Mendocino County Mental Health Plan
Behavioral Health & Recovery Services
Mobile Crisis Benefit Implementation Plan

2023

Contents

Mendocino County Behavioral Health Delivery System

Mendocino County Behavioral Health and Recovery Services (BHRS) provides specialty mental health and substance use disorder treatment to Mendocino County Medi-Cal and indigent populations. Mendocino County provides Mental Health Services Act and wellness and preventions services to the community.

Mental Health Services

Mendocino County contracts with community-based organizations for specialty mental health service delivery. Mental Health Services Act funded programs are prioritized to augment specialty mental health services by filling gaps in service, providing whatever it takes wraparound for the most severely impacted individuals, providing prevention and early intervention to prevent the severity of mental illness, and providing community education for the broader community around mental health symptoms, risk factors, suicide prevention, and other mental health topics. Mendocino County is committed to delivering services in a most accessible, least restrictive environment within a coordinated system of care that is respectful of a person's family, language, heritage and culture. BHRS Mental Health programs work to maximize independent living and improve quality of life through community-based treatment, maximizing the resources available to the community, and educating ourselves, the community, and individuals and families being served of the resources and hopeful possibilities of treatment and recovery. Mendocino County commits to managing our fiscal resources responsibly and effectively, while ensuring efficiency and productivity. BHRS coordinates with the mild to moderate mental health system provided by the Managed Care Plan through primary care providers and local clinics and Tribal Health Clinics through the use of authorizations to release confidential information, referral and care coordination meetings, and multidisciplinary meetings and or case conferencing when needed.

A full list of the specialty mental health services can be outlined at the Mental Health services website https://www.mendocinocounty.org/departments/behavioral-health-and-recovery-services/mental-health-services

Substance Use Disorder Treatment Services

Mendocino County is part of the Partnership Health Plan of California Regional Model for Drug Medi-Cal Organized Delivery System (DMC-ODS). Mendocino County is one of several counties in the regional model. DMC-ODS programs follow the continuum of care model from the American Society of Addiction Medicine (ASAM) criteria for substance use treatment and medically indicated level of care. Substance Use Disorder Treatment is programs that assist participants with substance use disorders to create and maintain a healthy, balanced lifestyle free of alcohol and other drug abuse. Treatment programs use evidence-based curricula, and all treatment staff are certified or registered by the State of California. Treatment services include individual and group settings and can include development of treatment plans, crisis response, collateral sessions with family, and ultimately discharge planning. Treatment programs include Outpatient Treatment, Women's Perinatal Treatment- WINDO, Adult Drug Court-OPTIONS, Family Dependency Drug Court, Probation treatment services through AB109, Adolescent treatment. Programs that are not formal treatment include a Diversion Education program, school based prevention and education groups, and social and emotional learning programs such as Friday Night Live and Elevate Youth. The Mendocino County Substance Use Disorder Treatment programs are

outlined in https://www.mendocinocounty.org/departments/behavioral-health-and-recovery-services/substance-use

Coordination Strategies between Mental Health Plan and Drug Medi-Cal-Organized Delivery System

Mendocino County Behavioral Health and Recovery Services (BHRS) is an integrated unit between the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). BHRS holds routine unit meetings for training, information sharing, and collaboration between Mental Health Plan employees and DMC- ODS.

Mobile crisis services will be a rapid response, community-based assessment and intervention for Medi-Cal beneficiaries experiencing a behavioral health crisis. Use of de-escalation and stabilization techniques, rehabilitation, and linkage to appropriate resources will aid to either stabilize the crisis in their situation or connect them with the most appropriate resources. The goal of mobile crisis will be to reduce emergency and law enforcement utilization when not necessary for safety or medical stabilization, while promoting client skills at stabilizing and connecting to resources in their "home" environment.

Mobile crisis teams will consist of mental health rehabilitation specialists, peers, clinicians, and or substance use counselors. Mobile crisis teams will be knowledgeable of the behavioral health and other community resources and will be capable of referring and providing warm handoffs to both mental health and substance use services as appropriate in addition to other support and community resources.

Mobile crisis teams will respond to both mental health and substance use crises. Mobile crisis teams will be trained to administer naloxone or Narcan in the course of delivering mobile crisis response.

Coordination with Specialty Mental Health Crisis response

Mobile crisis teams and specialty mental health crisis teams shall divide services based on the location of the crisis response. Crises occurring in specialty mental health offices, emergency departments, and to some extent schools and supported housing environments with 24/7 Full Service Partnership services will be the responsibility of specialty mental health service providers. Crisis response in the field and outside of specialty mental health offices and the emergency departments shall be the purview of the mobile crisis teams. On occasions in which crisis demand is high and response capacity is low, mobile crisis teams may respond to the emergency department; if this is necessary, the specialty mental health billing code will be used as opposed to the crisis benefit. Specialty mental health crisis responders may contribute to mobile crisis response, however billing for the mobile crisis benefit will only occur when all mobile crisis benefit criteria are met. Crisis response teams may also collaborate with other field based response service providers to ensure the least restrictive level of care standard and all available resources for stabilization and de-escalation are utilized.

The Mobile Crisis Benefit- Billing Processes & Coordination with DMC-ODS and Medi-Cal

BHRS currently provides and bills for specialty mental health services under the Medi-Cal Mental Health Plan and services under DMC-ODS. BHRS conducts all the billing processes for these services through Netsmart's AVATAR. BHRS will leverage the existing processes to include the mobile crisis benefit. Once the Mobile Crisis Implementation plan is approved, BHRS will add the code into our system in AVATAR for mobile crisis workers to begin using subsequent to December 31, 2023. Crisis workers will complete documentation in AVATAR which meets the criteria for the crisis assessment tool. The mobile crisis benefit will be requested to be added to approved Mendocino County taxonomy codes. Mobile crisis

benefit services will only be billed when the conditions of mobile crisis are met, community based, staffing requirements, and with use of tools which utilize all required elements (dispatch, assessment, and safety planning.) BHRS has existing policies which outline the use of the electronic health record for documentation, review and monitoring of documentation, and will utilize existing policies in application of the mobile crisis benefit.

Mobile Crisis Team Training

Mendocino County mobile crisis teams will be required to complete Mendocino County and Behavioral Health and Recovery Services employee onboarding and training for general staff in addition to completing mobile crisis specific training modules. Onboarding and new employee training include training in being a mandated reporter, confidentiality, code of ethics, cultural and linguistically responsive and appropriate practices, and other required trainings for BHRS staff. In addition, mobile crisis teams are required to undergo training with a local law enforcement partner regarding radio use and communication, safety on scene in higher risk calls with law enforcement, and other safety and communication considerations. Existing mobile crisis team member are in the process of completing the mandated training. The mobile crisis program manager has completed all trainings. The mobile crisis supervisors will have completed all the trainings by December 3, 2023, and the remaining mobile crisis workers will have finished all mandated trainings by December 31, 2023.

BHRS mobile crisis teams will be required to complete the following Mobile Crisis Benefit trainings prior to serving as a mobile crisis worker and utilizing the Mobile Crisis Benefit by December 31, 2023. Mobile crisis workers will not bill to the mobile crisis benefit if training is not completed. Mandated trainings include:

Conducting a Crisis Assessment

This is a three and a half hour training reviewing best practices for mobile crisis assessment. The training focuses on person centered, brief intervention, and resolution focused approaches showing the shift in crisis response prior to mobile crisis benefit implementation and expectations post implementation. The training will highlight using your observations, safety determinations, personal strengths and coping skills, and community supports and resources to determine the least restrictive wholistic next steps for the person in crisis. There is a discussion of narrative storytelling as an assessment style and combining all the crisis responder observes, hears, and discusses with the individual(s) in crisis to determine the most appropriate response.

Trauma-Informed Care Training

This two and a half hour training looks into specifics of providing trauma informed care. Trauma informed care considers the impact of trauma and adverse childhood experiences, the social drivers of health, and other factors on an individual's health and behavioral wellbeing and looking at the impacts of trauma on body, mind, and interpersonal relationships. Trauma can begin prebirth, can be event based, and can be chronic and complex. Anyone can be impacted by crisis at any age. Mobile crisis should mitigate the impacts of trauma. This training reviews the impacts of trauma on the brain and human development and the crisis response. A person in crisis (panic) is not able to engage in reason and higher-level brain functioning until the brain regulation is managed. The crisis team also needs to regulate their own responses in responding to crisis to not further escalate the dynamic.

Harm Reduction Strategies

This two and a half hour training explores strategies to reduce harm in use of substance use when responding to mobile crises. This training has a trauma informed and culturally responsive lens to harm reduction and a whole person approach to strategies, including recognizing that harmful coping skills are still coping skills and emphasizing trauma informed practices in engaging support and services to avoid further traumatization by forcing treatment. Harm reduction is about providing individuals the

information and tools to change harmful and/or life-threatening behaviors in a way that works for them and avoids telling the person to simply stop harmful coping skills. A review of the stages of change is included.

