Santa Cruz County Behavioral Health

Mental Health Services Act Innovation

Crisis Now Project | FY 23-24 Annual Report

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RDA CONSULTING

SANTA CRUZ COUNTY HEALTH SERVICES AGENCY | SANTA CRUZ COUNTY BEHAVIORAL HEALTH

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This report was developed by RDA Consulting under contract with Santa Cruz County Behavioral Health.

RDA Consulting, 2024

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Executive Summary

Through the support of Mental Health Services Act (MHSA) Innovation (INN) funding awarded in 2023, Santa Cruz County Behavioral Health (SCCBH) launched its Crisis Now project initiative aimed at building a sustainable and comprehensive crisis response system with fidelity to the Crisis Now model.[1] This model includes adoption of four key components, including: (1) High-Tech Crisis Call Centers, (2) Mobile Crisis Response Teams (MCRTs), (3) Crisis Care Facilities, and (4) Essential Principles and Practices. This project aims to support Santa Cruz County in helping those in need of crisis services in using a "no wrong door" approach. This includes crisis call centers and mobile crisis teams that accept all patients without restrictions such as medical clearance, prior authorization, insurance, or level of crisis. In doing so, the County aims to increase patient access to crisis services and direct individuals to the most appropriate type and level of care for their needs. SCCBH's MHSA INN 3-year funding period for Crisis Now began in September 2023, and the team has since made considerable progress in expanding and optimizing the County's crisis response system to align with the Crisis Now model.

Evaluation Overview

In partnership with SCCBH, RDA Consulting (RDA) is conducting a multi-year evaluation of Crisis Now in Santa Cruz County using a mixed-method approach to address the following evaluation questions:

Evaluation Domain	Evaluation Question
Project Implementation	1. How is the Crisis Now model implemented over time?
Patient Service Access	2. To what extent does the implementation of the Crisis Now model impact patient access to BH crisis response services?
Patient Service Outcomes	3. To what extent does the implementation of the Crisis Now model impact patient outcomes?
System-level Outcomes	4. To what extent does the implementation of the Crisis Now model impact the SCCBH system overall?

This evaluation employed both qualitative and quantitative data collection methods, including focus groups and surveys with crisis continuum stakeholders, as well as collection of secondary data and records. The evaluation team analyzed these data sources to develop baseline indicators of SCC Crisis Now project implementation, patient

[1] crisisnow.com

service access, patient service, outcomes, and system-level outcomes for FY23-24. These baseline findings will provide a basis for comparison in future years to identify changes as the Crisis Now project continues implementation. In comparing these baseline findings to subsequent benchmarks shared in future-year annual MHSA INN reports, RDA will be able to address the evaluation questions by observing changes over time.

Key Evaluation Findings

EQ1: Baseline Crisis Now Model Implementation

This section highlights the Crisis Now project's first year of implementation, including the extent to which the project has been implemented, changes and ongoing developments, and key successes and opportunities for improvement.

In late 2022, RI International conducted an initial assessment of Santa Cruz County's crisis continuum and its fidelity to the Crisis Now model. This assessment included a rating for each of the model's components on a scale of one to five, with one indicating "minimally implemented" and five indicating "fully implemented." Below is a high-level summary of this initial fidelity assessment.

Baseline Fidelity to Crisis Now Model

Crisis Now Model Component	2022 Fidelity Score from RI Int'l	Key Strength Areas	Key Growth Areas
High Tech Crisis Call Centers	2 out of 5 ***Basic***	• 988 and SCC Crisis Call Line are operational • SCC Crisis Call Line has prompt answering times, connects callers to crisis facilities, utilizes systemic suicide screening and safety planning and a trauma-informed recovery model, and provides follow-up support	• System is not yet using GPS technology to better link 988 callers with the nearest mobile crisis response team (MCRT), dispatch MCRTs, or provide direct linkage to services such as outpatient appointments and crisis facilities
24/7 Mobile Crisis	2 out of 5 ***Basic***	• SCC operates multiple MCRTs, including Mobile Emergency Response Team for adults (MERT) and youth (MERTY), and Mental Health Liaisons (MHLs) • Quick MCRT response times and meets patients anywhere	• MCRTs are not yet dispatched by crisis call center nor yet provide 24/7 coverage • Incorporating peer support specialists in the workforce • Transportation for clients who are voluntarily seeking services • Coordination across MCRTs

		• MCRTs use systemic suicide screening and safety planning • MCRTs supported diversion through services to resolve crises with a rate over 60%	
Crisis Care Facilities	3 out of 5 ***Progressing***	• SCC operates a 12-chair Crisis Stabilization Program (CSP) • CSP served youth, accepted law enforcement drop-offs, utilized trauma-informed and least-restrictive intervention models, and provided crisis chairs at a ratio of at least 5 per 100,000 people	• Reducing CSP exclusionary criteria, including medical clearance and insurance status, and increasing staffing to avoid diverting individuals in crisis to local emergency departments
Essential Principles & Practices	2 out of 5 ***Basic***	• All three key elements above are represented and functioning with some alignment to the Crisis Now model	• Absence of peer support specialist as a significant role in all levels of the crisis response system • MCRTs are not yet providing 24/7 coverage

Key Project Implementation Changes & Ongoing Developments

Crisis Now Model Component	High-Level Finding
High Tech Crisis Call Centers	• Though the County sought to employ 988 as the primary phone number for accessing crisis services, the team faced two key barriers: (1) 988 was not yet configured with geo-location to direct callers to call centers based on area codes, and (2) DHCS requirements via the BHIN 23-025 mandated the use of a toll-free phone number and excluded 988 from use. Community members can currently access crisis services by calling the SCC Crisis Call Line 24 hours a day at 1-800-952-2335.[2] • Both MERT/Y and the Family Services Agency (FSA) mobile crisis team have started to use the Beacon app to dispatch teams into the field, allowing for a streamlined approach while the teams are using the SCC Crisis Call Line.
24/7 Mobile Crisis	• At the time of this report, the County's MCRTs are operating 24/7; however, there are still some field-based staff vacancies (on the MERT and MHL teams) and some staff who are in training (on the FSA overnight shift).

[2] santacruzhealth.org/crisisresponse

Crisis Care Facilities	• After Telecare stopped serving youth at the Crisis Stabilization Program (CSP), SCCBH partnered with Watsonville Community Hospital and Pacific Clinics, who began operating a diversion project for youth out of the Watsonville Community Hospital Emergency Department, with financial support from the Innovation Project (including funding for two staff members) and Dominican Hospital. • To address the current lack of treatment facilities for youth, the County is expecting to open a new facility that will include an 8-chair Crisis Stabilization Unit and 16-bed Crisis Residential Program for youth in 2025.
Essential Principles & Practices	• SCCBH is exploring options that will allow them to hire peer support specialists and develop a strong peer-based culture. • MHLs provide annual training to law enforcement about how to respond to a person experiencing a mental health crisis. • The County is continuing to explore opportunities for collaboration across the crisis continuum, such as partnering with peer-based agencies and community-based organizations who provide crisis care.

Key Project Successes & Opportunities for Improvement

Area	High-Level Finding
Support for the Crisis Now Model	• There is wide community support for changes to the crisis continuum, especially for 24/7 mobile crisis coverage. • Some community stakeholders are concerned that the already limited resources in crisis care facilities and emergency departments will be stretched even thinner as the Crisis Now project scales up.
Experience of the Rollout	• When asked about whether the new FSA mobile crisis team launch had been completed smoothly and effectively, most crisis continuum stakeholders surveyed either disagreed or were uncertain (12 out of 18). • Hiring and staff retention has been a challenge during implementation, with longstanding understaffing issues and lack of competitive pay making it difficult to attract new qualified candidates and retain current staff. • There were several obstacles during the rollout of the Crisis Now project, such as securing liability insurance and physical office space, and challenges with linking the after-hours SCC Crisis Call Line team to the new mobile crisis staff from FSA. • The addition of the mobile crisis swing shift in the Fall of 2024 already helped expand coverage of crisis services to more people who normally would have limited options after hours.
Knowledge of Changes to Crisis Continuum	• Most crisis continuum stakeholders surveyed had a solid understanding of the changes to the behavioral health crisis response system (14 out of 18), but fewer felt that the changes had been clearly communicated to them (11 out of 18). • There is a need for additional communication with crisis continuum stakeholders, including service providers and community members, about the changes to the crisis continuum.

Collaboration	• Most crisis continuum stakeholders surveyed felt that the County makes space for collaboration through ongoing meetings (14 out of 18). However, some stakeholders reported that this communication was inconsistent.

EQ2: Baseline Indicators of Patient Access to Behavioral Health Crisis Services

This section highlights baseline indicators of patient access to behavioral health crisis services within Santa Cruz County, including baseline stakeholder perceptions of access to crisis services, as well as characteristics of clients served by MCRTs and CSP admissions during FY23-24.

Baseline Patient Access to Crisis Services

Crisis Now Model Component	High-Level Finding
High Tech Crisis Call Centers	• Most crisis continuum stakeholders surveyed agreed or strongly agreed that the crisis call lines are easy to use (8 out of 12), and half agreed that the call lines are effective in connecting patients to behavioral health crisis services (6 out of 12).
24/7 Mobile Crisis	• The County's MCRTs, including MERT, MERTY, and MHLs, responded to a total of 1,988 incidents during FY23-24, for a combined average of 166 incidents per month. • Monthly MCRT incidents decreased slowly throughout FY23-24, with a notable decrease in December 2023 attributed to staff vacation time, loss of key MHL staff, and shifts in data collection due to early and ongoing refinement of crisis incident databases. • Most MERT and MERTY incidents during FY23-24 were initiated by phone, and most reflected initial calls for crisis service (versus follow-up service calls). • MCRT incidents occurred in a variety of locations and regions, and teams served clients of varying backgrounds and characteristics (see table below). • When asked about the ease of getting support from MCRTs, the availability of MCRTs, and the quick response of MCRTs during behavioral health crisis, a fairly even split of crisis continuum stakeholders disagreed, agreed, and were uncertain.
Crisis Care Facilities	• The County's CSP, operated through Telecare, admitted a total of 1,312 patients during FY23-24, for an average of 109 patients per month. Monthly CSP admissions remained relatively steady throughout FY23-24, with a notable decrease in December 2023. • About half of crisis continuum stakeholders surveyed agreed that the County's facility-based crisis centers, such as Telecare's CSP, are accessible to patients who need their services (7 out of 12). • Among crisis continuum stakeholders surveyed, about half disagreed or strongly disagreed that there are minimal barriers to behavioral health service access in Santa Cruz County (7 out of 12).

Key Baseline Characteristics of Patients Served Across MCRT Incidents

	MERT (n=438 incidents)	MERTY (n=211 incidents)	MHLs (n=1,339 incidents)
Age	73% 25-64	85% under 18	66% 25-64
Gender	49% Male	53% Female	56% Male
Race/Ethnicity	45% White 18% Hispanic	27% White 33% Hispanic	57% White 23% Hispanic
Housing Status	58% Stably Housed	91% Stably Housed	50% Stably Housed

EQ3: Baseline Behavioral Health Patient Outcomes

This section highlights baseline indicators of behavioral health patient outcomes in Santa Cruz County, including baseline stakeholder perceptions of patient crisis dispositions and appropriate level of care placement, as well as the frequency of MCRT-initiated psychiatric holds, emergency department visits, and service referrals during FY23-24.

Baseline Patient Outcomes

Outcome	High-Level Finding
Stakeholder Perceptions of Crisis Dispositions & Level of Care Placement	• Most crisis continuum stakeholders surveyed agreed or strongly agreed that MCRTs successfully de-escalate behavioral health crises (8 out of 12), that crisis centers stabilize patients (9 out of 12), and that people are better off because of MCRT services (8 out of 12). • Most crisis continuum stakeholders surveyed agreed or strongly agreed that crisis call lines have connected individuals to the appropriate level of care for their needs (8 out of 12). In contrast, nearly all stakeholders disagreed or were uncertain in response to the notion that the Crisis Now expansion has reduced unnecessary behavioral health emergency hospitalizations (11 out of 12). • Several stakeholders reported that it is too early in the Crisis Now implementation process to know whether the system has demonstrated positive effects.
MCRT-initiated Psychiatric Holds	• Over one third of all MCRT incidents involved a psychiatric hold assessment during FY23-24 (37%). • Of the MCRT incidents in which psychiatric hold assessments were completed, most did not result in a written psychiatric hold (65%).
MCRT-initiated Emergency Department Visits	• For the overwhelming majority of MCRT incidents during FY23-24, clients were not sent or taken to the emergency department at Watsonville Community or Dominican Hospitals (85%).
MCRT-initiated Service Referrals	• MCRTs provided a variety of service referrals to clients during mobile crisis incidents that occurred throughout FY23-24, including referrals to SCCBH or other mental health services, law enforcement or MHLs, emergency department, and insurance or other medical services.

EQ4: Santa Cruz Behavioral Health System Baseline Indicators

This section highlights baseline indicators of Santa Cruz County's Behavioral Health System, including baseline hiring for SCCBH and FSA crisis staff, as well as system-level factors that may be associated with Crisis Now efforts, including emergency department boarding and diversion and EMS (Emergency Medical Services) workload during FY23-24.

Baseline SCCBH & FSA Crisis Workforce Snapshot

	MERT	MERTY	MHLs	FSA
Current BH leadership staff	1 manager; 1 supervisor; 1 supervisor vacancy			1 manager; 3 supervisors
Current BH field-based Staff & Vacancies	4 hired; 2 vacancies	4 hired; no vacancies	3 hired; 4 vacancies	12 hired; no vacancies
Core Partner(s)	SCCBH, FSA	SCCBH, Volunteer Center	Sheriff's Office, Watsonville PD, Santa Cruz PD	SCCBH
Coverage	7 days per week, 8am-6pm	7 days per week, 8am-6pm	7 days per week, 8am-6pm	7 days per week; 4:30am-8am next day

Baseline Hospital Boarding, Emergency Department Diversion, & EMS Workload Indicators

Area	High-Level Finding
Boarding	• During focus groups in 2024, local hospital staff shared that their emergency departments were often overwhelmed by the number of behavioral health patients that they receive and indicated that they aren't always able to provide the most appropriate level of behavioral health care.
Emergency Department Diversion	• SCC's two hospital emergency departments went on diversion for a combined 266 total hours over the course of FY23-24. Average monthly time on diversion was 20 hours for Dominican Hospital and 2 hours for Watsonville Community Hospital. Total diversion hours varied month to month, with a sharp increase during January 2024.
EMS Workload	• Focus groups with EMS leadership indicated system levels regularly drop to "level 1 or 0," meaning there is only one available ambulance or no available ambulances in the County to respond to emergencies. • EMS data indicated that approximately 12% of ambulance calls for service were considered behavioral health-related in FY23-24. • During FY23-24, the Unit Utilization Rate (UUR) was 0.5, meaning that, on average, an ambulance could be expected to spend 50% of its time occupied on calls. Per EMS leadership, Santa Cruz County is aiming for a UUR of 0.4, a workload level which is associated with a higher quality of patient care.

