Crisis Now Multi-County Innovation Plan

Mental Health Services
Oversight & Accountability Commission

CRISIS NOW ACADEMY

County Name: **Cohort 1/Pilot** Santa Cruz County

Date submitted: July, 2023

Project Title: *Crisis Now* Multi-County Innovation Plan

Total amount requested: $5,168,834

Duration of project: September 1, 2023 through August 30, 2026 (3 years)

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☒ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☒ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☒ Increases access to mental health services to underserved groups
- ☒ Increases the quality of mental health services, including measured outcomes
- ☒ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

The primary problem identified by stakeholders is that many barriers exist when attempting to access behavioral health (BH) crisis services, such as a lack of available crisis care services and/or a lack of capacity, restrictive admission criteria, unprepared staff, strong presence of uniformed and armed security, etc.

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) defines behavioral health (BH) crisis services, as:

> "A direct service that assists with de-escalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery."

Like a physical health crisis, a BH crisis can be devastating for individuals, families and communities. While a crisis cannot be planned, we can plan how services are structured and organize them to best meet the needs of those individuals who experience a BH crisis. Too often

that experience is met with delay, detainment and even a denial of service in a manner that creates undue burden on the person, law enforcement, emergency departments, and criminal justice systems.

Due to lack of appropriate intervention, individuals experiencing a BH crisis are often taken to hospital emergency departments (EDs), or are charged and transported by law enforcement to detention facilities; and too often, they experience adverse outcomes. A study by Schar School of Policy and Government (Ramezani et al, 2022), concludes that U.S. jails are de facto mental health institutions, with nearly ten (10) times as many individuals with serious mental illness in prisons and jails than in state psychiatric hospitals. Hospital emergency departments (EDs) are experiencing an increase in the number of individuals seeking crisis care. Most EDs lack both the resources and staffing to respond appropriately and are forced to "board" those in crisis until they can find available psychiatric inpatient beds, the numbers of which have greatly reduced. This predicament – which can leave these individuals isolated, bound to beds and/or parked in hallways for hours or even days – is detrimental. These long waits, often in chaotic ED environments, may exacerbate symptoms and trigger trauma responses "Boarding" also occurs due to a lack of discharge options that may include housing and/or other appropriate supports in the community. In addition, "boarding' consumes hours of law enforcement officers' time, which they commonly refer to as, "wall time."

Another unproductive dynamic involves BH crisis dispositions by EDs. These have become known as, "streeting." This occurs when those with presenting BH conditions are not appropriately screened and triaged and, as a result, are discharged prematurely usually without appropriate treatment and/or supports. In either case, "boarding" or "streeting" is damaging to not only those in crises, but also frequently the significant others who must endure these dynamics as well (Beyond Beds). From a cost standpoint, ineffective interventions in EDs or jails are poor uses of resources, and they exacerbate costs. Inappropriate utilization of the ED to implement BH interventions that perpetuates the crisis response dynamic of the "revolving door" saps the resources of health care, law enforcement, the judiciary, incarceration settings, and social services. The ED is an expensive setting and can result in unnecessary and costly admissions for public and private insurers. Likewise, costs associated with 911 dispatch, law enforcement, EMS, and the criminal justice system for those in crisis, are costs that could be better spent and with better outcomes, using an adequately resourced BH crisis response system.

Participating Counties are facing several barriers in the implementation of a 24/7/365 Crisis Response System with adequate support structures. The chief hurdles identified by county personnel, stakeholders and community partners are:

1. **Competing Priorities**: Number of competing priorities and California's major Behavioral Health initiatives and expansion with strict deadlines for plan and implementation. For instance, the mandatory implementation of the Medi-Cal Community-Based Mobile Crisis Intervention Services benefit by December, 2023 (BHIN No. 22-064). Participating counties have reported major concerns regarding this implementation within the timeline, given their lack of expertise in the area, as well as manpower to plan, design, and implement/optimize a mobile crisis response that meets state requirements and federal guidelines.

2. **Workforce Shortage:** Communities across the nation are challenged by a limited workforce to meet the needs of individuals with mental health and substance use needs. Difficulty in hiring/retaining qualified staff and a diverse workforce representative of the communities serves as a major barrier. While this pertains to licensed and license eligible staff, it also applies to peer support specialists, community health workers, and other support services necessary to manage an effective crisis continuum of care system. The workforce shortage has also negatively impacted counties at the administrative level, leaving several vacancies in their BH departments, inclusive of high-level positions such as BH Directors, MHSA Coordinators, etc. These vacancies are taking a toll on current administrative personnel and impeding them to commit to projects and impacting the mandatory implementation of Community-Based Mobile Crisis Intervention Services.
3. **Funding Issues:** Without financial support for construction, equipment, and start-up costs associated with the establishment of the crisis continuum of care services, it is very challenging for counties to standup these services. Moreover, most counties do not have the assets necessary to assume the administrative/personnel costs and therefore, without capital and initial financial operating assistance, these services will not be established appropriately and/or timely.
4. **Rural:** Rural and frontier communities face unique workforce and geographic challenges that make it more difficult to deliver high quality crisis services that meet the needs of the region. System leaders should evaluate opportunities to leverage technology and existing program capacity to deliver care to maximize access to timely services.
5. **Outcomes/Data:** The establishment of metrics and data track/trend can play a transformative role in setting, refining, and evaluating strategies and programs. Key performance indicators offer pathways to shared understanding and crisis response services delivery expectations. Improved data collection and analysis includes how data is interpreted to plan and effectuate change.

The *Crisis Now* Multi-County Innovation project presents participant counties with an innovative opportunity to complement and strengthen their crisis response systems in a manner aligned to the *Crisis Now* Model, while allowing for flexibility in the context of competing priorities and challenges. This project aims to construct a model that is tailored to the unique needs of California, offering both fidelity to the *Crisis Now* Model and flexibility.

Given the ever-expanding inclusion of the term "crisis" by entities describing service offerings that do not truly function within the context of SAMHSA's National Guidelines for Behavioral Health Crisis Care (2020) and hence, do not truly offer "no-wrong-door" services, it is important to distinguish what crisis services are and what they are not.

A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. An effective crisis care response system saves lives and dollars by progressively expanding its capacity and thereby it's potential to serve as a diversion from law enforcement involvement, including arrest, booking, and detention; and from emergency department utilization and hospitalization.

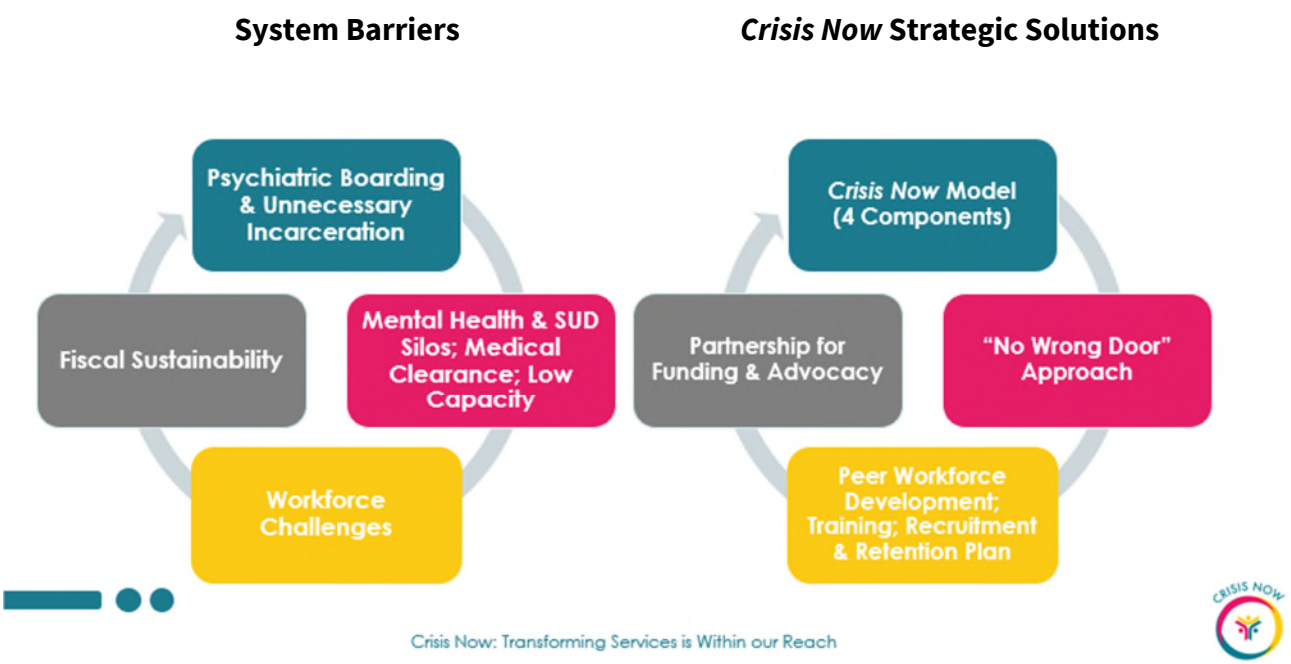
Crisis response services are for anyone, anywhere, and anytime without having to undergo a prescreening process or medical clearance in advance of accessing crisis care. Emergency medical response services operated in communities around the country include: (1) 911 accepting all calls and deploying resources based on the assessed need of the caller; (2) law enforcement, fire or ambulance is dispatched to wherever the need is in the community; and (3) hospital emergency departments (ED) serving everyone that presents regardless of the referral source. Similarly, according to The National Action Alliance for Suicide Prevention publication, Crisis Now: Transforming Services is Within Our Reach (2016), a proven strategy to crisis response requires four core elements:

- High-tech Crisis Call Centers that coordinate all aspects of an immediate crisis response.
- Mobile Crisis Outreach Teams that work in the community with those at risk and reduce the need for uniformed officers to provide mental health triage in the streets.
- Facility-based Crisis Centers that divert away from hospital EDs and arrest, booking, and detention, while providing crisis-specific interventions in safe and secure environments; and
- Commitment to evidence-based safe care practices, such as Trauma-Informed Care, Zero Suicide principles, and a multidisciplinary approach to crisis resolution.

An effective crisis care that saves lives requires a systemic approach with these key elements in place. Such services can provide prevention and/or diversion from more costly and coercive crisis services and allow individuals to remain in the community. The *Crisis Now* model enables counties to assess community crisis care needs, enhance access to care, and realize overall cost savings. The *Crisis Now* model is endorsed by the National Association of State Mental Health Program Directors (NASMHPD) and Crisis Intervention Team (CIT) International.

The *Crisis Now* Innovation Plan offers a methodology for how to best align crisis care services by harnessing data and technology, drawing on the expertise of those with lived experience, and incorporating evidence-based suicide prevention practices. The *Crisis Now* model is an innovative approach that is in full alignment with state requirements and federal guidelines. This model offers best practice implementation of a fully efficient crisis response system that addresses the challenges and barriers reported by participating counties and community stakeholders,

inclusive of the implementation of a mobile crisis response services (in alignment with State requirements; BHIN No. 22-064), workforce development and training, and of the removal of barriers accessing facility-based crisis services through the implementation of a “no wrong door” approach.



RI has supported participating Counties by facilitating an initial assessment and planning process to optimize each county’s respective crisis response system. RI applied the *Crisis Now* Scoring Tools with each participating County to determine their level of alignment with each core service component of the *Crisis Now* Model. The graphic below illustrates this overall crisis response system assessment framework:

For detailed information, such as participating counties' level of readiness for each component of the Crisis Now system, summary score, and analysis, consult Appendix A under the section "Gap Analysis."

RI and the participating Counties facilitated county-wide diverse stakeholder engagements with key community members and partners to determine the specific needs of each community. The communities at large support the need to improve crisis care and identified BH crisis response services and suicide prevention as a priority. For detailed information on community and stakeholder engagements, consult Appendix A under the section "Community Program Planning Process (CPPP)."

The COVID-19 pandemic has exacerbated the need for BH services and resources. Its impact includes insecurity over employment or financial issues resulting from the lockdown, increased isolation, distress, depression, and fear. Levels of individuals experiencing BH crises and issues continue to increase, while access to appropriate BH care is consistently in short supply.

In 2021, an estimated 12.3 M adults seriously thought about suicide, 3.5M adults planned a suicide and an estimated 1.7M adults attempted suicide in the U.S. (Centers for Disease Control and Prevention, 2023). Suicide is the second leading cause of death in the U.S. for ages 20-34 and the third for ages 10-19. Overall, suicide is the 14th leading cause of death in California (American Foundation for Suicide Prevention, 2023). Throughout the state of California, suicide is the:

- 2nd leading cause of death for ages 25-34
- 3rd leading cause of death for ages 10-24
- 6th leading cause of death for ages 35-44
- 8th leading cause of death for ages 45-54
- 9th leading cause of death for ages 55-64
- 18th leading cause of death for ages 65+

Almost five (5) times as many people died by suicide in 2019 than in alcohol-related motor vehicles accidents. Approximately 77% of communities is California did not have enough mental health providers to serve residents in 2021. Mental health and substance use disorders are the most significant risk factors for suicidal behavior. According to CalVDRS (California Violent Death Reporting System, 2020), the following notable circumstances surrounding suicide across the lifespan:

- 22% of individuals under the age of 18 years old had a recent or imminent crisis; 9% had either alcohol dependence, substance use issues, or both;
- 27% of individuals age 18-24 years old had either alcohol dependence, substance use issues, or both; 25% had a recent or imminent crisis;
- 36% of individuals age 25-64 years old had either alcohol dependence, substance use issues, or both; 23% had a recent or imminent crisis;
- 20% of individuals age of 65 years and older had a recent or imminent crisis; 11% had either alcohol dependence, substance use issues, or both

Improving and maintaining access to BH crisis care services and resources, including someone to call (988 Crisis Lifeline), someone to come to you (mobile crisis services), and a safe place to go (facility-based crisis centers) are critical components of the infrastructure necessary for suicide prevention. Implementation of the evidence-based safe care practices, such as Trauma-Informed Care, Zero Suicide Framework, and a multi-disciplinary approach to crisis resolution are key components of safe care.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

This *Crisis* Now Multi-County Innovation Project represents an innovative opportunity for a diverse group of participating Counties (Cohort 1/Pilot: Santa Cruz) to work together to implement and optimize their respective BH Crisis Response System that responds to individuals experiencing a BH crisis using the nationally recognized and innovative *Crisis Now* Model. RI, an operator and national/international consultant of the *Crisis Now* framework, will utilize assessment results and subsequent analyses of each participating County's crisis response system in comparison to national best practices. This process will be followed by developing a set of recommendations on how each county can optimize its crisis response system. RI and participating Counties are also committed to conducting a series of focus groups and stakeholder/partner

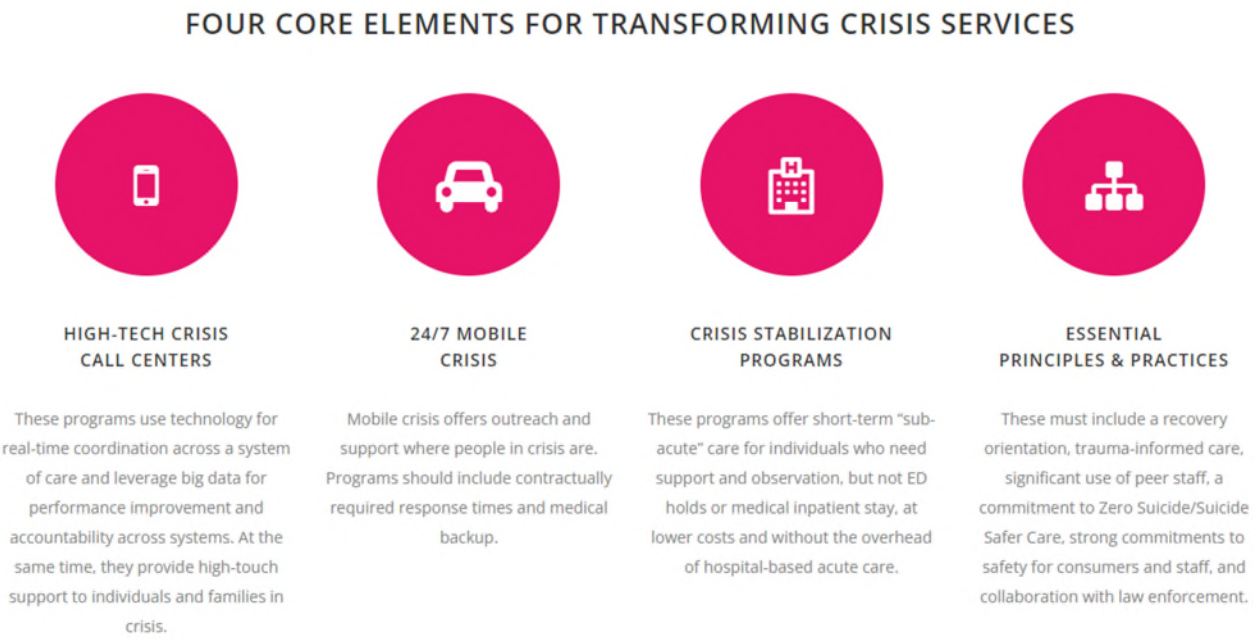
engagements to each of the respective communities have the opportunity to effect this evaluation, planning and implementation process.

