CalHHS

AB 988 Chart Book

An Inventory of Needs, Services and Gaps of the Behavioral Health Crisis System

December 30, 2024

**Disclaimer: The information presented in this document is drawn from various sources. It is presented as a resource used to collect information and inform development of the Five-Year Implementation Plan.*

Table of Contents

I. Purpose of the Chart Book

AB988 and the Purpose of the Chart Book

- This Chart Book is a compendium of information gathered for *Building California's Comprehensive 988-Crisis System: Five-Year Implementation Plan to the State Legislature*.
- It seeks to provide data and information relevant to the following Recommendation Area of AB988:
  - (12) Findings from a comprehensive assessment of the behavioral health crisis services system that takes into account infrastructure projects that are planned and funded. These findings shall include an inventory of the infrastructure, capacity, and needs for all of the following:
    A. Statewide and regional 988 centers
    B. Mobile crisis team services, including mobile crisis access and dispatch call centers
    C. Other existing behavioral health crisis services and warm lines
    D. Crisis stabilization services
- The purpose is to inform the development of recommendations and activities contained in the Five-Year Implementation Plan, to document known behavioral health (BH) crisis service needs and services in California, and to outline key gaps in the BH crisis care continuum.

Methodology

- The Chart Book is an amalgamation of available information and data gathered from across the planning process; it presents a snapshot of crisis needs and services.
- Data sources are listed on each slide and include month and year of publication and/or when the data were collected or accessed
- Data sources include but are not limited to:
    - Publicly available datasets and dashboards (e.g., those accessed through CalHHS Open Data Portal), previously completed assessments and research publications, and federal, state, and county websites
    - Information provided by members of the 988 Crisis Policy Advisory Group (PAG), the Comprehensive Assessment Workgroup, and other workgroups organized as part of the 988 Five-Year Implementation Plan's development
    - Interviews and surveys conducted with state departments and agencies, 988 Crisis Centers, county behavioral health departments, relevant county partners (including but not limited to additional call lines and answer services, mobile crisis providers, first responder organizations, emergency departments, and other facilities that can receive persons experiencing a behavioral health crisis)

Note: County interviews focused on Los Angeles, Nevada, Riverside, Santa Clara, and San Luis Obispo Counties.

Desired Outcomes

Gaps in the Chart Book are drawn from four desired outcomes that animate a future state crisis care continuum for California.

The Future State…	Characterized by…
Consistent statewide access	▪ Increased capacity, affordability, and range of services ▪ Connecting people in crisis to immediate and ongoing care
High-quality services	▪ An array of essential crisis services across the continuum ▪ A comprehensive strategy for data measurement and quality of care that is inclusive of all populations and geographies
Coordination across and outside the continuum	▪ Offering the least restrictive responses to crisis ▪ Robust formal and informal community-based partnerships
Serves the needs of all Californians	▪ Services that are culturally and linguistically responsive ▪ Services that are person- and family-centered ▪ Services that are delivered regardless of insurance/payer source

Organization of the Chart Book

Data in the Chart Book are organized as follows:

- **Crisis Needs:** Population-level data of behavioral health crisis needs across California, including select information on populations of focus identified through the planning process
- **Call Demand Data:** Select information on utilization of 911, 988, and available crisis service utilization data
- **Inventory of Crisis Resources/Current and Planned Investments:** Select information from across California's behavioral health crisis care continuum (preventing crisis, responding to crisis, and stabilizing crisis)
- **Challenges and Opportunities to Meeting Needs/Demands:** Key takeaways from the Comprehensive Assessment Workgroup and specific gaps identified most relevant to the Five-Year Implementation Plan
- **Additional Facility Data:** Counts of different crisis receiving facilities in California

II. Crisis Needs

Understanding Crisis Needs in California

The purpose of this section is to identify current behavioral health crisis needs across California

- Data are organized by key indicators of population need and/or service demand:
  - Behavioral health-related mortality
  - Behavioral health morbidity
  - Police contacts and mental illness
  - Additional data on populations of focus
- Data points include, where applicable:
  - A California to national comparison
  - Geographic variations across CA state (e.g., by region/rurality)
  - Historical trends, as available
  - Demographic disparities, as available (e.g., stratified by race/ethnicity, age, sex, insurance status, etc.)
  - Information relevant to populations of focus identified in the CalHHS Crisis Care Continuum Plan and through the 988 Crisis planning process
- *Definition Note (California Department of Public Health):
  - Crude rates are the number of new cases (or deaths) occurring in a specified population per year, usually expressed as the number of cases per 100,000 population at risk
  - Age-adjusted rates are a weighted average of crude rates, where the crude rates are calculated for different age groups and the weights are the proportions of persons in the corresponding age groups of a standard population

Key Indicators of Population Need and/or Crisis Service Demand

1. Behavioral Health-Related Mortality
   a. Suicide rates
   b. Drug overdose fatalities
2. Behavioral Health Morbidity*
   a. Behavioral health-related emergency department (ED) visits
      i. Drug-related overdose ED visits
      ii. Non-fatal self-harm ED visits
      iii. ED treat-and-release from non-fatal self-harm injury (epicenter CA injury data online)
   b. Inpatient psychiatric stays
      i. Drug-related overdose hospitalizations
      ii. Psychiatric hospital transfers for non-fatal self-harm injury
3. Police Contacts and Mental Illness
   a. Incarceration at national, state, county levels
   b. Behavioral health-related involuntary treatment and incarceration as available
4. Additional Data on Populations of Focus:
   a. Persons with intellectual/developmental disabilities
   b. Veterans
   c. Unhoused persons

Indicators are drawn from both available research and future desired outcomes (as described on slide 6).

- Suicide and drug overdose fatalities are common population level surveillance data points used by departments of public health in California and nationally
- Presentation of individuals at emergency departments (EDs) with behavioral health conditions and ultimately admissions to inpatient psychiatric and substance use disorder (SUD) units are suggested by Brookings as key bellwethers for crisis needs
- Police contacts are indicative of a legislative aim of state and federal 988 legislation: the reduction of unnecessary law enforcement

1. Behavioral Health-Related Mortality:
(a) Suicide rates
(b) Drug overdose fatalities

Key Takeaway #1

Death by Suicide

- Almost 50,000 people died by suicide in the United States in 2022; 4,312 of those were in California.*
- California's age-adjusted suicide rate in 2022 was 10.4 deaths by suicide per 100,000 population, lower than the national rate of 14.2 per 100,000 population.**
- Across the state, suicide rates vary widely in rural and remote areas, experiencing higher rates both in California and nationally.**
- In 2021, Native populations had the highest rates of suicide of any racial/ethnic demographic.**
- Apart from multiracial youth, youth ages 10-24 have experienced a decline in suicide rates in California from 2021 to 2022, with Black youth having the highest suicide rates of any racial/ethnic demographic in California,** with LGBTQIA+ youth also at elevated risk.***
- Based on overall population rates, the highest risk of suicide was among males aged 85 years and older.**
- In 2020, suicide deaths among veterans aged 18 over accounted for 15 percent of all suicides in California.****

Sources:
*America's Health Rankings analysis of CDC WONDER, Multiple Cause of Death Files, United Health Foundation
**California Department of Public Health, California Injury Data Online EpiCenter, last accessed October 2024
***The Trevor Project, last accessed October 2024
****California Department of Public Health – Suicide among Veterans in California, 2020

Key Takeaway #1

Drug-Related Overdose Deaths

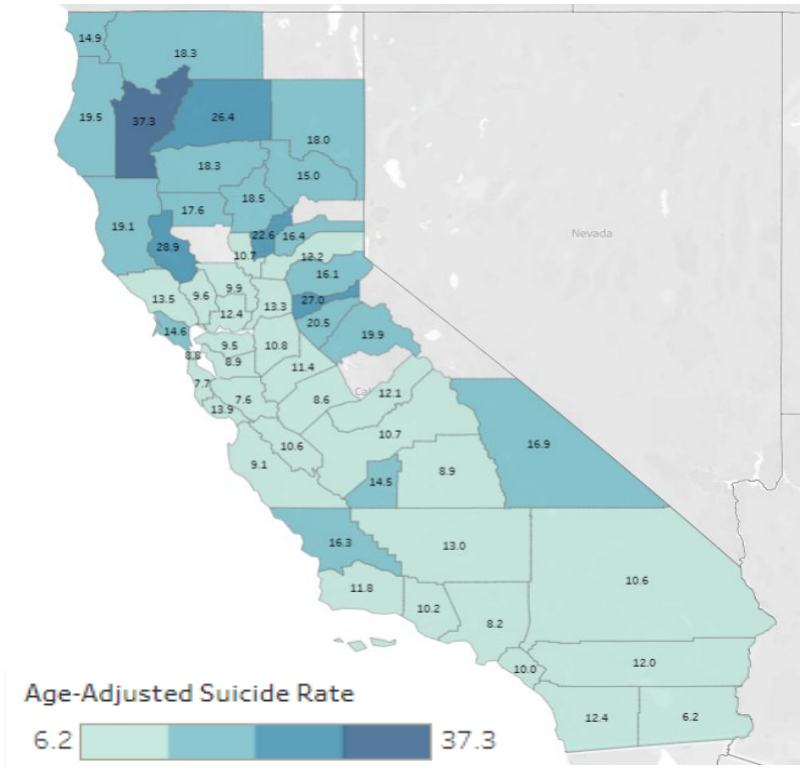
- Similar to national trends, California has experienced an increase in drug-related overdose deaths from 2020 to 2023, with Native Americans dying at the highest rate.
- Notably, the state overall had the 15th lowest drug overdose mortality rate in the country.*
- In 2022 regarding all drug-related overdose deaths in California:***
  - Native American and Alaska Natives had the highest age-adjusted rate for all drug-related overdose deaths in California.
  - 30- to 34-year-olds had the highest crude rate of all drug-related overdose deaths, followed by 55 to 59-year-olds in California.
- In 2022, opioids were the most common cause of drug overdose deaths.**
- In 2022 regarding any opioid-related overdose death in California:***
  - Native American and Alaska Natives had the highest crude rate of any opioid-related overdose death.
  - 30- to 34-year-olds had the highest crude rate of opioid-related overdose deaths compared to other age groups.

Sources:
*America's Health Rankings analysis of CDC WONDER, Multiple Cause of Death Files, United Health Foundation
** National Center for Health Statistics – Drug Overdose Mortality by State
***California Overdose Surveillance Dashboard. Prepared by California Department of Public Health (CDPH - Substance and Addiction Prevention Branch (SAPB).

1a. California Suicide Rates Overall

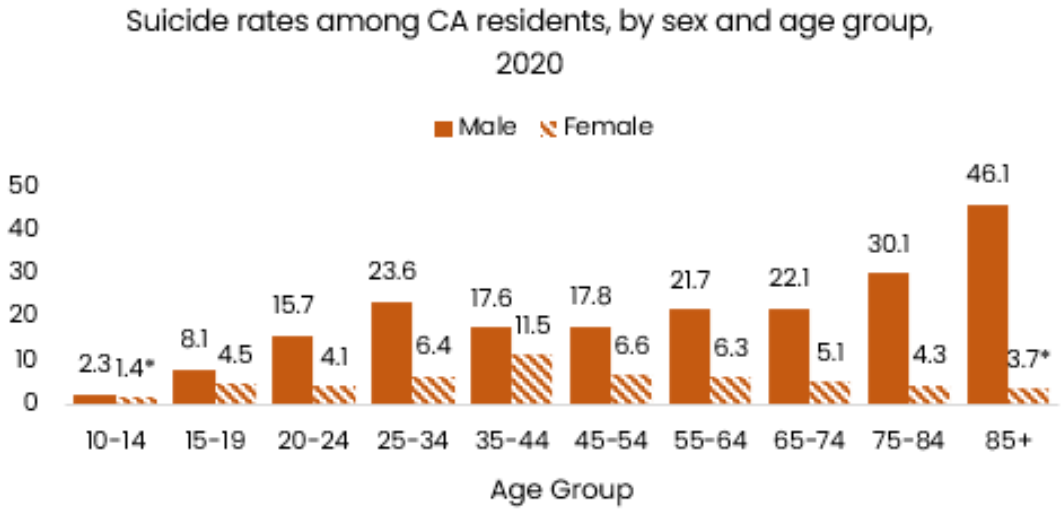
- California's suicide rate in 2022 was 10.4 deaths by suicide per 100,000 population, lower than the national rate of 14.2 deaths by suicide per 100,000 population.
- In 2022, a total of 4,277 individuals died by suicide in California.
- These rates vary widely by California county. The 2017–19 suicide rate per 100,000 population ranged from a high of 37.3 in Trinity County to a low of 6.2 in Imperial County.

Age-Adjusted Suicide Rate per 100,000 by County, 2017-2019



In 2020 in California:

- The highest rates of death by suicide were in males aged 85 years and older (46.1 per 100,000).
- Most people who died by suicide were White (61%) or Hispanic (23%).
- The highest rates of death by suicide were among people who were White (16.7 per 100,000).

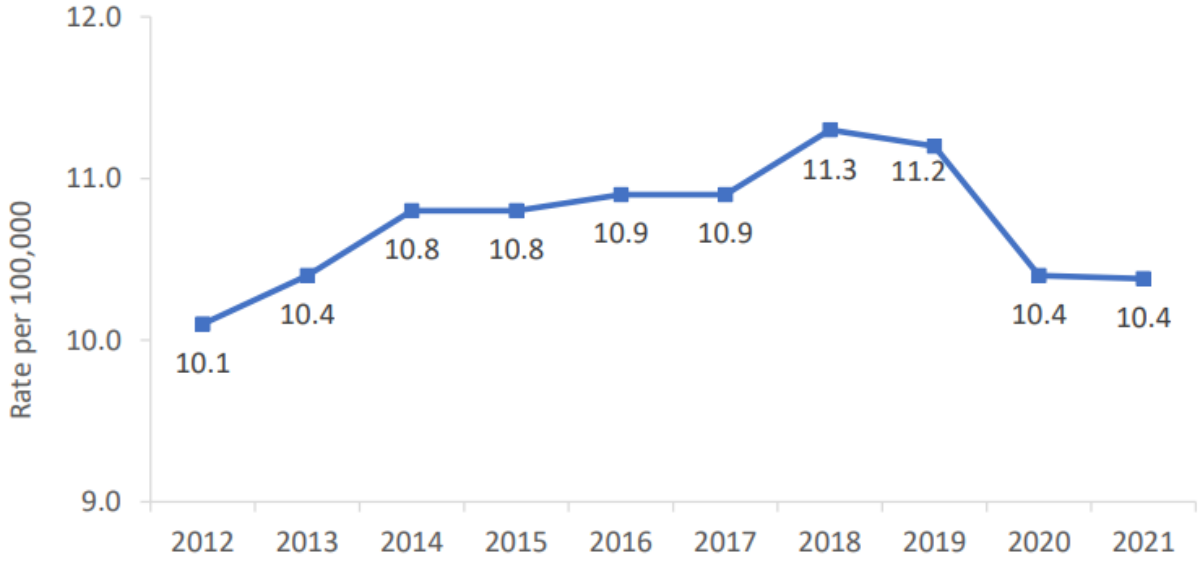


Source: America's Health Rankings analysis of CDC WONDER, Multiple Cause of Death Files, United Health Foundation; California Department of Public Health, California Injury Data Online EpiCenter; "Living Well / Reducing Suicide," Let's Get Healthy California

1a. Suicide Rates and Self Harm in California Over Time

Although suicide rates in California remained the same between 2020 and 2021, **self-harm ED visit rates in California increased almost six percentage points (5.7%) during the same period.**

Suicide Rates (per 100,000) among CA Residents, 2012-2021



Self-Harm Emergency Department Visit Rates (per 100,000) Among CA Residents, 2016-2021

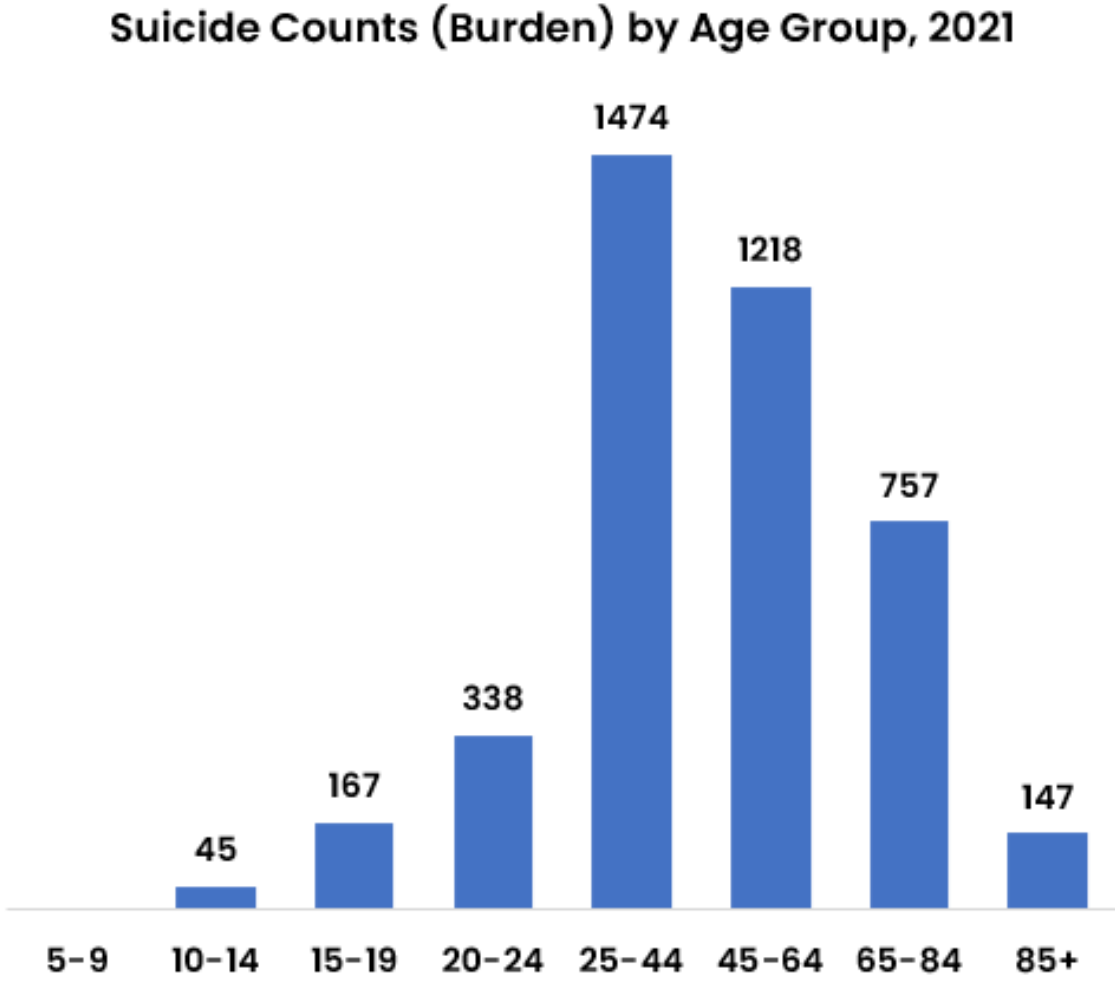
Source: Injury Data Brief: California Suicide and Self-Harm Trends in 2021

1a. Disparities in Suicide by Age: Burden for Youth and Older Adults

United States

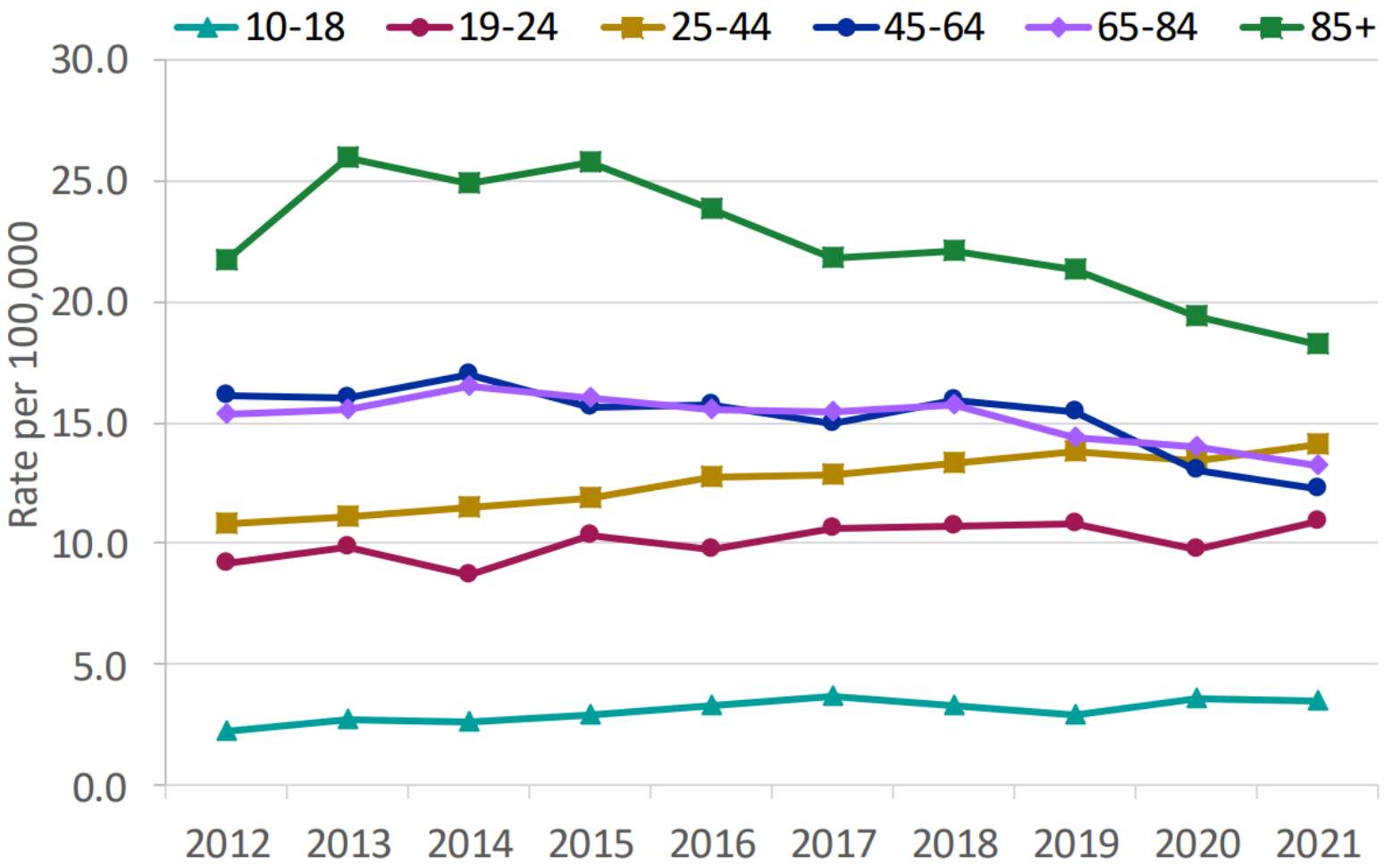
- Adults aged 35–64 years account for 46.8% of all suicides in the United States, and suicide is the 8th leading cause of death for this age group.
- **Youth and young adults** ages 10–24 years account for 15% of all suicides (11.0 per 100,000). Although youth die by suicide at a lower rate than other age groups, **suicide is the second leading cause of death and increased by 52.2% between 2000-2021**.
- **Adults ages 75 and older have one of the highest suicide rates** (20.3 per 100,000). Men ages 75+ have the highest rate (42.2 per 100,000) compared with other age groups.

California



Source: Centers for Disease Control and Prevention WONDER – Accessed 1/23/24; CDPH

1a. Older Adults and Youth Suicide Rates Over Time 2012-2021

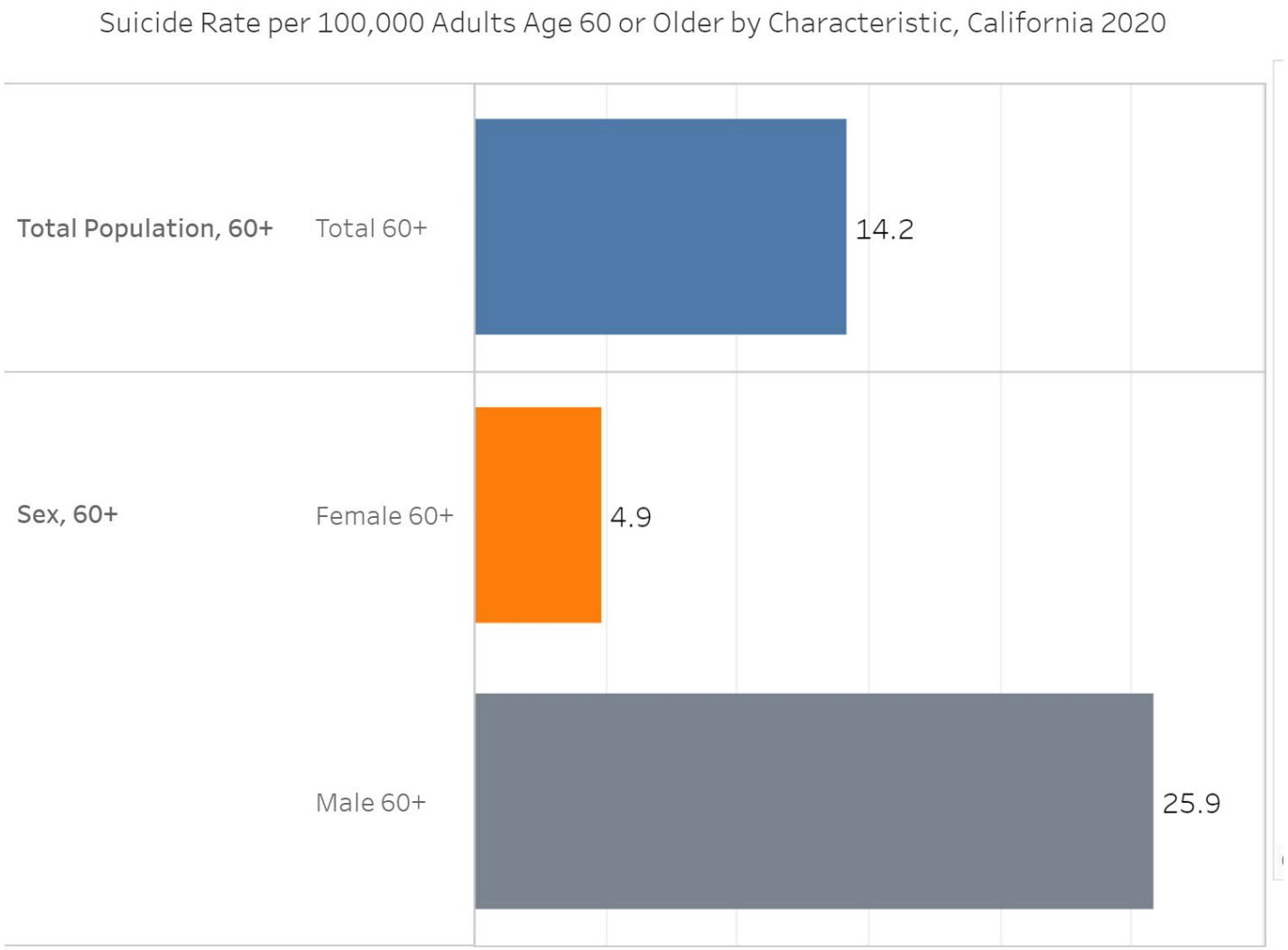


Between 2020 to 2021 in California:

- **Adults older than age 85 have the highest suicide rates** across all age groups.
- **Youth ages 19-24 had the largest increase in suicide rates**, compared with other age groups.

Source: 2011-2013 deaths: CDPH, Death Statistical Master File (DSMF); 2014-2021 deaths; CDPH, CA Comprehensive Master Death File (CCMDF); 2012-2021 population: CA Department of Finance P-3 Population Projection File (2010-2060); July 2021 Release

1a. Older Adults: Suicide Rates in California by Sex

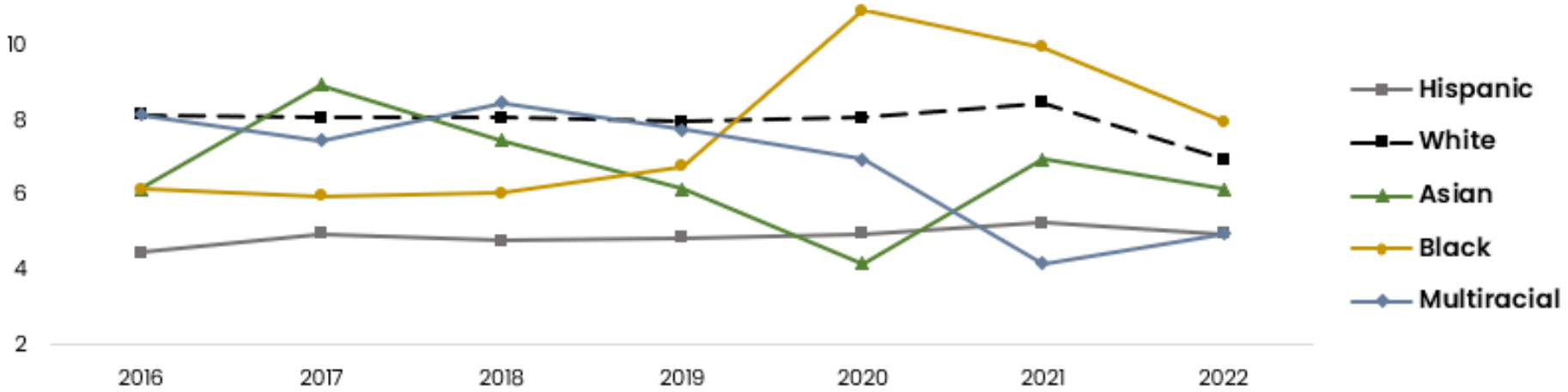


- Older males (ages 60+) are five times more likely to die from suicide than older females*

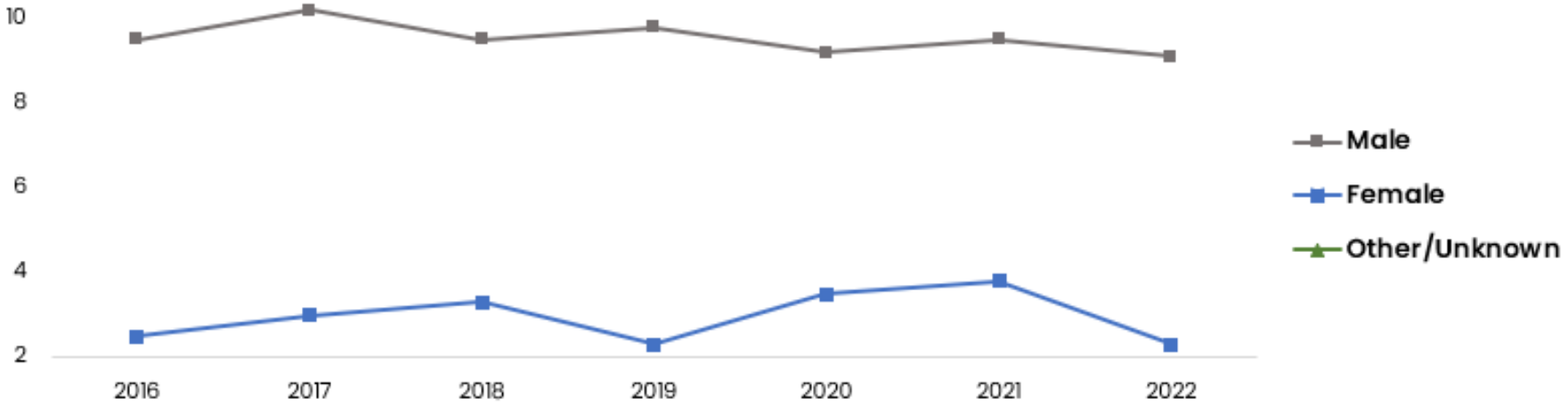
Source: Let's Get Healthy California; Note: nationally – and in California – females attempt suicide at higher rates than males:
*Bommersbach, T. J., Rosenheck, R. A., Petrakis, I. L., & Rhee, T. G. (2022). Why are women more likely to attempt suicide than men? Analysis of lifetime suicide attempts among US adults in a nationally representative sample. *Journal of affective disorders*, *311*, 157–164.

1a. Youth Suicide Rates: Racial/Ethnic and Sex Differences

Suicide Rates (per 100,000) among CA Youth (Ages 10-24) by Race/Ethnicity, 2016-2022



Suicide Rates (per 100,000) among CA Youth (Ages 10-24) by Sex, 2016-2022



For youth aged 10-24 in California:

- With the exception of **multiracial youth, suicide rates for youth declined** in 2021 to 2022.
- Of reported rates, **Black youth continued to have the highest rates of suicide as of 2022 (8 per 100,000)***
- Suicide rates decreased for both young men and women in 2021 to 2022.

Source: CDPH, California Suicide and Self Harm Trends in 2020 Data Brief; California Department of Public Health, California Injury Data Online EpiCenter – Accessed 2/17/24; National Center for Health Statistics: Suicide Among Adults Age 55 and Older, 2021

**Note*: American Indian and Alaska Native and Pacific Islander youth are excluded from inclusion due to identification concerns and rate instability (rates based on fewer than 20 events and considered unstable or unreliable)

1a. LGBTQIA+ Youth and Suicide

United States - 2021

- High school students who identify as LGBTQIA+ have higher rates of suicide attempts than heterosexual students.
- In 2021, youth identifying as lesbian, gay, or bisexual reported attempting suicide at a rate five times higher than among heterosexual students (26.3% vs. 5.2%).

Source: Jones SE, Ethier KA, Hertz M, et al. Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic — Adolescent Behaviors and Experiences Survey, United States, January–June 2021

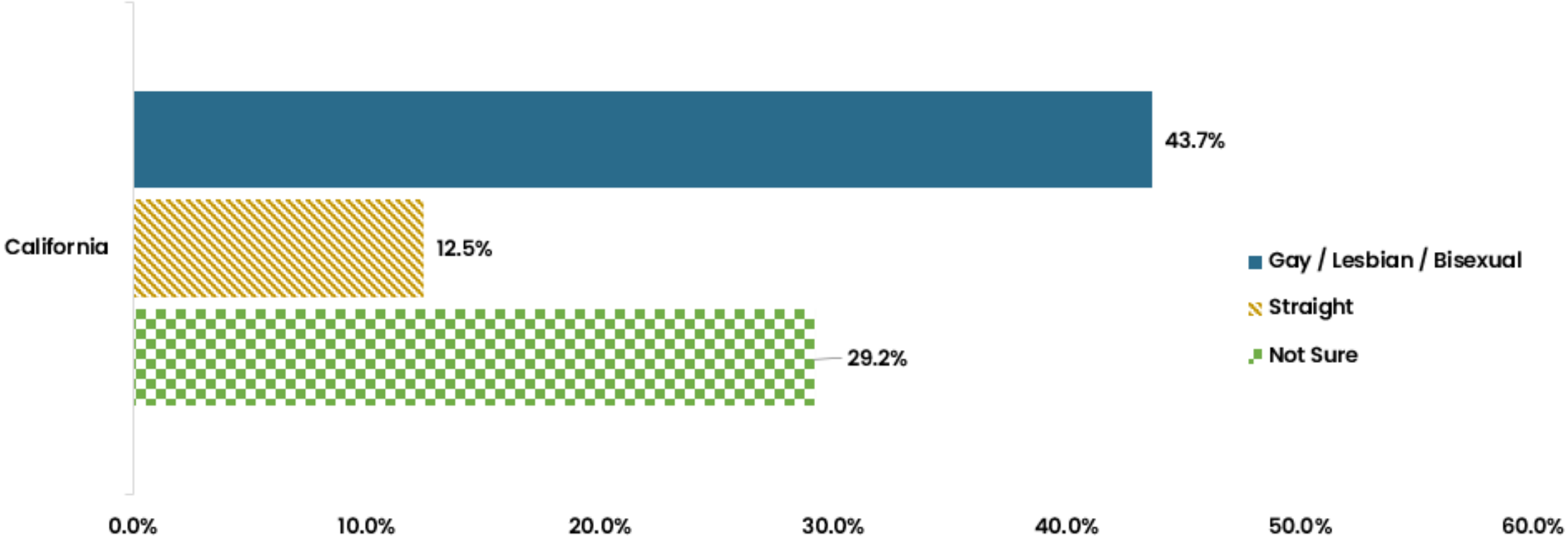
California - 2022

- 44% of LGBTQIA+ youth seriously considered suicide in the past year, including 54% of transgender and nonbinary youth.
- 4% attempted suicide in the past year, including 19% of transgender and nonbinary youth.
- 62% wanted mental health care in the past year and were unable to get it, including 58% of transgender and nonbinary youth.
- 70% reported that they have experienced discrimination based on their sexual orientation or gender identity

Source: The Trevor Project

1a. School-Age Children: Suicidal Ideation by Sexual Orientation

Suicidal Ideation (Student Reported), by Sexual Orientation, 2017-2019



Definition: Estimated percentage of public school students in grades 9 and 11, and enrolled in non-traditional programs, who seriously considered attempting suicide in the previous year, by sexual orientation.

In 2017-2019, an estimated 43.7% of these students identifying as gay, lesbian, and bisexual seriously considered attempting suicide in the previous year.

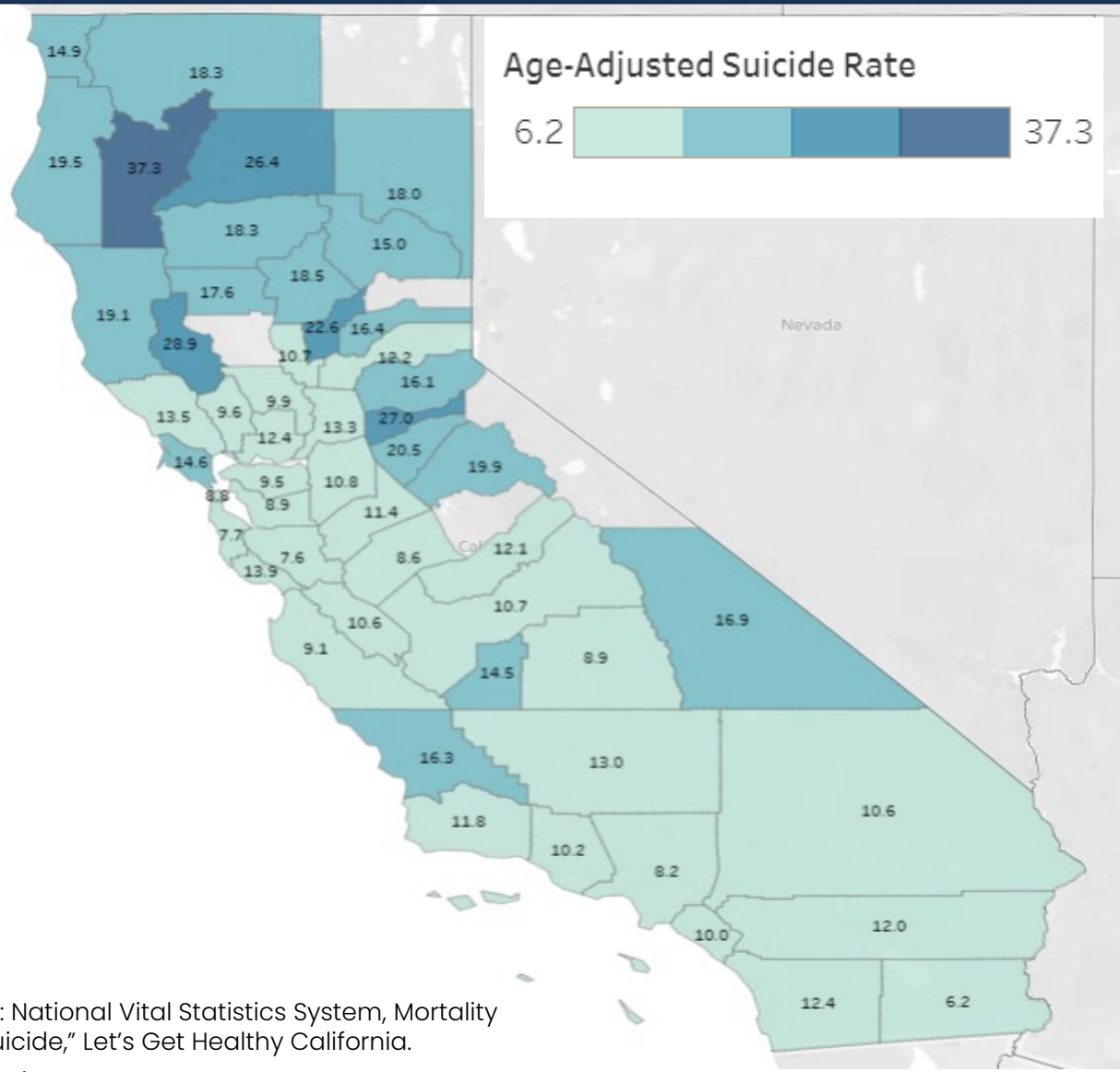
Source: KidsData – Suicidal Ideation (Student Reported), by Sexual Orientation, WestEd, California Healthy Kids Survey (CHKS) & Biennial State CHKS. California Dept. of Education (Aug. 2020).

1a. Rurality and Suicide: County Suicide Rates

- Nationally, suicide rates correspond closely with population density; large central metropolitan communities have a rate of 11.6 per 100,000 versus a noncore (non-metro) rate of 21.7 per 100,000.

- Similarly, overall suicide rates in California are higher in more rural and remote areas of the state:
  - Trinity County (37.3 per 100k)
  - Shasta County (26.4 per 100k)
  - Lake County (28.9 per 100k)
  - Amador County (27.0 per 100k)
  - Humboldt (19.5 per 100k)
  - Yuba (22.6 per 100k)
  - Inyo (16.9 per 100k)

- The median age of rural California residents is 51 (six years older than the median age of urban California residents); 18.4% of rural Californians are over 65.

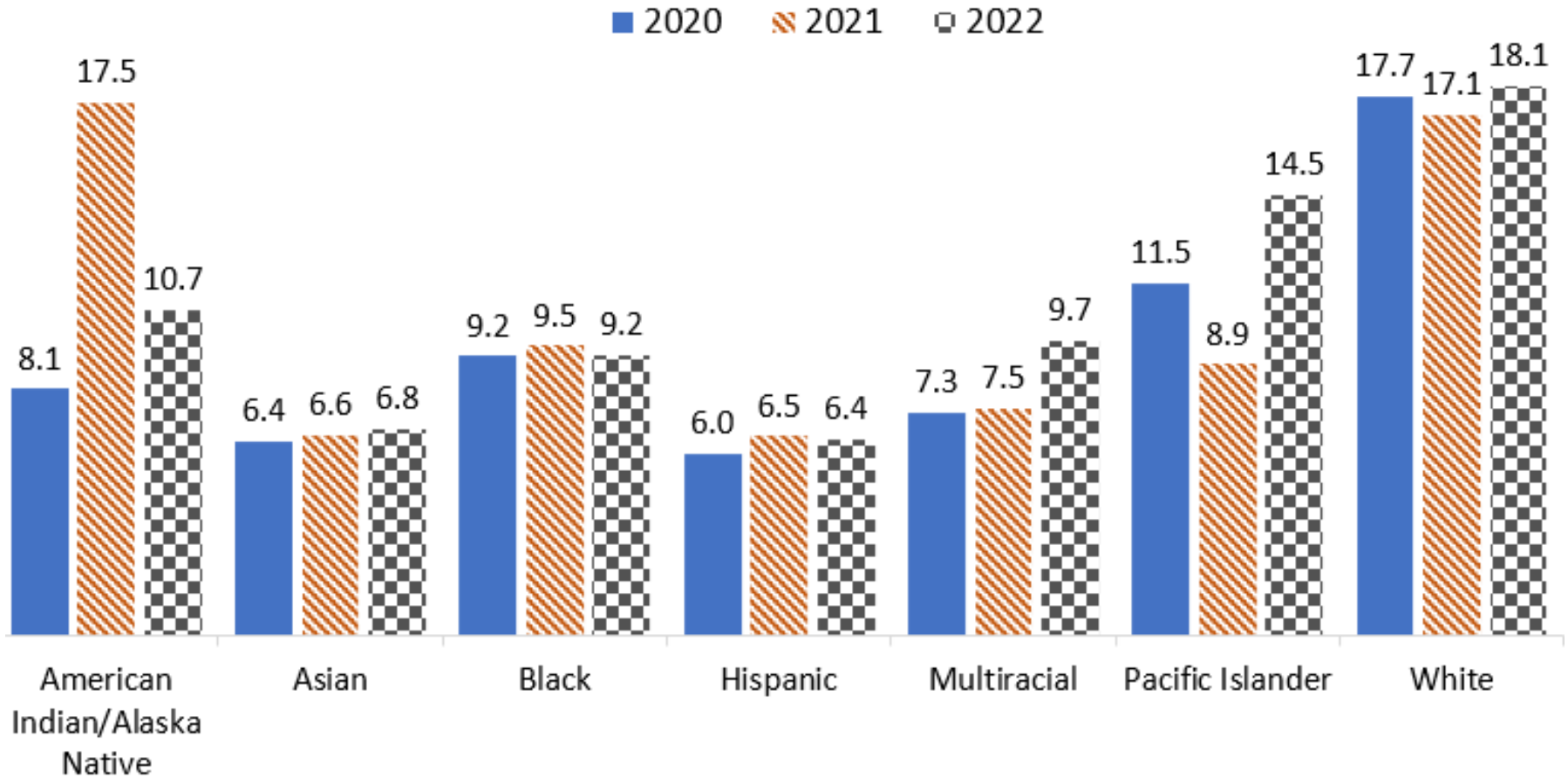


Source: Centers for Disease Control and Prevention, National Center for Health Statistics: National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2023; "Living Well / Reducing Suicide," Let's Get Healthy California.

**Note*: American Indian and Alaska Native (2020 & 2022) and Pacific Islander (2020 & 2021) rates are based on fewer than 20 events and are considered unstable or unreliable

1a. Racial and Ethnic Disparities in Suicide

CA Suicide Rates (per 100,000 residents) by Race/Ethnicity, 2020-2022



- In 2021, American Indian/Alaska Native (AI/AN) and White Californians had the highest rates of suicide in CA.
- In 2022, AI/AN had the third highest rate of suicide in CA, after White and Pacific Islander in California.

Source: CDPH, California Suicide and Self Harm Trends in 2021 Data Brief; California Department of Public Health, California Injury Data Online EpiCenter – Accessed 11/1/24; National Center for Health Statistics, Data Brief: Suicide Among Adults Age 55 and Older, 2021; Centers for Disease Control and Prevention Suicide Data and Statistics, National Center for Injury Prevention and Control

1a. Veterans and Suicide

United States - 2022

- Suicide was the 13th leading cause of death among veterans overall, and the second leading cause of death among veterans under age 45 in 2022.
- Veterans had an age- and sex-adjusted suicide rate that was 57.3% greater than the non-veteran U.S. adult population.
- Veterans accounted for about 13.9% of suicides among adults in the United States.