Introduction

In July 2023, Santa Cruz County Behavioral Health (SCCBH) was awarded three-year Mental Health Services Act (MHSA) Innovation (INN) funding from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to implement their Multi-County Crisis Now project. All INN projects must be approved by the MHSOAC, and counties are required to submit annual, as well as final INN Project Reports at the conclusion of the pilot. The MHSA INN funding and the Crisis Now project, along with its FY23-24 baseline evaluation findings, are described in the sections that follow.

MHSA Innovation

In 2004, stakeholders throughout the mental health system in California joined together in support of Proposition 63, the Mental Health Services Act (MHSA). The MHSA was intended to "expand and transform" the public mental health system according to the values of 1) Recovery, Wellness, and Resiliency; 2) Consumer and Family Driven; 3) Community Collaboration; 4) Cultural Competency; and 5) Integrated Services. MHSA provided an infusion of funds to support programs that serve public mental health consumers, their families, and communities.

INNOVATION (INN)

INN projects are new, creative mental health practices/approaches that contribute to the learning process in the mental health field. INN projects must be developed in partnership with communities through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served individuals.

The purpose of the Innovation (INN) component of MHSA is to pilot new and emerging mental health practices and approaches that seek to address the needs of unserved and underserved populations and that contribute to learning across the state. As such, MHSA INN funds provide an opportunity for counties to implement innovative mental health services and learn about implementing practices that have the potential to transform the behavioral health system. Pursuant to Welfare and Institutions Code Section 5830, all MHSA Innovation projects must meet the following requirements:

<u>Address one of the following as its primary purpose</u>:

- Increase access to underserved groups.
- Increase the quality of services, including measurable outcomes.
- Promote interagency and community collaboration.
- Increase access to services.

Support innovative approaches by doing one of the following:

- Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.
- Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.
- Introducing a new application to the behavioral health system of a promising community

Project Overview

Project Background

In California, suicide is the 13th leading cause of death.[3] This figure is even higher for young adults, with suicide being the second leading cause of death for those between the ages of 25-34. Mental health and substance use disorders are significant risk factors for suicidal behavior.

Despite the acute need for mental health services, most California residents believe there are not enough mental health care workers to serve the needs of residents.[4] In Santa Cruz County (SCC), the need for behavioral health crisis services has continued to increase. According to the regional 988 call center that serves SCC, there was a 93% increase in incoming 988 calls from 2021 to 2022.[5] Unfortunately, the current crisis continuum of care is unable to adequately meet the growing needs of the community. A 2023 community engagement process revealed significant barriers to County crisis service access, including a lack of 24/7 access to mobile crisis response, a significant workforce shortage particularly at the crisis stabilization program (CSP), lack of appropriate services for youth, and lack of appropriate post-crisis services to ensure recovery.[6] In addition, due to lack of appropriate intervention, those experiencing behavioral health crises are often met with delay, detainment, or denial of service in a manner that creates undue burden on the individual, law enforcement, emergency departments, and criminal legal systems.[7]

The onset and ongoing effects of the COVID-19 pandemic exposed an existing need for behavioral health services and resources across the world. Between early 2020 and late 2023 In the United States, approximately 29-43% of those in the United States experienced symptoms of anxiety or depression.[t] In 2021, an estimated 12.3 million adults seriously thought about suicide, 3.5 million adults planned a suicide, and an estimated 1.7 million adults attempted suicide in the U.S.[t t]

[3] Centers for Disease Control and Prevention. (2020). *Web-based Injury Statistics Query and Reporting System (WISQARS) Fatal Injury Reports.* Retrieved from webappa.cdc.gov/sasweb/ncipc/mortrate.html
[4] https://cultureishealth.org/wp-content/uploads/2022/11/CCMHSS-Final-Report.pdf
[5] Santa Cruz County Crisis Now Multi-County MHSA Innovation Plan (July, 2023).
[6] Santa Cruz County Crisis Now Multi-County MHSA Innovation Plan (July, 2023).
[7] Santa Cruz County Crisis Now Multi-County MHSA Innovation Plan (July, 2023).

Crisis Now Project Goals & Objectives
• Build a sustainable and comprehensive crisis response system with fidelity to the Crisis Now model and sufficient flexibility to account for Santa Cruz County's unique needs and existing resources. • Increase patient access to behavioral crisis care and efficiently use workforce resources.

In response, Santa Cruz County is implementing the Crisis Now Innovation Project to strategically plan implementation of the Crisis Now Model. This established multi-pronged crisis care model includes high-tech crisis call centers to coordinate immediate crisis response, mobile crisis teams to respond to crises in the community, facility-based crisis centers that help divert individuals from hospital emergency departments and arrests, and a commitment to evidence-based safe care practices (such as trauma-informed care).[8]

Target Population

The Crisis Now project is designed to accept and serve any individual in need of crisis services in Santa Cruz County. The model emphasizes a "no wrong door" approach that accepts all patients without restrictions such as medical clearance, prior authorization, insurance, or level of crisis. Given that nearly half of Americans will experience a mental illness in their lifetime,[9] the potential target population within Santa Cruz County is significant. In SCCBH's MHSA Innovation Plan, RI International estimated that over 6,582 individuals will require acute crisis intervention services each

According to 2020 Census estimates, there are a total of 270,870 residents in Santa Cruz County. The vast majority are White alone (86.5%), under 65 (81.9%), and have a median household income of $104,409.[t] However, there are significant disparities within Santa Cruz County. The County has the highest number of unhoused residents per capita in the state, as well as a high incidence of substance use disorder.[tt]

[8] crisisnow.com

[t] National Center for Health Statistics. (2020-2024). U.S. Census Bureau, Household Pulse Survey, Anxiety and Depression. Retrieved from https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm

[tt] SAMHSA (2021). Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health. Retrieved from samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.71a

[9] National Council for Mental Wellbeing. (2019). *5 surprising mental health statistics*. Retrieved from mentalhealthfirstaid.org/2019/02/5-surprising-mental-health-statistics

year in Santa Cruz County, with over half of these individuals estimated to require admission to a 23-hour crisis facility with recliners.[10]

Project Design

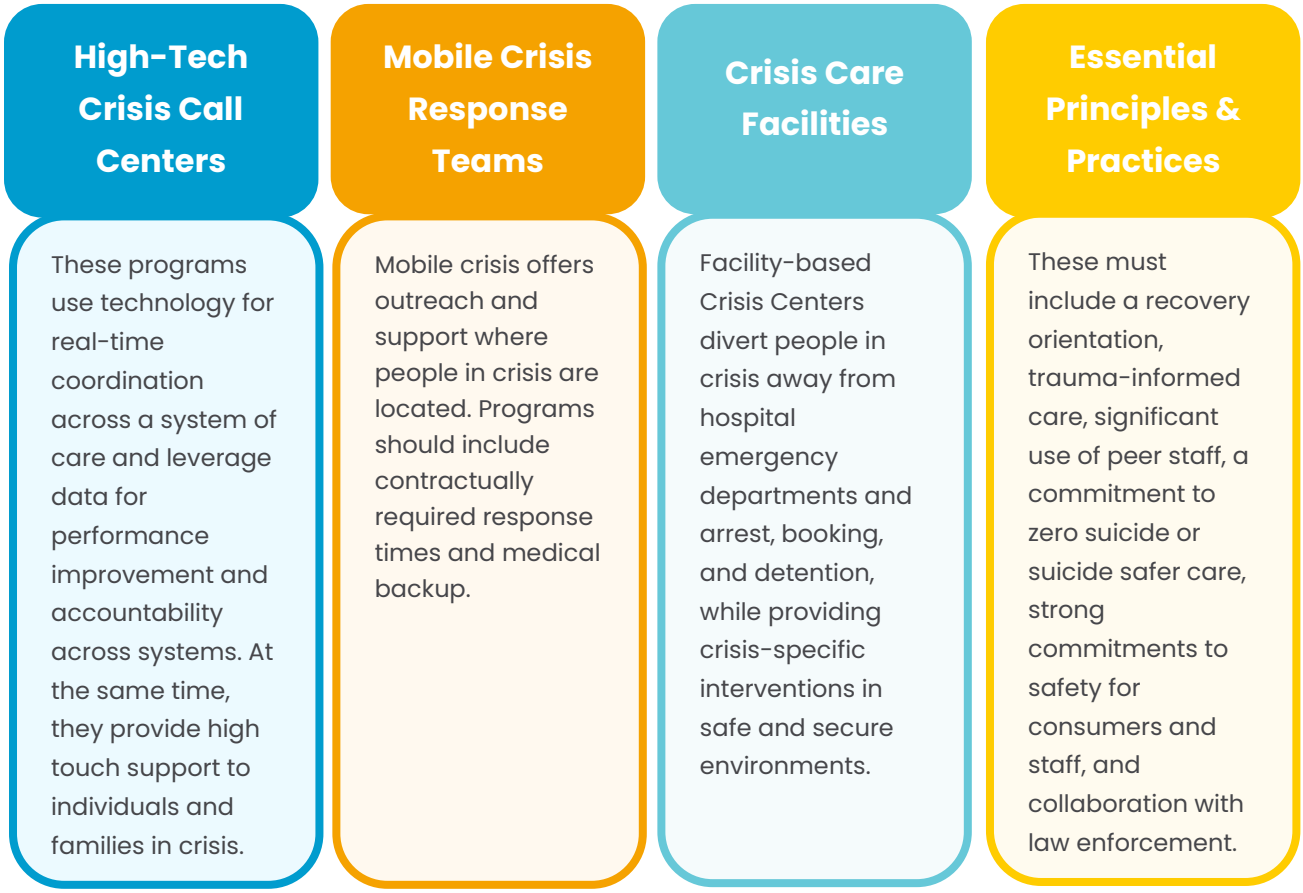
With significant input from community stakeholders, care providers, and subject matter experts, the Crisis Now model was designed to support a dynamic system that can efficiently meet the complex needs of those experiencing behavioral health crises. Coordination between services is essential to ensure that people in crisis are supported, regardless of where they present for services. To this end, the Crisis Now model consists of four core interdependent elements: (1) High-Tech Crisis Call Centers, (2) Mobile Crisis Response Teams (MCRTs), (3) Crisis Care Facilities, and (4) Essential Principles and Practices, (see Figure 1). See **Appendix A** for additional details about each of these components.

[10] Santa Cruz County Crisis Now Multi-County MHSA Innovation Plan (July, 2023).

[t] U.S. Census Bureau. (2020). Population Estimates, April 1, 2020 (V2023) -- Santa Cruz county city, CA. Quick Facts. Retrieved from census.gov/quickfacts/fact/table/santacruzcountycalifornia

[tt] Applied Survey Research. (2022). *Homeless count and survey comprehensive report.* Retrieved from housingforhealthpartnership.org/Portals/29/HAP/Providers/Data/2022PITFullReport.pdf

Figure 1. Four Core Elements for Transforming Crisis Services[11]



Project Implementation

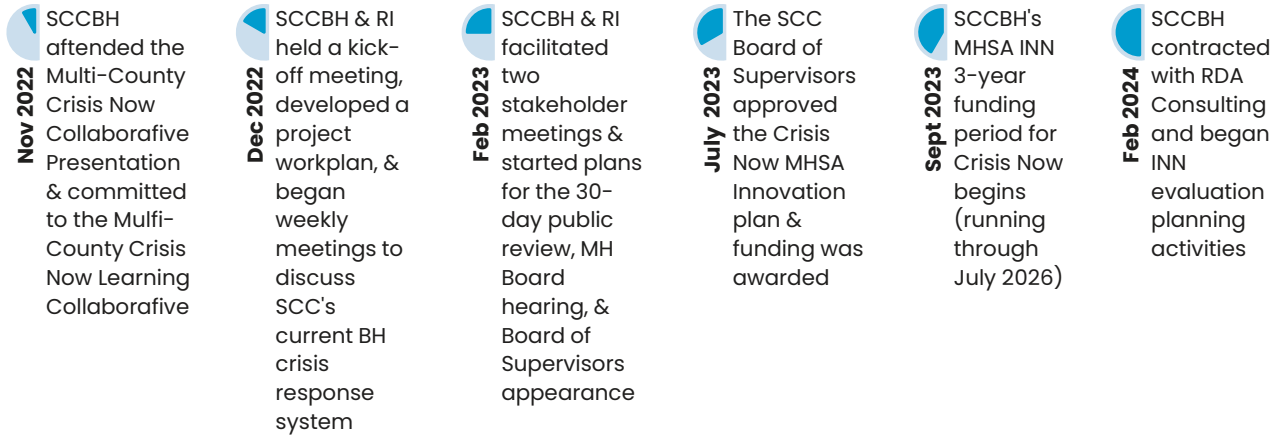
Prior to their MHSA Innovation funding, Santa Cruz County Behavioral Health (SSCBH) sought out opportunities to examine and improve their behavioral health crisis response system, beginning in November 2022 with their commitment to the Multi-County Crisis Now Learning Collaborative (see Figure 2) and subsequent proposal of an MHSA INN project aimed at optimizing county's behavioral health crisis response system and align it with the Crisis Now Model. After partnering with RI International (an expert in the Crisis Now Model) to identify gaps and recommendations for implementation of Crisis Now, the County Board of Supervisors approved the Crisis Now MHSA INN plan in July 2023, and funding began in September 2023. SCCBH's Crisis Now innovation project is funded by $5.2 million from the MHSOAC over three years, through July 2026.

As they continued working to identify gaps and recommendations for optimizing changes to SCC's crisis response system into the Fall of 2023, SCCBH contracted with RDA

[11] Santa Cruz County Crisis Now Multi-County MHSA Innovation Plan (July, 2023).

Consulting (RDA) to support MHSA Innovation reporting and evaluation in February 2024. Thereafter, SCCBH collaborated with RDA to plan the evaluation and begin data collection for the first annual MHSA INN report (see Figure 2).

Figure 2. SCC Crisis Now: Administrative Project and MHSA INN Funding Timeline



Both before and since their MHSA funding began in September 2023, SCCBH has made great progress in expanding and optimizing the County's crisis response system to align with the Crisis Now model (see Baseline Evaluation findings for more detail about baseline model fidelity and implementation). **Appendix B** depicts a systems map of Santa Cruz County's current crisis continuum, with a summary of the key components below.

