Missoula City-County Behavioral Health Crisis Guide

The Right Response, at the Right Time, Every Time

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Published by the Crisis Intervention (CIT) Program in partnership and close collaboration with the First Responder Behavioral Health Crisis Services Council

Table of Contents

Acknowledgements

The Missoula City-County Behavioral Health Crisis Guide: The Right Response, at the Right Time, Every Time, was adapted from Arizona's Pima County Crisis Protocol[1] with permission from Pima County, Arizona. Pima County is a nationally recognized leader in behavioral health crisis response and Missoula Emergency Responders are grateful for Pima County's leadership in the field and openness to sharing their Crisis Protocol to inform the development of the Missoula City-County Behavioral Health Crisis Guide.

The Missoula City-County Behavioral Health Crisis Guide is intended to offer an overview of the crisis system broadly, and the local crisis system specifically. This Guide includes information for Missoula's Emergency Responders and related crisis response professionals for successfully navigating the local crisis care continuum, particularly as relates to behavioral health crisis care. While Emergency Responders are the primary audience, Service Providers and Community Members can reference this Guide to understand the existing continuum of care, and how to navigate that continuum of care.

Missoula's Crisis Intervention Team Program Manager, Theresa Williams, LCSW, CMHPP, initiated the development of a local Guide to the Behavioral Health Crisis System in 2021 when Missoula County received Montana State Department of Health and Human Services Crisis Diversion Grant Funding to shore up the county's behavioral health crisis response system. Professionals involved in preliminary efforts and early drafts include Dr. James Quirk, MD (Chief Medical Officer at Partnership Health Center), Suzin Kratina (Board President, NAMI Missoula), Dr. Jen Malloy, PhD (Faculty, School of Social Work, University of Montana), Gretchen Neal, MS, CHES (prior Mental Health Coordinator, Partnership Health Center), and Kate Spence, MSW (Practicum Student, Missoula CIT Program). While many professionals and organizations offered information specific to their role or agency for inclusion in this Crisis Guide, including review and approval of specific sections, there were a handful of individuals that took primary ownership of compiling, synthesizing, writing, and editing the final Behavioral Health Crisis Guide. Special thanks are extended to Theresa Williams, LCSW, CHMPP (Crisis Intervention Team Program Manager, City of Missoula); Ursula Holloway, LCSW (Lead Behavioral Health Clinician, Missoula Mobile Support Team); Deputy Zach Barber (Sherriff's Office, Missoula County); Alana McCreery, MPA (prior Crisis Intervention Team Program Data Analyst, City of Missoula); and, Mary Parrish, MS (current Crisis Intervention Team Program Evaluator, City of Missoula).

While the Crisis Intervention Team Program facilitated the development of the current Behavioral Health Crisis Guide, this final product reflects strong collaboration from a diversity of local and regional professionals and organizations working in or adjacent to behavioral health crisis response. Thank you for your time, energy, and expertise in developing this guidance and serving Missoulians with grit, heart, and empathy. **Our community is grateful for all Emergency Responders whose coordinated partnership across systems of care helps ensure that Missoula's behavioral health crisis response system offers any neighbor in crisis with the right response, at the right time, every time.**

[1] https://vitalysthealth.org/wp-content/uploads/2017/08/Pima-Crisis-Protocol-2016-FINAL.pdf

Missoula City-County Behavioral Health Crisis Guide

The Right Response, at the Right Time, Every Time: Purpose and Overview

The Missoula City-County Behavioral Health Crisis Guide is intended to serve as a reference tool for understanding and navigating the behavioral health crisis system broadly, and Missoula's behavioral health crisis system specifically (Table 1). The Behavioral Health Crisis Guide (hereafter referred to as "BH Crisis Guide" or "Guide") is intended for use by Missoula's First Responder Behavioral Health Crisis Services Council, whose members and partners are inclusive of City, County, and University of Montana Law Enforcement, City and County First Responders, and City and County Behavioral Health Crisis Advocates representing Medical, Legal, and Nonprofit Sectors. The First Responder Behavioral Health Crisis Services Council (hereafter referred to as "First Responder Council" or "Council") and their partners coordinate and collaborate to connect neighbors experiencing behavioral health crises with the most appropriate and least restrictive service proportionate to the neighbor's need, while maintaining safety for the neighbor in crisis, the responding professionals, and the wider community. Refer to the Appendix for an overview of First Responder Council, which was formally established March 2023.

Council members and Council partners continue working toward the ideal behavioral health crisis response system as recommended by Substance Abuse and Mental Health Services Association's (SAMHSA) National Guidelines for Behavioral Health Crisis Care Toolkit[2] and the Crisis Now Model[3], as operationalized through the Crisis Intervention Team (CIT) Program Memphis Model[4]. While SAMHSA has developed more recent behavioral health crisis system guidance, the Crisis Intervention Team Program has a strong historical investment in creating and sustaining an ideal behavioral health crisis response system. Locally, **the Missoula Crisis Intervention Team Program effectively bridges the gap between emergency responders and behavioral health crisis professionals, services, and organizations.** Bridging this gap reflects emergency responders ongoing prioritization of primary consumer health and safety, where the primary consumer is the neighbor in crisis and the emergency responder/s offering immediate de-escalation, preliminary stabilization, and connections to appropriate therapeutic and/or community interventions.

[2] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[3] https://crisisnow.com/

[4] https://www.citinternational.org/resources/Pictures/CoreElements.pdf

Local system partners that approved this BH Crisis Guide have a shared vision, mission, and values that center the neighbor in crisis. See Table 2 for more detailed Behavioral Health System Goals. By approving this reference tool, agency representatives on behalf of their professional organizations agree to continually foster a health-promoting environment by:

- ✓ Ensuring there is "no wrong door" access to behavioral health crisis services, thereby providing community members experiencing behavioral health crises with the right service, at the right time, every time; and,

- ✓ Enhancing organizational and system-level operations through shared policies and protocols; and,

- ✓ Prioritizing the health and safety of neighbors, responders, and the public while efficiently and effectively using public resources.

Missoula Crisis System Partners agree to work on behalf of neighbors experiencing behavioral health crises, pledging that people experiencing behavioral health crises receive appropriate services at a level of care that promotes resilient and healthy individuals and communities. To ensure the Missoula Behavioral Health Crisis System is held to a high and overarching standard, all system partners are committed to adopting agency-specific behavioral health crisis response policies, procedures, and/or protocols within their respective departments, as outlined in the First Responder Council By-Laws and Strategic Plan (see Appendix). Of important note, **the Missoula City-County BH Crisis Guide does not supersede existing internal organizational protocols and/or industry standards and requirements; rather, the Missoula City-County BH Crisis Guide complements internal organizational protocols and/or industry standards and requirements.**

Table 1. Missoula City-County BH Crisis Guide: Quick-Look Overview

THIS GUIDE DOES ☑ ☑ ☑	THIS GUIDE DOES NOT ☒ ☒ ☒
Acts as a roadmap to behavioral health crisis care, ensuring neighbors experiencing behavioral health crises receive the right response, at the right time, every time. Offers detailed guidance for First Responder Behavioral Health Crisis Services Council members and partners for delivering coordinated behavioral health crisis services to neighbors in need. Demonstrates First Responder Behavioral Health Crisis Services Council member and partner commitment to creating, sustaining, and evaluating an ideal behavioral health crisis care continuum. Outlines pertinent protocols, policies, and procedures specific to navigating the behavioral health crisis care continuum.	Override professional and/or statutory responsibility and/or obligation to provide the most clinically appropriate intervention based on each individual situation, balanced with individual and community safety. Address or conflict with First Responder Behavioral Health Crisis Services Council member's and partner's mandatory policies and procedures. Exempt First Responder Behavioral Health Crisis Services Council member and partner agencies from the responsibility of providing adequate clinical supervision to internal staff. Serve as a legal and binding contract or Memorandum of Understanding. Create or delegate obligations or financial responsibilities.

Table 2. Behavioral Health Crisis System Goals[5],[6]

Behavioral Health Crisis System Goals

- **Improve safety** for all parties involved in the experience of, response to, and resolution of a behavioral health crisis event.
- **Increase appropriate connections** to effective and timely behavioral health crisis professionals, services, and supports.
- **Strategically use law enforcement** during behavioral health crisis situations, such as when there are imminent safety threats or criminal concerns, while also increasing the role of behavioral health professionals and other community supports in de-escalating a crisis and connecting to care.
- **Reduce the trauma** experienced during a behavioral health crisis, and thus contribute to a neighbor's long-term resiliency and recovery.
- **Continuously enhance Missoula's response to individuals experiencing a behavioral health crisis** through ongoing quality improvement and routine evaluation.

Adapted from the Crisis Intervention Team International Best Practices Guide.

Continuous Quality Improvement

The First Responder Council developed this Guide with input, review, and approval from participating partners. The Council will retain responsibility of continuous quality improvement of the BH Crisis Guide, including hosting an annual convening of participating partners to review both behavioral health crisis response broadly and the current version of the Guide specifically. The Council will annually update the Missoula City-County BH Crisis Guide, incorporating partner feedback and emerging best practice guidance into any subsequent revisions as appropriate. Future updates will reflect both the current state of Missoula's behavioral health crisis care continuum and the ideal system we continue striving toward.

To ensure efficient and effective communication and coordination regarding this Guide, each First Responder Council member and partner agency will identify one primary contact ("CIT Agency Coordinator") and one secondary contact for routine communications with the Missoula Crisis

[5] Note: The Crisis Intervention Team Model acknowledges that there are times when an individual with mental illness commits a crime for which arrest is the appropriate response. Sometimes an individual with mental illness may display criminal behavior that is unrelated to mental health concerns and/or sometimes criminal behavior is so serious that an officer has no choice but to make an arrest.

[6] https://www.citinternational.org/resources/Best%20Practice%20Guide/CIT%20guide%20desktop%20printing%202019_08_16%20(1).pdf

Intervention Team Program as outlined in the Missoula Crisis Intervention Team Program Participation Agreement (see Appendix).

The Missoula City-County BH Crisis Guide shall remain a living document, subject to ongoing updates. A standing agenda item will be included in each First Responder Behavioral Health Crisis Services Council meeting to review the document and determine if any substantive or minor edits are needed. Some examples of possible changes could be information about a new behavioral health crisis service, or a system, policy, or legislative change at the State, County, or Local level that impacts behavioral health crisis care.

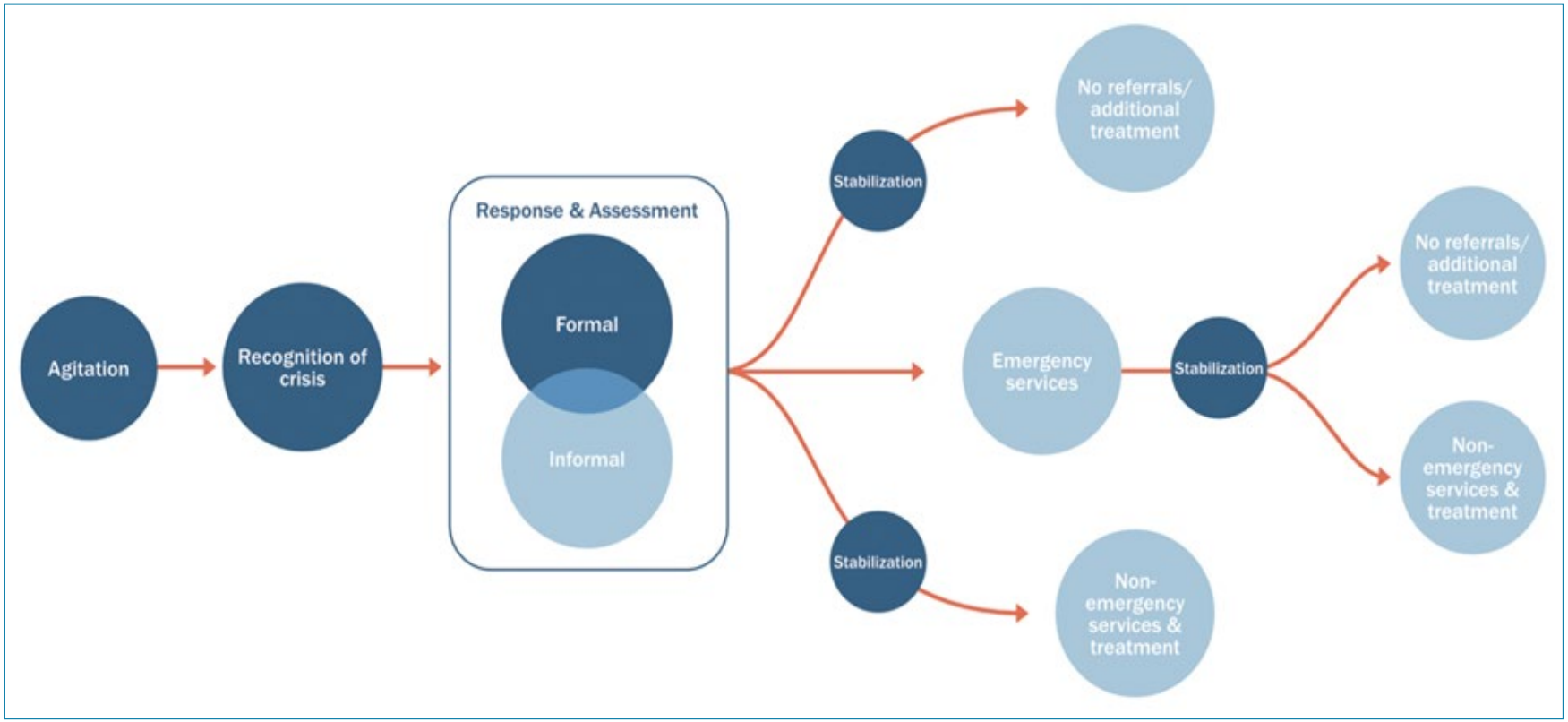
The Behavioral Health Crisis System

The elements of the Behavioral Health Crisis System, including referral, assessment, and service implementation processes, as well as the roles and responsibilities of each participating agency, are outlined in detail throughout this document. These elements provide both guidance for, and expectations of, all entities operating in coordination across the Missoula Behavioral Health Crisis Care Continuum. Of note, resource and system capacity to meet local-level needs are dynamic. If resources or services are unavailable in Missoula, neighbors are encouraged to explore resource or service options in neighboring counties.

Behavioral Health Crisis Care Continuum and Crisis System Partners

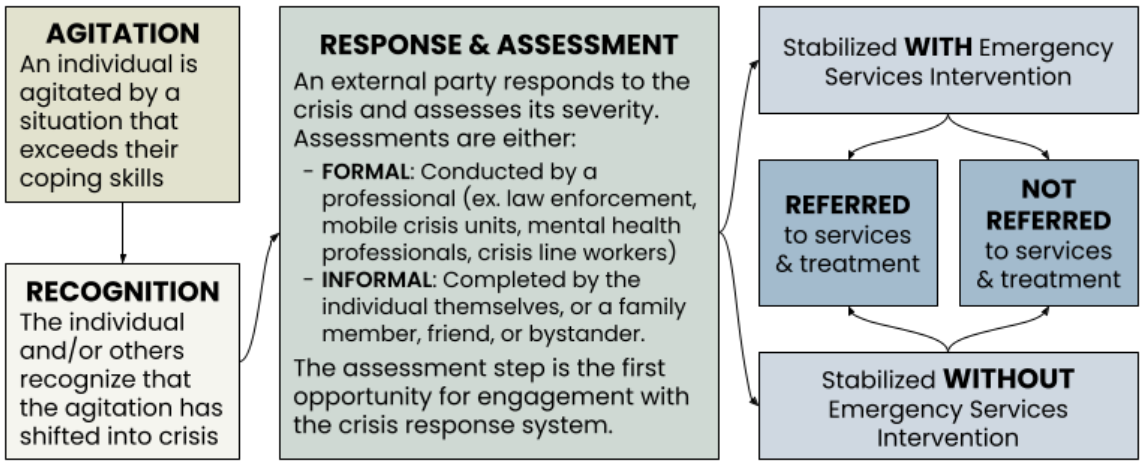
While a crisis is unpredictable and often longer than a single moment, there is a general pathway along which a neighbor in crisis engages with the behavioral health crisis response system. Figure 1 reflects the general pathway, and Figure 2 offers a detailed explanation of stages along that pathway.