Collaborative, Culturally Responsive Crisis Safety Planning

This two and a half hour training presents strategies to empower individuals in crisis to prevent and avoid further crisis. The training outlines safety plan strategies at various stages of the crisis experience. Including warning signs, building plans for those that can be asked for help, hotlines and professional crisis resources, and protecting the environment by removing lethal means. The training outlines various methods of removing lethal means including safe firearm transfers. The training reviews the empowerment of the safety planning experience when person centric. The training reviews considerations for children in developing a safety plan as well as the impacts on cultural practices on developing a safety plan. Sample tools are reviewed.

Introduction to Culturally Responsive Crisis Care for Tribal and Urban Indian People

This is an hour and a half long training addressing culturally responsive interventions. The training provides strategies and cultural de-escalation strategies. The training introduces the broader context of historical trauma and systemic racism on the experience of crisis. The training reviews the impacts of intersectionality in assessing crisis risk and de-escalation strategies. The training reviews looking at acute, chronic, and systemic crisis. The iceberg model of culture is reviewed and how to use it in context of a culturally humble and trauma informed crisis assessment. Additional strategies include the use of a multidisciplinary team, jurisdictional considerations on sovereign land, and consideration of traditional healing practices in coping and responding to crises.

Crisis Intervention & De-Escalation Strategies

This two hour training reviews escalation cycle and opportunities and best practices for de-escalation. The training addresses the physiological and emotional response to crisis as well as preparing and adapting crisis response throughout the crisis response. Ensuring the involvement of all relevant parties in responding to a crisis and the best time to enhance de-escalation and not further escalate the person. Identifying the roles of the responding team members, establishing rapport and building consensus. Prioritizing the needs of the client and the team members responding, and re-prioritizing as appropriate throughout the response.

Crisis Response for Adult Individuals with Intellectual and/or Developmental Disabilities

This two hour training reviews intellectual and developmental disabilities and dual diagnoses, and explores practical strategies for identifying warning signs, risk factors and communication strategies. The training also outlines strategies for non-verbal or sensory challenges. The training also explores strategies to engage natural supports in safety planning. Cultural considerations in working with ID/DD individuals in crisis.

Crisis Response for Youth and Families Including Intellectual/Developmental Disabilities

This two hour training reviews trauma informed de-escalation and crisis resolution with youth with ID/DD. The training includes Child Welfare Service involved youth. The training outlines ways to identify risk, involving care givers, and giving youth as much choice as possible for trauma informed care. The role of a controlled calm environment, with interviewer on the same level and avoiding power struggles or triggering interactions. Behavioral management strategies are explored as well.

Additional Enhanced and supplemental trainings are available at the Med-Cal Mobile Crisis Training and Technical Assistance Center (M-TAC) website https://camobilecrisis.org/archived-required-trainings/

Writing a Mental Health Detention (5150 Training)

Mobile crisis workers will undergo and annual training by BHRS director or designee to review the Welfare and Institution Codes surrounding mental health detention. The training will be two hours for initial training, and at least one hour for annual renewals. Training will review a brief history of changes in mental health detentions, the criteria for detention, proper completion of the 72 hour detention form under Welfare and Institutions Codes under sections 5150/5585, the least restrictive level of care standard. The training reviews mandated reports briefly including Tarasoff warnings. The training will also review the trauma of detention and strategies for minimizing impact on client, family members, and the crisis team. The training also reviews procedures for revoking a hold when an individual no longer meets criteria.

Drug Overdose Reversal (Naloxone/Narcan) Training

All mobile crisis team members will be trained in how to administer Narcan/naloxone. This training is conducted internally by BHRS staff. It includes a review of the signs indicating an overdose has occurred, attempting to rouse the person, calling for emergency services, turning the person on their side, administering Narcan, and if able to do so safely, begin resuscitation.

Additional training requirements are required of all BHRS staff will be expected of mobile crisis team members or contractors.

Dispatch Procedures- Crisis Line 1-855-838-0404

Prior to Mobile Crisis Benefit implementation, Mendocino County mobile crisis teams responded to calls initiated by 911 emergency response, referrals from the SMH Crisis Line, Heads Up a non 911 referral from Law Enforcement, direct calls from the client, family member, or community, and calls from other community providers.

Mendocino County's pre-implementation dispatch procedures are driven by Law enforcement due to staffing constraints. Mendocino County mobile crisis workers carry radios tuned to dispatch and law enforcement communications in order to efficiently respond to calls with Law Enforcement.

Specialty mental health crisis services respond to all emergency rooms in the county and by phone 24 hours a day, 7 days a week, 365 days per year. These calls are triaged via the Mendocino County Crisis line 1-855-838-0404 which is published in all mental health plan documents, on the Mendocino County website, and in various telephone and hotline resources. The Mendocino County Access Line and North Bay/National Suicide Prevention Hotline (988) both triage to the Mendocino County Crisis Line as do other hotlines. This line will triage for Mobile Crisis dispatch so that the community does not need to learn an additional crisis line.

Mendocino County's plan for dispatch upon implementation of the mobile crisis benefit, will be to have a single point of contact 24/7 mobile crisis line combined with the existing Crisis Line: 1-855-838-0404. Calls will be triaged by the crisis line and using a dispatch screening triage tool, dispatch will determine whether the call can be stabilized via phone, whether mobile crisis dispatch is warranted, whether other urgent responders are appropriate, or whether outpatient follow up is appropriate. Existing crisis line staff will be trained in the mobile crisis triage and dispatch tool by December 31, 2023. The existing crisis line triage staff will have the schedule and contact information of the mobile crisis team members. When capacity and staffing warrant it, mobile crisis and specialty mental health crisis may collaborate response, provided the composition of the responding team meets the mobile crisis benefit.

Recruitment for additional mobile crisis staff have been continuous since 2021. Mobile crisis is currently able to be dispatched at least 12 hours a day seven days a week, and more several days a week. Mendocino County is in the process of leveraging and negotiating existing contracts to expand coverage to 24/7/365 by December 31, 2023. This will leverage specialty mental health crisis staff and on call staff.

Crisis calls with an individual that is unconscious, suspected to have ingested opioids, or other substances that may have the individual in an urgent medical attention will be referred to 911 for Emergency Medical Service dispatch.

Crisis callers with access to lethal means and intent will be referred to 911 for law enforcement response. Crisis callers threatening harm with method and intent with access to means will be referred to 911 due to safety risk. Mobile crisis will respond in a dual response strategy due to safety risk factors.

Callers that do not meet criteria for 911 transfer will be triaged to determine if they can be stabilized via verbal intervention with crisis workers on the dispatch/crisis line, or whether mobile crisis response is warranted.

The crisis line/dispatch number is currently not answered by an answering line when crisis workers are at capacity; the line triages through a series of lines until it is answered Specialty Mental Health services currently answer this line and triage for stabilize in place and specialty mental health crisis.

A sample tool for dispatch triage is attached at the end of this document.

Coordination with 911 & 988

Mendocino County Behavioral Health and Recovery Services Coordinates closely with 911 and 988. Prior to implementing the Mobile Crisis Benefit, the BHRS mobile crisis response was a dual response model, and calls were initiated with Law Enforcement. Mendocino County 911 dispatch currently triages calls that do not warrant law enforcement response to mobile crisis. These calls can be either immediate/urgent response which are responded to by a team of two mobile crisis workers, or "heads up" calls where the law enforcement contact indicated a non-urgent need for follow up that is responded to by mobile crisis or mobile outreach workers as soon as they are able between urgent mobile crisis response. 911 dispatch triages calls for medical emergency, criminal emergency, and/or mental health emergency. In cases of mental health emergency, mobile crisis responds either with law enforcement or without depending on safety considerations. When the emergency includes medical concerns Emergency Medical services also respond. Mobile crisis responders have a component of learning dispatch procedures as part of their mobile crisis onboarding.

In addition, Mendocino County contracts with service providers North Bay Suicide Prevention Hotline and 988 service coordination. Mobile crisis workers carry law enforcement radios and are assigned call signs. Mobile crisis workers are called by dispatch for 911 calls with a behavioral health component. Expanded collaboration is expected in utilizing the Mobile Crisis Benefit.

Crisis Assessment Tool

All Mendocino County mobile crisis responses will include at a minimum a risk assessment of danger to self, others, and/or grave disability and a plan for safety. Menodocino County mobile crisis will collect information and completes a crisis assessment tool during or following the crisis intervention which reviews the information gathered from the client which are contributing factors to the crisis, stressors, stregnths/protective factors, other whole person factors which may be stressors or protective factors, any mini mental status concerns and a determination and next step plan for safety.