- **Incident Origin**: Behavioral health crisis incidents are initiated via 911, the SCC Crisis Call Line, and/or the 988 crisis line operated by a local nonprofit, Family Service Agency (FSA).[12]
- **Response Type**: Depending on the incident origin described above and information provided by the caller, a variety of resources may be dispatched to respond. These may include law enforcement, emergency medical services via local fire departments or county wide ambulance services, or one of the county's Mobile Crisis Response Teams (MCRTs), which include: (1) Mental Health Liaisons (MHLs), clinicians who co-respond to behavioral health crises with local law enforcement, (2) Mobile Emergency Response Team (MERT), operated by SCCBH and who respond to adults experiencing behavioral health crises, and (3) Mobile Emergency Response Team for Youth (MERTY), operated by SCCBH and who respond to youth experiencing behavioral health crises.[13]

[12] fsa-cc.org

[13] For more information about each of Santa Cruz County's crisis response programs, visit: santacruzhealth.org/HSAHome/HSADivisions/BehavioralHealth/CrisisInterventionTeam(CIT)/MentalHealthEmergency.aspx

- **Incident Disposition**: Depending on a variety of factors related to the behavioral health crisis and the patient's needs, crisis dispositions vary and may include on-scene resolution, voluntary transport to a hospital or psychiatric facility, or a psychiatric hold (i.e., 5150/5585).
- **Definitive Care**: Santa Cruz County's definitive care options for behavioral health crises include (1) hospital emergency departments, including Dominican Hospital and Watsonville Community Hospitals, which have 24 beds and 12 beds, respectively, (2) the Crisis Stabilization Program[14] and Psychiatric Health Facility[15], both operated by Telecare, and (3) an out of county psychiatric facility, where patients may go in situations where SCC definitive care options are full.
- **Ongoing Care**: Options for ongoing behavioral health care in Santa Cruz County are varied, and include many community resources (e.g., NAMI, Diversity Center), private and county-based outpatient care (e.g., SCCBH's Walk-in Access centers, Connections Santa Cruz), and long-term inpatient care.

[14] telecarecorp.com/santa-cruz-county-csp
[15] telecarecorp.com/santa-cruz-psychiatric-health-facility

Evaluation Overview

In February 2024, SCCBH partnered with RDA Consulting (RDA) to begin a multi-year evaluation of the Crisis Now project, concluding in 2026. The purpose of this evaluation is to: (1) evaluate Crisis Now implementation processes and outcomes; (2) support continuous project improvement efforts; and (3) satisfy and comply with MHSA INN regulatory requirements, including annual and final evaluation reports to the MHSOAC. This first annual report provides baseline evaluation findings for the Crisis Now project for FY23-24 (July 1, 2023-June 30, 2024).

Evaluation Domains and Questions

To guide this evaluation, RDA used SCC's crisis response continuum structure, the Crisis Now project model and mission, the interests and priorities of SCCBH staff and partners, as well as MHSA INN and other applicable reporting requirements, to develop targeted, measurable evaluation questions (EQ) classified within four larger domains: (1) Project Implementation, referring to the processes and mechanics by which the Crisis Now project is enacted; (2) Patient Service Access, referring to the Crisis Now recipient-level service utilization; (3) Patient Service Outcomes, referring to the Crisis Now recipient-level outcomes associated with their participation; and (4) System-level Outcomes, referring to the larger-scale changes observed within the crisis system. The evaluation questions and relevant domains to be addressed through this multi-year evaluation are presented in Table 1.

Table 1. SCC Crisis Now Project Evaluation Questions and Domains

Evaluation Domain	Evaluation Question
Project Implementation	1. How is the Crisis Now model implemented over time?
Patient Service Access	2. To what extent does the implementation of the Crisis Now model impact patient access to BH crisis response services?
Patient Service Outcomes	3. To what extent does the implementation of the Crisis Now model impact patient outcomes?
System-level Outcomes	4. To what extent does the implementation of the Crisis Now model impact the SCCBH system overall?

Data Collection

As part of the initial evaluation planning process, RDA and SCCBH collaborated to identify, discuss, and develop qualitative and quantitative data sources to address the evaluation questions. Table 2 summarizes the evaluation domains, measures, and corresponding data sources used for this baseline evaluation. For additional details on each data source, see **Appendix C**.

Table 2. SCC Crisis Now Project Evaluation Data Measures and Sources

Evaluation Domain	Measures	Data Source(s)
Project Implementation	Project implementation changes made over time; Project implementation successes, challenges, and lessons learned; Extent of fidelity to Crisis Now model	Stakeholder focus groups; Stakeholder survey; Crisis Now fidelity assessments; Project meeting notes
Patient Service Access	Crisis Now patient demographics and characteristics; Service data for crisis call lines, MCRTs, and CSP	MERT/Y and MHL Workbooks; CSP Data Sheet; Stakeholder survey; Stakeholder focus groups; Project meeting notes
Patient Service Outcomes	Crisis Now patient dispositions, linkage to appropriate level of care, psychiatric holds, emergency department visits, and service referrals	MERT/Y and MHL Workbooks; Stakeholder survey; Stakeholder focus groups; Project meeting notes
System-level Outcomes	Staff engagement; EMS diversion rates; Ambulance drawdown rates; EMS behavioral health call volume	Stakeholder focus groups; Workforce tracker; EMS records; Stakeholder survey; Project meeting notes

Data Analysis

To address the previously described evaluation questions, RDA triangulated findings from multiple data sources to develop baseline findings for the FY23-24 Crisis Now project evaluation. These baseline findings will provide a basis for comparison in future years to identify changes as the Crisis Now project continues implementation. In comparing these baseline findings to subsequent benchmarks shared in future-year annual MHSA reports, RDA will be able to address the evaluation questions by observing changes over time.

Separate analytic approaches were used to analyze quantitative and qualitative data. To assess measures from the quantitative data sources listed above, RDA used descriptive

statistics to calculate basic frequencies and percentages for measures, such as the number of MCRT incidents that took place during FY23-24, demographics of those who accessed MCRT services, and stakeholder survey responses.

Data gathered from the qualitative data sources, including the stakeholder focus groups, project meeting notes, and portions of the stakeholder surveys, were analyzed using a systematic approach. Responses were transcribed, reviewed, and thematically analyzed to identify recurring themes and key takeaways that informed baseline findings relevant to the evaluation questions.

The quantitative and qualitative baseline results were synthesized and interpreted together to develop mixed-methods findings. After analyzing the qualitative and quantitative data separately, RDA ventured deeper into the evaluation findings to identify connections and areas of overlap across data. RDA also engaged SCCBH staff and stakeholders in discussions around baseline findings to further contextualize results.

Limitations and Considerations

Data Availability & Measurement: Data for this evaluation was limited to that which was available and retrievable from SCCBH and stakeholders during the evaluation period. Although the evaluation team made diligent efforts to secure data reflecting the baseline evaluation period of July 1, 2023-June 30, 2024, some data sources include information from periods closely before (e.g., Crisis Now fidelity assessment data from Fall 2022) and closely following (e.g., project meeting notes, focus groups, and stakeholder surveys from February-October 2024) this period. Additionally, proxy measures were used in some cases where data sources were unavailable (e.g., because data did not exist on the number of crises in which an MCRT was unavailable, this evaluation used the frequency of monthly incidents as one indicator of crisis service access via MCRTs).

Selection & Social Desirability Bias: Focus group and survey data are often subject to selection bias (i.e., self-selection into data collection activities resulting in lack of true participant and community representation), as well as recall or social desirability bias (i.e., inaccurate data provided by respondents due to lack of memory recall or attempts to appear socially desirable). These inherent limitations emphasize the importance of triangulating multiple quantitative and qualitative data sources where it is possible to maximize validity and reliability of findings.

Causal Relationships: The analytic techniques and methodology proposed for this evaluation cannot establish *causal* relationships between project elements and

outcomes. It is important to note that, because the Crisis Now project will exist in the real world (versus a controlled setting), any changes or improvements observed may be due to factors unrelated to the Crisis Now project (e.g., environmental factors that this evaluation cannot control for). Therefore, this evaluation will explore non-causal associations or relationships between the Crisis Now project and observed outcomes.

Baseline Evaluation Findings

EQ1: Baseline Crisis Now Model Implementation

This section highlights the first year of Crisis Now Project implementation, describing the extent to which the model has been implemented and the changes made to the project. It also details key successes and challenges around support for the model, experience of the rollout, knowledge of the system, and collaboration.

Summary

In 2022, Santa Cruz County was rated as having "basic implementation" of the Crisis Now model. Since this initial assessment, SCCBH has enhanced their Crisis Call Line capabilities, expanded mobile crisis hours, are building a new youth facility, and are training staff in alignment with the model. In general, there is widespread support for an expanded crisis continuum of care and for the changes made, but many stakeholders still are unaware of what has changed and what is yet to come.

Fidelity to Crisis Now Model

In late 2022, RI International conducted an initial assessment of Santa Cruz County's crisis continuum and its fidelity to the Crisis Now model. This assessment culminated in a rating for each of the model's components on a scale of one to five, with one indicating "minimally implemented" and five indicating "fully implemented." Below is a high-level summary of this initial fidelity assessment.

High Tech Crisis Call Centers

2 out of 5

Basic Implementation

RI International scored Santa Cruz County's crisis call center services at a two out of five, or as having the "basic" components of the Crisis Now call center hub criteria. In justifying this score, RI noted that 988 is operational in the County and calls are answered by a call center affiliated with the National Suicide Prevention Lifeline. The SCC Crisis Call Line, operated by SCCBH, has prompt answering times, directly connects callers to facility-based crisis providers, utilizes systemic suicide screening and safety planning (C-SRSS) and a trauma-informed recovery model, as well as provides follow-up support.

Several areas were identified for progress toward Crisis Now model fidelity, including utilizing GPS technology to better link callers with the nearest mobile crisis response team (MCRT), dispatching MCRTs, and providing direct linkage to services such as outpatient appointments and crisis facilities.

24/7 Mobile Crisis

2 out of 5

Basic Implementation

RI International scored Santa Cruz County's mobile crisis response teams (MCRTs) at a two out of five, or as having the "basic" components of the Crisis Now mobile crisis service criteria. RI noted that the County operates multiple types of MCRTs through their MERT, MERTY, and MHL teams, but they have limited availability and are not dispatched by the crisis call center. RI found that MCRTs responded to calls within 1 hour throughout the County, received access to limited electronic health information, used systemic suicide screening and safety planning, and supported diversion through services to resolve crises with a rate over 60%.

Several areas were identified for progress toward Crisis Now model fidelity, including expanding mobile crisis service to provide 24/7 coverage, incorporating peer support specialists in the workforce, transporting clients who are voluntarily seeking services, coordinating across multiple MCRTs, and aligning more closely with best practices.

Crisis Care Facilities

3 out of 5

Progressing Implementation

RI International scored Santa Cruz County's crisis care facilities at a three out of five, or as "progressing." RI pointed to the 12-chair Crisis Stabilization Program (CSP) in SCC as "operating with some level of congruence to the Crisis Now model." At the time of the assessment, the crisis receiving center served youth, accepted law enforcement drop-offs, utilized trauma-informed and least-restrictive intervention models, and provided crisis chairs at a ratio of at least 5 per 100,000 people.

Several areas were identified for progress toward Crisis Now model fidelity, including reducing the exclusion criteria for the CSP (e.g., raising the threshold for mandatory hospital medical clearance prior to CSP admission, expanding the types of insurance accepted) and increasing staffing to avoid diverting individuals in crisis to local emergency departments.

Essential Principles and Practices

2 out of 5

Basic Implementation

RI International scored Santa Cruz County's alignment with best practices by using the scoring sheets from the previous three categories: high tech crisis call centers, 24/7 mobile crisis, and crisis care facilities. The county's crisis continuum was scored at a two out of five overall, or as having the "basic" components of the Crisis Now model. RI noted that all three elements of the model are represented and functioning with some alignment to the Crisis Now model. Key areas

for progress included embedding peer support specialists as a significant role in all levels of the crisis response system and providing 24/7 mobile crisis service coverage.

Key Project Implementation Changes & Ongoing Developments

Since the initial assessment made by RI international in 2022, Santa Cruz County has implemented numerous changes to their crisis continuum and other changes are in development.

High Tech Crisis Call Centers

Community members can access crisis services by calling the SCC Crisis Call Line 24 hours a day. Though the County initially sought to employ 988 as the primary phone number for accessing crisis services, the team faced two key barriers: (1) 988 was not yet configured with geo-location to direct callers to call centers based on area codes, and (2) DHCS requirements via the BHIN 23-025 mandated the use of a toll-free phone number and excluded 988 from use. SCCBH decided to use their existing Crisis Call Line that provides support 24 hours a day. This would allow anyone in the Santa Cruz area, regardless of area code, to connect with Santa Cruz crisis response. The County hopes to integrate with 988 as dispatch features like geolocation are implemented.

Dispatch is managed using the Beacon app. Both MERT/Y and the Family Services Agency (FSA) mobile crisis team have started to use the Beacon app to dispatch teams into the field. This allows for a more streamlined approach while the teams are using the SCC Crisis Call Line. The Beacon app allows both dispatch and MCRTs to see the location of other units, their call status (on scene, transporting, in-service etc.), dispatch case notes associated with the caller, as well as previous interactions at the same address or phone number. This allows MCRTs to arrive prepared to best support a community member experiencing a behavioral health crisis.

24/7 Mobile Crisis

At the time of this report, **the County's MCRTs are operating 24/7; however, there are still some field-based staff vacancies** (on the MERT and MHL teams) **and some staff who are in training** (on the FSA overnight shift). SCCBH anticipates completing additional hiring and staff training by the end of 2024, at which point 24/7 MCRT operations will be fully staffed and in service.

Crisis Care Facilities

Pacific Clinics is providing specialty trained youth crisis interventionists for a diversion project in partnership with Watsonville Community Hospital Emergency Department. In July 2023, Telecare stopped providing services to youth at the CSP. In response, the County launched a temporary project at Watsonville Community Hospital Emergency Department. Two staff members are embedded within the emergency department to

provide assessments, support, and recommendations for how to proceed with patients daily from 8am-8pm.

The County is building a new facility for youth. The County is expecting to open a new facility in Live Oak with 24 beds, including an 8-chair CSP and 16-bed Crisis Residential Program. It is meant to address the current lack of treatment facilities for youth and is expected to open in the summer of 2025.

Essential Principles and Practice

SCCBH is working to increase peer capacity in the County. Leadership shared that there is not currently a strong peer culture within direct care roles in the County. They are exploring options that will allow them to hire individuals with lived expertise and provide the support that peers need, including a connection to Peer Support Specialist certification. The FSA mobile team exemplifies the values of the peer recovery movement of personal autonomy in treatment; there are no clinicians on the team and staff do not have the authority to issue involuntary psychiatric holds (both factors that can help build trust with individuals in crisis).

Staff are provided ongoing training in alignment with the Crisis Now model. MHLs provide annual training to law enforcement about how to respond to a person experiencing a mental health crisis. Training content includes a review of 5150 criteria, crisis intervention, and de-escalation skills.

The County is continuing to explore opportunities for collaboration across the crisis continuum. In addition to the ongoing crisis continuum meetings, the County is considering plans to partner with non-County entities who provide crisis care. This would include peer-based agencies and community organizations who offer these vital services.

Successes and Opportunities for Improvement

Support for the Crisis Now Model

There is wide community support for changes to the crisis continuum, especially for 24/7 mobile crisis coverage. Staff and leadership report hearing positive feedback from community members about the goal to provide 24/7 coverage for mobile crisis services. There has been moderate engagement with various public education activities, including training on crisis services with community partners, crisis continuum meetings, town halls, and the Crisis Now Academy. Additionally, community partners expressed faith in a committed and dedicated leadership team to serve the community well.