Figure 1. The Behavioral Health Crisis Pathway: Broad Overview[7]



[7] Green, Salemo, & Jones. (2021). Missoula County Behavioral Health Crisis System. Report by JG Research & Evaluation for Missoula's Strategic Alliance for Improved Behavioral Health Coalition. Report available upon request. JGR Figure from Report page 5.

Figure 2. The Behavioral Health Crisis Pathway: Detailed Overview[8]



The crisis event is considered resolved at the end of one of the pathways depicted in Figures 1 and 2. It is important to note, however, that an individual may experience multiple crises, and thereby reengage with the crisis pathway. As such, the behavioral health crisis response system must support a neighbor's engagement and re-engagement with crisis response systems by connecting an individual in crisis with the most appropriate type and level of behavioral health service, support, or resource for both short-term stabilization and long-term resiliency and recovery. A coordinated and integrated crisis continuum helps foster individual and community health and safety now and in the future.

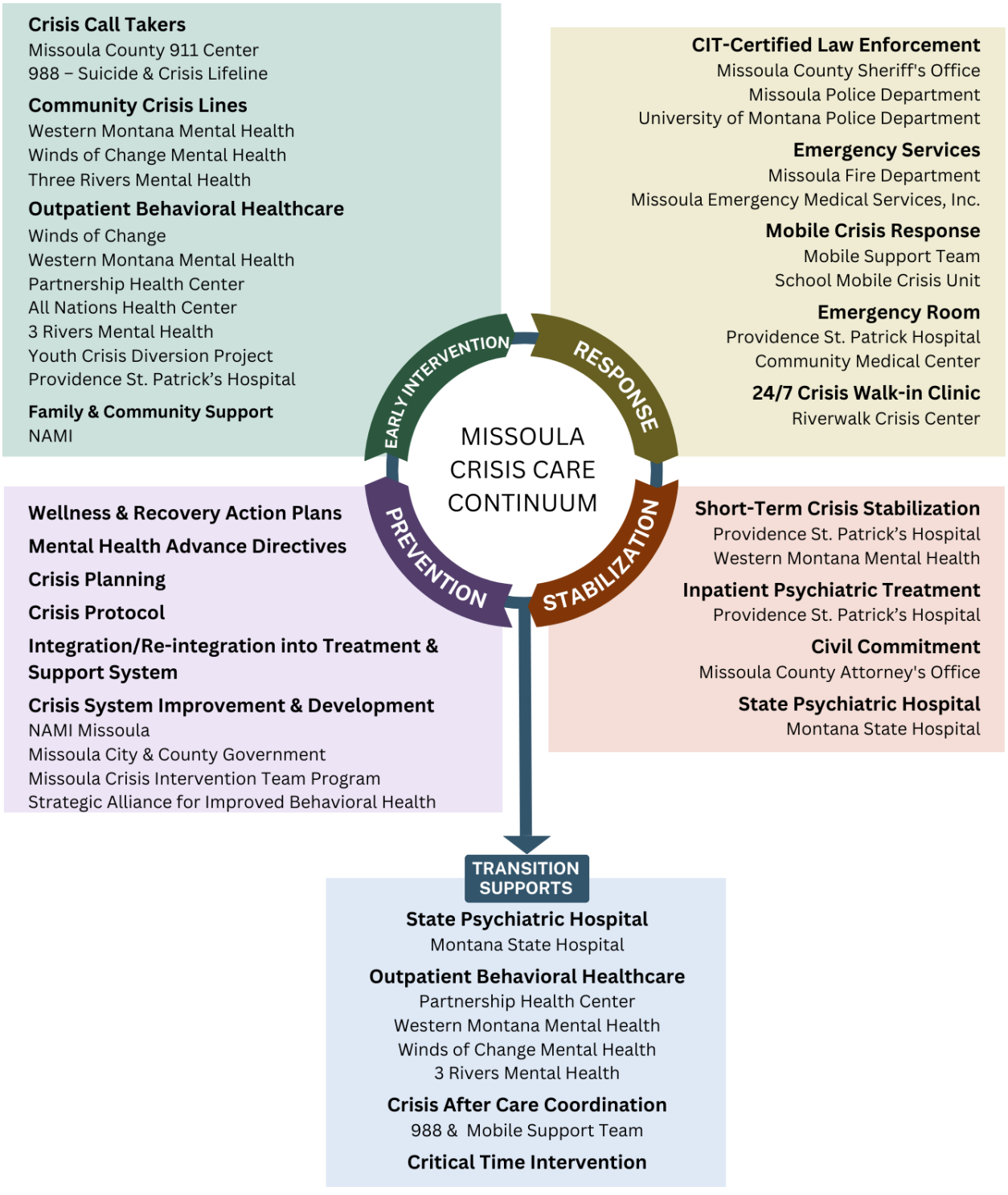
The Behavioral Health Crisis Care Continuum consists of all community organizations and services that are available to an individual as they move through the general crisis pathway. This continuum has four main stages including Early Intervention, Response, Stabilization, and Prevention. Transition Support is prioritized throughout each stage and is critical for a neighbor's ability to maintain a sense of stability amidst stage changes. Table 3 provides an overview of key crisis continuum terms and definitions. Figure 3 visualizes the current Missoula Behavioral Health Crisis Care Continuum, including currently available services, supports, and resources offered by different partner organizations.

[8] Behavioral Health Crisis Pathway, Detailed Overview Figure 2 informed by Green, Salemo, & Jones. (2021). Missoula County Behavioral Health Crisis System. Report available upon request.

Table 3. Crisis Continuum Stages and Definitions

Crisis Continuum Stage	Definition
Early Intervention	Services **before** a crisis becomes an emergency or services that support and assist a neighbor in connecting with the most appropriate and least restrictive service.
Response	**Immediate, urgent care or assessment** offered to a neighbor actively experiencing a crisis.
Stabilization	Services that support the **safe de-escalation** of a neighbor's behavioral health crisis.
Prevention	Services that support neighbors who are at a higher risk of experiencing a crisis by **linking them with comprehensive supports upstream** to minimize the likelihood of experiencing a crisis broadly or minimize the intensity or length of a crisis moment specifically.
Transition Support	Services across the entire continuum of care that **help ensure a neighbor moves seamlessly across the continuum of care**.

Figure 3.1 The Missoula Behavioral Health Crisis Care Continuum



Behavioral Health Crisis

This section defines "behavioral health crisis", offers an overview of behavioral health crisis services currently available in Missoula, and describes the types of professionals and organizations a crisis responder or individual in crisis may encounter before, during, or after a crisis event.

What is a Behavioral Health Crisis?

A behavioral health crisis is measured by the person experiencing it. If the situation exceeds the person's current coping skills, the person is in crisis. Behavioral Health Crisis Services are available to individuals of any age, including folks experiencing or living with Substance Use Disorder, Alzheimer's Disease, Dementia, and/or an Intellectual Disability.

Behavioral Health Crisis Services and Supports

This section offers an overview of behavioral health crisis services broadly and currently available behavioral health crisis services in Missoula specifically. Subsections describe the types of organizations, professionals, services, and resources that an individual may encounter before, during, or after a crisis event.

An ideal behavioral health crisis response system offers someone to talk to, someone to respond, and a place to go, operationalized through shared principles and practices that ensure 'the right response at the right time, every time, for anyone in crisis.' Refer to Figure 4 below for the Crisis Now Framework, which consists of Four Pillars: Someone to Call, Someone to Respond, Somewhere to Go, and Principles and Practices[9]. Please note, this Crisis Now visual depiction does not display the overarching principles and practices that operationalize the framework. Principles and Practices are the Fourth Crisis Now Pillar, which is best visualized as an umbrella across the system.

While the first three Crisis Now Pillars are self-explanatory, Essential Principles and Practices merit a brief overview in advance of offering information and guidance about specific crisis care pathways. Principles and Practices reflect core tenets and guiding values of an ideal behavioral health crisis response system. These include trauma-informed care, Zero Suicide/Suicide Safer Care, hope for recovery, commitment to safety, and collaboration with law enforcement. In addition to values, which reflect the system culture, Essential Principles and Practices also consist of the rules, regulations, and standards specific to individual responder roles, distinct care settings, and coordination and collaboration across roles and settings.

[9] https://crisisnow.com/

Subsequent Missoula City-County BH Crisis Guide sections are presented in alignment with the Crisis Now Pillars to help expedite access of relevant guidance at the time it is needed. Readers are encouraged to review to the section or sections relevant to the current need, whether that need is **Someone to Call, Someone to Respond, Somewhere to Go**, or the **Principles and Practices** that operationalize the system.

Figure 4. Crisis Now Framework as Visualized from the Alaska Mental Health Trust Authority.[10]

Crisis Care: Someone to Call

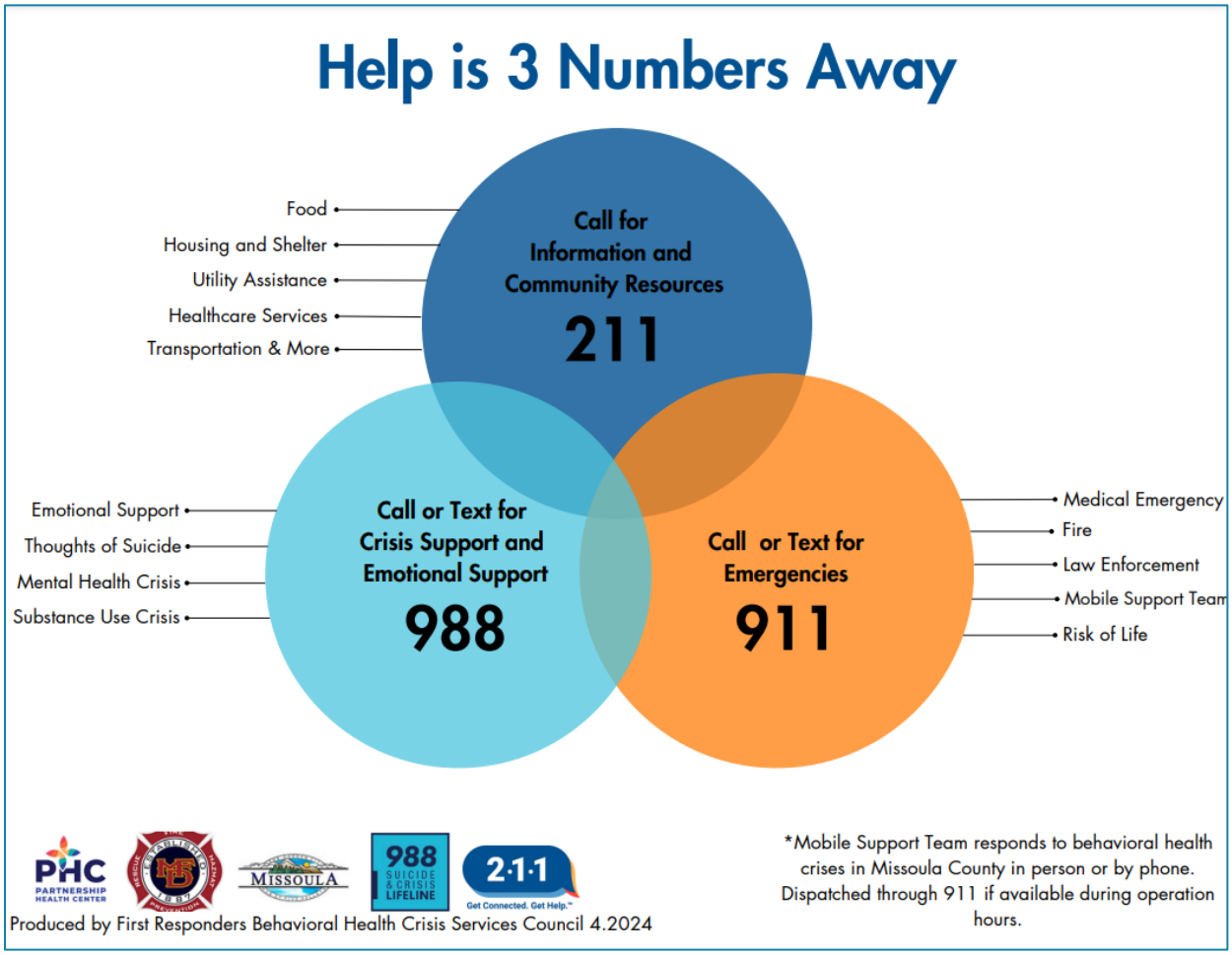
Help is Three Numbers Away

There are three, three-digit phone numbers that anyone in the United States can call to connect with a Non-Emergency Resource Specialist for general information about community resources (211); a Crisis Call Specialist for crisis and/or emotional support (988); and/or a Telecommunicators Call Taker for deploying in-person emergency response services (911).

[10] https://alaskamentalhealthtrust.org/alaska-mental-health-trust-authority/what-we-do/crisis-continuum-of-care/

These three telephonic service options—211, 988, and 911—are visually depicted in Figure 5 and further described below. Presentation of these three national resources is followed by a quick-look table of local, organization-specific crisis lines for established clients.

Figure 5. Help is 3 Numbers Away: Quick-look Overview of 211, 988, and 911[11]



Non-Emergency Resource Specialists

Non-Emergency Resource Specialists, like Montana 211 Call Takers, offer general resource information and connections to resources for non-emergency needs.

- **Individuals seeking non-emergency resources and information can call 2-1-1 to connect with a Montana-based Non-Emergency Resource Specialist** that can share current and accurate information about community resources in the community of interest. Individuals can also access Montana 211 by visiting Montana211.org. Information and services can be easily searched by organization and/or keyword.

[11] "Help is 3 Numbers Away" Original Visual Created by Missoula's FRBHCSC 988-911-MST Workgroup, April 2024.

Crisis Call Specialists

Crisis Call Specialists are generally the first point of contact during a crisis event. These professionals make critical decisions about the appropriate response to alleviate the crisis in a timely, effective, and trauma-informed manner. **Crisis Call Specialists include 988 Suicide & Crisis Lifeline Call Specialists and 911 Telecommunicators and Dispatchers.**

- **Crisis Call Specialists**, like those staffed at 988 Lifeline, provide free and confidential counseling via telephone-based conversation, web-based chat, or text message to individuals experiencing crisis.

- **911 Telecommunicators and Dispatchers** have a responsibility to gather real-time information about the circumstances of the emergency call and the response need. By asking standardized follow-up questions, 911 staff gather pertinent details about the caller's history as relates to the current call, determine if the individual poses an imminent threat to themselves or others, and determine if a law enforcement response is needed to support person and scene safety and de-escalation. 911 Telecommunicators are trained for and required to listen for signs that an emergency call involves a behavioral health crisis component. This training helps 911 staff identify and resource or dispatch an appropriate emergency response in alignment with the Telecommunicator's knowledge, skills, and training, with consideration of the different emergency resources available at the time of the call.

Montana 211: Get Connected and Get Help

Montana 211 is part of the national 211 network that offers information for non-emergency services ranging from things like housing and social services to healthcare providers, utility assistance, and more. Montana 211 was established in 2005 to provide single-point-access to health and human resources for Montana residents, as well as provide information and coordination in times of disaster. All 211 Centers undergo accreditation and meet ongoing standards to retain accreditation. Montana 211 covers five regions of the state, including a call center located and hosted at the Missoula-based Human Resources Council that serves the Western Region. As of late summer 2024, Montana 211 Call Specialists operate on a standard Monday through Friday business schedule. Inquiries outside of those hours will be followed up during routine business hours. The Montana 211 website can be accessed at any time.[12]

988 Suicide & Crisis Lifeline: US National Suicide Prevention & Mental Health Crisis Line

Montana 988 is the National Suicide Prevention Lifeline Network. Calls made to 988 in Montana are routed to one of our three Lifeline Call Centers. Current Montana Lifeline Call Centers include Voices of Hope in Great Falls, The Help Center in Bozeman, and Western Montana Mental Health Center in

[12] https://montana211.org/index.php (Accessed 5.16.2024).