During Phase one (1), gaps in existing crisis response services, project demand, and sustainability to support the optimization of the respective crisis response system within the County will be identified. This Phase will also provide support for the integration of the Community Program Planning encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of Santa Cruz County communities.

Phase two (2) will focus on implementing the optimizing changes identified in Phase 1 to alleviate demand pressures on local law enforcement, correctional institutions, and hospital emergency rooms. As these changes are realized, optimal dispositional care options in less restrictive care settings will become available to the community. During this Phase, RI will also continue to provide consulting, project management (planning, coordination, and facilitation), training, and technical assistance (TA) for the execution of the strategic work plan to implement the recommendations identified in Phase 1. This will include coordination with the County, with key community partners, and MHSOAC.

An independent third-party evaluator will collect data during Year one (1) in order to determine baseline performance. Subsequent year performance evaluations will continue throughout the life of this project in order to measure against this baseline to determine community impact, utilization and overall savings.

The *Crisis Now* Multi-County Innovation Project offers an opportunity for participating counties to receive a comprehensive assessment of their respective crisis response systems, inclusive of the four core elements for transforming crisis services (consult chart below) and to determine how to implement, optimize and/or align current crisis response services with the *Crisis Now* Model. This process is also intended to address the gaps and barriers in crisis care in these systems. These gaps result in beneficiaries not receiving timely BH interventions, unnecessary suffering and despair, and frequent psychiatric boarding and engagement with law enforcement. Neither a traditional emergency department or a law enforcement response is designed to meet the unique needs of individuals in a BH crisis. Gaps in the availability of community-based crisis response and other BH care can result in individuals waiting in hospitals for hours to days or taken to jail because appropriate treatment settings are not available or do not exist.



B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

The *Crisis Now* model became practice-based evidence on how to best serve individuals experiencing a BH crisis at anytime, anywhere, or anyplace. This practice challenges providers to meet the needs of the individual in crisis first, the needs of the community second, and the needs of the organization last. This means prioritizing expedient processes, accepting everyone every time, and utilizing a recovery, trauma-responsive, and peer-based model.

In addition to the essential structural or programmatic elements of a crisis response system, the *Crisis Now* model established a list of the following essential qualities that must be "baked into" comprehensive crisis response systems:

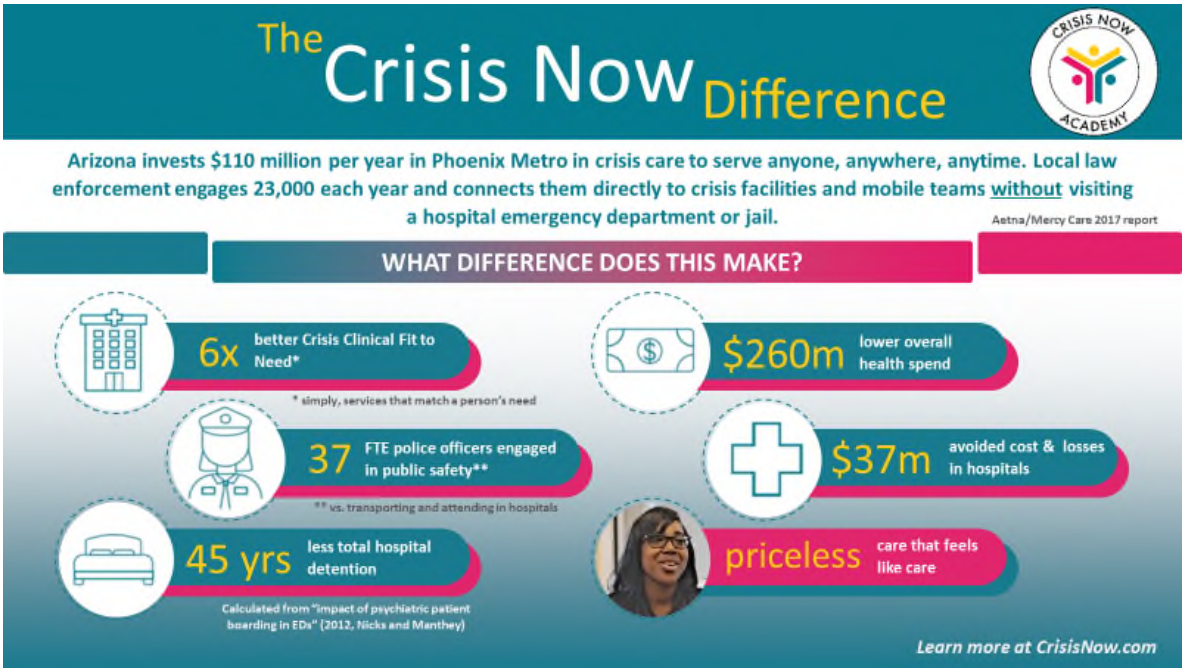
1. Addressing recovery needs, significant use of peers, and trauma-informed care;
2. "Suicide safer" care;
3. Safety and security for staff and those in crisis; *and*
4. Law enforcement and emergency medical services collaboration.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

Crisis response systems are critical infrastructure for local provider organizations serving individuals with serious mental health and SUD needs. Effective systems can improve outcomes for individuals while reducing avoidable law enforcement involvement and preventing incarceration.

The *Crisis Now* model enables counties to assess community needs, enhance access to care and realize overall cost savings. The *Crisis Now* model is associated with practices that divert from law enforcement involvement with a BH crisis and it is endorsed by the National Association of State Mental Health Program Directors (NASMHPD) and Crisis Intervention Team International (CIT) and it became the backbone of SAMHSA's *National Guidelines for Behavioral Health Crisis Care* (2020).

The *Crisis Now* Model has shown promise in many localities, both nationally and internationally. In the 4.5-million-person Maricopa County (Phoenix, Arizona), the continuum of crisis services implemented overtime incrementally evolved into the *Crisis Now* model with remarkable outcomes. Outcomes have included the following: decrease in inpatient hospitalization spend by $260 million, thirty-seven (37) full-time equivalent (FTE) police officer's time was spent engaged in public safety, and reduction in ED accumulated boarding time of forty-five (45) years annually. Results are shown in the infographic below (Crisis Now Business Case).



D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

RI used its Crisis Now Resource Need Calculator to project the crisis response system's capacity needs. This innovative Calculator offers an estimate of optimal crisis system resource allocations to meet the needs of the community. It also calculates the impact on healthcare costs associated with the incorporation of these resources. The calculator analyzes a few data elements that includes population size, average length of stay in various system beds, escalation rates into higher levels of care, readmission rates, bed occupancy rates, and local costs for those resources.

For detailed information, such as individuals to be served by different levels of care within the crisis continuum and projected costs, consult Appendix A under the section "Local Needs: Capacity Estimate."

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

The *Crisis Now* model utilizes a "No Wrong Door" approach, where **all** individuals seeking behavioral health crisis care services are accepted without restrictions, such as medical clearance, prior authorization, insurance type (underinsured or noninsured), level of crisis and etc. Each participating County has its unique demographics and needs. Appropriate data will be utilized to ensure the model is designed to support populations served.

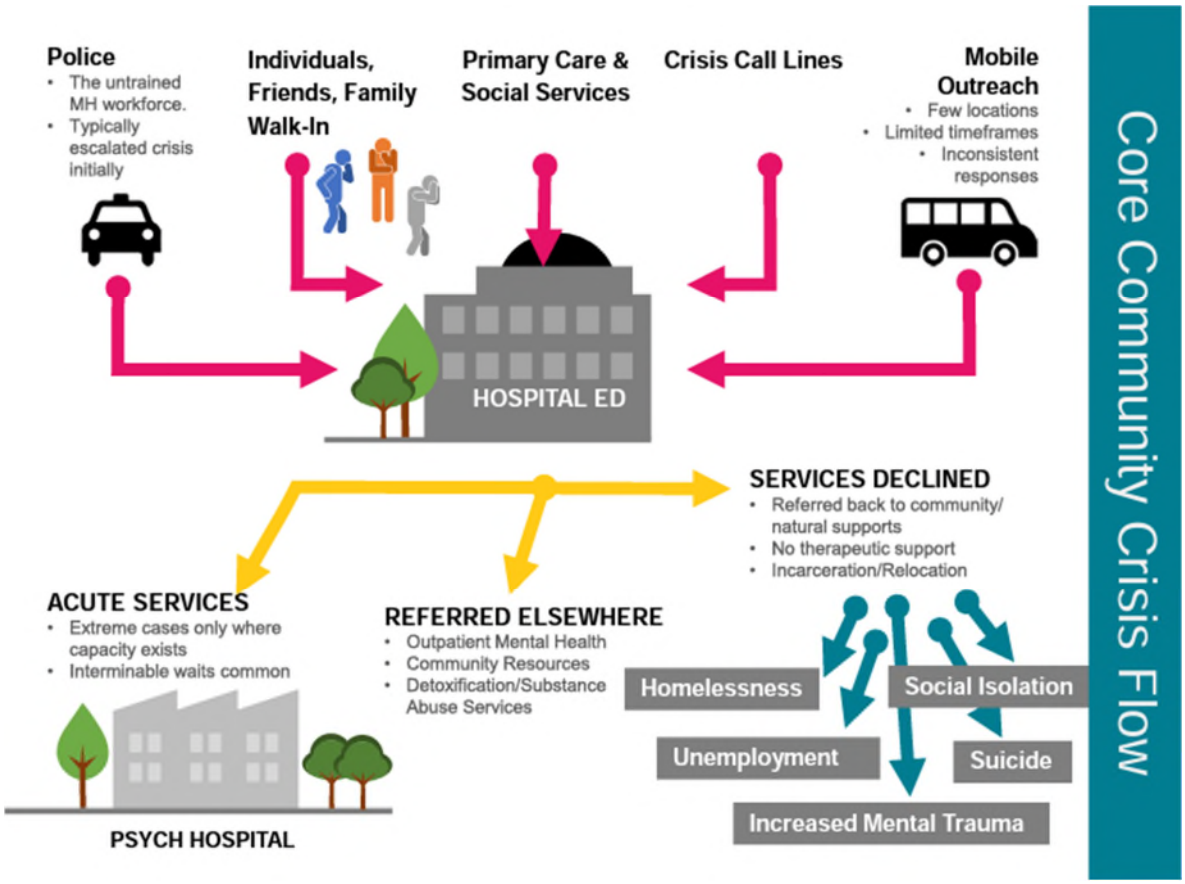
RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The *Crisis Now* Multi-County Innovation Plan will incorporate learnings from previous *Crisis Now* Model studies and implementations, and most importantly learnings from the California *Crisis Now* Academy participants (i.e. Placer County).

The underlying issues that impede the appropriate interventions for a person in a BH crisis are complex. For instance, many large service systems may be involved with someone who has complex needs. Each of these intervening service systems have their own respective missions, cultures, competencies, and entry points with rules for accessing services. The BH system has its own complexities and issues with having a dearth of intermediate and intensive community-based treatment options that serve people in their natural environments. Care for these individuals is left too often, to EDs and hospitals at one end of the care continuum, and routine outpatient services on the other (Crisis Services Role in Reducing Avoidable Hospitalization).

There are significant legal issues that serve as barriers to accessing BH crisis care, including professional scope of practice laws, facility and service licensing (including ambulance emergency destination restrictions), and protections for those in care, including medical clearance and "certifications for involuntary admissions."



Financing of BH treatment services has its own set of challenges, since insurers (public and private) have their own systems, rules, and payment rates that only reimburse certain services operated by only certain facility and provider types (Sustainable Funding Crisis Coding Billing). In addition, there are still those who are uninsured and require safety net funding in order to access services. The infographic below depicts the traditional community crisis flow (Crisis Now: Business Case):

According to the paper published by the National Association of State Mental Program Directors (NASMHPD) and co-authored by RI's CEO, David W. Covington, LPC, MBA, Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness, August 2018, individuals in crisis often interface with the justice system, first responders, hospital emergency departments (EDs) and correctional facilities (A Comprehensive Crisis System). These resources are essential to supporting a healthy community, but they are not designed to meet the unique needs of individuals experiencing a BH crisis.