California - 2020

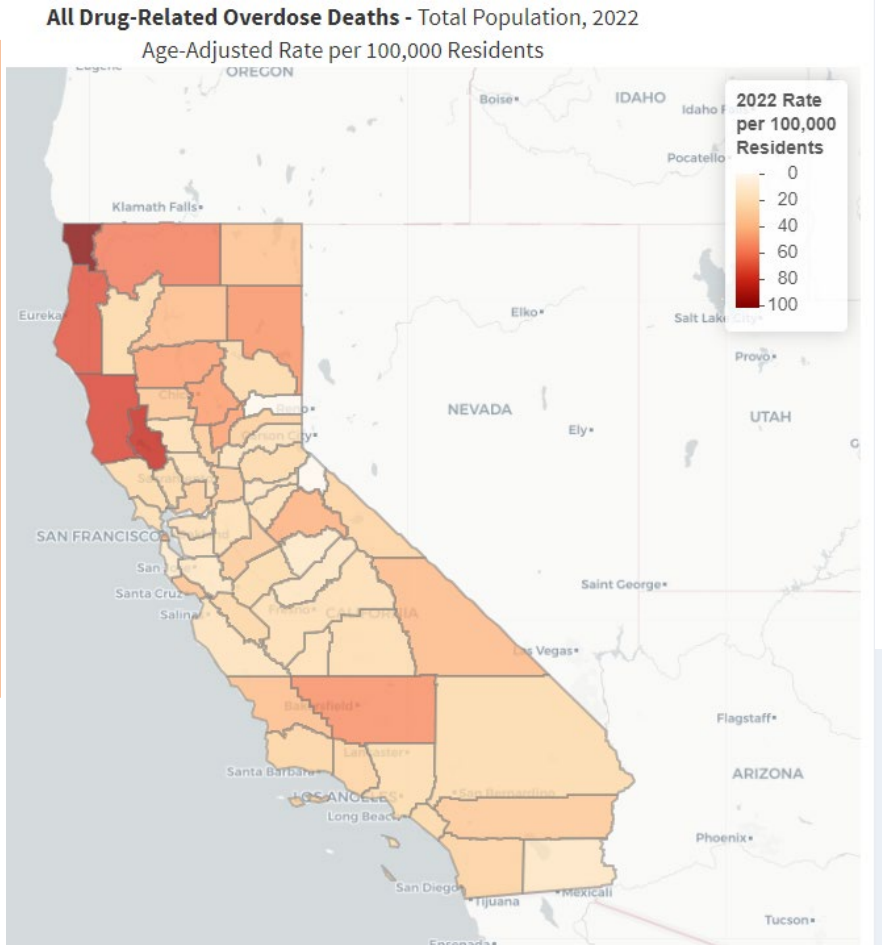
- In 2020, suicide deaths among veterans aged 18 years and older accounted for 15% of all suicides that year.
- 40% of veteran suicides were in the 65–84 age group, 20% occurred in the 45–64-year-old age group, and 14% were in the oldest age group (85 years and older).
- Most veteran suicides were among White (80%) and Latino/a (10%) individuals.
- Los Angeles and San Diego, the two most populous counties in California, had the largest number of suicide deaths among veterans, accounting for 28% in 2020.

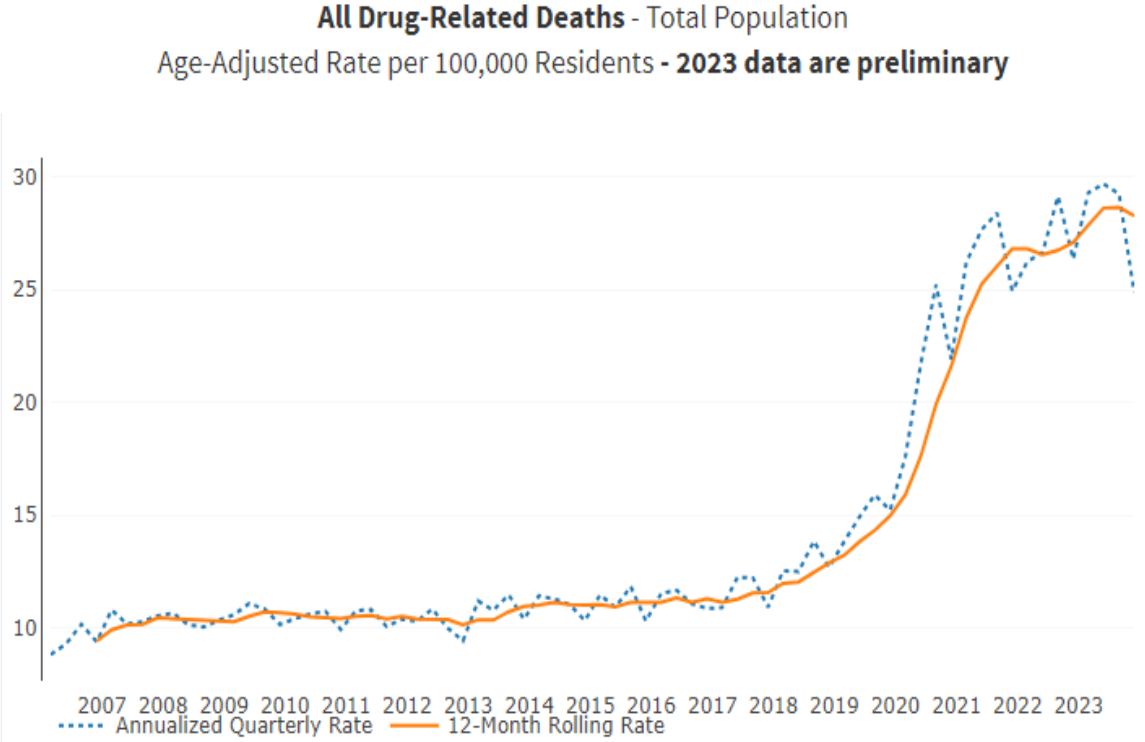
Source: U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, 2022 National Veteran Suicide Prevention Annual Report, 2022; California Department of Public Health - Suicide Death among Veterans in California, 2020

1b. California Drug Overdose Fatalities Overall

California's age-adjusted rate of **all drug-related** overdose deaths of 27.11 per 100K residents (11,002 deaths) is lower than a national age-adjusted rate of 32.6 per 100K residents (107,941 deaths)

All Drug-Related Overdose Deaths, 2022: Age Adjusted Per 100,000 Residents



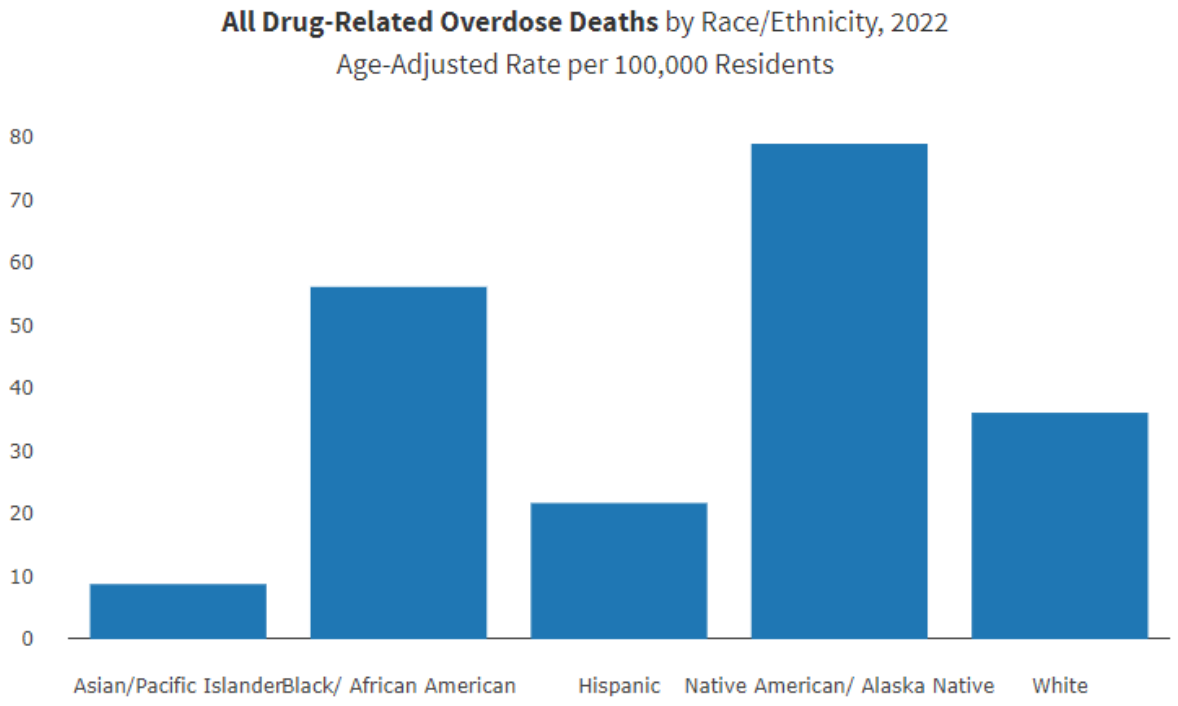


Age-adjusted rates of **all drug-related** overdose deaths in California increased from 2019-2023 by 89%

Source: California Overdose Surveillance Dashboard. Prepared by California Department of Public Health (CDPH) - Substance and Addiction Prevention Branch (SAPB) – Accessed 11/1/24; Centers for Disease Control and Prevention, National Center for Injury Prevention and Control Databrief

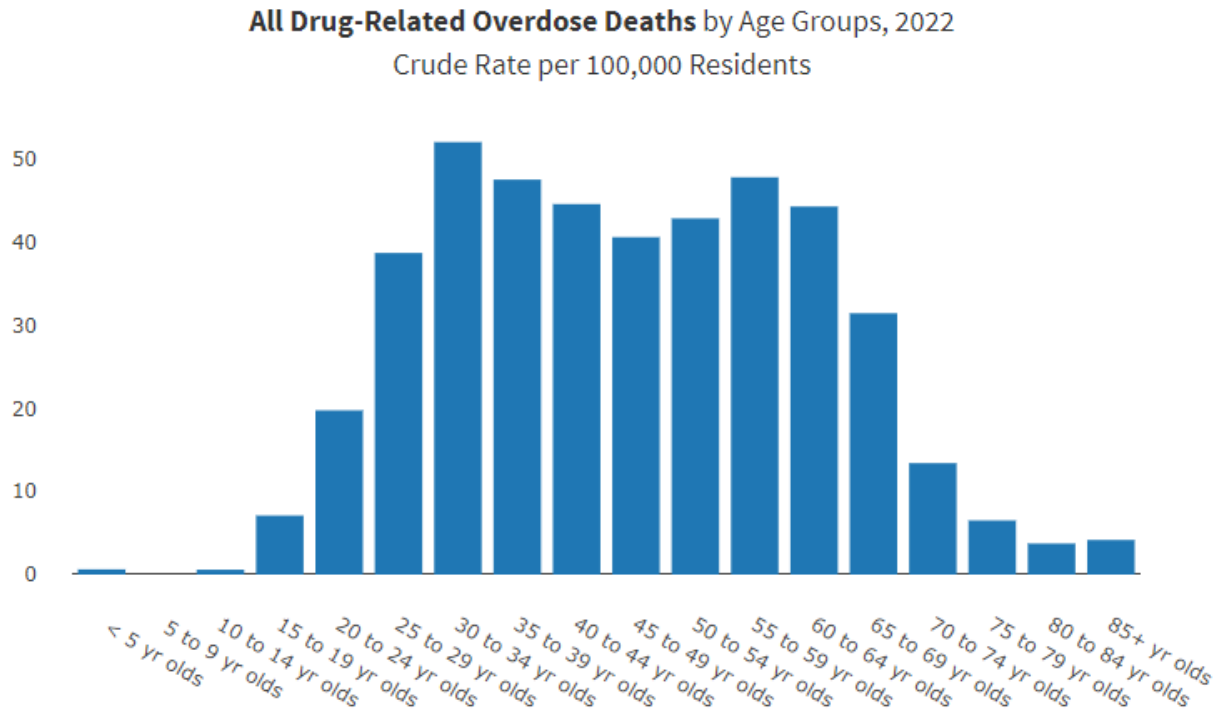
1b. All Drug Overdose Fatalities by Race/Ethnicity and Age in California

All Drug-Related Overdose Deaths, by Race/Ethnicity, 2022: Age Adjusted Per 100,000 CA Residents



In 2022, Native American and Alaska Natives had the highest age-adjusted rate for **all drug-related** overdose deaths (78.98 per 100K residents) in California.

All Drug-Related Overdose Deaths, by Age Group, 2022: Crude Rate Per 100,000 CA Residents



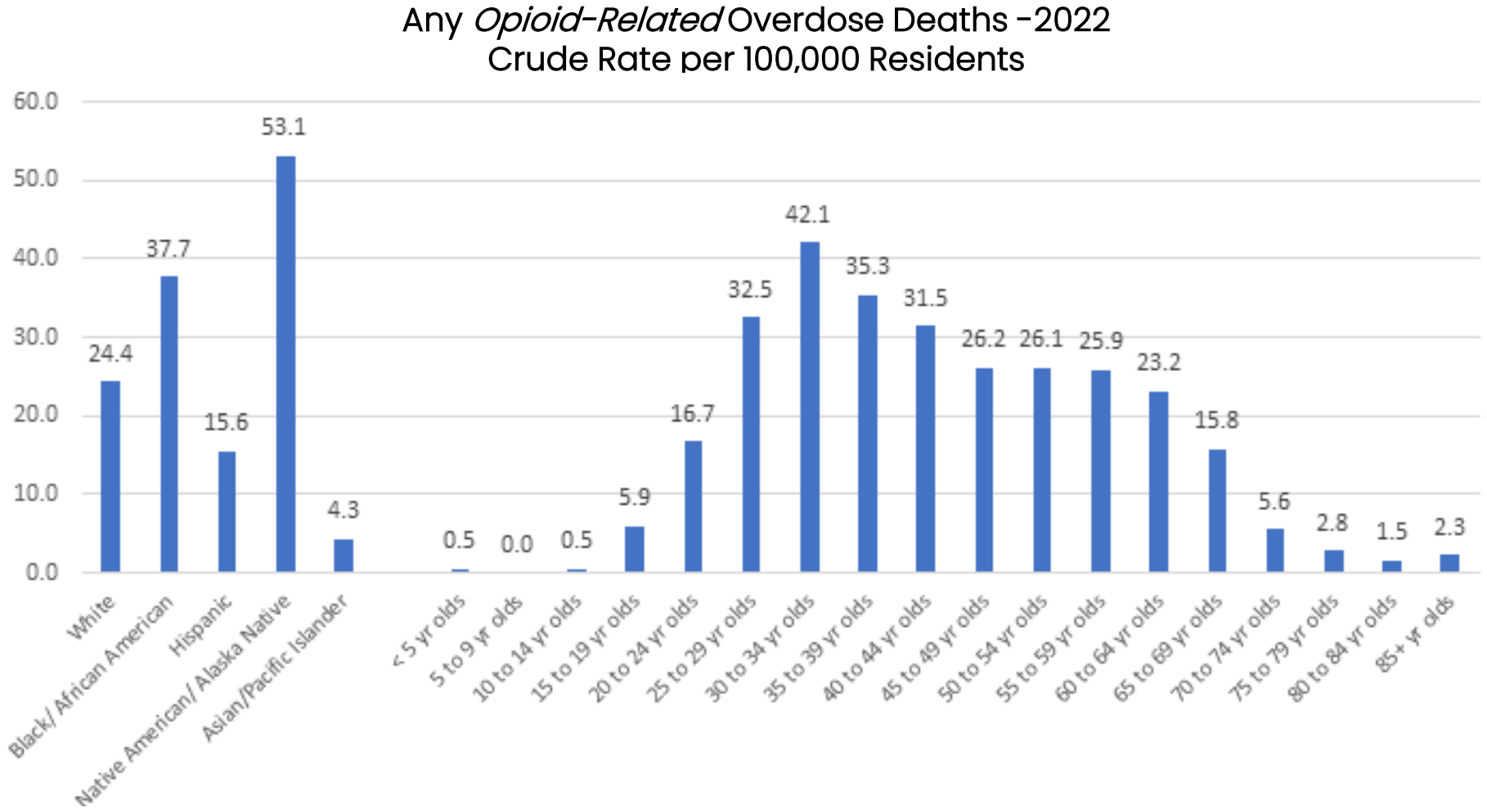
In 2022, 30- to 34-year-olds had the highest crude rate (52.14) of **all drug-related** overdose deaths, followed by 55 to 59-year-olds (47.90).

Source: California Overdose Surveillance Dashboard. Prepared by California Department of Public Health (CDPH) - Substance and Addiction Prevention Branch (SAPB) – Accessed 2/21/24; Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

* ***Definition Note***: All drug-related overdose deaths includes all overdose deaths, regardless of intent (e.g., unintentional, suicide, assault, or undetermined). This indicator does not include: (1) deaths related to chronic use of drugs (e.g., damage to organs from long-term drug use), 2) deaths due to alcohol and tobacco, and 3) deaths that occur under the influence of drugs, but do not involve acute poisoning (e.g., a car crash that occurred because the driver was drowsy from taking a prescription drug).

1b. Opioid Overdose Fatalities by Race/Ethnicity and Age

- In 2022, there were 7,385 deaths related to **opioid overdoses** in California.
- In 2022, Native American and Alaska Natives had the highest crude rate (53.1) of any **opioid-related** overdose death.
- 30- to 34-year-olds had the highest crude rate (42.1) of **opioid-related** overdose deaths compared to other age groups.



Source: California Overdose Surveillance Dashboard. Prepared by California Department of Public Health (CDPH) - Substance and Addiction Prevention Branch (SAPB) – Accessed 2/21/24.

* ***Definition Note***: Any opioid-related drug overdose deaths caused by acute poisonings involve any opioid as a contributing cause of death, regardless of intent (e.g., unintentional, suicide, assault, or undetermined). Opioids include both prescription opioid pain relievers such as hydrocodone, oxycodone, and morphine, as well as heroin and opium. Deaths related to chronic use of drugs (e.g., damage to organs from long-term drug use), are excluded from this indicator.

2. Behavioral Health-Related Morbidity:
(a) Emergency Department Visits
(b) Inpatient Psychiatric Stays

Key Takeaway #2

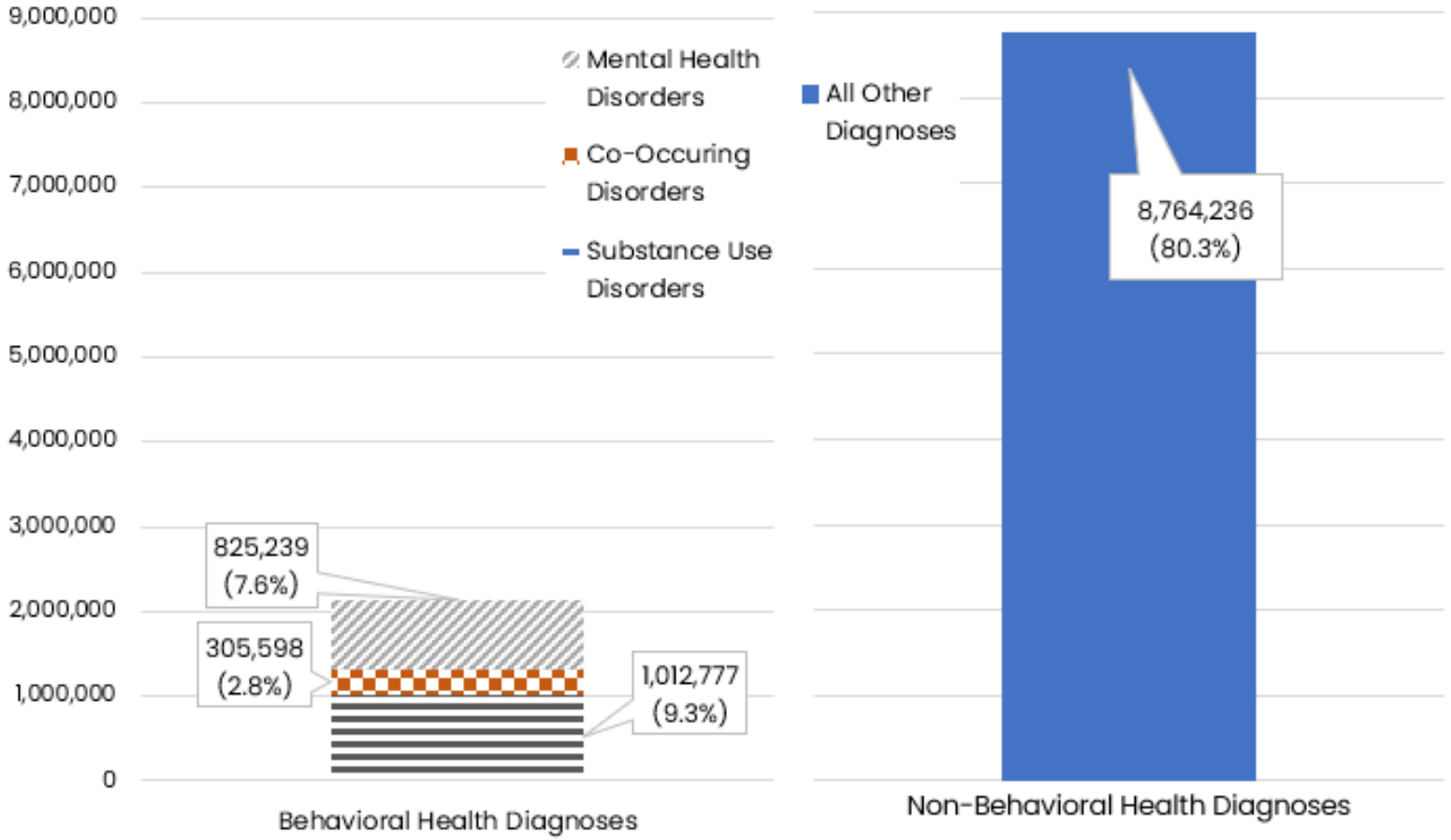
- While suicide rates in California remained steady from 2020 to 2021 (10.4 per 1000,000 residents), emergency department (ED) visits for self-harm decreased during the same period (79.3 to 85.0 per 100,000 residents).*
- Patients with behavioral health conditions accounted for a sizable portion of ED visits in 2021; among individuals who visited the ED with a diagnosis of a mental health, co-occurring disorder, or substance use, disorder in 2021, 47% had Medi-Cal insurance.**
- The number of California opioid-related ED visits more than doubled between 2019-2023 (9,076 to 21,309 visits) and was over five times the number of visits in 2007 (4,075 to 21,309 visits***
- In 2022, California had an age-adjusted rate of all drug-related overdose ED visits of 143.75 per 100K residents (55,598 visits), compared with a national rate of 133.9 per 100K individuals.****

Sources::
*Injury Data Brief: California Suicide and Self-Harm Trends in 2021
**HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022: California Department of Health Care Access and Information (HCAI) Inpatient Hospitalizations and Emergency Department Visits for Patients with a Behavioral Health Diagnosis in California: Patient Demographics
***National Center for Health Statistics – California, accessed August 17, 2024
****California Overdose Surveillance Dashboard, prepared by California Department of Public Health (CDPH) - Substance and Addiction Prevention Branch (SAPB); DOSE Dashboard: Nonfatal Overdose Emergency Department and Inpatient Hospitalization Discharge Data

2a. Behavioral Health-Related ED Visits – Patient Diagnoses

- In 2021, patients in California with behavioral health diagnoses accounted for 2,143,614 emergency department (ED) treat and release visits—**approximately one-fifth of all ED visits** (10,907,850 total)
- Of those visits, **most (47%) were for substance use disorders (SUDs),** followed by mental health disorders (38%), and co-occurring disorders (15%).

Number of Behavioral Health and Other Patient Diagnosis in California Emergency Departments, 2021



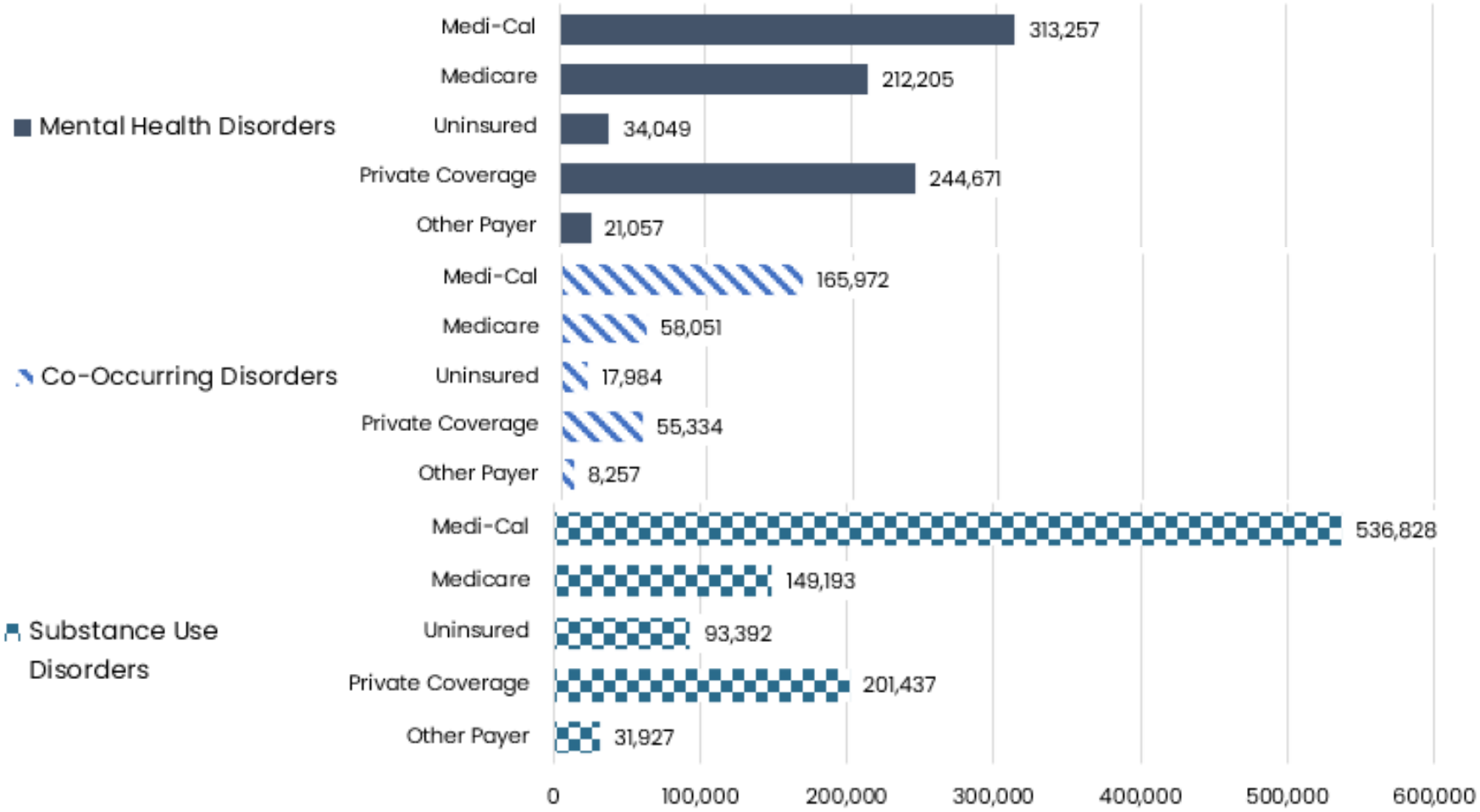
Sources: HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022

* ***Definition Note***: HCAI defines behavioral health as an umbrella term that covers mental health (e.g., mood disorders; intentional self-harm, suicidal ideation, and suicide attempts; schizophrenia and other psychotic disorders) and substance use disorders (e.g., alcohol-related disorders; cannabis-related disorders, hallucinogens-related disorders); co-occurring disorders (the patient has at least one Mental Health Disorder and at least one Substance Use Disorder)

2a. Behavioral Health-Related ED Visits by Expected Payer #1

- In 2021, **Medi-Cal was the most common expected payer** for behavioral health-related ED visits.
- **Private payers covered more mental health** disorders than co-occurring or substance use disorders
- Uninsured and Medi-Cal patients were more likely to be treated in the ED for substance use disorders than for mental health disorders or co-occurring disorders.

Number of Behavioral Health Diagnosis in California Emergency Departments, by Expected Payer, 2021

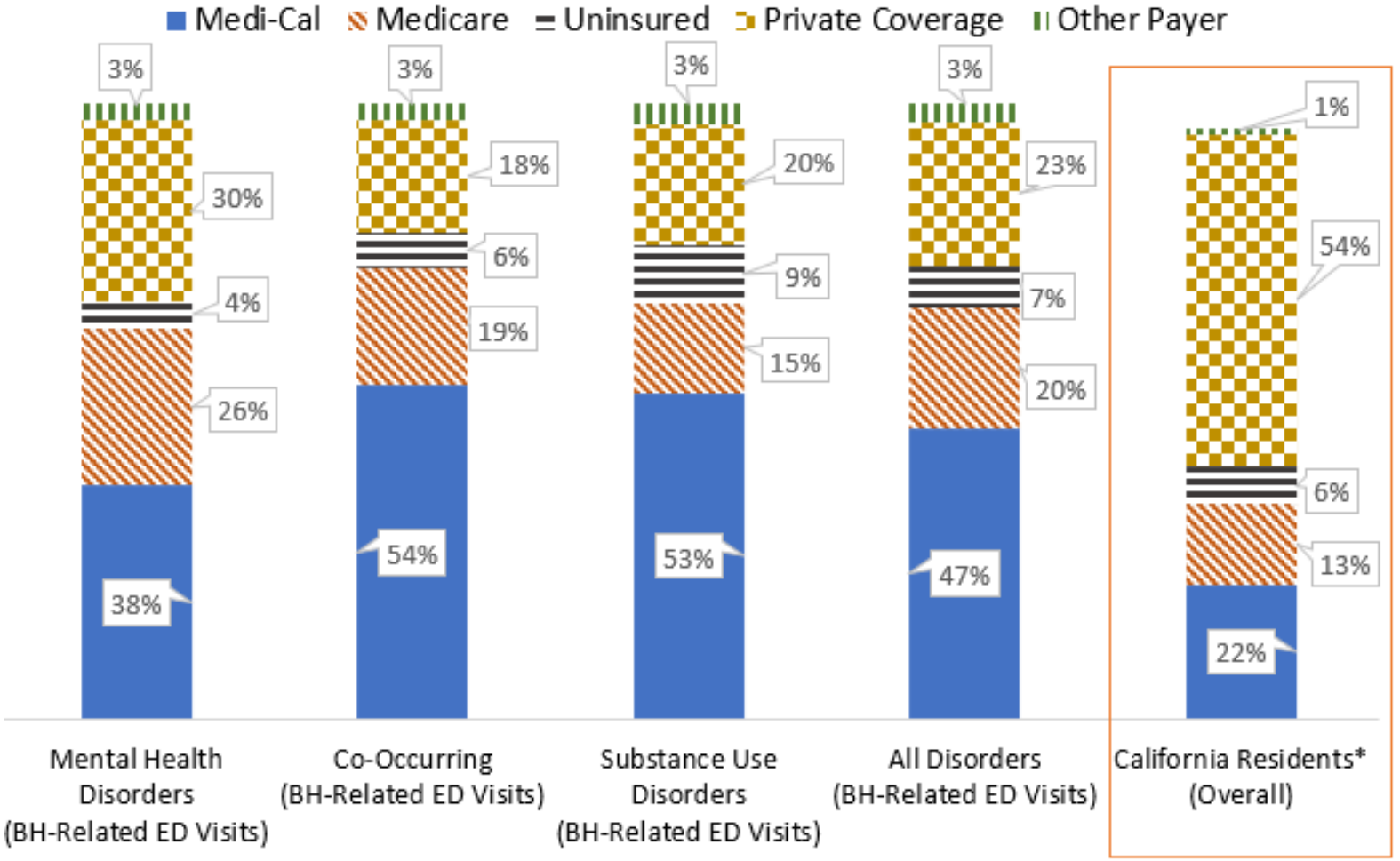


Sources: HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022

2a. Behavioral Health-Related ED Visits by Expected Payer #2

- While Medi-Cal was the most common expected payer for behavioral health-related ED visits, private coverage was the most common payer for all California residents.
- California residents overall were less likely to be covered by Medi-Cal than those who were treated in the ED for behavioral health - related diagnoses.

Sources of Insurance Coverage, by Behavioral Health Diagnosis in California Emergency Departments and Overall Coverage, 2021



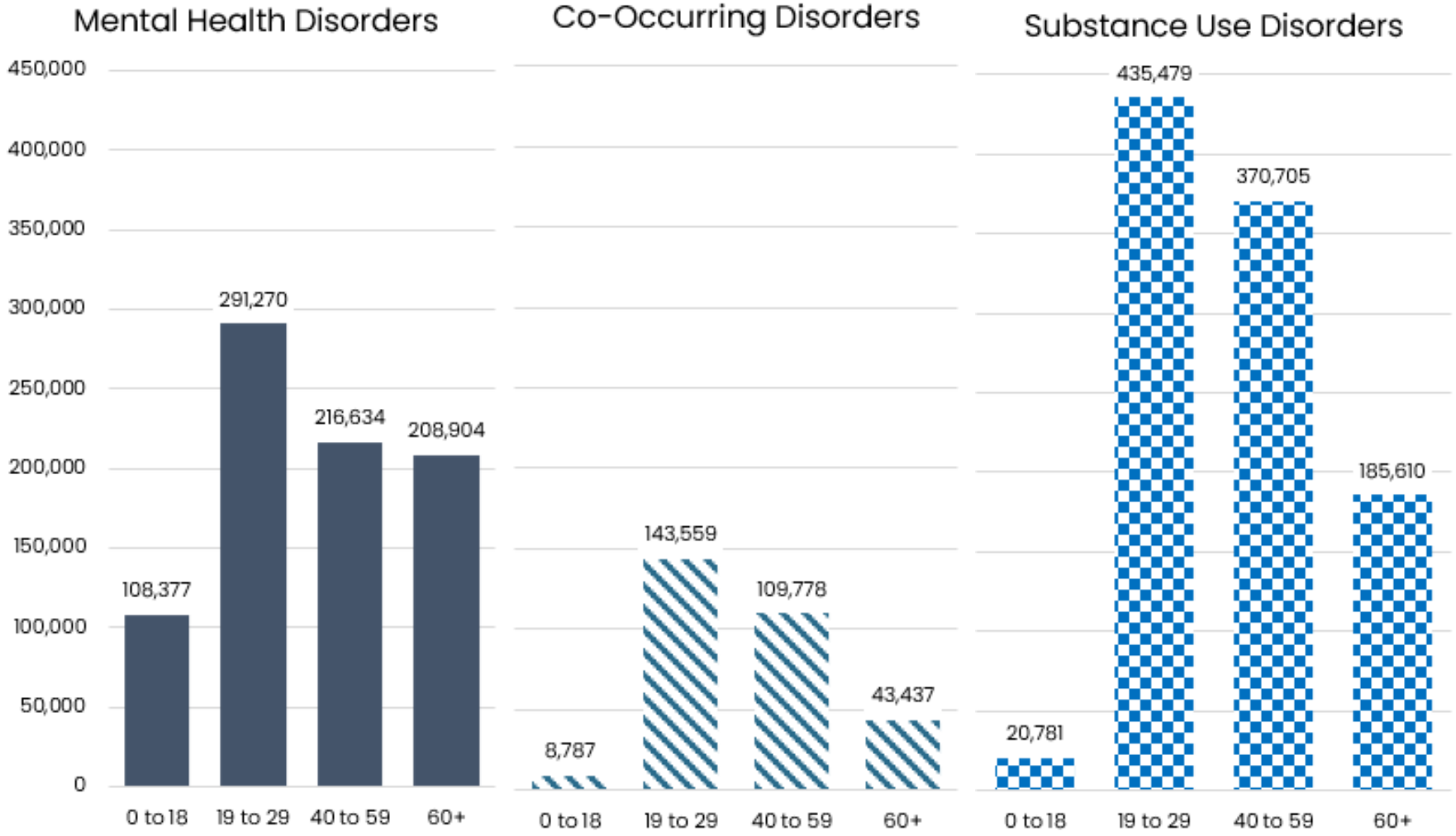
Note: This graph does not depict the 4% of California residents who are covered by both Medicare and Medi-Cal

Sources: HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022; Insurance data from California Health Care Almanac – Medi-Cal Facts and Figures June 2024

2a. Behavioral Health-Related ED Visits – Age

In 2021, the 19 to 39 years old age group had the largest proportion of ED visits across all three behavioral health categories (mental health disorders, co-occurring disorders, and SUDs).

Number of Behavioral Health Diagnosis in California Emergency Departments by Age Group, 2021

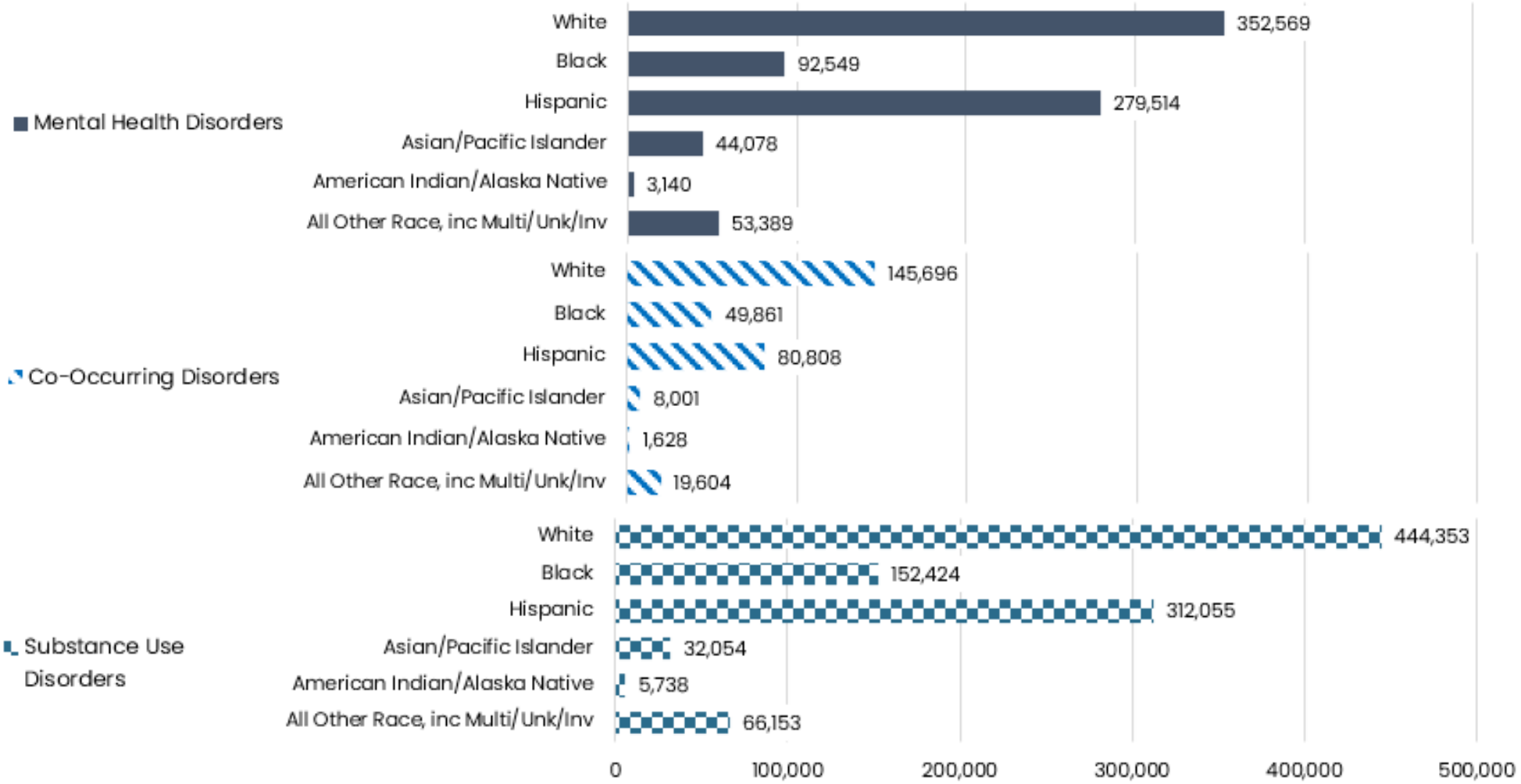


Sources: HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022

2a. Behavioral Health-Related ED Visits – Race/Ethnicity

In 2021, White individuals had the highest number of ED visits across behavioral health diagnoses in California.

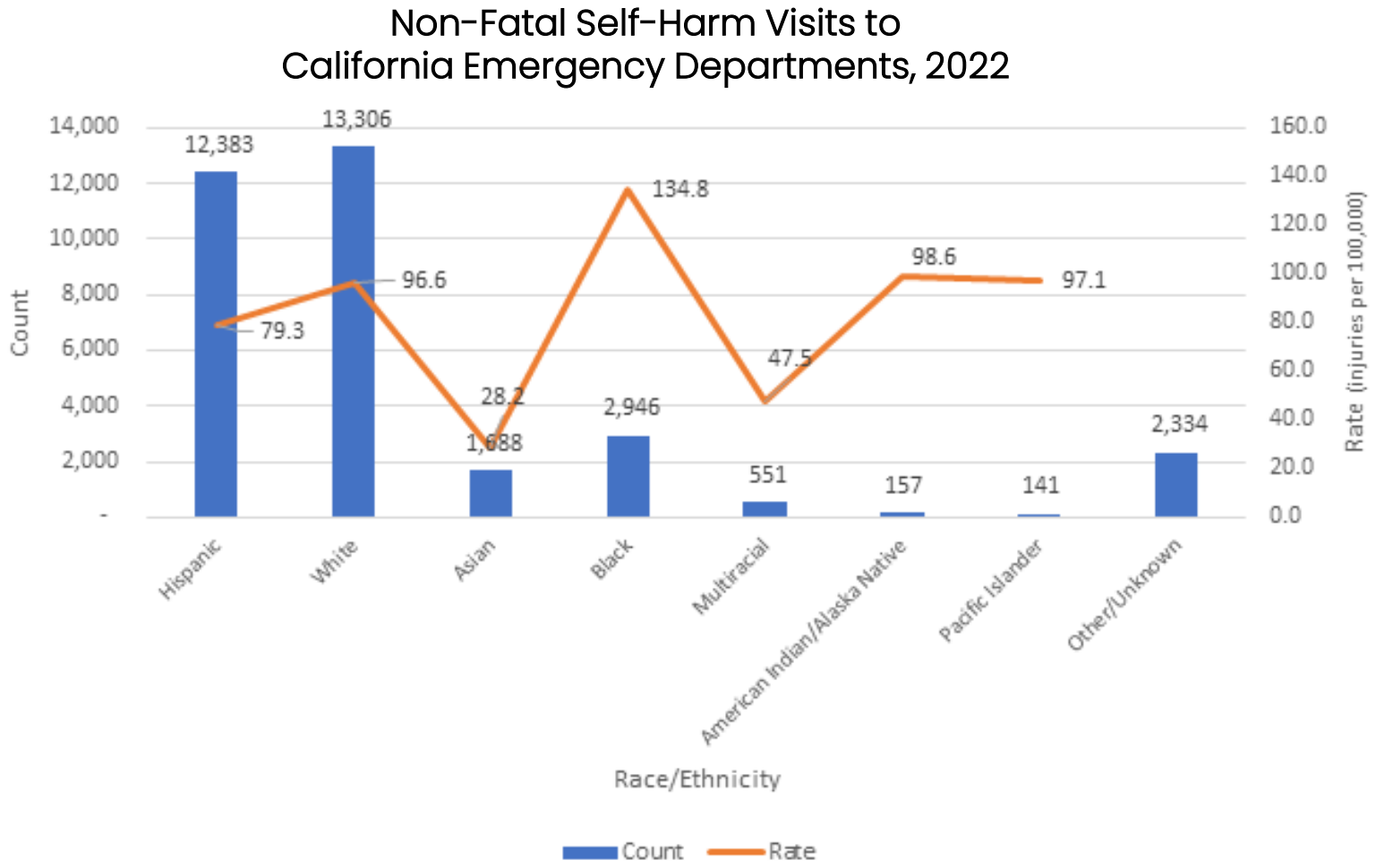
Number of Behavioral Health Diagnosis in California Emergency Departments by Race/Ethnicity, 2021



Sources: HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022

2a. Non-Fatal Self-Harm ED Visits – by Race/Ethnicity

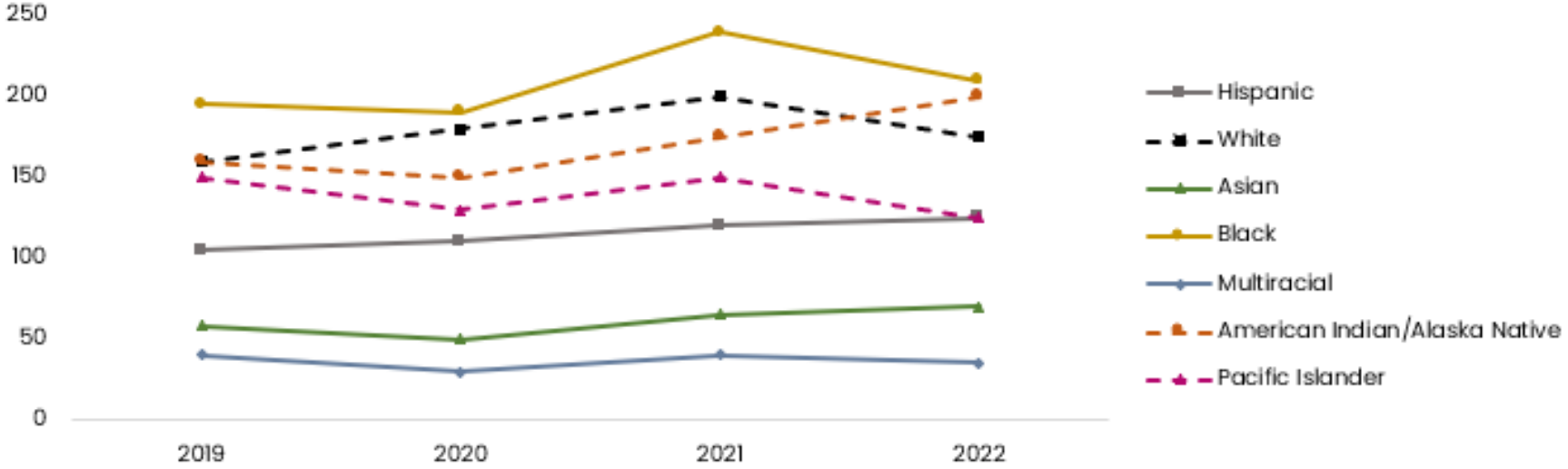
- In 2022, California had a rate of non-fatal self-harm ED visits of 85.8 per 100,000 residents (33,506 visits), compared with a national rate of 148.2 per 100,000 individuals in 2021.
- In 2022, Blacks/African Americans had the highest rate of all non-fatal self-harm ED visits (134.8 per 100,000 residents) in California



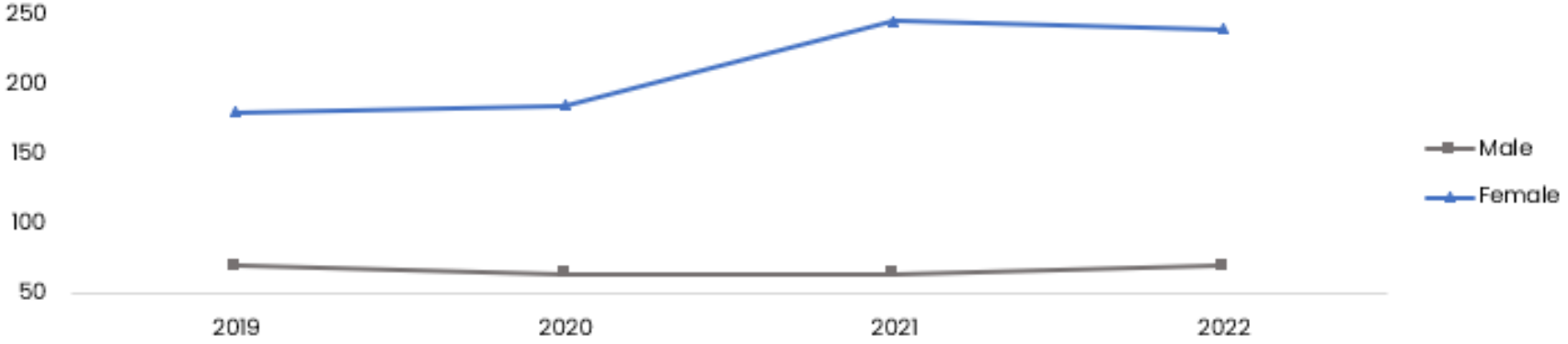
Source: California Department of Public Health - California Injury Data Online EpiCenter – Accessed 2/21/24; Office of Disease Prevention and Health Promotion – Healthy People 2030: Reduce emergency department visits for nonfatal intentional self-harm injuries – IVP-19 Data

2a. Non-Fatal Self-Harm ED Visits Among Youth Under 25

Self-Harm ED Visit Rates (per 100,000) among CA Youth (Under 25) by Race/Ethnicity, 2019-2022



Self-Harm ED Visit Rates (per 100,000) among CA Youth (Under 25) by Sex, 2019-2022



For youth under 25:

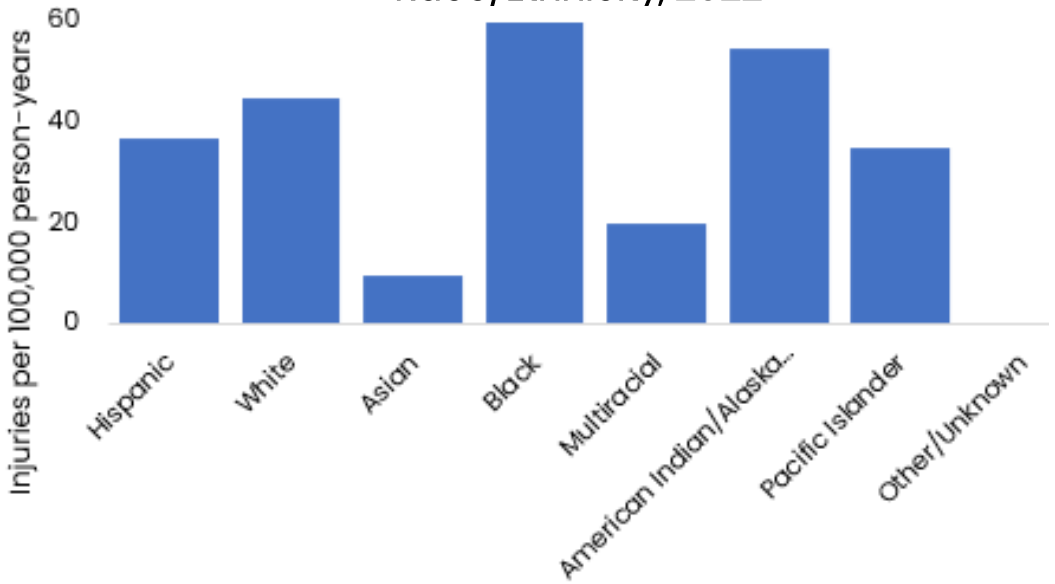
- Black youth had the highest rates of self-harm ED visits as of 2022.
- American Indian/Alaska Native youth, Latine youth, and Asian youth saw increases in self-harm ED visit rates from 2021 to 2022 (with American Indian/Alaska Native youth accounting for the greatest increase).
- Female youth experienced an increase in self-harm ED visit rates from 2020 to 2021, but a slight rate decrease from 2021 to 2022.
- Male youth experienced a slight increase in self-harm ED visit rates in 2021 to 2022.