Some stakeholders are concerned that the already limited resources will be stretched even thinner as Crisis Now scales up. During focus groups, stakeholders shared

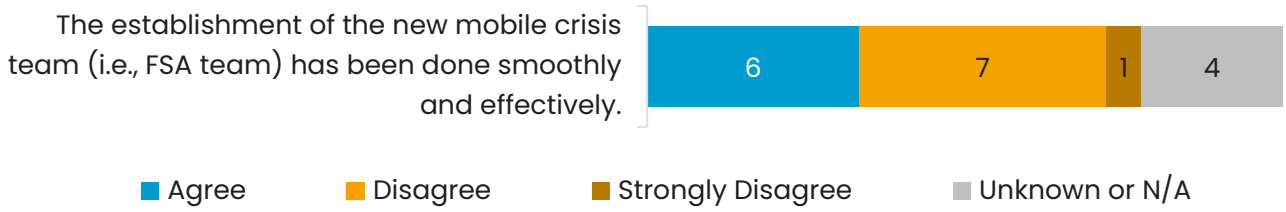
experiences of crisis care facilities and emergency services having very limited capacity to serve the community. As the Crisis Now project scales up, there is concern that the system will not be able to handle the increased call volume. One stakeholder shared some concerns about the County's data collection and reporting capacity, particularly around equity measures like race/ethnicity and sexual orientation and gender identity/expression (SOGIE).

Experience of the Rollout

When asked about whether the new FSA mobile crisis team launch had been completed smoothly and effectively, most crisis continuum stakeholders surveyed either disagreed or were uncertain (12 out of 18; see Figure 3).[16] Both stakeholder survey respondents and focus group participants shared that initial implementation has felt hasty, and that the County "rolled out programs before they were ready." Though some acknowledged that this was due in part to the state mandate to provide 24/7 mobile crisis services, most stakeholders agreed the rollout has been challenging.

> *"The county and FSA still have a lot of setup work that needs to be done. They truly got the cart before the horse on this. They are playing catchup now, but all it does is confuse things." -Stakeholder Survey Respondent*

Figure 3. Stakeholder Perceptions of the Rollout, FY23-24, N=18[17]



Hiring and staff retention has been a challenge during implementation. Staff and community partners shared that many agencies in the crisis continuum have been understaffed for years. During the process of hiring staff for the new FSA mobile crisis team, it has been difficult to identify potential candidates who are qualified and interested in the work. The pay for these positions is also not competitive compared to

[16] The stakeholder survey was completed in September and October of 2024 and yielded 18 respondents, including 9 behavioral health providers (50%), 4 law enforcement officers (22%), 3 EMS/fire personnel (17%), 1 medical/healthcare provider (6%), and 1 social services provider (6%).
[17] Data Source: Stakeholder Survey

similar positions in neighboring counties, making it difficult to attract new candidates and retain current staff.

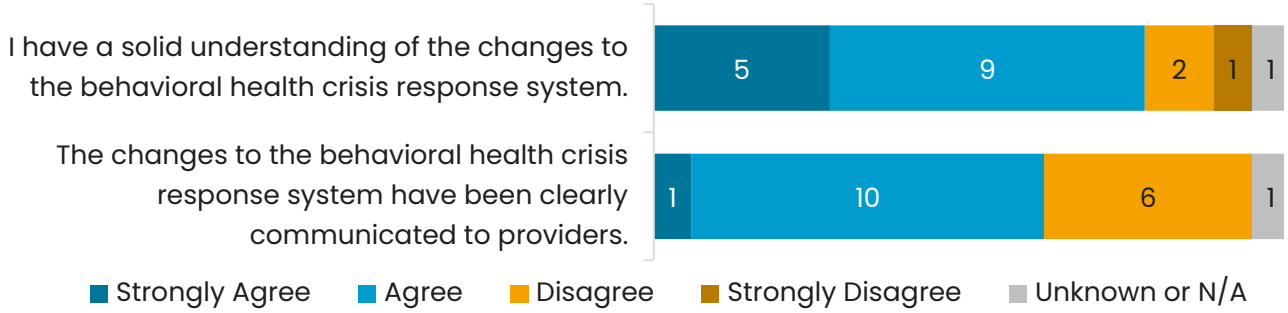
There were several obstacles to the rollout of the project. The after-hours SCC Crisis Call Line staff were not initially informed of the new swing shift mobile crisis team at FSA; consequently, Crisis Call Line staff were initially not directing callers to this team. The County also faced technical difficulties in setting up the phone tree for their Crisis Call Line, delaying the public launch of the phone number. Other early challenges included securing liability insurance, fully staffing the mobile crisis team, and sorting out physical office space.

The addition of the swing shift has already helped expand coverage of mobile crisis services. Since launching this year, the swing shift team has been able to serve people in crisis who normally would have limited options after hours.

Knowledge of the Changes to the Crisis Continuum

Most crisis continuum stakeholders surveyed have a solid understanding of the changes to the behavioral health crisis response system (14 out of 18)**, but fewer feel that the changes have been clearly communicated to them** (11 out of 18; see Figure 4). While some stakeholders stated that the County has regularly engaged them throughout the process, others shared that they did not know much about the new services being offered. Although many stakeholders are attending crisis continuum meetings, several of them expressed uncertainty about the state's Behavioral Health Information Notice (BHIN) requirements, the nature of the Crisis Now model, and the changes that have been implemented in SCC so far. Service provider stakeholders who do know about the changes have not yet shared the information with other staff or clients. **There is a need for additional communication with crisis continuum stakeholders, including service providers and community members, about the changes to the crisis continuum.**

Figure 4. Stakeholder Knowledge of the Changes to the Crisis Continuum, FY23-24, N=18[18]



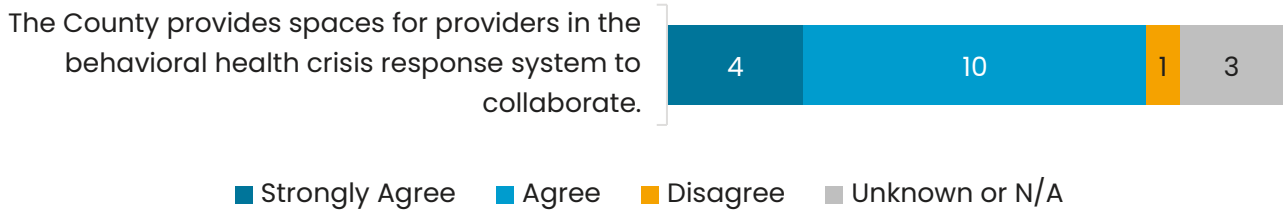
[18] Data Source: Stakeholder Survey

Collaboration

Most crisis continuum stakeholders surveyed feel that the County makes space for providers to collaborate (14 out of 18; see Figure 5). Stakeholders cite the monthly crisis continuum meetings as a place to "promote community stakeholder awareness and collaboration." Some providers named specific teams, like MERT and the MHLS, as being strong collaborators.

> *"When I have worked with MERT in the past they have been wonderful partners. I have truly been amazed with their capacity to ensure safety and de-escalate." -Stakeholder Survey Respondent*

Figure 5. Stakeholder Perceptions of Collaboration, FY23-24, N=18[19]



However, some stakeholders shared challenges with collaboration and communication. Some community partner focus group participants said that communication with stakeholders has been inconsistent, particularly for those who do not attend the crisis continuum meetings. Additionally, ongoing union negotiations and the potential for a strike may have impacted staff morale and willingness to collaborate with the County. The FSA team shared that they are not yet able to access the electronic health record (EHR) system that the County uses, complicating hand-offs between the day and swing shifts.

EQ2: Baseline Indicators of Patient Access to Behavioral Health Crisis Services

This section highlights baseline indicators of patient access to behavioral health crisis services within Santa Cruz County for comparison to future years as Crisis Now continues its implementation. Specifically, this section describes baseline crisis continuum stakeholder perceptions of access to crisis call centers, MCRTs, and crisis care facilities in

[19] Data Source: Stakeholder Survey

Santa Cruz County, as well as characteristics of clients served by MCRTs and CSP admissions during FY23-24.

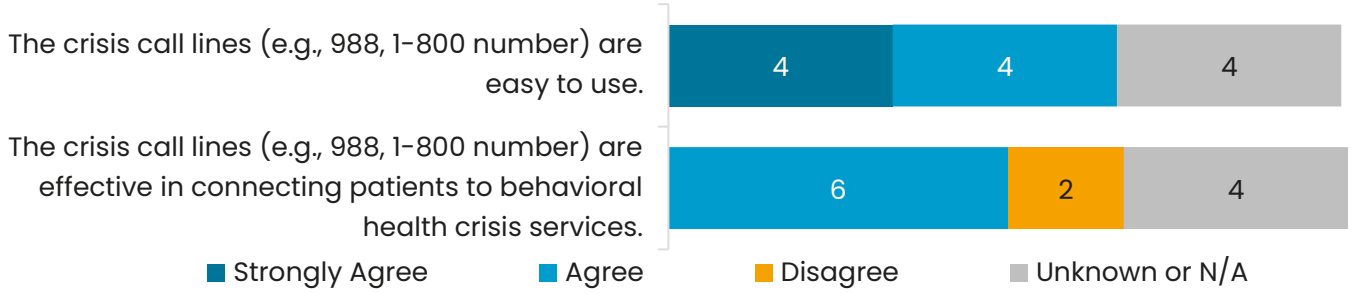
Summary

During FY23-24, SCC Mobile Crisis Response Teams responded to nearly 2,000 incidents with varying needs and characteristics. Crisis care facilities admitted just over 1,300 patients. Overall, crisis continuum stakeholders report that crisis call lines are accessible to community members. However, stakeholder perceptions of MCRT and CSP accessibility are somewhat mixed.

High Tech Crisis Call Centers

Among crisis continuum stakeholders surveyed, many agreed that the existing crisis call lines are user-friendly and provide effective service access. Specifically, most stakeholders surveyed agreed or strongly agreed that the crisis call lines are easy to use (8 out of 12), and half agreed that the call lines are effective in connecting patients to behavioral health crisis services (6 out of 12; see Figure 6).

Figure 6. Stakeholder Perceptions of Crisis Call Lines, FY23-24, N=12[20]



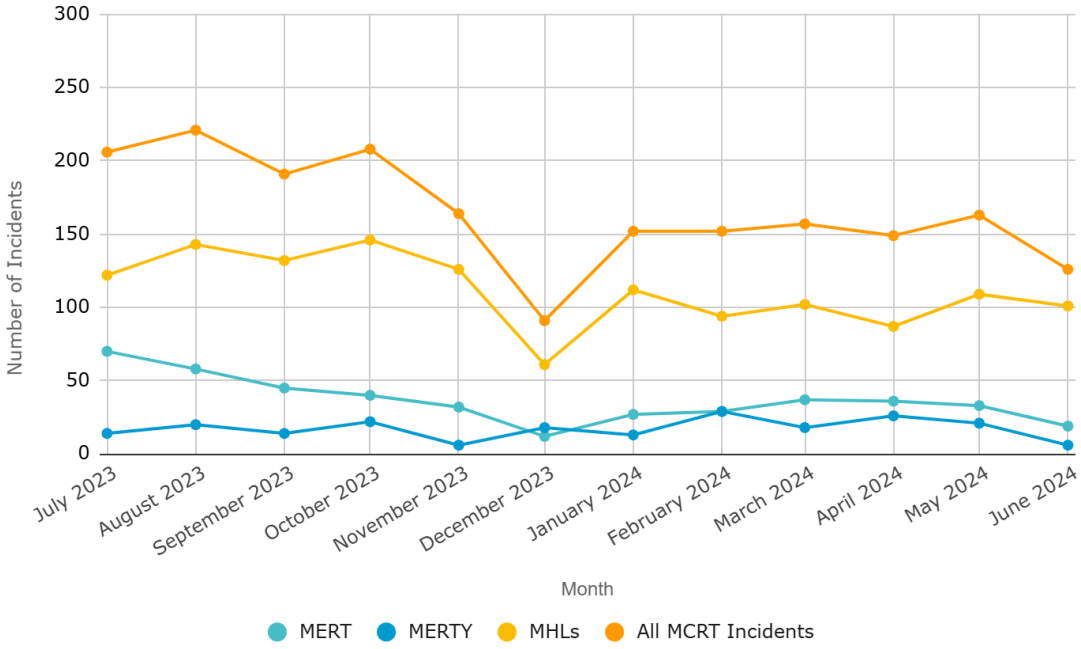
24/7 Mobile Crisis

MCRT Incident Characteristics

The County's MCRTs, including MERT, MERTY, and MHLs, responded to a total of 1,988 incidents during FY23-24, for a combined average of 166 incidents per month. Most incidents during this period involved the three MHLs (n = 1,339), followed by MERT (n = 438) and MERTY (n = 211). The MHLs responded to 112 average incidents per month, while MERT and MERTY responded to 37 and 18 average incidents per month, respectively. Overall, the number of monthly MCRT incidents decreased slowly throughout the fiscal year, with a notable decrease in December 2023 (see Figure 7). County staff attribute these observed decreases to staff vacation time throughout November 2023-January 2024, loss of key MHL staff in January and May of 2024, and shifts in data collection due to early and ongoing refinement of crisis incident databases.

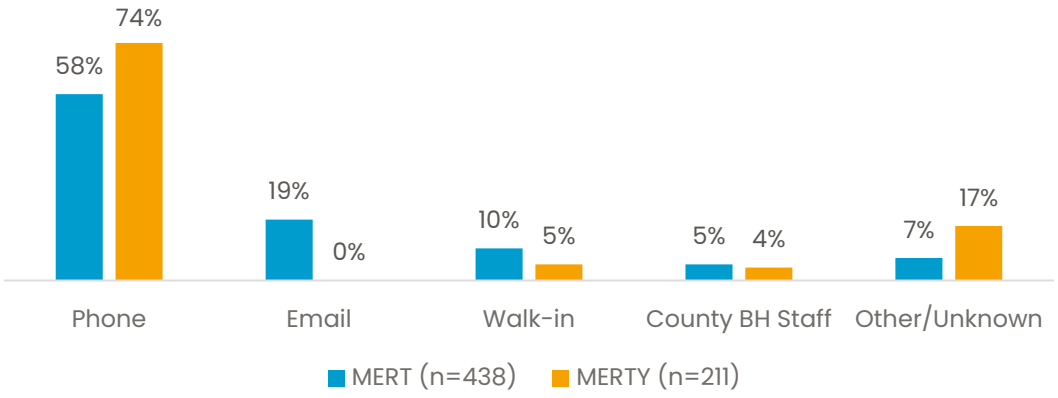
[20] Data Source: Stakeholder Survey

Figure 7. Monthly MCRT Incidents, FY23-24[21]



Most MERT and MERTY incidents during FY23-24 were initiated by phone requests for service (58% and 74%, respectively; see Figure 8). Less-frequent service request types included email, walk-in, and initiation by County behavioral health staff.