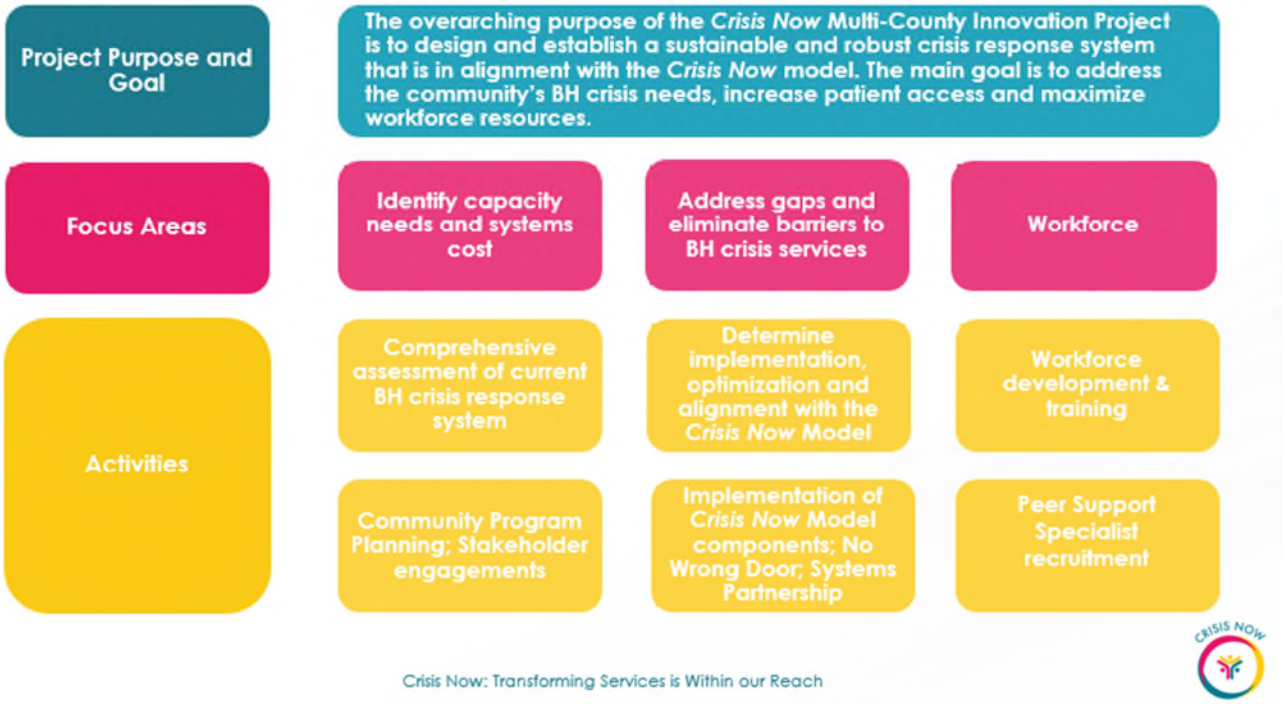
The desired model is to connect individuals to a crisis provider as quickly as possible using a systemic method that is analogous to the healthcare delivery system's approach to medical emergencies. This prototype can also be used as a tool to help model reimbursement for these similar crisis services in a manner consistent with parity expectations (Sustainable Funding Crisis Coding Billing). The chart below demonstrates the differences between our 911 medical emergency response systems in comparison to our traditional BH crisis response systems. The final column illustrates how an optimized crisis response system, can operate on par to our traditional medical emergency response system. In so doing, those with BH conditions in crisis can be subject to life-saving interventions, rather than routinely being endangered and traumatized, or even worse, exposed to deadly force. The table below highlights how the BH crisis response systems are intended to be comparable to emergency medical response systems:

Medical Emergency Response versus a BH Crisis Response			
	Medical System	Traditional BH System	National Guidelines
Call Center	911	Crisis Line or 911	Crisis Line - 988 in 2022
Community Service	Ambulance / Fire	Police	Mobile Crisis Team
Facility Option	Emergency Dept.	Emergency Dept. or Arrest/Detention	Acute Crisis Observation & Stabilization Facility
Facility Response	Always Yes	Wait for Assessment	Always Yes
Escalation Option	Specialty Unit (PRN)	Inpatient if Accepted	Crisis Facility or Acute (PRN)

In some parts of the country, the work of building out crisis response systems has been long standing or recently begun in earnest. The *Crisis Now* model incorporates technology, crisis centers, case processes, suicide prevention, and more improved management of persons in distress than had been available through traditional medical emergency department response, and a methodology that de-emphasizes routing individuals to psychiatric inpatient beds as a single option (Crisis Services: Meeting Needs, Saving Lives). The *Crisis Now* model has gained tremendous traction and was described in a well-circulated 2016 report spearheaded by two behavioral health thought leaders. The *Crisis Now* Model presents a roadmap to safe, effective crisis care that diverts people in distress from the emergency department and jail by developing a continuum of crisis care services that match people's clinical needs. This reduces and prevents suicides while providing more immediate and targeted help for a person in distress. Also, it cuts the costs of care by reducing the need for psychiatric hospital bed usage, emergency department visits, and law enforcement overuse. The *Crisis Now* model became practice-based evidence on how to best serve individuals experiencing a behavioral health crisis at anytime, anywhere, or anyplace.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.



This *Crisis Now* Multi-County Innovation Project intends to increase access to quality BH crisis response services, to promote interagency and community collaboration, as well as, to contribute to new learning and to increased capacity for participating Counties through the provision of technical assistance (TA) and evaluation. This project will assess the overall impact at both the systems-level (i.e. decrease in psychiatric boarding and unnecessary involvement with the criminal justice system), as well as, at the client-level (i.e. improved crisis clinical fit to need and increase in patient access to services).

This project will utilize an outside evaluator and the respective County's internal system analysis resources to identify the key quantitative data to collect and measure, as well as, determine the most effective ways to capture the relevant data through current information systems, such as electronic health records (EHR), and automated reporting performance management systems. Qualitative data will be garnered by studying stakeholder and agency relationships, reviewing shared protocols, and examining formal partnerships with other systems (i.e. hospitals, schools, and law enforcement). Evaluation questions that this project aims to answer include, but are not limited to, the following:

1. Will the implementation of the innovative *Crisis Now* Model
    a. Improve patient access to BH crisis response services and overall outcomes, while decreasing BH ED admissions?
    b. Divert individuals experiencing a BH crisis from jail?
    c. Increase the number of clients who will enter crisis response services voluntarily, reducing the need of for involuntary 5150s?
    d. Improve service recipient outcomes?
2. Will the development, training, and recruitment of Peer Support Specialists improve overall workforce recruitment and decrease the number of vacant positions in BH crisis care services?
3. Will the optimization of the crisis response system lead to compelling cost savings?

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

First, RI and the participating Counties will utilize the four (4) *Crisis Now* Scoring Tools (Call Center Hub, Mobile Crisis Service, Crisis Receiving Center, and *Crisis Now* System) throughout the duration of the project. The scorecards will be utilized to assess and measure each County's progress and fidelity towards best practice alignment with the *Crisis Now* Model. The scorecards are useful in tracking crisis response system performance across differing levels of model alignment and the results can be utilized to inform key operational decisions related to crisis response system optimization. For detailed information on the *Crisis Now* Scoring Tools and baseline determined for participant County, consult Appendix A under "Gap Analysis."

Second, RI will support participating Counties in identifying, procuring, and establishing an ongoing governance structure and process for partnering with a third-party evaluator ("evaluator"). The evaluator will provide an independent assessment of the project's impact and will meaningfully assess the aforementioned learning goals via a formal evaluation process.

A description and example of measures for each of the evaluation questions follow below. Participating Counties and key stakeholders/community partners, with the support from RI and the evaluator, will develop and finalize a comprehensive set of measures after contracting with the evaluator. The evaluation plan will include a timeline for defined deliverables and will crystallize the evaluation questions, measurement tools, metrics, data-sharing requirements and resulting evaluation activities. The evaluation planning activities will also include developing and confirming a strategy for each participating County to gather, collect and record data on a consistent basis.

In order to have a BH crisis response system that is increasingly sophisticated, metrics will be utilized to measure how well participating Counties are adopting the model and identify areas of misalignment, so that modification planning can be initiated. As the respective crisis response systems mature, it is anticipated that there will be increasing demands for measuring quality, inclusive of demonstrating successes and value (or lack thereof), identifying weaknesses to inform quality continuous improvements (CQI) and plan-do-study-act (PDSA) cycles, while maintaining a focus on the needs of service recipients and on achieving their respective recovery goals.

The table below proposes potential qualitative and quantitative measures to assess the impact of the implementation of the *Crisis Now* Model at the systems- and client-levels. Note that the time period for observing, collecting and evaluating data and metrics may need to end sooner (i.e. end of 4th year), to allow sufficient time for the evaluator to measure and synthesize findings and to share outcomes with participating Counties and their stakeholders. Participating Counties, RI, and the evaluator will refine the aforementioned questions, as well as, determine the exact measures and an appropriate evaluation methodology for assessing system- and client-level impact.

Participating Counties will identify and finalize measures, data sources, and learning goals during the first year of the project, solidified in a shared evaluation plan, with support from the evaluator and RI. Given the complexity of the changes expected, it will be beneficial for the evaluator to be identified and onboarded prior to finalizing the specifics of the evaluation plan.

Example Measures	Example Data Source	Evaluation Question
Increased patient access to BH crisis services	Quantitative (referral and admissions); Qualitative (stakeholder engagements)	1
Increased service recipient satisfaction	Quantitative (self report via customer satisfaction survey); Qualitative (stakeholder engagements)	1
Decreased/avoided psychiatric boarding	Quantitative (data from hospitals)	1
Decreased/avoided unnecessary incarceration	Quantitative (data from LE)	1
Decreased drop-off time from first responders (LE, EMS, etc.)	Quantitative (data collected at program level)	1, 3
100% referrals accepted	Quantitative (data collected at program level)	1, 3
Increased percentage of calls resolved by phone	Quantitative (data collected from call centers/dispatcher)	1, 2
MCT average response time within 60 minutes or less	Quantitative (data collected at program level)	1, 2
Increased percentage of mobile crisis responses resolved in the community	Quantitative (data collected at program level)	1, 2
Decreased percentage of admissions in crisis facilities requiring a higher level of care	Quantitative (data collected at program level)	1
Decreased readmission rate (under 3 days; within 4 - 20 days; more than 20 days)	Quantitative (data collected at program level)	1
Decreased number of staffing vacancies	Quantitative (data collected from providers, County)	2
Increased number of Peer Support Specialists trained/recruited within crisis response programs	Quantitative (data collected from providers, County)	2
Increased cost savings within the different systems	Quantitative (data collected from other systems/partners; data based on number of LE drop-offs, referrals from hospitals, etc.)	3
Reduces inpatient spend and/or hospital EDs costs/losses	Quantitative (data collected from other systems/partners; data based on number of LE drop-offs, referrals from hospitals, etc.)	3

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

Participating Counties intend to contract with a consulting firm that will provide technical assistance to support counties with project implementation activities. RI, an operator and national/international consultant of the *Crisis Now* framework, with the support of the MHSOAC, is leading the participating Counties through the process of developing and implementing the *Crisis Now* Multi-County Innovation Project. RI will act as the project lead and project manager, providing consultation and customized recommendations, project management (planning, coordination, and facilitation), training, and technical assistance (TA) for the execution of the *Crisis Now* strategic work plan.

Participating Counties will also identify and contract with an evaluation partner. The evaluation partner will support this multi-county initiative in the design and implementation of a shared assessment to evaluate the project learnings and community impact.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

Community involvement from stakeholders is critical to the development and implementation of this project. Appendix A includes detailed information about each participating County's stakeholder engagements, and their overall Community Program Planning Process (CPPP). Since the CPPP is ongoing, stakeholders will continue to be included at all levels (planning, implementation, and evaluation process) of the *Crisis Now* Multi-County Innovation Project. Stakeholders will continue to receive updates and have the ability to provide input throughout the life of this project, inclusive of participation through focus groups, stakeholder engagements and interviews.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A. Community Collaboration: This is a multi-county collaboration to eliminate the barriers associated with crisis care and to access the supports needed to optimize their respective BH crisis response systems. Participating Counties will continue to work closely and collaborate with local CBOs, hospitals, and partner agencies to ensure continue partnerships and support in serving individuals experiencing a behavioral health crisis and their family.

B. Cultural Competency: The *Crisis Now* Model is focused on cultural competency, by ensuring policies, procedures, and activities incorporate the value of racial, ethnic, cultural diversity, and by maintaining a workforce that reflects the community.

C. Client-Driven: The *Crisis Now* Model is client-driven and challenges providers to meet the needs of the individual in crisis first. Crisis providers must engage in person-centered planning and treatment, while assessing risk for violence and collaboratively develop de-escalation and safety plans for individuals served.

D. Family-Driven: The *Crisis Now* Model engages with the individual experiencing a BH crisis, as well as, engaging the person's family and informal supports in service planning.

E. Wellness, Recovery, and Resilience-Focused: The *Crisis Now* Model established the following to be a few of its essential qualities:
   - Addressing recovery needs,
   - Significant use of peers, and
   - Trauma-informed care.

   The significance of a recovery-oriented approach is critical for those in crisis. In an outmoded, traditional model, crises typically reflect "something wrong" with the individual. Risk is seen as something to be contained, often by means of an involuntary commitment to an inpatient psychiatric unit. In worst-case scenarios, people end up restrained on emergency room gurneys or in jails. These actions in turn, are traumatizing to those who are subjected to them, and often they further reinforce the likelihood that the person will soon again recycle through this same revolving door of inadequate crisis interventions. In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized, but the basic approach is fundamentally different. Crises are viewed as challenges that may present opportunities for growth. When crises are ameliorated in comfortable and familiar settings, people feel less alone and isolated with their feelings of anxiety, panic, depression, and frustration. This creates a sense of empowerment and belief in one's own recovery, and ability to respond effectively to future crises. The recovery-oriented approach to crisis care is integral to transforming a broken system.

F. Integrated Service Experience for Clients and Families: The *Crisis Now* Model is an approach of coordination and integration with different services and systems within the community (i.e. law enforcement and emergency medical services collaboration). Collaborating within systems is an effective and efficient way of resolving BH crisis and preventing future crises. The *Crisis Now* Model advocates for s strong partnerships between BH crisis care systems and law enforcement for public safety, suicide prevention, connections to care, justice system diversion, and the elimination of psychiatric boarding in emergency departments.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

This *Crisis Now* Multi-County Innovation Project intends to engage each County's stakeholders (i.e. crisis services recipients and their natural supports, crisis response staff, other service providers, and key community partners) throughout its duration, including in the evaluation process. Participating County's established Cultural Competency Committees will be informed on a regular basis throughout the life of this project and will be invited to be engaged and provide feedback.

Stakeholders will be engaged via virtual and in-person meetings, as well as surveys. Their input will be critical to ensure that the crisis response system's design, service delivery, and evaluation, are culturally and linguistically appropriate, inclusive and responsive, and that any potential barriers to access and/or BH inequities are proactively identified and addressed.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The C*risis Now Transforming Crisis Services: Business Case* suggests that a comprehensive crisis response system is affordable and within reach of most communities. The cost of crisis response services can be further supported by the reinvestment of savings from the decreased spend on hospital-based services and incarceration/detention. In Maricopa County, Arizona for example (which includes the greater Phoenix area), the associated savings of a crisis response system containing all three-core components have experienced the following system efficiencies in 2018:

- Thirty-seven (37) full-time equivalent (FTE) police officers' time was spent engaged in public safety, instead of being engaged with BH crises;
- Reduction in ED accumulated boarding time of forty-five (45) years annually; and
- Decrease in inpatient hospitalization spend by $260 million.

The escalating costs communities pay for not investing in a comprehensive crisis response system are unsustainable; manifesting as increasing demands on law enforcement, other first responders, criminal justice systems, emergency departments, service providers of all types, and public and private payers. These escalating demands in our communities are pushing the limits of what is affordable and sustainable, while resulting in adverse outcomes for those in need of

care and the communities within which they reside. The impact to vulnerable and marginalized members of our communities, and their families, is devastating. A comprehensive crisis response system that includes the three core components is essential to all communities. Getting to zero unnecessary admissions for BH conditions to emergency departments and jails (where only nuisance crimes have been committed) are attainable goals for this Project through the implementation of the *Crisis Now* Model.

Participating Counties will plan for a phased crisis response system optimization which will require, monitoring service demand, utilization and performance, metrics, while securing sustainable funding. A comprehensive Financial Plan will be developed that will delineate the costs associated with the Mobile Crisis Teams (MCT), Crisis Stabilization Units (CSU), and Psychiatric Health Facilities (PHF) as those are phased in while also protecting the revenue to offset these costs. The financial plan/model will align with CalAIM's payment reform initiatives.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

Throughout the development of this *Crisis Now* Multi-County Innovation Project, RI has maintained ongoing communication with MHSOAC regarding county outreach efforts, project progress, contract deliverables, areas of further collaboration, and project expectations. As the project progresses, RI will continue to communicate with MHSOAC leadership on the project's progress. Additionally, RI and/or participating Counties will collaborate with the Commission to determine if and when presentations to the MHSOAC may be appropriate for further disseminating project accomplishments and lessons learned along the way.