Missoula. Together, these call centers provide coverage to every county in Montana. To date, Montana's 988 Call Centers have been ranked in the top three US states for "call handling" rates with less than 10% of calls made in Montana being routed to another call center in the network backup system. This means that more than 90% of calls from Montanans to 988 are assisted by Montanans that are familiar with local-level resources, services, and supports[13].

Currently, Missoula's 988 Call Center can concurrently alert Missoula County 911 if/when a 988 call reaches a health and safety threshold that necessitates more intensive services than what 988 can support or resolve with telephonic conversation alone. If/when a 988 Call Specialist concurrently notifies Missoula County 911 about the need for dispatched, in-person emergency services, such as Law Enforcement, the 988 Call Specialist remains on the line with the original caller (i.e., community member in crisis), while adding 911 Dispatch to the same call. In this manner, the community member in crisis remains connected to care telephonically, while 911 Dispatch listens to the need and deploys the most appropriate and least restrictive emergency response, given what responders and services are currently available at the time of the call.

Through Missoula's First Responder Behavioral Health Crisis Services Council, Missoula's 988 has developed a strong working relationship with Missoula 911 Dispatch, local law enforcement, and local first responders, including Missoula's Mobile Support Team. Through Missoula's Crisis Intervention Team Program, these system partners are exploring appropriate ways to offer behavioral health crisis response resources with creativity and innovation, while maintaining individual and community safety. For example, Memorandums of Understanding between Missoula 988 and Missoula County 911, and Missoula 988 and Missoula Mobile Support Team, are in the process of being implemented to enhance communications and care across behavioral health crisis services.

Refer to Table 4 below for a quick-look overview of 988 Lifeline, including 988 Lifeline in Montana. View Figure 6 for 988 Montana Service Areas.

[13] https://dphhs.mt.gov/suicideprevention/988 (Accessed 3.25.2024)

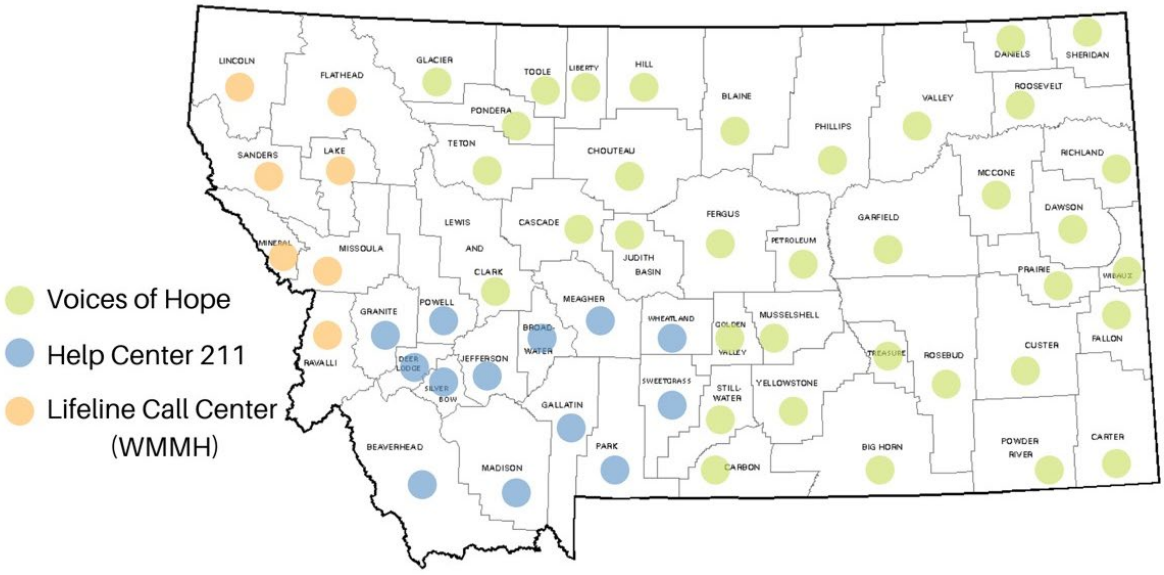
Table 4. Overview of 988 in the US and Montana

Overview of 988: US and Montana

- 988 provides free and confidential emotional support to people experiencing a non-life-threatening suicidal crisis or emotional distress, 24 hours a day, 7 days a week, across the US.
- Montana houses three 988 Crisis Call Centers, including one in Missoula County.
- All Montana 988 Crisis Call Centers are accredited through either the International Council for Helplines or the American Association of Suicidology. All Montana 988 Crisis Call Centers provide evidence-based and best practice crisis response training for Crisis Specialists.
- Local Crisis Center Specialists are familiar with local community mental health resources. Once a caller is stable, 988 Specialists help a caller identify potential supportive services that are geographically proximate to the caller for follow-up services.
- With a caller's consent, 988 can conduct follow-up with all callers within 72 hours of the initial call to ensure a caller's sustained safety and stability. Additionally, 988 in Missoula County was awarded a "Follow-up Grant" which allows them to offer callers the option to receive routine check-ins at a frequency of the caller's choosing for up to 12 months. Caller consent is required to participate in long-term follow-up support.
- Montana's 988 Suicide & Crisis Lifeline is an effective, life-saving safety net for those experiencing a mental health crisis, especially those with nowhere else to turn.

If you or someone you know is in a non-life-threatening crisis, please call 988.

Figure 6. 988 Montana Service Areas[14]



Local Resource Crisis Lines

Many Missoula agencies independently operate agency-specific crisis lines, offering crisis counseling to established clients and/or consumers. Individuals with established care are encouraged to utilize their service provider's crisis line for non-life-threatening crises. Missoula agencies with member-only crisis lines are listed in Table 5.

As a reminder, 211 is another non-emergency service staffed by trained Non-Emergency Resource Specialists. Montana 211 can be reached telephonically by dialing 2-1-1 or by an end user (i.e., person seeking services) texting their 5-digit zip code to "898211"). While Montana 211 Call Lines now operate Monday through Friday during standard business hours, the Montana 211 website can be accessed online at any time. Visit "montana211.org" for current and accurate information about non-emergency health and social services resources in Missoula. Lastly, Montana 211 also hosts The Bright App, a Montana Behavioral Health Resource Guide, that offers real-time information about mental health providers, including mental health providers currently accepting new clients.

[14] https://dphhs.mt.gov/suicideprevention/988 (Accessed 3.25.2024)

Table 5. Missoula Agency-Specific Crisis Lines for Established Clients and/or Consumers

Local Missoula Agency	Crisis Line for Established Clients/Consumers
Riverwalk Crisis Receiving Center	406-532-9703
3 Rivers Mental Health Center	406-529-1800
We Care Behavioral Health	406-370-2940
Western Montana Mental Health	406-532-8949
Winds of Change Mental Health	406-529-4997
Youth Crisis Diversion Project: *For youth, young adults, & families*	406-327-3046

Missoula County Office of Emergency Management: 911 Dispatch

All life-threatening behavioral health emergencies are triaged through 911 Dispatch. If Crisis Intervention Team Officers and/or the Mobile Support Team are needed, callers must relay that request to the 911 call taker, who will triage the call, notify responding agencies of the request, and dispatch the most appropriate and readily available response resource. Crisis Intervention Team Officers are law enforcement personnel that volunteer to receive a 40-hour intensive training in mental health (i.e., conditions, signs, and symptoms), de-escalation techniques (i.e., Universal Greeting, Distance, Back-up, Empathy, Awareness, and Time), and community health (i.e., currently available resource and service options). **Of note, any call from law enforcement or other emergency responders to 911 is treated as a priority and is quickly triaged so that additional resources can be efficiently and effectively deployed to an active incident.** Refer to Missoula Crisis Intervention Team Program Training in the Appendix for more information about the CIT 40-hour Basic Training Academy and other CIT Program training offerings, including evidence-based Mental Health First Aid.

Crisis Care: Someone to Respond

Crisis and Emergency Responders

Crisis and Emergency Responders are dispatched to crisis and emergency situations. These two terms are used interchangeably in this BH Crisis Guide. Examples of Crisis and Emergency Responders include law enforcement, firefighters, paramedics, emergency medical technicians (EMTs), and mobile behavioral health crisis units. The following two sections outline distinct types of Crisis Responders—someone to respond—that are currently available to the Missoula community. These sections describe different responders by type, service, scope, and legal authorities, where applicable.

Missoula City-County Mobile Support Team

The Missoula City-County Mobile Support Team, or MST, operates as Missoula's Behavioral Health Crisis Mobile Unit. **The MST responds to people experiencing a behavioral health crisis. This specialized unit provides support by exploring options and solutions with the person in crisis, linking the neighbor in need to essential services and resources.** Any deployed MST Unit consists of a two-person team with one behavioral health clinician and one EMT. These personnel provide immediate in-person and/or telephonic assessment and intervention. In alignment with best practices, the MST also provides options for time-limited follow-up services with a dedicated MST case facilitator after the initial event is resolved. Refer to Table 6 for a quick-look overview of MST's scope and services.

- **MST Behavioral Health Clinicians** complete risk assessments and suicide screenings, offer therapeutic interventions, utilize de-escalation tactics, make referrals to community resources, and provide warm handoffs (i.e., transitional supports) to other, appropriate service organizations for ongoing support and care.

- **MST EMTs** assess and treat low acuity medical issues and help determine if the person in crisis has any underlying medical conditions. EMTs help maintain scene safety, communicate with other first responders and Dispatch via radio, and manage interagency field communications.

- **MST Case Facilitators** are also critical team members. Case Facilitators may respond in the field without a clinician or EMT to provide essential follow-up with clients after the initial crisis encounter. This helps ensure that the neighbor, now an established MST client, remains stable after the crisis moment, and that the client is connected with necessary and appropriate community resources and services. MST case facilitation is an individualized and time-limited service.

Missoula's Mobile Support Team operates two units each day. The MST is currently available seven days a week from 10:00 am to 8:00 pm. **Community members can access the MST service by contacting 911 and describing the observed need for a behavioral health crisis response.** Of note, currently, 911

Dispatch is the entity that discerns the emergency call type, identifies the most appropriate and available emergency response, and deploys those appropriate and available resources. If the MST is already attached to calls, other emergency responders will be deployed. People contacting 911 for Emergency Services are strongly encouraged to offer specific incident information and anticipated needs to inform the deployment of appropriate and available services. This includes callers offering behavioral health information and observations, which will then be communicated from Dispatch to Emergency Responders assigned to the incident.

MST response time expectations are two minutes from dispatch to enroute, typically making patient contact within 10 minutes. The MST is available for neighbors inside and outside of city limits, serving all of Missoula County. MST is also able to offer telephonic support in lieu of an in-person visit, and/or offer telephonic support while they are enroute to meet the person in need. MST will refer clients to 988 Lifeline when appropriate.

Additionally, MST Clinicians can offer real-time support to law enforcement in the field, and/or MST Clinicians may provide collateral information to a crisis receiving facility (e.g., hospital emergency room, crisis receiving facility, etc.) by completing a Mental Health Referral Form (see Appendix). The Mental Health Referral Form (MHRF) is a mechanism for documenting observations from a field encounter that can help inform the next clinical steps at an appropriate medical facility, as determined by receiving facility clinical staff.

Of note, Missoula County 911 Dispatch Center Staff and other first responders can and will request that MST collaboratively respond to behavioral health calls as an additional unit complementing a routine emergency response service like EMS, Fire, or Law Enforcement during MST hours of operation. When MST is not in-service or is unavailable because units are already attached to calls, first responders will continue responding to crisis calls, including behavioral health crisis calls. Law Enforcement and first responders also have the option to submit an MST Referral for Subject/Client follow-up after an initial crisis event has been resolved. This helps ensure individuals that were in crisis remain stable after the crisis event and are connected to appropriate health and social services for related health needs.

Table 6. Missoula MST Overview of Scope and Services

MOBILE SUPPORT TEAM DOES ☑ ☑ ☑	MOBILE SUPPORT TEAM DOES NOT ☒ ☒ ☒
Deploy through 911 Dispatch. Provide mobile consultation, screening, and brief intervention to individuals in crisis. Prioritize stabilization in the least restrictive setting and entry into the continuum of mental health care at the most appropriate level. Operate an accessible van with ability to transport voluntary clients who are deemed safe to do so and who meet specific MST transport criteria as outlined in Table 7, MST Transport Options Checklist. Reduce First Responders' involvement in calls primarily attributed to a behavioral health concern, so First Responders can remain available for emergency medical needs and public safety response.	Respond to calls before 10 am or after 8 pm. Officially assess and transport someone to the ER for an involuntary emergency detention. Accept referrals or calls for service directly from members of the public. Provide long-term case management.

Missoula City-County MST Behavioral Health Crisis Transportation Requirements

Each behavioral health crisis event must be evaluated from a clinical perspective, which is a critical consideration when determining what type of transport is most appropriate for the person in crisis, while maintaining safety.

If a person seen by the MST voluntarily elects to receive a higher level of care than what the MST can provide, the MST will identify whether MST transport can be provided in a safe manner by using the checklist in Table 7.

Table 7. Missoula MST Transport Options Checklist

MST Transport Options Checklist

MST prioritizes the most appropriate and least restrictive transportation option in alignment with individual and public safety considerations and needs.

1. **Natural supports (friends/family)**
2. **The outpatient service provider**
3. **The receiving facility**
4. **The Mobile Support Team**
5. **Law Enforcement or Ambulance**

Crisis Intervention Team-Trained Responders

In Missoula, at present, law enforcement and other first responders are commonly the first to arrive at a call for service with a behavioral health component. This fact is not ideal for many individuals experiencing a behavioral health crisis. However, Missoula continues working toward the ideal behavioral health crisis response system in which any community member can easily access 'the right response, at the right time, every time it's needed for a behavioral health crisis.' This means that emergency responders of all types act as critical "connectors" to other services and resources.

Living in a rural state with a limited behavioral health crisis workforce and limited behavioral health crisis infrastructure means that local communities like ours will need to be innovative and resourceful when tailoring best practice behavioral health crisis response to the community. As we continue working toward an ideal and complete continuum of care with a robust array of behavioral health crisis services, Missoula's Crisis Intervention Team Program offers comprehensive, practical training to a diversity of crisis personnel, emergency responders, behavioral health specialists, behavioral health advocates, and community members. In this manner, more individuals have more awareness, knowledge, and understanding of mental health, de-escalation, and currently available crisis resources and services. This means that a range of professionals and neighbors can respond to a behavioral health crisis with safety, compassion, empathy, and options for connections to appropriate behavioral health

professionals, services, and resources. Refer to the Appendix to learn more about Missoula's Crisis Intervention Team Program and its training offerings.

Missoula CIT-trained police officers and first responders are members of the Behavioral Health Crisis Response System who are best suited to respond to individuals experiencing a behavioral health crisis event in Missoula. CIT-trained personnel have successfully completed intensive specialist training for behavioral health crisis response. **If a neighbor in crisis calls 911, they can request a "CIT-trained" response. 911 will advise responding agencies about the request and the responding agencies will do their best to meet that request with the services and staffing available at the time of the request.** Table 8 outlines the features of the voluntary Missoula Crisis Intervention Team Program 40-Hour Basic Academy training, as well as the knowledge and skills participants take away from the training. Table 9 offers research findings about the efficacy of the CIT 40-hour Basic Academy Training.

During a crisis event, CIT-trained Responders can help de-escalate the crisis, while also managing the safety of the person in crisis, family members, bystanders, and other emergency personnel. Additionally, CIT-trained Responders gather critical information from 911 Dispatch, the Subject/Client, and any collaterals with the goal of more fully understanding the current event and assessing appropriate next steps. The information gathered is synthesized and communicated directly to the next appropriate professional or service point, such as clinical staff at Riverwalk Crisis Center or the hospital emergency room.