Figure 8. MCRT Service Request Types, FY23-24[22]

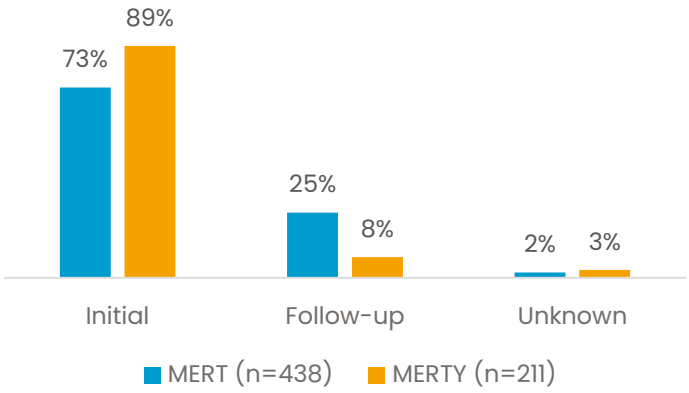


The vast majority of MERT and MERTY incidents during FY23-24 represented initial calls for crisis service (73% and 89%, respectively; see Figure 9). Fewer incidents reflected follow-up service contacts.

[21] Data Source: MERT, MERTY, & MHL Workbooks

[22] Data Source: MERT, MERTY, & MHL Workbooks. Information about service request types were not available for MHLs.

Figure 9. MCRT Service Contact Types, FY23-24[23]



Most MCRT incidents were classified as mental health-related; fewer were alcohol/drug-related. Across all MCRTs, over 80% of incidents were considered mental health-related (see Figure 10). Although few incidents were considered alcohol/drug-related across MCRTs (based on available data), MHLs had the highest proportion of incidents classified as such (33%; see Figure 11).

Figure 10. Mental Health-Related MCRT Incidents, FY23-24[24]

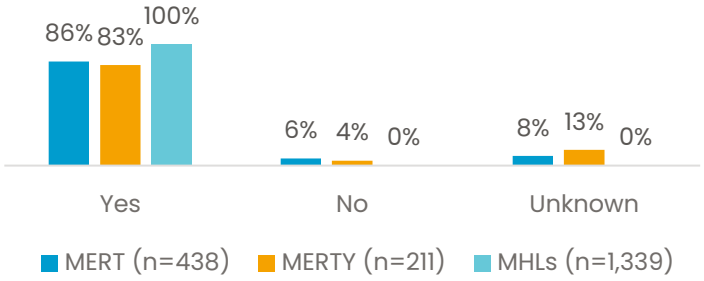
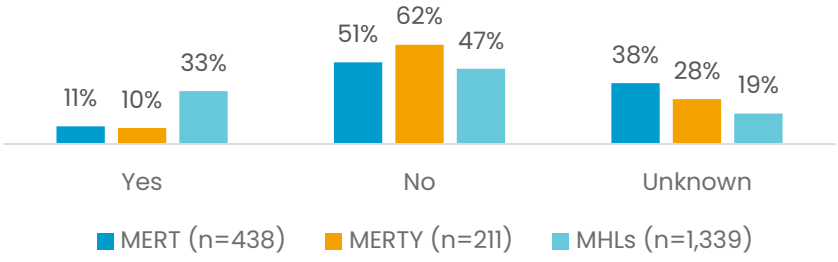


Figure 11. Alcohol/Drug-Related MCRT Incidents, FY23-24[25]



MCRT incidents occurred in a variety of locations and regions. Most MERT incidents took place over the phone (70%) in Santa Cruz (59%). MERTY incidents were more evenly

[23] Data Source: MERT, MERTY, & MHL Workbooks. Information about service contact types were not available for MHLs. Note that "Follow-up" contact types are inclusive of follow-up through the County's Rapid Connect Program (RCP).
[24] Data Source: MERT, MERTY, & MHL Workbooks.
[25] Data Source: MERT, MERTY, & MHL Workbooks.

spread across phone and emergency departments in Santa Cruz and Watsonville. Similarly, MHL incidents were spread fairly evenly across Santa Cruz, South County, and Mid-County (see Figures 12 and 13).

Figure 12. MCRT Incident Location Type, FY23-24[26]

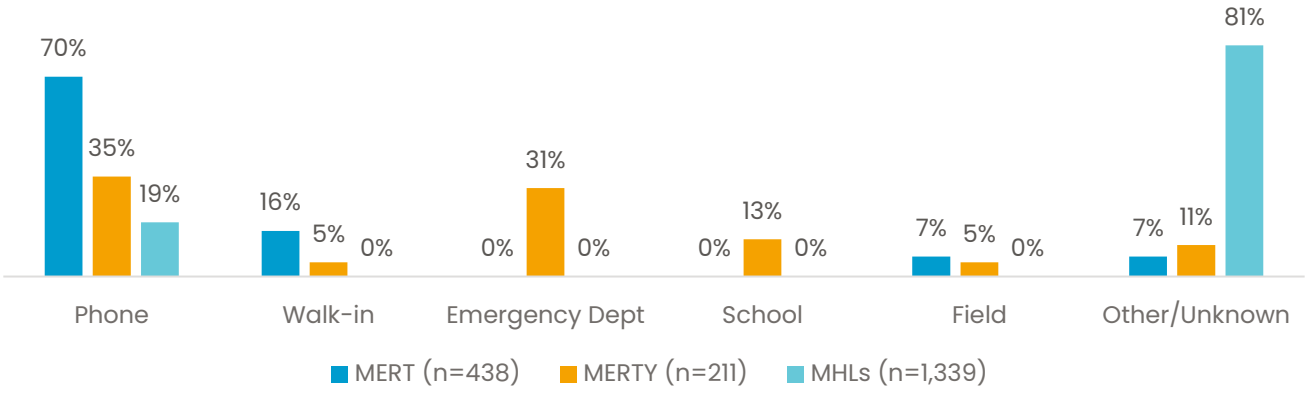
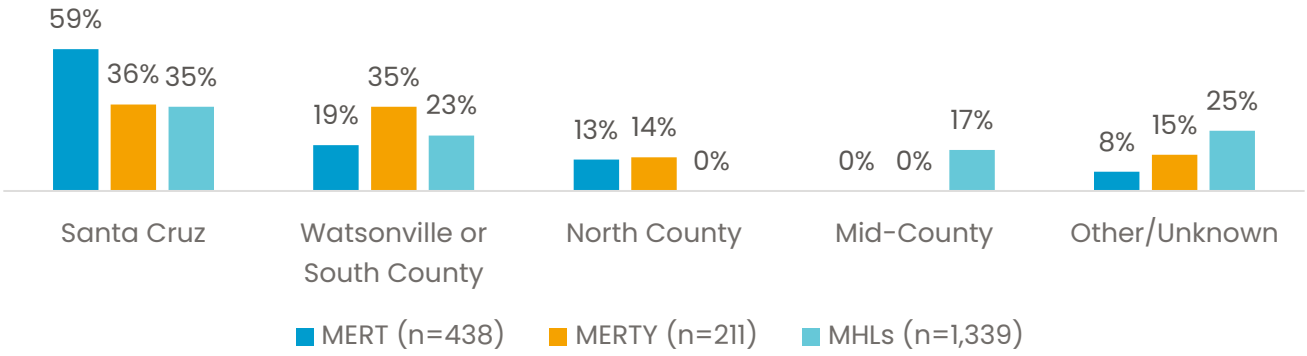


Figure 13. MCRT Incident Region, FY23-24[27]



Characteristics of Clients Served Across MCRT Incidents

The MCRTs served clients of varying backgrounds and characteristics (see Table 3). Most MERT and MHL incidents involved clients between 25-64 years old (73% and 66%, respectively), while the majority of MERTY incidents involved youth under the age of 18 (85%). Most MHL incidents involved male clients (56%), approximately half of MERT incidents involved male clients (49%), and most MERTY incidents involved female clients (53%). In line with 2023 census data for Santa Cruz County[28], the majority of MERT, MERTY, and MHL incidents involved clients who identified as White (45%, 27%, and 57%, respectively) or Hispanic/Latinx (18%, 33%, and 23%, respectively). The vast majority of MERT, MERTY, and MHL incidents involved clients whose primary language was English (92%, 85%, and 64%, respectively). Additionally, although the majority of all MCRT incidents

[26] Data Source: MERT, MERTY, & MHL Workbooks.
[27] Data Source: MERT, MERTY, & MHL Workbooks.
[28] Source: 2023 Census for Santa Cruz County; census.gov/quickfacts/santacruzcountycalifornia

involved clients who were stably housed at the time, MERT and MHL incidents involved a much higher proportion of unhoused clients (26% and 35%, respectively) compared to MERTY incidents (0% based on available data).

Table 3. Characteristics of Clients Served Across MCRT Incidents, FY23-24[29]

Category	MERT (n=438 incidents)		MERTY (n=211 incidents)		MHLs (n=1,339 incidents)	
	n	%	n	%	n	%
Age						
Under 18 years	0	0%	179	85%	85	7%
18-24 years	26	6%	20	10%	119	9%
25-44 years	191	44%	0	0%	546	41%
45-64 years	125	29%	0	0%	340	25%
65+ years	56	13%	0	0%	177	13%
Unknown	40	8%	12	5%	72	5%
Gender						
Male	216	49%	81	38%	749	56%
Female	205	47%	111	53%	570	43%
Another Gender or Unknown	17	4%	19	9%	20	1%
Race/Ethnicity						
White	196	45%	57	27%	766	57%
Hispanic/Latinx	79	18%	70	33%	306	23%
Another Race/Ethnicity	27	6%	24	11%	108	8%
Unknown	136	31%	60	28%	159	12%
Primary Language						
English	399	92%	180	85%	861	64%
Another Language or Unknown	39	8%	31	15%	478	36%
Housing Status						
Stably Housed	256	58%	193	91%	672	50%
Unhoused (Sheltered)	68	16%	0	0%	111	8%
Unhoused (Streets)	43	10%	0	0%	355	27%
Another Status	41	9%	0	0%	135	10%
Unknown	30	7%	18	9%	66	5%

Stakeholder Perceptions of MCRT Access

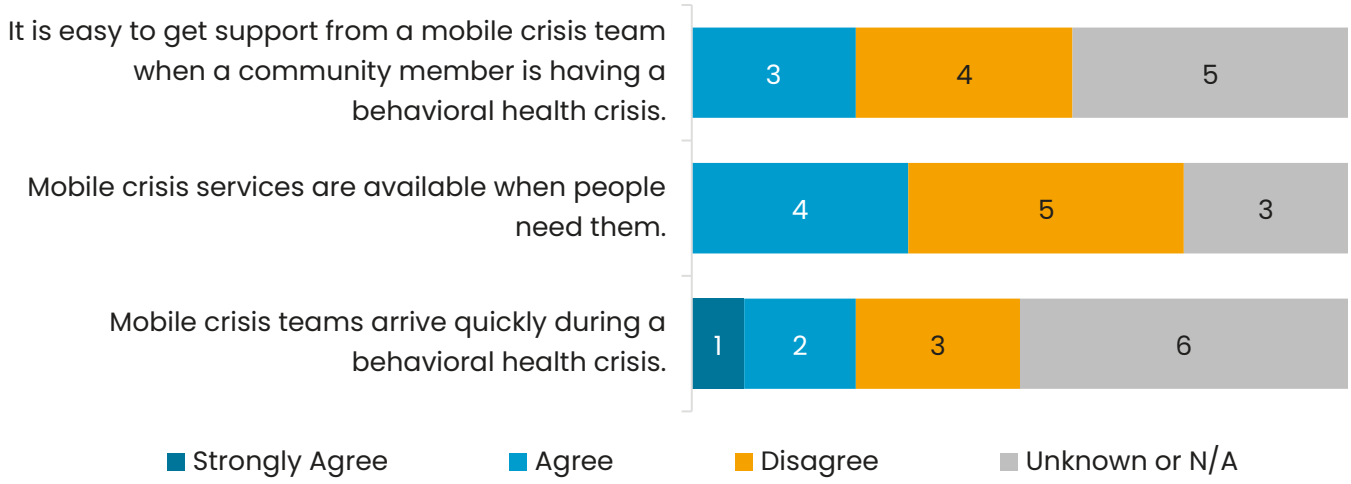
Among crisis continuum stakeholders surveyed, opinions were somewhat divided about the ease, availability, and swiftness of the existing MCRTs. Specifically, when asked about the ease of getting support from MCRTs, the availability of MCRTs, and the quick response of MCRTs during behavioral health crisis, a fairly even split of stakeholders

[29] Data Source: MERT, MERTY, & MHL Workbooks. Note that client characteristics are presented at the MCRT incident-level (i.e., clients may be duplicated across incidents). Categories falling under "Another Race/Ethnicity" include African American, Asian/Asian American, Native American/Alaskan, Native Hawaiian/Pacific Islander, and Multiracial.

disagreed, agreed, and were uncertain (see Figure 14). Several stakeholders indicated that it is too early to comment on the effectiveness of the MCRT expansion as part of Crisis Now. Some shared that more funding is needed to adequately staff and train the MCRTs and suggested the use of community health workers who are fully trained in risk assessment and management.

"Other than our in-house MHL who works Monday-Friday from 8am-5pm, I have not seen or heard the FSA Mobile Crisis Teams in action yet, other than MERT during daytime hours." -Stakeholder Survey Respondent

Figure 14. Stakeholder Perceptions of MCRTs, FY23-24, N=12[30]



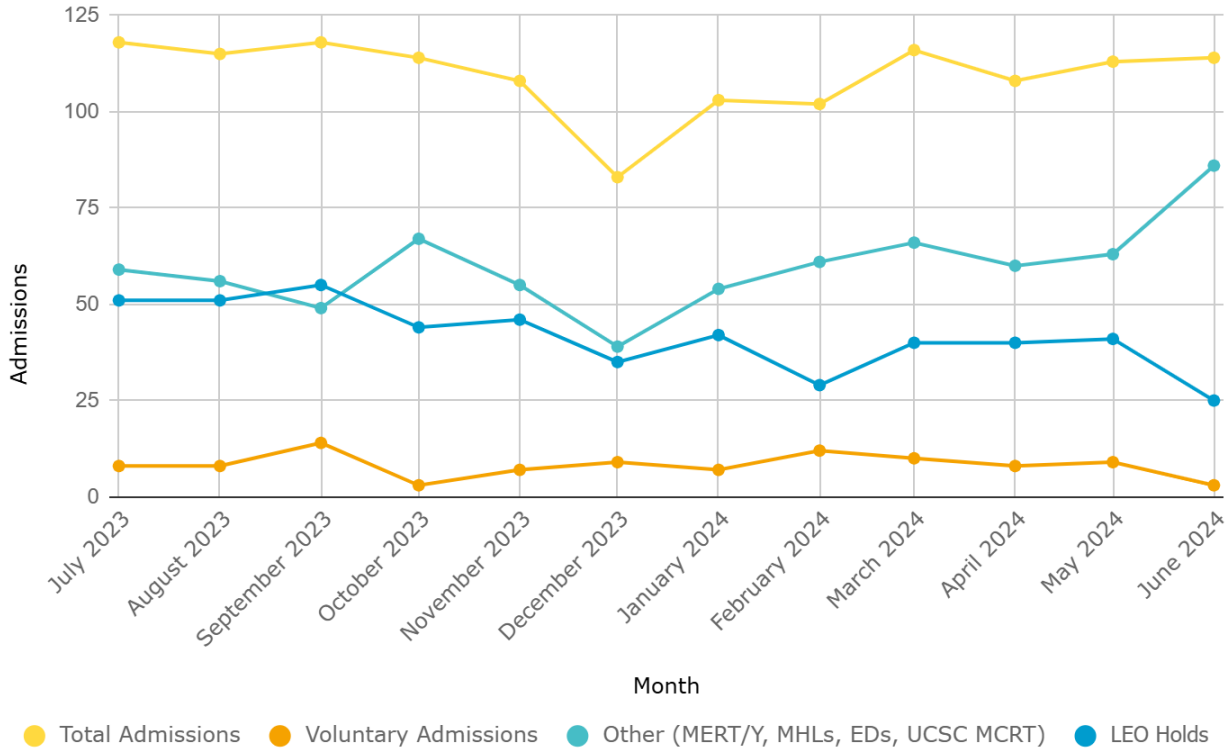
Crisis Care Facilities

CSP Admissions

The County's CSP, operated through Telecare, admitted a total of 1,312 patients during FY23-24, for an average of 109 patients per month. Most CSP admissions during this period were a result of referrals from MCRTs or Emergency Departments (EDs) (n = 715) or psychiatric holds made by law enforcement officers (LEOs) (n = 499), while a minority of were voluntary admissions (n = 98). The CSP had 60 average admissions from MCRTs or EDs per month, 42 average admissions from LEO psychiatric holds per month, and 8 average voluntary admissions per month. Overall, the number of monthly CSP admissions incidents remained relatively steady throughout the fiscal year, with a notable decrease in December 2023 (see Figure 15).