Source: California Department of Public Health - California Injury Data Online EpiCenter – Accessed 2/13/24; Office of Disease Prevention and Health Promotion – Healthy People 2030: Reduce emergency department visits for nonfatal intentional self-harm injuries – IVP-19 Data

2a. ED Treat-and-Release from Non-Fatal Self-Harm Injury

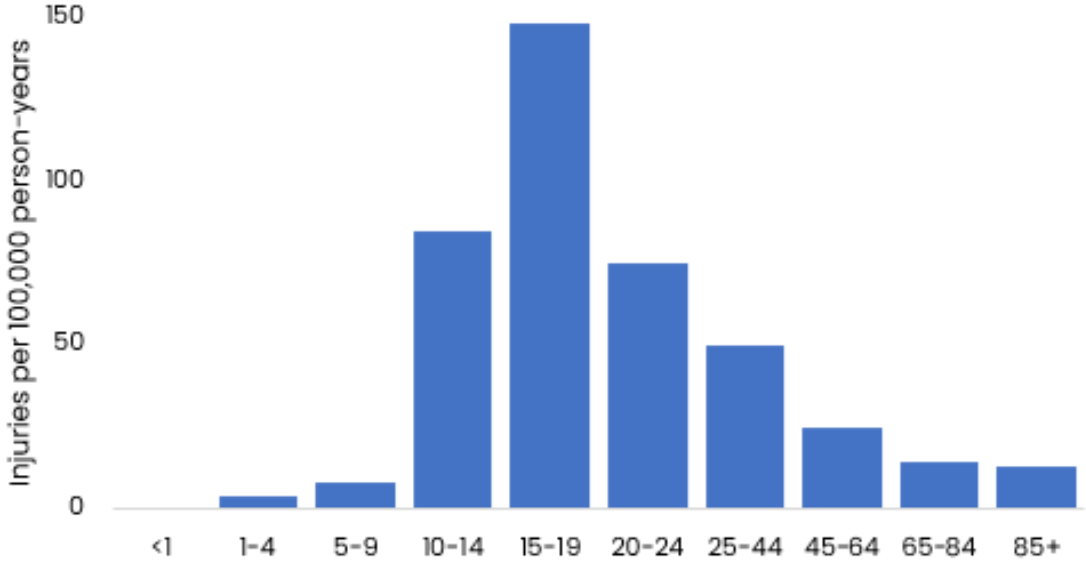
In 2022, the crude rate of ED treat-and-release visits in California due to non-fatal self-harm injury was 40.1 per 100,000 residents (15,658 visits).

Non-Fatal Self-Harm Injury Treat-and-Release ED Visit Rates by Race/Ethnicity, 2022



In 2022, Black individuals had the highest crude rate of ED treat-and-release visits in California due to non-fatal self-harm injury at 64.4 per 100,000 residents (1,407 injuries).

Non-Fatal Self-Harm Injury Treat-and-Release ED Visit Rates by Age, 2022



In 2022, 15- to 19-year-olds had the highest crude rate of ED treat-and-release visits in California due to non-fatal self-harm injury at 149.8 per 100,000 residents (3,954 injuries).

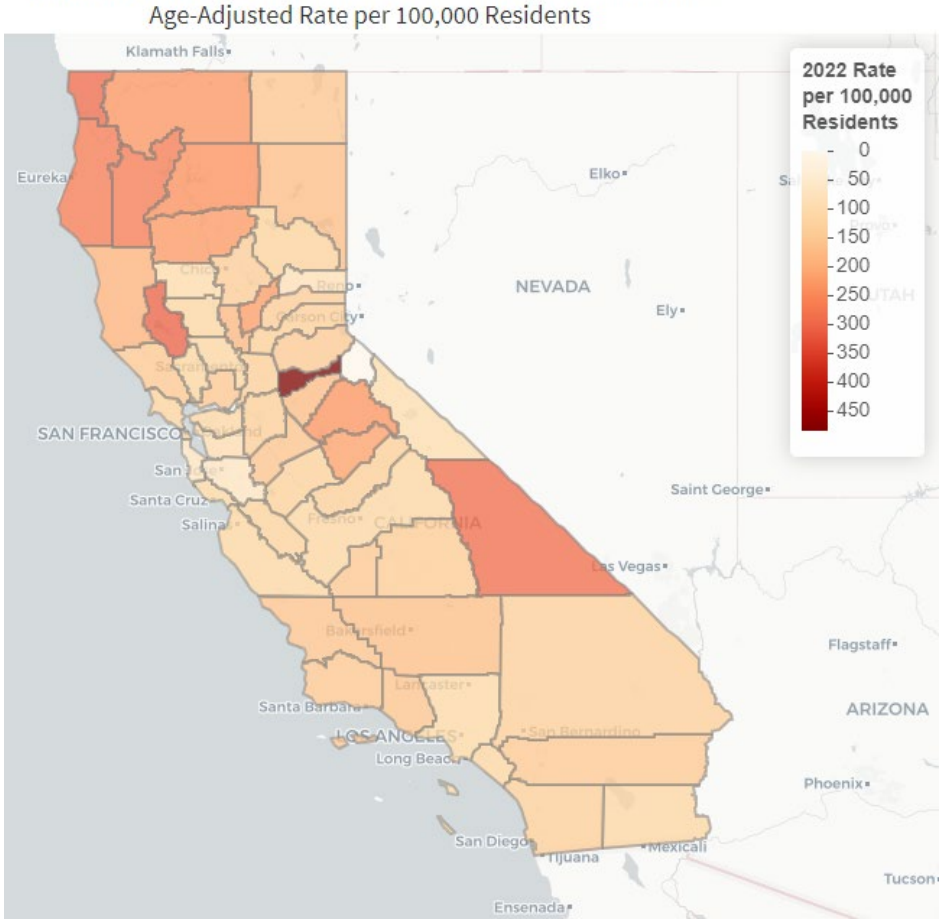
Source: California Department of Public Health - California Injury Data Online EpiCenter – Accessed 2/13/24

Note: Treat and release visits include patients discharged to home or self care (routine discharge); discharged/transferred home under the care of organized home health service organization in anticipation of covered skilled care; Left against medical advice or discontinued care; discharged/transferred to court/law enforcement; and those discharged home with hospice care. These cases exclude ED visits that result in transfers to acute, non-acute, and psychiatric hospitals, as well as cases where the disposition is unknown.

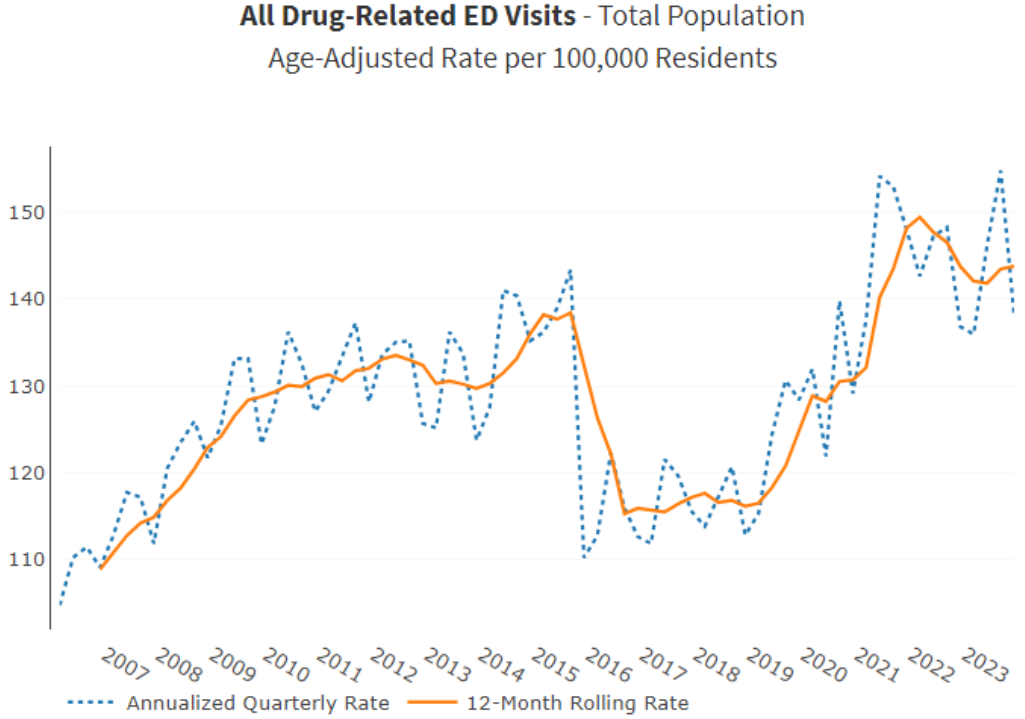
2a. Drug-Related Overdose ED Visits

In 2022, California had a higher age-adjusted rate of all drug-related overdose ED visits of 143.75 per 100,000 residents (55,598 visits), compared to a national rate of 133.9 per 100,000 individuals.

All Drug-Related Overdose ED Visits, 2022
Age-Adjusted Rate per 100,000 Residents



All Drug-Related Overdose ED Visits, 2007-2023
Age-Adjusted Rate per 100,000 Residents

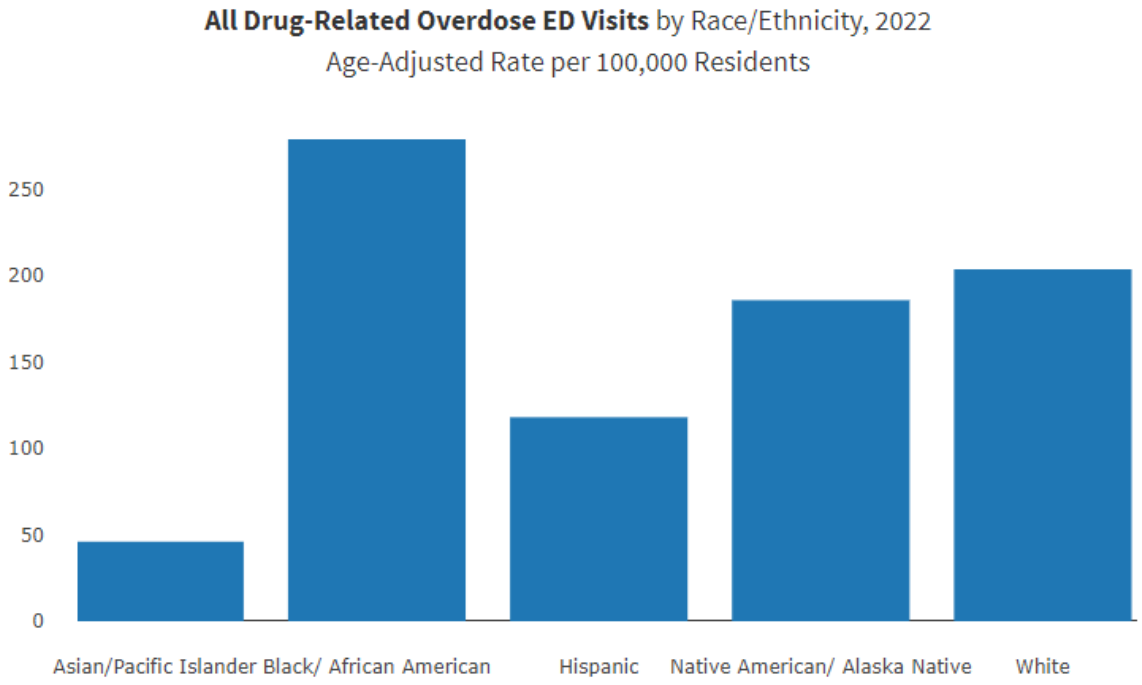


There was an increase in all drug-related ED visits in 2019–2022; however, drug-related ED visits decreased in 2022 and then slightly increased in 2023.

Sources: California Overdose Surveillance Dashboard, prepared by California Department of Public Health (CDPH) - Substance and Addiction Prevention Branch (SAPB) – Accessed 11/1/24; DOSE Dashboard: Nonfatal Overdose Emergency Department and Inpatient Hospitalization Discharge Data

2a. Drug-Related Overdose ED Visits by Race/Ethnicity and Age

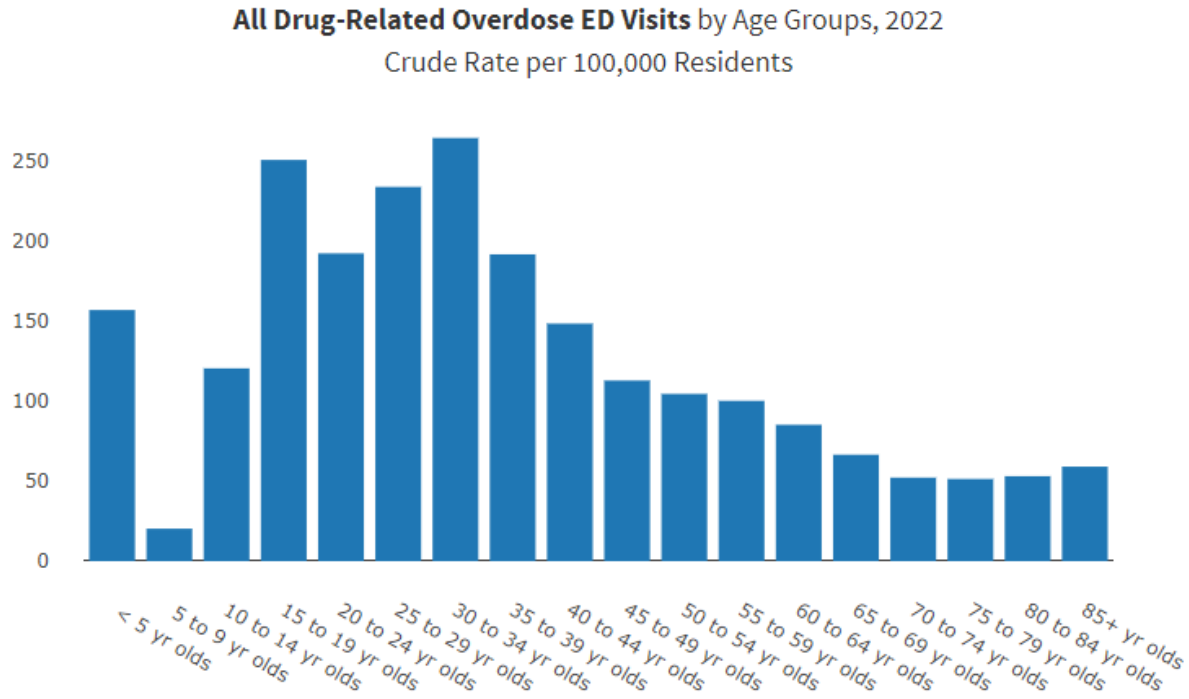
All Drug-Related Overdose ED Visits by Race/Ethnicity, 2022
Age-Adjusted Rate per 100,000 Residents



In 2022, Blacks/African Americans had the highest age-adjusted rate of all drug-related overdose ED visits (279.19 per 100,000 residents) in California.

The highest crude rate for all drug-related overdose ED visits in California was from 30- to 34-year-olds (264.77) followed by 15- to 19-year-olds (251.05) in 2022.

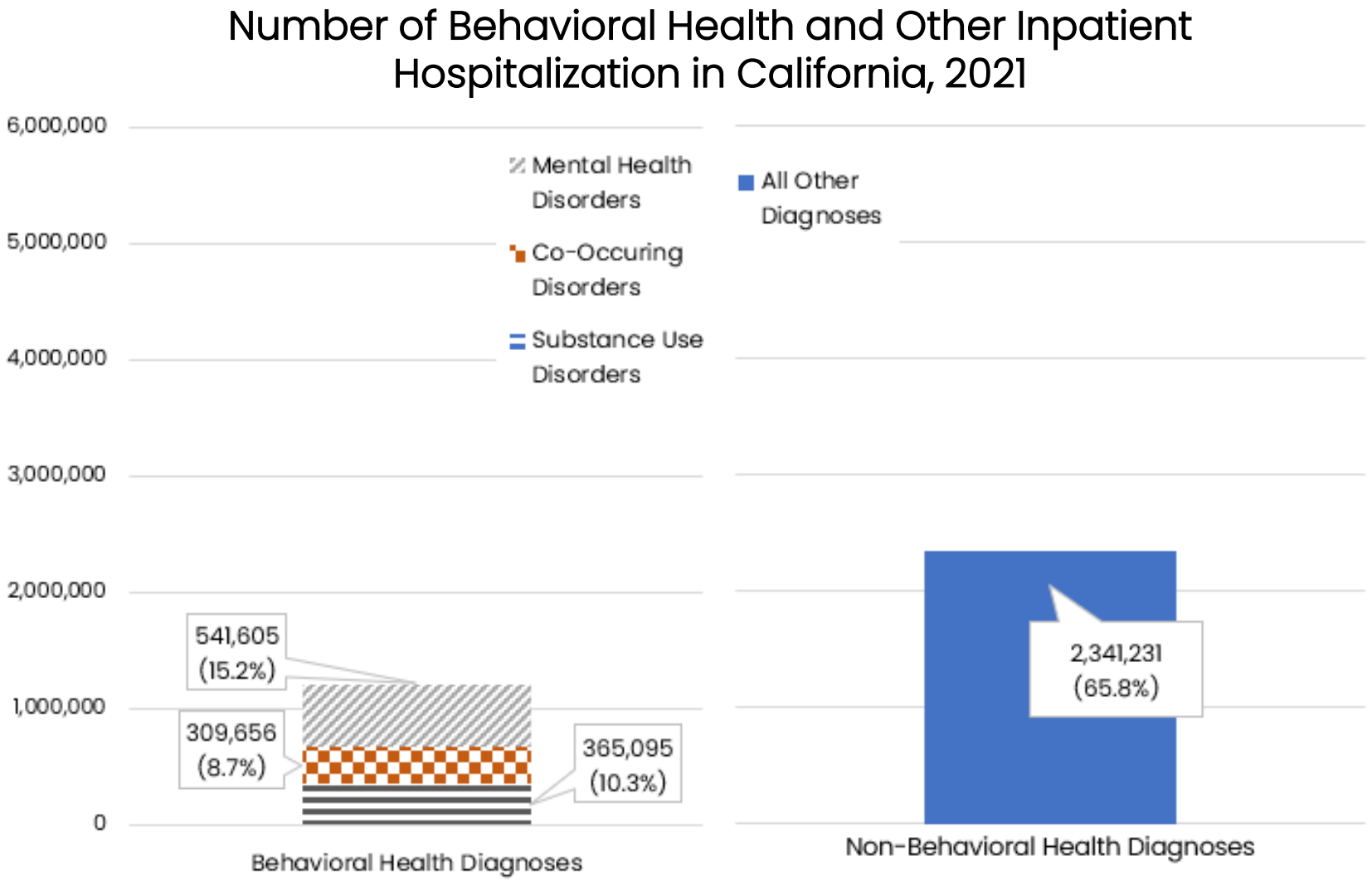
All Drug-Related Overdose ED Visits by Age Group, 2022
Crude Rate per 100,000 Residents



Sources: California Overdose Surveillance Dashboard, prepared by California Department of Public Health (CDPH - Substance and Addiction Prevention Branch (SAPB) – Accessed 2/21/24; Substance Abuse and Mental Health Services Administration, 2023; Drug Abuse Warning Network: Findings from Drug-Related Emergency Department Visits, 2022 in Substance Abuse and Mental Health Services Administration (No. PEP23-07-03-001)

2b. Inpatient Psychiatric Stays by Diagnoses

In 2021, **approximately one-third** of all inpatient hospitalizations in California were patients with behavioral health diagnoses (1,216,356 of 3,557,587).

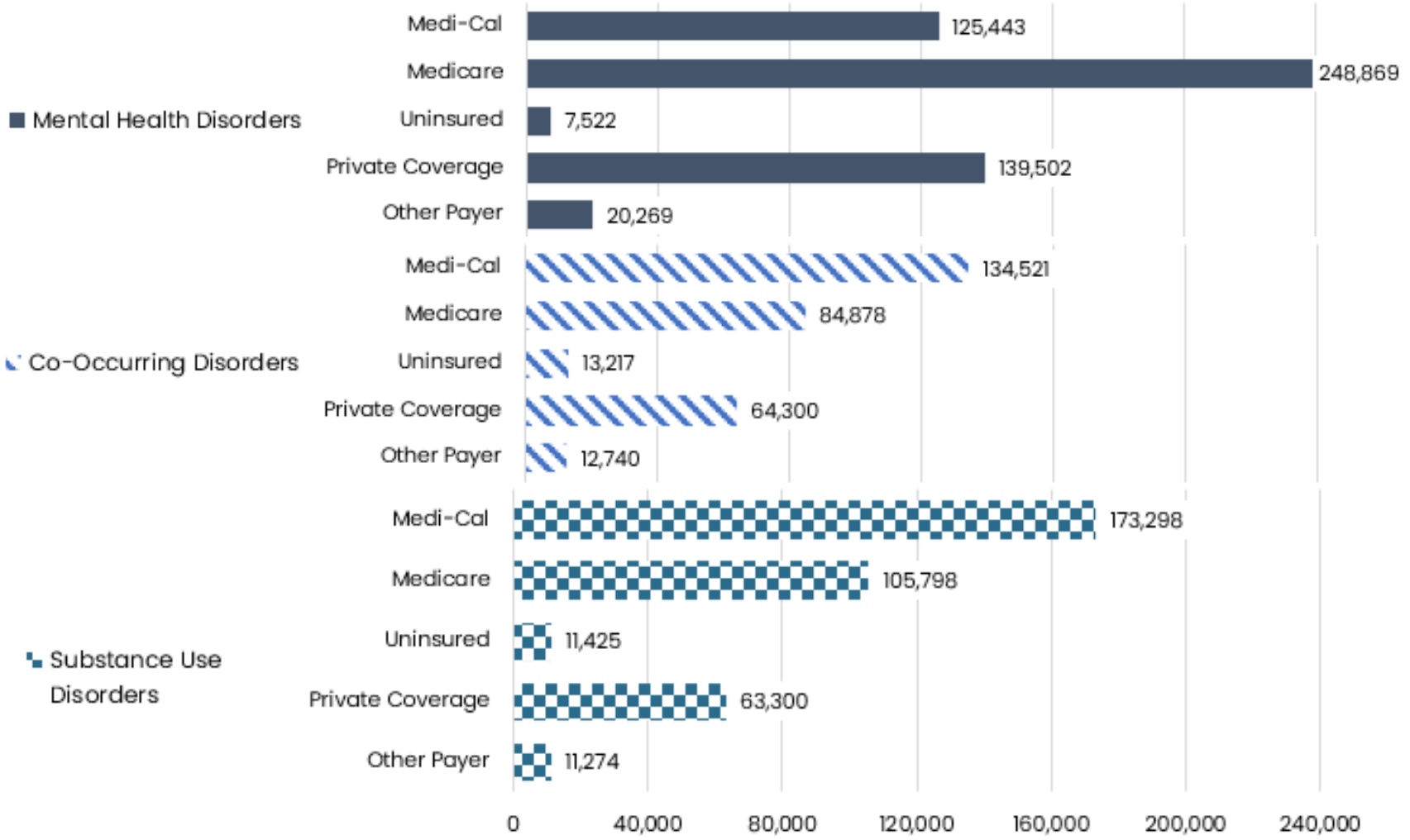


Sources: HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022

2b. Inpatient Psychiatric Stays – Expected Payer

- In 2021, Medi-Cal was the most common expected payer for co-occurring disorders and substance use disorders for inpatient care settings.
- Private payers covered more mental health disorders than co-occurring or substance use disorders
- Medicare was the most common payer for mental health disorders for inpatient care settings

Number of Behavioral Health Diagnoses Among Inpatient Hospital Encounters by Payer, 2021

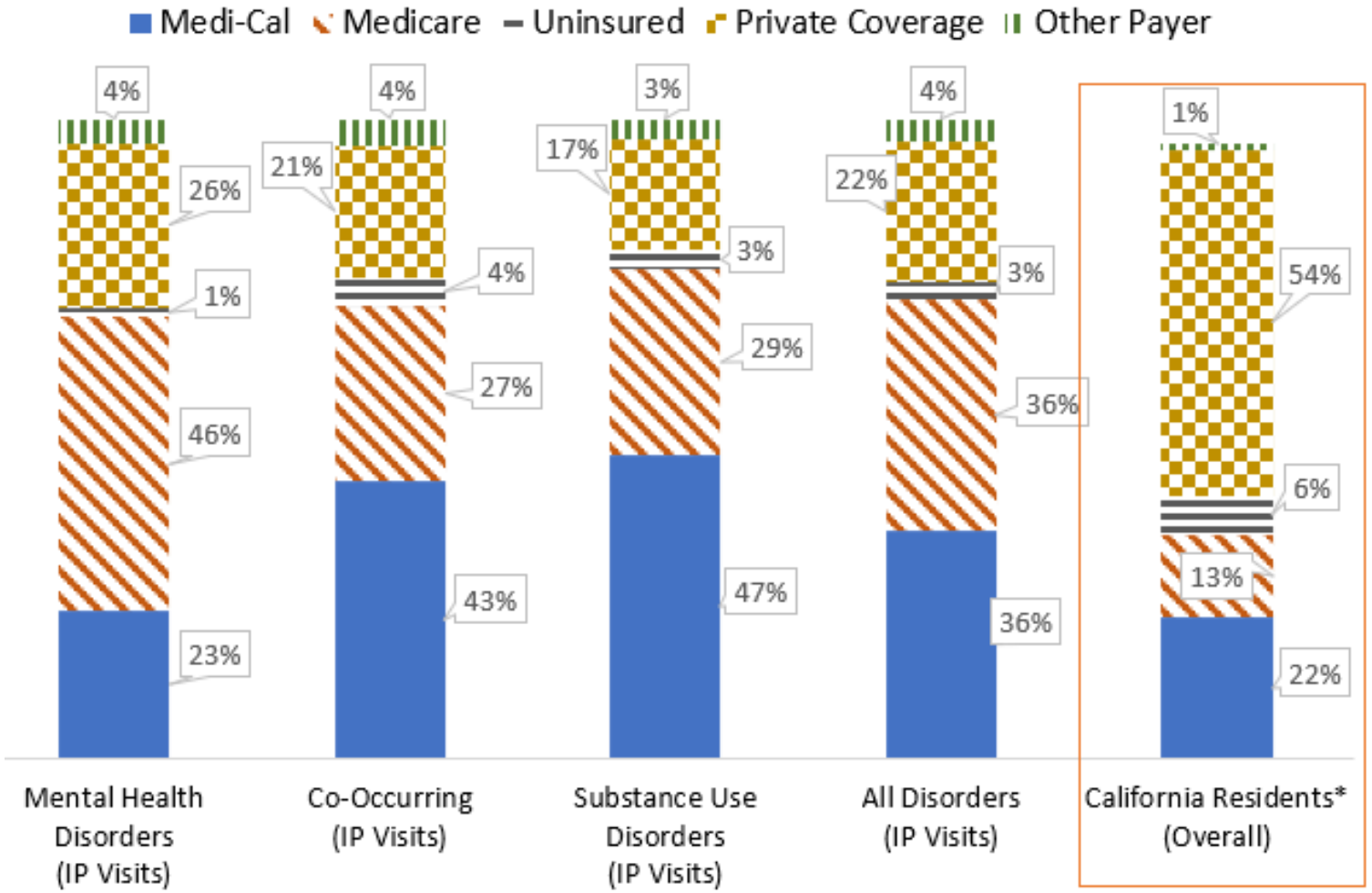


Sources: HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022

2b. Inpatient Psychiatric Stays by Expected Payer

- While Medi-Cal was the most common expected payer for co-occurring disorders and substance use disorders for inpatient care settings, private coverage was the most common payer for all California residents.
- Medicare was the most common payer for mental health disorders in inpatient care settings (46%), whereas Medicare only covered 13% of all California residents.
- California residents were less likely to have Medi-Cal coverage compared to those hospitalized for psychiatric reasons in the state.

Sources of Insurance Coverage, by Inpatient Psychiatric (IP) Stays in California and Overall Coverage, 2021



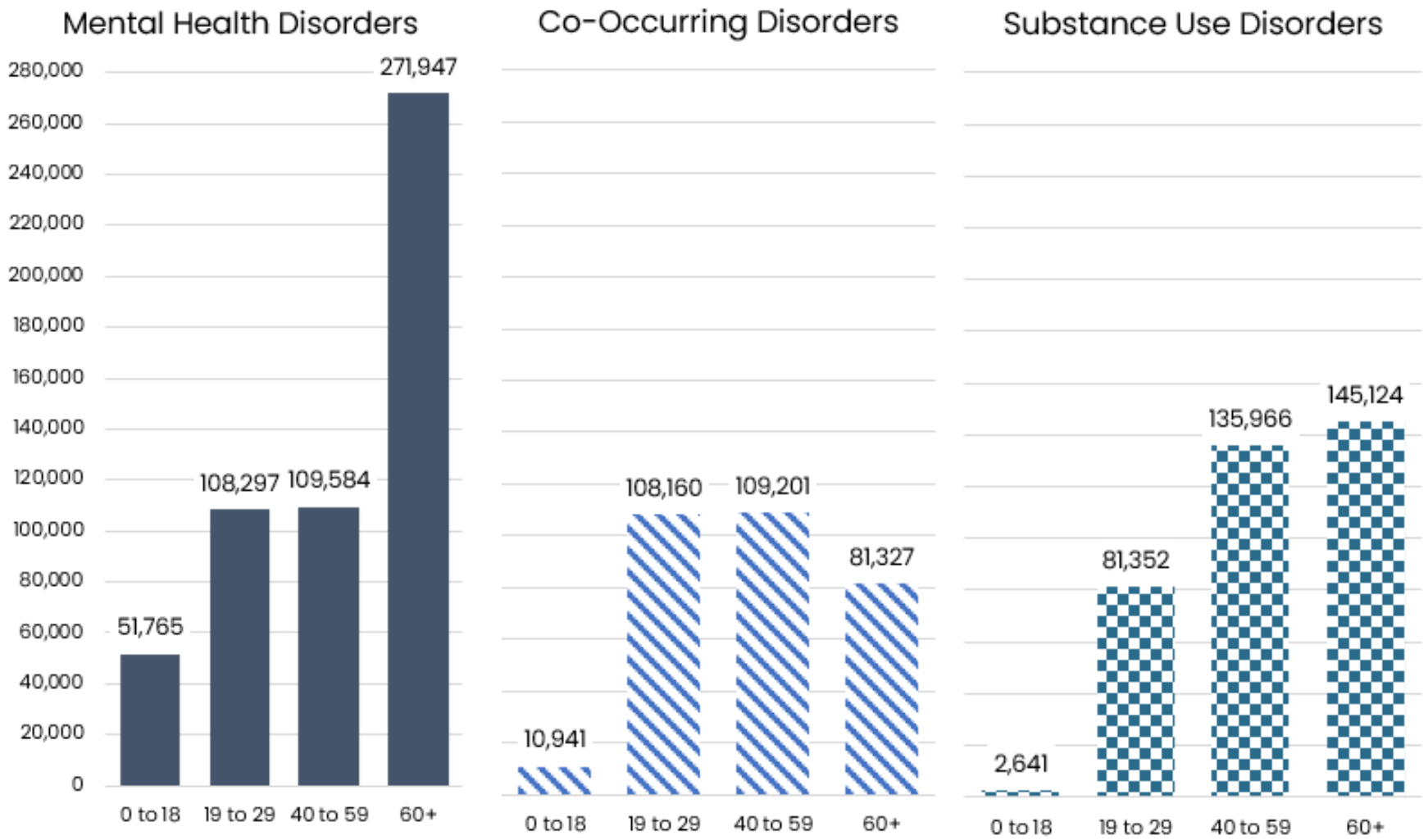
*Note: This graph does not depict the 4% of California residents who are covered by both Medicare and Medi-Cal

Sources: HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022

2b. Inpatient Psychiatric Stays – Age

In 2021, for patients with a mental health disorder diagnosis, the 60+ age group comprised approximately half of all inpatient hospitalization **numbers**.

Number of Behavioral Health Diagnosis by Age, Among Inpatient Hospitalization in California, 2021

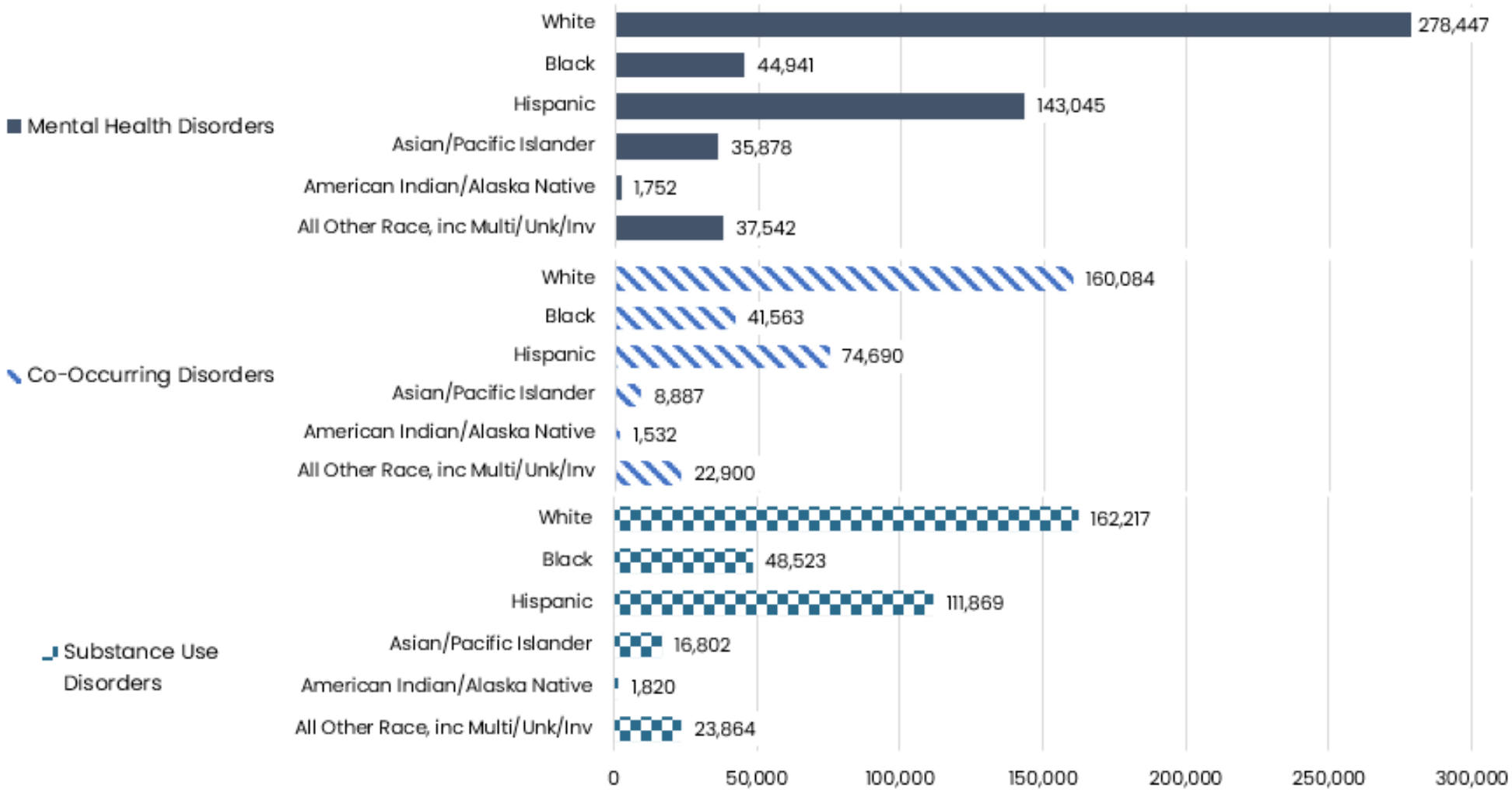


Sources: HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022

2b. Inpatient Psychiatric Stays – Race/Ethnicity

In 2021, White individuals had the highest **number** of hospitalizations across behavioral health diagnoses in California.

Number of Behavioral Health Diagnosis by Race/Ethnicity, Among Inpatient Hospitalization in California, 2021

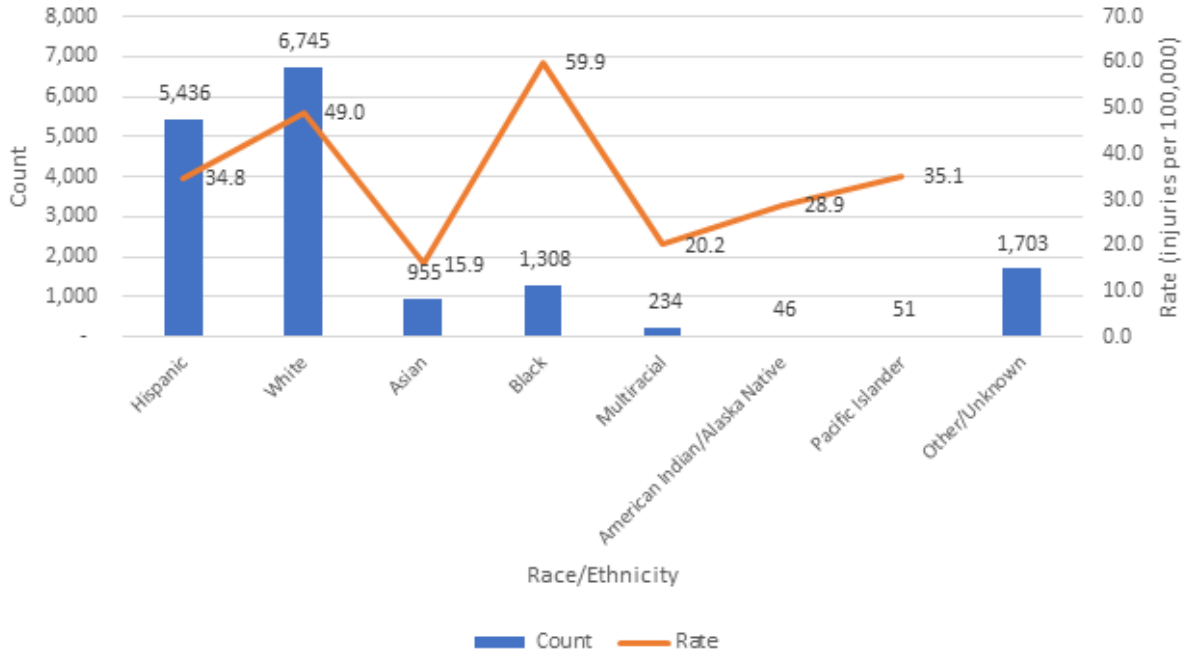


Sources: HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022

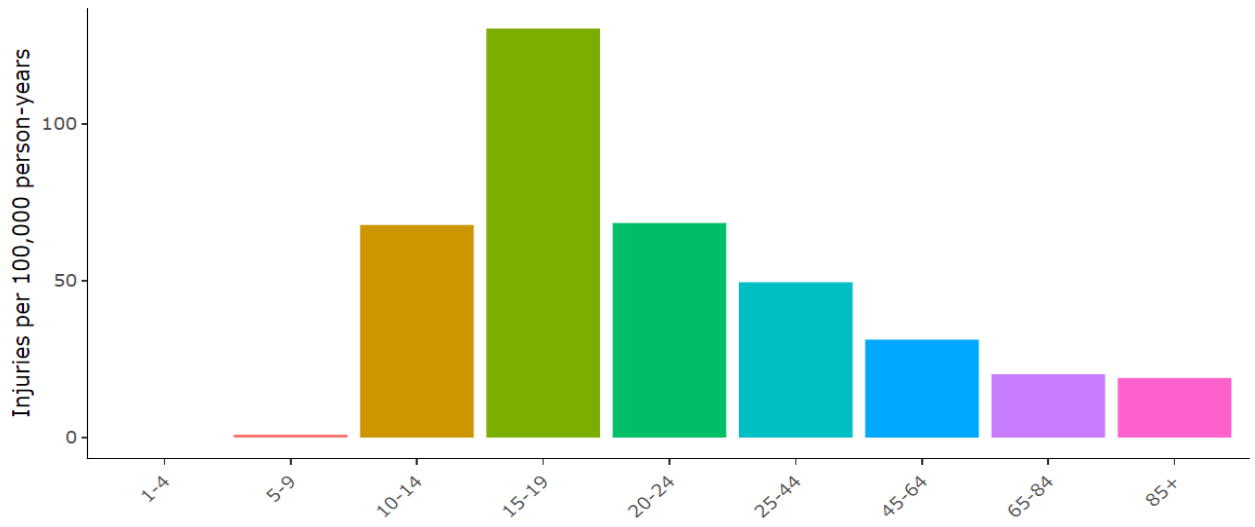
2b. Non-Fatal Self-Harm Hospitalizations by Race/Ethnicity and Age

In 2022, California had a crude rate of non-fatal self-harm hospitalizations of 42.2 per 100,000 residents (16,478 visits).

Non-Fatal Hospitalizations, 2022



Non-Fatal Self-Harm Injury Hospitalization Rates by Age, 2022



In 2022, Blacks/African Americans had the highest crude rate of all non-fatal self-harm hospitalizations (59.9 per 100,000 residents) in California.

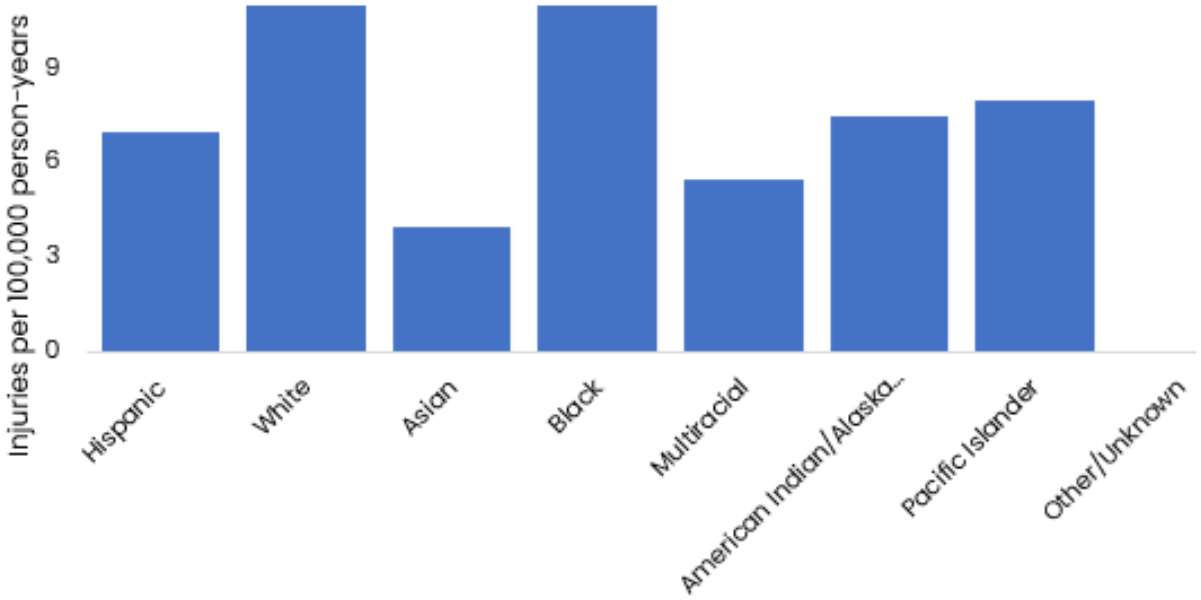
In 2022, teens ages 15 to 19 had the highest crude rate of hospitalizations in California due to non-fatal self-harm injury at 130.5 per 100,000 residents (3,446 injuries).