Table 8. Missoula CIT 40-Hour Basic Academy Components and Participant Take-Aways

CIT BASIC ACADEMY TRAINING COMPONENTS	CIT-TRAINED RESPONDER TAKE-AWAYS
• The opportunity to learn from licensed behavioral health specialists, experienced CIT Responders, and community service providers. • Education in topics like mental illness signs and symptoms, co-occurring disorders, child and adolescent issues, medical conditions, psychotropic medications, and legal issues. • Advanced communication and de-escalation techniques with opportunities for skill-building through presentations, simulations, and realistic scenario practice. • A unique opportunity to participate in discussions with individuals who live with a mental illness and/or their family members. • Opportunities to connect with and learn from other local law enforcement, first responders, and social services providers, creating a critical opportunity for relationship building and shared understanding across service sectors.	• Recognize and appropriately address individuals in the community who are experiencing a behavioral health crisis, and/or living with a mental illness, and/or a living with a co-occurring substance use disorder. • Appropriately de-escalate a person in crisis with effective communication strategies. • Connect a person to appropriate behavioral health professionals, services, and resources when needed. • Voluntarily transport an individual to their healthcare provider/s. • Transport an individual to the appropriate level and type of care for an emergency psychiatric evaluation. • Work productively with behavioral health providers, community service providers, and other responders across the continuum of behavioral health care. • Communicate key information to Crisis Receiving Facility staff to ensure the individual in crisis gets the care they need when they need it.

Table 9. Research Evidence of the Efficacy of the Crisis Intervention Team Program 40-hour Academy[15]

The CIT 40-Hour Basic Academy training has been shown to:

- **Increase behavioral health awareness and reduce mental health stigma.** Several evaluations have found that CIT training improves officer knowledge surrounding behavioral health-related challenges, reduces stigma associated with behavioral health, and increases officer empathy and confidence in their ability to successfully intervene in a crisis incident.
- **Increase knowledge of available behavioral health services.** For CIT to serve as a deflection and diversion program, officers need to be aware of currently available alternatives to formal arrest. Research has found that CIT training successfully increases officer awareness of behavioral health services within their communities and increases their buy-in and support for individuals in behavioral health crisis referred to alternative services.
- **Enhance de-escalation techniques.** Finally, evaluations have also found that CIT training increases officer knowledge of and confidence in implementing de-escalation techniques, which increases safety and reduces trauma.

Crisis Care: A Place to Go

Crisis Receiving & Stabilization Facilities

Both Crisis Receiving Facilities and Crisis Stabilization Facilities offer the community "no-wrong-door" access to behavioral health and substance use care, 24 hours per day, 7 days per week, 365 days per year.

Crisis Receiving Facilities are defined as any medical or behavioral health service provider that acts as an entry point into behavioral health care for people in crisis. Crisis Receiving Facilities are most often furnished with recliner-type chairs, which are conducive to rapid assessment and observation, shorter lengths of stay (under 24 hours), and increased communication between staff and patients.

[15] https://www.theiacp.org/sites/default/files/IDD/Review%20of%20CIT%20Evaluations.pdf

Crisis Stabilization Facilities offer a higher level of care to de-escalate the severity of a person's distress and/or their need for urgent care over a longer time period, typically ranging from 24 hours to 10 days per visit. Crisis Stabilization Facilities are designed to prevent or relieve a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation with ongoing clinical and medical supervision for persons who do not require inpatient services.

Table 10 compares Crisis Receiving and Stabilization Facilities, highlighting commonalities and differences between the two service models. Please note that the information in Table 10 is directly informed by State Department of Health and Human Services and Montana Code Annotated. Local examples of Crisis Facilities are described below.

Providence St. Patrick Hospital

Providence St. Patrick Hospital (PSPH) located in Missoula, Montana is the only Level II Trauma Center in Western Montana, Northern Idaho, and Southwestern Montana. PSPH is comprised of 24 departments, including **Adult and Adolescent Inpatient Units** and an **Adolescent Partial Hospitalization Program** for individuals experiencing behavioral health crises.

Inpatient Psychiatric Units

When a medical condition or developmental issue has a negative effect on a person's emotions and behavior, they need treatment and intervention from a care team that understands their physical and mental health needs. Psychiatric Inpatient Teams offer inpatient treatment and hope for recovery for adult and adolescent patients living with a primary psychiatric diagnosis. Inpatient Psychiatric Units focus on healing and recovery through strategies like lifestyle changes, family therapy, medication, and psychotherapy for both voluntary and involuntary patients.

Adolescent Partial Hospitalization Program

PSPH's **Adolescent Partial Hospitalization Program** is an outpatient service treating individuals ages 12-18 years old, who are experiencing behavioral or emotional difficulties. The program provides assessment, crisis stabilization, and treatment for children and adolescents living with a mood disorder, emotional difficulties, and/or maladaptive behaviors.

Table 10. Comparison of Crisis Receiving and Crisis Stabilization Facilities[16] [17]

	Crisis Receiving Facility	Crisis Stabilization Facility
Purpose	• ER and/or Jail Diversion • Support, Assessment, Rapid Stabilization • Refer and Link to Care	• ER and/or Jail Diversion, Alternative to Hospitalization • Assessment, Stabilization, Support, Treatment • Refer and Connect to Care
Stay Length	• Under 24 hours	• 24 hours to 10 days, with an average stay of 3 days
Capacity	• Typically, 4-24 Observation Seats/Beds	• Typically, 4 with no more than 16 Beds
Intake & Access	• Referral Sources: Law Enforcement, Mobile Support Team, Medical & Behavioral Health Providers, Emergency Room, 988 • General: Walk-ins welcome	• Referral Sources: Hospital, Healthcare, Behavioral Health Providers • General: Mobile Support Team, Law Enforcement, Ambulance Transfer
Transport	• Law Enforcement, Mobile Support Team, or Self	• Law Enforcement or Ambulance Transfer
Walk-Ins	• Walk-ins are welcome if space permits.	• Not permitted without referral.
Admission	• Open to all people, particularly individuals experiencing acute mental health, substance use, and/or co-occurring crises. • Voluntary and/or Involuntary Care • Medical status appropriate for setting	• Open to behavioral health patients needing more than 24 hours of treatment, but not needing hospital-level inpatient care. • Voluntary and/or Involuntary Treatment • Medical status appropriate for setting
Staffing	• Professionally licensed/credentialed staff like Prescribing Nurse Practitioners, Psychologists, Clinicians, Addiction Counselors, Social Workers, consulting Psychiatrists (including tele-psychiatry) • Administrative Support and Security	• Professionally licensed/credentialed staff like Psychiatrists, Prescribing Nurse Practitioners and/or Physician Assistants, Psychologists, Clinicians, Addiction Counselors, Social Workers • Administrative Support and Security Staff
Licensing	• If a Crisis Receiving Facility is operated by a licensed Mental Health Center, it is endorsed as an Outpatient Crisis Facility. • If a Crisis Receiving Facility is operated by a licensed Hospital, it is endorsed as an Outpatient Crisis Facility.	• A Crisis Stabilization Facility is endorsed as an Inpatient Crisis Facility per the standards for BH Inpatient Facilities (ARM Subchapter 37.106.17, including additional requirements specified in ARM 37.106.1946).

[16] Informed by https://npr.brightspotcdn.com/f0/11/021282294eecbe18176fc09b7dee/mt-crisis-svcs-a-wiche-bhp-report-for-dphhs-bhdd-sept-2022-approved-final-1.23%5D.pdf (pages 45-46)

[17] Informed by Montana Code Annotated: https://leg.mt.gov/bills/mca/title_0530/chapter_0210/part_0140/section_0030/0530-0210-0140-0030.html

	Crisis Receiving Facility	Crisis Stabilization Facility
Local Examples	• Providence St. Patrick Hospital Emergency Room • Community Medical Center Emergency Room • Riverwalk Crisis Receiving Center at Western Montana Mental Health	• Dakota Place at Western Montana Mental Health Center • West House (Hamilton) at Western Montana Mental Health • Providence St. Patrick Hospital Adult & Adolescent Inpatient Units and Adolescent Partial Hospitalization Program

Western Montana Mental Health Center

Western Montana Mental Health Center provides comprehensive treatment programs for adults and children living with mental health conditions who live in Montana. Clients are eligible for a diversity of treatment options ranging from in-depth assessments to inpatient crisis stabilization services, individual therapy, group therapy, residential housing, psychiatric/medication management, peer support services, inpatient and outpatient addictions services, and children's mental health services.

Riverwalk and Dakota Place

Western Montana Mental Health Center hosts a **Crisis Receiving Facility** and a **Residential Crisis Stabilization Facility** in Missoula. See Table 10, above, for reference.

Riverwalk Crisis Center is a Crisis Receiving Facility providing short-term de-escalation for adults, 18 years of age or older, experiencing acute behavioral health crises. It meets requirements of Administrative Rule Montana (ARM) 37.106.1976, "Outpatient Crisis Stabilization Facility" and is endorsed as an Outpatient Crisis Facility.[18] Riverwalk can accommodate up to 16 guests at one time. Each guest is allowed a maximum stay of 23 hours and 59 minutes per crisis event, with an average stay for a single event expected to be 5-7 hours. Riverwalk clients work with their treatment team and crisis facility staff to resolve the immediate crisis and co-create a care plan following client discharge. Riverwalk also assesses if a guest needs a higher or lower level of care, services, or treatment, and helps implement those transition services with community partners. **As of summer 2024, Riverwalk operating hours range from 12-hours per day to 24 hours per day, 7 days per week, 365 days per year.** If changes occur to Riverwalk operating hours and/or bed availability, Riverwalk staff will notify Missoula 911/Dispatch directly, so Emergency Responders have real-time information about currently available service options. **Missoula 911/Dispatch will have the most current and accurate information regarding Riverwalk's operating hours and bed availability, and Emergency Responders are strongly encouraged to verify availability of services prior to connecting to care.**

[18] https://dphhs.mt.gov/assets/BHDD/AdultMHGeneralDocs/MontanaCrisisFacilitiesPlanningReport.pdf (Accessed 8.19.24)

The Riverwalk Crisis Center operates as a **"no-wrong door"** entry point to behavioral health care: all guests will receive an assessment at intake and will be connected to the most appropriate and least restrictive service or treatment in alignment with the guest's identified need. This means that Riverwalk clinical staff and care coordinator personnel conduct triage and connect a guest to care, including care outside of Western Montana Mental Health Center if/when appropriate.

Of note, guests must meet the following additional criteria to access services at Riverwalk: voluntarily engage in crisis care and independently tend to bodily functions without staff assistance. While Riverwalk offers services to individuals in crisis that may or may not have a drug or alcohol component, individuals must be within a medically stable threshold to receive services at the Center. If the medical need related to drug and/or alcohol exceeds the level of services offered at Riverwalk, a guest will be directed and/or transported to a higher level of care that provides more intensive medical oversight and treatment options.

Dakota Place, also located on Western Montana Mental Health Center's Missoula Campus, is a **Crisis Stabilization Facility** providing residential behavioral health treatment for behavioral health patients needing more than 24 hours of treatment, but not needing hospital-level in-patient care. Dakota Place currently has 5 voluntary beds and 2 court-ordered emergency detention (involuntary) beds.

Crisis Care: Principles and Practices

Crisis Care Principles and Practices are a necessary component of an integrated and effective behavioral health crisis response system. A diversity of professionals and organizations engage with the behavioral health crisis response system, all of which are bound by their professional and organizational standards, including statutory mandates. In addition to the shared values previously described in this Guide, knowledge of principles and practices broadly, as well as knowledge of policies and practices for professionals and service points specifically (e.g. law enforcement, first responders, clinicians, physicians, hospitals, jails, etc.) helps crisis responders and community members understand how different roles and organizations operate within and across a shared crisis care continuum.

Shared principles and practices—and shared understanding of those principles and practices—are a critical component of a functional, robust crisis care continuum. Interagency agreements or interagency protocols help create and sustain an effective, efficient, and coordinated system of care that centers the person in crisis, while maintaining individual and public safety. Understanding professional and agency-specific policies and procedures, as well as the development and implementation of shared policies and procedures, helps ensure that an individual in crisis receives 'the right response, at the right time, every time – any time it is needed' in our community, for our community. In an ideal behavioral health crisis response system, anyone experiencing a behavioral health crisis could be quickly connected to an appropriate type and level of service, regardless of 'how' or 'where' that individual first engages with the

system. **Law enforcement and first responders act as critical "connectors" who help foster linkages to behavioral health services and supports if/when behavioral health is identified as the primary need in any given incident response.** If/when an incident involves both a criminal and a behavioral health component, Law enforcement use their skills, knowledge, discretion, and statutory authority to assess the incident and address the person in crisis with an appropriate response.

The following section offers information about Mental Health Services at the Missoula County Detention Facility, Voluntary and Involuntary Commitment Criteria and Processes, Missoula's Mental Health Referral Form, and what to expect when engaging with different professionals, providers, and/or service points along the behavioral health crisis care continuum.

Understanding Mental Health Services at the Missoula County Detention Facility

Missoula County Detention Facility (MCDF) provides contracted mental health care services to people detained in the facility. This includes, but is not limited to, suicide prevention/intervention, care coordination, counseling, and medication management. General information and specific options are offered below. Table 11 offers specific pathways for connecting with MCDF Staff about mental health concerns and/or needs.

- Upon getting remanded and booked into the facility, law enforcement completes a Remand Form and answers questions relating to mental health and safety observations. Next, **Detention Officers conduct a mental health screen and questionnaire which includes information about a detainee's previous and current mental health treatment as well as current and previous suicide attempts and/or suicidal thinking**. This is the detainee's opportunity to share specific information as relates to their known mental health needs including, but not limited to, formal diagnosis, existing established clinical providers, and/or existing established treatment including prescribed medications and pharmacy information.

- **A detainee's established clinical provider could contact MCDF on behalf of their patient to offer specific behavioral health information** directly from clinical provider to Detention Facility Mental Health Staff for the health and safety of the person of interest.

- **A natural support (e.g., family, friend, advocate) could also contact the Detention Facility on behalf of the individual of concern and offer specific behavioral health information as an advocate.** If or when a personal support is acting as an advocate, it is of utmost importance that the advocate shares current and accurate information regarding the individual of interest's known mental health history and current needs, as well as contact information for established clinical providers and/or pharmacies if they are concerned that the detainee did not report this information to law enforcement or detention staff. This helps Facility Mental Health Staff initiate a provider-to-provider contact to verify health information.

    - Examples of helpful information include the individual of interest's current prescribing physician and/or the current pharmacy for accessing prescribed medications.

- If/when this critical contact information is directly offered to Detention Facility Mental Health Staff, they can then verify the information provider-to-provider and implement steps in alignment with the individual of interest's current health needs and treatment plan, within the scope and availability of facility mental health services.

- The Mental Health Staff will not be able to provide healthcare information to the natural support without a signed release of information.

Table 11. Possible Pathways for Advocating for Mental Health Needs at Missoula County Detention Facility

Possible Pathways for a Personal Support Advocating for Mental Health Needs of a Person Detained at Missoula County Detention Facility

- ✓ Call **MCDF** at 406-258-4000 and request to be transferred to the **Medical Department**. Offer the Medical Department pertinent mental health information, including existing providers, prescribing providers, and/or prescribed medications. Advocate could also encourage a mental health evaluation on behalf of the person experiencing Detention.

- ✓ After-hours and on weekends, call **MCDF Shift Sergeant** on duty 406-258-4017 and offer the Shift Sergeant pertinent mental health information.

- ✓ If the individual of interest has an **existing Probation and/or Parole Officer** (PO), the individual of interest's support system could try contacting the PO and asking the PO to advocate for the health and safety of the person of interest directly to Detention Facility Staff.