RI and the participating Counties will develop and implement a project communication strategy to appropriately disseminate information to stakeholders on a consistent basis. One of the communication vehicles that will be employed will be a quarterly stakeholder newsletter. RI and participating Counties will also facilitate annual stakeholder meetings through the life of this project to discuss the project's progress and challenges, as well as, to elicit feedback from community members.

Project reports and updates will be distributed and shared throughout County's Community Program Planning Process and other relevant meetings.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

Crisis Now Model, crisis response system, crisis care continuum, Mobile Crisis Team, Crisis Receiving Facility, 988

TIMELINE

A) Specify the expected start date and end date of your INN Project

September 1st, 2023 – July 30th, 2026

B) Specify the total timeframe (duration) of the INN Project Three (3) Years)

C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Activity	Start	End	2023	2024	2025	2026
Capacity Needs & Modeling						
Crisis Now Academy (abbreviated version)	9/4/2023	9/29/2023				
Discovery: Data Gathering	9/1/2023	10/31/2023				
Discovery: Stakeholder Meetings	9/15/2023	11/1/2023				
Crisis Line/Mobile Crisis Team						
Strategy: Develop MCT Implementation Plan	9/1/2023	10/31/2023				
Strategy: Crisis Line/MCT Integration	12/1/2023	3/1/2024				
Implementation: MCT	12/1/2023	1/30/2024				
TA: MCT	1/1/2024	7/30/2026				
Facility-Based Crisis						
Strategy: Develop Implementation Plan	1/1/2024	6/30/2024				
Implementation: Facilities	7/1/2024	6/30/2025				
TA: Facilities	7/1/2025	6/30/2028				
Workforce						
Discovery: Needs	9/1/2023	12/1/2023				
Strategy: Development and Training	12/1/2023	2/29/2024				
Implementation: Training	3/1/2024	6/30/2024				
General						
Project Management	9/1/2023	7/30/2026				
Technical Assistance	9/1/2023	7/30/2026				

Crisis Now Innovation - Project Workplan	
Core Area 1: Project Management & Stakeholder Communication	
Core Area Goal: The County, County contractors and stakeholders are aligned on project objectives and regularly updated on INN plan progress	**Timeframe**
1.a. Plan and convene monthly contract check-ins	Monthly
1.b. Plan and convene monthly project planning meetings	Monthly
1.c. Monthly updates to internal implementation workplan	Monthly
1.d. As needed, participate in County meetings, track best practice research, and presentations	Ongoing
1.e. Plan and convene quarterly Multi-County Project Management Team meetings	Quarterly
1.f. Develop quarterly implementation update newsletter to be sent to all stakeholders	Quarterly
1.g. Plan and convene countywide annual meeting for all stakeholders to update on project progress, key initiatives, and next steps	Annual
Core Area 2: Systems Development & Coordination	
Core Area Goal: Key systems and resources are aligned and coordinated to support full implementation of the *Crisis Now* framework	**Timeframe**
Subarea 2.1: Training	
2.1a. Plan and facilitate an abbreviated Multi-County *Crisis Now* Academy Training	Annual (Year 1)
2.1b. Develop crisis training list for workforce	Annual (Y1 & Y2)
Subarea 2.2: Messaging	
2.2a. Assist County to develop a public communication strategy	Annual (Year 1)
2.2b. Assist County to develop the initial message and change management process for BH Crisis to include partnership plan	Annual (Year 1)
2.2c. Communication with stakeholders	Ongoing
Subarea 2.3: Operations	
2.3a. Assist County with crisis services providers recruitment/optimization	Annual (Y1 & Y2)
2.3b. Assist County to develop/review RFP for recruitment of crisis services providers	Annual (Y1 & Y2)
2.3c. Assist County to develop SOPs	Annual (Y1 & Y2)
2.3d. Forecast crisis flow volumes and required capacity	Annual (Year 1)
2.3e. Develop client journey (program workflow)	Annual (Y1 & Y2)
Subarea 2.4: Workforce	
2.4a. Develop Staffing Model (composition and pattern)	Annual (Year 1)
2.4b. Support County to enhance existing behavioral health workforce recruitment and retention strategies	Annual (Y1 & Y2)
2.4c. Support County to enhance existing behavioral health workforce development strategies	Ongoing
2.4d. Support the growth and training of County's peer support specialist workforce	Ongoing
2.4e. Support County to coordinate workforce trainings (best practice and mandatory)	Annual (Y1 & Y2)
Subarea 2.5: Funding & Sustainability	
2.5a. Develop budget and start-up costs for implementation of crisis services	Annual (Year 1)
2.5b. Track and assist County to apply for funding opportunities for crisis care services	Ongoing
Subarea 2.6: Data & System Monitoring	
2.6a. Identify data metrics and key performance indicators for each type of crisis service, including reporting timeframes	Annual (Year 1)
2.6b. Collaborate with County to determine mechanism for tracking and reporting provider data and key performance indicators	Annual (Y1 & Y2)
2.6c. Meet and obtain quotes for project data evaluator to collect baseline data and conduct ongoing monitoring of systems performance and evaluation of systems change	Immediately (Year 1)
2.6d. Collaborate with County to develop plan to transition systems monitoring functions to a countywide accountability entity	Year 3
Subarea 2.7: Collaboration & Partnership	
2.7a. Collaborate with community members and partners	Ongoing
Core Area 3: Report	
Core Area Goal: Documentation of discovery, prediction, strategy, workplan, project management	**Timeframe**
3.a. Assessment and System Design Report & Implementation Plan	Annual (Year 1)
3.b. Annual INN Report (project update)	Annual (Y1, Y2 & Y3)
3.6 Project Management Tool/Workplan	Ongoing

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

BUDGET NARRATIVE

Overview of Project Budget and Sources of Expenditures: All Counties
The total proposed budget supporting Cohort 1/pilot participating county in pursuing this Innovation project is approximately $5.16M over 3 years (Appendix A). This includes project expenditures for four (4) different primary purposes: Personnel, Operations, Consulting, and Evaluation.

Counties will contribute varying levels of funding towards a collective pool of resources that will support the project expenditures, excluding County-Specific Costs. The appendix includes additional detail on each participating County's specific contributions and planned expenditures.

Budget Narrative for Shared Costs: All Counties
Each participating County will contribute to a shared pool of resources that will support the consultant (RI International) and the evaluator (third-party; TBD) costs associated with the project. These contracts will operate across the cohort of participating Counties, as well as support each individual county according to their own unique needs.

RI International Consulting Costs
RI will lead participating Counties through system design, implementation plan and TA over the life of this project. These costs will fund RI teams who will provide a wide range of services and subject matter expertise to each county as they optimize their crisis continuum of care founded on the principles of the *Crisis Now* Model. RI will facilitate an abbreviated *Crisis Now Academy* Training for each participating County in order to provide in-depth understanding of the model and its principals, assessment and system design to optimize their current crisis services, implementation plan for new services and/or principles, and ongoing technical assistance with subject matter experts in the model through the life of this Innovation project.

Evaluation Costs
RI and participating Counties will determine the appropriate procurement process, as well as statement of work, budget, and funding plan for a third-party evaluator within the first three (3)

months of the project. The evaluator, in coordination with each participating county, community partners and RI, will be responsible for developing a formal evaluation plan, conducting evaluation activities, and producing all evaluation reports required for this project.

Budget Narrative for County-Specific Costs

The remaining project costs are intended to support additional county-specific expenditures. Counties will be responsible to fund these costs directly. The appendix includes detail of each county's specific projected expenditures.

Crisis Now Multi-County Innovation Plan

APPENDIX

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APPENDIX A
Santa Cruz County

Santa Cruz County Behavioral Health

County Contact Personnel

Karen Kern: Deputy Director
Danielle Long: Crisis Continuum Program Manager
James Russel: Director of Access and Community Crisis Continuum Services
Chief Deputy Jacob Ainsworth: County Sheriff's Office

Introduction

In December 2022, Santa Cruz County Behavioral Health joined the Multi-County *Crisis Now* Learning Collaborative, which is designed to facilitate the analysis of the existing crisis response system in comparison to the *Crisis Now* Model and to create an Innovation Project to optimize Santa Cruz County's Behavioral Health Crisis Response System.

Project Overview & Timeline

During the first phase of this project, Santa Cruz County Behavioral Health (SCCBH) partnered with RI International (RI), a national consulting organization, through a contract between RI and the Mental Health Services Oversight and Accountability Commission (MHSOAC) to identify unmet needs in the community and design a new approach to eliminate barriers and optimize the County's behavioral health crisis response system.

- **November 2022**: SCCBH Health staff attended the Multi-County *Crisis Now* Collaborative Presentation that focused on the *Crisis Now* Model and goals for the Multi-County *Crisis Now* Innovation Project.
- **November 2022**: SCCBH committed to the Multi-County *Crisis Now* Learning Collaborative.
- **December 2022**: SCCBH and RI had a kick-off meeting and discussed details of the project and developed a comprehensive project workplan and deadlines.
- **December 2022 – February 2023**: SCCBH and RI met weekly to discuss the county's current behavioral health crisis response system and its challenges. Moreover, the project team facilitated two (2) stakeholder meetings in the month of February and started plans for the 30-day public review, MH Board hearing, and Board of Supervisors calendar date for appearance.

Gap Analysis

Someone to Call: Call Center Hub

The "front door" of a modern crisis system is a 988 crisis call center hub that meets National Suicide Prevention Line (NSPL) standards, participates in the national network, and has been designated by Vibrant Emotional Health, under contract with SAMHSA, and the State of California to be a technology-enabled 988 crisis call center. Since 2005, SAMHSA has funded multiple research projects to evaluate the critical role of crisis call centers as indispensable resources for suicide prevention. Nationally more than 180 call centers have met the standards of and have participated in the NSPL network. Such a crisis call center is equipped to connect individuals in a behavioral health (BH) crisis to needed care. These programs use Global Positioning System (GPS) technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems every minute of every day.

That real-time care coordination requires electronic linkage with every BH inpatient and residential bed and with every outpatient treatment slot in the service area. At the same time, they provide high-touch support to individuals and families in crisis that adheres to NSPL standards. In order for crisis call centers to be accessible to youth, it is critical that they include the technology and the staffing to support both texting and chat capabilities.

The crisis call function can be further complemented by a Peer-to-Peer Warm Line, which is staffed by Certified Peer Support Specialists. This service can provide 24/7 readily accessible support, outreach, and post-vention which can prevent the emergence of future crises or re-stabilize an individual who is beginning to feel over-stressed, overcome with drug cravings, or feelings of loneliness, hopelessness, and burdensomeness.

The new national crisis call number, 988, holds the promise of an equitable healthcare response to a healthcare issue that provides better outcomes as people receive the services and supports they need to remain in their communities and thrive. This promise will only be fulfilled if adequate resources are available to accommodate increased call/chat/ text volume, as well as the continuum of crisis care services that can respond as appropriate. Crisis care services are more impactful when they include and are informed by individuals with diverse backgrounds, including lived experience, who are trained to respond in an empowering and culturally responsive manner.

Vibrant Emotional Health (Vibrant), the administrator of the National Suicide Prevention Lifeline, has provided recommendations and defined the vision and mission of 988 as follows:

- Vision: 988 serves as America's mental health safety net. It will reduce suicides and mental health crises and provide a pathway to well-being.
- Mission: Everyone in the U.S. and its territories will have immediate access to effective suicide prevention, crisis services and behavioral healthcare through 988.

The key features of 988 include:

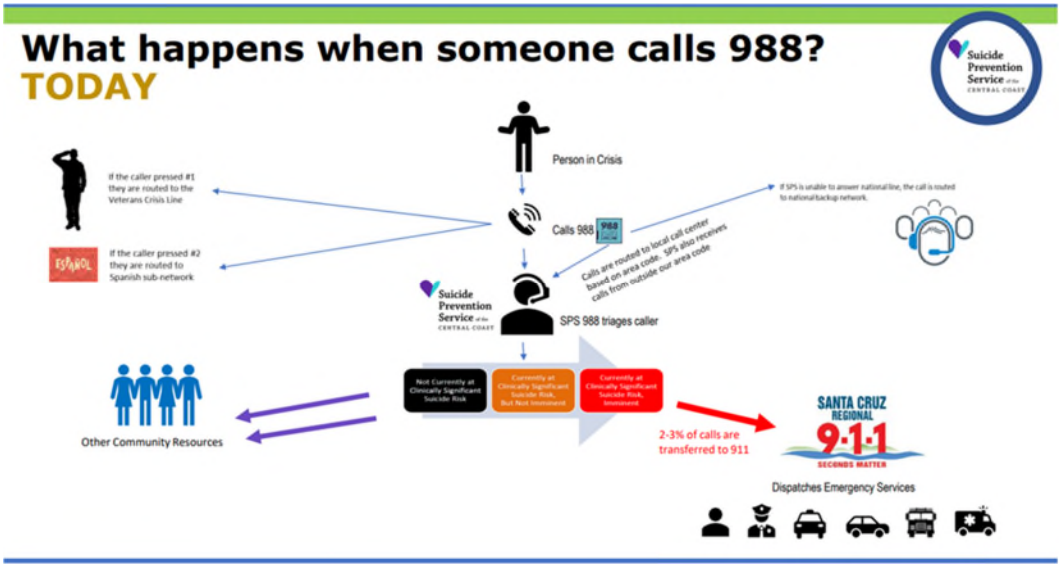
a. Universal and Convenient Access, including omnipresent public awareness and varying modalities for individuals to access 988 through their preferred method of communication;
b. High Quality and Personalized Experience that is tailored to the unique needs of the individual while also in line with identified best practices;
c. Connection to Resources and Follow Up to ensure all persons contacting 988 receive additional local community resources as needed.

Santa Cruz County Behavioral Health Crisis Line Response

There are a few 24 hours and 7 days per week Helplines and Hotlines within the County of Santa Cruz:

- Suicide and Crisis Lifeline: 988
- 24-Hour Access Line: 1-800-952-2335
- Santa Cruz County Crisis Stabilization Program: 1-831-600-2800

The 988 Crisis Line operates 24 hours/day, 7 days/week as the entry point for mental health services in Santa Cruz County. Calls are answered by the Suicide Prevention Service of the Central Coast, a regional call center assigned to Santa Cruz County, San Benito County and Monterey County. Calls are triaged and routed to appropriate resources. Currently, the caller is referred to appropriate community resources if they are not presenting as a danger to self or others. Approximately 2-3% of the calls are determined to be at a clinically significant risk level and routed to 911, for emergency services dispatch, evaluation and/or transportation for the appropriate level of care. According to the regional call center, there has been an 93% increase in incoming calls from 2021 to 2022. The illustration below demonstrates the current 988 process flow available when someone with a Santa Cruz County area code calls 988:



To assess the alignment of Santa Cruz County to national best practices, the *Crisis Now* Scoring Tool for Call Center Hub was applied. Santa Cruz needs to build out the technological capabilities to make 988 a true "crisis contact center hub." For instance, adding technology to allow for geo-location, outpatient appointments, direct referrals to available crisis beds, and dispatching MCTs. There should also be negotiated call transfer protocol agreements between the nine Public Safety Answering Points (PSAP) within Santa Cruz County and the 988 call center.