Source: California Department of Public Health - California Injury Data Online EpiCenter – Accessed 2/21/24.

2b. Psychiatric Hospital Transfers for Non-Fatal Self-Harm Injury Hospitalizations

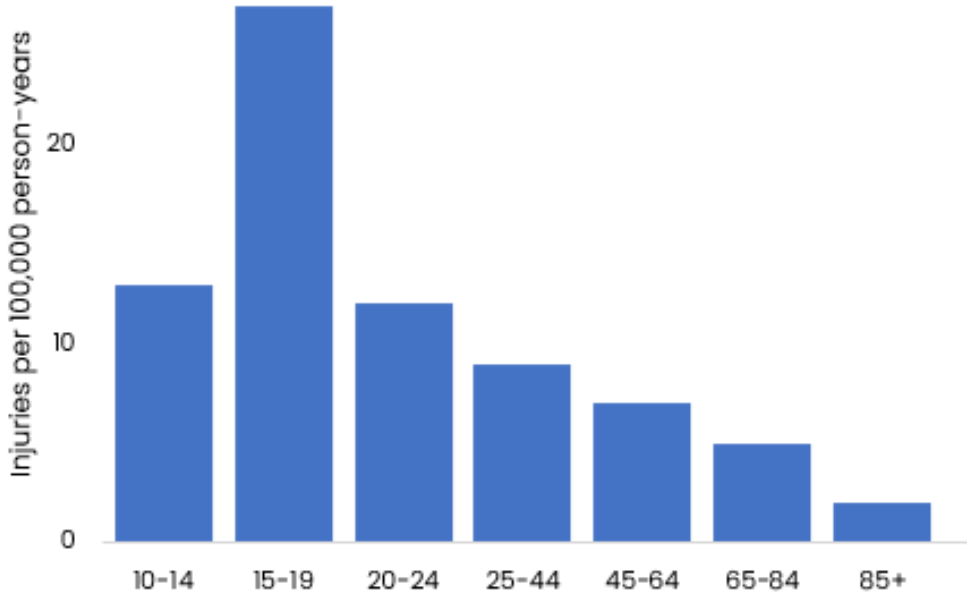
In 2022, the crude rate of psychiatric hospital transfers from non-fatal self-harm injury hospitalizations was 8.6 per 100,000 residents (3,355 transfers) in California.

Non-Fatal Self-Harm Injury Hospitalization Psychiatric Hospital Transfer Rates by Race/Ethnicity, 2022



In 2022, Black individuals had the highest crude rate of psychiatric hospital transfers in California from non-fatal self-harm injury hospitalizations at 10.8 per 100,000 residents (235 injuries), followed closely by White individuals with a rate of 1.5 (1,448 injuries).

Non-Fatal Self-Harm Injury Hospitalization Psychiatric Hospital Transfer Rates by Age, 2022



In 2022, youth ages 15 to 19 had the highest crude rate of psychiatric hospital transfers in California from non-fatal self-harm injury hospitalizations at 28.0 per 100,000 residents (738 injuries).

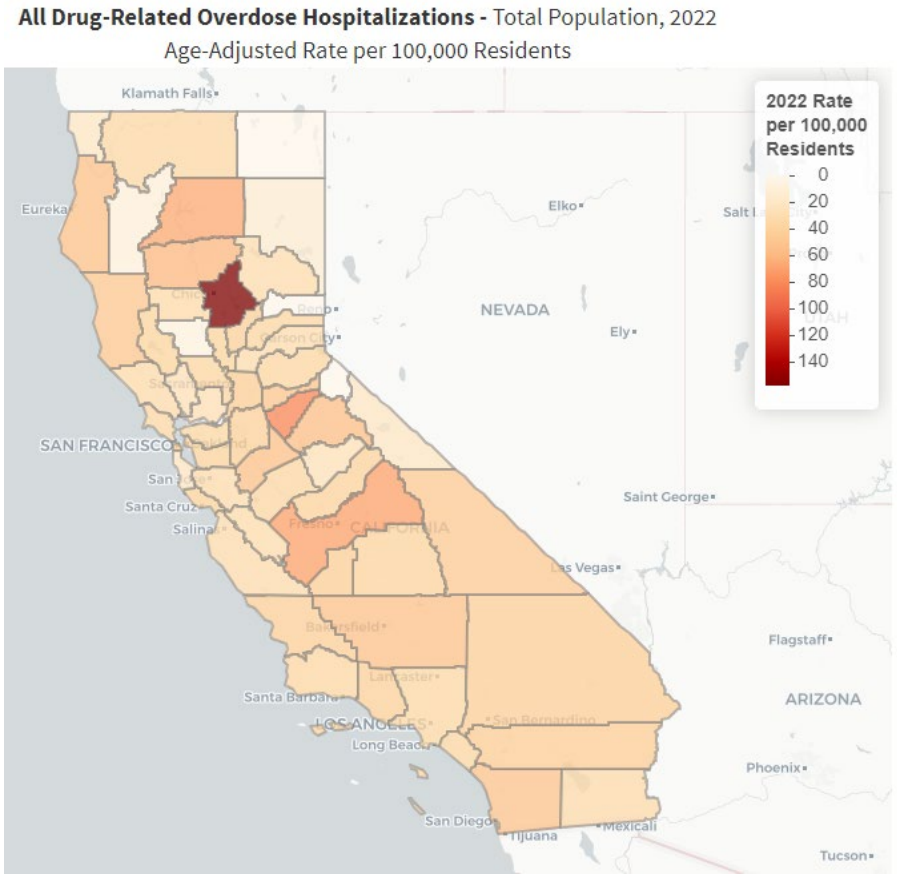
Source: California Department of Public Health - California Injury Data Online EpiCenter – Accessed 2/21/24

*__Definition Note__: A psychiatric hospital transfer refers to those discharged/transferred to a psychiatric hospital or psychiatric distinct unit of a hospital

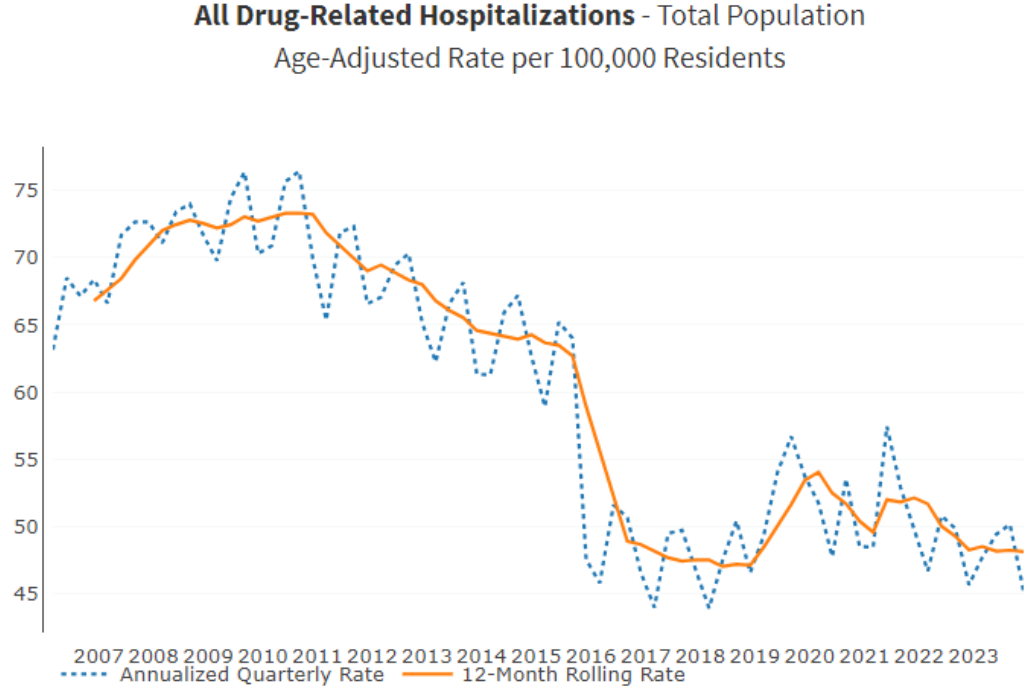
2b. Inpatient Psychiatric Stays for Drug-Related Overdose

In 2022, California had an age-adjusted rate of all drug-related overdose hospitalizations of 48.27 per 100,000 residents (19,996 hospitalizations), compared with a national rate in 2022 of 49.8 per 100,000 individuals

All Drug Related Overdose Hospitalizations, 2022 Age Adjusted Rate per 100,000



All Drug Related Overdose Hospitalizations, 2006-2023, Age Adjusted Rate per 100,000

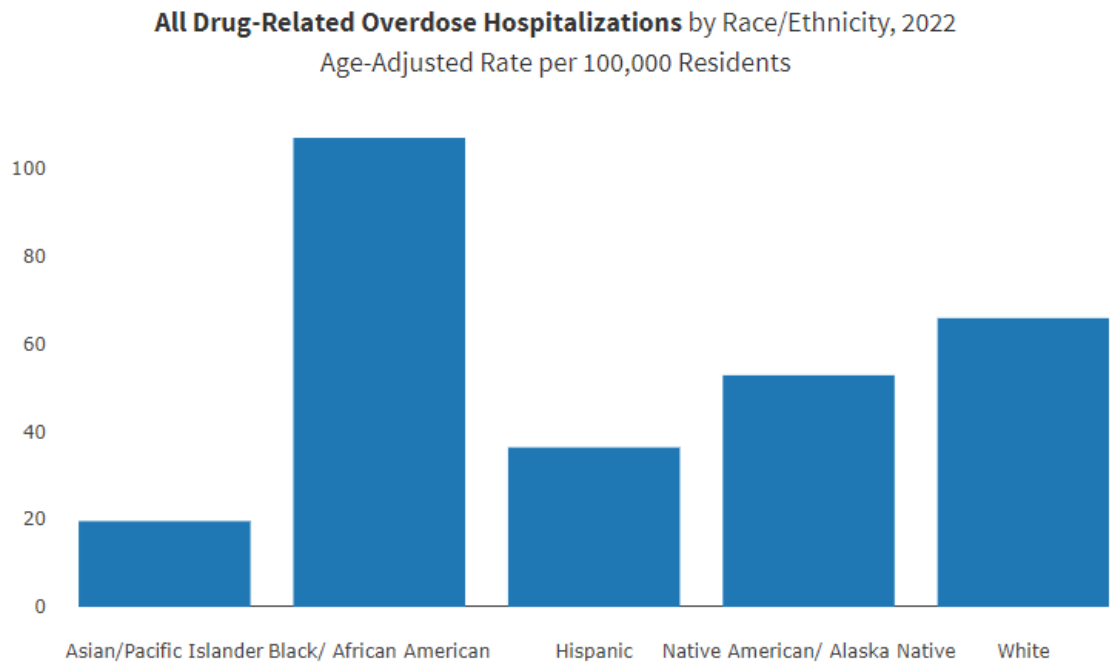


Although the age-adjusted rate of all drug-related hospitalizations from 2019 to 2020 increased, all drug-related hospitalizations decreased overall from the beginning of 2020 (54.06) to the end of 2023 (48.14).

Source: California Overdose Surveillance Dashboard, prepared by California Department of Public Health (CDPH) - Substance and Addiction Prevention Branch (SAPB) – Accessed 11/1/24; Centers for Disease Control and Prevention, 2019 Annual Surveillance Report Of Drug-related Risks And Outcomes

2b. Drug-Related Overdose Hospitalizations by Race/Ethnicity/Age

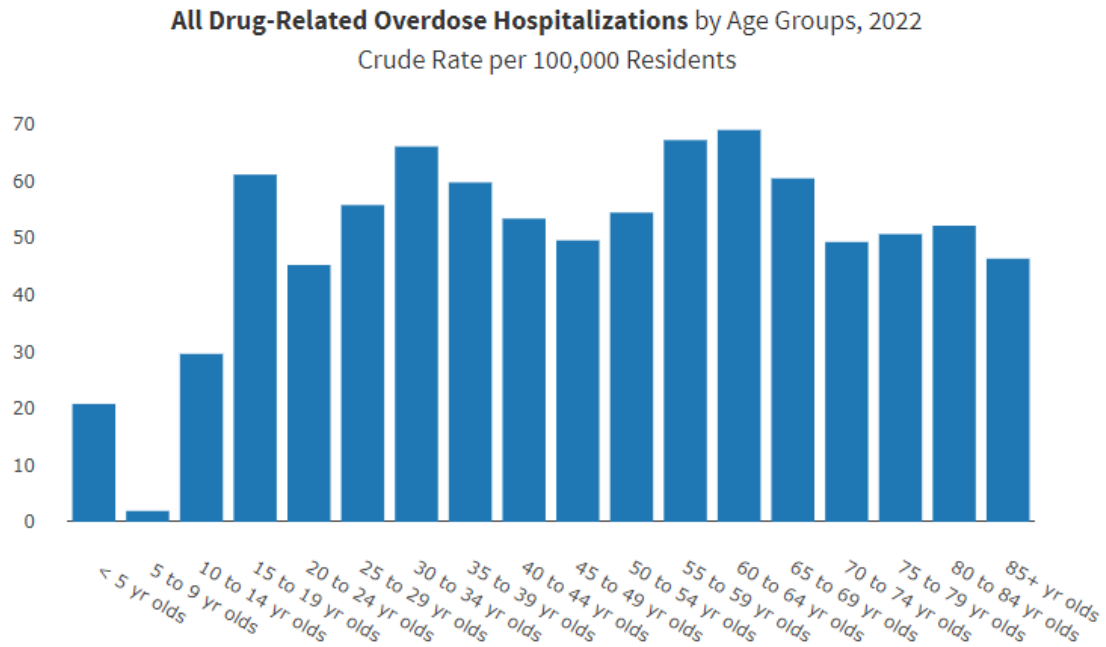
All Drug Related Overdose Hospitalizations by Race/Ethnicity 2022, Age Adjusted Rate per 100,000



In 2022, Black/African Americans had the highest age-adjusted rate of all drug-related overdose hospitalizations (107.09 per 100,000 residents) in California

The highest crude rate for all drug-related hospitalizations in California was from 60- to 64-year-olds (69.06), followed closely by 55- to 59-year-olds (67.27), then 30- to 34-year-olds (66.14), and then by 15- to 19-year-olds (61.20) in 2022

All Drug Related Overdose Hospitalizations by Age Group 2022, Crude Rate per 100,000



Source: California Overdose Surveillance Dashboard, prepared by California Department of Public Health (CDPH) - Substance and Addiction Prevention Branch (SAPB) – Accessed 2/21/24; Centers for Disease Control and Prevention, 2019 Annual Surveillance Report Of Drug-related Risks And Outcomes

3. Police Contacts and Mental Illness

(a) Incarceration at national, state, county levels

(b) Behavioral health-related involuntary treatment and incarceration as available

Key Takeaway #3

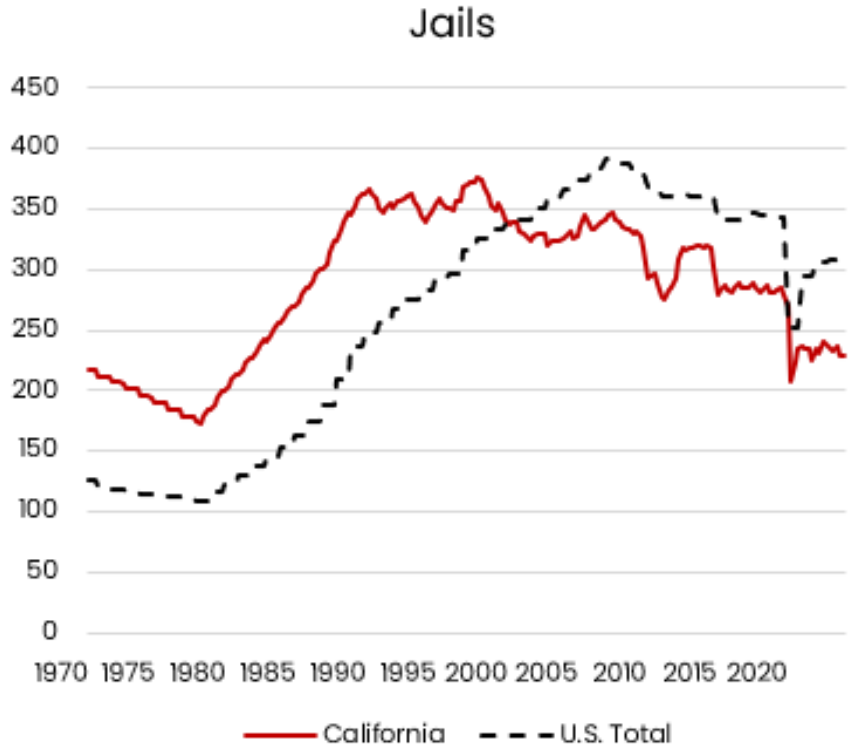
- Police are disproportionately likely to use force against individuals with serious mental illness (SMI) or to injure individuals with SMI.
- According to one study, individuals with SMI are 11.6 times more likely to experience police use of force than individuals without SMI.*
- An analysis of use of force data in California from 2021 shows that more than four in 10 people treated for non-fatal gunshot wounds from a police encounter were diagnosed with a mental health condition and/or an SUD.**
- Race can further increase an individual's risk of experiencing police force, with police in California disproportionately likely to use force against Latine and Black or African American individuals.***

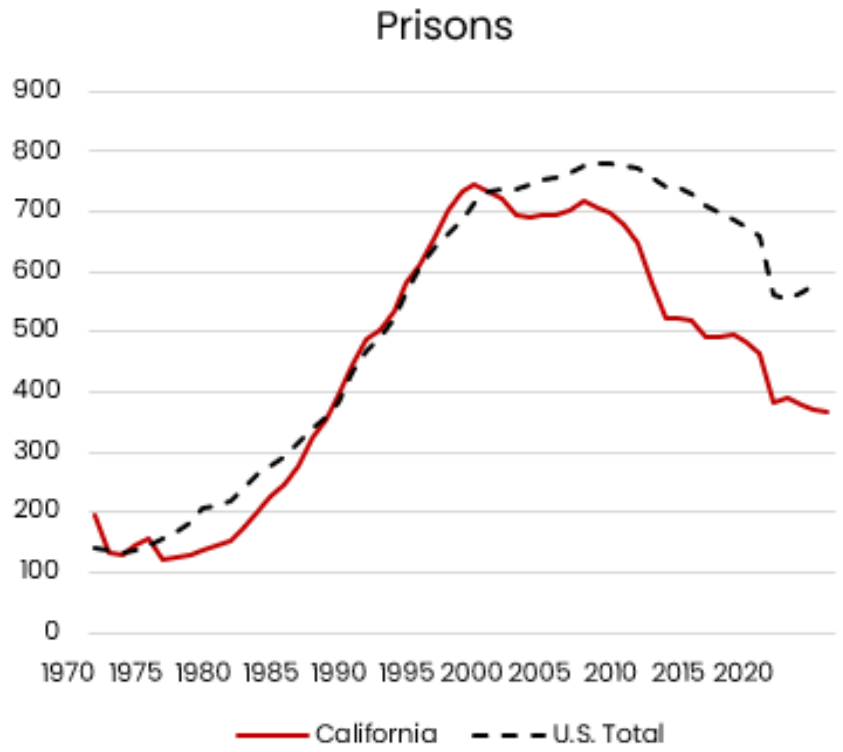
Sources:
* Laniyonu, A., Goff, P.A., BMC Psychiatry, Measuring disparities in police use of force and injury among persons with serious mental illness, 2021
** Public Policy Institute of California, Police Use of Force and Misconduct in California
*** California Department of Public Health, Demographic Report on Health and Mental Equity in California

3a. Incarceration: National, State, County Levels

In 2020, California had lower rates of incarceration compared to the United States.

Total Incarcerations per 100,000 Residents Ages 15-64, 2020





Source: Vera Institute of Justice Incarceration Trends

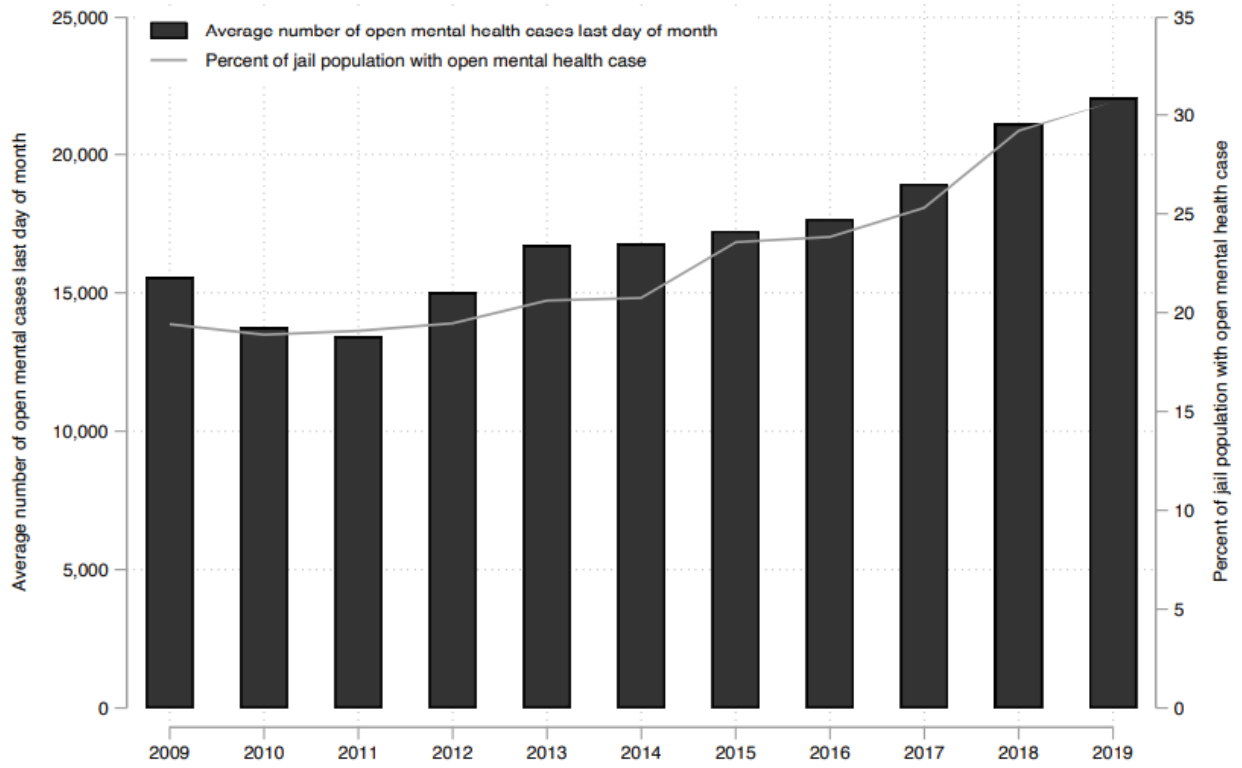
3a. Incarceration in California

CA Department of Corrections and Rehabilitation's data from 2015-2016 suggest that among those returned to their communities:

- 23.1% had severe to moderate mental health needs
- 57.7% had substance use treatment needs

Estimated Count and Prevalence of Active Mental Health Cases in Jails Statewide, 2009-2019

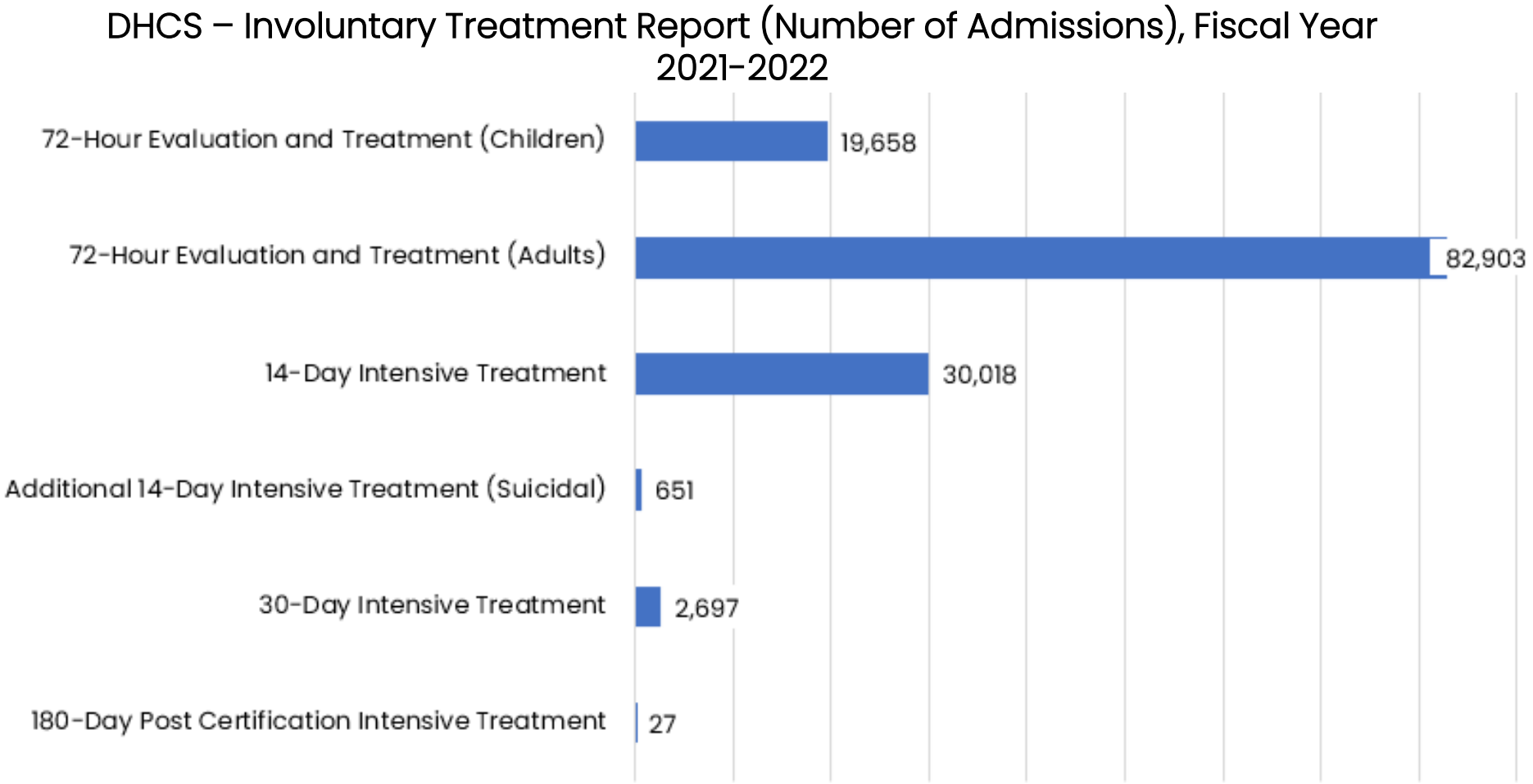
Figure 2a. *Estimated Count and Prevalence of Active Mental Health Cases Statewide, 2009 - 2019*



[The Prevalence of Mental Illness in California Jails is Rising: An Analysis of Mental Health Cases & Psychotropic Medication Prescriptions](), 2009-2019.

Source: [Council on Criminal Justice and Behavioral Health, Behavioral Health Care and the Justice-Involved: Why It Is So Important]();
California Health Policy Strategies

3b. Involuntary Treatment in California



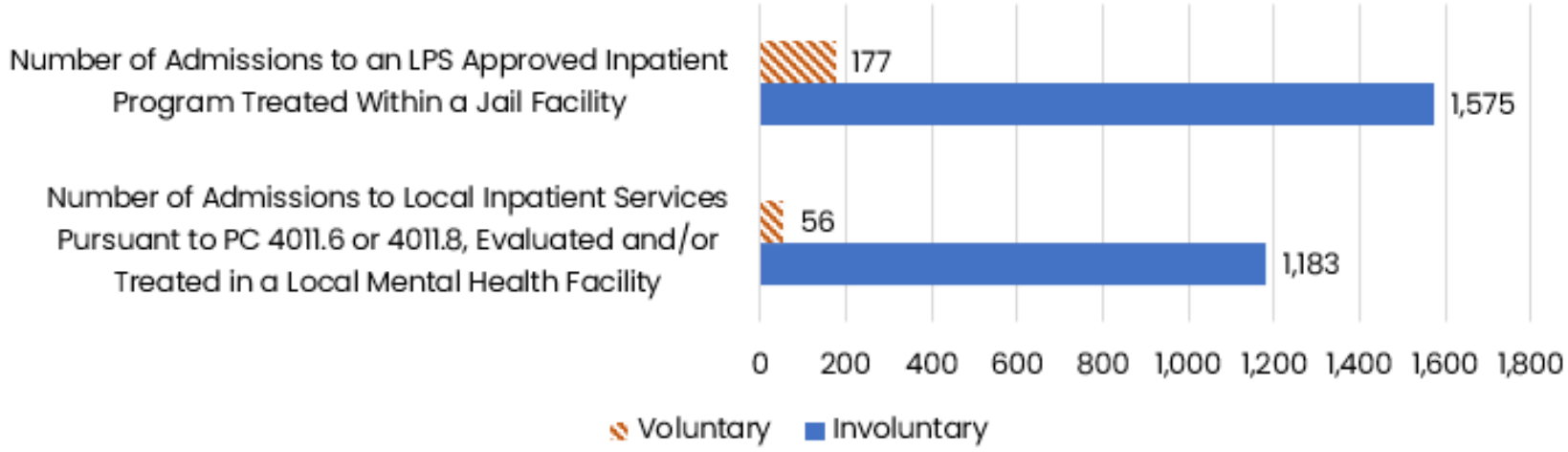
The highest number of involuntary treatments were from adult admissions for 72-hour evaluations and treatments (82,903) followed by certifications for 14-day intensive treatments (30,018).

Source: DHCS Senate Bill 929 Report to Legislature, March 2024

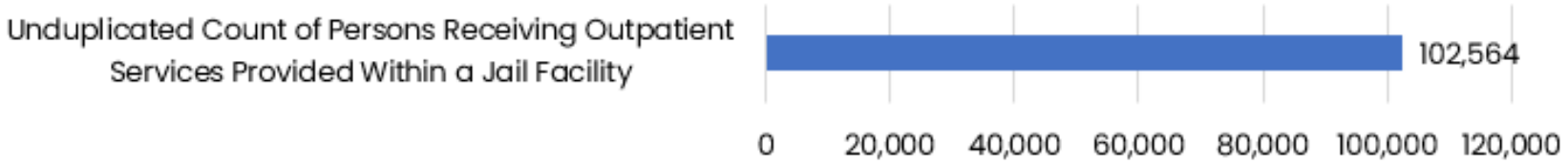
Note: The involuntary treatment numbers reflected in this slide are not specific to jailed individuals, but rather include all involuntary behavioral health and SUD treatment in a public or private facility

3b. Services Provided to Persons Detained in Jail Facilities in California

Admission and Transfers for Treatment, SFY 2021-2022



Outpatient Mental Health Services Provided to Persons Detained in Jail Facilities, SFY 2021-2022



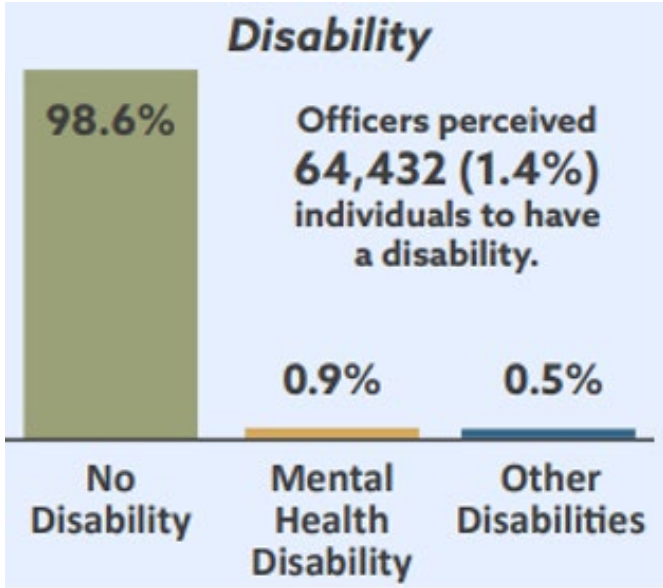
- There were more involuntary than voluntary admissions to both Lanterman-Petris-Short (LPS) - approved treatment programs within a jail facility and admission transfers to local mental health services.
- 102,564 individuals were receiving voluntary and involuntary outpatient services within a jail facility.

Source: DHCS Senate Bill 929 Report to Legislature, March 2024

**Note*: County LPS designated facilities are mental health treatment facilities that the county has determined have the capacity to provide evaluation and treatment services, approved by the State DCHS, and licensed as a health facility as defined in subdivision (a) or (b) of Section 1250 or 1250.2 of the Health and Safety Code or is certified by the DHCS to provide mental health treatment. A designated facility may include, but is not limited to, a licensed psychiatric hospital, a licensed psychiatric health facility, and certified crisis stabilization units.

2022 Racial and Identity Profiling Act ("RIPA") Stop Data in California

- In 2022, 1.4% of individuals stopped by officers were *perceived* to have one or more disabilities (64,432 individuals).
  - Among those *perceived* to have a disability, the most common disability reported by officers was a **mental health disability*** (68.4%, n=41,724).
- Stops leading to a sole resisting arrest charge:
  - Individuals with *perceived mental health disabilities* had the highest percentage of stops that resulted in a sole resisting arrest charge among perceived or known disability groups (0.46%), which was **5.7 times the state average**.
  - When *no disability was perceived*, the percentage of stops with resisting arrest as the sole charge was **slightly below the statewide average** (0.08%).



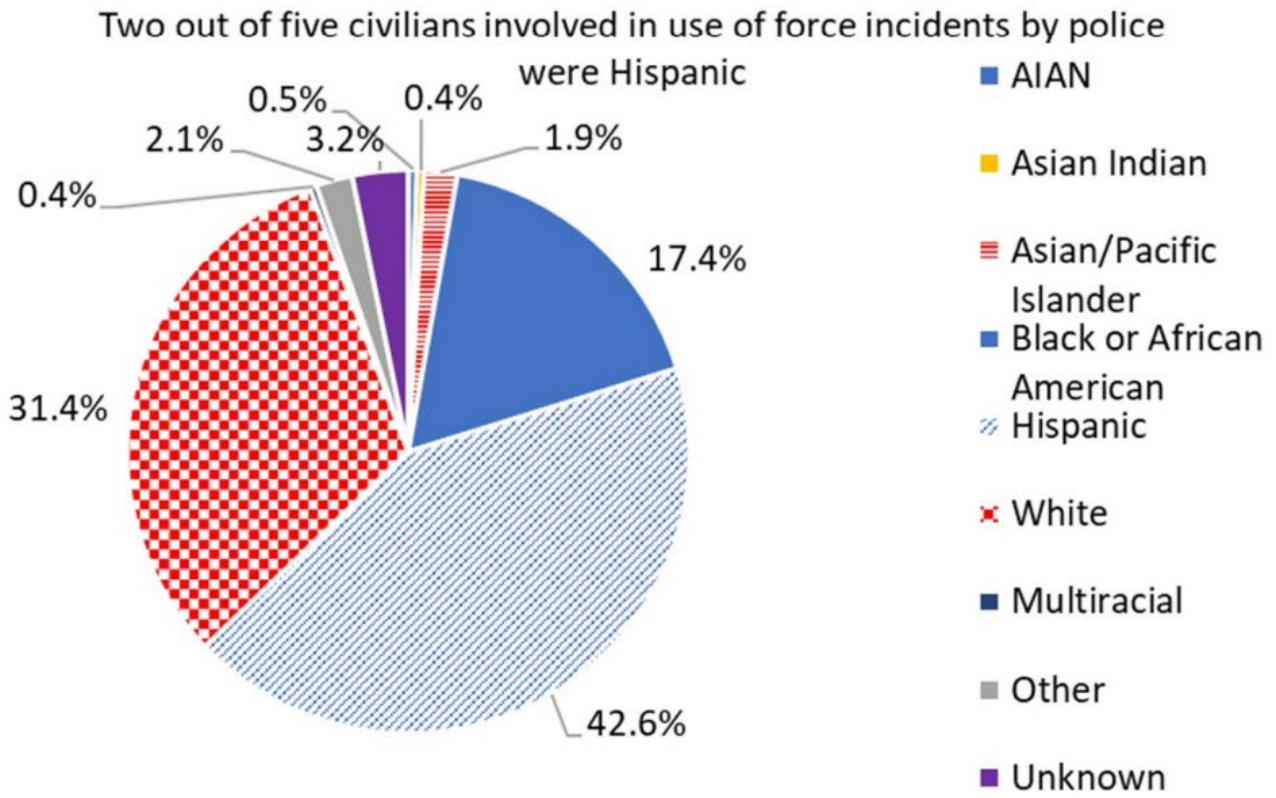
Note: From 2020-2022, the percentage of stopped individuals who officers perceived to have a disability (1.4%) and the percentage of those who officers perceived to have a mental health disability (0.9%) remained steady.

Source: Open Justice – Data Portal; Office of the Attorney General, Racial and Identity Profiling Advisory Board Annual Report 2024;
*Note: The report does not define "mental health disability." Office of the Attorney General, Racial and Identity Profiling Advisory Board 2024 Report Quick Facts

Race and Ethnicity of Civilians Involved in Use of Force by Police

- In 2020, a total of 745 civilians in California experienced use of force by police
- Of the civilians involved in use of force incidents by police:
  - 42.6% were Latine
  - 31.4% were White
  - 17.4% were Black or African American

Percentages of race and ethnicity of civilians involved in use of force by police, California, 2020



Source: California Department of Justice, Use of Force Incident Reporting (Table 7), 2020.
Note: Incidents involved the discharge of a firearm or use of force resulting in serious bodily injury or death; Unknown=unknown race/ethnicity because civilian fled the scene; AIAN=American Indian and Alaska Native.

Source: California Department of Public Health, Demographic Report on Health and Mental Equity in California

4. Additional Data on Populations of Focus:

(a) Persons with Intellectual/ Developmental Disabilities

(b) Veterans

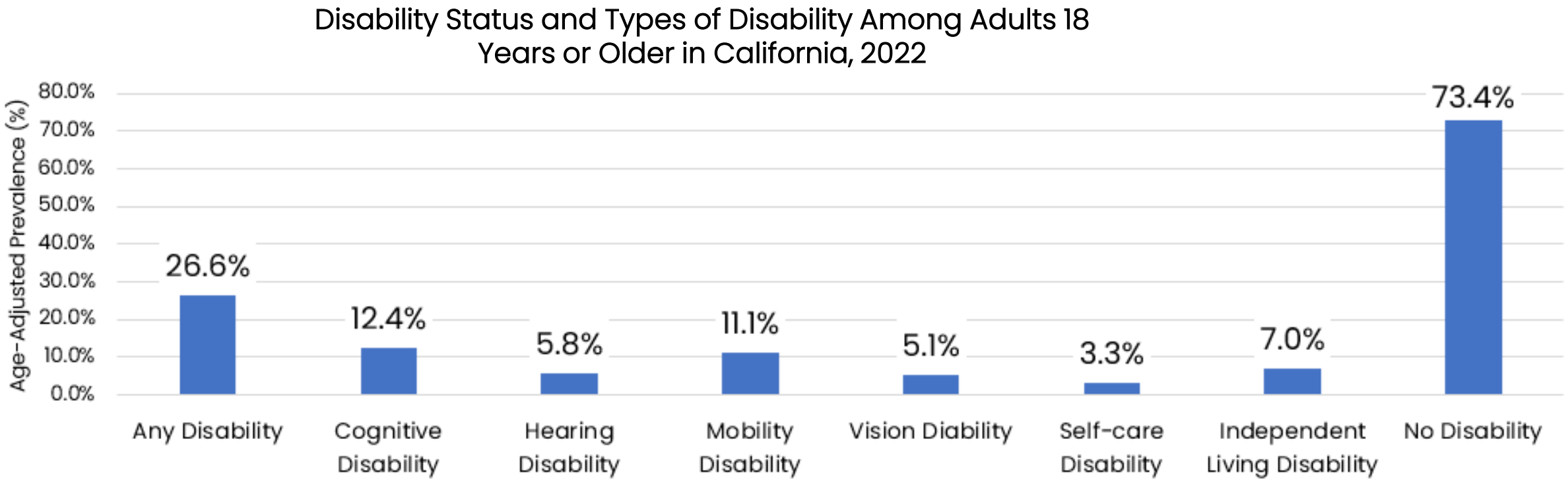
(c) Unhoused Persons

Key Takeaway #4

- Persons with Intellectual/Developmental Disabilities
  - More than one-quarter of Californians have a disability, and adults with disabilities are more likely to have depression than adults without disabilities.*
  - Most persons served by the Department of Developmental Services in 2021 were ages 22 to 31 and diagnosed with an intellectual disability, autism, or both.**
- Veterans
  - According to a 2023 RAND study, nearly one-quarter of participating veterans were at risk of dying by suicide.
  - Almost two-thirds of veterans in the study reported knowing someone who died by suicide; however, many veterans did not seek mental health care.***
- Unhoused Persons
  - The number of unhoused persons in California is growing, and drug/alcohol overdose is the leading cause of mortality among Los Angeles's unhoused population.****

Sources:
*CDC Disability and Health Data System (DHDS); Behavioral Risk Factor Surveillance System, 2022
**California Department of Developmental Services, CMF and CDER data for status 1, 2, 8, and U in July 2022
***RAND-USC Epstein Family Foundation Center for Veterans Policy Research, The State of the American Veteran: The Southern California Veterans Study, 2023
****The U.S. Department of Housing and Urban Development (HUD) point-in-time (PIT) counts, Annual Homeless Assessment Report and HUD memorandum; L.A. County Department of Public Health

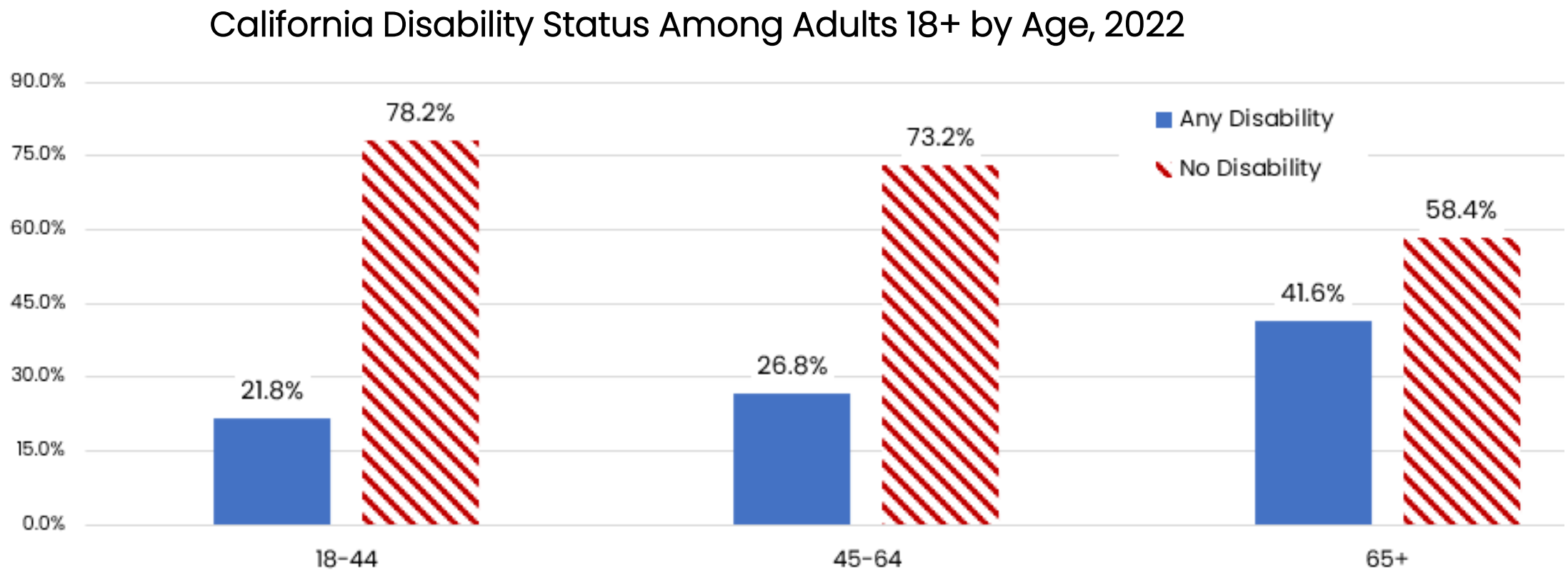
4a. Persons with Disabilities in California by Disability Status



- Over one-quarter of Californians (26.6%) had a disability in 2022, similar to the national percentage.
- Of those with disabilities, slightly less than half reported a cognitive disability (47.2%), followed by persons with mobility disabilities (42.9%).