The Crisis Intervention Contact, BHRS' crisis assessment tool should be used a tool to ensure all relevant factors to determine best intervention strategiense risk and safety assessment factors have been considered. It does not need to be completed in order, or as a survey for the individual in crisis to complete all sections or check list.

Demographic Information

This section of the Crisis Assessment Tool collects as much demographic information as is available and able to be obtained during the crisis assessment. Client name, date of birth, address, gender identity, ethnicity, language, contact information, location of assessment and quick risk screening.

Presenting Problem/Current Situation

This part of the assessment includes listening to the client's report of what contributed to the current situation. This will include who requested the crisis response and through what dispatch process. This section will include information about where the crisis intervention occurred, whether any emergency personnel are present and any reports from others involved, such as law enforcement, neighbors, family, medical personnel, etc. This section should include what the individual in crisis (or the family unit) considers the priority needing to be addressed.

Stressors

This section of the assessment tool is an opportunity to identify chronic and new stressors to help identify potential strategies to help de-escalate. Stressors may include recent changes or losses such as personal relationships, financial problems, loss of housing, recent move, divorce, or loss of job, recent incarceration, new medical diagnosis, change in medication. Stressors can also include chronic trauma or impacts of involvement in the child welfare system, criminal justice system, or other impacts from social drivers of health. The section should include an assessment of the impact of these on the current crisis experience.

Brief Substance Use History

This section of the assessment tool is an opportunity to identify relevant substance use factors. If the individual in crisis is currently under the influence of a substance this should be noted, chronic substance use, abuse, and/or addictions can be noted. Any treatment attempts, harm reduction skills or information the individual has. This section should include an assessment of the impacts of the history of substance use on the crisis experience.

Medical History

This section of the assessment tool should include any known allergies and medical conditions. This section should include any known medications. If the individual is currently experiencing medical distress or being seen by medical practitioners, the information should be included here. The crisis

worker should note if the person in crisis has terms they prefer to use for medical diagnoses, or if there are differences from client perspective and medical personnel. Factors such as changes in eating or sleeping habits can be included here as well.

Mental Health/Psychiatric History

This section of the assessment tool should include any known mental health diagnoses and medications and any known psychiatric hospitalizations. The crisis worker should note how the individual in crisis defines their experience, and whether it is different than described by mental health practitioners.

Social, Cultural, Family History & Support

This section of the assessment tool should review potential protective factors and the degree to which the individual in crisis is engaged with these systems. This section can include formal supports such as involved agency support systems and informal supports such as family and neighbors. Relevant familial relationships should be included here. Cultural factors relevant to the crisis, protective factors and supports should be included. Religious affiliations relevant to the crisis, protective factors and supports should be included. The client's level of engagement and benefit gained from protective factors should be considered and included in the assessment. Authorizations to communicate with people identified in this section should be obtained if the client is willing to allow for support with after care plans.

Strengths

This section of the crisis assessment tool should include personal strengths of the individual in crisis. It can include internal strengths and qualities such as resiliency or perseverance or behavioral strengths such as a prior success with sobriety or overcoming challenges, or engagement with supports.

Mental Status Exam

This section of the assessment tool is an inventory of factors that give insight into mental health impacts to functioning. Identifying appearance, motor activity, speech, affect, mood, thought content, thought processes, memory, orientation to person, place, time, and situation, the degree of intensity of suicidal or homicidal thought, intent, plan, or attempts. This section should also include any factors pertaining to the individual's ability to meet their basic food clothing and shelter that are impacted by the mental health symptoms and factors.

Determination and Plan

This section is the culmination of all the components catalogued in the crisis assessment tool. What are the immediate resolutions for the crisis, what are the next steps for the individual and any support providers/people to follow through. If a mental health detention is written, that will be included, as well as any transition to other crisis or hospital placement information if known prior to the end of the crisis contact. Any follow up appointments should be both included in this section and provided to the client. If the crisis team will provide post crisis follow up, this should also be included in as much specificity as available, up to frequency, duration, and intensity. Any plan goals for the client should be articulated in the client's words, strengths that support the goal can be included, and any barriers that the individual may need support in overcoming. If a formal plan is written, the client should sign and receive a copy.

A sample safety plan document is included at the end of this Implemenation Plan.

Community Engagement Activities & Notification of Beneficiaries

Mendocino County Behavioral Health & Recovery Services has multiple community stakeholder feedback opportunities. Stakeholder feedback and input on programs is sought in written, verbal, and electronic formats. We use feedback sessions, surveys, and comments and suggestion cards. Stakeholder and community engagement includes engaging partner agencies that also provide behavioral health services, health care professionals, criminal justice systems, client engagement, client family member engagement, and the general public. Meeting frequency can vary from monthly to biannually. Community engagement activities and opportunities to provide or receive information include but are not limited to:

- Mental Health Services Act & Quality Improvement Committee Forums
- Cultural Diversity Committee
- Behavioral Health Advisory Board Meeting
- Consumer Perception Surveys
- Mental Health Awareness Survey
- Consumer Events & Key Informant Interviews
- Stepping Up Collaborative
- Crisis Intervention Team Task Force
- Heads Up Collaborative
- Coordination of Care meetings with providers
- Participation in Multidisciplinary meetings
- NAMI Community Collaboration meetings
- The Mendocino County Behavioral Health Website
- The Grievance and/or Issue Resolution Process
- Public Comment Periods for the Mental Health Services Act Plan
- Participation in Health Fairs, community events, and other information sharing opportunities in the community.

Prior to full implementation the BHRS mobile crisis team has initiated partial mobile crisis implementation via the Crisis Care Mobile Units (CCMU) grant funding. With mobile crisis response that is not yet able to respond 24/7 we have been building relationships with the community, we have been present at community service and response meetings and have been responding with law enforcement to crisis with a behavioral health nature. This has allowed the community to become familiar with the mobile crisis teams.

We have created marketing materials and engagement tools for working with the crisis clients. Marketing materials includes standard items such as brochures, fliers, and business cards, but they also include stress management and sensory items to help engage clients in the fight or flight mode of a crisis. Items are small in order to be safe to give a person and are also designed to be left behind.

Mobile crisis provides data on services and outcomes to the Quality Assurance and Performance Improvement Committee, the Chief Executive Officer report to the Board of Supervisors and Public, the Behavioral Health Advisory Board, and the Crisis Intervention Team Task Force.

The mobile crisis benefit was added to the 2024 Beneficiary Handbook including that Mendocino County will have the benefit available and a brief description of services. The Beneficiary Handbook was made available in English and Spanish and a letter notifying beneficiaries of the changes was sent to all beneficiaries in our electronic health record in both English and Spanish and with additional language taglines included. This packet of information was mailed to all beneficiaries on December 1, 2023.

Sharing Data with the Community

BHRS has multiple activities which are intended to inform the community of services provided. The BHRS Website is one comprehensive electronically available tool. The BHRS Prevention and Wellness unit in coordination with Mental Health Services Act Outreach for Recognitions of Signs and Symptoms of Mental Illness, conducts multiple outreach to health fairs, community events, Farmer's Markets, schools, clinics, family resource centers and other centers of the community to provide information and resources on services provided by BHRS and contracted providers as well as informational materials.

One of the roles of the Mobile Outreach and Prevention Services program is to be in most rural communities checking in with community based organizations to inform of BHRS services, including the mobile crisis benefit, and support individuals in need to connect with thee services. Mobile Outreach and Prevention Services (MOPS) was designed to respond to the remote areas of the community which do not have emergency departments and may have time delays for emergency response. The goal of the program was to address behavioral health concerns pre crisis development and to link and support individuals to engage in services and de-escalate concerns to prevent escalation to emergency level response. The teams connect with their service area community based organizations, community centers and clinics to inform local providers and community members of available services as well as identify and connect with individuals that may be experiencing symptoms which may lead to crisis. The program provides both a preventative and follow up component for those in crisis in the most isolated areas of our community.

Sharing Data and Evaluation Findings

Community Engagement and notification activities include opportunities for stakeholders to both learn about the news, data, and information from BHRS programs as well as for stakeholders to provide feedback. Data on clients served and outcome measures are reported at the meetings, as are the results of any oversight, reviews, audits, or other evaluation feedback. Information from stakeholder events is posted on the Mendocino County BHRS website. In addition, current mobile crisis and crisis response data have been included in reports and dashboards on the SMHS Data Reports and Analysis page: https://www.mendocinocounty.org/departments/behavioral-health-and-recovery-services/mental-health-services/data-reports-and-analysis

Coordination with Law Enforcement

Mendocino County Behavioral Health and Recovery Services has established a close relationship with law enforcement in the implementation of mobile crisis and mobile outreach services prior to the Mobile Crisis Benefit Implementation. Crisis workers carry law enforcement radios and have call signs, to be dispatched to 911 dispatch calls of a behavioral health nature. Crisis workers conduct part of their orientation with partner law enforcement agencies, to learn the communication call signs and to learn safety procedures and communication around when law enforcement will take lead versus when crisis teams take lead.