Understanding Commitment Criteria and Processes

Voluntary Process

Anyone experiencing a behavioral health crisis who is willing and able to consent to treatment may call a crisis line, self-refer to a crisis receiving center, or call 9-1-1 where a first responder will assess and coordinate transport to a facility-based service as needed. If the person experiencing the crisis is unwilling or unable to voluntarily consent to treatment, then an Involuntary Process for Commitment may be appropriate. Of note, **only certain professionals have the legal authority to implement an Emergency Detention and/or Involuntary Commitment**, as described below.

Involuntary Process

According to **Montana Mental Health Act, Title 53, Chapter 21, Part 1 of Montana Code Annotated (MCA)[19],** when an emergency situation exists, a peace officer may take any person who appears to have a mental disorder and to present an imminent danger of death or bodily harm to the person or to others or who appears to have a mental disorder and to be substantially unable to provide for the person's own basic needs of food, clothing, shelter, health, or safety into custody only for sufficient time to contact a professional person for emergency evaluation. If possible, a certified Mental Health Professional Person should be called prior to taking the person into custody.

If the Mental Health Professional Person agrees that the detained individual is a danger to themself or to others and that an emergency situation exists, then the individual may be detained and treated until the next regular business day. At that time, the Professional Person shall release the detained person or file findings with the County Attorney who, if the County Attorney determines probable cause to exist, shall file the petition provided for in **MCA 53-21-121 through 53-21-126** in Missoula County. In either case, the Mental Health Professional Person shall file a report with the court explaining the professional person's actions.

The Missoula County Attorney may make arrangements with a federal, state, regional, or private mental health facility, or with a mental health facility in the County for the detention of persons. If an arrangement has been made with a facility that does not, at the time of the emergency, have a bed available to detain the person at that facility, the person may be transported to the Montana State Hospital or to a behavioral health inpatient facility, mentioned above, or if full, the nearest facility closest to Missoula County, for detention and treatment. This determination must be made on a case-by-case basis, and the Professional Person at the local facility shall certify to the County Attorney that the facility does not have adequate room at that time.

Before a person may be transferred to the Montana State Hospital or to a behavioral health inpatient facility, the Montana State Hospital or the behavioral health inpatient facility must be notified prior to transfer and shall state whether a bed is currently available for the person. If the Professional Person determines that a behavioral health inpatient facility is the appropriate facility for the emergency detention and a bed is available, the County Attorney shall direct the person to the appropriate facility to which the person must be transported for emergency detention.

An Involuntary Person at an Outpatient Service Provider during Business Hours

During regular business hours, outpatient service providers will provide crisis intervention to enrolled members or clients who are in the presence of their treatment provider. If the outpatient service

[19] https://leg.mt.gov/bills/mca/title_0530/chapter_0210/parts_index.html

providers are unable to safely engage the person in intervention or treatment, they will call 9-1-1. The responding officer will request the MST for a collaborative crisis response as appropriate and when available.

An Involuntary Person at Missoula County Adult or Juvenile Detention Facility

If a person detained to the Missoula County Detention Facility is unwilling or unable to accept treatment for their mental disorder and Detention Staff, Medical Staff or Mental Health Staff have evidence that an emergency situation exists, those staff will refer the person of concern to their contracted on-call Certified Mental Health Professional Person for evaluation, following the MCA process described above.

Involuntary Treatment for Children

MCA Title 53[20] contains provisions that allow for the voluntary evaluation and treatment of children. If a child needs involuntary treatment and the parents or legal guardians are unwilling to admit the child for evaluation or treatment, the Department of Health and Human Services Centralized Intake should be contacted, and a report should be made. The phone number for this process is 866-820-5437.

Missoula Mental Health Referral Form

In 2022 and 2023, local Referring Agencies and Receiving Facilities collaboratively improved a pre-existing mental health referral form template. The current Missoula Mental Health Referral Form (MHRF Version 3) enhances continuity of information between Referring Agencies and Receiving Facilities, as relates to an individual's crisis. More specifically, **the MHRF is a mechanism for a Referring Agency to offer clear information about their encounter with a person in behavioral health crisis by documenting their initial field observations of that person's behavior as relates to mental health, safety, and basic needs.**

Referring Agency personnel complete a MHRF before connecting a person in crisis to an appropriate Receiving Facility. A completed MHRF is securely transferred from Referring Agency personnel to appropriate medical/clinical staff upon arrival to a Receiving Facility. This means that medical and clinical staff immediately have a more complete picture of an individual's current crisis (i.e., signs, symptoms, behaviors, and history if known or disclosed), which helps inform medical and clinical staff of the next most appropriate step for care planning for the person in crisis.

Currently participating Referring Agencies include Missoula Police Department, Missoula County Sheriff's Office, University of Montana Police Department, Missoula County Probation and Parole, and Missoula City-County MST. Western Montana Mental Health Center, including Riverwalk Crisis Center and Dakota

[20] https://leg.mt.gov/bills/mca/title_0530/chapters_index.html

Place, as well as Community Medical Center, and PSPH are currently participating Receiving Facilities. To date, all partners have been implementing the MHRF in good faith, recognizing its immense benefit to the efficient and effective stabilization of the individual in crisis. Participating partners have worked toward formalizing their MHRF participation with a Memorandum of Understanding, with formal authorization from all partners expected Fall 2024.

Missoula's Crisis Intervention Team Program manages the MHRF form template and facilitates associated process steps including template refinements, data entry and analysis, and quality improvement. All participating partners are beholden to their industry standards as relates to criminal justice and/or health information. Privacy and confidentiality standards are retained throughout all MHRF process steps, including storage of information. Table 12 offers a quick-look overview of the purpose and intention of the MHRF, while Table 13 reflects the information that Emergency Responders (Referring Agencies) document in the MHRF to help inform care planning as determined by Receiving Facility clinical staff.

Table 12. Missoula Mental Health Referral Form Intent

The Missoula Mental Health Referral Form

- **Improves communication between Emergency Responders (Referring Agencies) and Crisis Receiving and Stabilization Facilities (Receiving Facilities).**
    - Effective communication between these parties is essential because Emergency Responders observe the patient on scene and have a thorough understanding of the patient's current behaviors, risks, and needs, and can effectively share that information with a Receiving Facility at patient intake.
- **Improves patient outcomes.**
    - Patients are more likely to be connected to the correct level and type of care when Mental Health Professionals at Receiving Facilities have more comprehensive information in advance of formal clinical assessment of the individual in crisis.
- **Highlights community needs and gaps in the Crisis Care Continuum**.
    - By tracking crisis data trends across a set of completed MHRFs, we are better equipped to understand behavioral health crisis-related incidents, their contributing factors, and how the local Crisis Care Continuum responded to an individual in crisis. Identifying trends in these areas helps system partners identify areas of improvement and/or pursue funding for additional services that might prevent or mitigate behavioral health crises in the future.

Table 13. Information Documented in the Missoula Mental Health Referral Form

Type of Information (Form Field)	Description
Incident Information	A brief description of the incident, including whether the person of concern: • Demonstrated a risk of harm to themselves or others, • Demonstrated an inability to meet basic needs, and/or • Prior relevant contact with Law Enforcement, including within the past 24 hours.
Subject, Referring Party, & Collateral Information	• Person of Concern's Name and Date of Birth • Referring Party's Name and Contact Information • Initial "Call for Service" type (i.e. Suicidal Person, Welfare Check, etc.) • Brief narrative of encounter, including Referring Party's observations in the field and any relevant collateral information, particularly as they relate to health and safety.
Behaviors, Substances, & Injuries	Referring Party's observations of the incident including: • The individual of concern's behavior, including if hallucinations and/or delusions observed. • The person of concern's drug, alcohol, and/or prescribed medication involvement. • Any injuries observed prior to engagement with the Referring Party and any injuries sustained during the encounter. -
Care Coordination	• Whether an individual of concern's medical provider or case manager was notified of the incident. • Whether the individual of concern was referred to services during the incident.
Deflection	• Section completed by Law Enforcement only, who have the legal authority to cite and/or arrest. Deflection reflects Law Enforcement understanding of mental health and discernment of behavioral health and/or criminality in any given incident or event. This is an enhanced measure of Law Enforcement personnel acting as Community Caretakers and "connectors" to crisis care.
Follow-Up, Completed by Receiving Facility	A Mental Health Professional Person at the Receiving Facility completes this section of the MHRF after it is received by the Referring Agency. The Receiving Facility retains a complete copy of the MHRF with patient records for continuity of medical information. The Mental Health Professional Practitioner can document the following: • Their efforts to follow up with the Referring Party • Where the individual was sent for stabilization • Whether the individual was referred for outpatient care • Mental Health Professional Practitioner Narrative

Crisis Response and Considerations by Type of Facility

Different types of facilities warrant different crisis response methods due to the varying need in each environment. Below is an attempt to broadly define different types of institutions and summarize a reasonable crisis response plan for each. As a standard rule, each organization should follow their internal protocol and procedures and use this BH Crisis Guide as a supplemental resource for crisis response planning and implementation.

As stated in **MCA Title 53 Chapter 21 Part 1**, a "Mental health facility" or "facility" means the State Hospital, the Montana Mental Health Nursing Care Center, or a hospital, a behavioral health inpatient facility, a mental health center, a residential treatment facility, or a residential treatment center licensed or certified by the Department of Health and Human Services that provides treatment to children or adults with a mental disorder.[21] A correctional institution, correctional facility, or jail is not a mental health facility within the meaning of this Part.

Missoula County Detention Facility

The Missoula County Detention Facility has an established process and contracted providers to assist persons who are experiencing a mental health crisis while detained to their facility.

Hospitals

It is standard practice for hospitals to offer assessment and referral services by a Certified Mental Health Professional Person in the emergency department setting. Individual hospitals may have internal policies and/or protocols regarding crisis response services in addition to the supplementary Missoula City-County BH Crisis Guide.

MCA 53-21 states that a "Secured crisis stabilization facility (SCSF)" means a secure in-patient facility operated by a licensed hospital, critical access hospital, or a licensed mental health center that provides evaluation, intervention, and referral for individuals experiencing a crisis due to serious mental illness or a serious mental illness with a co-occurring substance use disorder.[22] The facility may only provide secured services to a client when a detention exists as defined in 53-21-129, MCA.

Additionally of note, **MCA definition**[23] of "Mental health professional":

> (a) a certified professional person;
>
> (b) a physician licensed under Title 37, chapter 3;

[21] https://leg.mt.gov/bills/mca/title_0530/chapter_0210/part_0010/sections_index.html

[22] https://leg.mt.gov/bills/mca/title_0530/chapter_0210/part_0010/section_0290/0530-0210-0010-0290.html

[23] https://leg.mt.gov/bills/mca/title_0530/chapter_0210/part_0010/section_0060/0530-0210-0010-0060.html

(c) a clinical professional counselor licensed under Title 37, chapter 39;

(d) a psychologist licensed under Title 37, chapter 17;

(e) a clinical social worker licensed under Title 37, chapter 39;

(f) an advanced practice registered nurse, as provided for in **37-8-202**, with a clinical specialty in psychiatric mental health nursing;

(g) a physician assistant licensed under Title 37, chapter 20, with a clinical specialty in psychiatric mental health; or

(h) a marriage and family therapist licensed under Title 37, chapter 39.

Inpatient Psychiatric Facilities

As defined in **MCA 53-21-102** "**Behavioral health inpatient facility**" means a facility or a distinct part of a facility of 16 beds or less, licensed by the Department, that is capable of providing secure, inpatient psychiatric services, including services to persons with mental illness and co-occurring chemical dependency.[24]

The Missouli MST will not respond to an inpatient psychiatric facility. **Inpatient psychiatric facilities should follow their internal policies and procedures in the event an individual in crisis needs a higher level of care than what the inpatient facility provides.**

Group Homes and Residential Facilities

Group Home staff are expected to be trained in crisis intervention and de-escalation techniques and provide crisis intervention and de-escalation services as needed and appropriate. During the home or facility's regular business hours, the outpatient service provider and/or crisis lines like 988 Lifeline should be contacted first for coordination of care and any related discussions surrounding outpatient treatment needs. In an emergency situation, or outside of regular business hours, call 9-1-1 and request the MST and/or a CIT-Trained Officer and they will respond if/when available and appropriate.

Community Health Centers

Community Health Centers primarily offer prevention services, sometimes including Integrated Behavioral Health Care. This means that Community Health Centers are best equipped to provide services before a crisis occurs or stability maintenance after a crisis event. While professionals in these settings have training in mental and behavioral health, including crisis intervention techniques, these settings are not the most appropriate place for resolving acute behavioral health crises in real-time.

[24] https://leg.mt.gov/bills/mca/title_0530/chapter_0210/part_0010/section_0020/0530-0210-0010-0020.html

Examples of Community Health Centers include Federally Qualified Health Centers and Community Mental Health Centers. In Missoula, this includes All Nations Health Center and Partnership Health Center.

Community Health Centers will follow their internal policies and procedures in the event an individual guest or client experiences a behavioral health crisis in their care setting. These professionals and organizations are encouraged to follow their internal policies and protocols in the event an individual in crisis in their setting needs a higher level of care than what the primary medical setting provides.

Private Psychiatrist or Medical Practitioner Office

A private practice psychiatrist or a medical professional can contact the MST via 911 if/when a patient is experiencing an acute behavioral health crisis while in their office and provider attempts to de-escalate and utilize safety plans were not successful. MST will respond if the call is during their hours of operation and if a unit is available. The MST will provide assessment, crisis intervention, and recommendations for further treatment if applicable. If the person is currently in an "emergency situation," law enforcement will need to respond independently or collaboratively with the MST to ensure safety as previously described.

Housing and Houseless Service Providers

Housing and Houseless Service Providers in Missoula include places and spaces like Blue Heron Place (permanent supportive housing), the Poverello Center (short-term shelter with shared dorms), Hope Rescue Mission's Temporary Safe Outdoor Space (short-term shelter with individual pallet units), Johnson Street Shelter (temporary shelter with communal sleeping areas), and YWCA Meadowlark (long-term shelter with individual and family units)

All local shelters, temporary shelter spaces, and housing resource programs such as those mentioned above, have worked with partnering agencies to develop crisis workflow guides. This includes a Medical and Mental Health Decision Tree that clearly outlines steps organizational staff can implement to safely and effectively respond to a variety of behavioral health concerns. In addition to training staff on the Medical and Mental Health Decision Tree, many Crisis Intervention Team Program Partners have historically participated in additional safety and crisis de-escalation and crisis response training through the Missoula Crisis Intervention Team Program.

Emergency Responders and service provider staff experience great benefit from ongoing training opportunities for new and long-term staff. Ongoing training through the Crisis Intervention Team Program helps ensure that professionals are aware of existing services and resources, changes to those services and resources, and how to appropriately access those services and resources. Additionally,

opportunities to practice de-escalation and crisis communications with expert guidance during training sessions means that these critical skills remain fresh and are readily accessible tools in their crisis response toolkit.

University of Montana

The University of Montana (UM) has an array of behavioral health crisis options for on-campus students experiencing a behavioral health crisis, which are described below.

UM's Behavioral Intervention Team (BIT) is a campus-wide team of appointed professionals responsible for identifying, assessing, and responding to serious concerns and/or disruptive behaviors by students who may threaten the health and/or safety of the wider campus community. The BIT reviews referrals between 8:00 am and 5:00 pm, Monday through Friday. UM's BIT referral form can be found by visiting their website[25].

Curry Counseling and Curry Health Center on UM's Missoula campus provides one-time appointments in-person or via tele-counseling for registered UM students experiencing "urgent" behavioral health needs. This urgent, one-time appointment occurs within the same day or the following day of the crisis event. A student experiencing a mental health crisis during routine business hours should call Curry Counseling Center at (406) 243-4712 to inquire about a same day emergency appointment. In most cases, the student can be seen by a clinician within 48 hours. Curry Counseling Center does not offer walk-in appointments; however, Curry Health Center (medical) can support and triage students in crisis. The Health Center has walk-in appointments available Monday through Friday from 8:30 am -11:00 am and Monday, Wednesday, Thursday and Friday from 1:00 pm - 4:00 pm. They can be reached at (406) 243-4330.