Source: CDC Disability and Health Data System (DHDS); Behavioral Risk Factor Surveillance System, 2022

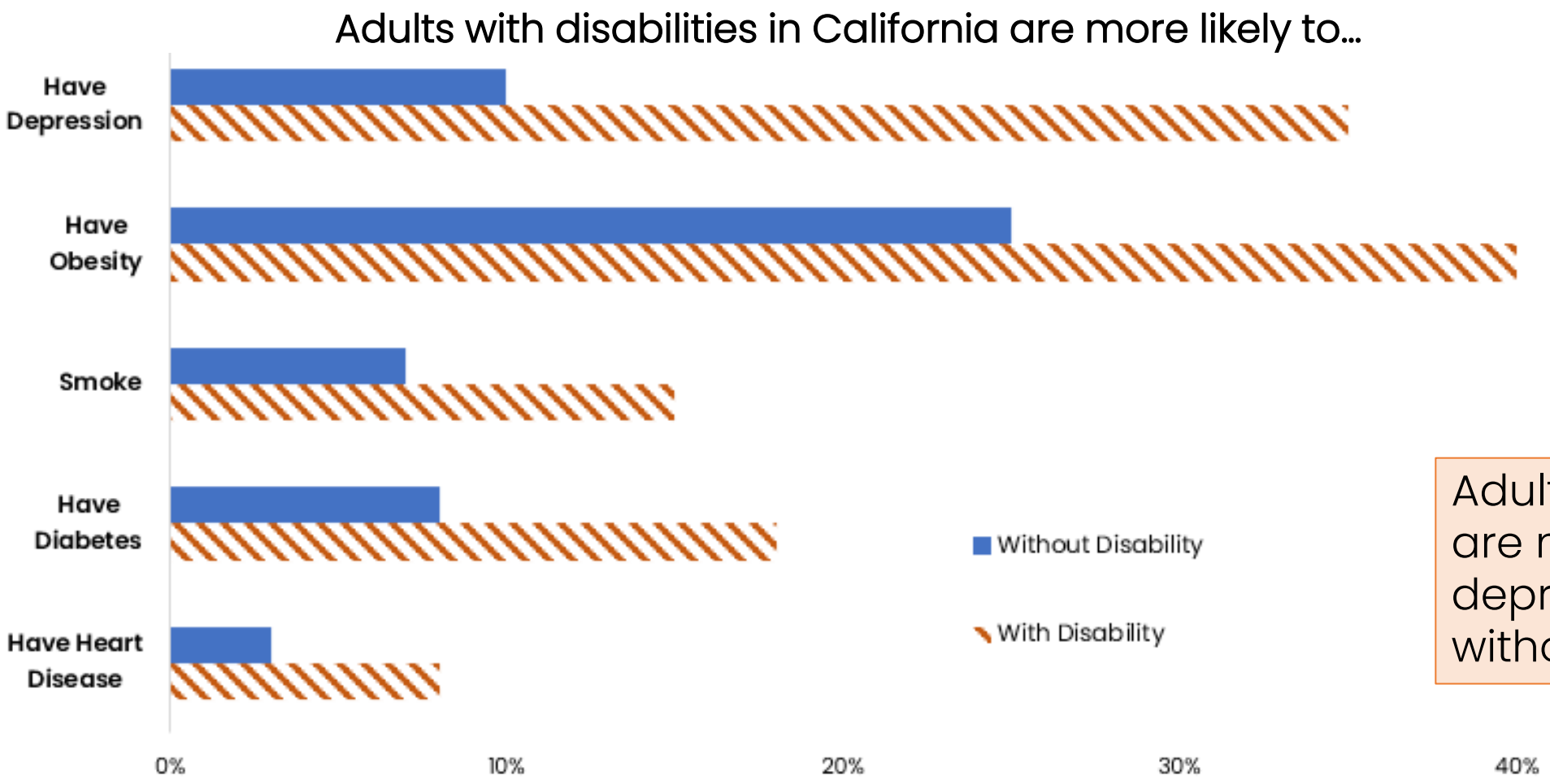
4a. Persons with Disabilities by Disability Status and Depression



Similar to national percentages, older adults were more likely to have a disability than other age groups

Source: 2022 Disability and Health Data System (DHDS); Behavioral Risk Factor Surveillance System, 2022

4a. Persons with Disabilities in California by Health-Related Outcomes

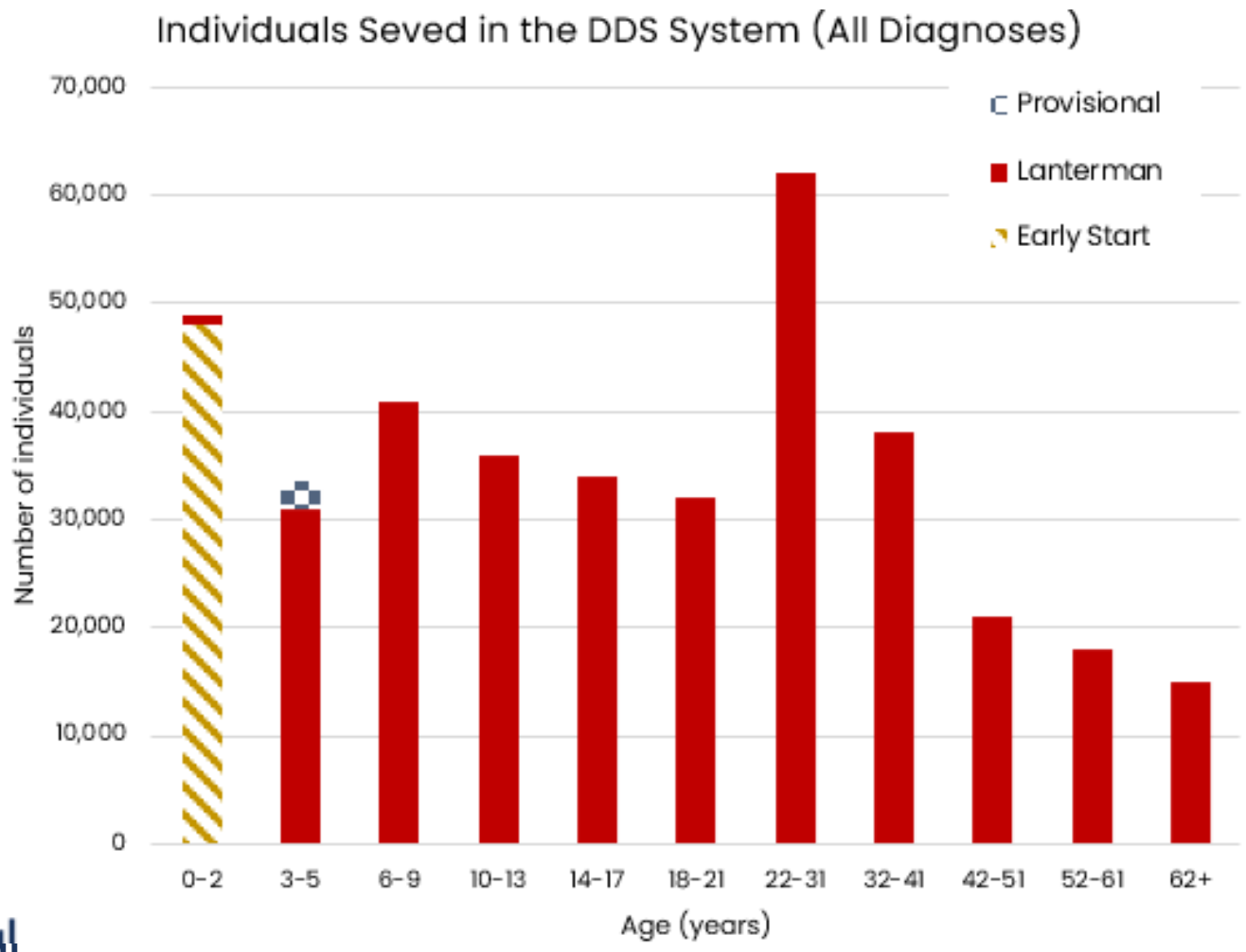


Adults with disabilities are more likely to have depression than adults without disabilities

Source: Behavioral Risk Factor Surveillance System, 2021

4a. Persons with Disabilities in California by Age and Diagnosis

Individuals Serviced by CA Department of Developmental Services by Age, 2022



By Diagnosis (Lanterman)

Intellectual Disability	53%
Autism	47%
Epilepsy	12%
Cerebral Palsy	11%
Other (5th Category)	11%

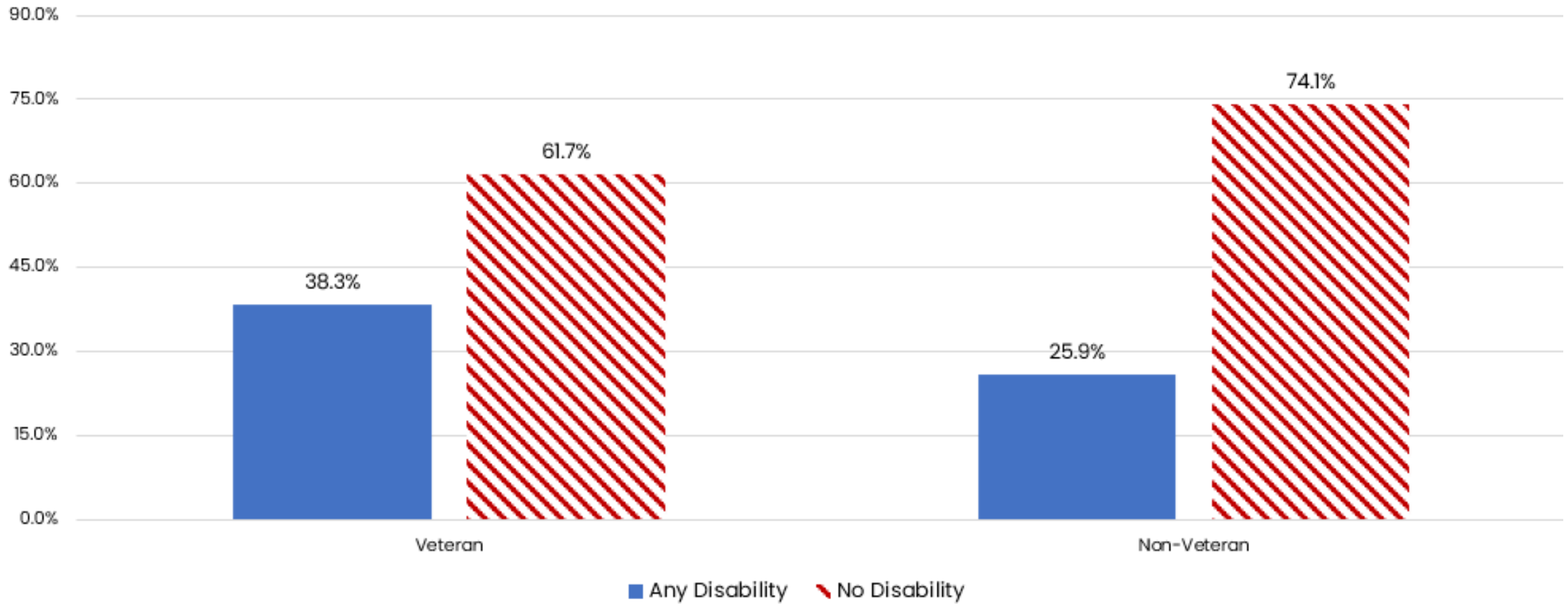
Note: An individual may have more than one diagnosis and may be counted under multiple diagnoses, i.e., duplicated counts

- The majority of persons served by the CA Department of Developmental Services in 2022 were ages 22 to 31 and diagnosed with either an intellectual disability, autism, or both.
- For FY 2022-2023, the state regional center had served 459,395 people.

Source: California Department of Developmental Services, CMF and CDER data for status 1, 2, 8, and U in July 2022

4a,b. Persons with Disabilities in California by Veteran Status

Veterans were more likely than non-veterans to have a disability.

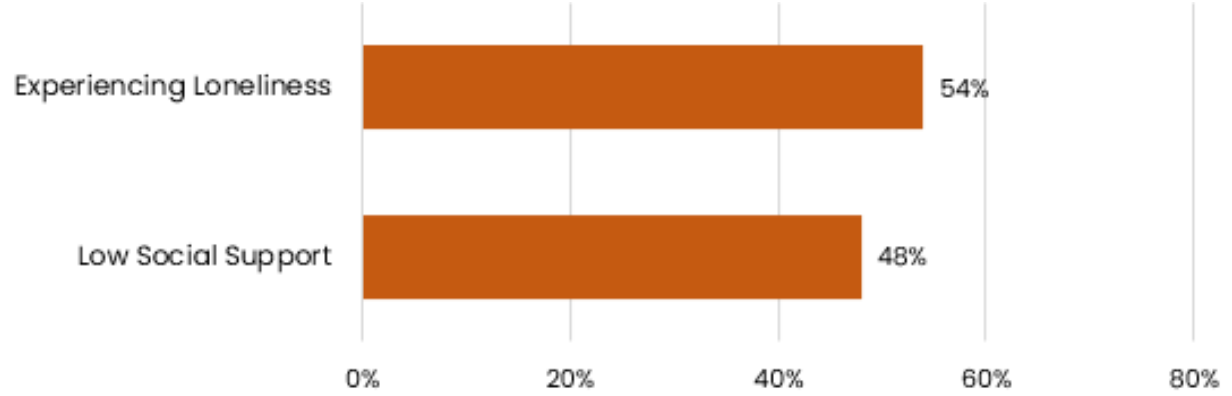


Source: 2022 Disability and Health Data System (DHDS); Behavioral Risk Factor Surveillance System, 2022

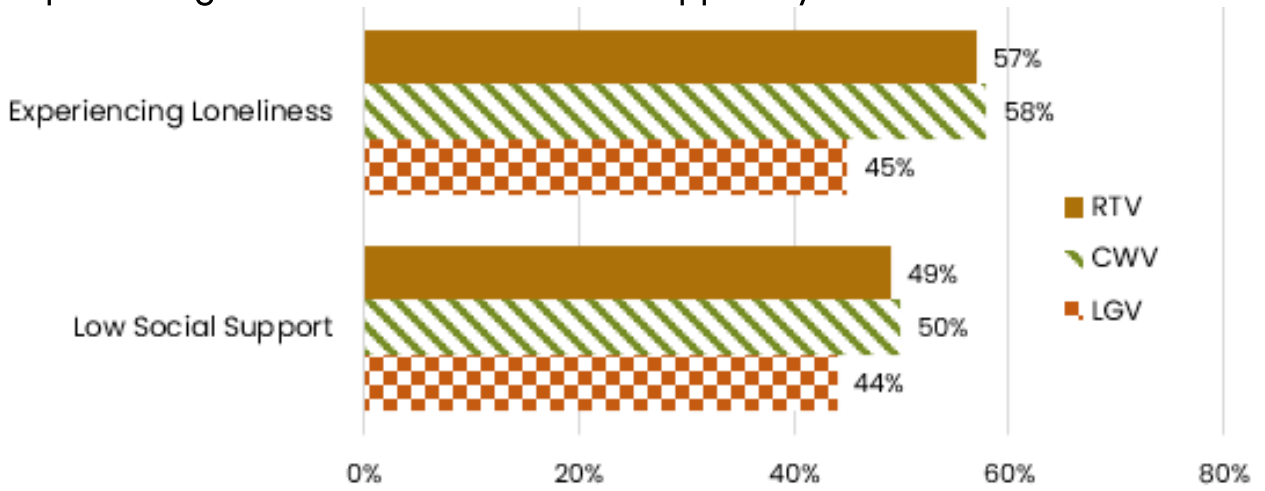
4b. Veterans and Behavioral Health in California

- California is home to almost 1.3 million veterans (4% of the state's population), the third largest veteran population of any U.S. state.
- According to a large, regional study of veterans in Los Angeles, Orange County, and San Diego with data collected between July 2022 and June 2023 (N=3,188; 42% in Los Angeles, 39% San Diego, 19% Orange County):
  - Nearly one-quarter of the veterans in the study were at risk of dying by suicide; recently transitioning veterans were at the highest risk.
  - Almost two-thirds of veterans in the study knew someone who died by suicide.
  - Many veterans do not seek care for mental health, believing that they have the skills to manage their behavioral health, a consistent and pervasive barrier to veterans getting the mental health care they need.

17a Loneliness and Social Support, Veterans Who Meet the Criteria for Experiencing Loneliness and Low Social Support



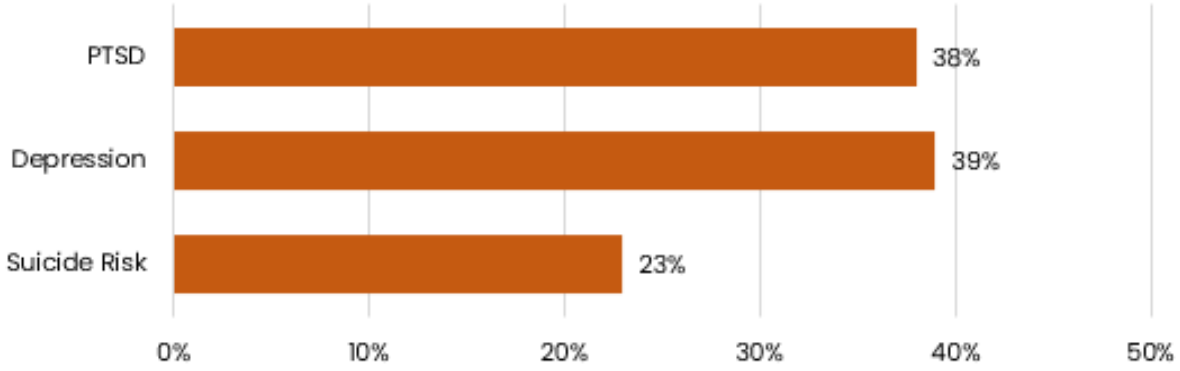
17b Loneliness and Social Support, Veterans Who Meet the Criteria for Experiencing Loneliness and Low Social Support by Era



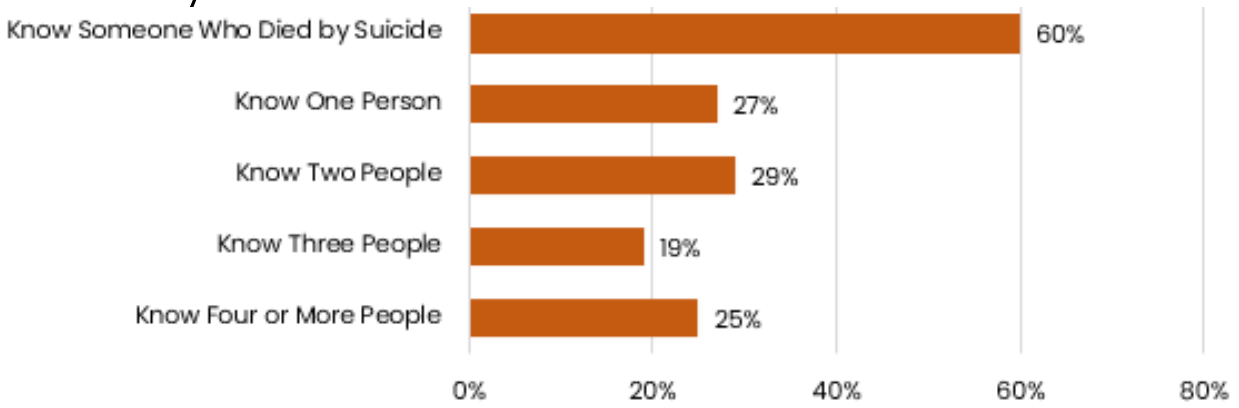
Source: US Census, ACS Data 2023;
RAND-USC Epstein Family Foundation Center for Veterans Policy Research, The State of the American Veteran: The Southern California Veterans Study, 2023

4b. Veterans in California – PTSD, Depression, and Suicide Risk

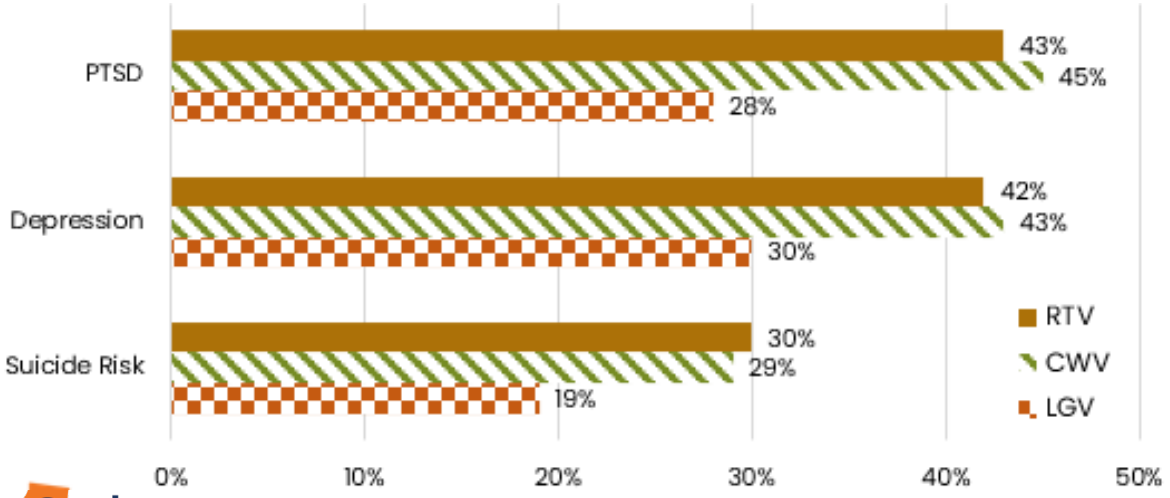
29a Percent of Veterans Who Screened Positive for Probable PTSD, Probable Depression, and Risk for Suicide



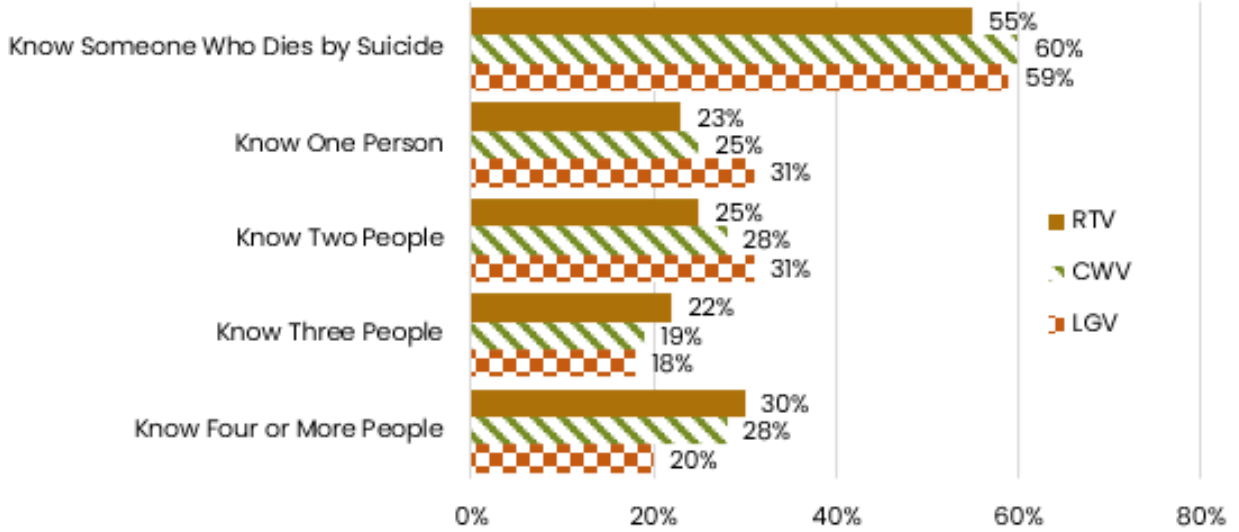
30a Suicide Exposure, Percentage of Veterans Who Report Knowing Someone Who Died by Suicide



29b Percent of Veterans Who Screened Positive for Probable PTSD, Probable Depression, and Risk for Suicide be Era



30b Suicide Exposure, Percentage of Veterans Who Report Knowing Someone Who Died by Suicide be Era

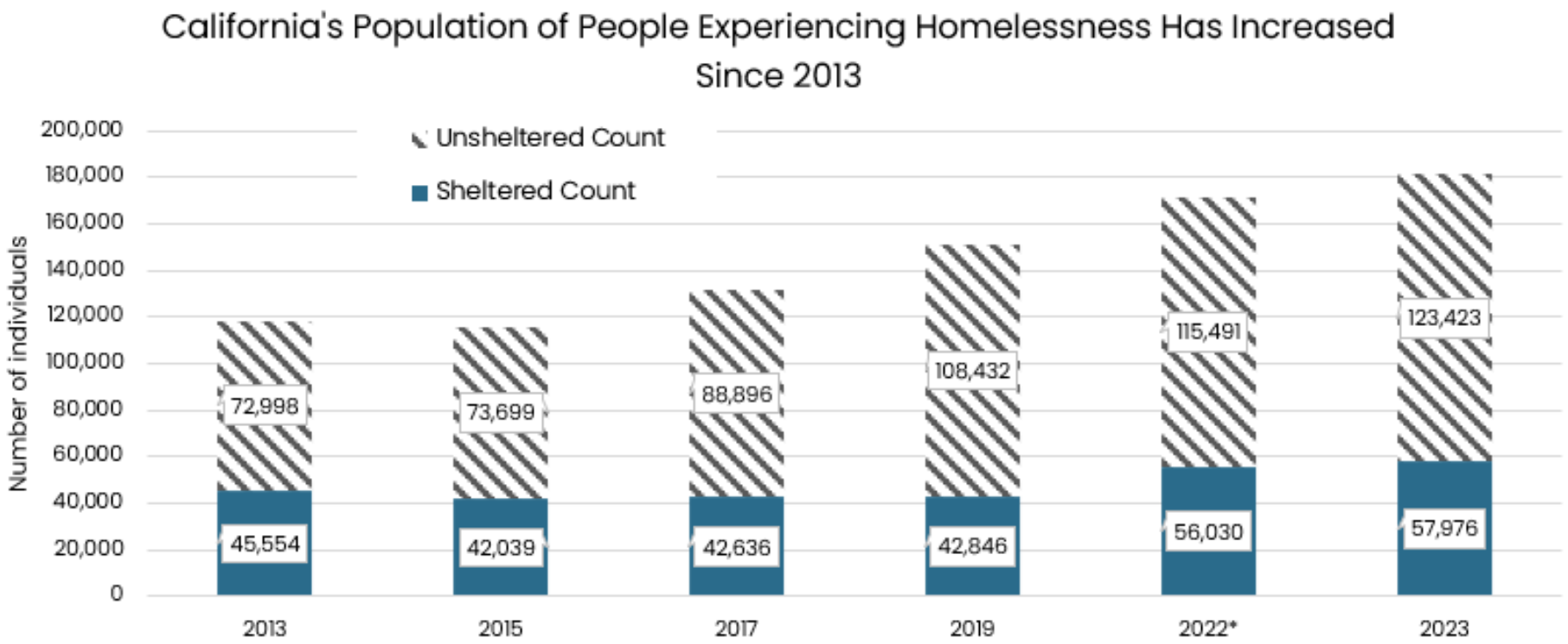


Source: RAND-USC Epstein Family Foundation Center for Veterans Policy Research, The State of the American Veteran: The Southern California Veterans Study, 2023

4c. Unhoused Persons and Behavioral Health

The number of unhoused persons in California is growing, with the number of unsheltered persons growing faster than those who have housing.

Sheltered and Unsheltered Unhoused Counts, 2013-2023



Note: HUD requires Continuum of Care (CoCs) to conduct a PIT count of people experiencing sheltered homelessness annually and a count of people experiencing unsheltered homelessness at least biennially. To present the total number of people experiencing homelessness, we therefore used to the year in which both categories of PIT counts were conducted.

*HUD waived the PIT count requirement for unsheltered homelessness in 2021 because of the COVID-19 pandemic, but it required the count again in 2022.

Source: The U.S. Department of Housing and Urban Development (HUD) Point-in-Time (PIT) Counts, Annual Homeless Assessment Report and HUD memorandum

4c. Unhoused Persons and Mental Health Conditions

According to the California Statewide Study of People Experiencing Homelessness (CASPEH), with data collected between October 2021 and November 2022 (N=3,198):

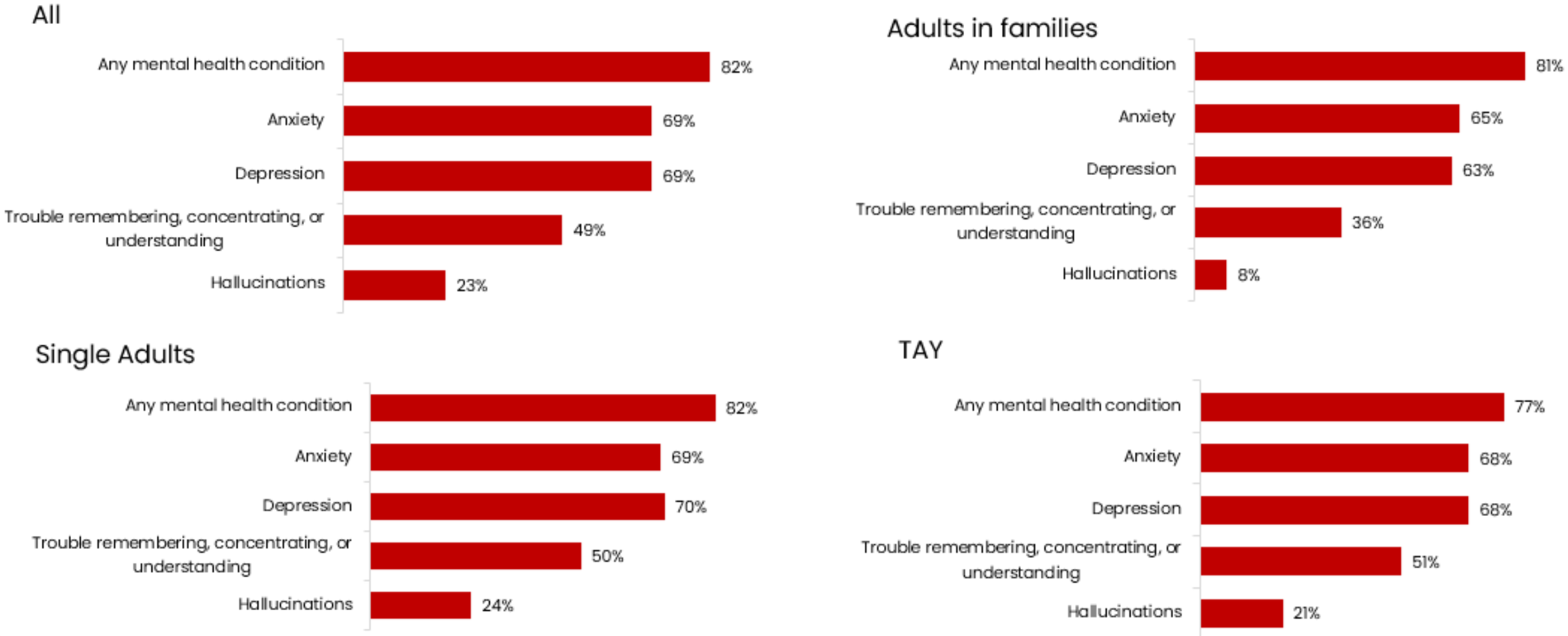
- 82% of participants experienced a mental health condition in their lifetime
    - Most common were depression (69%) and anxiety (69%), with 23% reported experiencing hallucinations
- 25% reported ever receiving a diagnosis of post-traumatic stress disorder
- 56% reported that their first hospitalization had occurred prior to their first episode of homelessness
- 15% of adults in families, 28% of single adults, and 32% of TAY reported a mental health-related hospitalization
- 31% of participants attempted suicide at some point in their lifetime
- 21% of adults in families reported a suicide attempt, while 32% of single adults and 32% of TAY* reported a suicide attempt

*Transition age young adults (TAY; young adults aged 18-24 not living with minor children)

Source: Kushel, M., Moore, T., et al. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative.

4c. Unhoused Persons and Mental Health Conditions

Self-Reported Mental Health Conditions at Any Point in Participants' Lifetime by Family Structure, 2023



*Transition age young adults (TAY; young adults aged 18-24 not living with minor children)

Source: Kushel, M., Moore, T., et al. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative.

4c. Unhoused Persons and Substance Use

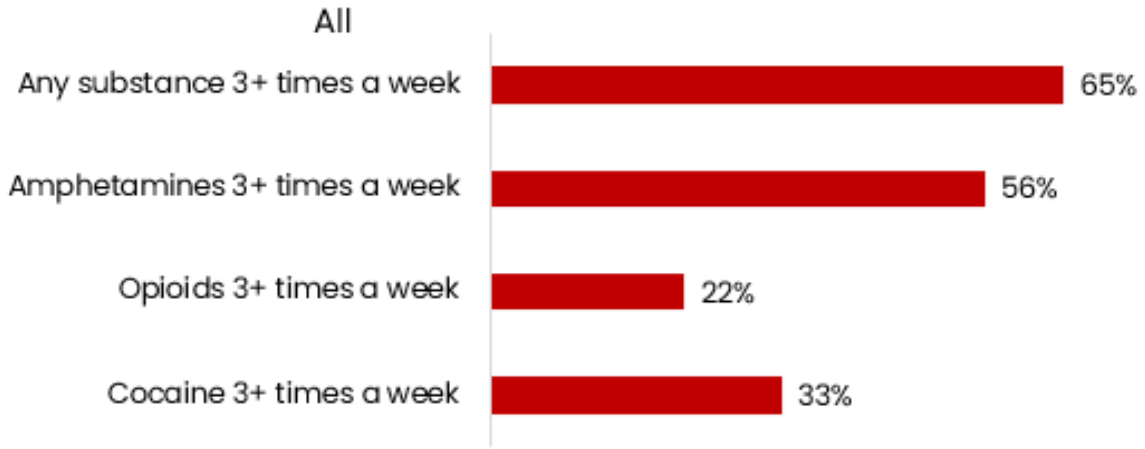
According to the California Statewide Study of People Experiencing Homelessness (CASPEH), with data collected between October 2021 and November 2022 (N=3,198):

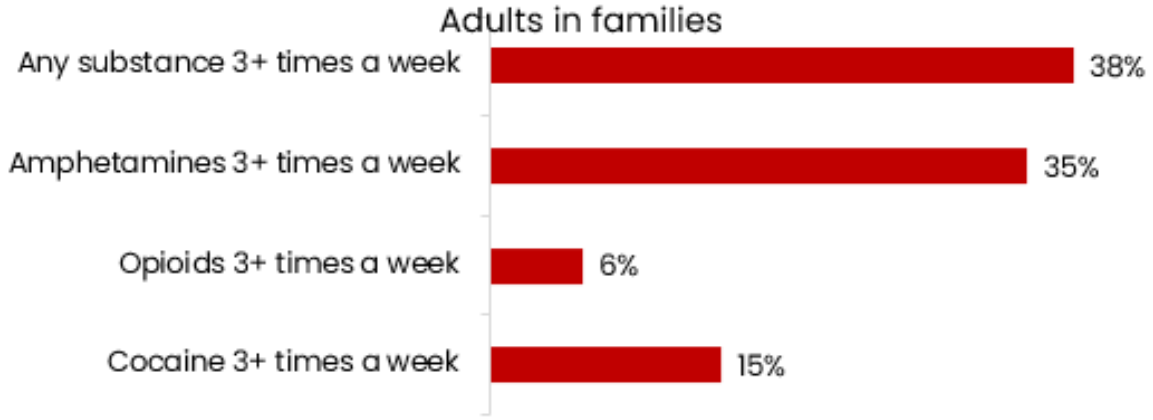
- 65% of participants reported ever using either amphetamines, cocaine, or non-prescribed opioids regularly (3+ times a week)
  - 56% reported a period in their life using amphetamines at this frequency
  - 33% reported regular cocaine use in their life
  - 22% reported regular non-prescribed opioid use in their life
- 64% of those who reported regular substance use, began this use before their first episode of homelessness

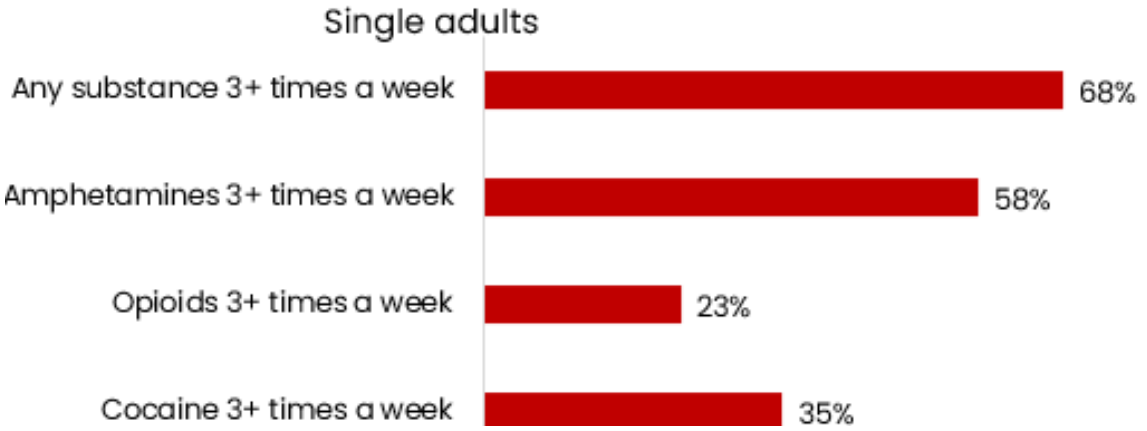
Source: Kushel, M., Moore, T., et al. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative.

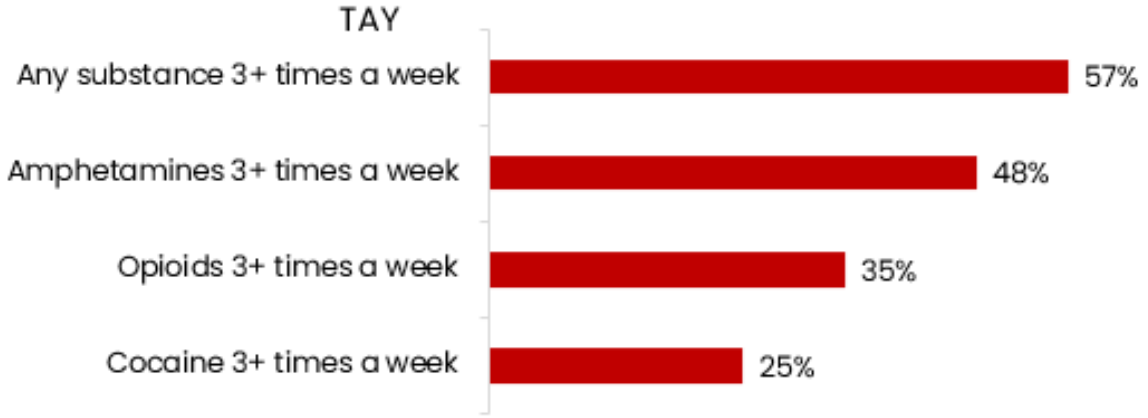
4c. Unhoused Persons and Substance Use

Proportion of Participants Who Reported Regular Substance Use Ever in Their Lives by Family Structure, 2023









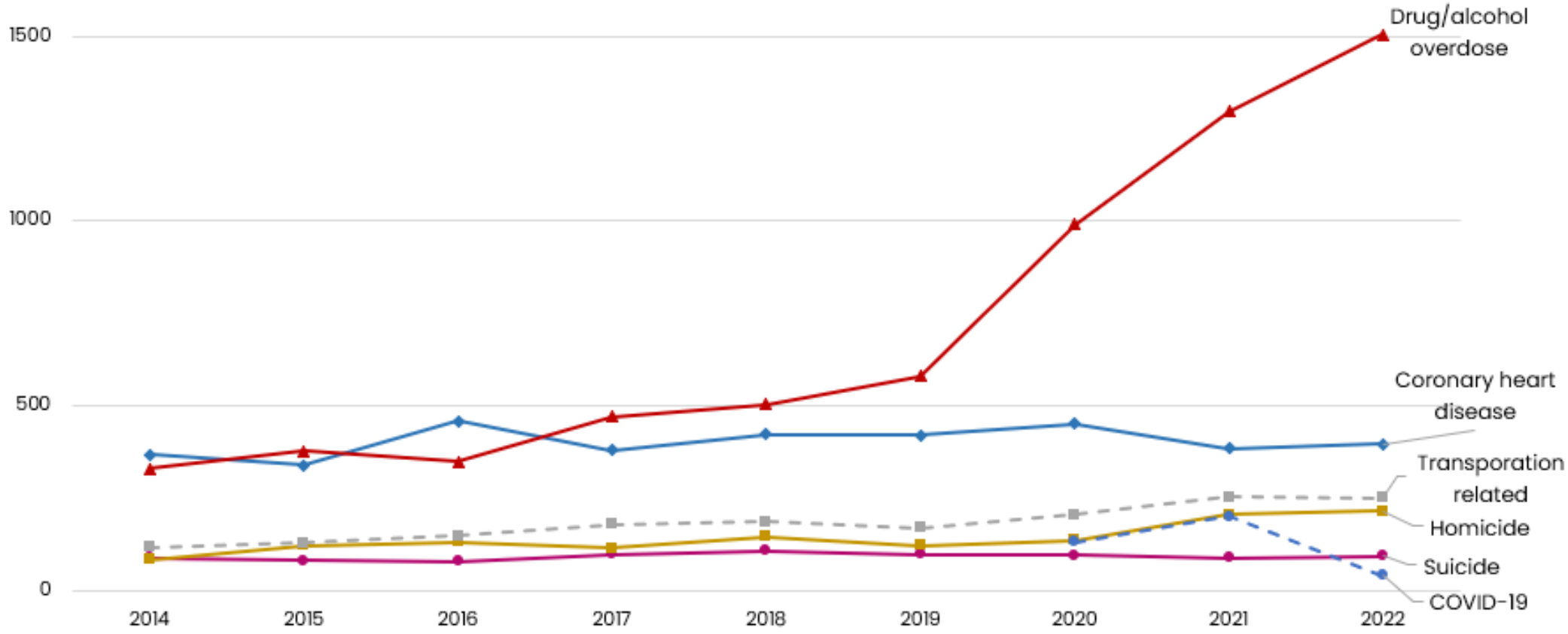
*Transition age young adults (TAY; young adults aged 18-24 not living with minor children)

Source: Kushel, M., Moore, T., et al. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative.

4c. Unhoused Persons and Behavioral Health

Drug/alcohol overdose is the leading cause of mortality among unhoused population in Los Angeles County.

Mortality Rates by Cause Among Los Angeles County's Unhoused Population, 2014-2022



Source: L.A. County Department of Public Health

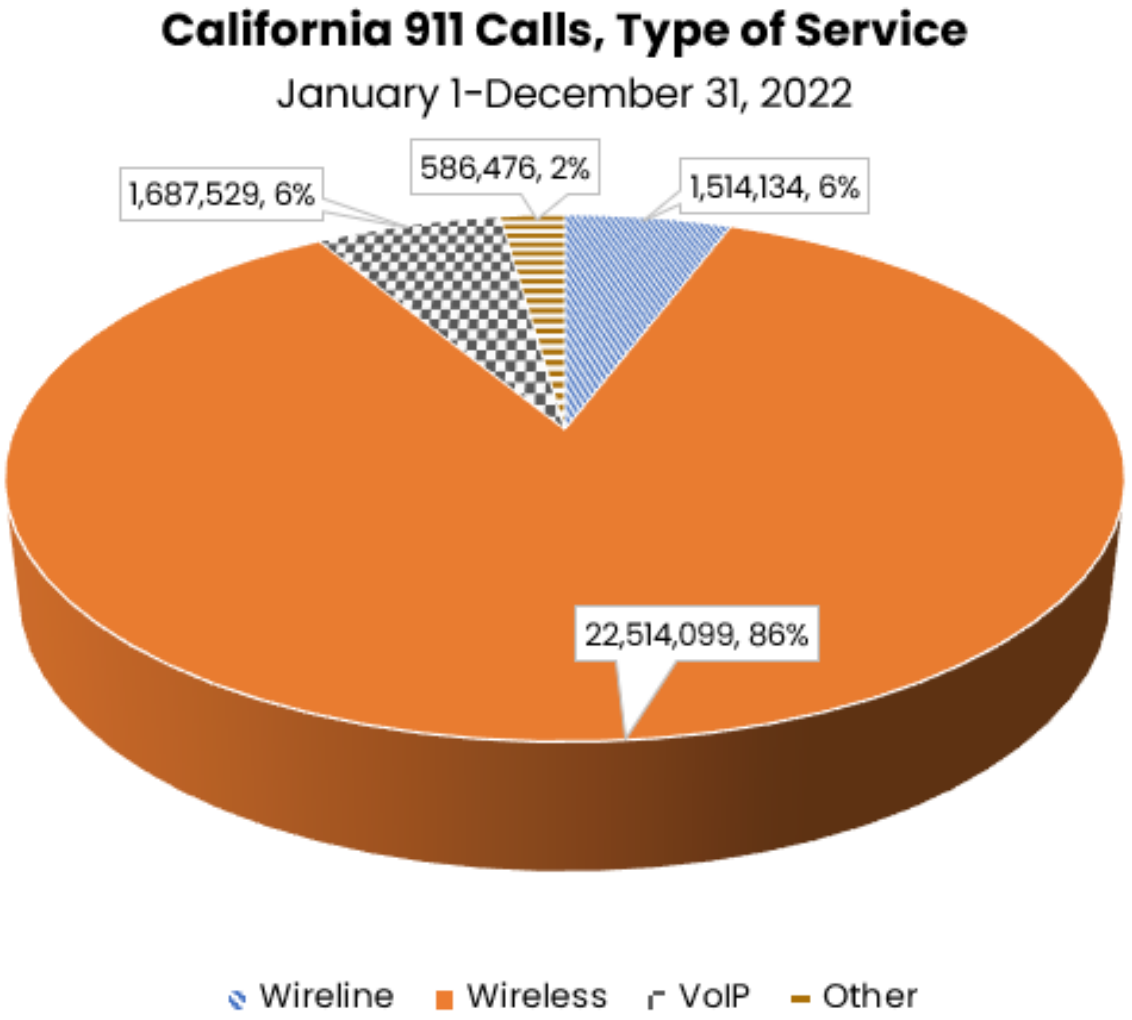
III. Demand and Utilization Data

Demand and Utilization Data for California

- The purpose of this section is to provide demand and utilization data on known parts of the crisis care continuum; it is non-exhaustive.
- Data include:
  - Call data for 911 and emergency dispatch response requests
  - Call data from 988
  - Crisis Now calculator estimated demand
  - California utilization data maps that show emergency department and hospital admission information for those presenting with a mental health condition
  - Medi-Cal Specialty Mental Health Services data for crisis intervention services, crisis residential treatment services, and crisis stabilization services

911 Data – California and National

- An estimated 240 million calls are made to 911 in the United States annually.
  - In 2022, Californians contacted 911 26.3 million times (1 in 10 of all calls nationally).
- 80% or more of 911 calls are from wireless devices.
  - In California, 86% are from wireless devices and only 6% are wireline.
- The United States has 6,100 primary and secondary Public Safety Answering Points (PSAPS), which are where 911 are routed.
  - California has 441 PSAPS (392 primary and 49 secondary).