The mobile crisis teams have multiple ways in which they coordinate with law enforcement. The goal is for the mobile crisis team to respond without law enforcement when possible, and when co response does occur to take the lead except in situations where there is a weapon or other safety concern.

Dual Response Mobile Crisis & Transition to Mobile Crisis Benefit

Dual Response Mobile Crisis is how mobile crisis teams have been operating prior to Mobile Crisis Benefit Implementation beginning in 2021. Mobile crisis teams are co-trained with law enforcement during the onboarding period on safety and communication practices. Mobile crisis teams are assigned radios and call signs and are contacted by dispatch when a call comes through of a behavioral health nature. Mobile crisis teams meet law enforcement at the site where the client is, whether that is a home, side of the road, business, or other community-based locale. Mobile crisis workers take lead unless there are safety or medical considerations requiring law enforcement or EMS to take lead, attempting to engage the individual and de-escalate the crisis. The goal of this crisis response is to de-escalate to the point that the individual will voluntarily accept services. In voluntary situations the mobile crisis team will either arrange for follow up check ins with the individual and/or warm hand off to link to additional services. Additional services can include community-based supports, outpatient specialty mental health treatment, substance use treatment, or voluntary transport for further mental health crisis assessment at an emergency department or crisis center when warranted. Linkage and follow up can include connection to any appropriate follow up resource.

In situations where the client is unable or unwilling to participate voluntarily in next step treatment and mental health detention criteria are met, the mobile crisis worker or law enforcement officer will write the detention. In most cases the mobile crisis worker writes the detention, and when safe to do so the mobile crisis worker will transport to the emergency department. A similar triage is used to the dispatch triage to determine whether transport with mobile crisis is safe and appropriate. In situations where safety risks have been determined considerable, law enforcement will transport to the emergency department.

In doing pre mobile crisis benefit implementation we have had situations where criteria are met, and the individual is unwilling to go to the hospital either with law enforcement or mobile crisis. In cases where no public safety concerns are met, members of law enforcement are willing to enforce the detention due to concerns of escalating the situation. In these cases, the crisis worker will attempt to engage the client further, but if we are not successful, we have left the client in situation with a detention written but not enforced. In those cases, mobile crisis does follow ups over time to further engage the individual.

In some mobile crisis responses with law enforcement, it is determined that an individual has committed a crime that warrants arrest. In these situations, the law enforcement member makes that decision. The mobile crisis worker will communicate the mental health components which may be a factor in the collaboration with law enforcement.

Existing specialty mental health crisis services respond to the crisis line, crisis centers, and all emergency rooms in the county and by phone 24 hours a day, 7 days a week, 365 days per year. These calls are triaged via the Mendocino County Crisis line 1-855-838-0404 which will triage for Mobile Crisis dispatch not initiated by 911. Existing crisis line staff will be trained in the mobile crisis triage and dispatch tool by December 31, 2023. The existing crisis line triage staff will have the schedule and contact information of the mobile crisis team members. When capacity and staffing warrant it, mobile crisis and specialty mental health crisis may collaborate response, provided the composition of the responding team meets the mobile crisis benefit. 911 dispatch will be able to triage calls that do not warrant law enforcement response to this line and/or directly to mobile crisis responders via radio communication.

Recruitment for additional mobile crisis staff have been continuous since 2021 and receipt of the Community Crisis Mobile Units, however due to staffing shortages, Mobile crisis is currently only able to be dispatched between 12-15 hours per day seven days a week. We are in the process of leveraging and negotiating existing contracts and staffing to utilize specialty mental health providers and qualified existing staff on call to expand coverage to 24/7/365 by December 31, 2023.

Mobile Outreach and Prevention Services

Mobile Outreach and Prevention Services (MOPS) is a program that was initiated under the Investment in Mental Health Wellness Grant to provide pre crisis response to prevent behavioral health concerns from developing into a crisis. The program initially developed as a co response model with a mental health rehabilitation specialist and sheriff services technician partnering to respond to the remote areas of the community which do not have emergency departments and may have time delays for emergency response. The goal of the program was to address behavioral health concerns pre crisis development and to link and support individuals to engage in services and de-escalate concerns to prevent escalation to emergency level response. Over time this program was not able to maintain the sheriff services technician role due to hiring capacity and then the ending of grant funding.

The program continues as an outreach program with mental health rehabilitation specialists responding to the remote and rural locations of north county, north of Willits, south coast south of Fort Bragg, and the inland valleys outside Ukiah. The teams respond to new calls as teams of two, and communicate with law enforcement, most frequently the Mendocino County Sheriff's Office, to ensure awareness of location in case of escalated contacts. The team provides a very low threshold for service response in order to develop engagement, connect with individuals demonstrating any level of behavioral health condition until we are able to develop enough rapport to refer, link, and connect clients to the appropriate services. Appropriate services may include anything from connection to local community-based support organizations, or linkage to specialty mental health services. The Mobile Outreach and Prevention Services teams are not case managers and do not maintain long-term care management support relationships with outreach individuals; they do follow up with and support individuals in their

target service areas for brief periods until they are able to connect successfully through warm hand offs with appropriate levels of services.

The program works closely with the mobile crisis team, providing a second member when needed in their service areas. Mobile Outreach and Prevention Services team members hold 5150 cards and communicate and coordinate with law enforcement and mobile crisis as needed for supporting individuals in the MOPS communities that do require higher level of care and intervention through the mental health detention process.

Heads Up Referrals

This program is a collaboration between Behavioral Health and Recovery Services (BHRS) and Department of Social Services (DSS)Homeless Services and Homeless Outreach Teams and law enforcement to engage frequent contacts of law enforcement with behavioral health conditions and or are living homeless with the appropriate services. The program arose around an attempt to better engage individuals in the community that come into contact with law enforcement for minor infractions or no criminal behavior but do not appear to be engaged. Members of law enforcement refer individuals that they have contact with that do not meet 5150 criteria and do not warrant arrest but appear to need additional support with addressing behavioral health conditions and/or issues of homelessness. Following the referral, the BHRS and DSS teams determine which team will take lead in outreaching to the individual, based on prior knowledge of the client or concerns indicated by the law enforcement officer in making the referral.

BHRS's outreach is conducted by either MOPS or mobile crisis team members to identify risk factors, begin engagement and referral to appropriate services.

The program is a pilot collaboration, and relevant stakeholders met monthly in early implementation, and now meet quarterly to address data, progress, and resolve any challenges.

Jail Discharge Planning

Behavioral Health and Recovery Services through Mental Health Services Act has a program which provides discharge planning and linkage for jail inmates with behavioral health conditions. The program is designed to work with inmates within sixty (60) days of release, and the mental health rehabilitation specialist assigned to this program works closely with correctional facility staff and jail medical staff to identify individuals that may meet this criterion. The program takes referrals from corrections, Jail medical services, self-referred clients, and the mental health rehabilitation specialist also reviews the booking log for individuals known to have behavioral health conditions.

The mental health rehabilitation specialist assigned to jail discharge planning attends a weekly meeting which is a collaboration meeting between stakeholders impacted, Jail custody staff, jail medical staff, probation, discharge planning, and specialty mental health providers and substance use treatment providers. The meeting reviews challenges and strategies to meet the needs of inmates being released and complications which arise from unanticipated releases. Coordination with specialty mental health crisis occurs for inmates that are anticipated to need more intensive mental health assessment and or treatment upon release from jail.

The jail discharge planner role is to begin engaging inmates, identifying behavioral health needs, and secure when the individual is willing, the necessary releases of information to support completion of

referrals and establishing behavioral health follow up services post release. The jail discharge planner provides a warm handoff, when the inmate is willing, to connect with after care services and the jail discharge planner follows up with the client post release until they are connected to services or decline further involvement. The jail discharge planner participates in other stakeholder meetings such as Medication Assisted Treatment communication meetings for inmates, and ReEntry stakeholder meetings held by Inmate Services/Restorative Justice programs. The discharge planner, as a mental health rehabilitation specialist, can support mobile crisis teams to provide an additional team member, especially when responding to crises with individuals with whom he has rapport. He also follows up with inmates that were arrested subsequent to a co-responder mobile crisis where law enforcement determined arrest was warranted.