[30] Data Source: Stakeholder Survey

Figure 15. Monthly CSP Admissions, FY23-24[31]



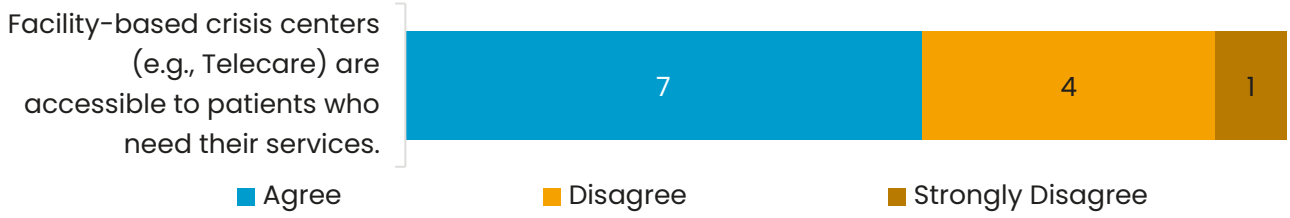
Stakeholder Perceptions of CSP Access and Overall Behavioral Health Crisis Services

About half of crisis continuum stakeholders surveyed agreed that the County's facility-based crisis centers, such as Telecare's CSP, are accessible to patients who need their services (7 out 12; see Figure 16). Some survey respondents shared that crisis care facilities are accessible for adults, but not for youth. Others indicated that the CSP frequently causes delays in patient care.

> *"Facility-based crisis centers are accessible for adults. It is an extreme barrier to not have facility-based crisis centers for teens. Sending them to the ER and then having them be transported is to a facility as far as Modesto is terrible."*
> *-Stakeholder Survey Respondent*

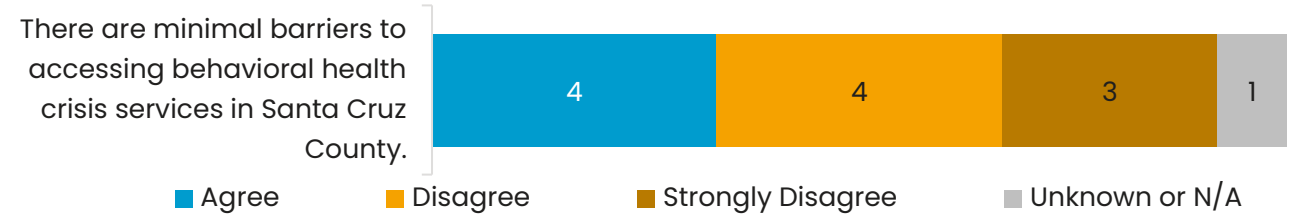
[31] Data Source: CSP Database

Figure 16. Stakeholder Perceptions of CSPs, FY23-24, N=12[32]



Among crisis continuum stakeholders surveyed, about half disagreed or strongly disagreed that there are minimal barriers to behavioral health crisis service access in Santa Cruz County (7 out of 12; see Figure 17). Focus group participants cited stigma around receiving care, negative previous experiences with the crisis system, and limited capacity of resources as barriers to accessing behavioral health services in Santa Cruz County.

Figure 17. Stakeholder Perceptions of Barriers to Crisis Service Access, FY23-24, N=12[33]



EQ3: Baseline Behavioral Health Patient Outcomes

This section highlights baseline indicators of behavioral health patient outcomes in Santa Cruz County for comparison to future years as Crisis Now continues its implementation. Specifically, this section describes baseline crisis continuum stakeholder perceptions of patient crisis dispositions and appropriate level of care placement, as well as the frequency of MCRT-initiated psychiatric holds, emergency department visits, and service referrals during FY23-24.

Summary

Crisis continuum stakeholders report that MCRTs are effectively de-escalating crises and connecting individuals to the resources that are most appropriate for their level of need. Stakeholders have mixed perceptions about whether most clients are placed into the most appropriate level of care, and many are unclear whether the changes to the crisis continuum have led to a decrease in unnecessary hospitalizations. In FY23-24, most

[32] Data Source: Stakeholder Survey
[33] Data Source: Stakeholder Survey

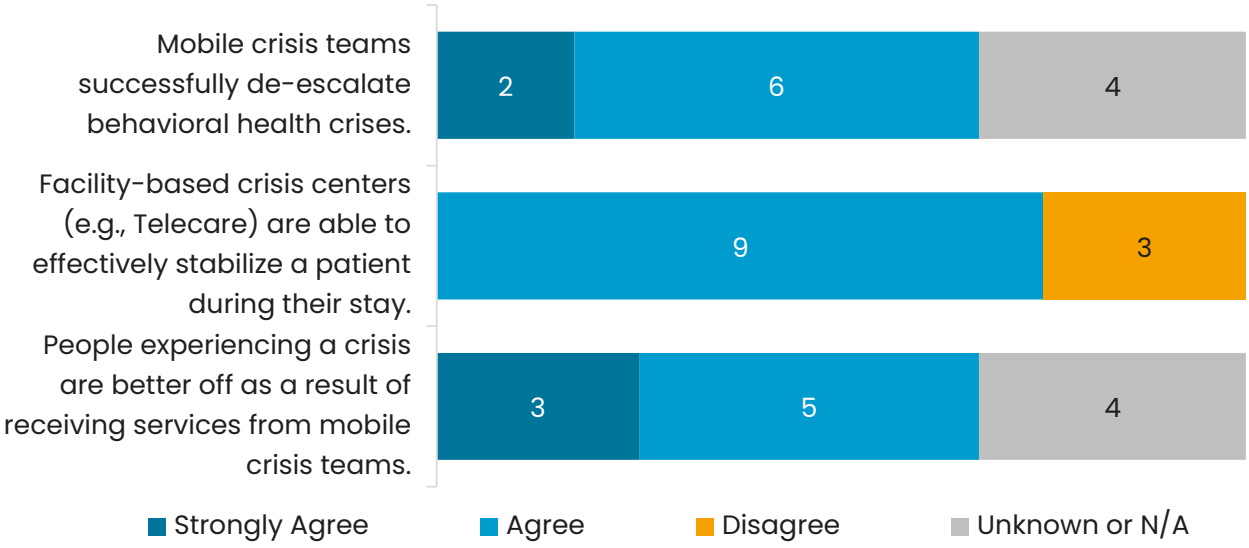
MCRT incidents did not involve a psychiatric hold assessment or transport to an emergency department. MCRTs provided a variety of service referrals to clients during mobile crisis incidents that occurred throughout FY23-24.

Stakeholder Perceptions of Crisis Dispositions

Most crisis continuum stakeholder survey respondents agreed or strongly agreed that MCRTs successfully de-escalate behavioral health crises (8 out of 12)**, that crisis centers stabilize patients** (9 out of 12)**, and that people are better off because of MCRT services** (8 out of 12; see Figure 18). During focus groups, law enforcement stakeholders further agreed that MHLs are an invaluable resource for safely and effectively meeting the needs of community members who are experiencing a behavioral health crisis.

> *"MHLs were the best addition to the [police] department—so beneficial and helpful. They changed the dynamic." -Focus Group Participant*

Figure 18. Stakeholder Perceptions of MCRT & Crisis Care Facility Effectiveness, FY23-24, N=12[34]



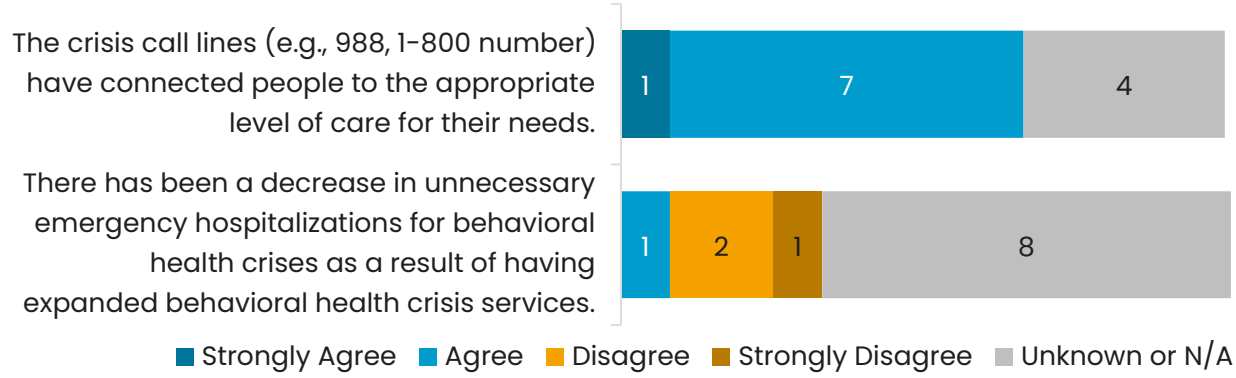
Stakeholder Perceptions of Appropriate Level of Care Placement

Early crisis continuum stakeholder perceptions about system placement of clients into appropriate levels of care varied. For instance, two thirds of stakeholder survey respondents agreed or strongly agreed that crisis call lines have connected individuals to the appropriate level of care for their needs (8 out of 12). In contrast, nearly all respondents disagreed or were uncertain in response to the notion that the Crisis Now

[34] Data Source: Stakeholder Survey

expansion has reduced unnecessary behavioral health emergency hospitalizations (11 out of 12). Several survey respondents indicated that it is too early in the Crisis Now implementation process to know whether the system has demonstrated these positive effects.

Figure 19. Stakeholder Perceptions of Level of Care Outcomes, FY23-24, N=12[35]



MCRT-Initiated Psychiatric Holds

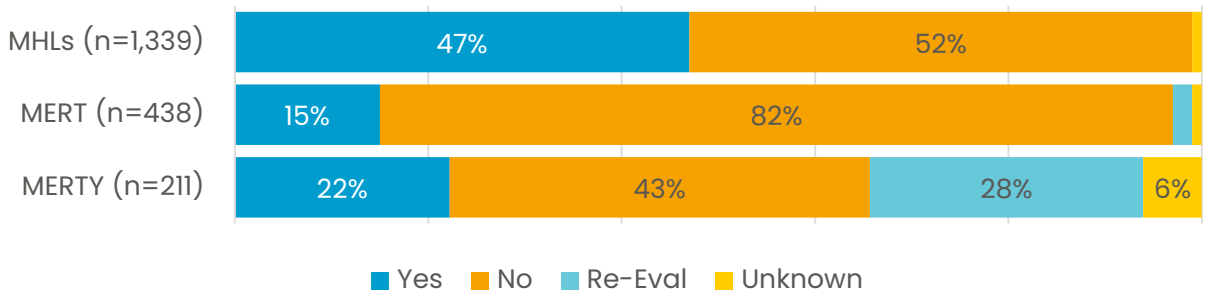
Psychiatric holds (also referred to as "5150" holds for adults and "5585" holds for youth) are a type of involuntary behavioral health disposition for individuals whose mental health disorder renders them a danger to others, to themselves, or gravely disabled.[36] The primary goal of a psychiatric hold is to mitigate the risk of harm to self or others and provide behavioral health support, for up to 72 hours, to stabilize an individual in crisis.

Over one third of all MCRT incidents involved a psychiatric hold assessment during FY23-24 (37%; see Figure 20). However, nearly half of MHL incidents involved a psychiatric hold assessment (47%), while 22% of MERTY incidents and 15% of MERT incidents involved the completion of a psychiatric hold assessment.

[35] Data Source: Stakeholder Survey

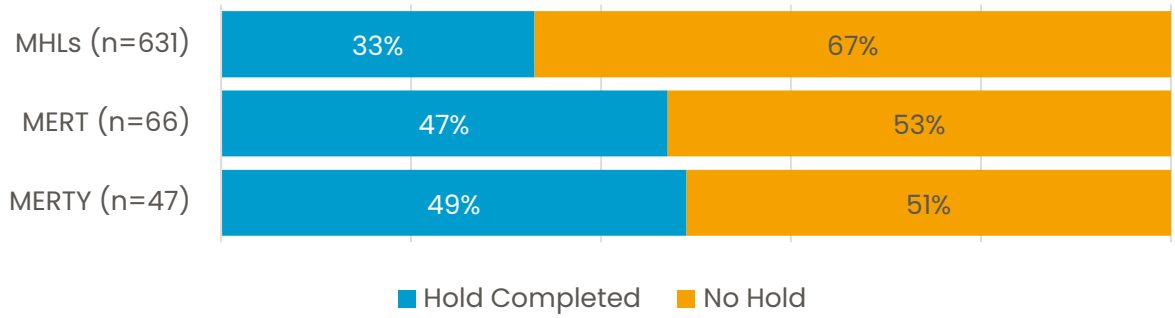
[36] California Legislative Information. (n.d.). *Code section*. California Code, WIC 5150. leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5150

Figure 20. Proportion of MCRT Incidents with Psychiatric Hold Assessments, FY23-24[37]



Of the MCRT incidents in which psychiatric hold assessments were completed, most did not result in a written psychiatric hold (65%; see Figure 21). A smaller proportion of assessments performed during calls served by MHLs resulted in holds (33%) compared to those performed during calls served by MERT (47%) and MERTY (49%).