***Crisis Now* Scoring Tool (Call Center Hub)**									
	Level 1 (Minimal)		**Level 2 (Basic)**		**Level 3 (Progressing)**		**Level 4 (Close)**		**Level 5 (Full)**
☑	Call Center Exists	☑	Meets Level 1 Criteria	☐	Meets Level 2 Criteria	☐	Meets Level 3 Criteria	☐	Meets Level 4 Critieria
☑	24/7 Call Center in Place to Receive BH Crisis Calls	☑	Locally operated 24/7 Call Center in Place to Receive Calls	☐	Hub for Effective Deployment of Mobile Teams	☐	Formal Data Sharing in Place Between Crisis Providers	☐	Integrated Data that Offers Real-Time Air Traffic Control (Valve Mgmt)
☑	Answer Calls Within 30 Seconds	☑	Answer Calls Within 25 Seconds	☑	Answer Calls Within 20 Seconds	☑	Answer Calls Within 15 Seconds	☐	GPS-Enabled Mobile Team Dispatch by Crisis Line
☑	Cold Referral to Community Resources or Better Connection to Care	☑	Warm Hand-off to BH Crisis Providers	☑	Directly Connects to Facility-Based Crisis Providers	☑	Coordinates Access to Available Crisis Beds	☐	Shared Bed Inventory and Connection to Available Crisis and Acute Beds
☑	Meets NSPL Standards and Participates in National Network	☑	Staff Trained in Zero Suicide / Suicide Safer Care and BH Services (ASSIST)	☐	URAC Call Center or Similar Accreditation	☐	Single Point of Crisis Contact for the Region	☐	24/7 Outpatient Scheduling with Same Day Appointment Availability
		☐	Call Abandonment Rate Under 20% (Data not collected)	☐	Call Abandonment Rate Under 15%	☐	Call Abandonment Rate Under 10%	☐	Call Abandonment Rate Under 5%
		☐	Shared MOUs / Protocols with Crisis Providers	☐	Some Call Center Access to Person-Specific Health Data	☐	Some Access to Person Specific Data for All Crisis Providers	☐	Real-Time Performance Outcomes Dashboards Throughout Crisis System
		☑	Priority Focus on Safety / Security	☐	Some Peer Staffing within Call Center	☐	Shares Documentation of Crisis with Providers	☐	Shared Status Disposition of Intensive Referrals
						☐	Peer Option Made Available to All Callers Based on Need	☑	Trauma-Informed Recovery Model Applied
						☑	Systematic Suicide Screening and Safety Planning (C-SSRS)	☑	Suicide Care Best Practices That Include Follow-up Support
								☐	Full Implementation of all 4 Crisis Now Modern Principles (Required)
Assessed Level =	**2**	**Justification of Rating**: 988 was implemented and calls are answered by a NSPL affiliated call centers in the state of California. Some data is tracked/collected.							

Someone to Respond: Mobile Crisis Teams

Mobile crisis services are intended to operate on a 24/7/365 basis and are typically comprised of a two-person (licensed clinician and peer support partnerships are common) mobile crisis team (MCT) that offers assessment, outreach, and support where people in crisis are, either in the person's home or a location in the community (not a healthcare facility). The two-person model is intended to assure greater safety for the teams in their work in the community, to ensure that those served have the best opportunity for engagement, and to allow for the transportation of those served when warranted, eliminating the need for overuse of the police and ambulances for transportation. Recently, programs have shown greater success by using GPS-enabled technology dispatched from the crisis contact center to efficiently connect individuals in crisis with the nearest available mobile team. Programs should include contractually required response times and medical backup. The MCT provides a timely face-to-face response and requires the capacity to intervene quickly, day or night, wherever the crisis occurs. In cases where the person in crisis cannot be stabilized, the MCT assists in transferring this person to a higher-level of care and will provide transportation for those that are voluntary when it is safe to do so.

Community-based mobile crisis intervention services are crisis intervention services provided to individuals experiencing a BH crisis whenever and wherever the service is needed. According to "Cal. Code Regs. Tit. 9, § 1810.209" Cal. "Crisis Intervention" is defined as "a service, lasting less than 24 hours, to or on behalf of a beneficiary, for a condition that requires more timely response than a regularly scheduled visit."

To meet the "qualifying" requirement, community-based mobile crisis intervention services must be:

- Provided to a Medicaid beneficiary who is experiencing a BH disorder crisis;
- Provided outside of a hospital or other facility setting;
- Furnished by a multi-disciplinary mobile crisis team that consists of at least one BH care professional capable of assessing the individual and other professionals or paraprofessionals with appropriate expertise in BH crisis response (e.g. nurses, social workers, peer support specialists, etc.); *and*
- Available 24 hours per day, every day of the year.

Additionally, the mobile crisis team members must:

- Be trained in trauma-informed care, de-escalation strategies, and harm reduction;
- Be capable of responding in-person to the crisis in a timely manner;
- Be able to provide services, such as screening and assessment, stabilization and de-escalation, as well as follow-up care coordination, referrals, and transportation assistance as needed; and
- Maintain the privacy and confidentiality of patient information and relationships with relevant community partners.

Santa Cruz County Behavioral Health Mobile Crisis Response

There are two (2) different mobile crisis response models actively operating within Santa Cruz County and they are structured as follows:

Mobile Emergency Response Team (MERT)

MERTs are available for adults and for youth (MERTY). MERTs are comprised of clinical staff with authority per Welfare and Institutions Code (WIC) 5150 and 5585 to perform evaluations for involuntary detention of mental disordered adults and children respectively. When responding to a call for youth in crisis, a family partner is also available to be dispatched. MERT is expected to respond to requests for mobile psychiatric services county-wide Monday through Friday from 8 AM to 5 PM. Mobile services can be requested by anyone via phone (800.952.2335).

Mobile Response Mental Health Liaisons

Co-responder teams staffed by a law enforcement officer and a mental health liaison (MHL), who is a behavioral health clinician. This team is available through the Watsonville PD, Santa Cruz PD, and the Sheriff's Office. Teams are dispatched through Netcom and available seven (7) days per week, from 8 AM to 6 PM. Community members can request a MHL to respond with the LE officer when calling 911.

To assess the alignment of Santa Cruz County to best practices, the *Crisis Now* Scoring Tool for Mobile Outreach was applied. The assessment level for mobile crisis response services has been evaluated at the Basic Level 2. With Santa Cruz' plans to increase the availability of mobile response, this enhancement will contribute to improving mobile response services alignment with best practices. As CA and Santa Cruz County are building a peer support specialist workforce, this will also add momentum to the quest for better alignment with best practices. Mobile Crisis Teams will need to have shared protocols with the 988 crisis call center since this service is deployed by the Santa Cruz Helpline, where protocols are in place. To be consistent with the *National Guidelines*, mobile crisis response teams should be better coordinated, more easily dispatched, equipped to manage the transport of clients on voluntary status, staffed with clinicians and peers.

***Crisis Now* Scoring Tool (Mobile Crisis Service)**							
	Level 1 (Minimal)		**Level 2 (Basic)**		**Level 3 (Progressing)**		**Level 4 (Close)**		**Level 5 (Full)**
☑	Mobile Teams are in Place for Part of the Region	☑	Meets Level 1 Criteria	☐	Meets Level 2 Criteria	☐	Meets Level 3 Criteria	☐	Meets Level 4 Critieria
☑	Mobile Teams are Operating at Least 8 hours Per Day in at least part of	☑	Mobile Teams are Available Throughout the Region at Least 8 hours Per Day	☐	Mobile Teams are Available Throughout the Region at Least 16 hours Per Day	☑	Formal Data Sharing in Place Between Mobile Teams and All Crisis Providers	☐	Real-Time Performance Outcomes Dashboards Throughout Crisis System
☑	Mobile Teams Respond to Calls Within 2 Hours Where in Operation	☑	Mobile Teams Respond to Calls Within 2 Hours Throughout the Region	☑	Mobile Teams Respond to Calls Within 1.5 Hours Throughout the Region	☑	Mobile Teams Respond to Calls Within 1 Hour Throughout the Region	☐	GPS-Enabled Mobile Team Dispatch by Crisis Line
☑	Mobile Teams Complete Community-Based Assessments	☐	Mobile Team Assessments include All Essential Crisis Now Defined Elements	☑	Directly Connect to Facility-Based Crisis Providers as Needed	☑	Support Diversion Through Services to Resolve Crisis with Rate Over 60%	☐	Support Diversion Through Services to Resolve Crisis with Rate Over 75%
☑	Mobile Teams Connect to Additional Crisis Services as Needed	☐	Staff Trained in Zero Suicide / Suicide Safer Care and BH Services	☑	Some Mobile Team Access to Person Specific Health Data	☑	Mobile Teams Receive Electronic Access to Some Health Information	☐	All Mobile Teams Include Peers
		☐	Shared MOUs / Protocols with Call Center Hub	☐	Shared MOUs / Protocols with Call Center and Crisis Facility-Based Providers	☑	Shares Documentation of Crisis with Providers	☐	Shared Status Disposition of Intensive Referrals
		☑	Priority Focus on Safety / Security	☑	Trauma-Informed Recovery Model Applied	☑	Some Peer Staffing within Mobile Teams	☑	Meets Person Wherever They Are - Home/Park/ Street / Shelter etc.
						☑	Systematic Suicide Screening and Safety Planning	☐	Real-Time Access to Electronic Health Records
								☐	Suicide Care Best Practices That Include Follow-up Support
								☐	Full Implementation of all 4 Crisis Now Modern Principles (Required)
Assessed Level = 2		**Justification of Rating**: Santa Cruz has two types of mobile crisis response: MERT(Y) and a co-responder model. Their availability is limited and teams are not dispatched via the crisis call center.							

Safe Place to Go: Crisis Care Facilities

Facility-based crisis services begin by offering short-term BH crisis care for individuals who need support and observation. Design of these facility-based crisis services may vary, but ideally, they include a medically staffed flexible observation and stabilization area with recliners, instead of beds, (usually limited to less than 24 hours of care); and operate under a "no wrong door" approach. Under this approach, walk-ins, law enforcement, and other first responder referrals, are immediately accepted without requiring any form of medical clearance prior to admission. This approach also includes accepting voluntary and involuntary admissions. Therefore, it is imperative that the facility is staffed and equipped to assure the health and safety of everyone within the facility. These centers are typically a high-speed assessment, observation, engagement, and stabilization service. Each admission receives the following services: a psychiatric evaluation by a Licensed Psychiatrist or Psychiatric Nurse Practitioner that includes a risk assessment and medication evaluation; a brief medical screening by a registered nurse to ensure that co-occurring medical issues are addressed; Substance Use Disorder (SUD) screening and assessment by a licensed clinician; a psychosocial assessment by a licensed clinician; crisis stabilization services utilizing a high engagement environment with a strong recovery focus and peer support model; and comprehensive discharge planning and community coordination of services.

These introductory crisis observation stabilization programs are typically paired with a subacute short-term (2-5 day) facility-based crisis program to offer more than 24 hours of care without escalating to more costly acute inpatient options that would result in longer lengths of stay and higher per diem costs. This facility needs to be licensed to accept involuntary guests and have the licensed ability to offer seclusion and restraint services, if needed. This unit is intended to serve approximately 30% of those admitted to the 23-hour center with recliners, who were not sufficiently stabilized during the 23-hour observation stay, and who may receive crisis stabilization services for up to fourteen (14) days.

Santa Cruz County Behavioral Health Crisis Care Facility Response

Santa Cruz County offers the following:

- Walk-in Crisis Services
- Crisis Stabilization Unit (CSU)
- Psychiatric Health Facility (PHF)

Walk-in Crisis Services

The Walk-in Crisis facility operates Monday through Friday from 8 AM to 5 PM (non-observed holidays). This site offers crisis assessments and intervention for adults and children. They also provide linkage and referrals to local providers for follow up care. Community members can access services on a self-referral basis by presenting at the facility located at 1400 Emeline Ave., Santa Cruz.

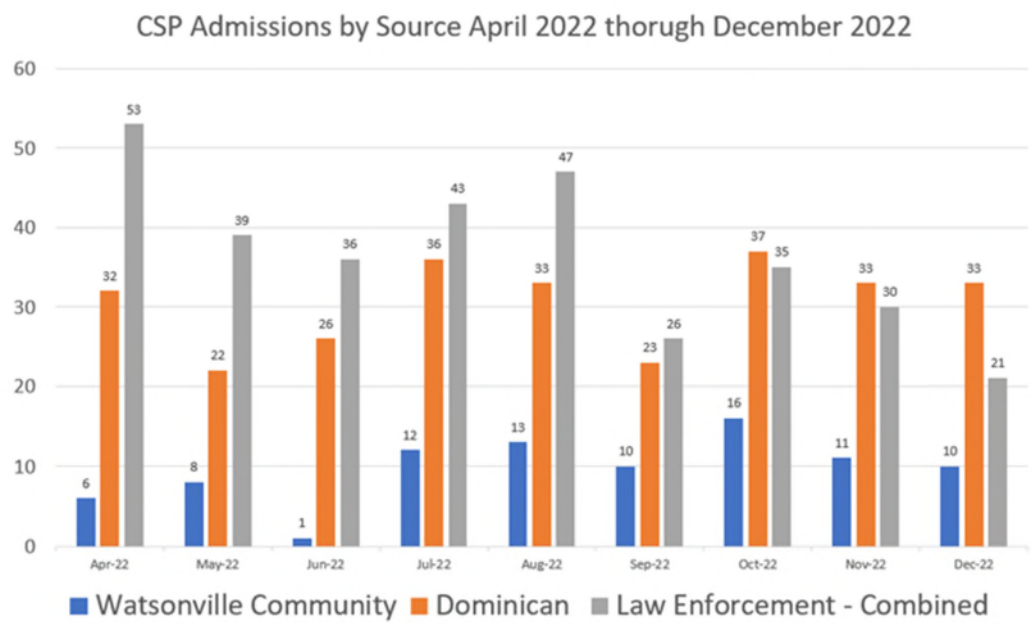
Crisis Stabilization Unit (CSU)

There is one CSU within Santa Cruz County operating with a total of twelve (12) chairs or recliners. Eight (8) of these chairs/recliners are designated for adults and this facility is Medi-Cal certified and County Lanterman-Petris-Short (LPS) designated that can operate as secure environment, accepting involuntary admissions, and providing intensive crisis stabilization services and supports to individuals who otherwise would be brought to an emergency room or end up in County detention. This facility has stays of up to twenty-three (23) hours and fifty-nine minutes and is licensed by the California DHCS. CSUs are intended to offer immediate care and linkage to community-based resources. In addition to MH crisis stabilization services, this facility delivers integrated services for those with co-occurring SUD. Community members can access this service on a self-referral basis by presenting at the facility located at 2250 Soquel Ave., Santa Cruz, or on an involuntary basis when placed on a 5150 (adult) or 5585 (youth) psychiatric hold. The number of monthly admissions at this facility averages at 106 individuals. Approximately 51% are referred by law enforcement.