Behavioral Health Services to Probation (AB109)

Behavioral Health and Recovery Services has a partnership with Probation under the Community Corrections Partnership (CCP) subsequent to AB109. Under this collaboration, AB109 funds a mental health clinician and partial substance use counselor to support individuals on probation with behavioral health needs. These services include initiating substance use education and treatment groups in jail prior to release and continues post release to enhance opportunities for substance sobriety and recovery from addictions. The mental health clinician provides services to probation individuals, prioritizing those on Post Release Community Supervision. The behavioral health services that warrant specialty mental health treatment, are referred to specialty mental health providers, but those that would meet mild to moderate services but may have additional challenges related to involvement in the criminal justice system are provided more intensive services co-located at the probation office to increase access and reduce recidivism.

Assisted Outpatient Treatment (AKA Laura's Law or AB 1421)

Assisted Outpatient Treatment (AOT) has been implemented in Mendocino County since a pilot in 2014. This program is a civil court assisted program for individuals (adults) that meet nine specific criteria of behavioral health diagnosis, level of risk, level of benefit, and history of high level of care needs. Individuals that meet criteria are engaged in the process overseen by the courts. This program has the capacity to collaborate with law enforcement when qualified or court involved individuals are not participating in the court review, but thus far in implementation, we have not required involvement of law enforcement to facilitate participation in court as all fully enrolled AOT clients have gone through the voluntary Settlement Agreement process. Mobile crisis teams shall refer clients that meet AOT criteria for further assessment and potential enrollment.

Coordination with Tribal Police

BHRS recognizes that when entering sovereign tribal nations and has, in communication with tribal nations, received requests to respect intergovernmental relations by communicating with the Tribal Office when on tribal land. Mobile crisis teams shall notify tribal offices when present on tribal land as quickly as is reasonable in responding to the crisis. Mobile crisis teams shall interact with tribal police in manners consistent with other law enforcement entities.

Coordination with Emergency Medical Services

When needed 911 dispatch coordinates with EMS. When medical emergencies are present in a mobile crisis call, the medical emergency takes precedent. Mobile crisis teams will wait for the medical team to complete their work prior to initiating the mental health assessment and triage.

When mobile crisis teams are in the community, if they experience a medical emergency, they will call for EMS response, and allow for the medical emergency to be resolved before resuming intervention and safety planning. All mobile crisis workers are trained to carry and administer Narcan/Naloxone for opioid reversals, when these are suspected in the field while simultaneously calling for EMS response.

When EMS responds to a medical emergency, if they identify a mental health response, they are referring these to either specialty mental health or mobile crisis depending on whether the individual will be transported to the emergency. These referrals are currently made through utilization of the 911 communication system; however, we are interested in expanding communication directly with the EMS provider.

Mendocino County has limited emergency medical services. The remote and rural nature of some of our communities can mean on occasion that mobile crisis teams will arrive on scene prior to emergency medical services. On these occasions, the mobile crisis team will begin to obtain what collateral information is available from the individual in crisis and others on site, to share with EMS when they arrive. The mobile crisis will allow EMS to take lead when medical risk exists.

In crisis response situations where there are safety risks and/or medical risks, the mobile crisis team will allow the medical and safety concerns to be addressed and resolved prior to fully intervening. The crisis line will use the dispatch triage tool to triage calls to 911 as needed. The BHRS mobile crisis team will work with others present, family or others in the environment to obtain collateral information about the crisis and providing support and stabilization for the others involved.

BHRS is interested in collaborating more closely with our EMS service provider in the future, with hopes of updating existing Memoranda of Understanding to possibly include greater opportunity for co-response and communication as appropriate and necessary.

Mobile Crisis Team Composition & Peer Roles

Mobile crisis teams will be comprised of multidisciplinary teams of two providers able to respond to mobile crises 24 hours a day, seven days a week. At least one of the providers must be capable of conducting a crisis assessment. At least one member of the mobile crisis team will be trained to administer naloxone and or Narcan. One provider may be available via telehealth if it is safe for mobile responder to respond alone, and the second provider's telehealth presence ensures the response meets expectations of time and distance standards. The multidisciplinary teams may include licensed practitioners of the healing arts (LPHA), Mental Health Rehabilitation Specialists, waivered/registered clinical practitioners, Physician, Nurse Practitioners, Licensed Vocational Nurse, Physician Assistant, Certified Nurse Specialist, Occupational therapist, Pharmacist Alcohol and other Drug Counselors, Community Health Workers, Emergency Medical Technicians, Paramedics, and Peer Support Specialists. Other qualified providers can be considered part of the mobile crisis team. The mobile crisis teams will have a supervisor and/or clinician available for consultation.

Peer providers have the unique lived experience that can be an asset in mobile crisis to bring a distinct value as a living representative that recovery is possible. Peer specialists provide an opportunity to engage the individual in crisis in a unique way and may be better suited to link the beneficiary to follow up services. Peer support providers may build on shared experiences to enhance the crisis intervention with the individual in crisis, their family members or other natural support and/or collateral supports. Peers can speak from a place of lived experience in discussing overcoming behavioral health challenges, the importance of engaging supports, and utilizing self-care. Peer support specialists should have state approved certification allowing for Medi-Cal billing. Wherever possible peer supports should be peers in multiple areas of intersectionality; for example, a peer with lived experience with mental health and homelessness will have better opportunities for rapport with an individual in crisis with mental health concerns and living unhoused.

Community Health Workers

Community Health Workers, like peer support specialists may include a variety of titles but are respected members of the community who add value to the mobile crisis team through their personal experience and connection to the community they serve. Community health workers may be community or patient navigators, promotores, community liaisons and other non-licensed professionals and paraprofessionals.

Transportation Policy

Whenever it is safe to do so, the BHRS mobile crisis team will transport clients from the scene of the crisis to the next step in their safety plan (hospital or warm handoff referral). Clients that are unsafe following a risk assessment, similar to the dispatch risk assessment tool, will be transported by law enforcement. Clients that are determined to be in a medical emergency will be transported by emergency medical services. Crisis workers will have both caged and uncaged vehicles available for transport.

Transporting Minors

Youth will not be transported by mobile crisis staff without permission from a legal guardian and a second person present. Except in cases of minor consent, the parent, guardian, or in loco parentis adult will be transported with the minor when mobile crisis transports a minor. All laws regarding transport of children will be adhered to at all times regarding car seats, youth in the front seat, and seat belts being worn at all times. When parental consent and or safety measures are unable to be followed, transport shall occur with law enforcement or emergency medical services. BHRS is in the process of finalizing a youth transportation policy, prior to implementation of the Mobile Crisis Benefit.

Warm Hand off

Warm hand off is a personal connection from one system or service provider to another. In the case of mobile crisis, the warm hand off will be the transition from a field-based crisis contact to a follow up service. In cases of mental health detention, mobile crisis will support communication and transition to the specialty mental health crisis worker and emergency department, even when they are not the transporting entity. This may include following to the emergency department to introduce the client to the emergency department and specialty mental health staff and to provide history and current status to the specialty mental health providers for further evaluation and triage to acute psychiatric hospitalization if needed.

In cases where mental health detention is not needed or warranted the warm handoff will occur in connecting to any other relevant resources. Relevant resources can be broad and may include supporting connection to local peer supports or community-based organizations or could include supporting connection to formal treatment through mental health or specialty mental health.

Follow up and Referral

Mobile crisis will offer a brief period of follow up with individuals seen in crisis, to the extent that the individual is willing to accept follow up. Follow up will occur within the first 72 hours post crisis contact. This follow up will include checking in with the individual and, with authorization to release confidential information, with their natural supports and family. Follow up activities will include monitoring the crisis resolution and determining whether there is need for further de-escalation tools, intervention or other activities and supporting choice and use of coping skills. Other purposes of follow up will include monitoring activation of the safety plan, supporting additional discussion of safety and crisis resolution if needed, supporting connecting with referral organizations and agencies, use of warm handoffs where possible and appropriate.

Mobile crisis teams shall be knowledgeable about behavioral health and social services supports and shall refer crisis clients as appropriate to mitigate future crises. This may include follow up with primary providers, specialty mental health treatment, substance use treatment, Tribal Health Care, intellectual

or developmental disability services, sobriety support aid groups, peer support programs, housing, food and other basic need supports, and other supports as needed. Mobile crisis workers are mandated reporters and will make reports related to Adult Protective Services, Child Protective Services, and Tarasoff Warnings as indicated. Mobile crisis teams shall document referrals in the note associated with the crisis contact.

The mobile crisis will attempt to collect data, when the client is willing to share the information, on how frequently the client successfully connects to any follow up services or formal referrals. If needed the mobile crisis team shall continue to support scheduling, arranging for transportation, and providing reminders as needed as part of the follow up. The mobile crisis team will also document if and when they are unable to reach or follow up with the client and the reason (e.g., client refused, unwilling to locate client, client in inpatient.) Mobile crisis will use collaborations via Mobile Outreach and Prevention and other BHRS field-based programs to support follow up and referrals.