Of importance, **Curry Counseling and Curry Health Center are open when classes are in session. Students who have withdrawn or graduated cannot use Curry services. Distance students, or online learners, cannot use Curry services. The first visit to Curry Counseling is always free for currently enrolled on-campus students.** A student experiencing a mental health crisis during routine business hours should call (406) 243-4712 to inquire about an emergency appointment. If an emergency appointment is not available, or the student is in need of urgent care before an appointment is available, they are encouraged to utilize one of the options described below.

After Curry business hours, individuals experiencing a crisis are encouraged to call the 988 Suicide and Crisis Lifeline. Other options include calling 9-1-1 and requesting the MST and/or a CIT-Trained Officer;

[25] BIT-Behavioral Intervention Team (umt.edu)

self-referring to Riverwalk Crisis Center; and/or visiting the emergency room at PSPH or Community Medical Center. If the student in crisis is transported to a higher level of care from Curry Health, communication and coordination will occur between Curry Health staff and the receiving service provider. Of note, **students on UM's campus can call 9-1-1 to be connected to the UM Police Department, and anyone calling 911 from campus is routed to UM Police Department, not City of Missoula Police Department.**

Missoula County Public Schools

Some schools in the Missoula County Public School District have **on-call Behavioral Health Crisis Specialists** who are available to respond on scene, as well as **School Resource Officers** who may be able to assist during a crisis event.

Missoula County currently operates one **School Crisis Mobile Unit** with services currently available at Sentinel High School, Big Sky High School, Meadow Hill, Washington Middle School, and CS Porter Middle School. **The School Crisis Mobile Unit can provide mental health evaluation on-site at the school and determine the appropriate type and level of care for the health and safety of the individual in crisis and the school community.** Currently, referrals to the School Crisis Mobile Unit come from a diversity of professionals including but not limited to school staff, parents and legal guardians, community resource specialists, psychiatric medication providers, MST, and the Crisis Diversion Project. The School Crisis Mobile Unit can also provide follow-up care to connect an individual and their family or support system to more long-term supports. Permission from a child or adolescent's guardian is required prior to receiving School Crisis Mobile Unit services. If/when there is an imminent high-risk safety situation, schools are encouraged to contact 911 directly. To learn more about the School Crisis Mobile Units, including updated service points (i.e., schools newly onboarded to the School Crisis Mobile Unit program), please contact Nicole Gratch, LCSW, at PSPH (Work Cell: 406-550-0829; Email: nicole.gratch@providence.org).

Provider Responsibilities During a Crisis

By State Statute, outpatient service providers need to have current and up-to-date safety and crisis plans, as well as Mental Health Advance Directives for any existing patients. The Missoula City-County BH Crisis Guide complements existing State requirements of provider responsibilities during a crisis event.

Crisis During Business Hours

During regular business hours, outpatient service providers will provide crisis intervention to their enrolled clients who are in a crisis and in their presence. Outpatient service providers should always strive to place a person in the least restrictive environment and should explore appropriate alternatives

prior to transferring the person in crisis to a higher level of care, like a Crisis Receiving Center or Emergency Department.

Crisis After Business Hours

After business hours, when an established client is not in the presence of their outpatient service provider, 911 could be contacted to dispatch the MST to assist the individual with crisis intervention and short-term stabilization. If the client is "community stabilized", MST will attempt to coordinate with the client's current clinical team to ensure stabilization is maintained. If the client is transferred to a higher level of care, communication and coordination will occur between the placement provider and the outpatient service provider for continuity of information and care coordination.

Continuity of Crisis Services During a Disaster

The Missoula County Local Emergency Planning Committee & Disaster Planning Committee[26] are the designated local agencies for addressing disasters in or impacting Missoula County. The Crisis Intervention Team Program will work with these designated agencies and community emergency responders to develop a response plan specific to the crisis system in the event a disaster impacts behavioral health crisis services.

Crisis System Accountability: Problem Resolution Process

Cross-discipline training, collaboration, and partnerships are essential to responding to and supporting someone experiencing a behavioral health crisis. A shared understanding of each partner agency's roles, responsibilities, and limitations within the Crisis Response System is key in maintaining the health and safety of neighbors, fellow emergency responders, organizations, and the crisis response system as a whole. While all system partners strive toward positive outcomes, there are opportunities for growth and refinement. As such, **participating partners agree to proactively resolve any conflicts that might arise through the communication process steps described below.**

Conflicts Between Specific Agencies or Disagreements Regarding Specific Situations

Conflicts between specific agencies or disagreements regarding specific situations should be resolved in real-time, at the lowest level, if possible, and resolved between the agencies and/or individuals directly involved by following each agencies' respective chain of command and/or grievance policies and procedures.

[26] LEPC & DPC | Missoula County, MT

If, after attempting to address conflict or disagreement internally and at the lowest level has proven unsuccessful, then the specific professionals and/or agencies directly involved in the issue are encouraged to contact the Crisis Intervention Team Program Manager via email to help mediate a resolution or outcome. The confidential "secure" email should include the date and time of the incident and a brief incident summary, including the individual of concern's name and date of birth if relevant. Additional CIT Partners can assist in this process if requested and relevant to the specific situation under discussion. Examples of conflicts and possible resolution pathways are offered below. These examples are not reflective of all considerations that might benefit from intentional resolution processes; rather, they help provide some general guidance on what might merit seeking a resolution process and how to appropriately implement a resolution process.

Examples of Conflicts or Disagreements Regarding Specific Situations and/or Shared Clients

Example 1: Agency A transported a person in crisis to Agency B, and Agency A completed the MHRF on behalf of a neighbor in crisis. Agency B assessed the patient and determined the disposition of discharging the patient back into the community. Within hours of being discharged from Agency B, the person is back on the radar of Agency A as the person is presenting in crisis again. Agency A expresses frustration to their supervisor that Agency B did not follow the process of contacting the referring party as stated in the Mental Health Referral Form.

Example 2: Agency C is providing intensive case management for a client that frequently presents in the emergency room and crisis stabilization unit. Agency D has encountered Agency C's client in crisis situations and provides informal case management services to the client without coordinating care with Agency C. Agency C expresses frustration to their supervisor that Agency D is duplicating services, rather than working together to support the client's stabilization and recovery.

Conflicts or Issues Related to System Barriers

The CIT First Responder Behavioral Health Crisis Services Council (Appendix) is an appropriate venue in which to discuss and navigate systemic issues that are reported to the Crisis Intervention Team Program Manager via email and/or identified in Crisis Stakeholder Coordination Meetings (Appendix). While differing viewpoints or challenges may naturally arise between Crisis Intervention Team Partners, including individuals, programs, and/or organizations, the FRBHCSC meeting is not the forum for resolving interpersonal or organizational differences. Rather, the FRBHCSC meeting is a venue for emergency responders, including law enforcement, to elevate system-level considerations that would be beneficial to discuss and problem-solve with system partners.

Examples of Appropriate System-Level Issues to Elevate with the FRBHCSC

Example 1: In a Crisis Intervention Team Stakeholder Coordination Meeting, Agencies E, F & G report concerns regarding long-term care and housing options for people that are unhoused and are frequently encountering first responders. In this example, the system consideration relates to the Social

Determinants of Health broadly, and housing specifically, as well friendly-faces to Emergency Responders and Emergency Service Facilities that would benefit from systemwide, cross-sector conversation.

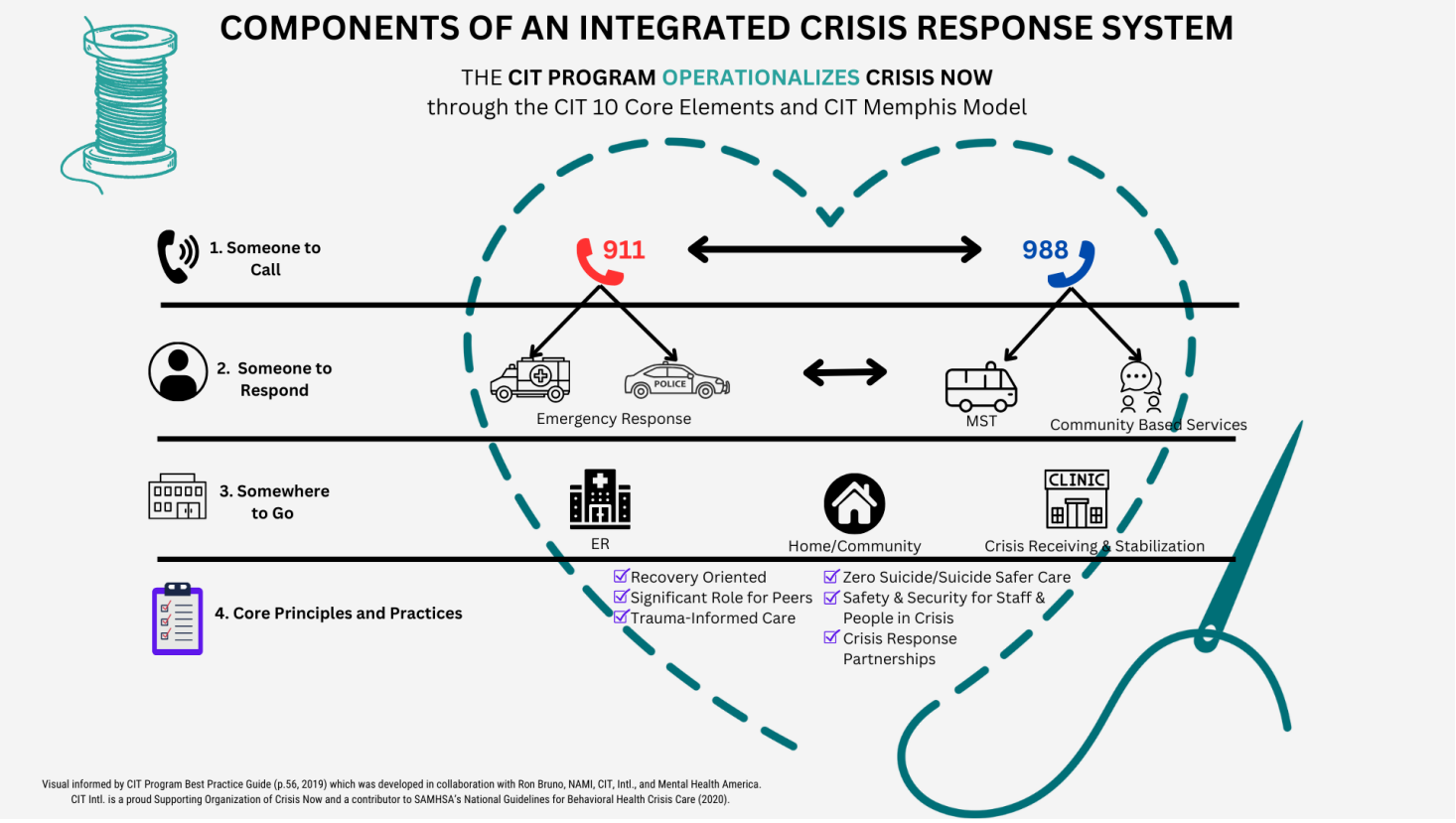
Example 2: In a Stakeholder Coordination Team Meeting, partners identify that they need a better understanding of emergency detention law and available resources. In this example, professionals identified a community need for training and education related to a specific component or components of behavioral health crisis care systems. The Council could consider the best way/s to offer training and education efficiently and effectively for behavioral health crisis system partners.

Missoula City-County Behavioral Health Crisis Guide

The Right Response, at the Right Time, Every Time

The Missoula City-County Behavioral Health Crisis Guide helps Emergency Responders understand the local crisis response system, including how to navigate the array of services and resources across the crisis care continuum. **Missoula is a community with strong collaborative partnerships and deep resiliency, particularly as relates to tending to and caring for friends and neighbors experiencing behavioral health crises.** This Guide is intended to help Responders quickly orient to the local continuum of crisis care, including appropriate options across that continuum of care depending upon the type or level of care needed. Refer to Figure 7 below to understand how **Missoulians are working together to offer the Right Response, at the Right Time, Every Time it's Needed.**

Figure 7. Components of Missoula's Integrated Crisis Response System



<<END OF MISSOULA CITY-COUNTY BH CRISIS GUIDE>>

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LEPC & DPC | Missoula County, MT 42

Appendix

Missoula First Responder Behavioral Health Crisis Services Council

<table>
<tr><th colspan="2">First Responder Behavioral Health Crisis Services Council</th></tr>
<tr><td colspan="2">The CIT First Responder Behavioral Health Crisis Services Council (FRBHCSC) convenes monthly to facilitate agency-specific improvements that enhance system-level responses to individual behavioral health crisis needs in Missoula's behavioral health crisis response system in alignment with CIT Programming and CIT International 10 Core Elements. The Council also serves as a single-point-of-entry for engaging with Missoula's First Responders and eliciting expert information and guidance from first responders as relates to systems-level improvements broadly, and new crisis response organizations and/or services specifically.

The FRBHCSC primary membership is comprised of representatives from all City and County first responder entities that are dispatched through 911, 24 hours a day, 7 days a week, 365 days each year. Primary members include the County Sheriff's Department, Missoula Police Department, Missoula 911/Dispatch, Missoula City Fire, Missoula Mobile Support Team, Missoula Emergency Services, and Missoula 988 Lifeline at Western Montana Mental Health Center. Smaller first responder agencies located in more rural parts of our community are invited to share their perspectives with one of the agencies, which will ensure that needs and opportunities from across the county are routinely elevated to the Council. Additional primary membership includes CIT Program Staff and a CIT Mental Health Advocate and CIT Program Advocate.</td></tr>
<tr><td>Goals</td><td>The purpose of the Council is multi-faceted and includes the following goals: increasing first responder awareness of and confidence in local behavioral health crisis system options when connecting a person in crisis to an appropriate level and type of care; developing and implementing standard CIT operating procedures and services within and across first responder agencies; participating in continuous quality improvement of the CIT Program broadly; and, advocating for the ongoing needs of community as informed by their day-to-day interactions with people experiencing behavioral health crises. Of note, in preliminary planning meetings, first responders identified the following guidelines, which reflect the Council's vision and values:

• We want to be collaborative, communicative, trusting, efficient, and effective.
• We want to recognize, respond to, and resource people in crises effectively, and deliver collaborative, timely (not time-limited), compassionate, and well-informed care.
• We do this work in hopes of saving time and costs, detecting early & diverting successfully, keeping people safe and helping them get well, using colleagues' expertise effectively & efficiently, and preventing personnel burnout.
Lieutenant Ben Slater (CIT Officer) serves as the Council's Chair with support from Elissa White, Project Tomorrow Coordinator (CIT Agency Representative), as Council Co-Chair.</td></tr>
<tr><td>Working Groups</td><td>• 9-1-1, 9-8-8 and Mobile Support Team Integration
• Social Services and First Responders (every other week)
• Hospitals and Jail (hospitals rotate every other month, jail once per quarter)
• Mental Health Referral Form
• Communications and Outreach</td></tr>
</table>

Measuring Success	Members are provided with a link to complete a plus/delta to provide feedback about the meeting.
Meeting Logistics	• First Wednesday of each month – 2:30 – 4:00 pm – In person, hybrid optional • Meeting agendas and minutes are distributed directly to each participating agency through their CIT Agency Representative. • Meeting agendas and minutes can be made available upon request through the Chair, Co-Chair, or CIT Program Manager. • Meetings are open to the public. Primary members are voting members as outlined in the Council Bylaws.