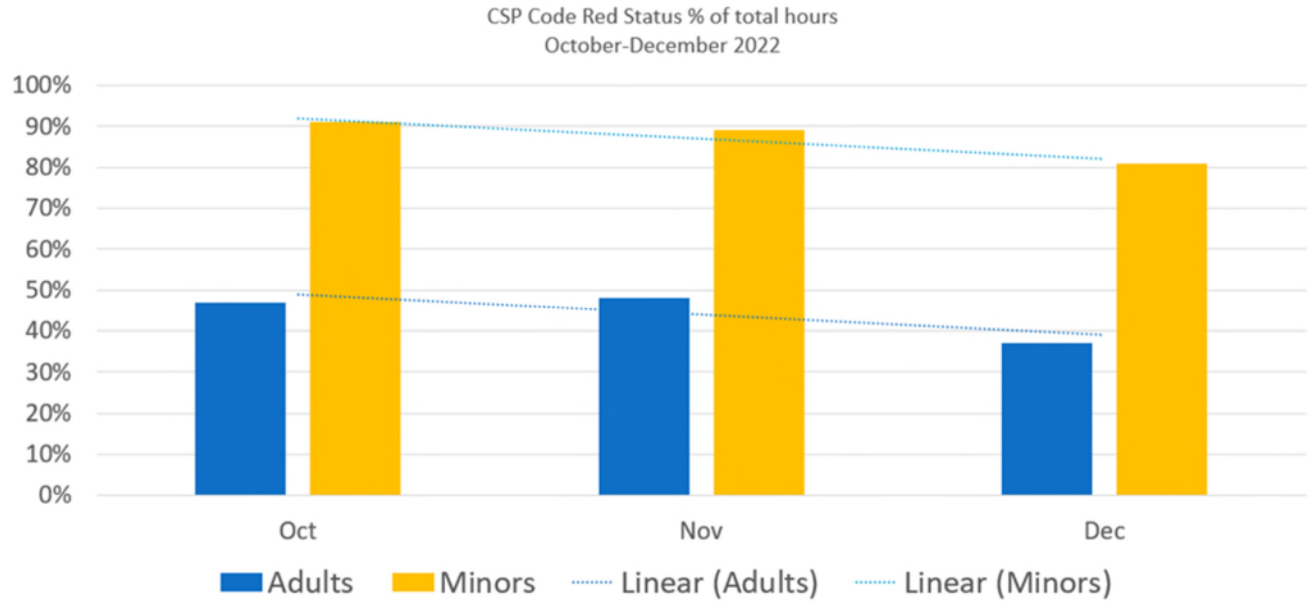
The following graph depicts the number of admissions by referral source from April/2022 through December/2022:

Receiving Center – Telecare CSP

AVG Monthly Admissions	
Santa Cruz County Sheriff's Office	21.5
Santa Cruz PD	21.1
Watsonville PD	4.5
Capitola PD	0.8
Scott's Valley PD	1.7
UCSC PD	1.7
Dominican	29.1
Watsonville Community	8.8
MERT/Y	2.8



This facility closely resembles the crisis receiving centers or entry level of crisis care that are featured in the *National Guidelines*. However, the CSU is currently not providing a "no-wrong-door" service, as individuals in crisis are denied services on a daily basis. According to the County and current provider, this is a result of the workforce shortage, personnel recruitment and retention challenges. The facility is often in "Code Red" status (not accepting admissions). The graph below depicts the percentage of hours that the CSU was on Code Red/Diversion for adults and youth from October/2022 through December/2022:



The total annual number of admissions for adults and children have declined over the years (see Table 1 below). According to the County and current provider, this is a result of the workforce shortage, recruitment and retention challenges. From 2019 through 2021, the average length of stay for adults has increased; however, the average length of stay for youth has reduced (see Table 2 below). During the same time period, the re-admission count and rate within 30 days has decreased for both adults and youth (see Table 3 & 4 below).

Table 1

Count of Crisis Chairs or Recliners Occurrences				
Year / Age Group	2019	2020	2021	Total
Adult	1750	1489	1397	4636
Children	225	215	205	645
Grand Total	1975	1704	1602	5281

Table 2

Average Length of Stay (days)				
Year / Age Group	2019	2020	2021	Total
Adult	1.1	1.2	1.7	1.3
Children	1.2	1.1	1.0	1.1
Grand Total	1.1	1.2	1.6	1.3

Table 3

Count of Readmissions (30-day)				
Year / Age Group	2019	2020	2021	Total
Adult	187	81	67	335
Children	11	5	6	22
Grand Total	198	86	73	357

Table 4

Readmission Rate (30-day)				
Year / Age Group	2019	2020	2021	Total
Adult	11%	5%	5%	7%
Children	5%	2%	3%	3%
Grand Total	10%	5%	5%	7%

There is a new all Youth CSU facility in Live Oak in the pipeline. The facility will provide youth receiving and crisis residential services, and it is scheduled to start operating on 2024.

Psychiatric Health Facility (PHF)

PHFs are licensed by the State Department of Health Care Services (DHCS) and they can provide 24-hour acute crisis stabilization care for those admitted to UCCs that cannot be stabilized in under twenty-four (24) hours. Care includes, but is not limited to, the following basic services: psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and appropriate food services. Santa Cruz County has one 16-bed, locked facility serving adults experiencing serious mental health crisis. Community members can access this service on a self-referral basis by presenting at the facility located at 2250 Soquel Ave., Santa Cruz, or on an involuntary basis when placed on a

5150 psychiatric hold.

The third score sheet of the *Crisis Now* Scoring Tool, assesses the best practice alignment of Crisis Receiving Centers or in the case of Santa Cruz County, Crisis Stabilization Unit (CSU). The CSU is Medi-Cal certified and County Lanterman-Petris-Short (LPS) designated facility that can operate as secure environments and accept involuntary admissions. The CSU provides intensive crisis services to individuals who otherwise would be brought to emergency rooms, including those on 5150/5585 involuntary holds. It provides up to 23 hours of immediate care, crisis intervention services, including integrated services for co-occurring SUD. Service is focused on recovery and linkage to ongoing community services and supports that are designed to impact unnecessary and lengthy involuntary inpatient treatment or arrest and detention.

***Crisis Now* Scoring Tool (Crisis Receiving Center)**							
	Level 1 (Minimal)		**Level 2 (Basic)**		**Level 3 (Progressing)**		**Level 4 (Close)**		**Level 5 (Full)**
☑	Sub-Acute Stabilization is in Place for Part of the Region	☑	Meets Level 1 Criteria	☐	Meets Level 2 Criteria	☐	Meets Level 3 Criteria	☐	Meets Level 4 Critieria
☑	Have 24/7 Access to Psychiatrists or Master's Level Clinicians	☑	Some Form of Facility-Based Crisis is Available Throughout the Region	☑	Crisis Beds / Chairs Available at a Ratio of at Least 3 per 100,000 Census	☐	Formal Data Sharing with Sub-Acute Stabilization and All Crisis Providers	☐	Real-Time Performance Outcomes Dashboards Throughout Crisis System
☑	In Counties with Sub-Acute Stabilization, at Least 1 Bed / Chair per 100,000 Census	☑	Crisis Beds / Chairs Available at a Ratio of at Least 2 per 100,000 Census	☑	Offers Crisis Stabilization / Observation Chairs as well as Sub-Acute / Residential	☑	Crisis Beds / Chairs Available at a Ratio of at Least 4 per 100,000 Census	☑	Crisis Beds / Chairs Available at a Ratio of at Least 5 per 100,000 Census
		☑	Shared MOUs / Protocols with Other Crisis Providers	☐	Multiple Providers Offering Facility-Based Crisis Services	☐	Support Diversion From Acute Inpatient at Rate Over 60%	☐	Support Diversion From Acute Inpatient at Rate Over 70%
		☐	Staff Trained in Zero Suicide / Suicide Safer Care and BH Services	☑	Some Crisis Facility Access to Person Specific Health Data	☐	Incorporates Crisis Respite Services into the Facility-Based Crisis Continuum	☐	No Refusal to First Responder Drop offs as Primary Service Location
		☑	Priority Focus on Safety / Security	☑	Trauma-Informed Recovery Model Applied	☐	Operates in a Home-Like Environment	☐	Bed Inventory and Referral Centralized Through Crisis Line
				☑	Direct Law Enforcement Drop-Offs Accepted	☑	Systematic Suicide Screening and Safety Planning	☐	Suicide Care Best Practices That Include Follow-up Support
				☑	Least Restrictive Intervention and No Force First Model	☑	Some Peer Staffing within the Crisis Facility	☐	Utilize Peers as Integral Staff Members
						☐	Sub-Acute Stabilization Receive Electronic Access to Some Health Information	☐	Shared Status Disposition of Intensive Referrals
						☐	Shares Documentation of Crisis with Providers	☐	Law Enforcement Drop-Off Time Less Than 10 Minutes
								☐	Full Implementation of all 4 Crisis Now Modern Principles (Required)
Assessed Level = 3		**Justification of Rating**: Santa Cruz has a Crisis Stabilization Unit with capacity for 12 chairs operating with some level of congruence to the *Crisis Now* model.							

The CSU operates closely to being aligned with *National Guidelines* and are assessed at Level 3: Progressing. However, the CSU tends to utilize exclusionary admission criteria and is not adequately staffed. Moreover, the CSU is not operating under a "no-wrong-door" approach for those experiencing an acute crisis, as they are often on "Code Red" status, declining and diverting clients to local EDs.

(**Note**: Crisis Residential Treatment (CRT) programs were not included in this assessment of alignment with BH crisis care best practices, because a residential LOC is not viewed to be a core crisis service within the *Crisis Now* model nor within the *National Guidelines*. Typically, residential treatment is considered to be an intermediate LOC and is not associated with or appropriate for the acuity level of care that crisis services demand. Nor does this LOC have the level of payment required to support acute crisis care.)

It should be pointed out that crisis care is not treatment. It is not about diagnostics and the development and execution of a treatment plan. It is instead about intervening with someone in crisis by de-escalating any extreme behaviors and subsequently helping to determine one's baseline functioning and identifying the precipitating event or events that moved this person beyond baseline. Once this is accomplished, subsequent interventions revolve around determining how to mitigate such events in the future and provide the necessary treatment and supports in the community to sustain baseline functioning, to prevent a recurrence, and reinforce recovery.

Summary

To assess Santa Cruz County's current crisis response system against best practice, RI utilized the results of each of the previously scored *Crisis Now* Scoring sheets for each of Santa Cruz County's core crisis service components. These results were fed into a composite crisis response system scoring sheet which appears below:

***Crisis Now* Scoring Tool (Crisis Now System)**									
	Level 1 (Minimal)		**Level 2 (Basic)**		**Level 3 (Progressing)**		**Level 4 (Close)**		**Level 5 (Full)**
☑	System Includes at Least Level 1 Implementation in All Areas of Crisis Now	☑	System Includes at Least Level 2 Implementation in All Areas of Crisis Now	☐	Meets Level 2 Criteria	☐	System Includes at Least Level 3 Implementation in All Areas of Crisis Now	☐	System Includes at Least Level 3 Implementation in All Areas of Crisis Now
☑	Some Implementation of at Least 2 Crisis Now Modern Principles	☑	Some Implementation of at Least 3 Crisis Now Modern Principles	☑	Some Implementation of all 4 Crisis Now Modem Principles	☐	Substantial Implementation of all 4 Crisis Now Modern Principles	☐	Full Implementation of all 4 Crisis Now Modern Principles
The 4 Crisis Now Modern Principles Are:		**1**	Priority Focus on Safety / Security	**2**	Suicide Care Best Practices (Systematic Screening, Safety Planning and Follow-	**3**	Trauma-Informed Recovery Model	**4**	Significant Role of Peers
Assessed Level = 2		**Justification of Rating:** All three elements of the *Crisis Now* model are represented and functioning within Santa Cruz County: call center, mobile crisis services and crisis receiving facility with some degree of congruency to the Crisis Now model.							
***Crisis Now* Scoring Tool (Summary)**									
Overall *Crisis Now* Score : 2		**Summary Notes:** Santa Cruz County's crisis response system alignement with national best practice remains at the Basic Level. A major drawback to keep from being rated at the Progressing Level is the absence of the peer support specialist as a significant role in all levels of the crisis response system. Also, the mobile crisis response services are not available 24/7.							

The overall assessment of Santa Cruz County's crisis response system against national best practice, speaks for itself. While a rating of "Basic" may, on-face-value, be disappointing, the Santa Cruz County community at large should be proud of how the crisis response system is progressing and how rapidly that progress is occurring. When this system is fully optimized, it will indeed be a model for the rest of the State. While there are localities that have become national exemplars in one or more components of the crisis response system as envisioned by the *National Guidelines*, no state or county as of yet, has made it a reality.

Local Needs: Capacity Estimate

RI used its *Crisis Now* Resource Need Calculator to project the staffing capacity needs of Santa Cruz County crisis response system. The innovative Calculator offers an estimate of optimal crisis system resource allocations to meet the needs of the community. It also calculates the impact on healthcare costs associated with the incorporation of these resources.

The calculator analyzes a few data elements that includes population size, average length of stay in various system beds, escalation rates into higher levels of care, readmission rates, bed occupancy rates, and local costs for those resources. In communities in which these resources do not currently exist, figures from comparable communities can be used to support planning purposes. The calculations are based on data gathered from several states and the *Crisis Now Business Case* that explains the rationale behind the model. A video can be seen on NASMHPD's www.crisisnow.com, which delineates this methodology. Quality and availability of outpatient services also influences demand on a crisis system so the Crisis Resource Need Calculator should be viewed as a guide in the design process.

As outlined in the *National Guidelines*, based on the LOCUS assessment data gathered in Georgia, it is anticipated that 200 individuals per 100,000 will experience a crisis that requires a service level more acute than can be accommodated by outpatient services or a phone intervention. Of that number, thirty-two percent (32%) would require a Mobile Crisis Management intervention. Research has resulted in the utilization of data to stratify the service level needs of those individuals; and that data can be applied to design a cost-effective crisis response system.

Timely access to vital acute psychiatric inpatient (hospital) care is frequently unavailable for individuals experiencing the most significant BH crises. A decade of Level of Care Utilization System (LOCUS) assessment data, gathered in Georgia by mobile crisis teams, emergency departments and crisis facilities indicates that 14% of individuals experiencing a crisis who have reached these higher levels of care have a clinical need that aligns with inpatient care (LOCUS level 6). A majority (54%) of these individuals, experiencing a BH crisis have needs that align better with services delivered within a crisis facility and 32% have lower level needs that would benefit from interventions by a mobile crisis team (LOCUS levels 1-4). It is important to note that this LOCUS data set does not include an assessment of individuals who have only contacted the crisis line. Therefore, it is used to only stratify the clinical needs of those engaged by higher levels of care and is not being used to predict crisis line resource needs.

As indicated above, it is expected that 200 individuals per 100,000 will experience a crisis that requires a service level more acute than can be accommodated by outpatient services or a phone intervention. According to demographic data obtained from the California State Census Data Center, Demographic Research Unit, there are a total **274,255** individuals in Santa Cruz County. When the aforementioned ration is applied, it would be expected that over **6,582** individuals would annually need more intense crisis services. Fifty-four percent (54%) of these, or **3,554** would be expected to require admission to a 23-hour crisis facility with recliners. Of that number, it would be expected that **1,465** would need to be transitioned to a crisis facility with beds to allow for a stay of up to seven days to further stabilize. Similarly, thirty-two percent (32%) or **2,106** would require MCT intervention. Based on the national KPI of a 30% escalation rate from a mobile crisis team to a crisis receiving facility, this would result in **632** referrals and potential transports to a facility-based crisis service. All of these projections and associated costs and system savings are portrayed in the *Crisis Now* Crisis System Calculator which appears below.