Culturally Responsive and Accessible Practices

Mendocino County Behavioral Health and Recovery Services provides has a commitment to linguistically appropriate, culturally responsive, accessible and competent services. Mendocino County conducts and annual Culturally and Linguistically Appropriate Service Standards (CLAS Standards) training and requires staff to be trained in additional cultural responsiveness training. Mendocino County requires staff to be trained in use of the language line for linguistic responsiveness when the service provider is not bilingual in the preferred language of the client and a translator/interpreter is not available. BHRS writes an annual plan and review of the cultural responsiveness of behavioral health and recovery services and the cultural composition of Mendocino. Mendocino is continuously working to improve cultural knowledge and understanding, engaging in contractual and Memoranda of Understanding for training, culturally specific service provision, and other collaborations with cultural experts, Tribal Government or Tribal Health Clinics, Promotores and community liaisons to specific cultures. BHRS also explores the impacts of historical trauma and systemic racism as well as intersectionality on the behavioral health of the individuals we serve. Mendocino County encourages the use of trauma informed, culturally responsive training and strategies to respond to behavioral health and recognizes that while we also prioritize evidence based practices, there may be community preferred practices for some cultural groups.

Mendocino County provides incentives for bilingual providers and has been recruiting for mobile crisis workers with intention of hiring bilingual providers when possible. If and when bilingual providers are unavailable to respond to a mobile crisis, the mobile crisis teams will use a qualified translator and/or Language Line Solutions for translating the crisis intervention. Mobile crisis teams are discouraged from using family members or friends as translators unless needed as there may be relationships or power differentials between the beneficiary and the family member that may impact the quality of the intervention due to the beneficiary either not feeling comfortable fully disclosing to the person translating and/or the person doing the translating filtering what is translated for some reason due to the relationship. Mobile crisis teams will not use family members for translation unless it is preferred by the beneficiary and the only way to engage the beneficiary in the intervention. When this occurs, the mobile team will include in documentation of the intervention the justification for using family/friend translation. Minors will never be used for translation.

The mobile crisis teams, as BHRS employees will follow all culturally and linguistically responsive policies. BHRS will review mobile crisis data for review in the Cultural Responsiveness Plan and will review the utilization and access given the cultural composition and other cultural considerations.

Activities related to monitoring the Cultural Responsiveness of Behavioral Health Programs include:

- Annual Cultural Responsiveness Plan and evaluation
- Cultural Diversity Committee meetings
- Cultural Responsiveness trainings
- Behavioral Health Advisory Board meetings
- Mental Health Services Act Forums
- Quality Assurance and Performance Improvement meetings
- Grievance and Issue Resolution Processes

- Community Collaboration Meetings with representatives of Tribal organizations and NAMI members
- Contracts and MOUs with cultural experts
- Cultural Responsiveness Policy & Procedures

Additional information around Behavioral Health and Recovery Services cultural responsiveness practices can be found at: https://www.mendocinocounty.org/departments/behavioral-health-and-recovery-services/mental-health-services/cultural-diversity-committee.

Mendocino County currently has threshold languages of English and Spanish. Required materials are produced in all threshold languages. BHRS produces mobile crisis marketing materials in English and Spanish. BHRS partners with CalMHSA to provide translation in other languages for required documents and will leverage that partnership for additional language translation as needed.

The mobile crisis benefit was added to the 2024 Beneficiary Handbook including that Mendocino County will have the benefit available and a brief description of services. The Beneficiary Handbook was made available in English and Spanish and a letter notifying beneficiaries of the changes was sent to all beneficiaries in our electronic health record in both English and Spanish and with additional language taglines included. This packet of information was mailed to all beneficiaries on December 1, 2023.

Mobile Crisis Strategies to Respond to Youth

Mobile crisis teams will respond to crises of all ages, and there will not be exclusions for any age. In responding to youth mobile crises, addition to the dispatch screening, a triage will be done with specialty mental health crisis services to determine whether they are able to respond, in particular to youth crises occurring at school. BHRS has grant funds under Mental Health Student Services Act funding to augment specialty mental health services to youth in schools with crisis, bullying, and dropout supports. When specialty mental health and/or MHSA service providers are able to conduct the crisis de-escalation or participate in the mobile crisis response to schools, that is preferred.

Mobile crisis members will conduct the crisis assessment with youth as with adults with additional consideration for minor consent and involvement of parents, guardians, and other involved caregivers. Mobile crisis workers will utilize trauma informed and culturally responsive approaches in responding to youth and will recognize that youth crisis may be a first point of contact to mental health services for youth and their families; the crisis assessment may be a triage point for a multitude of services needed by the youth and family which they may not be aware of. Mobile crisis will keep culturally responsive considerations in mind when working with youth and families and recognize that youth and families may not use terms of behavioral health in describing behaviors or behavioral health symptoms. In addition, LGBTQ+ youth may have additional stressors and factors contributing to behavioral health concerns which they may not feel comfortable discussing with parents, guardians, teachers, and or other caregivers acting in loco parentis.

BHRS recognizes that when a youth is in crisis the whole family system is also in crisis. Mobile crisis teams will include the parent or guardian in the assessment process wherever possible. The parent/guardian may have additional information and history or perspective on the crisis than the youth. Mobile crisis teams will consider the family system factors in the assessment process as well as in safety planning. The parent/caregiver should have input and commitment to the safety plan in addition to the youth if possible as a best practice to ensure a successful safety plan. Additional family or supports that are included in the safety plan should be notified and confirm their ability to provide supports (for example, respite, emotional support, or transportation to follow up appointments), and authorizations to communicate with those supports should be obtained during the assessment and intervention process. The intervention and assessment should explore and consider any areas of disconnect or disagreement with parents/caregivers as that may contribute to additional aspects of intervention needed (such as FURS or child welfare involvement if indicated). Parent/caregiver involvement and agreement with the assessment and safety plan will support successful plan follow through and follow up for the youth.

Minor Consent

Mobile crisis staff will be trained in minor consent laws as pertain to the crisis assessment. In California, laws in Health and Safety Code Section 124260 and the Family Code Section 6924 establishing that a minor 12 years of age or older to consent to mental health treatment or counseling on an outpatient bases, or to utilize residential shelter services if the minor is mature enough to intelligently participate in the treatment. The minor's parent or guardian is required to be involved in treatment unless the professional providing treatment to the minor determines that involvement would be inappropriate. This determination shall include consultation of the minor. One reason under the Family Code for determining that it is appropriate to treat a minor under minor consent, is in cases where the minor is

the alleged victim of incest or child abuse, or the minor would present a danger of serious physical or mental harm to self or others without the treatment or residential service. Treatment without parent or guardian consent shall be documented in the client record, as shall any attempt to contact parent/guardians and the rationale for the minor consent treatment. In situations of minor consent to treatment, the minor parent/guardian shall not be liable for payment for treatment except in situations in which they participate.

Mobile crisis teams shall consult a clinical team member in making the decision to treat a minor with out a parent or guardian consent.

Coordination with Child Welfare Services

Some youth in crisis may be involved in Child Welfare Services (CWS), and those situations the guardian may be a representative of CWS and or Probation. Mobile crisis teams will verify the non-parent guardian in these situations and involve them in the assessment and planning process. There may be factors pertaining to the CWS involvement that need to be considered in the assessment, de-escalation and determination for these youth.

Coordination with Family Urgent Response System Program

Family Urgent Response System (FURS) program is a 24/7 response service (1-833-939-3877) for linkage and response to current and former foster youth (through age twenty-one) and their care givers that are experiencing instability. The FURS program will have a county wide phone and mobile response to provide de-escalation to youth and their families. In the course of their duties FURS program may respond to mobile crisis teams and vise versa. The purpose of FURS is to reduce need for 911 intervention, placement disruption, and/or hospitalization. Mobile crisis response involving current or foster involved youth should include the FURS responders. FURS may have existing plans or stabilization, interventions, and de-escalation specific to the youth. FURS responders may also have access to temporary respite for youth or caregiver to allow for a break or space from stressors related to the crisis. FURS responders may also have resources for referral and follow up resources that the mobile crisis team may be unaware specific to foster family agencies and foster care youth.

The specialty mental health crisis responder, crisis line, and FURS hotline are all operated by the same community-based organization. Mobile crisis will work with them on protocol surrounding the triage and dispatch tool to ensure the best and least restrictive response team members are dispatched as well as processes for coordination.

Coordination with Redwood Coast Regional Centers

Mobile crisis teams shall be trained in recognizing intellectual and developmental disabilities (ID/DD). In the course of mobile response, if individuals are displaying symptoms of behavioral health and ID/DD, the mobile crisis worker will attempt to learn whether Redwood Coast Regional Service providers are engaged in treatment and supports with the client. When services are not present, but indicated, the mobile crisis team will make a referral to RCRC. Authorizations to release confidential shall be obtained wherever possible to ease communication and referral. This is especially important with youth, as identification of ID/DD in youth is critical to ensuring services can be established. Youth with involved regional center services may have additional resources available to them, and these should be considered in the course of the crisis assessment and plan development.