Figure 21. Proportion of MCRT Incidents where Psychiatric Hold Assessments Resulted in Psychiatric Holds, FY23-24[38]

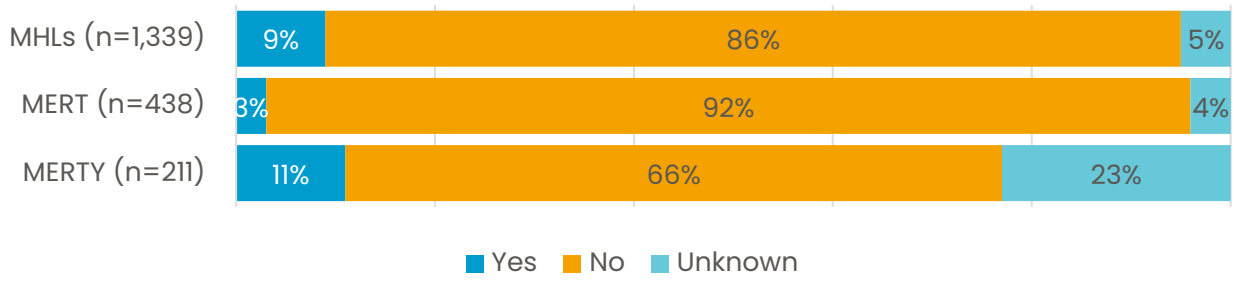


MCRT-Initiated Emergency Department Visits

For the overwhelming majority of MCRT incidents during FY23-24, clients were *not* sent or taken to the emergency department at Watsonville Community or Dominican Hospitals (85%; see Figure 22). Calls served by MHLs and MERTY had a slightly higher proportion of clients sent to the hospital (9% and 11%, respectively) compared to incidents responded to by MERT (3%).

[37] Data Source: MERT, MERTY, & MHL Workbooks
[38] Data Source: MERT, MERTY, & MHL Workbooks

Figure 22. Proportion of MCRT Incidents where Clients were Sent/Taken to Emergency Department, FY23-24, N=12[39]



MCRT-Initiated Service Referrals

MCRTs provided a variety of service referrals to clients during mobile crisis incidents that occurred throughout FY23-24 (see Table 4). Although approximately one-third of MERT and MERTY incidents involved clients who were already connected to services, MERT and MERTY staff made frequent referrals to SCCBH, Law Enforcement or MHLs, Emergency Departments, and insurance or medical care. Although fewer MHL incidents involved clients who were already connected to services, approximately one-third were referred to SCCBH or other mental health services.

Table 4. Key Service Referrals Made Across MCRT Incidents, FY23-24[40]

Category	MERT (N=438 incidents)		MERTY (N=211 incidents)		MHLs (N=1,339 incidents)	
	n	%	n	%	n	%
Already Connected to Services	144	33%	66	31%	111	9%
SCCBH or Mental Health	95	22%	56	27%	426	32%
Law Enforcement or MHLs	65	15%	23	11%	-	-
Emergency Department	43	10%	33	16%	49	4%
Private Insurance	12	3%	39	18%	-	-
Primary Care Provider/Medical	19	4%	20	9%	123	9%

EQ4: Santa Cruz Behavioral Health System Baseline Indicators

This section highlights baseline indicators of Santa Cruz County's Behavioral Health System for comparison to future years as Crisis Now continues its implementation.

[39] Data Source: MERT, MERTY, & MHL Workbooks

[40] Data Source: MERT, MERTY, & MHL Workbooks. Note that service referrals are presented at the MCRT incident-level and are not mutually exclusive (i.e., multiple service referrals were often made during the same incident).

Specifically, this section describes the baseline workforce development for SCCBH and FSA staff, as well as baseline crisis continuum stakeholder impressions and secondary administrative data on other system-level factors that may be associated with Crisis Now efforts, including emergency department boarding and diversion, and ambulance calls with a behavioral health component during FY23-24.

Summary

While there have been some challenges hiring for positions across the crisis continuum, the County has been working to hire staff to support mobile crisis teams. Boarding and emergency department diversion data suggest that other parts of the system, like hospitals and EMS, are also feeling the pressures of limited capacity.

Workforce Development

As with many Counties and projects, hiring and retaining staff has been challenging across the Santa Cruz County crisis continuum. Focus groups with stakeholders and leaders in behavioral health, 911 dispatch, law enforcement, fire departments, and emergency medical services indicate that staff recruitment and retention has been an ongoing challenge that poses a significant hindrance to robust system health. Staff note numerous factors that have contributed to this challenge, including the rising cost of living, competitive salaries out-of-county, as well as high burnout across crisis continuum care providers.

To provide 24/7 mobile crisis coverage as part of adherence to the Crisis Now model, SCCBH and FSA are currently working to hire and train staff (see Figure 23 for the intended teams and coverage periods). Currently, MERTY and FSA are fully staffed for their respective coverage shifts (i.e., day shift for MERTY; swing and night shifts for FSA). However, FSA is still training some hired staff for the overnight shift. The MERT and MHLs are still working to hire additional staff at the time of this report (see Table 5).

Figure 23. Mobile Crisis Response: Intended 24-hour Coverage Periods, FY23-24[41]

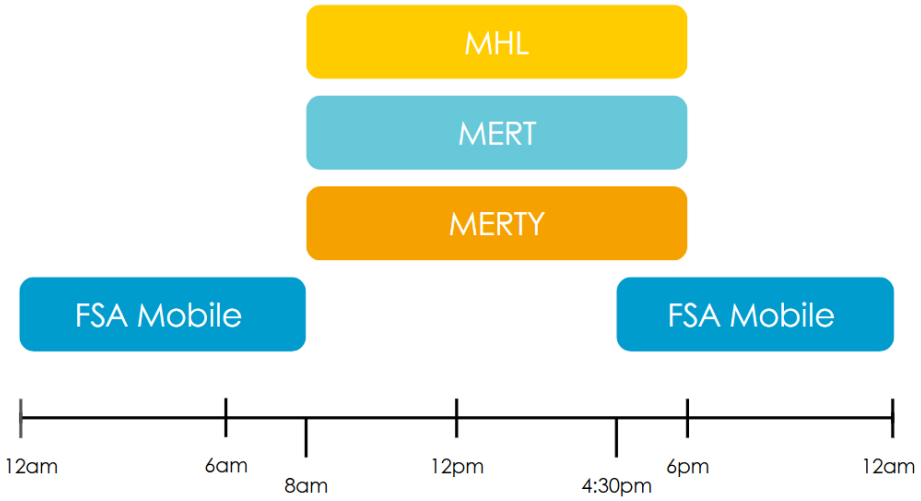


Table 5. MCRT Workforce Snapshot, Fall 2024[42]

	MERT	MERTY	MHLs	FSA
Current BH leadership staff	1 manager; 1 supervisor; 1 supervisor vacancy			1 manager; 3 supervisors
Current BH field-based Staff & Vacancies	4 hired; 2 vacancies	4 hired; no vacancies	3 hired; 4 vacancies	12 hired; no vacancies
Core Partner(s)	SCCBH, FSA	SCCBH, Volunteer Center	Sheriff's Office, Watsonville PD, Santa Cruz PD	SCCBH
Deployment	North & South Counties	North & South Counties	North & South Counties	North & South Counties
Coverage	7 days per week, 8am-6pm	7 days per week, 8am-6pm	7 days per week, 8am-6pm	7 days per week; 4:30am-8am next day

Boarding, Emergency Department Diversion, & EMS Workload

In its initial proposal for MHSA Innovation funding, SCCBH cited boarding[43] of behavioral health patients in emergency departments as a significant stressor on the health of the overall system. During focus groups, local hospital staff shared that their **emergency departments were often overwhelmed by the number of behavioral health patients**

[41] Data Source: Workforce Tracker
[42] Data Source: Workforce Tracker
[43] In this context, boarding refers to a practice in which behavioral health patients are held in emergency departments until a psychiatric care facility bed becomes available; U.S. Department of Health and Human Services. (2008, October 28). *A Literature Review: Psychiatric Boarding*. Office of the Assistant Secretary for Planning and Evaluation. aspe.hhs.gov/reports/literature-review-psychiatric-boarding-0

that they receive. Because the emergency departments in SCC have a limited number of beds for adults and youth (including 24 at Dominican Hospital and 12 at Watsonville Community Hospital), admission of patients on psychiatric holds or who have other behavioral health needs without an urgent medical concern strains emergency department capacity. Some hospital staff focus group participants described regularly having between six and eight patients on psychiatric hold in their emergency rooms.

"Even freeing up a single [hospital] bed would help the entire system."
-Hospital Focus Group Participant

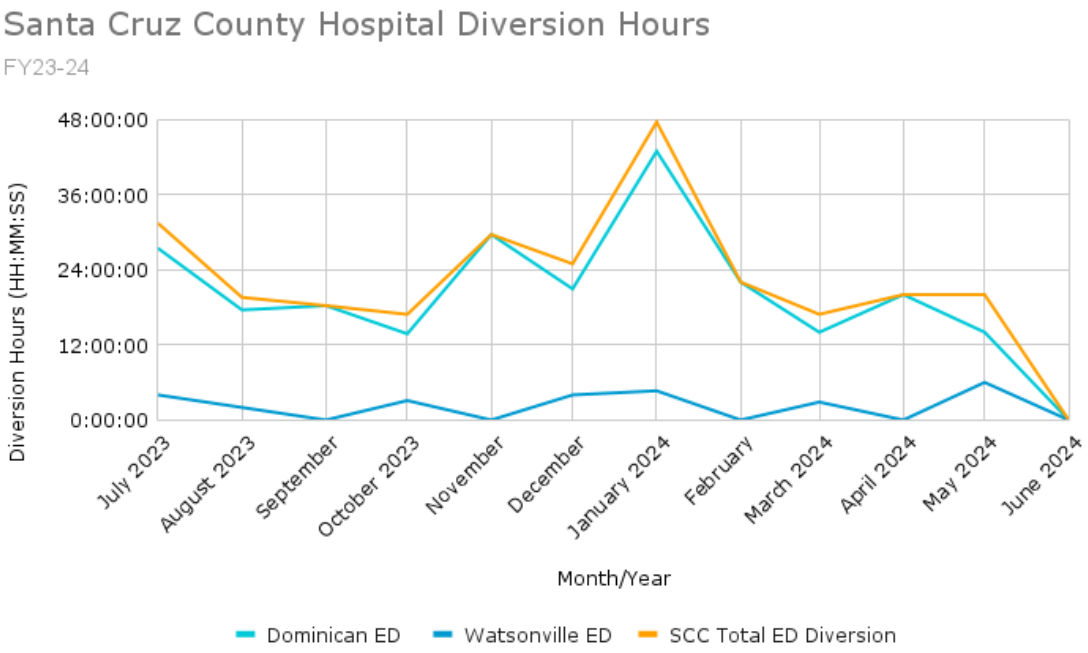
In addition to the strain that boarding places on hospital resources, emergency departments are often not considered the most appropriate level of care for patients experiencing a behavioral health crisis. Some focus group participants described the emergency department as a "dumping ground," resulting in patients waiting for long periods of time "without any support beyond having a bed and observation."

"We [Emergency Departments] are providing a safe storage place for mental health patients, but we're not providing any services beyond a watchful eye."
– Hospital Focus Group Participant

The strain that boarding creates for emergency departments can also impact the larger emergency health system. When emergency departments have reached critical capacity (i.e., they can no longer safely accept additional patients), the department will go on "diversion". Ambulances cannot transport patients to emergency departments on diversion; they must transport patients to the next closest and most appropriate emergency department, which may be across the County or outside of County limits. This may increase ambulance transport times, delaying definitive care for patients. Increased travel time to return to their service area also keeps ambulances out of service for longer periods, decreasing EMS availability and increasing response times. Both emergency department diversion and spikes in calls for service within the County (e.g., vehicular accidents that require multi-ambulance response) contribute to a decrease in available EMS resources. This strain on the system is referred to as ambulance "drawdown", as fewer and fewer ambulances are available for dispatch. **According to focus groups with EMS leadership, system levels regularly drop to "level 1 or 0", meaning there is only one available ambulance or no available ambulances in the County to respond to emergencies.**

SCC's two hospital emergency departments went on diversion for a combined 266 total hours over the course of FY23-24. Average monthly time on diversion was 20 hours for Dominican Hospital and 2 hours for Watsonville Community Hospital. As shown in Figure 24, total diversion hours varied month to month, with a sharp increase during January 2024 (with 47 total diversion hours across the two hospitals). Dominican Hospital's monthly diversion hours exceeded Watsonville Community Hospital's diversion hours each month during FY23-24, which may reflect Dominican Hospital's closer proximity to higher-population communities relative to that of Watsonville Community Hospital.

Figure 24. Monthly SCC Hospital Diversion Hours, FY23-24[44]

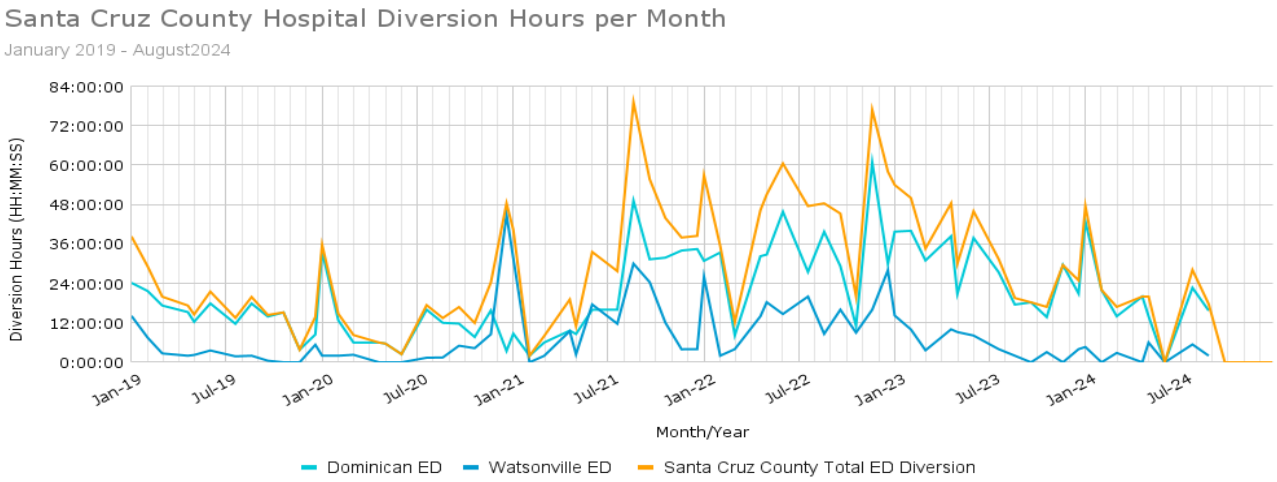


Because there are many factors that may impact system-level metrics like hospital diversion hours, this baseline evaluation considered possible residual effects of the Covid-19 pandemic on this measure. As shown in Figure 25, total diversion hours saw sharp increases and increased volatility between 2020 and 2023. Although diversion hours appeared to be trending downward beginning in 2023, average diversion hours and volatility still exceed some pre-pandemic levels. As noted in a 2022 Diversion Report completed by the Santa Cruz County Health Services Agency, the volatility in month-to-month diversion hours indicates that hospital emergency departments are regularly operating at or near capacity.[45]

[44] Data Source: EMS Records

[45] Emergency Medical Care Commission. (2024, October). "Item 6: Draft Annual Diversion Report (Greg Benson)." **In** Minutes of Santa Cruz County Emergency Medical Care Commission". 1400 Emiline Ave, Santa Cruz.