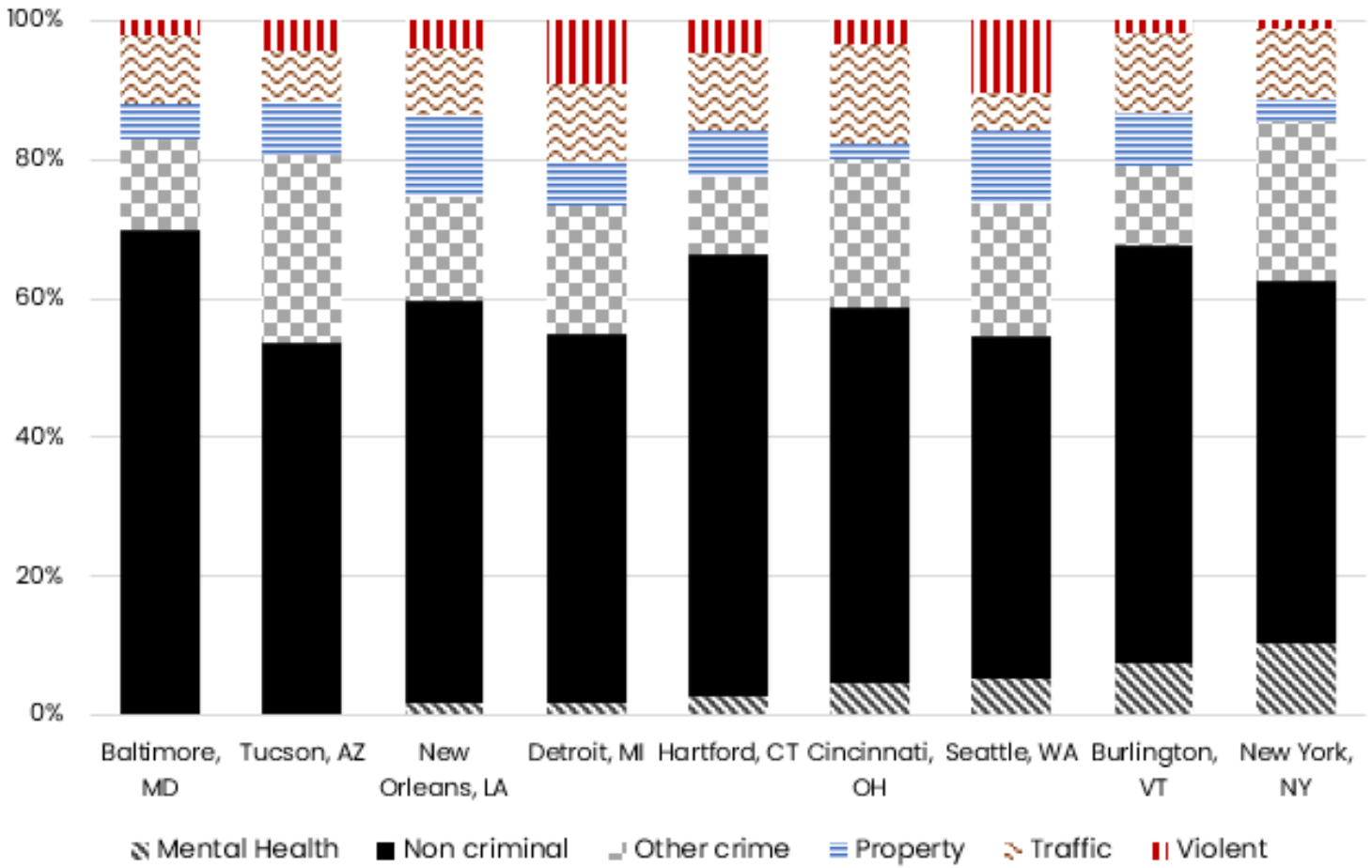


Sources: NENA 911 Statistics;
California Submission to FCC Communications Commission (Annual Fee Report) Approved OMB request (3060-1122), 2022

911 Data and Behavioral Health Emergencies

- Studies estimate that 5% to 15% of all calls to 911 are for behavioral health emergencies.
- A Vera Institute analysis of 911 call data in nine cities estimated that an average of 19% of calls could be answered by unarmed crisis responders.
- <u>For illustration purposes only:</u>
  - Using the 5% to 15% estimates as a *rough* proxy for behavioral health would equate to between 1.35 million and 4 million behavioral health-related calls being answered by 911 in California.
  - If 10% of the behavioral health-related calls to 911 were transferred to 988, that would be an additional 135,000-400,000 calls annually, an increase of between 35%-96% of current volume.

Breakdown of 911 Call Type Across Nine Cities



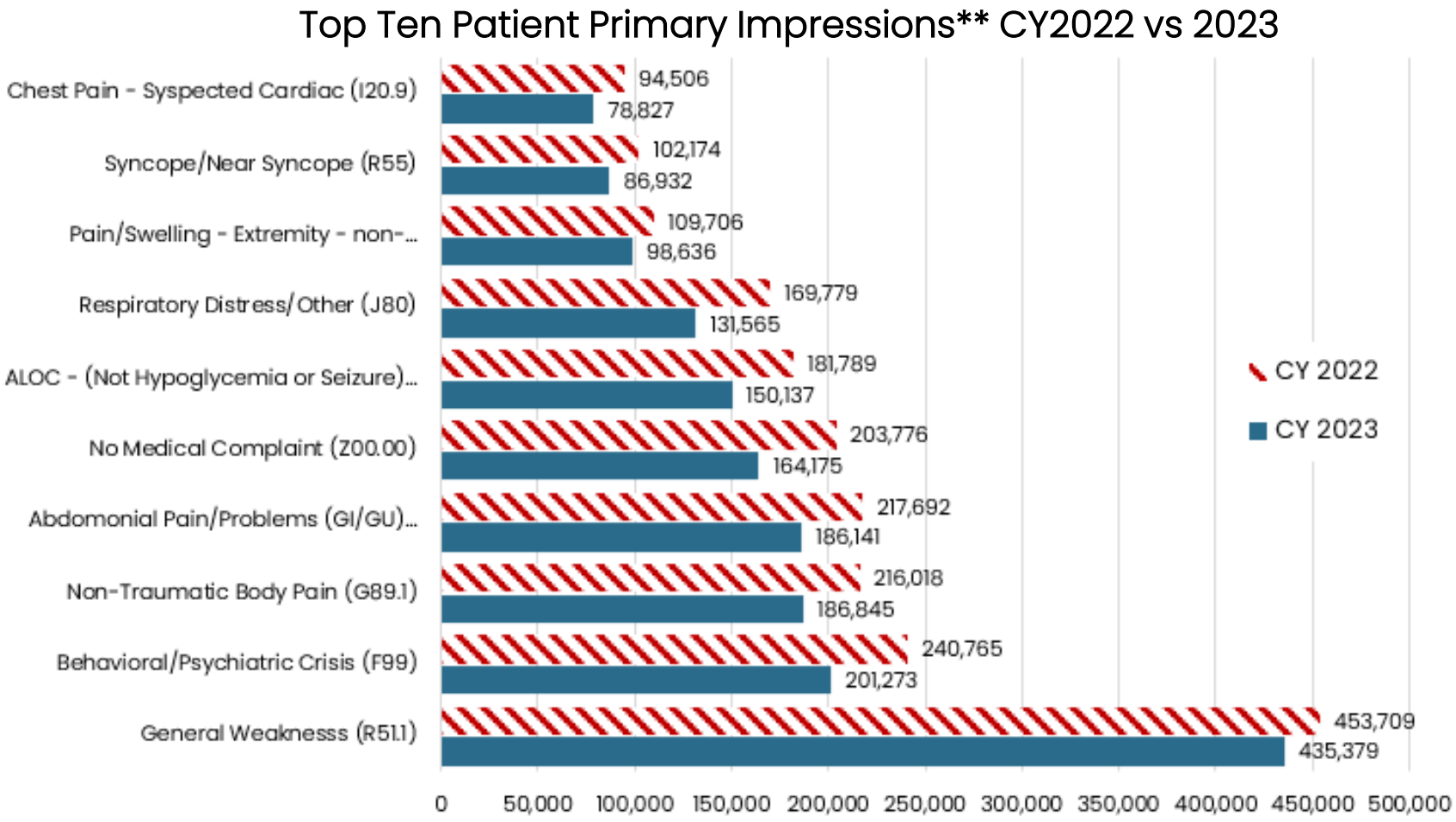
This stacked bar graph shows how across the nine cities analyzed, the majority of 911 calls involved noncriminal situations. Only a minor percentage of calls were for violent crimes.

Sources: Balfour, M. E., Hahn Stephenson, A., Delany-Brumsey, A., Winsky, J., & Goldman, M. L., Psychiatric Services, Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies, 2022; Vera Institute of Justice, 911 Analysis: Call Data Shows We Can Rely Less on Police, April 2022; Vera Institute of Justice, "The 911 Call Processing System: A Review of the Literature as it Relates to Policing", July 2019

EMSA Data – Primary Impressions by CA Emergency Responders

There were 4.6 million EMS primary impression records in calendar year (CY) 2022 and 3.8 million in CY2023 in the California Emergency Medical Services Information System (CEMSIS)*

- In 2022, approximately 5.2% of cases involved an individual with a Behavioral/Psychotic Crisis (F99)
- In 2023, approximately 5.3% of cases involved an individual with a Behavioral/Psychotic Crisis (F99)



Source: Emergency Medical Services Authority Annual EMS Data Report Calendar Years 2022 – 2023, page 34.
* The total number of all calls reported by EMS agencies into CEMSIS, including 9-1-1 Response, Interfacility Transfer, Medical Transport, Mutual Aid, etc.
**The EMS personnel's impression of the patient's primary problem or most significant condition which led to the management given to the patient (treatments, medications, or procedures); the EMS Data Report notes: "For analytical purposes data totals have been excluded from this chart due to the lack of specific information"; additional data limitations can be found in the full report.

EMSA Data – BH-Related Primary Impressions by CA Emergency Responders

In the first six months of 2024, there were approximately 2.1 million 911 calls with patient contacts.

- 200,963 were behavioral health-related.
- This equates to approximately 20% of EMS patient contacts with a behavioral health condition.

EMSA Behavioral Health Related 911 Calls with Patient Contact
January 1–June 30, 2024

Situation Provider Primary Impression	Total	Percent Incidents of all Patient Contacts	Rate per 100K Population
Behavioral/Psychiatric Crisis	122,057	5.8%	329.3
Alcohol Intoxication	40,789	1.9%	110.1
Overdose/Poisoning/Ingestion	35,863	1.7%	96.8
Agitated delirium	2,100	0.10%	5.7
Anxiety disorder, unspecified	154	0.01%	0.4
Totals	***200,963***	***9.5%***	***542.2***

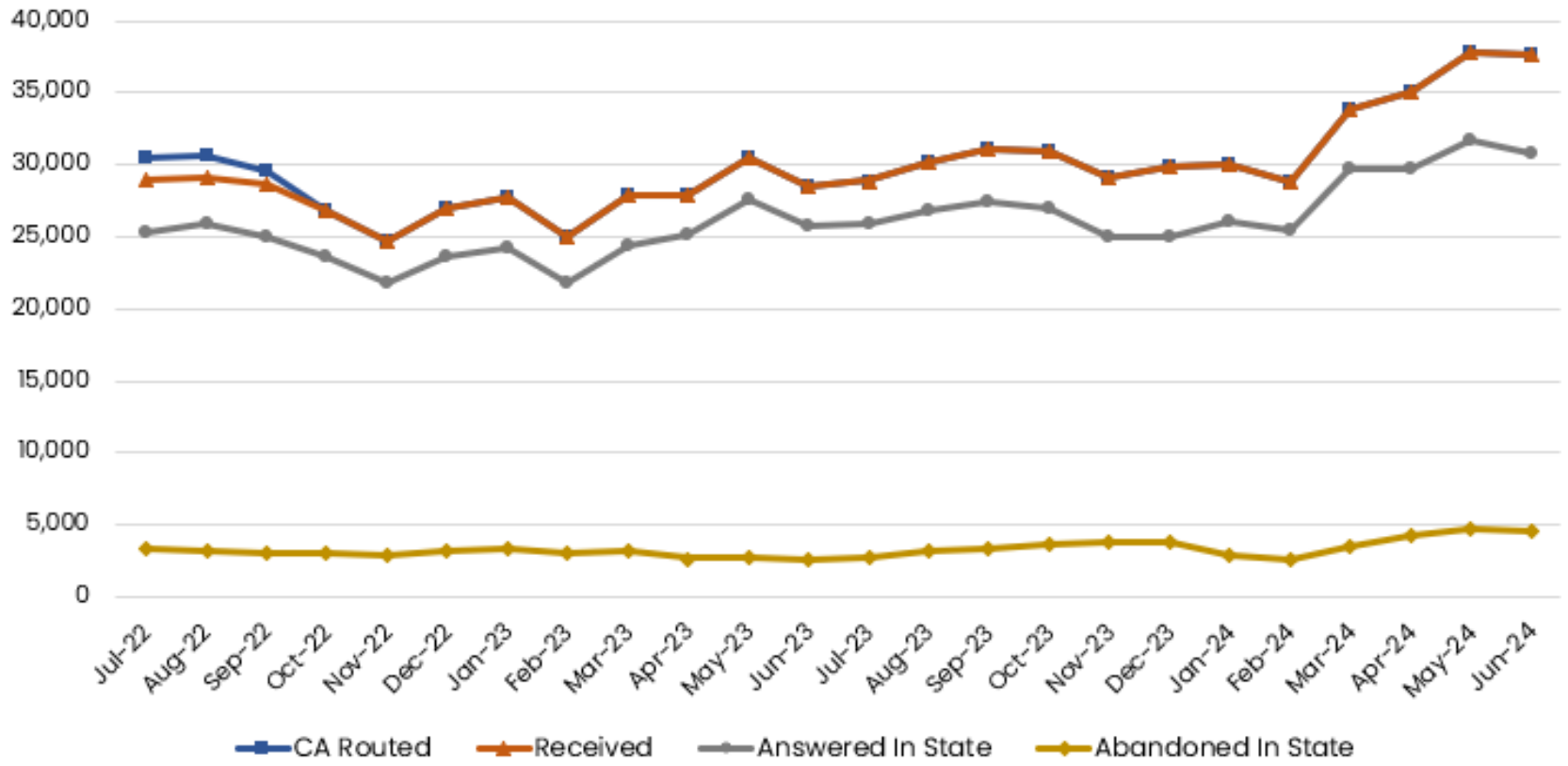
**Numbers exclude approximately 60% of data from San Diego.*

Sources: Emergency Medical Services Authority (EMSA); 2022 ACS 1-Year Estimates

988 Data – Call Volume from California and National 988 Lifelines #1

- In July 2022, when the U.S. transitioned from the 10-digit National Suicide and Prevention Lifeline to 988, over 30,000 calls were already being routed to California.
- Average monthly call volume in the first year (from July 2022 to June 2023) was 28,058 with an in-state answer rate of 88 percent.
- In the second year (July 2023-June 2024), average monthly call volume increased to 31,927, with a slightly lower in-state answer rate of 86 percent.

California and National 988 Suicide and Crisis Lifeline Total Calls Routed, Received and Answered July 2022-June 2024



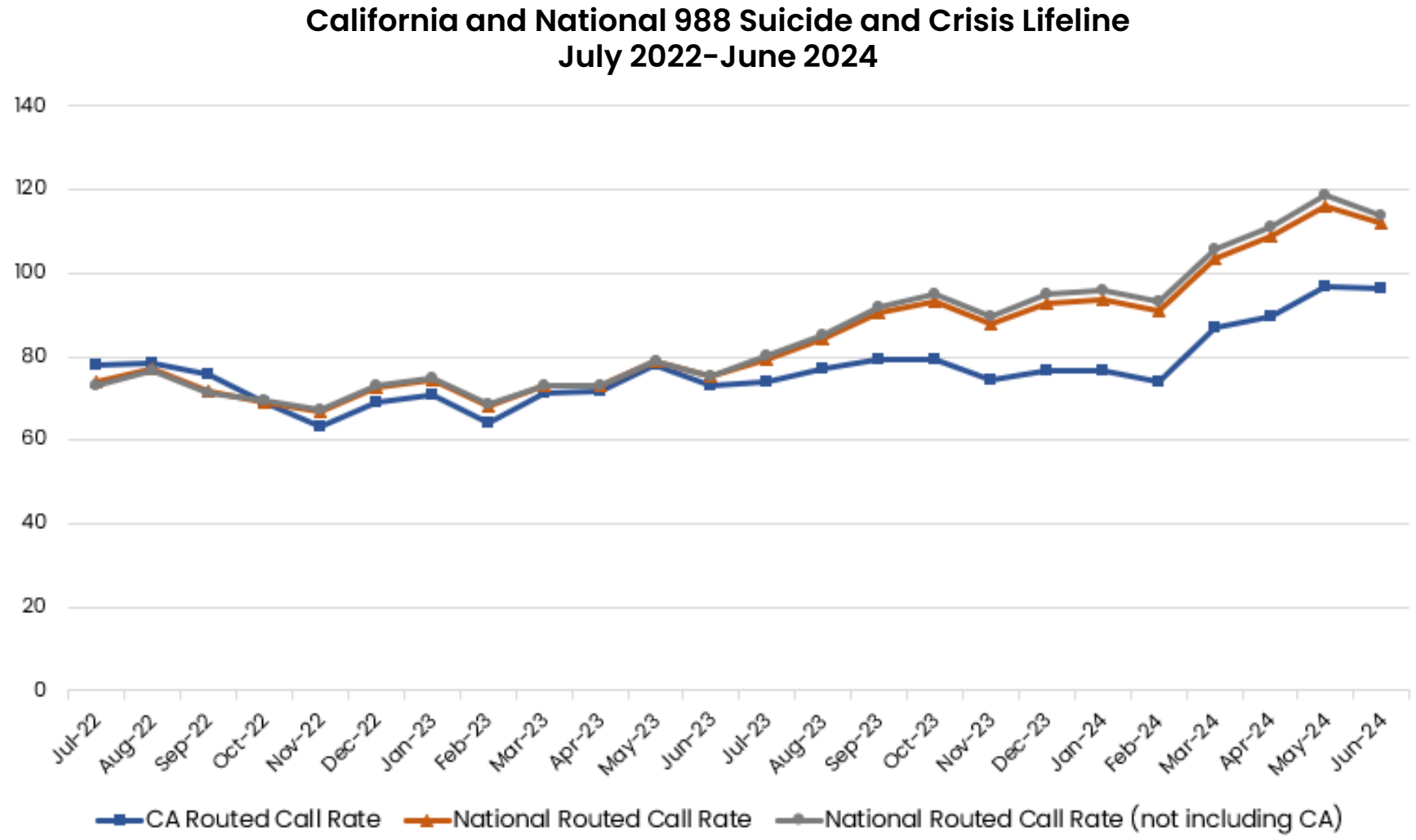
Source: Vibrant Emergency Intervention Data from the CA 988 Suicide and Crisis Lifeline

*Definition Notes (SAMHSA Performance Metrics):

- Contact received: A call, chat or text with the 988 Lifeline
- Routed: Contacts routed to a center after the person listens to the greeting (calls) or sent to a counselor after answering a pre-chat or pre-text survey (chat/text).
- Answered: Contacts who are connected to a 988 Crisis Center and then engaged by a counselor.
- Abandoned: Contacts that disconnect after being routed to a 988 Crisis Center and before being engaged by a counselor

988 Data – Call Volume from California and National 988 Lifelines #2

- From July 2022 to May 2023, California's rate of routed calls per 100,000 were similar to national routed call rates.*
- From May 2023 to June 2024, California's rate of routed calls per 100,000 was below the national rates.*



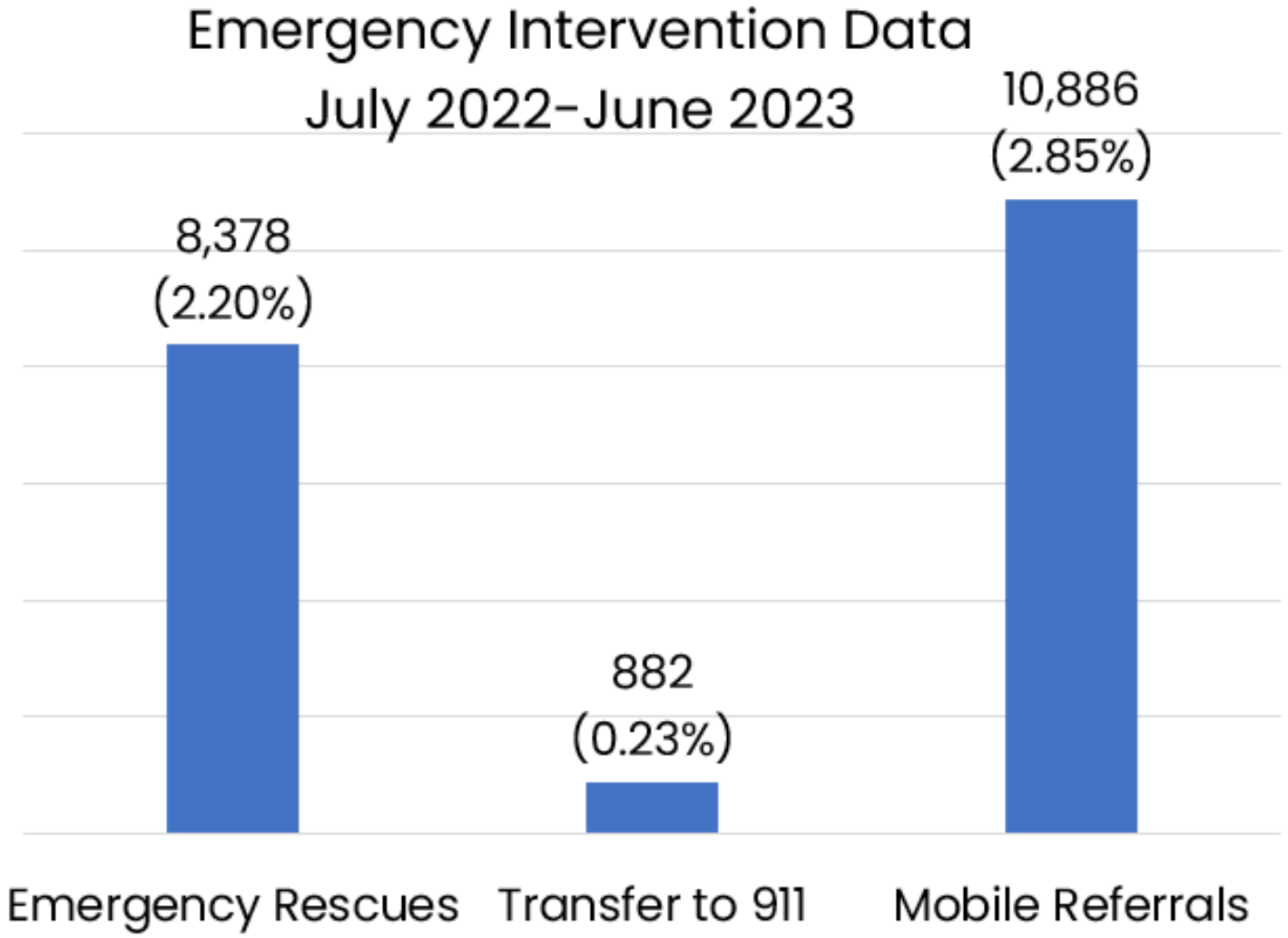
Source: Vibrant Emergency Intervention Data from the CA 988 Suicide and Crisis Lifeline

*Call data collected by 988 Crisis Centers within the California 988 Network fluctuates over time and can vary significantly from the values reported by Vibrant Emotional Health. As such, these values may differ from those reported by crisis centers themselves. Enhancing statewide data collection and analysis processes is an ongoing effort.

988 Data – California Emergency Intervention Data #1

Of the 381,534 contacts to a CA 988 Suicide and Crisis Lifeline between July 2022 and June 2023:

- 8,378 (2.20%) resulted in an emergency rescue
- 882 (0.23%) resulted in a transfer to 911
- 10,886 (2.85%) resulted in a mobile referral



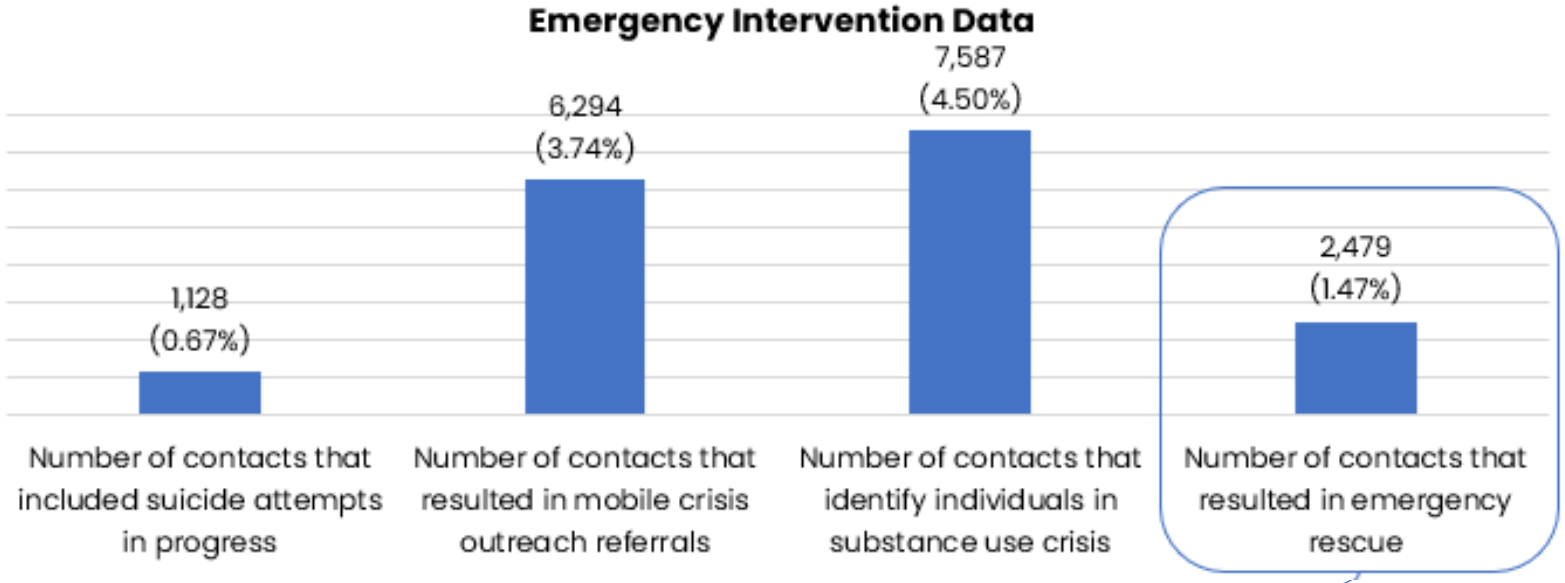
Note: Percentages reflect the proportion of total answered contacts

Source: Vibrant Emergency Intervention Data from the CA 988 Suicide and Crisis Lifeline

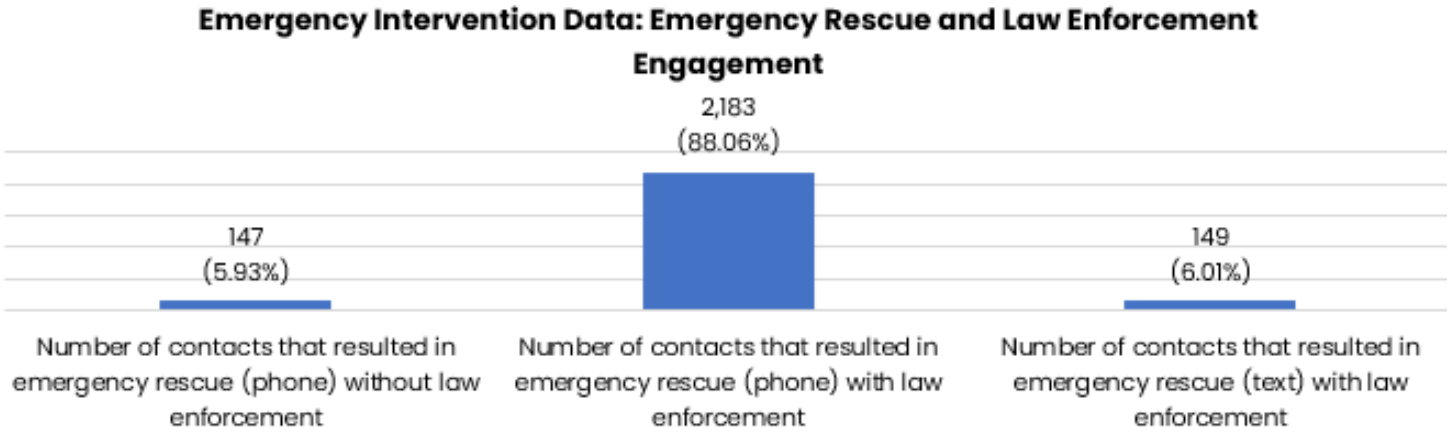
988 Data – California Emergency Intervention Data #2

- Between October 2023 and March 2024, the CA 988 Suicide and Crisis Lifeline answered*:
  - 155,046 phone calls
  - 3,997 chats
  - 9,454 texts
- Of the contacts that resulted in emergency rescues, the majority were received by phone and included law enforcement.

*Additional Notes: Emergency rescue numbers are collected for chat/text services but are very small and not included in the accompanying charts.. Also note that call data collected by 988 Crisis Centers within the California 988 Network can vary significantly from the values reported by Vibrant Emotional Health. As such, these values may differ from those reported by crisis centers themselves. Enhancing statewide data collection and analysis processes is an ongoing effort



Note: Percentages reflect the proportion of all answered contacts

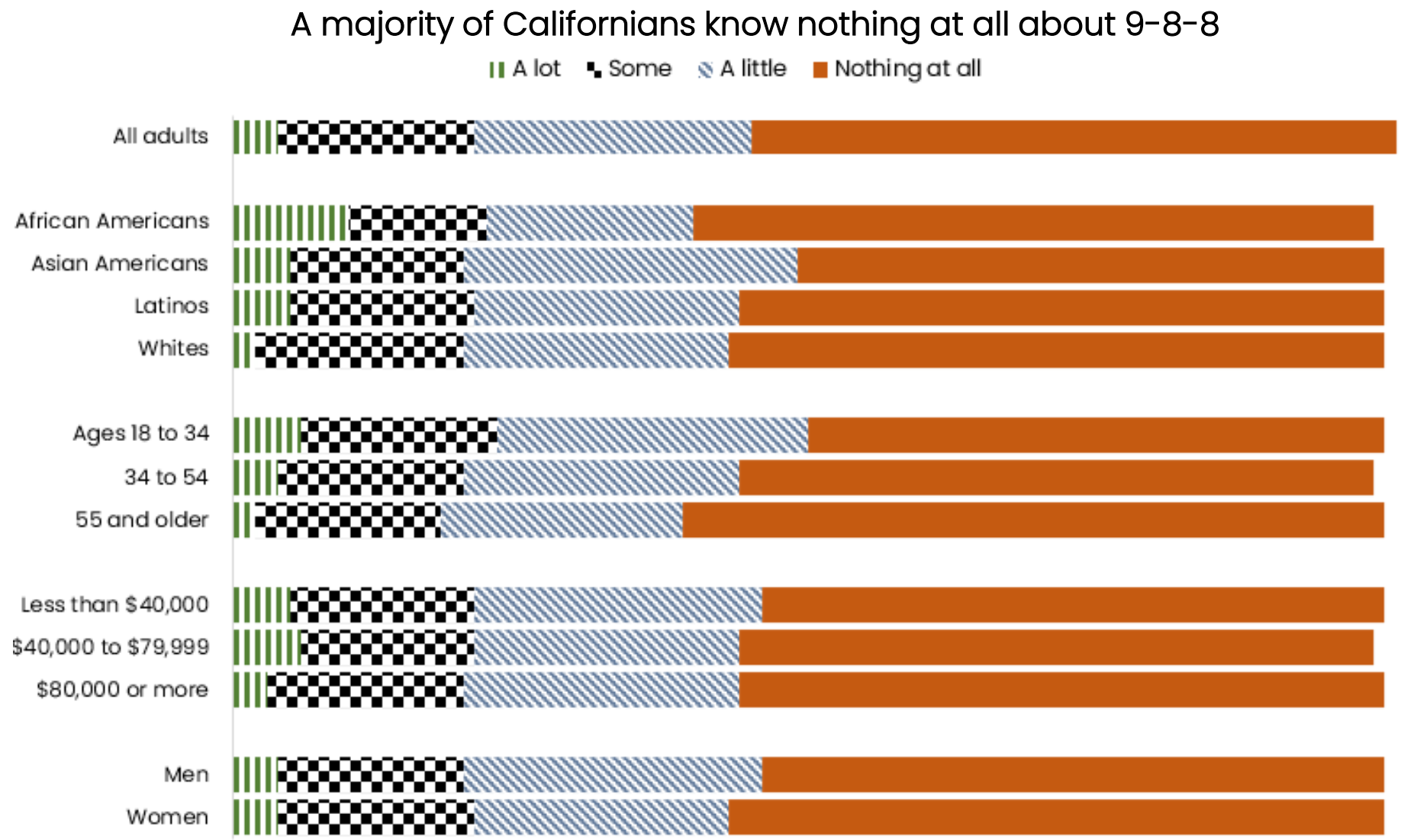


Note: Percentages reflect the proportion of answered contacts that resulted in emergency rescues.

Source: Vibrant Emergency Intervention Data from the CA 988 Suicide and Crisis Lifeline

988 Awareness in California

- According to a Sept. 2023 poll, most Californians said they knew "nothing at all" about 988 in a poll conducted in August-September of 2023.
- Younger people (ages 18 to 34) were more likely to know about 988 than older adults.
- Awareness of 988 in California was similar to that of national polling.



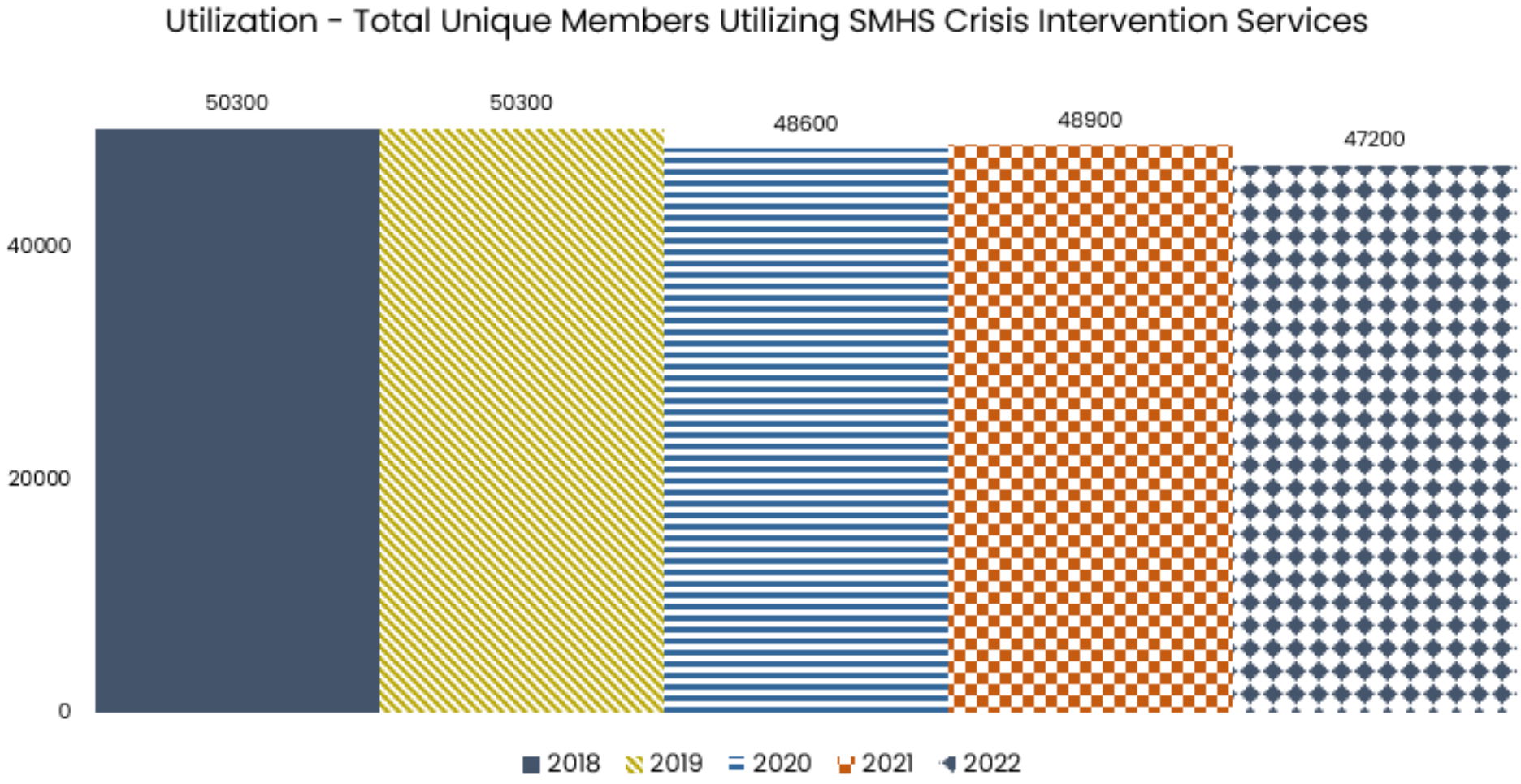
Source: PPIC Statewide Survey, September 2023, Survey was fielded from August 25-September 2023, PPIC blog.

Utilization of SMHS Crisis Intervention Services

- The total number of adult Medi-Cal beneficiaries who received SMHS **Crisis Intervention Services** decreased 6.1% between 2018 and 2022.
- Crisis intervention is an unplanned, expedited service to or on behalf of a beneficiary to address a condition that requires a more timely response than a regularly scheduled visit.

Specialty Mental Health Services (SMHS) Performance Dashboard

Adults Age 21 and Over



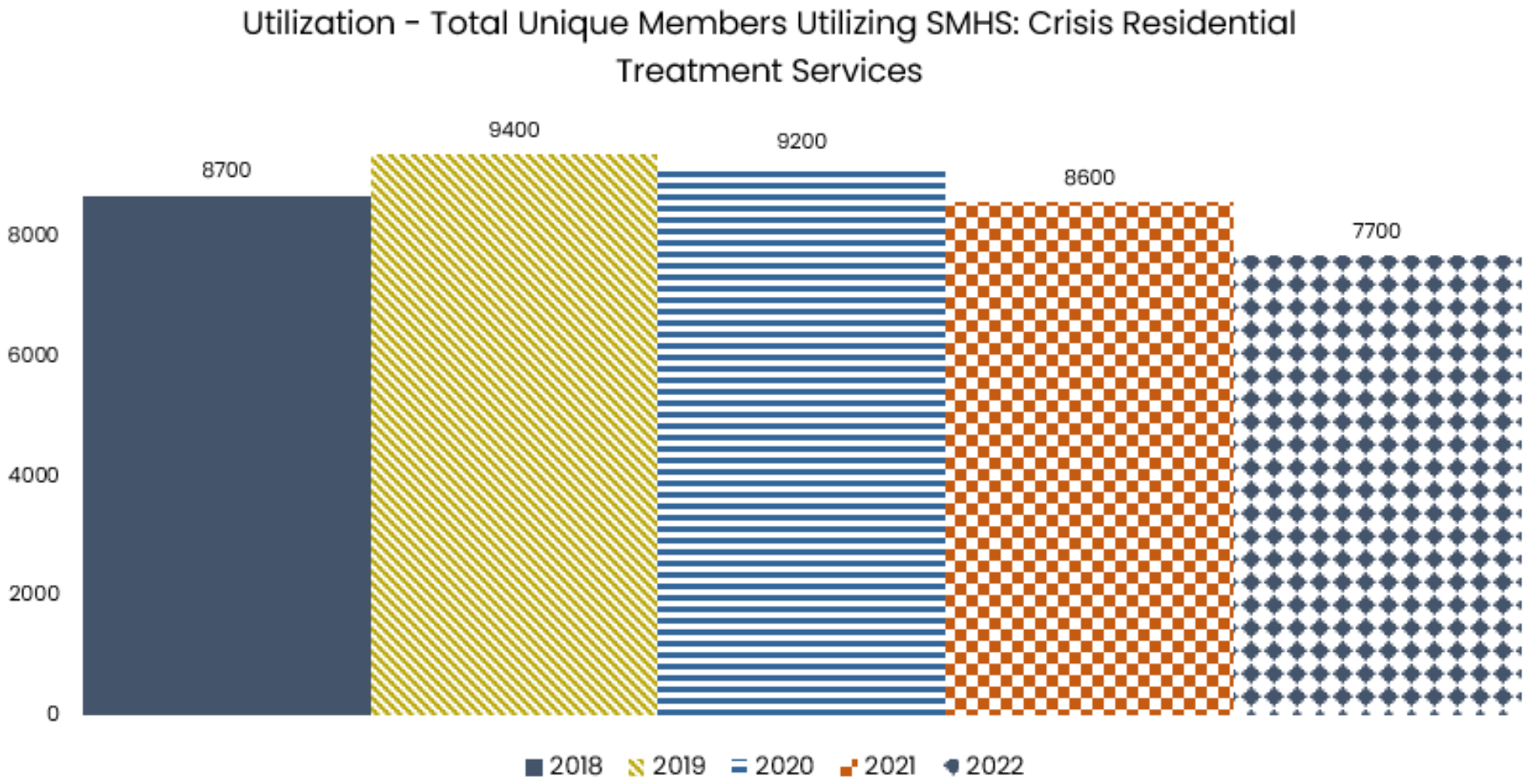
Sources: Adults Age 21 and Over Specialty Mental Health Services (SMHS) Performance Dashboard; Specialty Mental Health Services Billing Manual May 2024

Utilization of SMHS Crisis Residential Treatment

- The total number of adult Medi-Cal beneficiaries who received SMHS **Crisis Residential Treatment Services** decreased 11.5% between 2018 and 2022.
- Crisis Residential Treatment Services (CRTS) are therapeutic or rehabilitative services provided in a non-institutional residential setting that provides a structured program (short-term; 3 months or less) as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care.

Specialty Mental Health Services (SMHS) Performance Dashboard

Adults Age 21 and Over



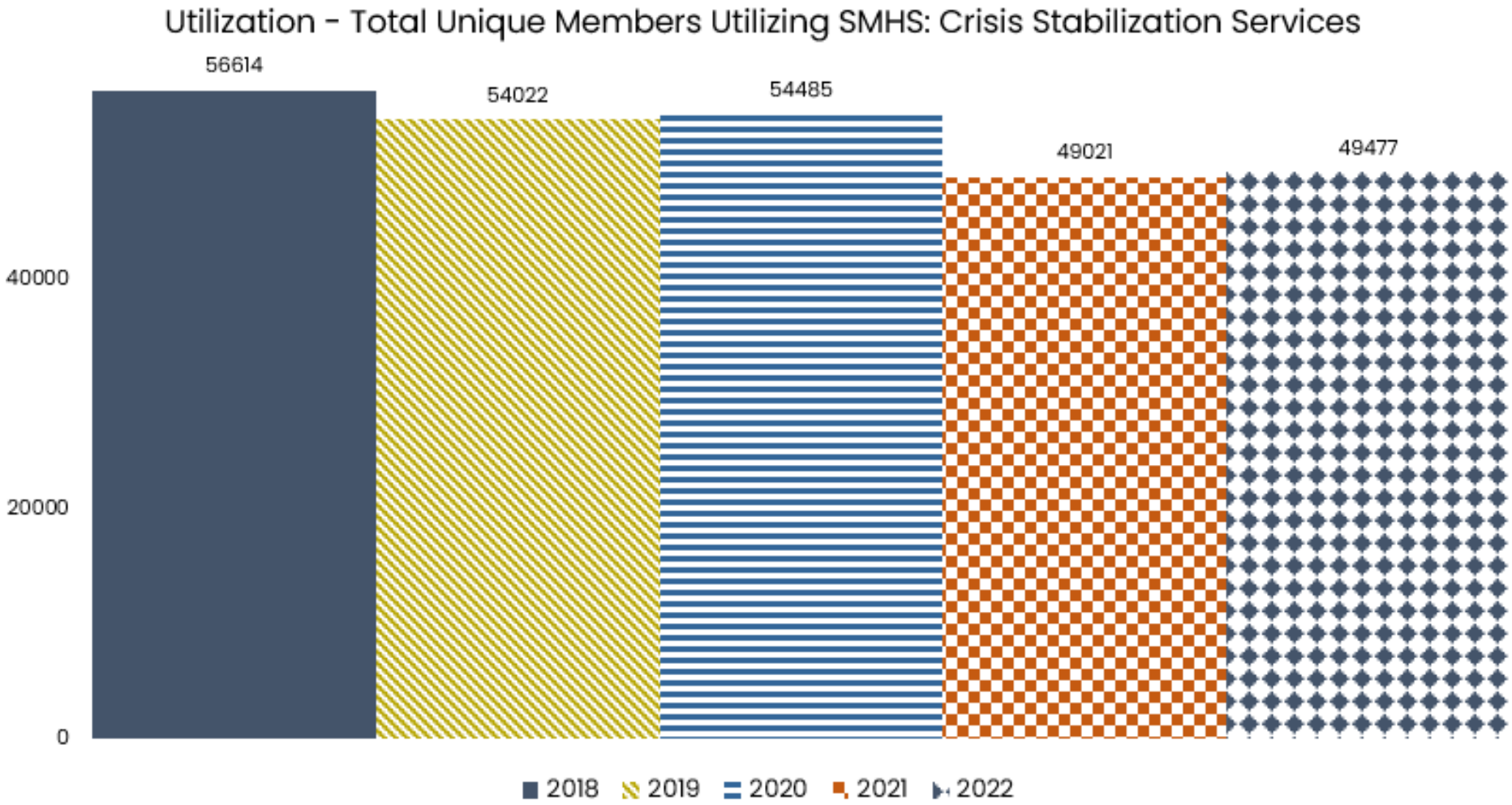
Sources: [Adults Age 21 and Over Specialty Mental Health Services (SMHS) Performance Dashboard](); [Specialty Mental Health Services Billing Manual May 2024]()

Utilization of SMHS Crisis Stabilization Services

- The total number of adult Medi-Cal beneficiaries who received **SMHS Crisis Stabilization Services** decreased 12.6% between 2018 and 2022.
- Crisis stabilization is an unplanned, expedited service lasting less than 24 hours to or on behalf of a beneficiary to address an urgent condition requiring immediate attention that cannot adequately or safely be addressed in a community setting.