Coordination with the Managed Care Plan

Behavioral Health and Recovery Services and specialty mental health providers have a Memorandum of Understanding (MOU) with the Managed Care Plan operated by Partnership Health Plan of California. The MOU outlines the expectations between the Mental Health Plan (MHP) and the Managed Care Plan pertaining to the division of responsibility for mental health treatment. Mental health treatment for individuals with specialty mental health medical necessity criteria are served by the MHP while those that do not meet medical necessity for severe mental health need impacting ability to function in activities of daily living are served by the MCP via primary care providers. The MOU outlines responsibilities such as basic requirements of each party, organization of each body, covered populations and service, oversight roles of each body, screening and assessment protocols, referrals between the MHP and MCP, beneficiary and provider education regarding covered services, after hours protocols, care coordination expectations, consultation protocols, expectations regarding laboratory testing, emergency room coverage, nursing facility services, inpatient psychiatric coverage expectations, information exchange parameters and regulations, grievance, complaint and appeal resolution processes, dispute resolution, and quality improvement requirements. The MOU also outlines expectations related to parity, referrals for substance use services, and expectations for transportation.

Care coordination is needed between the MCP and MHP for clients that may initiate access to services in one system of care but require the other system of care or for clients that may need to transition from one level of care when severity of symptoms and treatment needs change. Care coordination will include a formal notification of at least 24 hours, communication and discussion of existing client needs and care plan, and an overlapping period of warm hand off to ensure successful transition to the required level of care. Triage tools will be utilized by both entities to ensure screening and referral of individuals to the appropriate level of care. The MHP service providers and MCP meet routinely to discuss referral procedures, and information exchange protocols and to address any problem resolution that may be necessary. Individualized care coordination meetings can be established more frequently than oversight meetings to ensure successful transition of individual clients, in particular those with more complex care needs which may involve consultation or more intensive information exchange.

Oversight Expectations

Behavioral Health and Recovery Services has multiple levels of oversight. The mobile crisis unit operates under general supervision of a Program Administrator and the unit in coordination with similar service and field-based units are overseen by Senior Program Manager who falls under organizational oversight including Deputy Director, BHRS Director, all of whom fall under the Chief Executive Officer of Mendocino County who reports to the Board of Supervisors. Crisis workers will routinely meet with supervisors and or other management for individual supervision and guidance, team and unit meetings, BHRS trainings and staff meetings, unit and BHRS wide trainings, and other oversight activities as appropriate. In addition, clinical members of the mobile crisis team will engage in clinical supervision in accordance with their license requirements.

No mental health detention determination will be made by a single person. Mobile crisis workers will consult with the team members present, including law enforcement when relevant, to ensure least restrictive care standard and considerations are met and safety and risk factors have been addressed. The mobile crisis worker will consult with the on-call supervisor regarding determination of detention being warranted for final review and consideration of all factors. An on-call clinician will be consulted in situations where necessity of minor consent or Tarasoff Duty to Warn clinical considerations require clinical assessments and consultation for determination.

BHRS conducts multiple oversight activities to ensure quality services to Medi-Cal beneficiaries. Chief among the oversight activities are the Quality Assurance and Performance Improvement meetings to review data, evaluate access and challenges related to program utilization with staff and service providers and the Quality Improvement Committee to share data, collect feedback and discuss opportunities for improvement with the public and stakeholders. Grievance and Appeal Resolution processes provide an opportunity to review and address direct client complaints. BHRS has a Patient's Rights Advocate to provide support for clients to advocate for themselves regarding behavioral health rights and violations of rights related to being a behavioral health symptoms, treatment, or other experience related to being diagnosed with a behavioral health condition. A Compliance Committee of senior management reviews compliance with specialty mental health regulations, trainings, audit findings, and any corrective action plan statuses. Utilization management reviews program utilization and capacity, disparities in utilization of service including over and underrepresented services and populations. Beneficiary satisfaction surveys, consumer events, public stakeholder meetings, and opportunities for written feedback are strategies for consumers to provide feedback in a multitude of styles, settings, and thresholds of comfort to report feedback. Cultural Diversity Committee meetings collect stakeholder and public feedback regarding the cultural accessibility, responsiveness, and training needs of BHRS. Client chart audits are conducted for integrity and accuracy of documentation and billing. Performance Improvement Projects are conducted on clinical and non-clinical areas that have been identified as needing improvement as are additional less formal process improvements as needed.

The results of routine data review and analysis are shared in stakeholder meetings and on the BHRS website, as are the results of external and state reviews and audits.

Acronym List

AB109- Assembly Bill 109 in 2011 along with Assembly bill 119 and Senate Bill 678 created the Community Corrections Partnership a committee designed to address realignment related to reducing prison populations by returning non-serious, non-violent and non-sexual offenders to county jail and Post Release Community Supervision via Probation.

AOT- Assisted Outpatient Treatment otherwise known as Laura's Law or AB 1421.

BHIN- Behavioral Health Information Notice

BHRS- Behavioral Health and Recovery Services

CCMU- Crisis Care Mobile Units, a Department of Health Care Services program and grant funding to implement new or expanded mobile crisis units.

CCP- Community Corrections Partnership- a committee comprised of stakeholders making decisions in a Brown Act meeting related to the implementation of AB109.

CLAS Standards- Culturally and Linguistically Appropriate Service Standards- Fifteen standards divided into four key sections for advancing health equity and eliminating health care disparities outlined by the US Department of Health and Human Services' Office of Minority Health.

CWS- Child Welfare Services

DMC-ODS- Drug Medi-Cal Organized Delivery System

DSS- Department of Social Services

EMS- Emergency Medical Services

FURS- Family Urgent Response System- a 24 hour 7 day a week stabilization response resource for youth under 21 and their families that are currently or were formerly involved in the foster care system.

ID/DD- Intellectual Disabilities and/or Developmental Disabilities.

LPHA- Licensed practitioner of the healing arts, a clinical and licensed or waivered practitioner of medical health, mental health, and/or social work services and treatment.

MCP- Managed Care Plan

MHP- Mental Health Plan

MOPS- Mobile Outreach and Prevention Services

MOU- Memorandum of Understanding

M-TAC- Mobile Crisis Technical Assistance Center

PHC- Partnership Health Plan of California

Sample Dispatch Tool

Name of Dispatch Operator:
Greet the caller (*use a warm tone*):
Hello, this is Mobile Crisis Services. May I have your name and a good callback number in case this call gets disconnected? How may I help you?
Collect Contact Information and Location:
Caller's Name:
Name and Approximate Age of Person in Crisis
Relationship to Person in Crisis: ☐ Self ☐ Other: _____
Location for Services (address and/or description of location):
Screen for Urgent Medical Issues:
Is there an urgent medical issue? ☐ ☐
If there is an urgent medical issue, initiate 911 Emergency Medical Services: a. If the call is from a third party, ask them if the person in crisis is ***unconscious.*** b. Is the person at ***high risk for or in active*** opioid overdose? *If YES to a. or b., ask if Naloxone is on hand; if so, instruct the caller to administer it to the person in crisis (if they have not already done so).* *If NO to a. or b., ask if weapons were involved (if YES, ask type/kind: _____) and communicate this information to 911 dispatch.*
Conduct Safety Assessment:
1. Is the person in crisis threatening self-harm? ☐ Yes ☐ No a. If YES, ask if the person in crisis has a method or intention of acting on those threats. b. If YES, ask if the person in crisis has access to lethal means (e.g., firearm/weapon prescribed or other drugs [ask type and quantity]). c. If YES for lethal means, ask if the person in crisis has the intent to hurt anyone who attempts to intervene. *If YES to 1a, 1b, AND 1c, transfer to 911. Counties with a joint response model with law enforcement may dispatch co response team due to risk to safety.*

If NO to 1b AND 1c, a mobile crisis team dispatch and/or warm transfer to a crisis line (e.g., 988) may be appropriate. Engage the caller and explore what their needs are.

2. Is the person in crisis threatening to harm someone else? ☐ Yes ☐ No
    a. If yes, ask the identity of intended person(s):
    _____
    b. If yes, ask if the person in crisis has a method or intention to act on these threats.
    c. If yes to 2b, ask if the person in crisis has access to lethal means (e.g., firearm/weapon).

If YES to 2b and 2c, transfer to Law Enforcement to secure safety first. Then, when secure, the mobile crisis team will collaborate with Law Enforcement and/or other responders to determine when it is safe to intervene.

