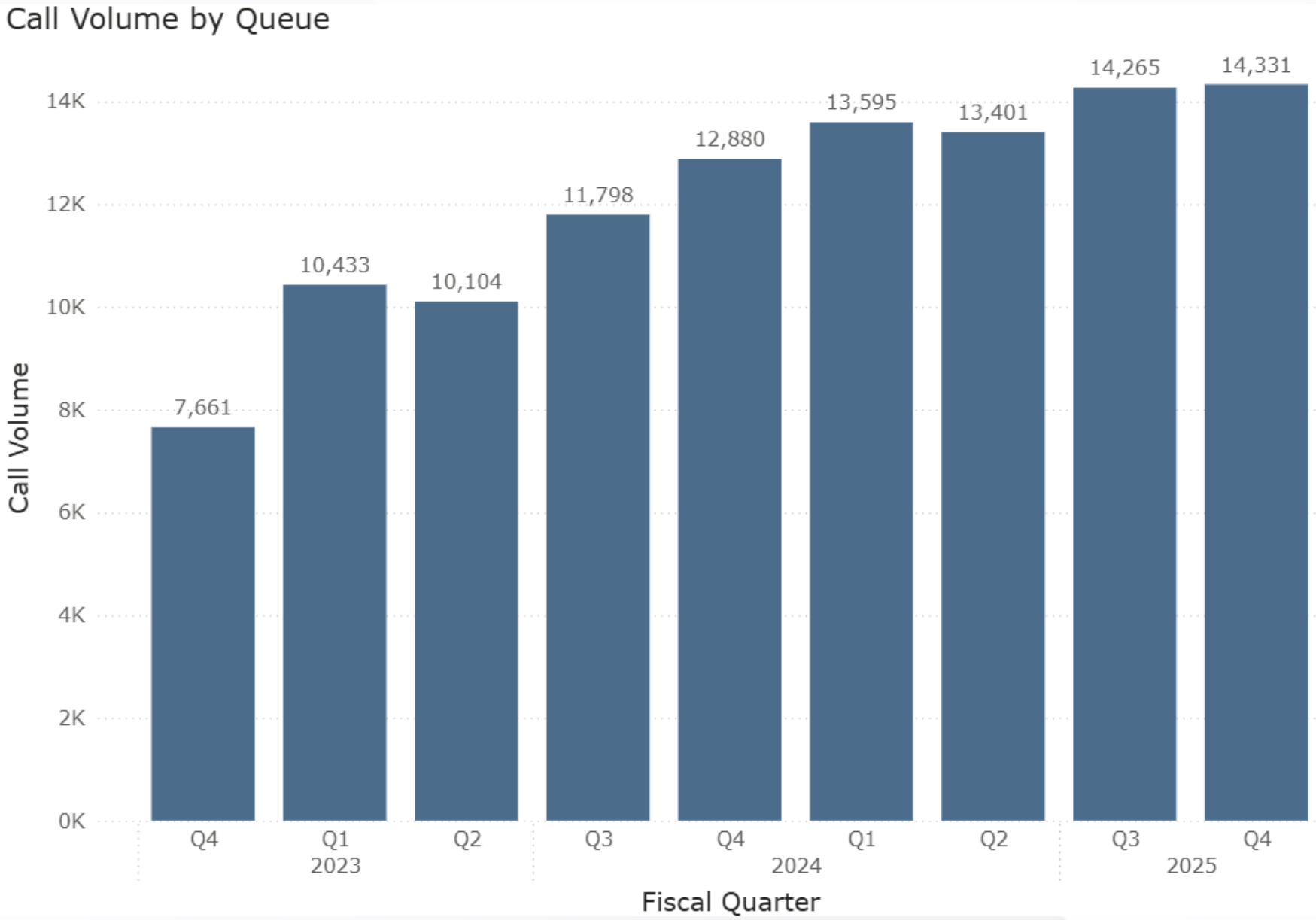
988 Regional Helpline

Call Volume All Phone #s

July 2024 – June 2025

Source = Behavioral Health Link

- Major mobile carriers began georouting to 988 Sept. 2024
- Funded through grant $ that accounts for call volume
- 91% of calls using the 988 # resolved on the phone
- 54% of 988 calls from Baltimore City



Crisis System Infrastructure – Someone to Respond

Mobile response teams for community-based, in-person assessment, counseling and connection to acute and ongoing care

24/7. Serves people across the lifespan. Staffed by peer & BH professional. 2 providers. 150+ dispatches per month. Not immediate response like police/fire. National standard = response in < 60 minutes. 50% of calls in Baltimore meet standard.