Figure 25. Monthly SCC Hospital Diversion Hours, 2019-2024[46]



On average, there are eight ambulances in service during the day shifts and five ambulances in service for night shifts, totaling 156 unit hours to cover Santa Cruz County. During FY23-24, EMS responded to over 28,000 calls for service in Santa Cruz County, with an average of 76.7 incidents per day. **EMS data indicate that approximately 12% of ambulance calls for service were considered behavioral health-related in FY23-24** (see Table 6). For the purposes of this evaluation, mental and behavioral health-related calls include the following provider impressions documented in patient care reports for EMS: behavioral health/psychiatric crisis (4.4%), overdose/poisoning/ingestion (3.4%), agitated delirium (0.1%), and alcohol intoxication (4.5%).

Table 6. SCC Behavioral Health-Related Ambulance Calls for Service, FY23-24[47]

Call Type	Number of Calls (FY23-24)	Weekly Average Number of Calls	Percentage of Total Call Volume
Behavioral/Psychiatric Crisis	1,233	23.7	4.4%
Overdose/Poisoning/Ingestion	951	18.3	3.4%
Agitated Delirium	39	0.8	0.1%
Alcohol Intoxication	1,258	24.2	4.5%
Total	**3,471**	**66.8**	**12.4%**

Unit utilization rate (UUR) is a measure of ambulance workload, which may be affected by the County's adoption of the Crisis Now model. For the purposes of this evaluation, the UUR is calculated by dividing the average number of calls for service by the total unit hours within a 24-hour period. **During FY23-24, the UUR was 0.5, indicating that, on average, an ambulance could be expected to spend 50% of its time occupied on calls**

[46] Data Source: EMS Records
[47] Data Source: EMS Records

(e.g., responding, treating, transporting). The UUR varies slightly between day and night shifts; the day shift UUR is 0.5, and the night shift UUR is 0.4. Target UURs vary between types of ambulance services, with 911 services aiming for a UUR between 0.3 and 0.5 to ensure there are enough available ambulances to respond to emergencies.[48] A lower UUR is also essential to mitigate provider fatigue and medical errors. Per EMS leadership, Santa Cruz County is aiming for a UUR of 0.4, a workload level which is associated with a higher quality of patient care.

Without hospital data, the number of ambulance transports to emergency departments for medically necessary reasons is not clear (versus the number of patients that may have been more appropriately directed to non-medical behavioral health services). In SCC, ambulances are not permitted to transport patients to the CSP; they are only allowed to go to an emergency department. Some focus group participants reported that ambulances are only called when there is a clear and urgent medical need; however, focus groups with EMS suggested that a sizeable portion of their behavioral health related calls likely did not require an emergency department evaluation. For example, some stakeholders noted that law enforcement may be inclined to have an ambulance transport an individual experiencing a behavioral health crisis if that individual is combative or attempts to engage in self-harm while in custody. However, others noted that reduced law enforcement capacity may prompt an officer or deputy to rely on an ambulance for transport.

As MCRTs increase the depth and breadth of their coverage, it is expected that that they will take a larger share of behavioral health-related calls. With a current total of ten MCRT units in service during a 24-hour period (including 4 MERT/Y day shift units, 2 FSA swing shift units, 1 FSA night shift unit, and 3 MHL teams), MCRT coverage is approaching the number of ambulances in service (13 ambulances) during the same period. The MCRT call volume is also expected to increase as crisis continuum stakeholders, community partners, and the public increase their awareness of MCRT services. This shift in call coverage would presumably improve measures like the UUR and ensure more individuals connect to services appropriate to their needs. The consensus among focus group participants is that **reducing the number of patients with psychiatric holds in the emergency department would substantially improve their capacity, thus improving the overall health of the crisis continuum**.

[48] Fitch, J. J., & Knight, S. (2017, August 2). The New EMS Imperative: Demonstrating Value. Fitch and Associates - Helping improve emergency services for over three decades.

Appendices

Appendix A

High-Tech Crisis Call Centers: *Someone to Call*

Crisis Call Centers play a crucial role in assessing and managing crisis situations by providing immediate crisis support over the phone, referring community members to the most appropriate resource(s) for their needs, and/or dispatching a mobile crisis team to provide in-person support.

Currently, 988 is a relatively new national crisis call number that is associated with nearly 200 call centers that meet National Suicide Prevention Line (NSPL) standards. To align with fidelity to the Crisis Now model, 988 call centers must meet robust technological requirements, including GPS for intervention with callers in imminent risk of harm, and linkage with service area in-patient and out-patient facilities to ensure resources are available before someone is referred. Additionally, 988 call centers must also be able to interact with community members through chat and texting capabilities. This is particularly important for lowering barriers to seeking support and reaching youth.

Mobile Crisis Response Teams: *Someone to Respond*

For those experiencing an acute crisis that requires in-person support for safe resolution, a mobile crisis team can provide excellent on-site care. Mobile crisis response teams (MCRTs) usually consist of a two-person (clinician and peer support specialist) team and provide timely face-to-face response and assessment. If a caller can be best served by remaining in the community through safety planning and follow-up, the MCRTs can support that process. If a caller cannot be stabilized in the community and would benefit from a higher level of care, MCRTs can support those transportation needs. MCRTs reduce the unnecessary dispatch of police and ambulance services–keeping system levels up and emergency response times down. Direct MCRT dispatch also helps maintain a calm environment for the caller, as the presence of officers and ambulances can escalate a situation for someone already in crisis.

To meet Crisis Now Model standards, MCRT services should be provided to “qualifying” calls and meet comprehensive operational requirements. For a crisis call to “qualify” for MCRT services it must be:

- Provided to an individual experiencing a behavioral health disorder crisis
- Provided outside of a facility setting
- Composed of multi-disciplinary staff, and
- Be available 24/7 throughout the entire year

Additionally, MCRT teams should have the capacity to:

- Respond in a timely manner
- Coordinate follow-up care, referrals, and/or transportation
- Adhere to privacy and confidentiality standards for patient records
- Provide trauma-informed care and harm reduction strategies, and
- De-escalate crises as needed

Crisis Care Facilities: *Somewhere to Go*

Whether through a mobile crisis response team evaluation or self-admission, those experiencing a mental health crisis should be able to access a therapeutic environment to receive further care. Crisis facilities operating under a Crisis Now framework utilize a "no wrong door" approach, where any individual may seek support at any point of entry in the crisis continuum without a referral, proof of insurance, or medical clearance prior to admission.

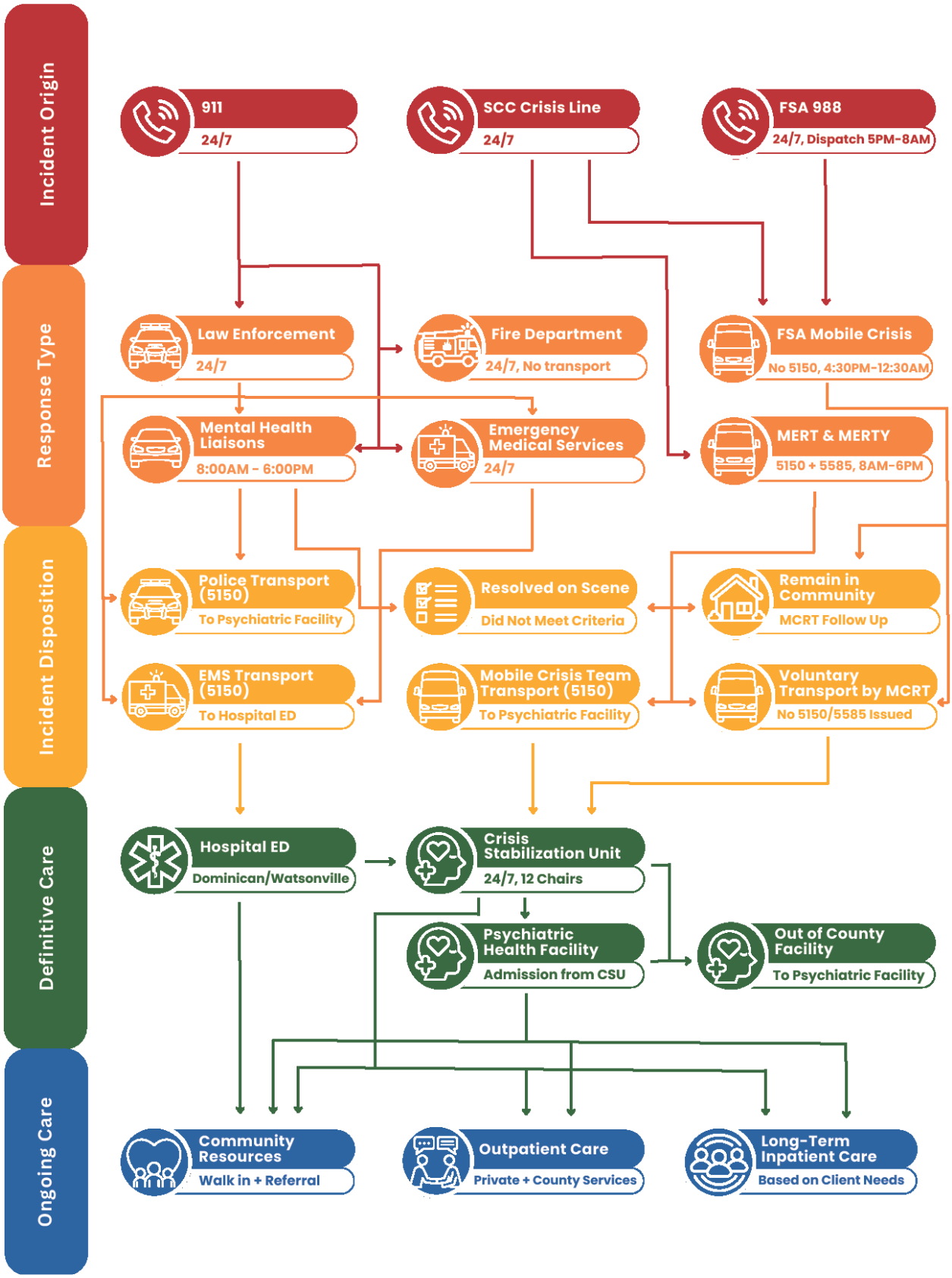
Crisis facilities provide the following services:

- Psychiatric evaluation by a psychiatrist or Psychiatric Nurse Practitioner that includes a risk assessment and medication evaluation, a brief medical screening by a nurse to address any potential co-occurring medical conditions
- A psychosocial assessment by a clinician
- Crisis stabilization services with a peer-focused, recovery-oriented methodology; and
- Comprehensive discharge planning with care coordination for future services.

For community members who may need crisis support beyond the initial 24-hour crisis stabilization period, they are paired with subacute short-term (2-5 day) facilities. These facilities must be able to accommodate individuals who are placed on involuntary psychiatric holds and be licensed to provide seclusion and restraint interventions.

Appendix B

Santa Cruz County Crisis Now Systems Map



Appendix C

Data Sources and Collection Tools

Stakeholder Focus Groups & Interviews. As part of the initial discovery for this evaluation, RDA completed 3 focus groups with a total of 19 crisis continuum stakeholders in March 2024, including leaders from field-based mental health frontline agencies (i.e., MCRTs), location-based mental health frontline agencies (i.e., SCCBH, CSP), medical first responders (i.e., EMS, hospitals), local law enforcement and dispatch, and community advisory and direct care stakeholders. To collect additional insights for this baseline evaluation, RDA completed 5 focus groups with a total of 13 crisis continuum stakeholders in September 2024, including leaders from field-based mental health frontline agencies (i.e., MCRTs), location-based mental health frontline agencies (i.e., SCCBH, CSP), medical first responders (i.e., EMS), local law enforcement and dispatch, and community direct care stakeholders. All focus groups took place virtually via zoom. Each focus group was designed to gather unique insights from each group based on their position within the Crisis Now continuum. Focus groups involved discussions of Crisis Now project processes and implementation thus far, including changes made over time, as well as early perspectives on Crisis Now patient access and outcomes. Stakeholder focus group data were used to inform baseline findings for evaluation questions 1-4. Due to their positions within the County, staff were not permitted to receive gift cards for their participation.

Stakeholder Survey. In partnership with SCCBH, RDA developed and administered a voluntary electronic survey to collect crisis continuum stakeholder insights about Crisis Now implementation progress, perceptions of crisis service access within SCC, as well as early impressions of impact for participants and the community. The survey was sent to stakeholders identified through SCCBH's crisis continuum stakeholder listserv. The survey was open for three weeks, and 18 total stakeholders completed the survey between September and October 2024. The stakeholders who responded included 9 behavioral health providers (50%), 4 law enforcement officers (22%), 3 EMS/fire personnel (17%), 1 medical/healthcare provider (6%), and 1 social services provider (6%). Stakeholder survey responses were used to inform baseline findings for evaluation questions 1-4. Due to their positions within the County, staff were not permitted to receive gift cards for their participation.

Crisis Now Fidelity Assessments. RDA used secondary assessment findings regarding SCCBH's fidelity to the Crisis Now model to further inform the findings in this baseline evaluation. SCCBH contracted with RI International and completed an assessment of

Crisis Now fidelity in the Fall of 2022. The results of this assessment were documented in the County's MHSA Proposal for Crisis Now and were used to inform baseline findings for evaluation question 1.

Project Meeting Notes. Each month since contracting with RDA in February 2024, SCCBH staff attend virtual monthly meetings with RDA to identify and discuss project implementation, updates, successes, challenges, and evaluation activities/progress. The written notes from each of these meetings were used to inform baseline findings for evaluation questions 1-4.

CSP Data Sheet. RDA used secondary data from SCCBH's Adult Crisis Stabilization Program (CSP) data sheet to inform baseline findings for evaluation question 2. This data sheet consisted of aggregate data on the total number of psychiatric holds the CSP received between July 2023 and June 2024, including the origin of the psychiatric hold and whether or not it was voluntary.

MERT, MERTY, and MHL Workbooks. RDA used Crisis Now participant data from SCCBH's existing crisis MERT, MERTY, and MHL program workbooks to inform baseline findings for evaluation questions 2 and 3. These workbooks consisted of incident-level data for MERT, MERTY, and MHL incidents that took place anytime between July 1, 2023-June 30, 2024. Information provided within the workbooks included: client demographics, descriptive information about the crisis incident, and service referrals.

Workforce Tracker. RDA collaborated with SCCBH to develop and complete a workforce tracker to inform baseline findings for evaluation question 4 regarding system-level outcomes related to workforce. This excel spreadsheet includes information regarding: SCCBH staff hires and retention; staff vacancy rate; and staff trainings, by topic.

EMS Records. RDA used aggregate data from SCC EMS to further inform baseline findings for evaluation question 4 regarding system-level outcomes. These records consisted of aggregate data on hospital emergency department diversion hours and ambulance drawdown times between 2019 to 2024.