If NO to 2b and 2c, offer mobile crisis team dispatch and/or warm transfer to a crisis line (e.g., 988) may be appropriate. Engage the caller and explore what their needs are.

If YES to 2c only, confirm that the person in crisis has no method or intention to act on threats of harm to someone else. Ask for the weapon to be secured before the mobile crisis team arrives. The mobile crisis team should be notified of this and determine if/when it is safe to intervene.

Is the person in crisis under the influence of any substances or alcohol? ☐ Yes ☐ No ☐ Unsure

If YES, ask type and quantity consumed (if known: _____) and communicate this information to the mobile crisis team or 911 dispatch during warm transfer.

Obtain Reason for Call:

Should be written from the caller's perspective.

Screen for Location Safety:

Is the location where services are needed unsafe for the person in crisis or for the mobile crisis team to deliver services? ☐ Yes ☐ No

Are any of the following a concern?

- ☐ Abusive Partner/Person on site
- ☐ Environmental Concerns (e.g., crowded/unsafe area, contagious health issue)
- ☐ Animals (dangerous/protective of owner)
- ☐ Weapons in Active Use in Area

Other: _____

If YES*, f*ollow the county plan for coordination with law enforcement and communicate the information during warm transfer/dispatch.

Note: While law enforcement officers may accompany a mobile crisis team when necessary for safety reasons, they shall not qualify as a member of the mobile crisis team for purposes of meeting Mobile Crisis Team Requirements.

Collect Additional Information:

Accessibility Needs (i.e., Preferred Language, Accessibility Needs, Vision or Hearing Impairment, Intellectual/Developmental Disability?)

Support Persons/Others on Location (e.g., Will third party caller remain with the Person in Crisis? Are others on location safe and supportive to the Person in Crisis?)

Time call ended:

Dispatch Decision:

____ Mobile Crisis Team will be Dispatched Under the Conditions of:
- _____Joint with Law Enforcement
- _____Sequentially after Law Enforcement Determines Scene Safety
- _____Other: _____

____ Mobile Crisis Team Dispatched (Team/Member Names: _____)

____ Mobile Crisis Team will NOT be Dispatched (Reason: _____)

Note: Reasons a mobile crisis team may not be dispatched may include client declined services, warm hand-off to 988, 911, etc.)

Language or Accessibility Needs (*communicated to mobile crisis team*):

____ Considerations Needed for Person in Crisis with I/DD
- _____ Sensory Preferences/Needs: _____
- _____ Other Preferences/Needs: _____
- _____ I/DD (consultant may be needed)

____ Preferred Language(s) Spoken by One or More Individuals: _____

____ Assistance for Visual Impairment Requested: _____

____ Assistance for Hearing Impairment Requested: _____

Sample Crisis Assessment Tool

Date of Service	MCRT Dispatch Time	Arrival Time	Service Duration
Beneficiary's Name		Date of Birth:	
Mobile Crisis Team Members' Names (on-site and/or virtually)			
Service Location/Address (where the intervention took place)			
Individual/Reporting Party Phone Number:			
Does the person in crisis need medical attention?		Yes	No

Crisis Event Description

Causes leading up to crisis event (e.g., psychiatric, social, familial, legal factors, substance use; collect collateral information when available from other persons present at the site)

Assessing for Psychosis or Mania

Are there things you are seeing or hearing that others might not be seeing or hearing? Are you feeling like you do not need to sleep?

Safety and Risk Assessment

Columbia Suicide Severity Rating Scale-Screener	**Past month**	
Ask questions that are bolded and underlined.	YES	NO
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g., "*I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		

4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts, but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***	YES	NO

- Low Risk
- Moderate Risk
- High Risk

An assessment can only determine the level of relative risk of death by suicide.

If they are at moderate or high risk of suicide continue with suicide plan questions below to assess access level of intention and access to means.

If the person in crisis does not endorse SI or SI with a plan, move to the section about violence and homicidality.

Suicide Plan Assessment		
Specific Plan and Intention to Act Upon Plan	Yes	No
Have you thought about when you would end your life?		
On a scale of 1 to 5, where 5 indicates you intend to act on your plan to kill yourself today, and 1 indicates you have no intention to act on your plan today, where do you rate yourself? 1 2 3 4 5		

Person in Crisis Means Assessment		
Have you thought about how you would kill yourself? *Do you have access to _____ ?*		
Person in Crisis Owns or Has Access to a Weapon or Firearm?	Yes	No
(Ask others present/involved in addition to the person) *Have you thought about how you would kill yourself?*		

Violence and Homicidality Risk Assessment		
Does the person in crisis have thoughts of violence towards a specific person or group?	Yes	No

***If person responds yes:**
Who are you thinking about hurting?

How often do you have these thoughts?

2. Is the person in crisis threatening to harm someone else?
   d. If yes, ask the identity of intended person(s): _____
   e. If yes, ask if the person in crisis if they have a method or intention to act on these threats.
   f. If yes to 2b, ask if the person in crisis has access to lethal means (e.g., firearm/weapon).

***Counties will need to establish their own protocols for response team composition based on their local resources. These protocols should be indicated below.

If YES to 2b and 2c,

If NO to 2b and 2c,

If YES to 2c only,

Person in crisis has intention to act upon thoughts of violence or homicidality.	Yes	No
When someone is as upset as you are, they can have thoughts of hurting the person who has hurt them. Have you had thoughts like this		
Assessing for Impulsivity		
Have you ever done something to put yourself or others at risk without thinking twice about it? *If person responds yes: Can you tell me what happened?*	Yes	No
Assessing for Substance Use		
Is the person in crisis currently impaired due to substance use (direct questioning and observation)	Yes	No
Tell me a little about your drug use. What do you like most about the drugs you use? *How do you take them? How often?* *What's positive about these drugs for you? And what's the other side?* *Tell me what you've noticed about your drug use. How has it changed over time?*		
Recent Hospitalizations/Current Relationships with Mental Health Providers		
Have you been hospitalized in the past 30 days for mental health care?	Yes	No
If yes, gather date of discharge and if any medications have been issued, started, or changed.		
Date of Discharge:	Medications Issued:	
Medications		
Are you currently taking any supplements or medications (prescribed for you or someone else) for mental health? If so which ones?		
Medications:	Dosage:	
Are you currently taking your medication?	Yes	No
When was your last dose?		
Medical History		
What illness or diseases have you experienced that may be impacting your situation today?		

Protective Factors, Strengths and Resources (e.g., strong sense of cultural identity, feeling connected to others, support from family and friends)
What are some people, activities, spiritual beliefs, pets, etc., that keep you going when you are having a hard time? *Do you have a support system in place, such as friends or family?* *What typically works to help you cope with stress or anxiety?* *What are your reasons for living?*

Determination of Safety		
After the initial crisis assessment, is the individual no longer at imminent risk?	Yes	No
Did the individual in crisis experience relief or find alternative solutions to the crisis?	Yes	No
Is the person able to remain safe in the community?	Yes	No
Is the person in crisis able to meaningfully engage in a safety plan?	Yes	No
Note if they respond in a manner or presentation that you are unsure of, seek consultation.		
Consultation:		
Child or adult safety concerns:		
Notes:		

Sample Safety Plan Tool

When I am Doing Well

How do you feel when things are going well in your life?

1. _____

2. _____

My Warning Signs of Potential Crisis

What feelings, thoughts, or beliefs would help you recognize that a crisis may be starting?

1. _____

2. _____

Ways to Support Myself

What are some healthy strategies, activities, (hobbies, interests, etc.) you enjoy that help you focus on taking care of yourself?

1. _____

2. _____

People or Social Settings That Provide Support

What connections do you have with family, friends, faith groups, communities, or pets? Where do you feel safe and supported?

Name/Place: _____

Name/Place: _____

Who Can I Reach Out For Help When I am in a Crisis?

Who s the person(s) and contact(s) that you can openly talk about your crisis with? Is there someone you could openly speak to about what is going on?

Name: _____

Name: _____

Connections with Professionals or Agencies I Can Reach Out to When I am in a Crisis

Professional/Agency Name: _____
Contact Information: _____
Local Emergency Departments: _____
Phone Number: _____

Ways to Make My Environment Safe

Are there things you can remove or put away to help keep you safe?

Are there any firearms/weapons in your home that can be stored safely? Is there someone who can support you with this?

Name: _____

Name: _____

Name: _____

Additional Resources:

988 Suicide and Crisis Lifeline **Available 24/7 Call or Text 988**
California Peer Run Warmline **Call or Text 1-800-845-6264**
The Trevor Project **Available 24/7 for LGBTQ+ youth 25 years and younger** **Call 1-866-488-7386 or text START to 678-678**
Crisis Text Line **Text HOME to 741741**
Trans Lifeline **Available 24/7** **Call 1-877-565-8860**