Specialty mobile response teams for children and youth

Provides crisis response 10 hours/day, 5 days/week & follow up and support for up to 6 weeks. Mobile response teams can refer for intensive follow up.

Specialty clinician police officer response

1 team available from 11am – 7 pm, 7 days week. Dispatched by 911. 900+ people/year. Includes direct dispatch & follow up from EPs initiated by BPD patrol.

Triage matrix to guide decision making & promote the least police response possible

Guidance for call takers to ensure consistency in what kind of team is dispatched by 988. Enhances transparency for the community on when law enforcement is requested by 988.

Community Peer Support Project

24/7 peer engagement in the community. Direct coordination with hospitals. Warm line: 410-357-7337. Implemented based on recommendation from a sentinel event review.

Mobile Response Teams

Total Mobile Request Volume

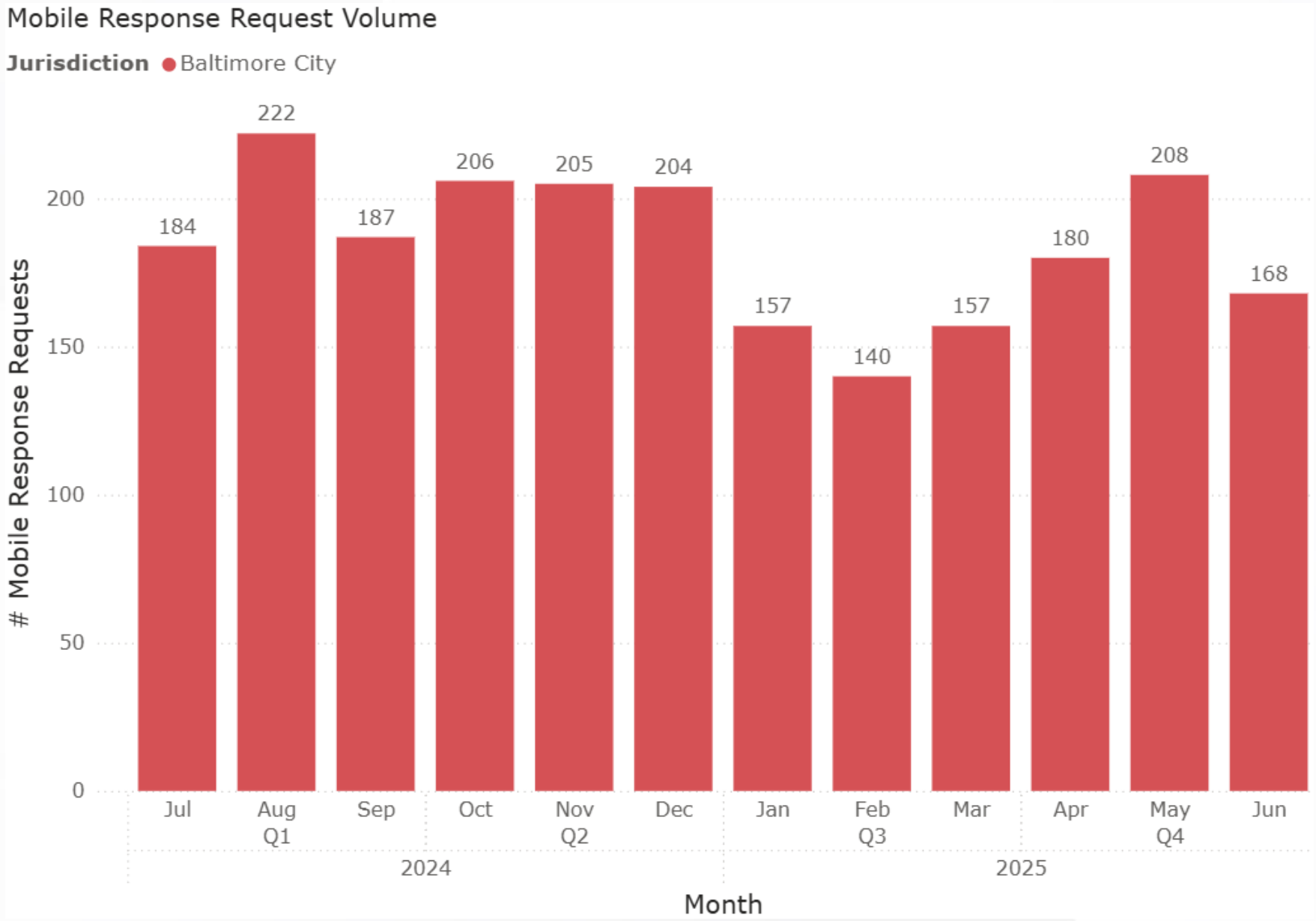
Baltimore City

July 2024 – June 2025

Source = Behavioral Health Link

Total requests = 2,218

- National & state standard = 60 minutes or less



Mobile Response Teams

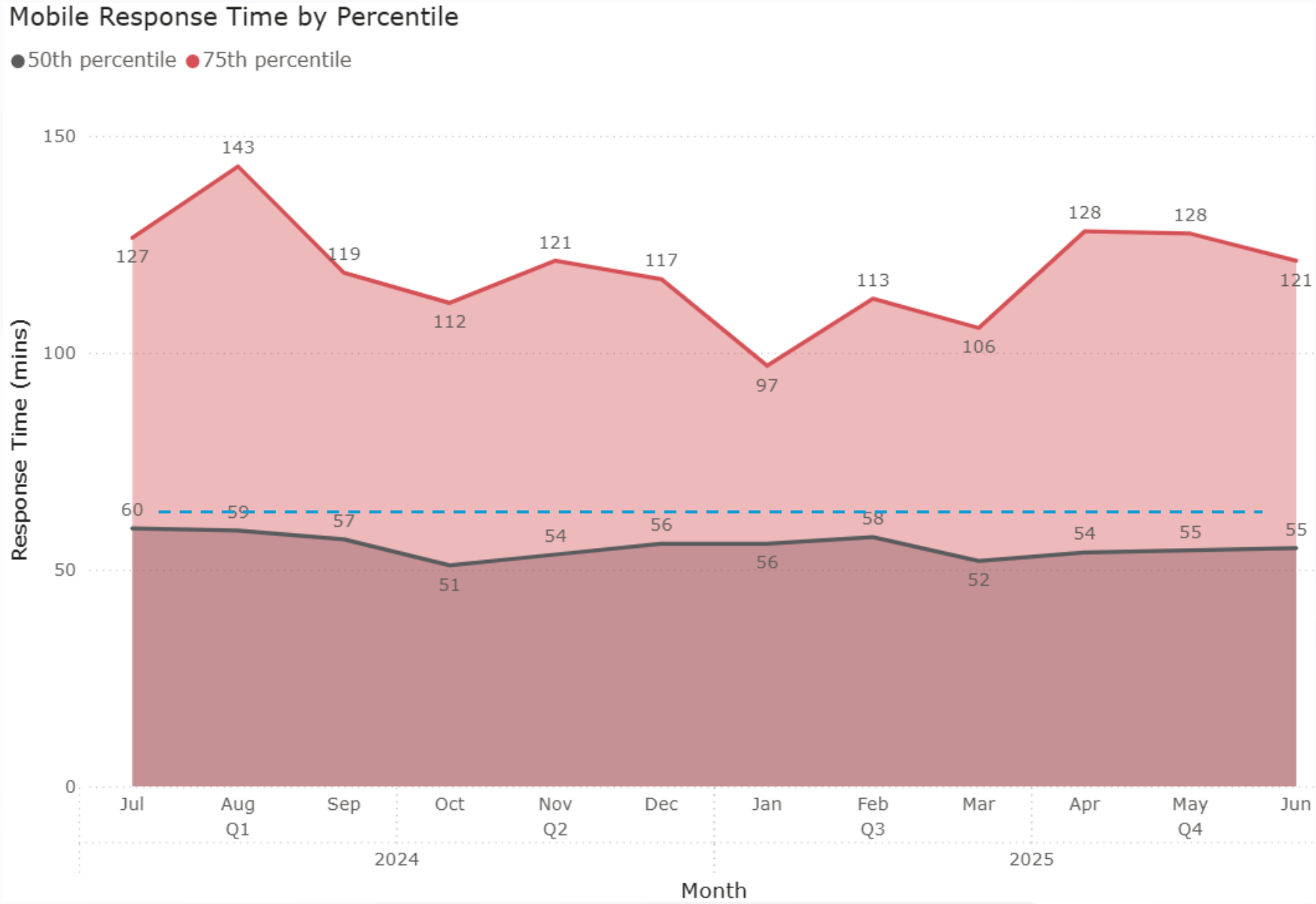
Total Response Time (Mins)