<<END OF FIRST RESPONDER BEHAVIORAL HEALTH CRISIS SERVICES OVERVIEW>>

Missoula's CIT Program Participation Agreement

Thank you for your interest in participating in Missoula's Crisis Intervention Team (CIT) Program. The CIT Program is housed and administered through the Missoula Police Department in collaboration with CIT Montana and our local partners. The goals of CIT are to:

- Improve safety during law enforcement encounters with people experiencing a behavioral health crisis, for everyone involved;
- Increase connections to effective and timely behavioral health services for people in behavioral health crisis;
- Use law enforcement strategically during crisis situations—such as when there is an imminent threat to safety or a criminal concern—and increase the role of mental health professionals, peer support specialists, and other community supports during crisis situations; and,
- Reduce the trauma that people experience during a behavioral health crisis, thus contributing to their long-term recovery.

There are five key volunteer roles in which individuals and agencies may participate in this innovative and collaborative program to ensure that we achieve these goals (see Annex A for Organizational Chart). An individual may have multiple roles within the program and an agency may have multiple staff in these roles. Each CIT participant fulfilling a volunteer role within their agency will need to complete this form.

- **CIT Program Coordinator**: Subject matter experts in the fields of law enforcement, behavioral health, and advocacy. They work closely with CIT Program Staff. Only one person will fill a CIT Program Coordinator role at a time and interested individuals must apply and interview for this position.
- **CIT Agency Coordinator**: Resident expert within their agency serving as the primary point of contact for CIT Program Staff and partners. CIT Agency Coordinators serve as representatives of their agency, both sharing agency insights and perspectives, and delegating involvement between CIT and their agency. A single agency may have more than one person in Agency Coordinator role if necessary. For example, agencies with multiple departments, programs, or divisions may have representatives for those distinct departments, programs, or divisions.). Agencies have discretion on the internal process for filling this role, while the Program ultimately approves the process and/or designee.
- **CIT Instructor:** Experienced CIT Officers or CIT 40-Hour Basic Academy graduates that participate in the planning and implementation of the 40-hour CIT Academies, in-services, and other training opportunities. The CIT Program requires a minimum of one CIT Instructor from each local law enforcement related agency, either sworn or non-sworn professionals. CIT Instructors must apply and interview for the position.
- **CIT Stakeholder:** Member of an agency that is directly involved in working with people that are experiencing behavioral health crises.

- **CIT Officer or Responder:** These are both sworn and non-sworn criminal justice involved Officers and First Responders who are primarily responsible for responding to individuals experiencing behavioral health crises.

Specific qualifications and responsibilities for different roles are attached.

Please review the CIT Program Participation Agreement on the next page. Interested individuals must complete the Agreement and submit a completed form to the CIT Program.

CIT PROGRAM PARTICIPATION AGREEMENT

Our agency agrees to participate in the CIT Program as follows (check all that apply):

☐ CIT Program Coordinator:
____ Law Enforcement
____ Mental Health
____ Advocacy

☐ CIT Agency Coordinator
☐ CIT Instructor
☐ CIT Stakeholder Coordination Team Member
☐ CIT Officer

By signing below, I acknowledge that I have read the specific qualifications, roles, and responsibilities, and I am willing to follow all the requirements to maintain my volunteer participation in the CIT Program. This agreement is effective for a period of two (2) years, commencing on the date signed below. CIT participants (or their agency on their behalf) can resign from their specific role(s) if they find they are unable to maintain any of the above responsibilities for any reason. To ensure both continuity within the program and as a professional courtesy, advanced notice of resignation is appreciated. If I have any questions or concerns, I will contact the CIT Program Manager immediately.

Name (printed): _____
Phone/Email: _____

Agency/Organization: _____ **Department/Program:** _____

_____ _____
Participant's Signature, with Date **Participant's Supervisor or Agency Director Signature, with Date**

In the absence of the Primary Participant, the following individual will serve as a back-up for CIT Program communication, coordination, and related activities.

Back-up Name, Role, and Email Address:
_____

_____ _____
CIT Program Manager (printed) **CIT Program Manager Signature, with Date**

CIT PROGRAM PARTICIPANT QUALIFICATIONS AND RESPONSIBILITIES

Qualifications for CIT Program Coordinator, CIT Agency Coordinator, and CIT Instructor:

- Must have completed (or must successfully complete within the year) the Missoula County CIT Academy (or another approved CIT Montana Academy) with successful demonstration of skill set implementation.
- Demonstrate comprehension of the CIT Core Elements.
- Must have both successful and favorable recommendation by a CIT Program Participant and/or Direct Supervisor.
- Maintain passion and excitement about program with a long-term commitment to the program.
- Demonstrate excellent communication skills, including interpersonal skills.
- Show excellent instruction and facilitation skills.
- Ability to problem solve and delegate.
- Public presentation experience preferred.
- Exhibit leadership in the community, as well as with peers and partners.
- Expert within their discipline.
- The Advocacy Program Coordinator must have a willingness to publicly self-identify as being in recovery from a mental health and/or substance use diagnosis and share their own story of recovery as an inspiration to others. Additionally, this Coordinator must be committed to helping voice the support, ideas, and concerns of consumers and family members.

Any interested candidate for any volunteer role must apply, interview and be accepted by majority vote by the CIT Program Manager and volunteer selection committee.

All CIT Program Participant Responsibilities:

- Participants must review the following guiding documents and CIT Missoula Program reports and forms:
  - CIT Memphis Model Core Elements
  - Crisis Intervention Team (CIT) Program: A Best Practice Guide for Transforming Community Responses to Mental Health Crises
  - CIT Response Infographic
  - CIT Mental Health Referral Form
  - Missoula City-County BH Crisis Guide (will send this to partners when it is finalized)
- Participants must:
  - Adhere to your agency's confidentiality agreement/policy and privacy rights.
  - Adhere to all expectations of your agency's CIT or Mental/Behavioral Health Policy (if applicable).
  - Commit to allowing the time, resources, and supervisory support to execute participant responsibilities in the CIT Program. At times, there may be grant funding available to cover some costs.
  - Commit to supporting training, reforming the crisis system, and advocating for universal access to behavioral healthcare.

Responsibilities of CIT Program Coordinator and CIT Agency Coordinator:

- Review and recommend, as needed, revisions to external and internal protocols, policies, procedures, and guidelines relating to behavioral health crises.
- Provide regular CIT Program updates to agency leadership.
- Help recruit and select CIT Officers and CIT Instructors for CIT Basic Academies and other relevant training opportunities.
- Mentor CIT Officers, clinicians, and/or first responders.
- Help educate supervisors, administrators, community partners, and consumers about CIT and hold other CIT partners accountable to the CIT 10 Core Elements.
- Gain permission and buy-in from agency leadership to carry out CIT responsibilities.
- Coordinate with mental health professionals, law enforcement, first responders and others relevant partners to provide proactive outreach to people who are the subject of frequent calls for service.
- Maintain up-to-date list of CIT-trained and certified personnel within your agency.
- Support CIT trained personnel (within your respective agency) who are responding to particularly challenging crisis calls, often by telephone or by coordinating directly with mental health or community services.
- Provide support in reporting de-identified data from your agency for quality improvement and/or CIT Program outcome/evaluation purposes.
- Participate in CIT Meetings, Inservice and/or Presentations, as your schedule allows. Examples include:
    - CIT International Conferences
    - CIT Stakeholder Coordination Team Meetings (if relevant to one's position)
    - CIT First Responder Behavioral Health Crisis Services Council
    - Other opportunities and training that may arise relating to CIT
- The average time commitment for CIT Program and Agency Coordinators is between two to five hours per week, depending on their role and rank within their agency and whether they are on rotating shifts. There are conferences and academies that require additional time, as well.
- Appoint a backup point of contact if/when you are unavailable as the primary contact.

Additional CIT Program Coordinator Responsibilities:

- Provide support to the CIT Program Manager in the continuous improvement of the CIT Program, including local-level implementation of the CIT International 10 Core Elements.
- Identify additional personnel for specific CIT roles as needed.

Additional CIT Agency Coordinator Responsibilities:

- Maintain an up-to-date roster of CIT-trained and CIT-certified personnel from your respective agency.

CIT Instructor Responsibilities:

- Assist in organizing and facilitating 40-hour CIT Basic Academies. This includes attending and actively participating in the CIT training planning meetings.
- Help one other CIT Montana community facilitate their 40-hour CIT Basic Academy once per year.
    - CIT Program Manager, CIT Program Coordinators and the specific Agency Coordinator will determine readiness of CIT Instructors for assisting at another Academy.

- Participate in 6 hours of Continuing Education every 2 years. Examples include:
    - CIT International Conference
    - Mental Health First Aid
    - NAMI Webinars
    - Bi-Annual CIT Montana Coordinator Training
    - Other opportunities that are relevant to CIT, if approved by the CIT Program Manager or the CIT Program Coordinator specific to one's profession (Law Enforcement, Mental Health, or Advocacy).

CIT Stakeholder Coordination Team Member Responsibilities:

- Read, understand and sign the Oath of Confidentiality.
- Commit to being present at most meetings and/or send an agency designee with the updated information when unable to attend. Agency Delegates or back-ups must also sign the Oath of Confidentiality).
- Commit to sharing and keeping their contact information (phone, cell, email addresses) up to date to encourage communication between meetings as needed.
- Commit to the following, to the best of one's ability:
    - Strive to be effective and efficient and not meet if and when it's not necessary.
    - Assume the best intentions—we are here to be solution-focused and achieve CIT Program goals with fidelity to the model.
- Utilize and complete the CIT Stakeholder Coordination Team Referral Form when elevating concerns about specific consumers.
- Commit to sharing relevant information with agency members within their own agency as appropriate.

CIT Officer Responsibilities:

- Responsible for maintaining up-to-date contact information with the CIT Program Manager or CIT Agency Coordinator if applicable.
- Responsible for notifying and keeping record of the 6 hours of CIT Continuing Education that is required every two years.
- Commit to CIT Program goals and utilize the tools and crisis services that are offered on behavioral health crisis calls for service (as appropriate).
- Notify the appropriate chain of command when they have encountered a barrier or system issue/concern. This could be the CIT Program Manager, the CIT Law Enforcement Program Coordinator and/or the Agency Coordinator.

<<END OF MISSOULA CIT PROGRAM PARTICIPATION AGREEMENT>>

Missoula CIT Program Training Offerings

Missoula CIT is committed to working collaboratively with first responder agencies to identify their behavioral health training needs as it relates to their services coordinated within a shared crisis continuum. Trainings may be presented either in-person or virtually. The CIT Program Manager is responsible for overseeing the CIT Training Subcommittee which plans the annual CIT Academy and supports CIT in-service learning and other trainings offered to first responders or members of the public. Trainings currently available include, but are not limited to:

Behavioral Health Crisis System Overview

This training covers what to expect from the Crisis System, how to access services, and what to do when issues arise. This training is generally 90 minutes but can be truncated to fit system partner needs.

Mental Health First Aid (MHFA)

MHFA training includes the Public Safety, Fire/EMS and Adult modules and is instructed in person (Adult Curriculum can be virtual). This is an eight-hour, three-year certification course that teaches first responders how to identify, understand and respond to signs of mental illnesses and substance use disorders. This training provides first responders with the skills needed to reach out and provide initial support to someone who may be developing a mental health or substance use problem and help connect them to the appropriate care. The training focuses on the unique experiences and needs of first responder personnel and is a valuable resource that can make a difference in their lives, their coworkers' and families' lives, and the communities they serve. Public Safety Officer Standards & Training (POST) continuing education credit hours are available to law enforcement. Please see the MHFA website for more information.

CIT Training

The CIT 40-Hour Basic Academy is designed for sworn law enforcement officers and we also encourage the participation of dispatchers, 911 call takers, corrections/detention officers, other non-sworn members of the department, mobile crisis team members, and fire and emergency medical services. This voluntary course involves a blend of learning modalities requiring a high degree of interactivity, including scenarios-based skills training, de-escalation skills, communication skills, and relevant local resources. The CIT Program is committed to assisting any Montana community interested in developing additional CIT programs. In the future, certified CIT Officers will be offered annual advanced training opportunities to maintain their certification ensuring that their understanding and skills remain relevant as our crisis system evolves. Visit Missoula's Crisis Intervention Team Program page for more information about CIT in Missoula.[27] Visit the CIT/MST Training and Speaker Request Form to review current training offerings with the option to submit a request for an existing training, a tailored training, and/or a speaker.[28]

[27] Missoula Crisis Intervention Team Program Overview: https://www.ci.missoula.mt.us/2763/Missoula-Crisis-Intervention-Team-CIT

[28] CIT/MST Training or Speaker Request Form: https://www.ci.missoula.mt.us/FormCenter/Fire-10/CITMST-Training-or-Speaker-Request-Form-321

Navigating Crises in the Workplace

This free training is intended to assist participants in navigating crisis situations and improving safety in their workplace or area they operate in. The training is interactive and includes scenario-based instruction. The training is intended to teach participants how to:

- Describe the definition of a crisis.
- Demonstrate how to identify, listen, respond, and support someone in crisis.
- Describe what is needed for 9-1-1 call-takers to ensure the right resources are dispatched to the scene.
- Explain the local behavioral health and houselessness resources in Missoula.

This training is not intended to discourage participants from calling 911 and it does not fully certify participants as a member of the Crisis Intervention Team (CIT). Information, techniques, and resources presented in this training are suggested tools to increase safety in the workplace and are not intended to provide solutions to everyday problems encountered. Please consult with your agency/business for official policies and procedures.

There is a 10-person minimum and 30-person maximum for this training. The class is only offered in-person. If you are interested in this training, please complete, and submit this form. Please note that our co-trainers need a minimum of 30 days' notice to schedule a training and they need interested departments/agencies to provide a two-month window of time that the training needs to be completed/scheduled. Ryan and/or Theresa will follow up within 5 business days of submission. Contact If you have any questions, please email Theresa Williams (williamst@ci.missoula.mt.us) and Ryan Kamura (kamurar@ci.missoula.mt.us) with questions.