Specialty Mental Health Services (SMHS) Performance Dashboard

Adults Age 21 and Over



Sources: [Adults Age 21 and Over Specialty Mental Health Services (SMHS) Performance Dashboard]; [Specialty Mental Health Services Billing Manual May 2024]

IV. Inventory of Crisis Resources/Current and Planned Investments

Essential Crisis Services

= Near term (by FY 23-24) * = Medium term (by FY 26-27) = Long term (by FY 28-29)

Preventing Crisis

Peer-Based Warmlines

Digital Apothecary
- CYBHI digital platform: BrightLife and Soluna

*Community Based Behavioral Health Services:
- Community-based social services
- School-based and school-linked services
- Primary care clinics and FQHCs
- Outpatient behavioral health care
- Peer support
- Harm reduction
- Medication for Addiction Treatment (MAT)
- Housing services
- Employment services

Responding to Crisis

Hotlines
- Operate 24/7/365
- Answer all calls (or coordinate back-up)
- Offer text / chat capabilities
- Be staffed with clinicians overseeing clinical triage

*Mobile Crisis Services
- Operate 24/7/365
- Staffed by multidisciplinary team meeting training, conduct, and capability standards
- Respond where a person is
- Include licensed and/or credentialed clinicians

Stabilizing Crisis

Crisis receiving and stabilization services
- Operate 24/7/365 with multidisciplinary team or other suitable configuration depending on the model
- Offer on-site services that last less than 24 hours
- Accept all appropriate referrals
- Design services for mental health and substance use crisis issues
- Offer walk-in and first responder drop-off options
- Employ capacity to assess & address physical health needs

Peer Respite

In-Home Crisis Stabilization

Crisis Residential Treatment Services
- Operate 24/7/365

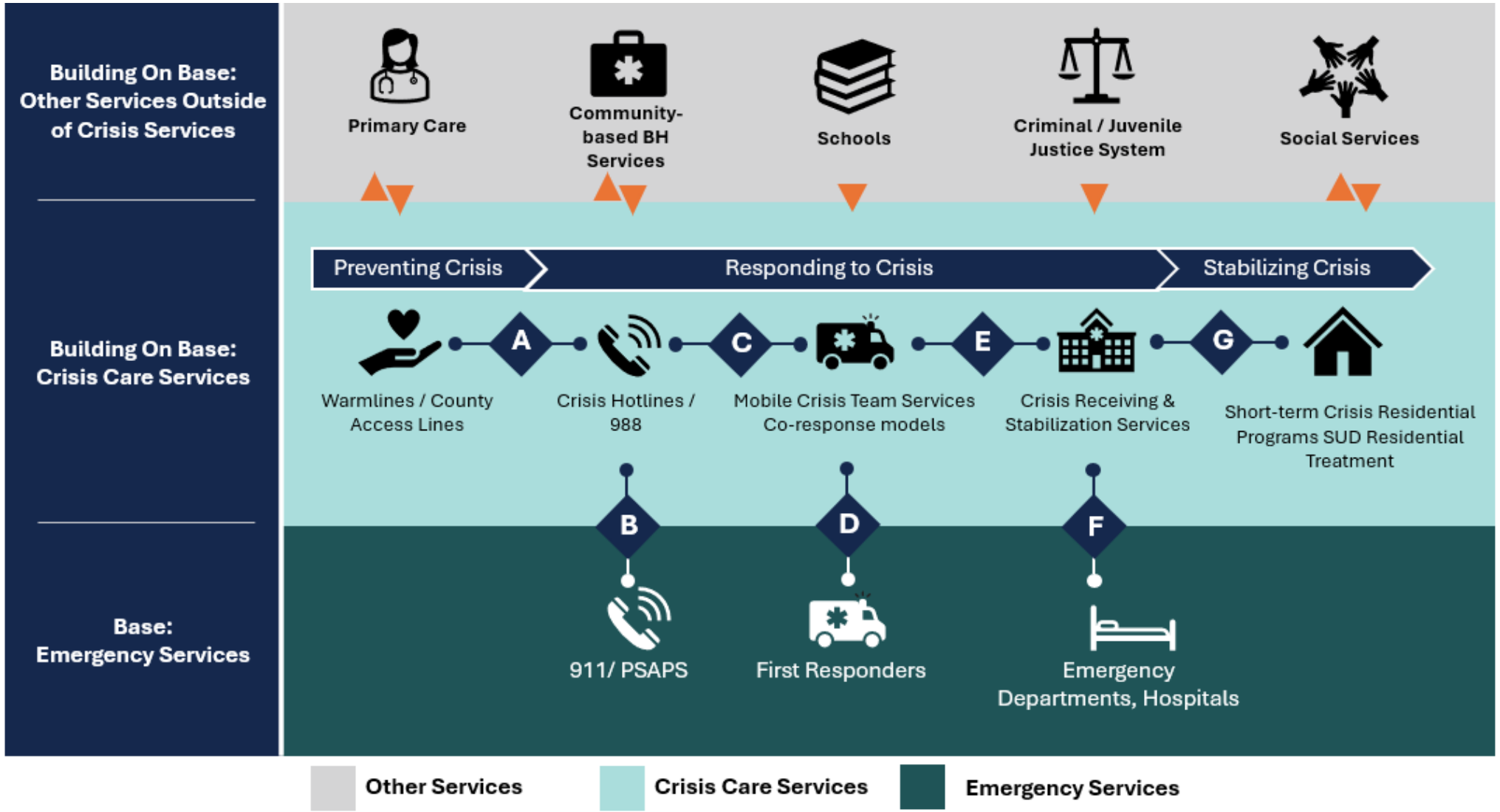
Stabilizing Crisis (cont.)

Post-Crisis Step-Down Services, such as (LT)
- Partial hospitalization
- Supportive housing

Sobering Center

Source: Adapted from California Health and Human Services Agency, "Behavioral Health Crisis Care Continuum Plan", 2023

Transitions in Care

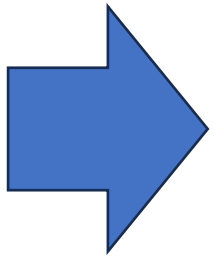


Adapted from California Health and Human Services Agency, "Behavioral Health Crisis Care Continuum Plan", 2023, page 25

1. Preventing Crisis

Preventing Crisis: Warmlines and Digital Apothecary

Preventing Crisis
Peer-Based Warmlines
Digital Apothecary



Examples

- **MHA-SF California Peer-Run Warm Line:** Provides accessible mental health support by using the wisdom of lived experience to connect, inspire hope, and empower our community toward unlimited recovery.
- **CalHOPE Warm Line:** Connects callers to other people who have persevered through struggles with stress, anxiety, depression—all emotions triggered by circumstances and events in everyday life. The peer counselors listen with compassion, provide non-judgmental support and guide people toward additional resources that can give hope and help them cope.
- **CalHOPE Connect:** Partnership with California Mental Health Services Authority, which has a statewide experienced workforce composed of peers, community mental health workers, and other non-licensed personnel. Individuals in need of emotional and/or crisis support can receive "visits" by phone, videoconference, smart device, or computer chat.
- **CCUIH/CalHOPE Red Line:** Peer support program run by the California Consortium for Urban Indian Health (CCUIH) that provides resources, referrals, and trauma-informed support for urban Indian and Tribal populations.
- **CYBHI digital platform:** BrightLife and Soluna are the first in a set of digital tools to be developed as part of a digital apothecary.

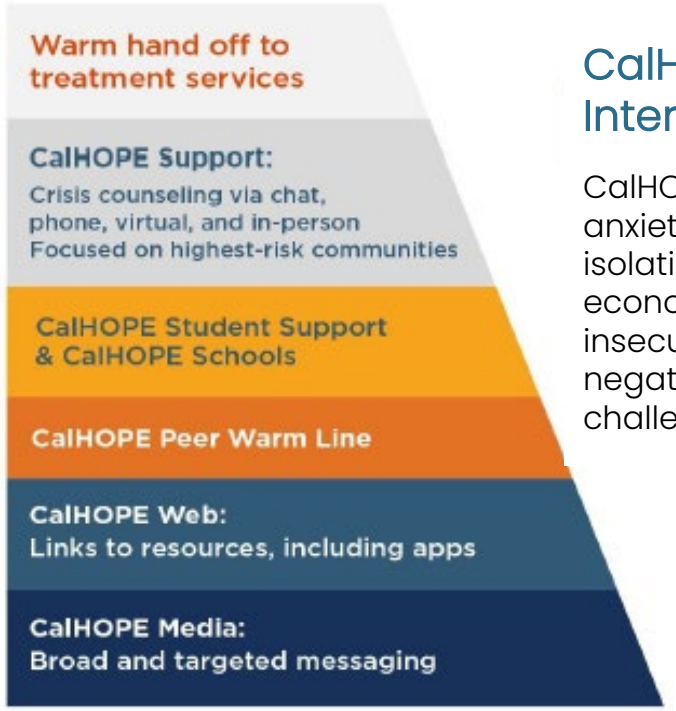
MHASF Peer-Run Warm Line

- MHASF operates **The California Peer-Run Warm Line and CalHOPE Warm Line** which offer free, accessible emotional support service.
- Available 24/7/365, MHASF's Warm Line provides support in English, Spanish, and over 240 other languages through translation.
- The service is operated by trained peer counselors who have experienced mental health challenges themselves, providing a unique level of understanding and hope to those who reach out.

Sources: Information provided by MHASF "Friendship Line Snapshot"

CalHOPE Warm Line and CalHOPE Connect

Overview



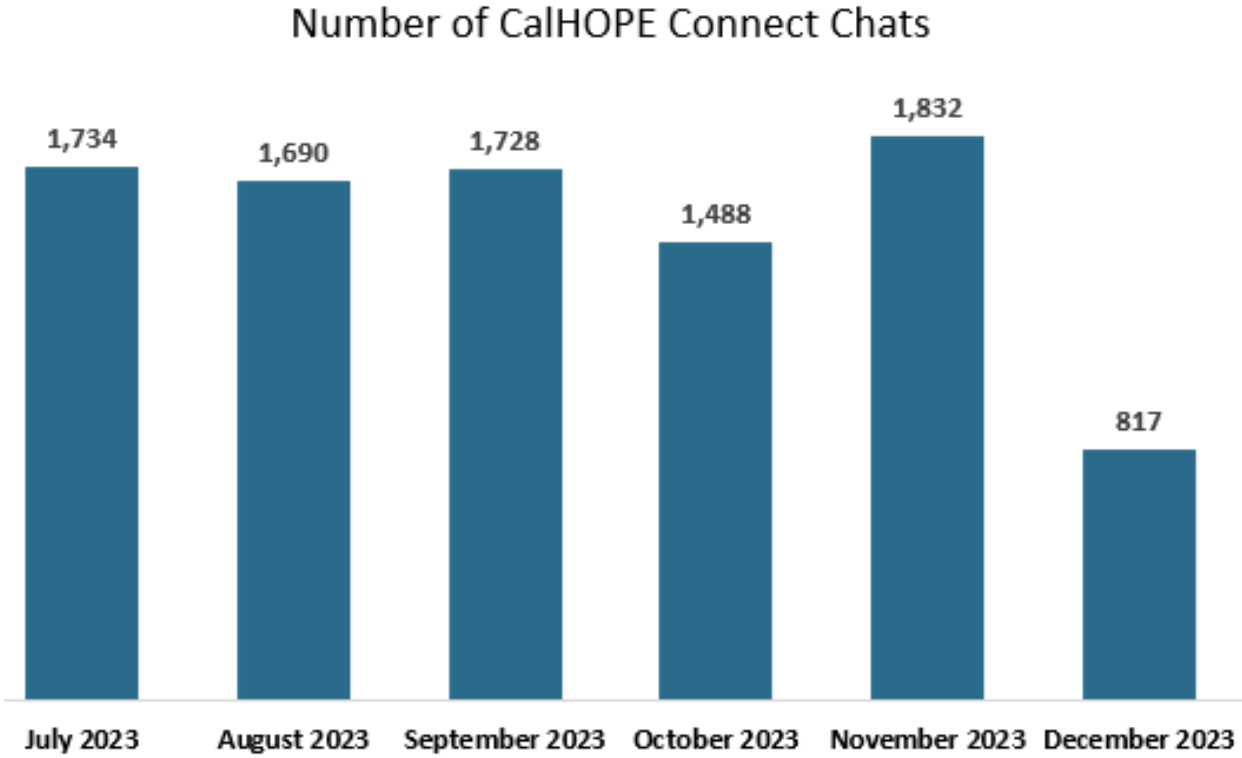
CalHOPE Layers of Intervention and Support

CalHOPE addresses the stress and anxiety that people may feel due to isolation, health challenges, economic uncertainty, food insecurity, worries, and other negative consequences of the challenges they face.

CalHOPE

CalHOPE Connect

CalHOPE Connect offers safe, secure, and culturally-sensitive emotional support for all Californian's. Individuals in need of assistance connect to community mental health workers through computer chat and are connected to county-based services if needed.

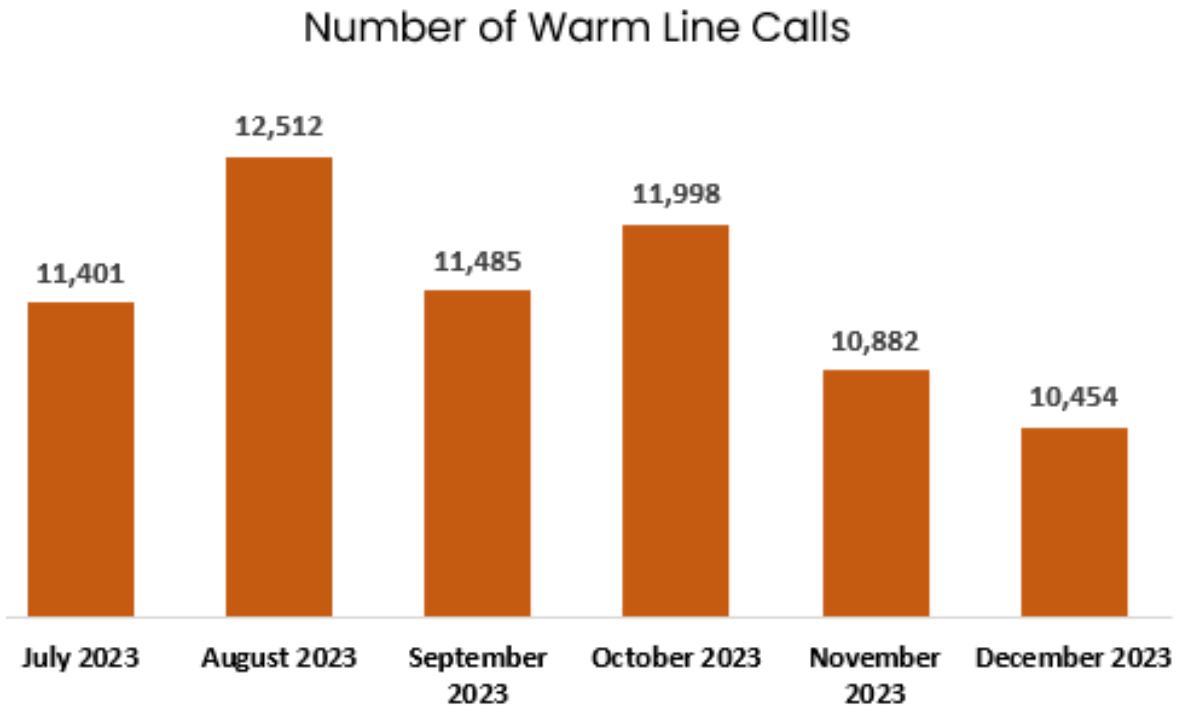


Source: CalHOPE Quarterly Progress Report, January 2024

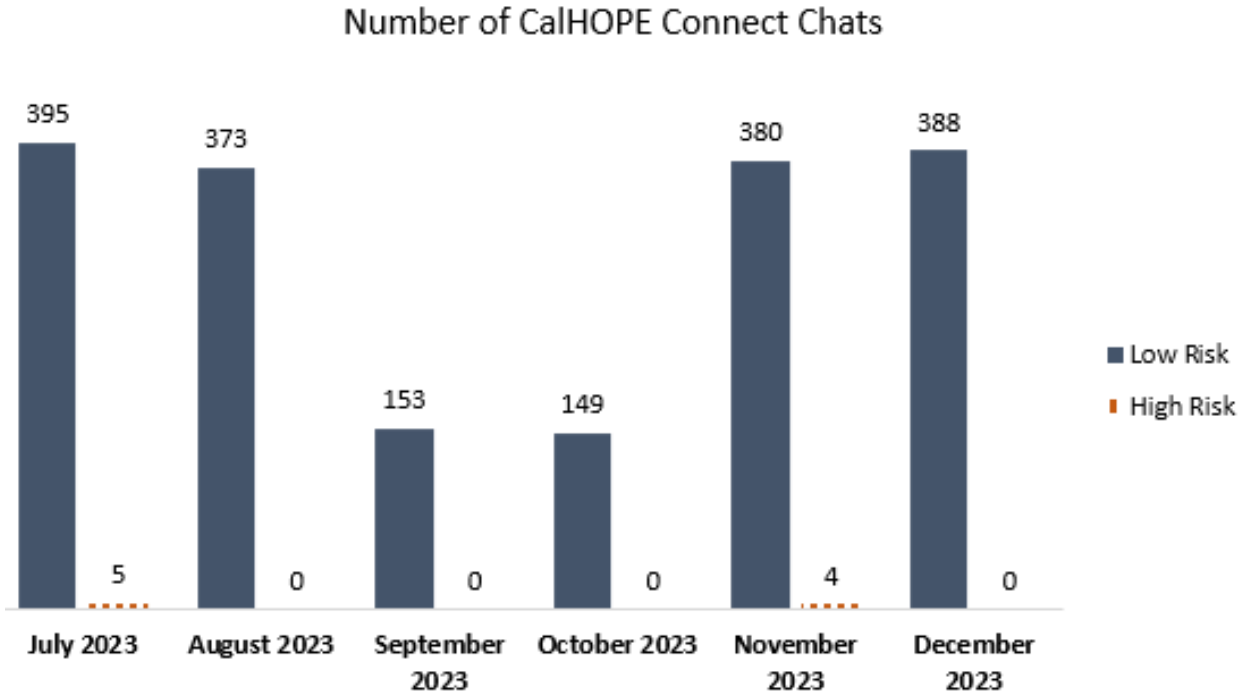
CalHOPE Warm Line

The CalHOPE Warm Line connects individuals to other people who have persevered through struggles with stress, anxiety, and depression. Peer counselors listen with compassion, provide non-judgmental support and guide individuals to additional resources that can help them cope.

A small percentage of calls to CalHOPE Warm Line were determined to be at a high risk of suicide



CalHOPE Warm Line (Cont.)

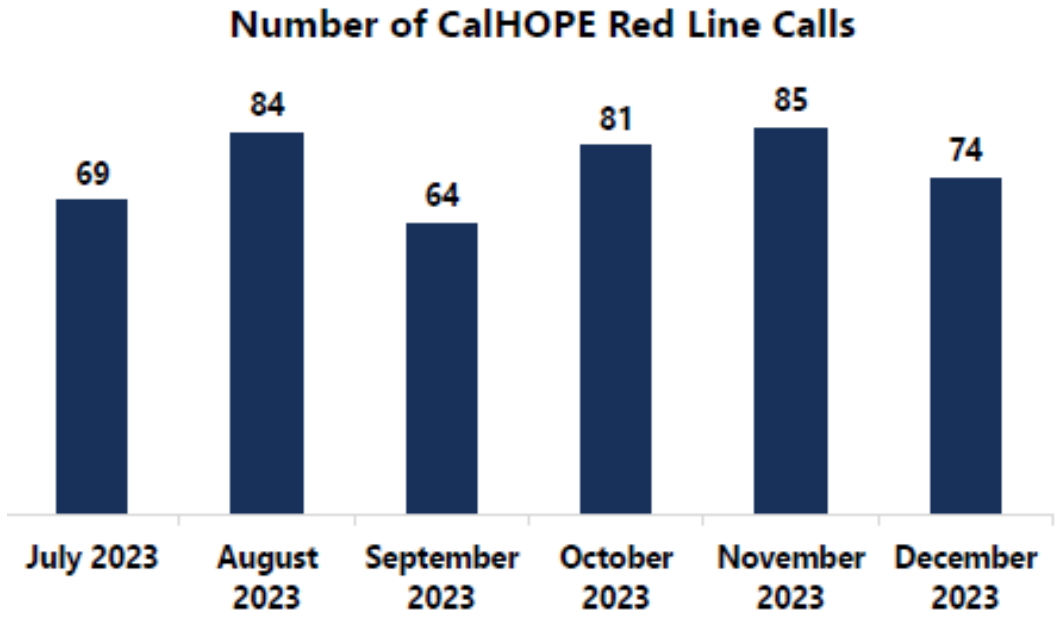


Source: CalHOPE Quarterly Progress Report, January 2024

**Low-risk denotes calls that were able to be deescalated and addressed through the Warm Line services. High-risk indicates calls requiring immediate crisis services and transferred to 988 by the Warm Line team.*

CCUIH/CalHOPE Red Line

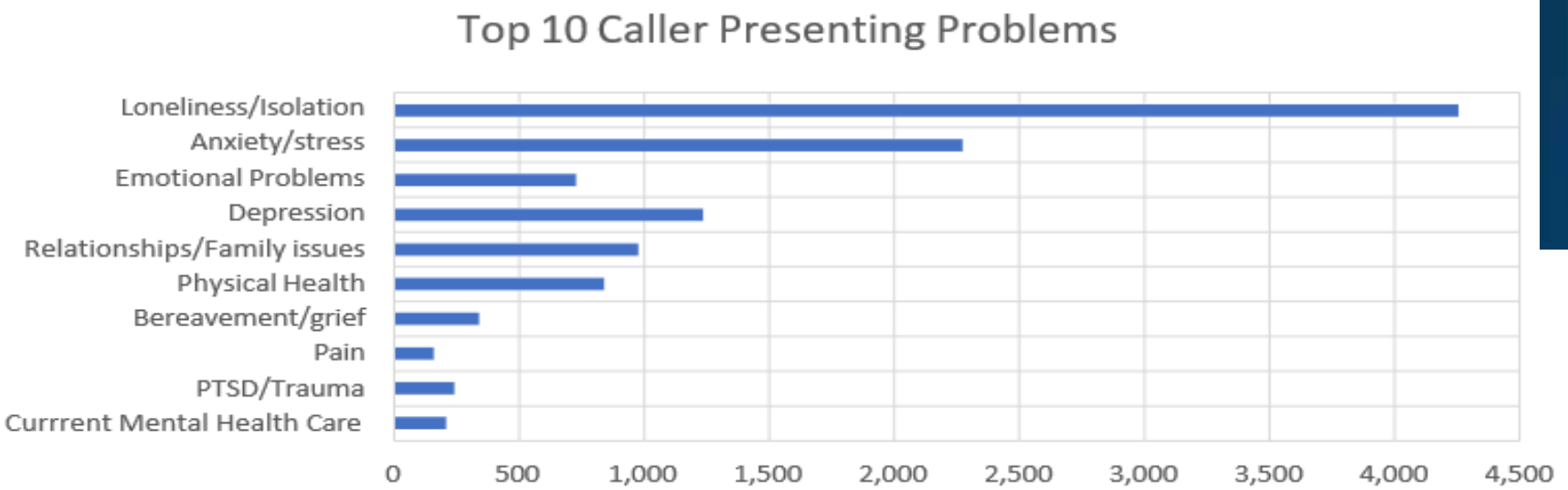
- The CCUIH/CalHOPE Red Line offers peer support services via phone, text/SMS, and live chat, including wellness resources, referrals to Urban Indian and Tribal populations living in California.
- Between July-December 2023, CalHOPE Red Line received 457 calls (approximately 76 Red Line calls per month).
- Services are offered Monday to Friday (9 AM-5 PM).
- Funded via SAMHSA and Federal Emergency Management Agency (FEMA) and affiliated with the California Department of Health Care Services (DHCS) CalHOPE program



Source: CalHOPE Quarterly Progress Report, January 2024 which notes that data on CalHOPE Red Line calls by region are limited due to this information being voluntarily provided by users. Total numbers reflected may differ from the total number of individuals engaged in service.

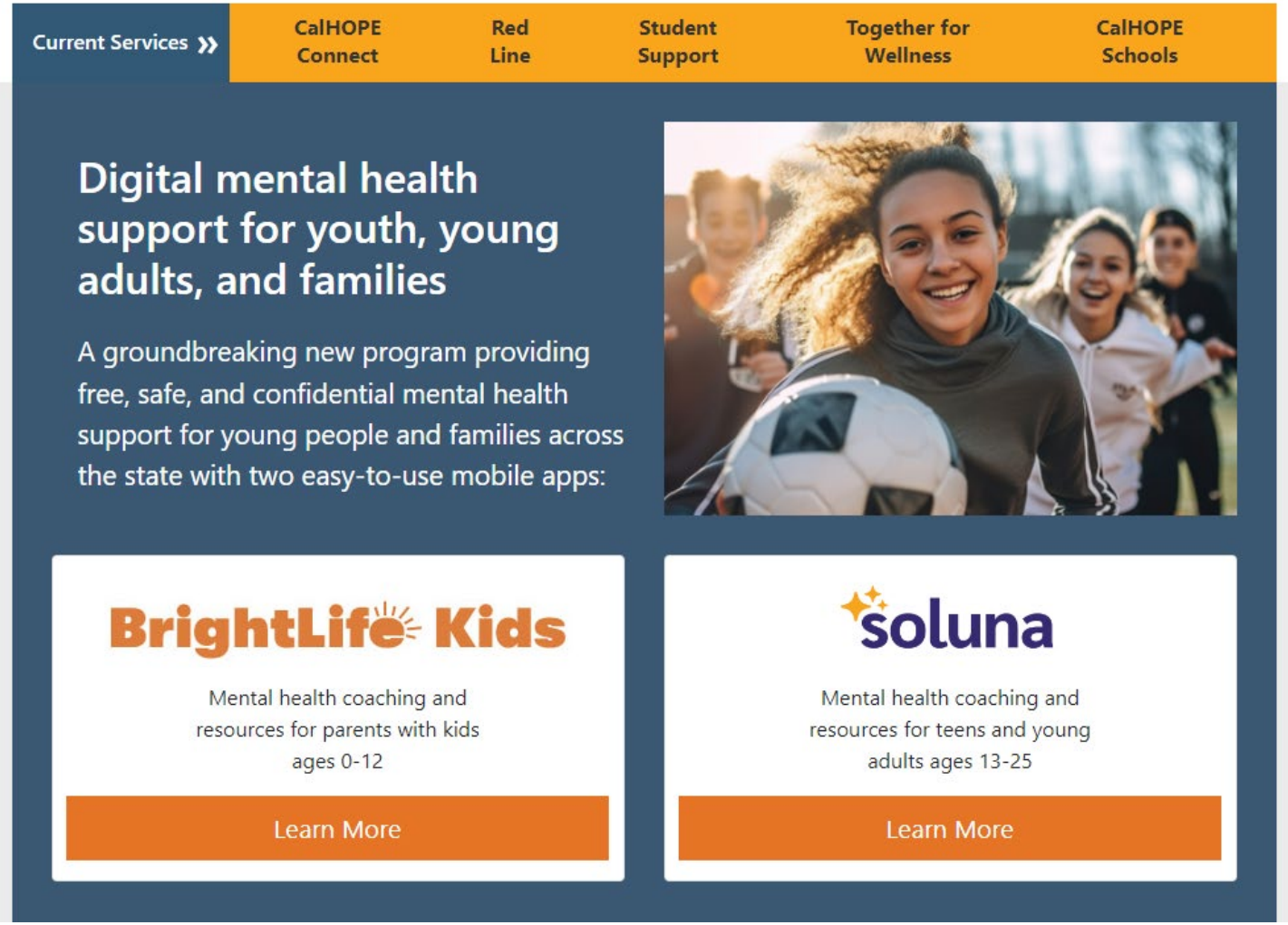
CDA Friendship Line

- California Department of Aging (CDA) reports that between April 2020 and November 2023 (43 months) **Friendship Line Volunteers** responded to 295,148 calls, or approximately 6,800 calls per month.
  - 54% of callers were female with 44% male, and 2% cited other gender identity.
  - 75% of callers identified as heterosexual and 25% as LGBTQIA+.
  - Whites represented the largest category of callers by ethnicity, followed by Latine, Black, Asian/Pacific Islander
  - Callers predominately identified as living alone and single



Source: Internal Data provided by MHASF "Friendship Line Snapshot"

CYBHI: Digital Tools



Please use the following links to reach these resources:

- BrightLife Kids
- Soluna

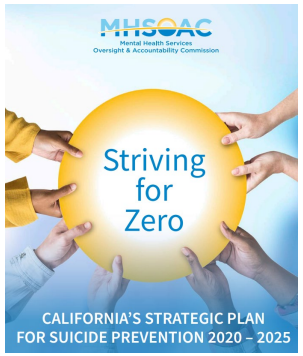
THE Warmline Federation

- Telemental Health and Emotional (THE) Support Coalition of California is a collaborative of telephonic, web chat, and text-based service in California focused on crisis prevention and emotional support services.
- Current members include:
  - California Consortium for Urban Indian Health (CCUIH)
  - Mental Health Association for Chinese Communities
  - Peer Voices: Orange County, Los Angeles, San Diego
  - Project Return Peer Support Network
  - Code Tenderloin
  - Mental Health America of San Francisco

- Goals Include
  - Inventory of Warm Line and Warm Line adjacent services
  - Community needs assessment for peer-based telemental health services
  - Integration of existing warmlines to support LGBTQIA+, BIPOC, rural, youth, elder, parent and caregiver, and other communities
  - Exploration of interoperability between providers

Source: Mental Health Association of San Francisco – California Warm Line Federation

Preventing Crisis: CDPH and Suicide Prevention



CDPH Reported Challenges to Suicide Prevention Efforts

- Public confusion over 988 rollout
- Timely access to local-level data
- Gaps/Diverse needs related to community resources, coordination, communication, and prevention strategies
- Limited resources and infrastructure
- Stigma surrounding mental health and suicide
- Caregiver engagement in youth suicide prevention
- Suicide prevention screening integration into routine practice and workflows
- Systemic and structural factors (e.g., workforce vacancies, lack of county resources such as mobile crisis services, siloing of efforts, and differences in systems across counties)

988-Related Suggestions

- Help normalize 988 via widespread and targeted marketing
- Dedicate funding, resources, and support to effectively promote 988

Source: Office of Suicide Prevention (OSP), 2023 Stakeholder Needs Assessment, Overview and Summary of Results

California's Master Plan for Kids' Mental Health

An integrated multi-year effort uniting historic investments across disciplines to more holistically serve the state's diverse children, youth, and families.

- CYBHI **is at the Core** of the Master Plan
- **$4.7B so every Californian aged 0 to 25 has increased access** to mental health and substance use supports

Additional investments and initiatives in coordination and collaboration with the CYBHI.

- $4.1B on a **community school** strategy to connect kids and families to essential services including health screenings, meals and more, as well as expanded learning opportunities
- $5B on **CalAIM,** to better integrate health and behavioral health services for low-income kids and improve child health outcomes, including prevention
- $1.4B to build the **healthcare workforce** that expands our capacity to meet the health needs of Californians, including children and families
- Additional State budget investments in school-based behavioral health workforce, such as school counselors

Source: Governor Newsom's Master Plan for Kids' Mental Health, August 2022; CBYHI 2023: Implementing the Vision

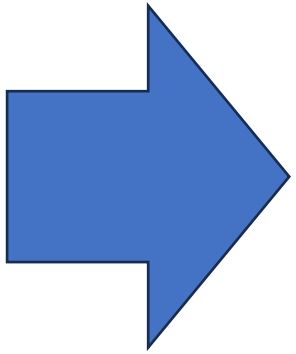
2. Responding to Crisis

(a) Someone to Contact

(b) Someone to Respond

2a. Responding to Crisis: Hotlines

Responding to Crisis
Some aspects of hotlines could include: • Operate 24/7/365 • Answer all calls (or coordinate back-up) • Offer text/chat capabilities



Examples

- 988 Suicide and Crisis Lifeline
  - California 988 Crisis Center Data
  - National Subnetworks:
    - Veterans Crisis Line
    - Spanish Language Line
    - LGBTQIA+ Service Line
- County Lines: Access, Substance Use, and Crisis Lines
- California Youth Crisis Line

Source: Adapted from California Health and Human Services Agency, "Behavioral Health Crisis Care Continuum Plan", 2023

2a. Someone to Contact: 988 Crisis Centers

- As of December 2024, there are 12 988 Crisis Centers operating in California as of December 2024, as part of the 988 Suicide & Crisis Lifeline national network
- Core functions of 988 Crisis Centers:
  - Support and de-escalation
  - Risk assessment
  - Safety planning
  - Connect to care/resources
  - Coordination of emergency services intervention, if necessary

All 988 Crisis Centers can be contacted by dialing 9-8-8. A full list of 988 Crisis Centers (as of December 2024), is listed below.*

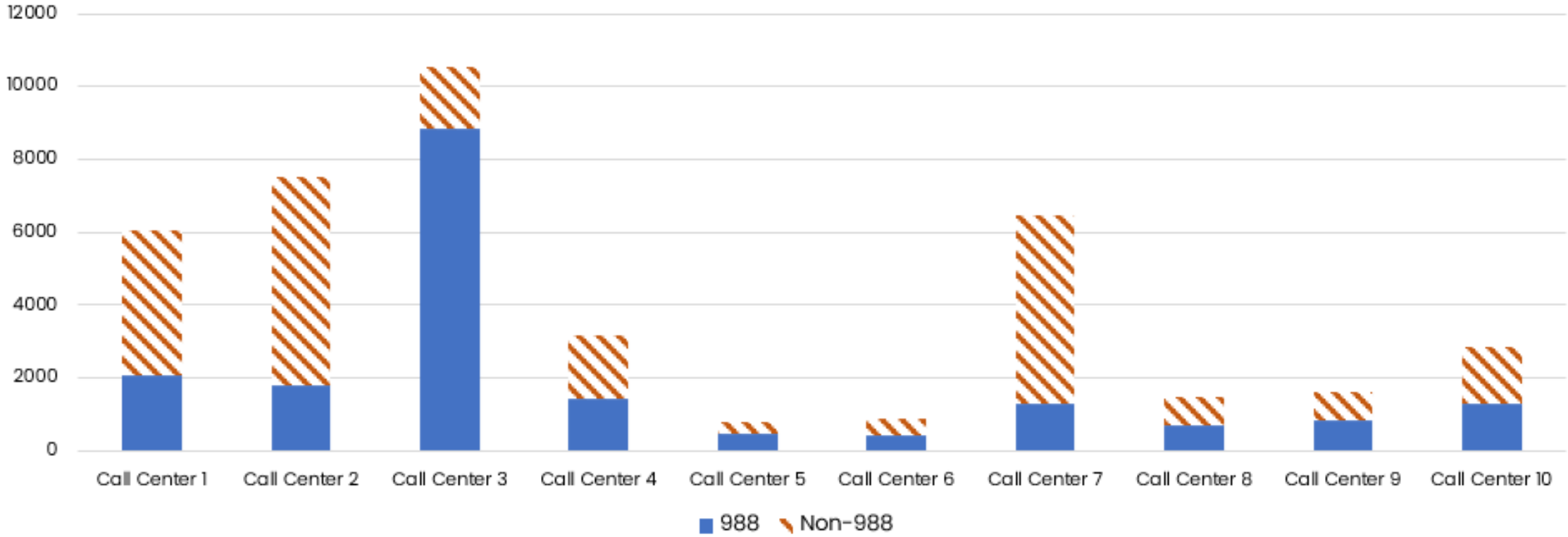
- Buckelew Programs: Novato, CA
- Kings View: Fresno, CA
- Contra Costa Crisis Center: Walnut Creek, CA
- Crisis Support Services of Alameda County: Oakland, CA
- Didi Hirsch Mental Health Services: Century City, CA
- Kern Behavioral and Recovery Services: Bakersfield, CA
- United Behavioral Health dba Optum: San Diego, CA
- San Francisco Suicide Prevention - Felton Institute: San Francisco, CA
- County of Santa Clara Behavioral Health Services: San Jose, CA
- Star Vista: San Francisco, CA
- Family Service Agency of the Central Coast: Santa Cruz, CA
- WellSpace Health: Sacramento, CA

Sources: Crisis Centers by State and U.S. Territory; 988 Lifeline Best Practices; 988 Suicide & Crisis Lifeline Suicide Safety Policy (2024); Discussion with California 988 Crisis Centers

Note: The cities listed represent the location of the 988 Crisis Centers; not the entire geographic areas covered by the 988 Crisis Center

2a. Someone to Contact: 988 Crisis Centers #2

- CA 988 Crisis Centers also receive non-988 routed calls (e.g., local crisis lines)
- Most Crisis Centers receive more non-988 routed calls than those routed through the 988 network

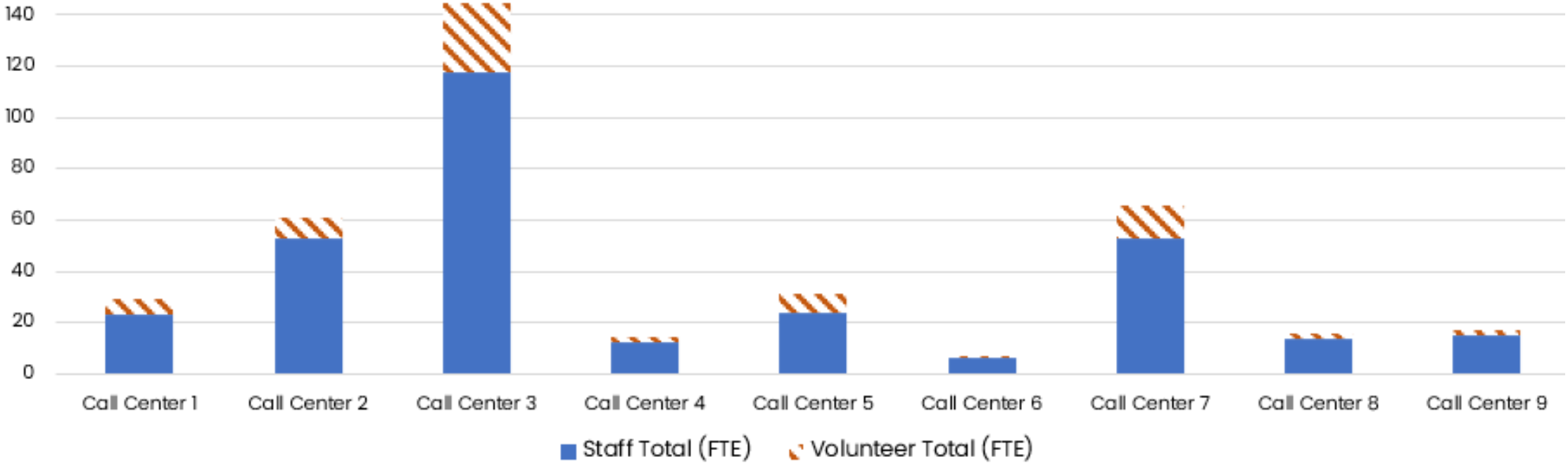


Source: Based on a February 2024 survey of the 12 current California 988 Crisis Centers aimed at understanding their operations and training requirements. The survey included open-ended questions.

Note: Due to differences in how 988 Crisis Centers responded, some responses have been omitted from the data; two Crisis Centers noted that they answered local crisis lines, but did not include call numbers and so have been excluded from the table.

2a. Someone to Contact: 988 Crisis Centers #3

- 11 of 12 CA 988 Crisis Centers operate with a mix of paid staff and volunteers (with the 12th employing all their call counselors)
- The total number of workers (paid staff + volunteers) at Crisis Centers ranges from 7 on the low end to 145 on the high *(average of 43)*
- All Crisis Centers rely on more paid staff than volunteers to support operations



Source: Based on a February 2024 survey of the 12 current California 988 Crisis Centers aimed at understanding their operations and training requirements. The survey included open-ended questions. Due to differences in how Crisis Centers responded, some response have been omitted from the data. In this instance, three 988 Crisis Centers responded to the question on staffing, but did not provide FTE totals and were therefore excluded from the graphic.

2a. Someone to Contact: 988 Crisis Centers #4

Staffing Supervision

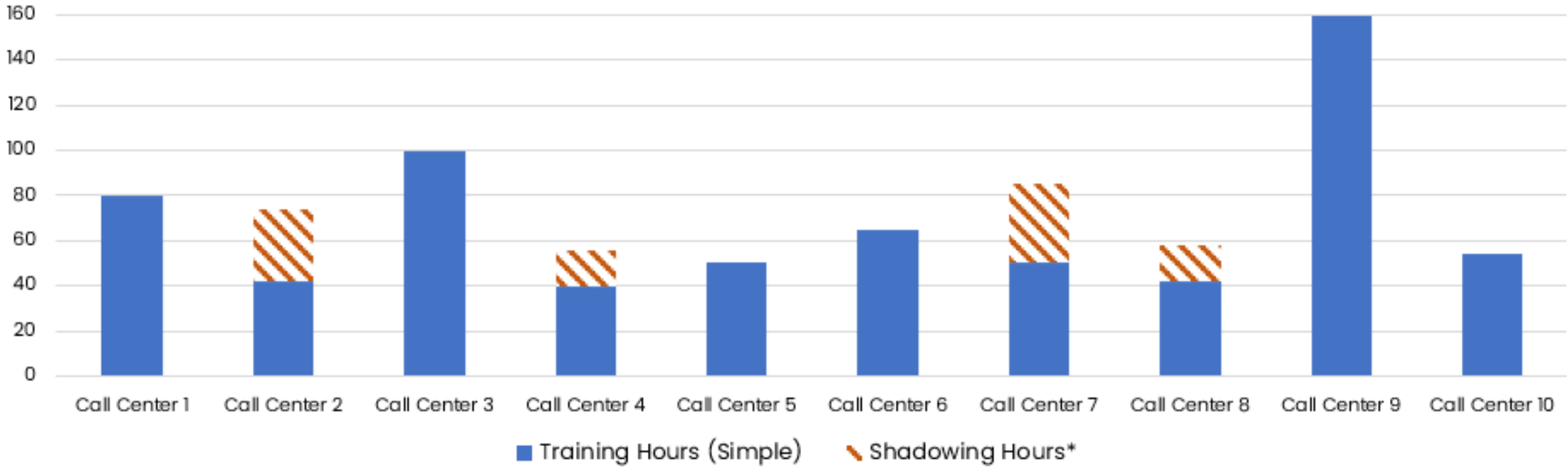
- The supervision ratios (i.e., the number of workers overseen by each supervisor) are similar for most Crisis Centers.
- 70% of Crisis Centers that provided their supervision ratio had a ratio at or below one supervisor for every 10 workers.
  - The highest ratio reported: 1 Supervisor: 5 workers
  - The lowest ratio reported: 1 Supervisor: 16 workers

Based on a February 2024 survey of the 12 current California 988 Crisis Centers aimed at understanding their operations and training requirements. The survey included open-ended questions. Due to differences in how Crisis Centers responded, some response have been omitted from the data;

2a. Someone to Contact: 988 Crisis Center #5

Training

- The questionnaire asked for the number of hours of training provided to new staff/volunteers during onboarding. Responses ranged from 160 on the high end to 40 hours on the low end.
- In addition to classroom/online trainings, Crisis Centers reported a range of 16 to 35 hours of call shadowing/apprenticeship.*



Source: Based on a February 2024 survey of the 12 current California 988 Crisis Centers aimed at understanding their operations and training requirements. The survey included open-ended questions. Due to differences in how Crisis Centers responded, some response have been omitted from the data. In this instance, two 988 Crisis Centers described their training program but did not indicate the number of training hours and therefore were excluded from the graphic.

*Note: Several 988 Crisis Centers mentioned that they provide call shadowing but did not provide hours requirements.

2a. Someone to Contact: 988 Crisis Centers and Mobile Services

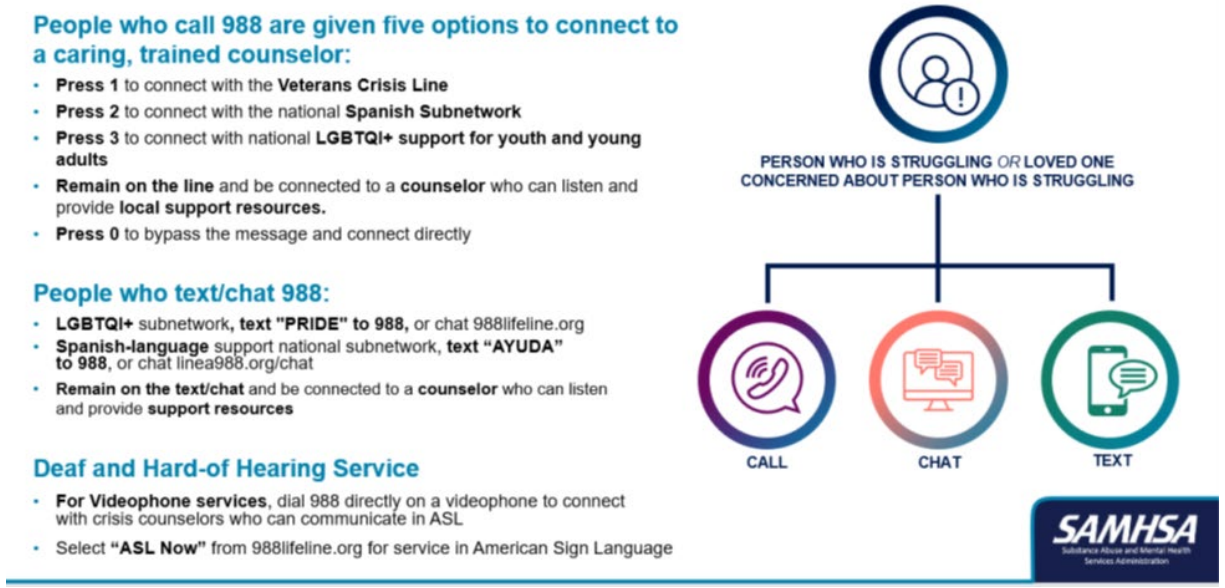
988 Crisis Centers were asked about mobile crisis services. Below is an overview of several types of services/roles and the number of Crisis Centers that indicated they provided that service/role.*

Service Element	Crisis Centers
Provide direct dispatch to mobile crisis	2 of 12
Provide a warm handoff to mobile crisis	11 of 12
Provide trainings for crisis counselors on how to engage mobile crisis	8 of 12
Access to youth specific mobile crisis teams	4 of 12

Source: Information provided by 988 Crisis Centers to CalHHS project team. Note: County Behavioral Health Agencies maintain Access Lines and offer mobile crisis services. DHCS data indicates that as of December 17, 2024, 48 counties are approved to provide mobile crisis services under the Medi-Cal Mobile Crisis benefit, which covers 98% of Medi-Cal members. More about these services are articulated on slide 120 of the Chart Book.

2a. Someone to Contact: National Data for 988 Subnetworks

- 988 National Veterans Crisis Line (VCL)
  - Between July 2022 and July 2024
    - Answered more than 1,638,138 calls/chats/texts.
    - This represents a 22.7% increase in calls, a 76.7% increase in texts, and a 27.5% increase in chats per day.
    - VCL has maintained an average speed to answer of 9.17 seconds.
- 988 National LGBTQIA Line
  - From December 2023 to March 2024
    - Nearly one in 10, 988 contacts, including 16% of all texts, were made via 988's LGBTQIA+ service
    - Most contacts to 988 came via calls for both the LGBTQIA+ service and the general 988 service, but those using the LGBTQIA+ service were about twice as likely to use text
    - LGBTQIA+ service line help seekers had double the call abandonment rate (21% v. 11%) and substantially longer call wait times than non-LGBTQIA service line contact



Sources: U.S. Department of Veterans Affairs News, Two years since launch of Dial 988 then Press 1, Veterans Crisis Line is supporting more Veterans than ever; KFF, Utilization of the 988 Suicide & Crisis Lifeline's LGBTQ Service, 2024

2a. Someone to Contact: County Access Lines

- Counties operate many different types of lines.
  - Past data show at least 90+ different county-operated lines.
- All 58 counties have an Access Line (including Sutter/Yuba).
  - "The Mental Health Plan (MHP) in each county is responsible for providing or arranging for the provision of Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries in their county. SMHS means the impact of the beneficiary's condition is severe enough for him/her to require the services of a specialist as opposed to a generalist in the field of mental health," according to DHCS.
  - Access Lines are required to operate 24/7. While some 988 call centers also provide access line services, most counties operate these lines themselves or contract these services out to non-988 Crisis Centers.
- All 58 counties also have SUD Access Line
  - 12 lines listed are the same as the County Access line, all others are different listings.
  - The state also has a statewide toll-free number [(800) 879-2772] to provide automated non-emergency substance use disorder treatment referrals.
  - Some counties list toll-free number numbers alongside crisis lines on their webpages; others have separate children and adult substance use lines.