Baltimore City

July 2024 – June 2025

Source = Behavioral Health Link

- National & state standard = 60 minutes or less



Mobile Response Teams

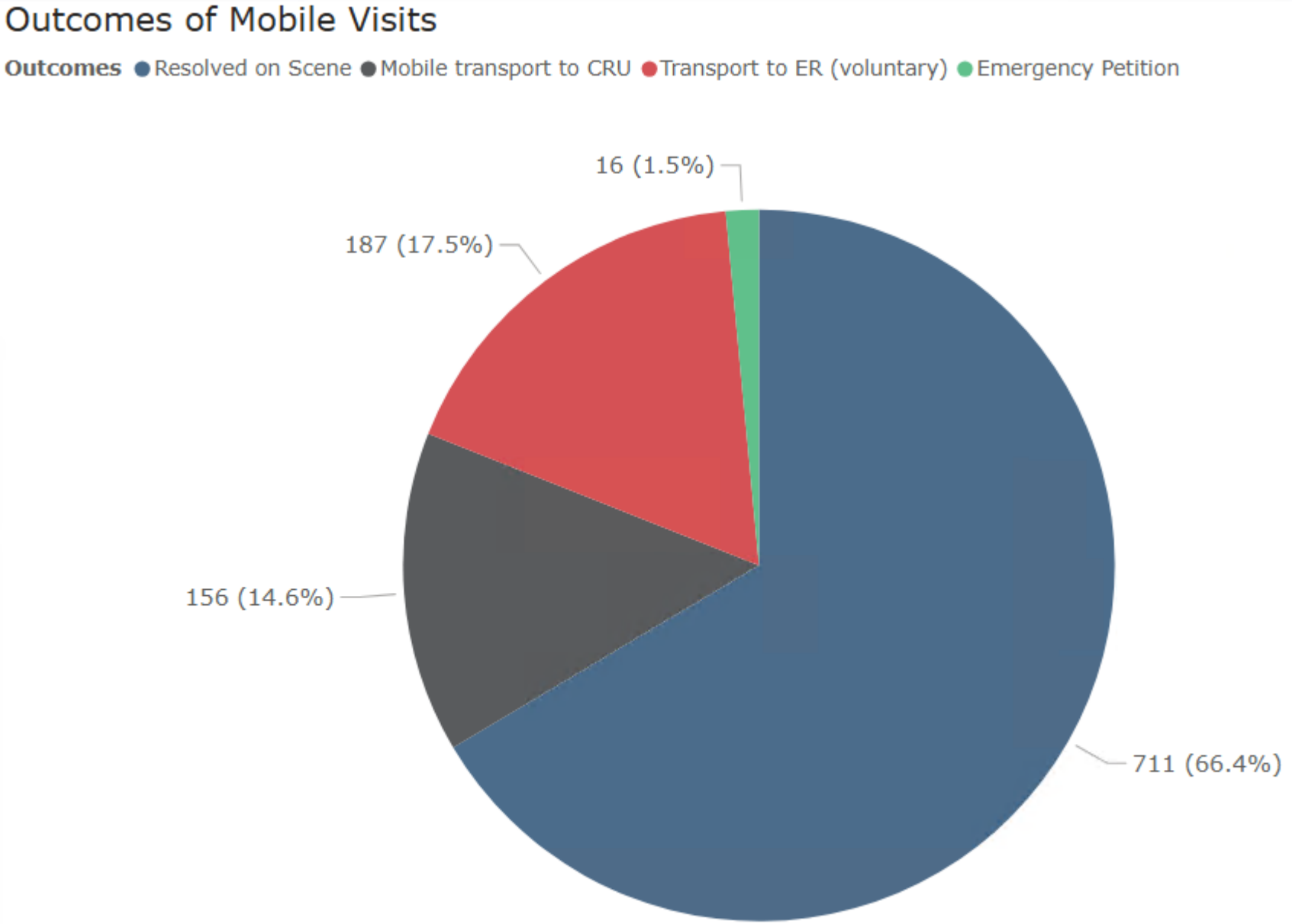
Outcome of Completed Visits

Baltimore City

July 2024 – June 2025

Source = Behavioral Health Link

- All completed visits where services were provided by mobile response teams dispatched through 988
- 81% resolved without ED visit
- Data reflect multiple teams supported through diverse funding resources



Crisis System Infrastructure – Somewhere to go

Urgent SUD services

24/7 assessment and stabilization for substance use. Connection to ongoing resources. Average length of stay = 24 hours. 1 provider = 35 beds. Serves 300+ people/mo. Access = walk-in or 988.