Training	Description	Logistics	Intended For
Behavioral Health Crisis System Overview	This training covers what to expect from the Crisis System, how to access services, and what to do when issues arise. This training is generally 90 minutes but can be truncated to fit system partner needs.	90 minutes, typically offered in-person, no cost to requesting entities	Any professional or professional organization, particularly those that intersect with behavioral health.
Mental Health First Aid (MHFA)	Mental Health First Aid (MHFA) training teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders. This training provides first responders with the skills needed to reach out and provide initial support to someone who may be developing a mental health or substance use problem and help connect them to the appropriate care. The training focuses on the unique experiences and needs of first responder personnel and is a valuable resource that can make a difference in their lives, their	8hr in-person course, 3-year certification, *valued at $170/person	MHFA for Adults; MHFA for Fire & EMS (including call takers and dispatchers, hospital security); MHFA for Public Safety; MHFA for Corrections Professionals

Training	Description	Logistics	Intended For
	coworkers' and families' lives, and the communities they serve.		
CIT Basic Academy	The CIT 40-Hour Basic Academy is a voluntary course that involves a blend of learning modalities requiring a high degree of interactivity, including scenarios-based skills training, de-escalation skills, communication skills, and relevant local resources. The CIT Program is committed to assisting any Montana community interested in developing additional CIT programs. In the future, certified CIT Officers will be offered annual advanced training opportunities to maintain their certification ensuring that their understanding and skills remain relevant as our crisis system evolves.	40 hr. in person course, 2-year certification with 6 hours of CEUs, $125 per person	Enrollment Prioritization: 1. Law Enforcement Agencies, 2. First Responder Agencies, 3. Supportive Service Provision Agencies, 4. Behavioral Health Agencies
Navigating Crises in the Workplace	The two-hour Navigating Crises in the Workplace training aims to help participants navigate crisis situations and improve safety in their workplace or area of operation. It is interactive and includes scenario-based instruction to teach participants how to define a crisis, identify and support those in crisis, ensure the right resources are dispatched, and explain local behavioral health and houselessness resources in Missoula.	2-hour course, typically delivered in-person; training tailored to trainee needs; no cost to requesting entities	Community workers who are interested in improving response with people who experience mental health crises.
CIT International Conference	"The CIT International Conference is the largest conference dedicated to supporting CIT programs and the law enforcement officers, mental health professionals, and advocates who make them possible. Each year, the conference brings together 1500 people from across the US, Canada, Europe, Africa, and	3 days, with optional pre-conference sessions, $2000 estimated costs per person. See CITI website for date and location.	Professionals interested in Improving Crisis Response in their Communities

Training	Description	Logistics	Intended For
	Australia to exchange ideas, learn best practices, and network." Participants can earn a certificate by engaging with the live exhibits and attending a selection from over 100 workshops offered.		
CIT Support Training for 911	"This 8-hour course of instruction is delivered virtually in two four-hour sessions conducted on consecutive days. The instruction prepares the 911call-taker to identify the possibility of the call being mental health related, utilize techniques to reduce the emotional level of the caller, and triage the call to dispatch appropriate services or complete a warm handoff to crisis services. If it is determined to dispatch CIT patrol officers, this training will assist in understanding what information should be gathered and relayed to the responding officer."	8 hr. online course, emergency call center personnel, $250 per person	Emergency Response Dispatchers
CIT Coordinator Certification	"This 8-hour course of instruction, that is delivered virtually in 4-hour sessions conducted on consecutive days, covers the tasks and topics of the various coordinators' roles and how to work with each other to develop or reform their community's crisis response system. Based on CIT International's publication, "Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises" this course is for all CIT coordinators, regardless of if you are currently serving in this capacity or plan to in the future.	8 hr. online course, 3-year certification, $450	CIT Coordinators
Continuing Education In-services	Throughout the year, lectures are provided by crisis response professionals, often provided during Stakeholder meetings. These lectures are recorded and available at request. Topics range from an overview of Involuntary commitment to an example of a crisis responder networking platform.	Varies, Provided by Professional Volunteers, $0	CIT Stakeholders and related professionals
16-hr CIT Partner Training	Crisis Intervention Partners (CIP) training is a 16-hour training modeled after the training component of Crisis Intervention Team (CIT)	16-hour, 2-day interactive training	Community workers who are interested in

Training	Description	Logistics	Intended For
	programs. CIP is designed for wide-ranging audiences interested in better understanding and improving interactions with people who experience mental health crises. Participants include correctional officers, 911 dispatchers, emergency personnel, hospital staff, teachers, social workers, and more. Through information and practice, CIP is re-training participants to effectively use attitudes, beliefs, and verbal/nonverbal skills as part of their response to crisis situations.		improving response with people who experience mental health crises.

<<END OF MISSOULA CIT PROGRAM TRAINING OFFERINGS>>

Version 3 Launched April 15, 2024

Completed Hardcopy: Stored at Receiving Facility (RF) **Photocopy:** Copy made at RF; Copy retained by Referring Party (RP) & saved with RP Report/s.

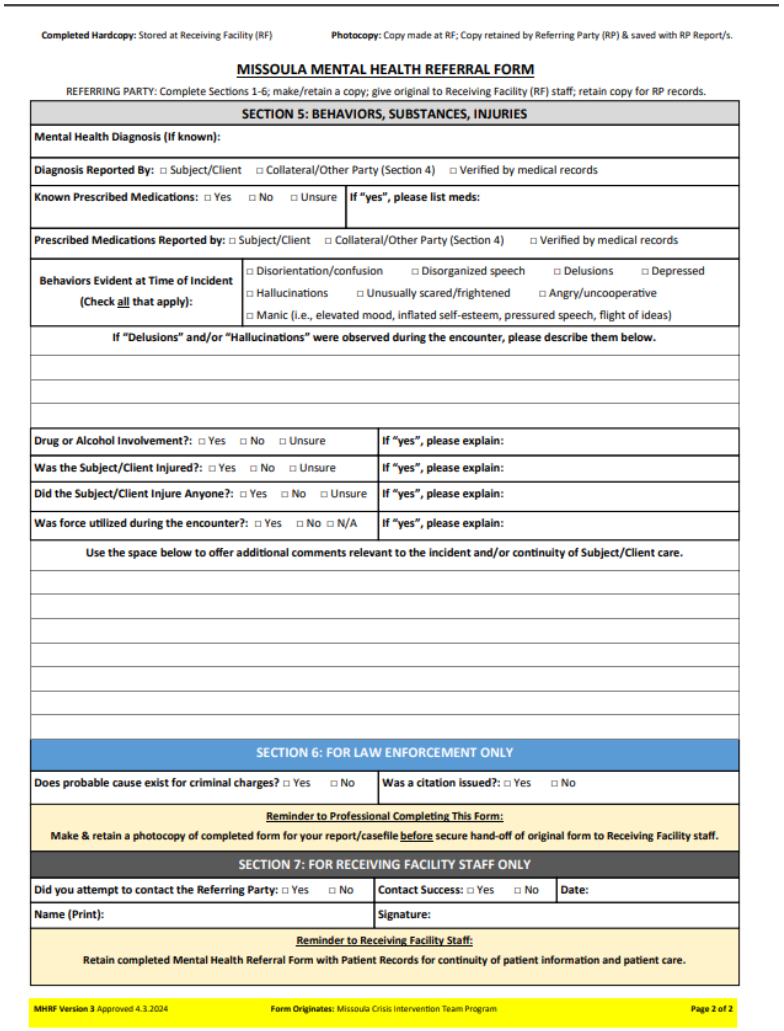
MISSOULA MENTAL HEALTH REFERRAL FORM

REFERRING PARTY: Complete Sections 1-6; make/retain a copy; give original to Receiving Facility (RF) staff; retain copy for RP records.

SECTION 1: GENERAL INFORMATION	
Date of Incident: **Call Type:** **Incident Number:**	**Status of Subject or Client at Time of Hand-off to Facility (Select one):** □ Voluntary □ Involuntary □ Involuntary & Under Arrest
Responding Agencies (Select all agencies involved in incident response): □ MCSO □ MPD □ MST □ P&P □ UMPD □ Other:	
Receiving Facility (Select one): □ Riverwalk □ Dakota Place □ Community ED □ Providence ED □ Other:	
SECTION 2: SUBJECT OR CLIENT INFORMATION	
Subject or Client Name:	**Subject or Client DOB:**
Subject or Client's Housing Status at Time of Incident (Select one): □ Housed □ Unhoused □ Unknown □ Facility: _____	
SECTION 3: REFERRING PARTY INFORMATION	
Name of Professional Completing this Form:	
Agency Affiliation of Professional Completing this Form (Select one): □ MCSO □ MPD □ MST □ P&P □ UMPD □ Other:	
Phone No. for Follow-up:	**Badge Number** (if applicable):
If more than one agency responded to the incident as reported in "Section 1: Responding Agencies", please list Name/s and/or Badge Number/s of other responding personnel that could offer additional information if needed. _____	
SECTION 4: INCIDENT INFORMATION	
Incident Address:	
How did the incident originate?:	□ Dispatched to call that was flagged as mental health-related □ Self-initiated □ Dispatched to a call that was **not** flagged as mental health-related □ Other:
Name of Complainant or Collateral, if applicable to the incident:	**Relationship of Complainant/Collateral to Subject/Client (Select one):** □ Family Member □ Significant Other/Partner □ Friend □ Mental Health Provider □ Stranger □ Other/Unknown
Complainant/Collateral Phone No. for Follow-up:	
Criteria for Commitment (Check all that apply):	**Imminent Danger to Self:** □ Suicide attempt □ Suicidal ideation (w/ plans/means) □ Non-suicidal self injury
	Imminent Danger to Others: □ Injury to others □ Threat of injury to others
	Unable to Meet Basic Needs: □ Food □ Clothing □ Housing □ Health □ Safety
Explain the incident in detail with respect to the specific Commitment Criteria identified above.	

MHRF Version 3 Approved 4.3.2024 **Form Originates:** Missoula Crisis Intervention Team Program **Page 1 of 2**

<<MISSOULA MHRF V3 CONTINUES ON NEXT PAGE>>



Completed Hardcopy: Stored at Receiving Facility (RF) **Photocopy:** Copy made at RF; Copy retained by Referring Party (RP) & saved with RP Report/s.

MISSOULA MENTAL HEALTH REFERRAL FORM

REFERRING PARTY: Complete Sections 1-6; make/retain a copy; give original to Receiving Facility (RF) staff; retain copy for RP records.

SECTION 5: BEHAVIORS, SUBSTANCES, INJURIES		
Mental Health Diagnosis (If known):		
Diagnosis Reported By: □ Subject/Client □ Collateral/Other Party (Section 4) □ Verified by medical records		
Known Prescribed Medications: □ Yes □ No □ Unsure	**If "yes", please list meds:**	
Prescribed Medications Reported by: □ Subject/Client □ Collateral/Other Party (Section 4) □ Verified by medical records		
Behaviors Evident at Time of Incident (Check all that apply):	□ Disorientation/confusion □ Disorganized speech □ Delusions □ Depressed □ Hallucinations □ Unusually scared/frightened □ Angry/uncooperative □ Manic (i.e., elevated mood, inflated self-esteem, pressured speech, flight of ideas)	
If "Delusions" and/or "Hallucinations" were observed during the encounter, please describe them below.		
Drug or Alcohol Involvement?: □ Yes □ No □ Unsure	**If "yes", please explain:**	
Was the Subject/Client Injured?: □ Yes □ No □ Unsure	**If "yes", please explain:**	
Did the Subject/Client Injure Anyone?: □ Yes □ No □ Unsure	**If "yes", please explain:**	
Was force utilized during the encounter?: □ Yes □ No □ N/A	**If "yes", please explain:**	
Use the space below to offer additional comments relevant to the incident and/or continuity of Subject/Client care.		
SECTION 6: FOR LAW ENFORCEMENT ONLY		
Does probable cause exist for criminal charges? □ Yes □ No	**Was a citation issued?:** □ Yes □ No	
Reminder to Professional Completing This Form: Make & retain a photocopy of completed form for your report/casefile before secure hand-off of original form to Receiving Facility staff.		
SECTION 7: FOR RECEIVING FACILITY STAFF ONLY		
Did you attempt to contact the Referring Party: □ Yes □ No	**Contact Success:** □ Yes □ No	**Date:**
Name (Print):	**Signature:**	
Reminder to Receiving Facility Staff: Retain completed Mental Health Referral Form with Patient Records for continuity of patient information and patient care.		

MHRF Version 3 Approved 4.3.2024 **Form Originates:** Missoula Crisis Intervention Team Program **Page 2 of 2**

All participating partners have PDFs and hardcopies of MHRF V3.

Generic Template available upon request.

<<END OF MISSOULA MHRF V3>>

Missoula Crisis Intervention Team Program Meetings

A Comprehensive Overview of Current CIT Program Meetings, including CIT-Facilitation

CIT Stakeholder Coordination Team Meetings	
The CIT Stakeholder Coordination Team proactively reviews critical behavioral health incidents and brainstorms solutions to connect individuals with needed treatment. In lieu of incarceration and/or multiple emergency room visits, CIT Stakeholder Coordination Team members works to identify solutions that are consistent with the needs of averting a serious and imminent threat to the health and safety of the patient or others. CIT Stakeholder Coordination Team meetings are facilitated by Theresa Williams, LCSW (CIT Program Manager, Missoula Police Department).	
Goals	• Improve communication and build trust among participating agencies, • Prevent duplication of services, • Coordinate information sharing for the benefits of the patients or clients being served, • Address the gaps in Missoula's Crisis Care Continuum to achieve the overall goals of the CIT Program.
Records & Privacy	The CIT Program Manager or their designee is responsible documenting meeting minutes. To ensure meeting records are saved and distributed in a manner that protects clients' confidentiality, all meeting minutes are password protected and distributed directly to partner representatives, only after they have signed the CIT Oath of Confidentiality and CIT Participation Agreement. When stakeholders wish to refer a client for discussion, they complete a secured, de-identified referral form.
Measuring Success	Clients are referred for discussion in these meetings in a structured referral form, which assesses concerns, incidents, current interventions, assistance needed, and desired outcomes. In the meetings following initial discussion, members report client updates (like case resolutions and client outcomes). Meeting success is measured through the analysis of referral and client outcome data. Members are also provided with a link to complete a plus/delta to provide feedback about the meeting.
Meeting Logistics	• This is a closed meeting. • New members are invited as needed. • Members meet biweekly (Mondays from 3:00 – 4:00 pm). • Meetings can be held either virtually and/or in person.

CIT Data Subcommittee Meetings	
The CIT Data Subcommittee is a multiagency team that improves responses to people with mental and substance use disorders through collection and analysis of data that demonstrates the CIT program's impact, identifies gaps in Missoula's crisis response system, and solidifies the CIT program's role in supporting law enforcement. Membership includes individuals with data science expertise from relevant partner agencies. The meeting is facilitated by the CIT Research and Evaluation Analyst. ****Of note, the Missoula CIT Data Subcommittee Meetings have been paused since Spring 2023 due to a staff vacancy and limited program capacity. The local CIT Program is currently evaluating the benefit of reconvening this work group and/or collaborating with system partners on a single data work group that services the community.**	
Purpose	The CIT Data Subcommittee supports the planning, collection, and analysis of data related to CIT's key metrics and performance indicators. • Identify and prioritize metrics that are relevant to CIT program goals. • Help plan an efficient data collection process. • Ensure plans for data collection are feasible and produce good quality data. • Assist with interpreting analysis results
Goals	• Identify meaningful data points that will assess how CIT is or is not meeting its goals. • Support access to data sources needed to assess CIT key metrics. • Identify areas for improvement within the CIT program and crisis response system. • Interpret data to inform CIT program and crisis response system decision-making
Measuring Success	The CIT Data Subcommittee will measure the success of meetings with a Plus/Delta tool. A link to a Microsoft Office Form is provided after each meeting. The Plus/Delta tool asks: What worked well during this meeting? What is one thing you would change for our next meeting?

CIT International and SAMHSA Data Elements (2019)

Tier	Definition	Data Points
Tier One: Mission Critical Data	Mission Critical Data is considered the most basic and essential data for CIT programs to collect to demonstrate productivity and basic impacts on the community.	Community Partnerships and Engagement, Training Participation, Number of Mental Health Calls for Service, and Number of Mental Health Calls Responded to by CIT Officers.
Tier Two: Intermediate Data	Intermediate Data builds onto and expands data gathered and analyzed at Tier One, producing a more complete picture of the CIT partnership's results and outcomes.	CIT Training Outcomes, Call Disposition (Referrals), Call Disposition (Arrest Rates), Injury Rates, and Use of Force.
Tier Three: Advanced Data	Advanced Data includes more ambitious data points and metrics, many of which will reflect the comprehensive impact of the entire CIT partnership.	Strength of Partnerships and Ownership, Crisis Response Times, Call Duration, Mental Health Call Descriptors, Treatment Continuity, and Impact on Jail Diversion.

CIT Training Subcommittee Meetings	
Instructors meet as often as necessary to plan and execute trainings relating to behavioral health, resources, safety, and de-escalation. The CIT Workforce Development and Training Coordinator manages the meeting invitations, agenda, and minutes.	
Goals	• Provide quality trainings that correspond with community needs/wants related to crisis response. • Recruit and train instructors to offer learning offer opportunities that meet public demand. • Receive and use feedback so that trainings are delivered to meet and/or exceed participant expectations. • Collect and review data.
Trainings	• Annual Basic CIT Academy • Mental Health First Aid • Navigating Crises in the Workplace
Measuring Success	CIT Instructors are provided with a link to complete an evaluation at the conclusion of the training to provide feedback on the planning and execution of the training. Training participants are also provided with an evaluation.
Meeting Logistics	• These are open meetings. • New instructors are recruited on a rolling and as needed basis. Link to the Instructor Recruitment Form can be found HERE or by emailing cit.team@ci.missoula.mt.us • CIT Academy Instructors meet monthly and MHFA Instructors meet quarterly. • Meetings can be held either virtually and/or in person.

<<END OF MISSOULA CIT PROGRAM MEETINGS>>