The potential capacity needed to serve all individuals needing in-person crisis care in Santa Cruz:

Breakdown	*Crisis Now* Model
Mobile Crisis Teams (assuming 40-hour work week)	1
Crisis Receiving Chairs/Recliners	13
Short-term Crisis Beds	11
Acute Psychiatric Inpatiend Beds	44

Santa Cruz County *Crisis Now* Crisis System Calculator	
Santa Cruz County Population Census (2020)	274,255
# Crisis Episodes Annually (200/100,000 Monthly)	**6,582**
# Initially Served by Acute Inpatient	921
# Referred to Acute Inpatient from Crisis Facility	366
Total # Episodes in Acute Inpatients	1,287
# of Acute Inpatient Beds Needed	**43**
Total Cost of Acute Inpatient Beds	**$31,164,561**
# Referred to Subacute Bed from Stabilization Chair	1,465
# of Subacute / Short Term Beds	**11**
Total Cost of Subacute / Short Term Beds	**$8,058,490**
# Initially Served by Crisis Stabilization Facility	3,554
# Referred to Crisis Facility by Mobile Team	632
Total # Episodes in Crisis Facility	4,186
# of Crisis Receiving Chairs Needed	**13**
Total Cost of Crisis Receiving Chairs	**$11,512,128**
# Served Per Mobile Team Daily (10 Hour Shift)	4
# of Mobile Teams Needed	**2**
Total # of Episodes with Mobile Team	2,106
Total Cost of Mobile Teams	**$546,822**
TOTAL of Unique Individuals Served	**6,582**
TOTAL Inpatient and Crisis Cost	**$51,282,001**

Assumptions	
ALOS of Acute Inpatient	11
Avg. Cost of Acute Bed/Day	$ 2,200

Local Review Process

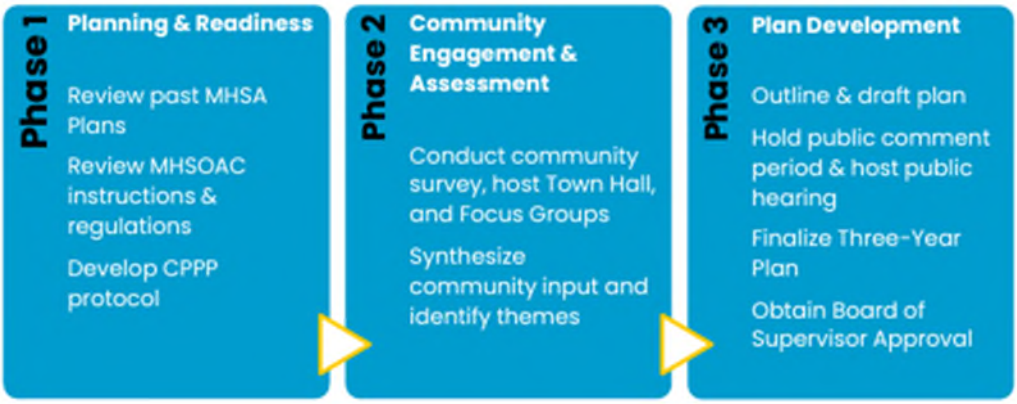
Local Steps	Date
Innovation Plan posted for 30-day Public Review	July/2023
Local Mental Health Board Hearing	TBD
Board of Supervisors (BOS)	TBD

Community Program Planning Process (CPPP)

As a part of the Three-Year MHSA planning process, SCBHS convened a series of community meetings, surveys, and focus groups to inform program planning efforts and budget allocation. The majority of engagement events and meetings took place in a virtual format via Zoom. During this process, the community identified the need to strengthen its BH crisis response system a priority for residents of Santa Cruz County.

Methodology

- February 2023: SCBHS initiated the CPP Process by developing a community focused framework to engage with providers, consumers, and their families as well as the broader Santa Cruz community. The CPPP moved through three unique phases:



Engagement Activities

SCBHS conducted community meetings and information-gathering activities to engage consumers, partners, and community members of the planning process to ensure that the plan reflects community experiences and suggestions.

- **Community Survey:** RDA designed and administered a countywide survey to include input from a wide range of consumers, community members, and partners, particularly those unable to attend the community town hall or a focus group. The survey was open from February 10th through February 27th, 2023 and was available in both English and Spanish. This anonymous survey included both Likert scale (12 items) and open-text questions (5 items) regarding respondents' experiences with MHSA services in Santa Cruz County, particularly how well SCBHS' MHSA-funded programs, services, and activities have been adapted to meet the community's mental health needs. The survey also included questions regarding respondent demographic characteristics and relationship to MHSA services to track and characterize community engagement. The survey was available online and promoted through posting to SCBHS' website, posted on the SCBHS Facebook page, and shared with MHSA partner listservs.

- **Town Hall & Listening Session:** SCBHS and RDA (third-party contractor) convened a virtual town hall and community listening session to gather input from providers and community members about their experiences with the behavioral health system and their recommendations for improvement. The town hall, hosted via Zoom, provided a platform to incorporate an MHSA training and educational overview for consumers, partners, providers and community in attendance. It also provided overviews of MHSA program areas and provided time for community discussion and for SCBHS & RDA to hear directly from those in attendance the strengths, opportunities for improvement and gaps in the current behavioral health system and programs for Santa Cruz County.

- **Focus Groups:** Focus groups were hosted to engage and hear directly from consumers, providers, and community partners. Five focus groups were conducted and were each approximately 1-hour in length. Four focus groups were conducted virtually, and one was conducted in-person. Focus groups were promoted through the SCBHS website, Facebook page, and a flier was shared with community partners.

- **Local Review Process:** Following the CPPP, a draft of the plan was posted publicly for 30 days for public comment. The plan was updated to include public comments received and presented by the SCBHS team at a public hearing convened by the local Mental Heath Advisory Board (MHAB) on April 20, 2023.

Community Program Planning Process (CPPP) Findings

As aforementioned, during the MHSA Three-Year Program Plan, quantitative and qualitative data was collected and analyzed accordingly. During the CPP Process, the need for a more robust crisis response service was identified. Many community members identified a need for more comprehensive crisis services in Santa Cruz County. These include the mobile crisis response services, as well as the Acute Psychiatric Health Facility.

Many respondents called for the mobile crisis response service to be available 24 hours a day instead of its current hours and requested that it not be tied to law enforcement, as that can be a barrier to accessing care. The acute psychiatric health facility is currently run by a contracted provider, and many community members and providers expressed concern with the way that it is currently being managed as well as its lack of capacity.

Individuals expressed a need for existing emergency response programs (e.g., MERT, MERTY) to expand their operating hours, and/or the development of new mobile crisis response units that operate on a 24-hour basis – including units that do not include law enforcement. In addition, individuals recommended expanding the number of inpatient and acute care beds within the County to meet the existing need, as well as additional mental health crisis helpline support services.

The *Crisis Now* Multi-County Innovation project was introduced to stakeholders during the CPPP and added to the FY2023-2026 MHSA Plan. Furthermore, the *Crisis Now* Multi-County Innovation Plan was posted for the 3-day public review on June 30, 2023. The Mental Health Board conduct a public hearing on June XX, XXXX beginning at X:XX p.m. at the [address]. No public comments regarding this Innovation Project was received. The plan was presented for Board of Supervisors approval on June 27, 2023.

Santa Cruz County Behavioral Health Services (SCBHS) indents to utilize Innovation funding to support participation in the Crisis Now model.

Stakeholder Engagements

RI and Santa Cruz County's representatives co-facilitated key stakeholder engagements with members of the local community crisis services, including: executive leadership, public safety, county officials, health, hospitals, behavior health (BH) treatment providers, schools, advocates, those with "lived experience" (personal and/or family members), and other key parties and safety net services providers. Two meetings were held virtually via Zoom platform on **2/21/2023** and **2/22/2023**. Spanish translation and closed caption were available. In each meeting, there was a discussion around the current state of crisis response services in Santa Cruz County, as well as an explanation of the *Crisis Now* model. Facilitators discussed the possibility of utilizing MHSA Innovation funds in order to optimize Santa Cruz County's current crisis response system. These stakeholder engagements also served as an opportunity for participants to have unanswered questions addressed and to share their respective perspectives on the current crisis response services available. These discussions also served to rally support for crisis response system optimization for youth and adults utilizing national best practices as a guide. In addition, in order to assure that a wide spectrum of perspectives on Santa Cruz County's crisis response system was attained, an electronic survey was distributed to all members of the community (Appendix B).

Over the course of public meetings, the following major themes were identified related to behavioral health crisis care in the Santa Cruz County community:

- Lack of 24/7 access to mobile crisis response
- Workforce shortage, leading to "Code Red" at the only CSU
- Lack of appropriate crisis services for the youth population
- Lack of appropriate aftercare options to ensure recovery

Potential Challenges and Barriers

Santa Cruz County is facing several barriers in the implementation of a 24/7/365 Crisis Response System with adequate support structures. The chief hurdles identified by Santa Cruz County personnel, stakeholders and community partners include, but are not limited to:

- **Competing Priorities**: Number of competing priorities and California's major Behavioral Health initiatives and expansion with strict deadlines for plan and implementation. For instance, the mandatory implementation of the Medi-Cal Community-Based Mobile Crisis Intervention Services benefit by December, 2023 (BHIN No. 22-064). Santa Cruz County personnel has reported major concerns regarding this implementation within the timeline, given their lack of expertise in the area, as well as manpower to plan, design, and implement/optimize a mobile crisis response that meets state requirements and federal guidelines.

- **Workforce Shortage:** Santa Cruz County is challenged by a limited workforce to meet the needs of individuals with mental health and substance use needs. Difficulty in hiring/retaining qualified staff and a diverse workforce representative of the communities serves as a major barrier. While this pertains to licensed and license eligible staff, it also applies to peer support specialists, community health workers, and other support services necessary to manage an effective crisis continuum of care system. The workforce shortage has also negatively impacted counties at the administrative level, leaving several vacancies in their BH departments. These vacancies are taking a toll on current administrative personnel and impeding them to commit to projects and impacting the mandatory implementation of Community-Based Mobile Crisis Intervention Services.

- **Funding Issues:** Without financial support for construction, equipment, and start-up costs associated with the establishment of the crisis continuum of care services, it is very challenging for Santa Cruz County to standup these services. Moreover, most counties do not have the assets necessary to assume the administrative/personnel costs and therefore, without capital and initial financial operating assistance, these services will not be established appropriately and/or timely.

- **Outcomes/Data:** The establishment of metrics and data track/trend can play a transformative role in setting, refining, and evaluating strategies and programs. Santa Cruz County has identified the need to establish appropriate key performance indicators to offer pathways to shared understanding and crisis response services delivery expectations. Moreover, there is a need to improved data collection and analysis to plan and effectuate changes in the system.

County Budget Narrative

Santa Cruz County will contribute up to $5.16M over the 3-year project period to support this Multi-County project. As of this time, This funding is not currently subject to reversion. A portion of these funds ($1.32M) will cover Santa Cruz County-specific expenditures, and the remainder ($3.84M) will be directed to costs associated with supporting the consultant (RI International), the evaluator (third-party; TBD), training (third party; TBD) and CBO personnel.

Personnel Costs

Costs in this category include salaries and benefits for County personnel and Community Based Organization contracted to operate crisis services.

Personnel (Salaries & Benefits)*	FY23/24	FY24/25	FY25/26	Total
Sr. MH Client Specialist II - Extra Help (1 FTE) LPHA	$ 60,020.00	$ 123,640.00	$ 127,350.00	$ 311,010.00
Sr. MH Client Specialist II - Overtime	$ 90,029.00	$ 185,461.00	$ 191,024.00	$ 466,514.00
MH Client Specialist II - Overtime	$ 78,560.00	$ 161,833.00	$ 166,688.00	$ 407,080.00
Sr./MHCS II On-Call	$ 25,584.00	$ 25,584.00	$ 25,584.00	$ 76,752.00
Total Personnel	$ 254,193.00	$ 496,518.00	$ 510,646.00	$ 1,261,356.00

*Expenses for 6 months; start date of January/2024

Operating Costs

Additional operating costs anticipated including equipment, technology, Community Program Planning and other expenses (i.e. printing materials for community stakeholder meetings, meeting space costs, as well as incentive to encourage stakeholder participation) are consistent and ongoing.

Operating Costs	FY23/24	FY24/25	FY25/26	Total
Laptop/cell phone	$ 3,000.00	$ -	$ -	$ 3,000.00
Community Program Planning	$ 15,000.00	$ 15,000.00	$ 15,000.00	$ 45,000.00
Other: Network connections fees; Supplies; Mileage	$ 6,000.00	$ 6,000.00	$ 6,000.00	$ 18,000.00
Total Operating	$ 24,000.00	$ 21,000.00	$ 21,000.00	$ 66,000.00

Consultant Costs

Costs in this category include Consulting Firm (RI International), Evaluating Firm (TBD), Training (TBD) and CBO Staffing. RI will lead Santa Cruz through system design, implementation plan and TA over the life of this project. The evaluator (TBD) will be responsible for developing a formal evaluation plan, conducting evaluation activities, and producing all evaluation reports required for this project. Outside entity will facilitate trainings in order to meet State mandates and meet workforce needs. CBO staff will provide services per requirement.

Consulting Costs	FY23/24	FY24/25	FY25/26	Total
Consulting Firm (RI International)	$ 212,628.00	$ 151,441.00	$ 86,270.00	$ 450,339.00
Evaluating Firm (TBD)	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ 300,000.00
Training (TBD)	$ 50,000.00	$ 50,000.00	$ 50,000.00	$ 150,000.00
CBO Staff (12 FTEs, on-call, PTO/sick/holidays)*	$ 575,333.00	$ 1,165,422.00	$ 1,200,385.00	$ 2,941,140.00
Total Consulting	**$ 937,961.00**	**$1,466,863.00**	**$1,436,655.00**	**$ 3,841,479.00**

Santa Cruz Budget

The below table demonstrates an estimated breakdown of budget expenditures and requested funds by fiscal year.