Opioid/stimulant crisis beds

24/7 medically managed high-intensity service for people using opioids or stimulants who need monitoring, counseling and support in a residential, community-based setting. Length of stay = 4 days. 2 providers. Access = 988 or call provider directly.

Residential SUD withdrawal management (ASAM level 3.7)

24/7 medically managed high-intensity service for people who need monitoring, counseling and support in a residential, community-based setting. Average length of stay = 7days. 3 providers. Access = call provider directly.

Mental health crisis beds

24/7 medically managed high intensity service for people who need monitoring, counseling and support in a residential, community-based setting. Average length of stay = 7 – 9 days. 1 provider. Serves 650+ adults/yr. Access = 988

Open Access Clinic

Same/next day outpatient appointments. 15 sites in Baltimore City. Access = 988 or call provider directly.

Crisis System Infrastructure – Accountability

Regional accountability structure

BHSB works with state to oversee regional services & system accountability. Grant funds services. Regularly convenes providers and other LBHAs. Partners with community to receive feedback & raise awareness of 988.

Crisis response standards and regulations

Agreed upon principles & practices developed in 2021 through community engaged process. Used to guide service development & promote consistency & accountability across the system. State regulations for mobile crisis response effective 1/1/2025.

Behavioral health awareness training for police

24 hrs for new recruits. 8 hrs for 911 specialists & police dispatchers. 40 hr specialized training for officers who volunteer to become Crisis Intervention Team (CIT) officers. Mandatory annual refreshers. CIT officers = 23% of patrol.

Dedicated direct line to 988 for BPD

Gives officers a direct connection to 988 call takers for support on scene & diversion to a mobile response team

Continuous quality improvement

Monthly review of crisis response data with providers & other LBHAs. Monthly case review with 1st responders.

Crisis System Infrastructure – Accountability

Consent Decree - Paragraph 97

Details city's responsibility to improve system of response for people experiencing a behavioral health crisis. Monitored by a federal judge. Releases bi-annual reports on progress.

Baltimore City Behavioral Health Collaborative (BCBHC)

Group of community stakeholders that oversees the City's response to Paragraph 97. Chaired by Mayor's Office, BPD & BHSB. Meets 6x/yr. Sub-committees meet bi-monthly (data, policy, training).

Consent Decree Monitoring Team Assessment

Evaluates BPD's compliance with requirements related to BH interactions, use of force, and crisis response. Includes review of call & response data, body worn camera footage, incident reports & EP paperwork

BPD & Fire Department Quality Assurance Processes

Multiple internal quality assurance audits/reviews to identify opportunities for improvement in health & safety response for the city

Sentinel Event Reviews

Multistakeholder process to examine critical incidents involving public safety response & identify opportunities for change within BPD, Fire Department and the larger BH system. Implementation of recommendations overseen by BCBHC.

System Opportunities – Someone to Call

- Collectively promote 988 across the city
- Increase # of clinicians in the 911 call center
- Workforce development – enhance recruitment & retention efforts for call takers

System Opportunities – Someone to Respond

- Implement alternative response teams
  - Trained, professional community responders that are not police/EMS
  - Denver, Albuquerque, etc.
- Shift wellness checks from police to community responders
- Improve use & deployment of CRT (police/clinician teams)
- Work force development: implement specialized recruitment/retention strategies for peers & clinicians to do community-based crisis work

System Opportunities – Somewhere to Go

- Invest in:
  - Peer respite
  - Crisis stabilization centers
  - Drop in locations

- Invest in coordinated & comprehensive outreach for proactive engagement before a crisis occurs

- Work force development: implement specialized recruitment/retention strategies for peers & clinicians to do community-based crisis work

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President and CEO
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Find more information at bhsbaltimore.org
Follow us at @bhsbltimore