New Innovative Plan Budget By FISCAL YEAR (FY)*	Crisis Now (FY2023/24 to FY2025/26, 3 years)			
EXPENDITURES	Beg: July 1, 2023		Ends: June 30, 2026	
NON RECURRING COSTS (equipment, technology)	FY23/24	FY24/25	FY25/26	Total
Laptop/cell phone (Extra-Help)	3,000	-	-	3,000
Total Non-recurring costs	**3,000**	**-**	**-**	**3,000**
Personnel (Salaries & Benefits)*	FY23/24	FY24/25	FY25/26	Total
Sr. MH Client Specialist II - Extra Help (1 FTE) LPHA	60,020	123,640	127,350	311,010
Sr. MH Client Specialist II - Overtime	90,029	185,461	191,024	466,514
MH Client Specialist II - Overtime	78,560	161,833	166,688	407,080
Sr./MHCS II On-Call	25,584	25,584	25,584	76,752
Personnel Operational Costs (Network Connections Fees/supplies/mileage)	6,000	6,000	6,000	18,000
Total Personnel	**260,193**	**502,518**	**516,646**	**1,279,356**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)	FY23/24	FY24/25	FY25/26	Total
Contractor: Recovery International	212,628	151,441	86,270	450,339
Contractor: Evaluation	100,000	100,000	100,000	300,000
Contractor(s): 12 FTE CBO staff*	556,145	1,145,658	1,180,028	2,881,831
Contractor(s): CBO staff, extra-help/on-call for support with vacations/sick/holidays*	19,188	19,764	20,357	59,308
Training	50,000	50,000	50,000	150,000
Total Contract Operating Costs	**937,961**	**1,466,863**	**1,436,655**	**3,841,478**
OTHER EXPENDITURES (please explain in budget narrative)	FY23/24	FY24/25	FY25/26	Total
Community Program Planning	15,000	15,000	15,000	45,000
Total Other Expenditures	15,000	15,000	15,000	45,000
BUDGET TOTALS	**FY23/24**	**FY24/25**	**FY25/26**	**Total**
Non-recurring costs	3,000	-	-	3,000
Personnel	260,193	502,518	516,646	1,279,356
Contract Operation Costs	937,961	1,466,863	1,436,655	3,841,478
Other Expenditures	15,000	15,000	15,000	45,000
Total Gross Budget	**1,216,153**	**1,984,381**	**1,968,300**	**5,168,834**
Administrative Cost Net of INN Funds	-	-	-	-
Grand Total	**1,216,153**	**1,984,381**	**1,968,300**	**5,168,834**

Expenditures By Funding Source and FISCAL YEAR (FY)				
Estimated total mental health expenditures for the entire duration of this INN Project by FY & the following funding sources:	**FY23/24**	**FY24/25**	**FY25/26**	**Total**
Innovative MHSA Funds	**1,093,703**	**1,737,154**	**1,713,799**	**4,544,656**
Federal Financial Participation	122,451	247,226	254,501	624,178
1991 Realignment				-
Behavioral Health Subaccount				-
Other (explain):				-
Total Expenditures by Funding Source and FY	1,216,153	1,984,381	1,968,300	5,168,834

*Expenses for 6 months, start date of January 2024.

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 23/24**	**FY 24/25**	**FY 25/26**			**TOTAL**
1.	Salaries	**212,363**	**437,467**	**450,591**			**1,100,421**
2.	Direct Costs	**41,830**	**59,050**	**60,054**			**160,934**
3.	Indirect Costs	**6,000**	**6,000**	**6,000**			**18,000**
4.	**Total Personnel Costs**	**260,193**	**502,517**	**516,645**			**$ 1,279,355**
	OPERATING COSTS*						
5.	Direct Costs						
6.	Indirect Costs						
7.	**Total Operating Costs**						**$**
	NON-RECURRING COSTS (equipment, technology)						
8.	Laptop/cell phone	**3,000**					**3,000**
9.							
10.	**Total non-recurring costs**	**3,000**					**$ 3,000**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs	**575,333**	**1,165,422**	**1,200,385**			**2,941,140**
12.	Indirect Costs	**362,628**	**301,441**	**236,270**			**900,339**
13.	**Total Consultant Costs**	**937,961**	**1,466,863**	**1,436,655**			**$3,841,479**
	OTHER EXPENDITURES (please explain in budget narrative)						
14.	**Community Program Planning**	**15,000**	**15,000**	**15,000**			**45,000**
15.							
16.	**Total Other Expenditures**	**15,000**	**15,000**	**15,000**			**$45,000**
	BUDGET TOTALS						
	Personnel (total of line 1)	**212,363**	**437,467**	**450,591**			**$1,100,421**
	Direct Costs (add lines 2, 5, and 11 from above)	**617,163**	**1,224,472**	**1,260,439**			**$3,102,074**
	Indirect Costs (add lines 3, 6, and 12 from above)	**368,628**	**307,441**	**242,270**			**$918,339**
	Non-recurring costs (total of line 10)	**3,000**					**$3,000**
	Other Expenditures (total of line 16)	**15,000**	**15,000**	**15,000**			**$45,000**
	TOTAL INNOVATION BUDGET	**1,216,153**	**1,984,381**	**1,968,300**			**$5,168,834**

BUDGET CONTEXT – EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for administration for the entire duration of this INN Project by FY & the following funding sources:**						**TOTAL**
1.	Innovative MHSA Funds						
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Administration**						
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 23/24**	**FY 24/25**	**FY 25/26**			**TOTAL**
1.	Innovative MHSA Funds	**100,000**	**100,000**	**100,000**			**300,000**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Evaluation**	**100,000**	**100,000**	**100,000**			**$300,000**
TOTALS:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 23/24**	**FY 24/25**	**FY 25/26**			**TOTAL**
1.	Innovative MHSA Funds*	**1,093,703**	**1,737,154**	**1,713,799**			**$4,544,656**
2.	Federal Financial Participation	**122,451**	**247,226**	**254,501**			**$624,178**
3.	1991 Realignment						**$**
4.	Behavioral Health Subaccount						**$**
5.	Other funding**						**$**
6.	**Total Proposed Expenditures**	**1,216,154**	**1,984,380**	**1,968,300**			**$5,168,834**

*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting**

**** If "other funding" is included, please explain within budget narrative.**

APPENDIX B
Santa Cruz County
Crisis Now Survey

APPENDIX B: SANTA CRUZ COUNTY *CRISIS NOW* SURVEY

Crisis Now Multi-County Survey

21	75:59	Active
Responses	Average time to complete	Status

1. Which of the following best describes you:

Person with lived experience/co...	6
Family member of a person with...	8
Behavioral health professional	12
None of the above	2

2. Select your age group:

Under 18	0
18–24	0
25–64	17
Over 65	4
Decline to state	0

4. Are you familiar with 988?

Yes	20
No	1

5. Someone to Call: Does your county currently have a Suicide/Crisis Lifeline?

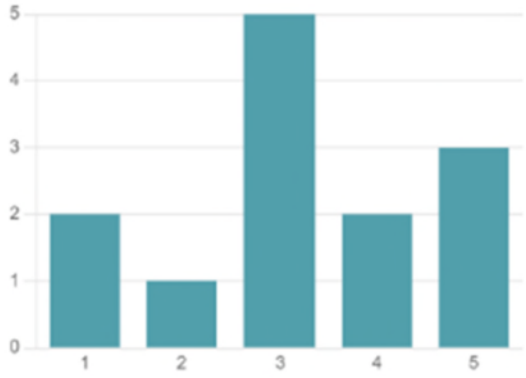
Yes	19
No	1
I don't know	1

6. Have you or someone you know utilized the Suicide/Crisis Lifeline?

Yes	14
No	7

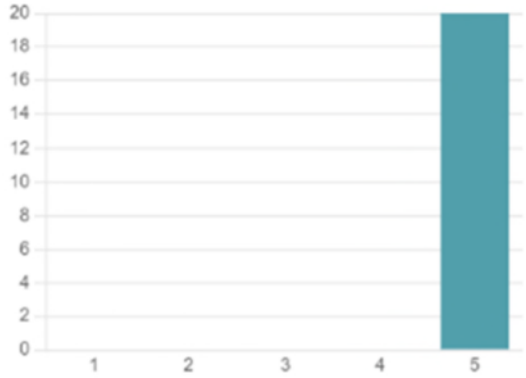
7. How satisfied were you/someone you know with the services provided by the Suicide/Crisis Lifeline?

3.23
Average Rating



8. How important it is for you to have someone to call (Suicide/Crisis Lifeline) if/when you/someone you know is experiencing a mental health crisis?

5.00
Average Rating



9. Someone to Respond: Does your county currently have a Mobile Crisis Response Team?

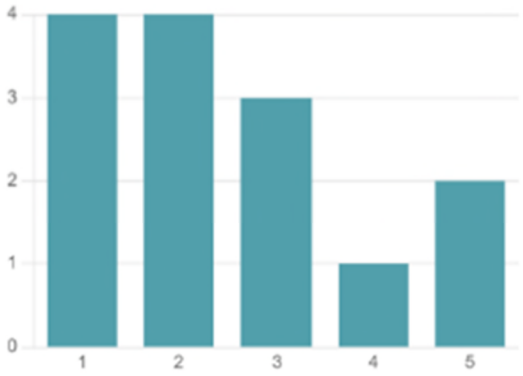
Yes	20
No	0
I don't know	1

10. Have you or someone you know utilized the Mobile Crisis Team?

Yes	16
No	5

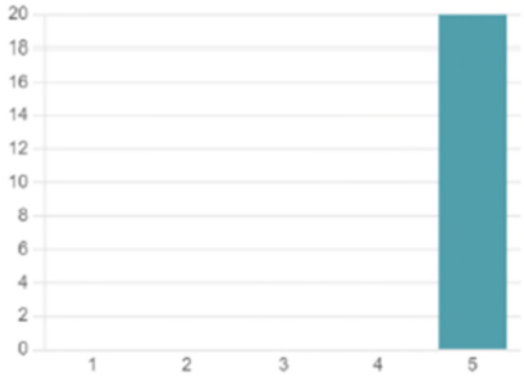
11. How satisfied were you/someone you know with the services provided by the Mobile Crisis Team?

2.50
Average Rating



12. How important it is for you to have someone to respond (Mobile Crisis Team) if/when you/someone you know is experiencing a mental health crisis?

5.00
Average Rating



13. Safe Place to Go: Does your county currently have a Crisis Receiving Facility (Mental Health Urgent Care, Crisis Stabilization Unit, Psychiatric Health Facility)?

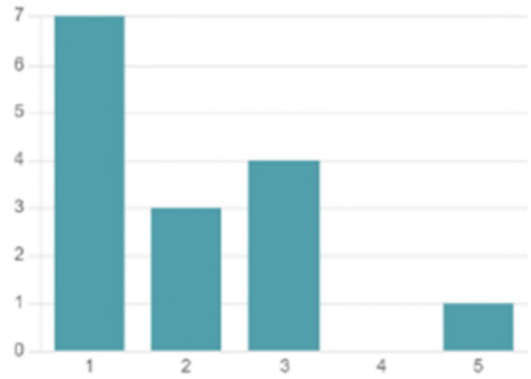
Yes	19
No	1
I don't know	1

14. Have you or someone you know utilized services from a Crisis Receiving Facility?

Yes	16
No	5

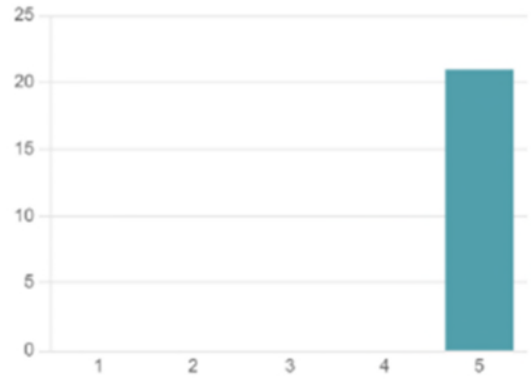
15. How satisfied were you/someone you know with the services provided by the Crisis Receiving Facility?

2.00
Average Rating



16. How important it is for you to have a safe place to go (Crisis Receiving Facility) if/when you/someone you know is experiencing a mental health crisis?

5.00
Average Rating



17. Thank you for joining us in improving our Crisis Care Response efforts! Please, feel free to add any other suggestions and/or recommendations.

9
Responses

Latest Responses
"We have more work to do to establish a 24/7 crisis response program i..."

MERT in Santa Cruz is currently only business hours, I want it to be 24/7 and able to go to more locations. I'd like our CSP to be better staffed and have more beds.

Santa Cruz County needs to ensure that it has sufficient capacity to not only receive clients, but to transfer them to appropriate levels of care. Currently, the County does not provide the full spectrum of care that the community needs. This means that clients are being placed in inappropriate levels of care because there is nowhere else to transfer the client.

Increase hours to 24-7 and number of staff available to go out on MERT, MERTY and ML calls
Start working on a long term plan for step-down units
Increase number of crisis beds and step down beds

I would like to be able to continue to giver feedback about the crisis response in our county

We really need services to keep things from becoming a crisis. It's largely too late once the MERT team is sent out.

The very largest issue is not enough alternative or stepdown facilities. We need places for people to be to get well.

Thank you for your dedication and service to our community. We look forward to working with you to create the ideal crisis response "system" for our community.

We have more work to do to establish a 24/7 crisis response program in Santa Cruz County.

I represent Unhoused people and they are the people I know who have used the services. Some folks have been put out in the middle of the night without any of their survival equipment- maybe they needed the bed for someone else? Folks tell me that they were sent out at 2 am in the freezing cold. I know that everyone is trying to help but some people at the service level seem to lack empathy. The people who are trying to recover from a crisis are not helped by this system.

Also, I understand that one problem with not having 24 /7 emergency response is because the County has been unable to hire people. When I looked for the job listings, I couldn't identify the ones that are for the 24 /7 emergency response. In fact, it is very hard to understand what any of the opening are for. I know people who are interested in possibly applying for these positions but can't find the listing. Can we have a clear jobs page with clear job descriptions in the titles?

APPENDIX C
Acronyms

APPENDIX C: ACRONYMS

AM	Ante Meridiem
ARPA	American Rescue Plan Act
ASIST	Applied Suicide Intervention Services Training
BH	Behavioral Health
BHCIP	Behavior Health Continuum Infrastructure Program
BHJIS	Behavioral Health Justice Intervention Services
BHIN	Behavioral Health Information Notice
CA	California
CalAIM	California Advancing and Innovating Medi-Cal
CalVDRS	California Violent Death Reporting System
CPPP	Community Program Planning Process
CBO	Community Based Organization
CEO	Chief Executive Officer
CHHSA	California Health and Human Services Administration
CIT	Crisis Intervention Training
CLAS	Culturally and Linguistically Appropriate Services
CRC	Crisis Receiving Center
CQI	Continuous Quality Improvement
C-SSRS	Columbia-Suicide Severity Rating Scale
CSU	Crisis Stabilization Unit
CY	Children and Youth
DHCS	Department of Healthcare Services
DHHS	Department of Health and Human Services
DSM	Diagnostic and Statistical Manual
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
FCC	Federal Communications Commission
FMAP	Federal Medical Assistance Percentages
FSP	Full Service Partnership
FTE	Full Time Equivalent

FURS	Family Urgent Response System
FY	Fiscal Year
GPS	Global Positioning Program
HPC	Hillmont Psychiatric Center
IPU	Inpatient Psychiatric Unit
LE	Law Enforcement
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Questioning
LOC	Level of Care
LOCUS	Level of Care utilization System
LMFT	Licensed Marriage and Family Therapist
LPS	Laterman-Petris-Short
MBA	Master of Business Administration
MCT	Mobile Crisis Team
MD	Doctor of Medicine
MERT	Mobile Emergency Response Team
MERTY	Mobile Emergency Response Team for Youth
MH	Mental Health
MHL	Mental Health Liaison
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight & Accountability Commission
MOU	Memorandum of Understanding
NASMHPD	National Association of State Mental Health Program Directors
NSPL	National Suicide Prevention Lifeline
NWD	No Wrong Door
PCBH	Plumas County Behavioral Health
PES	Psychiatric Emergency Services
PHF	Psychiatric Health Facility
PM	Post Meridiem
PDSA	Plan-Do-Study-Act
RI	Recovery Innovations; RI International
SAMHSA	Substance Abuse and Mental Health Services Administration
SCCBH	Santa Cruz Behavioral Health
SOW	Scope of Work

SUD	Substance Use Disorder
TA	Technical Assistance
URAC	Utilization Review Accreditation Commission
VCBH	Ventura County Behavioral Health
VP	Vice President
WIC	Welfare and Institutions Code
YCSU	Youth Crisis Stabilization Unit

APPENDIX D
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APPENDIX D: REFERENCES

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