Sources: DHCS SUD and Access Lines; **Note: Sutter/Yuba offer one line together**

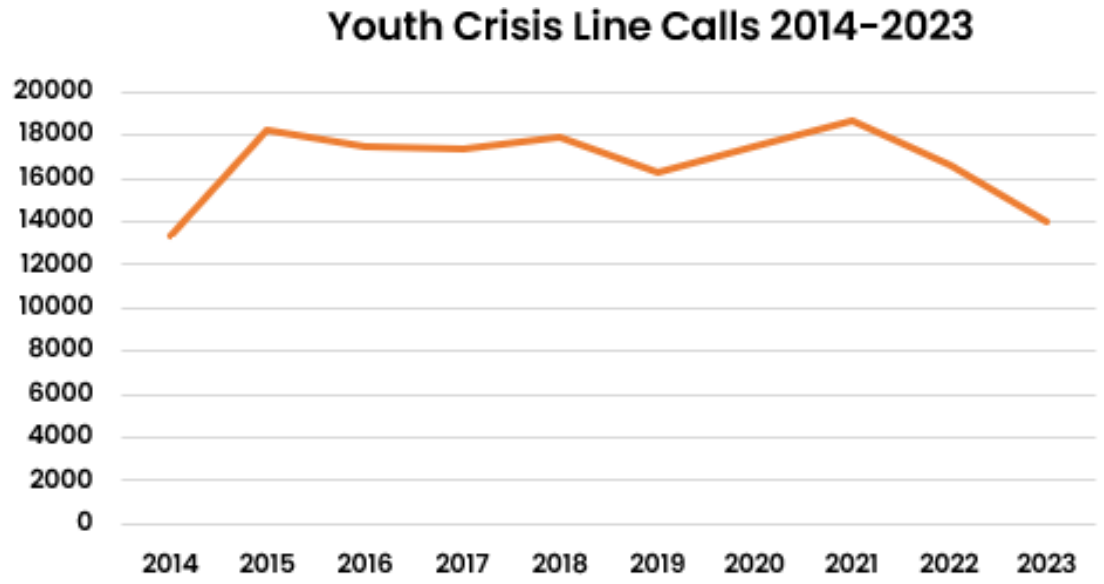
2a. Someone to Contact: County-Required Crisis Lines

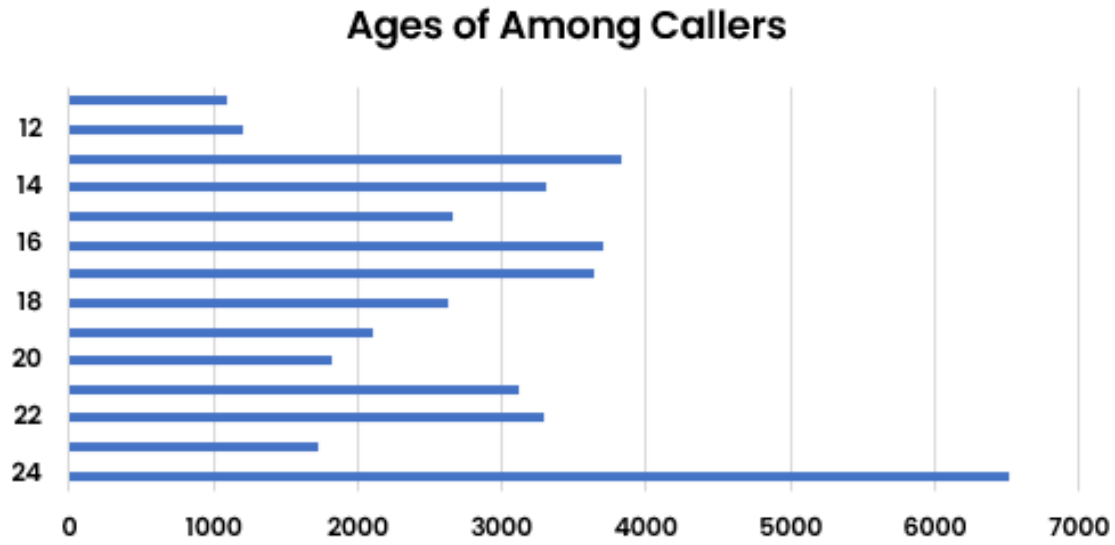
- The Medi-Cal mobile crisis services benefit requires counties to:
  - Identify "a single telephone number to serve as a crisis services hotline connected to the dispatch of mobile crisis teams to receive and triage beneficiary calls…"
  - "Identify and post a single telephone number that Medi-Cal beneficiaries who may require mobile crisis services can call. This number can be the same as the county's 24/7 access line, or an existing crisis line [sic] if the line has the capacity to respond to beneficiaries in crisis and to dispatch mobile crisis teams when appropriate."
  - "Coordinate with the 988 Suicide and Crisis Lifeline, local law enforcement and 911 systems, the Family Urgent Response System (FURS), and community partners to ensure beneficiaries have information about mobile crisis services."
- As of December 2024, publicly available data showed 44 counties with 24/7 crisis lines in place; all other counties listed these crisis lines as "coming soon," per MTAC – Crisis Lines.

Source: BHIN 23-025 and MTAC – Crisis Lines

2a. Someone to Contact: California Coalition for Youth Crisis Lines

- The CA Youth Crisis Line is a 24/7 statewide crisis call/chat and text line for youth (ages 12-24) and families in crisis.
- Provides crisis intervention, counseling, and referral to local service providers.
- Over a 10-year period (2014-2023), the line averaged 16,740 annual calls.
- Among contacts that provided their age, the median age was 21 years.
- Among contacts that provided their gender identity, a slight majority identified as male.
- Average call duration was nearly 15 minutes (14:57), with calls answered within 16 seconds.





Source: Data provided to CalHHS by California Coalition for Youth Crisis 6/14/2024

2a. Someone to Contact: Study of CA Suicide Prevention Hotlines

- A 2017 RAND Corporation evaluation of CalMHSA-funded California suicide prevention hotlines found the following:
  - The 2,568 adult respondents indicated their likelihood of engaging with the following resources if seeking help for suicidal thoughts:
    - Face-to-face help from mental health professionals (78%) and family/friends (72%) were the most preferred options, followed by visiting a website (66%) and calling a crisis line (62%).
  - Live monitoring by RAND raters assessed the overall level of caller satisfaction across assessed call lines on a scale of 1-5. Overall call satisfaction was 3.4 with very little variability across centers (range: 3.2–3.9).
  - Caller distress was assessed at both the beginning and end of the call, with just under half of callers experiencing reductions in distress.
  - Evaluators identified wide variability across call operators both in terms of caller demographics, issues discussed during calls and the quality of contacts and referrals.

Source: RAND, Suicide Prevention Hotlines in California: Diversity in Services, Structure, and Organization and the Potential Challenges Ahead, 2017. **Survey data was collected in 2013 and 2014.*

2b. Responding to Crisis: Mobile Crisis Response Teams

Responding to Crisis
Mobile Crisis Services • Operates 24/7/365 • Staffed by a multidisciplinary team meeting training, conduct, and capability standards • Responds where a person is • Includes licensed and/or credentialed clinicians

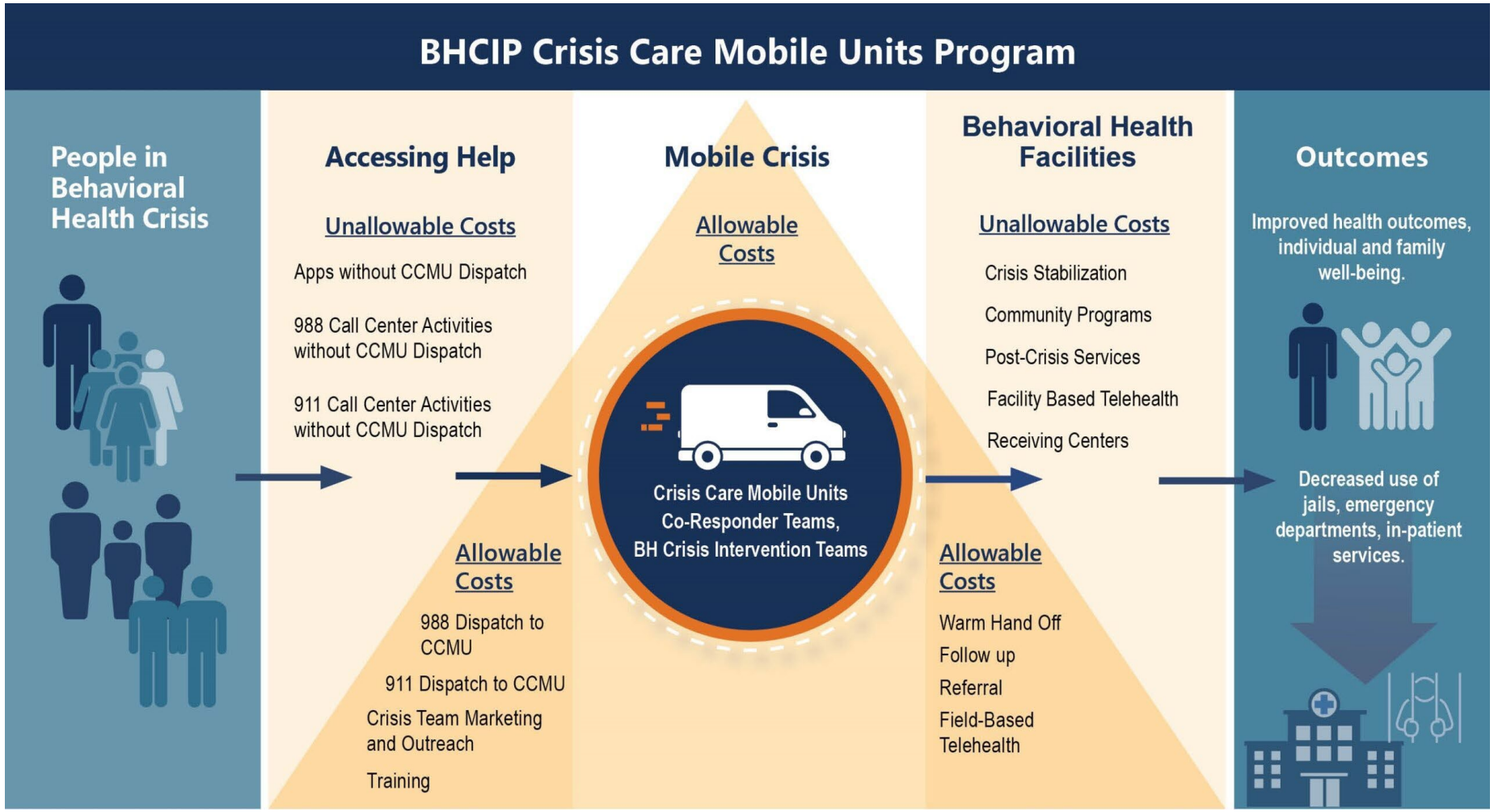
Examples

- Behavioral Health Continuum Infrastructure Program (BHCIP) Crisis Care Mobile Units (CCMU) Program
- Medi-Cal mobile crisis services and other community-defined crisis response models

2b. Someone to Respond: Crisis Care Mobile Units (CCMUs) #2

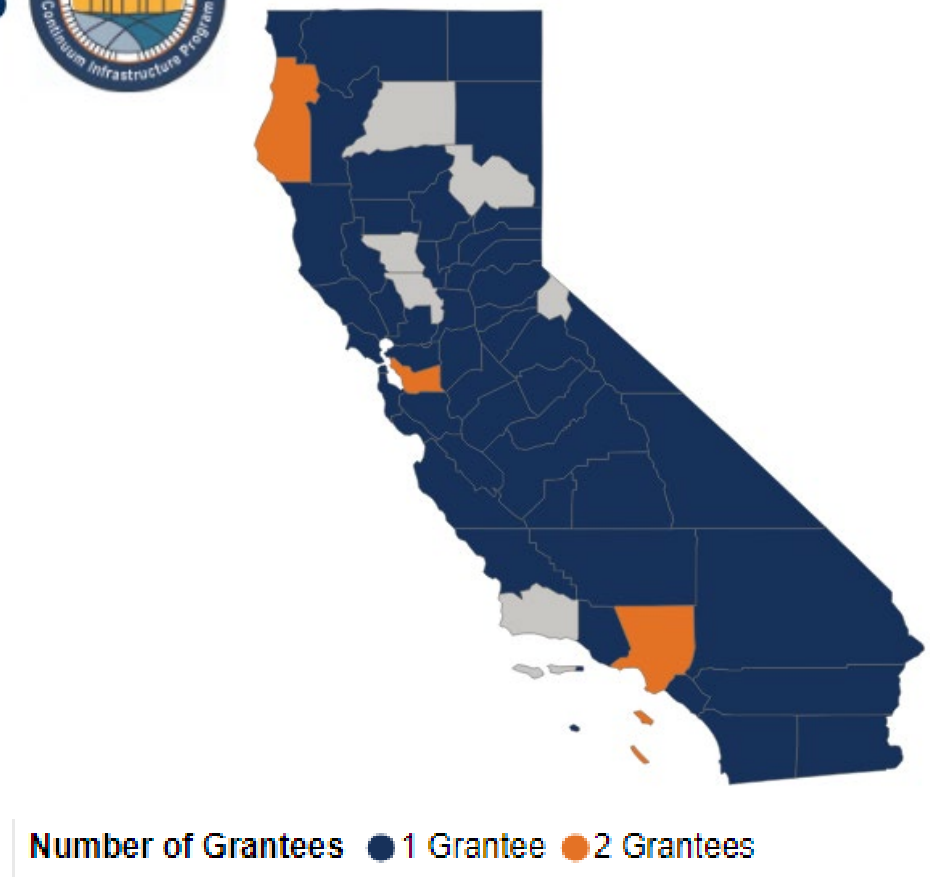
BHCIP and SAMHSA funding for mobile crisis response has supported growth in the number of mobile crisis teams across the state

- $202 million to 54* behavioral health authorities' mobile units across the state.
- Almost $7.5 million awarded to 23 Tribes/Tribal entities for vehicles to address behavioral health crises.
- As of September 2024, there were 458 mobile crisis teams created or enhanced through BHCIP



Source: BHCIP Crisis Care Mobile Units Program; Crisis Care Mobile Units Program Grant *Note:: this includes 51 County Behavioral Health Authorities (52 total Counties); 2 City Behavioral Health Authorities and 1 Tribe for CCMU services contracted

2b. Someone to Respond: Impact of CCMUs



Number of Grantees by County

Data obtained from 53 grantees who reported this quarter (July 1 – September 30, 2024)

458
Current Total Teams

79.5%
Current Percent of Grantees Servicing all Zip Codes in their jurisdiction

86.79%*
Current Percent of Grantees Providing Services

103,450
Total Service Episodes to Date

**This percentage represents 42 of 52 CCMU Grantees. The remaining grantees are yet to provide services due to workforce/hiring challenges*

Source: BHCIP Round 1 Data Dashboard as of July 2024

2b. Someone to Respond: Distribution of CCMU Teams

BHCIP Round 1: Crisis Care Mobile Units

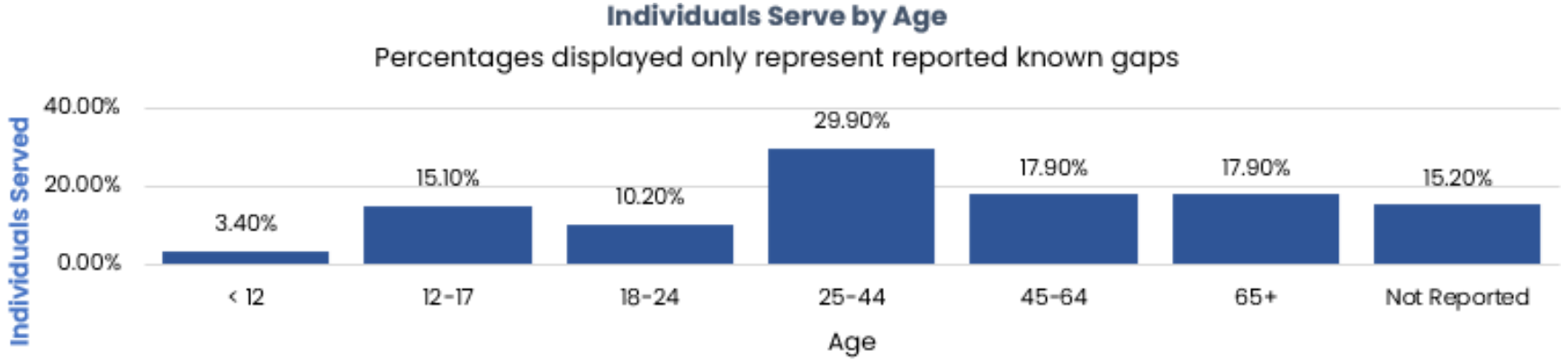
Data from CCMU Implementation Grantees for the July 1-September 30, 2024 Reporting Period

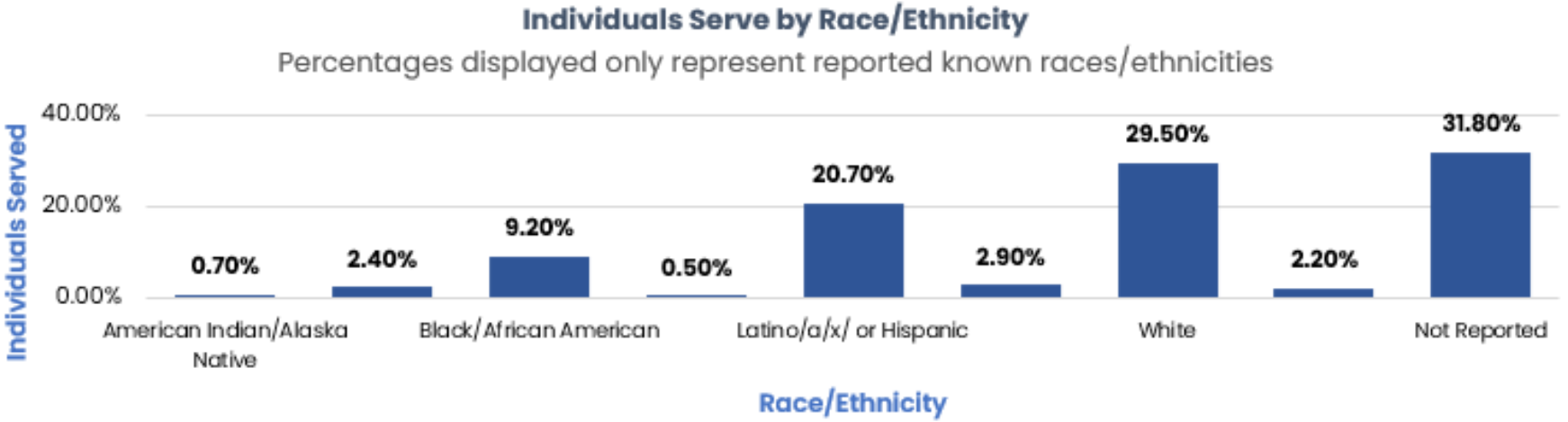
Funding for direct services has been provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA)

18,052
Total Unduplicated Individuals Served

As of September 30, 2024

- The most common age for an individual served by a CCMU was between 25 to 44 years
- The most common race/ethnicity of an individual served by a CCMU was White and Latinx, similar to state demographics
- Black/African Americans represented a higher percentage of responses by CCMUs relative to the share of the state's Black/African American population



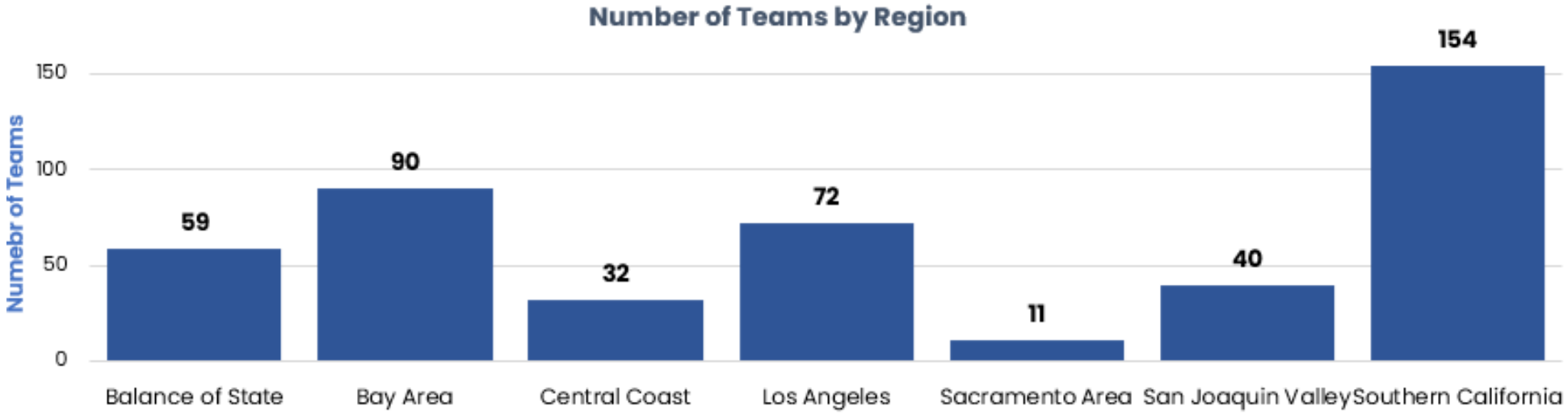


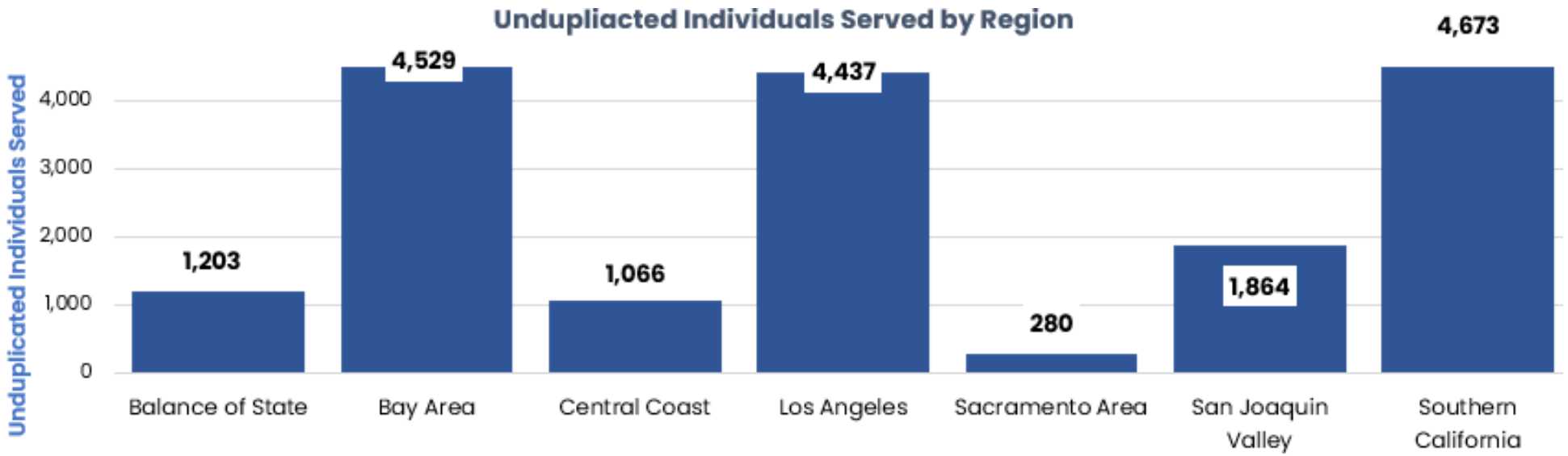
Source: BHCIP Round 1 Data Dashboard as of December 2024

2b. Someone to Respond: Who CCMUs Serve

In Q3 of 2024:

- The largest number of teams by region are in Southern California, followed by the Bay Area and Los Angeles.
- The largest number of unduplicated individuals served were in San Joaquin Valley, Los Angeles, and the Bay Area.





Source: BHCIP Round 1 Data Dashboard

2b. Someone to Respond: Resolution of Mobile Crisis Response

BHCIP Round 1: Crisis Care Mobile Units

Data from CCMU Implementation Grantees for the July 1 – September 30, 2024 Reporting Period

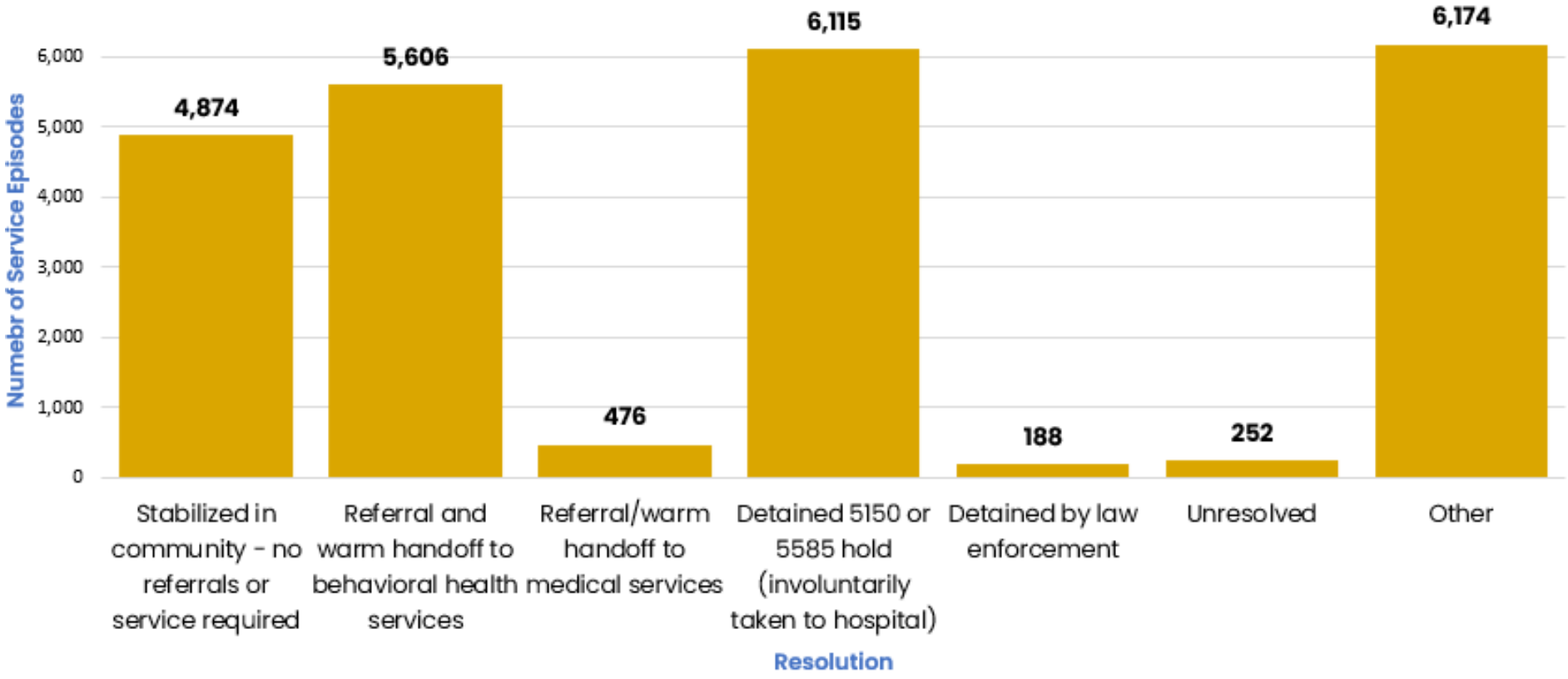
Funding for direct services has been provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA)

23,685
Total number of CCMU dispatches with CCMU services

In Q3 of 2024:

- The most common resolution for CCMUs was other (26%) followed by a 5150/5585 hold (roughly 26%), a warm handoff to BH services (24%), and stabilized in the community (20%).
- Law enforcement detainment was the least prevalent resolution.

Number of Service Episodes by Resolution



Source: BHCIP Round 1 Data Dashboard as of September 2024

2b. Someone to Respond: Typology of Response Models

Response Model	Emerging Designs of Community-Based Partnership Responses with Law Enforcement, Mental Health Providers, EMS, and Others
Dispatch-based behavioral health supports	Behavioral health specialists work within dispatch call centers to be available to assist with calls, provide consultation and support of call center workers and engage in frontline triage.
Police-based specialized police response	Law enforcement officers who are specifically trained to manage behavioral health crises and have knowledge of and access to the system to help support their response.
Police-based specialized mental health co-response	Typically involves behavioral health clinicians hired by police departments whose job is to accompany officers on calls where an individual might be in a behavioral health crisis or where a behavioral health specialist might be helpful.
Mental health-based mental health response	Also known as mobile crisis services, where a mental health unit, staff person, or team of staff respond directly at the scene of the crisis; law enforcement may or may not jointly and cooperatively appear on the scene.

Source: Lending Hands: Improving Partnerships and Coordinated Practices between Behavioral Health Police and other First-Responders, NASMHPD, 2022 offers one typology

2b. Someone to Respond: Medi-Cal Mobile Crisis Services Model (Enhanced)

Response Model	State of California
Short Description	• The state is working with all counties to provide mobile crisis services provided by a multidisciplinary team. These teams can provide de-escalation and relief to individuals experiencing a mental health or substance use crisis at home, work, school, or elsewhere in the community, based on approval of SPA 22-0043 • As of December 17, 2024, 48 counties are approved to provide mobile crisis services under the benefit, which covers 98% of Medi-Cal members. • Aim is to have access to coordinated crisis care multidisciplinary mobile teams 24/7/365 to provide community-based crisis resolution and reduce unnecessary law enforcement involvement and emergency department utilization • Many teams already operate and provide rapid response, individual assessment, community-based stabilization, follow-up, and coordination with other services and supports • Medi-Cal mobile crisis teams are trained to offer trauma-informed care and utilize de-escalation and harm reduction strategies, and to respond to needs of children and youth, provide culturally responsive and language appropriate care, support crisis safety planning, perform motivational interviewing, and work with individuals with intellectual or developmental disabilities • Timeliness standards require response within 60 minutes of dispatch in urban areas and within 120 minutes in rural areas
Key Community Partnerships	• Department of Health Care Services • County Behavioral Health Agencies • County Contracted Medi-Cal Providers
Funding Sources	• Medi-Cal Mobile Crisis Services Benefit (state and federal funding)

Source: Approved State Plan Amendment; December 2024 data provided by DHCS

2b. Someone to Respond: Community Paramedic + BH Model/Example

Response Model	San Francisco Street Crisis Response Team (SCRT)
Short Description	• Its mission is to offer an alternative to law enforcement for mental health crises and reduce emergency room visits. • As of March 2023, the team includes a community paramedic, an EMT or second paramedic, and a Peer Counselor or Homeless Outreach Team specialist, with behavioral health clinicians providing follow-up care. • Activated via 911 calls to provide rapid, trauma-informed care for individuals in acute behavioral health crises or with non-emergency needs. • Operates citywide 24/7 and links individuals to shelters, drug and alcohol sobering centers, mental health clinics, urgent care, and other support services. • Since launch in 2020 (through March 2024) has responded to 21,092 contacts, 53% of which were resolved on scene, 20% involved transport to a hospital, 19% included transport to social or behavioral health setting, and 4% with 5150 initiated on scene.
Key Community Partnerships	• Department of Emergency Management • San Francisco Fire Department • Department of Public Health • Department of Homelessness and Supportive Housing
Funding Sources	• City of San Francisco (project $13 million/year) via a city business tax • Funding from Robert Wood Johnson Foundation for an evaluation of SCRT
Other Notes	• Similar models mentioned in Cities of Los Angeles, Beverly Hills, Santa Monica • Sometimes referred to as advanced provider mobile teams

Sources: Street Crisis Response Teams; Council of State Governments Justice Center; San Francisco City Ordinance

2b. Someone to Respond: Community Based Model/Example

Response Model	West Hollywood Care Team
Short Description	• Launched in 2023 and operated by Sycamores, the team operates Monday through Friday, from 2:00 PM to 6:00 AM with the goal of operating 24/7/365 by end of 2024. • Offers a range of culturally competent services in unmarked SUVs with no lights and sirens; uses a harm reduction, trauma-informed approach that includes situation assessment, safety planning, welfare checks, grief and loss support, first aid, conflict mediation, and social service referrals. • Each shift is staffed by two peer support managers who have specialized training. • Dispatched through the 988 national crisis hotline (depending on the estimated time of arrival, the hotline can dispatch either an LA County Department of Mental Health Field Intervention Team or the West Hollywood Care Team). • Team can act as secondary responders when necessary and bridge individuals in crisis to the city's social services network but not a 911 emergency services responder. • Care Team members receive training, including CPR, first aid, and Narcan distribution, with a focus on cultural competence, especially for West Hollywood's LGBTQIA+ community.
Key Community Partnerships	• City of West Hollywood General Funds • 988 Call Center (Didi Hirsch) • Los Angeles County Department of Mental Health
Funding Sources	• City of West Hollywood ($7 million budget/3 years) • Los Angeles County Department of Mental Health
Other Notes	• Similar models mentioned in Santa Barbara and Long Beach

Sources: WEHO Online, Public Safety Commission gets a rundown on WeHo's Care Team; Interview with Los Angeles County Department of Mental Health (July 2024)

2b. Someone to Respond: Psychiatric Emergency Response Team Example

Response Model	Santa Clara PERT Team
Short Description	• Activated through 911 emergency response, County of Santa Clara's Psychiatric Emergency Response Teams (PERT) are two-person units comprised of a deputy or officer and a licensed mental health clinician • PERT provides a joint response for 911 calls for service that occur in designated law enforcement jurisdictions regardless of insurance status • PERT provides rapid crisis response for situations that require a law enforcement presence. The teams arrive in an unmarked vehicle, and PERT officers are dressed down to provide a more approachable, de-escalated response • PERT Clinicians are licensed mental health clinicians who are trained to work with law enforcement, conduct mental health evaluations and assessments, and assist in determining the appropriate disposition supporting individuals' needs and safety • PERT units have received Crisis Intervention Team (CIT) and Hostage/Crisis Negotiation training.
Key Community Partnerships	• Law Enforcement (Sheriff's Office and Santa Clara Police Department).
Funding Sources	• County of Santa Clara • Medi-Cal crisis services benefit
Other Notes	• Similar models mentioned in Los Angeles, Riverside.

Sources: Community mobile response teams; Interview with Santa Clara Department of Behavioral Health (July 2024)

2b. Someone to Respond: Behavioral Health Mobile Crisis Teams

Response Model	Riverside University Health System - Behavioral Health Mobile Crisis Teams
Short Description	Riverside University Health System – Behavioral Health has established three types of mobile crisis response services, all dispatched via a county-run dispatch center. • *Mobile Crisis Management Teams*: Teams include a clinical therapist, behavioral health specialist, substance use counselor, and peer support specialist. The team provides outreach, short-term therapy, substance use counseling, and case management with linkage to long-term services. There were 19 MCMTs as of July 2024. • *Mobile Crisis Response Teams*: Teams consist of clinical therapists, behavioral health specialists, and peer support specialists working collaboratively with law enforcement, emergency department personnel, and community members. They work to divert individuals to the appropriate level of care and reduce the need for inpatient hospitalization or incarceration. There were 12 MCRTs as of July 2024. • *Community Behavioral Assessment Teams*: Teams include a clinical therapist partnered with an officer from various local law enforcement agencies. The teams are dispatched when there is a potential safety concern. The team conducts a risk assessment and then diverts the individual in crisis to the lowest level of necessary care, which may include another mobile team type taking over. There were 17 CBATs as of July 2024.
Key Community Partnerships	• Sycamores (which provides overnight crisis response coverage – 8:00 PM to 8:00 AM) • Law Enforcement • Emergency Departments and Alternative Destinations (e.g., Mental Health Urgent Care, Sobering Centers, etc.) • School Districts
Funding Sources	• Riverside University Health System – Behavioral Health • Medi-Cal Mobile Crisis Services Benefit • Crisis Care Mobile Units Program Grant • Behavioral Health Justice Intervention Services Grant

Sources: Riverside University: Crisis Support System of Care; Interview with Riverside University Health System – Behavioral Health (July 2024)

2b. Someone to Respond: Schools and Colleges/Universities

Response Model	Riverside University Health System - Schools and Colleges/Universities
Short Description	• Riverside University Health System – Behavioral Health has established partnerships with local school districts and community colleges to support crisis response. • School Districts: Funded through a grant, RUHS-BH that placed teams of clinical therapists, peer support specialists, and parent partners on high school campuses. The teams work in collaboration with existing school district counselors to support students and reduce the need for crisis response. When crises do occur, the school districts and RUHS-BH teams have direct access to a Community Behavioral Health Team housed at a school facility. • Community Colleges/Universities: Funded through a grant, RUHS-BH hired and embedded clinical therapists within colleges and universities throughout Riverside to support on-campus crisis response. The embedded therapist – working closely with campus behavioral health staff – conducts the in-person response, assessment, and connection to care, with campus law enforcement engaged if a safety concern is present. The clinical therapist is a part of the larger RUHS-BH mobile response team and can call in additional support when needed.
Key Community Partnerships	• School Districts and the Riverside County Office of Education • Community Colleges and Universities
Funding Sources	• School Districts: Mental Health Student Services Act Grant • Community Colleges/Universities: Behavioral Health Justice Intervention Services Grant

Sources: Riverside University: Crisis Support System of Care; Interview with Riverside University Health System – Behavioral Health & school/community college partners (July 2024)

2b. Someone to Respond: Children and Youth Mobile Crisis Model

Response Model	Santa Clara County Mobile Response and Stabilization Services (MRSS)
Short Description	• Children and young adults ages 4 to 20. • Operates 24 hours, 7 days per week. • Contract provider: Pacific Clinics. • Provides stabilization and support services for children, youth, and young adults (through age 20) experiencing mental health crisis in the County of Santa Clara. Therapeutic teams will consult, assess for safety, and intervene through crisis counseling with the goal of community stabilization. Post crisis stabilization services will be provided to ensure linkage, referral, and care coordination to existing providers and/or refer for ongoing services. • Provides 24-hour in-person intervention or phone support to children, youth and young adults in the County of Santa Clara who are in acute psychological/emotional crisis.
Key Community Partnerships	• Pacific Clinics
Funding Sources	• County of Santa Clara
Other Notes	• Similar models mentioned in Contra Costa (Children's Mobile Crisis Response team); other providers include Sycamores and Seneca Family of Agencies

Sources: Community mobile response teams; Interview with Santa Clara Department of Behavioral Health (July 2024)

2b. Someone to Respond: Cal-Family Urgent Response System (Cal-FURS)

Background:

- Cal-FURS is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth

Services

- A toll-free hotline available 24 hours a day, 7 days a week staffed with caring counselors trained in conflict resolution and de-escalation techniques for children and youth impacted by trauma.
- County Mobile Response and Stabilization Teams also available 24 hours a day, 7 days a week.
- In-home de-escalation, stabilization, conflict resolution, and support services and resources.
- Ongoing support services beyond the initial mobile response.
- Hotline and mobile response staff trained in working with children and families who have experienced trauma.

Data

- A total of 4,987 calls came into the FURS Statewide hotline between January 1, 2023, and December 31, 2023. Of those, 2,086 calls were initiated by caregivers; 738 were initiated by current and former foster youth; the remainder were a combination of ineligible callers, disconnected or declined to answer.
- Out of the total of 2,086 calls received from caregivers, the largest group of callers were foster caregivers (61.4 percent) followed by adoptive parents (8.2 percent). Relative/NREFM and biological parents each represented just over 7 percent of the total calls.
- Of all calls (4,987), 41.2 percent were stabilized on the hotline without requiring any additional referrals to other services; 23.1 percent were referred to counties for a mobile response; 21.4 percent were provided referrals to other services; and 14.3 percent of callers either disconnected or declined services.

Source: CDSS Family Urgent Response System Website (accessed December 11, 2024); Family Urgent Response System (FURS) 2023 Legislative Report

2b. Someone to Respond: Community Paramedicine Study

Background:

- 2014: California Office of Statewide Health Planning and Development (OSHPD) approved an EMSA Pilot Project.
- 2020: AB 1544 authorized local emergency medical services agencies to develop community paramedicine or triage to alternate destination programs per EMSA regulations.
- 2021: Responsibility for the 14 pilot projects transferred from OSHPD to EMSA.

Alternate Destination – Mental Health

Four projects enrolled 5,093 persons between September 2015 and September 2020.

- 27% to 44%* of patients screened were directly transported to the mental health crisis center.
- Fewer were transferred to ED.
  - 1.9% were transferred to the ED within six hours of admission.
  - 1.3% of patients were rerouted to an ED because a mental health crisis center declined to accept them because they did not meet criteria for admission.

Alternate Destination – Sobering Center

Three projects enrolled 2,945 persons between February 2017 and September 2020.

- San Francisco: 98.2% were treated safely and effectively.
  - Fewer were transferred to the ED.
    - 1.7% transferred to ED within six hours of admission.
    - 0.1% rerouted because sobering center declined to accept them.
    - 0.2% admitted for inpatient medical care.
- In LA County, none were transferred to ED within six hours of admission.

Source: Institute for Health Policy Studies at UC San Francisco, "Update of Evaluation of California's Community Paramedicine Pilot Program," 2021

3. Stabilizing Crisis

-A Safe Place to Be

Essential Crisis Services – Stabilizing Crisis

= Near term (by FY 23-24) * = Medium term (by FY 26-27) = Long term (by FY 28-29)

Stabilizing Crisis

Crisis Receiving and Stabilization Services

- Operate 24/7/365 with multidisciplinary team or other suitable configuration, depending on the model
- Offer on-site services that last less than 24 hours
- Accept all appropriate referrals
- Design services for mental health and substance use crisis issues
- Offer walk-in and first responder drop-off options
- Employ capacity to assess & address physical health needs

Peer Respite

In-Home Crisis Stabilization

Crisis Residential Treatment Services

- Operate 24/7/365

Stabilizing Crisis (cont.)

Post-Crisis Step-Down Services, such as:

- Partial hospitalization
- Supportive housing

Sobering Center

Examples

- Crisis Stabilization Units
- EmPATH/Psych Emergency Services (PES)
- Sobering Centers
- Crisis Respite
- Behavioral Health Urgent Care Centers/ Mental Health Urgent Care Centers
- Crisis residential treatment programs
- Psychiatric health facilities
- Psychiatric inpatient hospitals
- General acute care hospitals

UC Davis Formative Study of SB-82

- The University of California Davis evaluated 15 crisis programs in California from 2018-2021, funded through SB-82 (passed in 2018).
  - Program timelines varied with start and end dates ranging from 2018-2024
- Programs funded through SB-82 varied based on location and funding but fit into four categories of service delivery: 1) prevention, 2) crisis access and lifeline, 3) mobile crisis assessment and triage, and 4) post-crisis follow-up
- Some findings across programs included:
  - Delivery of more than 81,000 services to over 17,000 clients from 2018-2021.
  - Fewer reported hospitalizations and improved client experiences.
  - Operational challenges in implementation largely related to staff recruitment and retention due to both high stress and perceived low compensation.
  - The most effective crisis care delivery tended to address basic needs of persons experiencing crisis, build provider skills through training, and work collaboratively with community partners.
  - Coordination challenges included balancing priorities and maintaining confidentiality with the more successful collaborations developing mutual respect, clear expectations, and effective communication.
  - There was a need for sustainable program funding beyond the grant funding period.
  - Follow-up support after a crisis and coordinating with community-based services was essential.

Source: California State Evaluation and Learning Support (Cal SEALS) for SB-82 Triage Grants

Somewhere to Be: Crisis Stabilization <23 hours #1

Service Type	Crisis Stabilization Units (CSU)	EmPATH/Psych Emergency Services (PES)
Definition	Provide behavioral health services on an urgent basis for less than 23 hours. Designed for people with a behavioral health condition that requires timelier response than regularly scheduled visit, but that does not require evaluation and stabilization in an ED. Those who require additional treatment and observation can be referred to Crisis Residential Services.*	EmPATH units offer empathetic rather than coercive care. These hospital-based outpatient programs rapidly admit all medically appropriate patients in psychiatric crisis, including people under involuntary psychiatric detention. The EmPATH unit serves as the destination for people with acute mental health conditions who are transferred from the ED.*****
Basic Information	• As of October 2024, there were 92 CSUs in 33 of 58 counties. • As of January 2024, 64 CSUs were certified facilities located in 27 of 58 counties; 19 of the 64 were county owned and operated.** • BHCIP Funded CSUs: 19 are being built/enhanced with an additional 66,523 beds/slots.*** • Crisis residential beds statewide can serve as step down option AND possible diversion from an ED. • Admin/documentation burden was cited as barriers to increased supply.****	As of November 2023:***** • Four programs meet the standard definitions. • Three Psychiatric Emergency Services have adopted the "EmPATH design/philosophy."****** • 12 were in development .

Sources: *DHCS, Assessing the Continuum of Care for Behavioral Health Services in California, 2022
** Data provided by DHCS (see appendix)
***BHCIP Round 5 Data Dashboard, August 2024
****Information gathered from Comprehensive Assessment Workgroup meetings
*****Definition from Psychology Today
******Data provided by California Hospital Association
*******See Scott Zeller. EmPATH Units: Improving Psychiatric Emergency Care*

Somewhere to Be: Crisis Stabilization <23 hours #2

Service Type	Sobering Centers	Crisis Receiving and Stabilization	Behavioral Health Urgent Care Centers/ Mental Health Urgent Care Centers
Definition	A short-term care facility designed to allow an individual who is intoxicated and nonviolent to recover from the acute effects of alcohol and drugs safely.*	Provide short-term (under 24 hours) observation and crisis stabilization services in a home-like, non-hospital environment.*	No state or formal definition but community-based (non-hospital setting) facility that is a walk-in outpatient clinic. Typically provides screening, assessment, crisis intervention, referral and short-term treatment.
Basic Information	• As of November 2020, 10 were operating in California and 6-8 were planned.** • As of October 2024, 24 Sobering Centers, including 3 "coming soon" were listed on National Sobering Living Collaborative website.*** • One of the 14 CalAIM Community Supports. • As of August 2024, BHCIP lists funding for 8 facilities (including 6 by DMC-ODS and/or Community Supports).****	• Variety of community-defined models operating across the state. • See Appendix.	• Found across the state, including Santa Clara County, Sacramento, Los Angeles County, Riverside, San Diego, Orange County, Placer, others.*****

Sources: *CCC-P Glossary
** CHCF Sobering Centered Explained
*** As of October 2024, according to the National Sobering Living Collaborative
****BHCIP Round 5 Data Dashboard
*****Data from 988-Crisis Comprehensive Assessment Workgroup meetings and reviews of county department of behavioral health websites

Somewhere to Be: Crisis Stabilization 24-72 hours

Service Type	Peer Respite	In-home Crisis Stabilization
Definition	Provide 24-hour observation and support until person stabilized. Provided by crisis workers or trained counselors, including peer support specialists (BHCCP).*	Family stabilization teams that provide short-term, intensive in-home services to individuals who have been assessed to be at imminent risk of psychiatric hospitalization or out-of-home placement but can live safely in the community and out of the hospital with appropriate support.
Basic Information	• As of August 2024, seven listed on National Empowerment Center Website, including in Alameda, Los Angeles, Santa Cruz, and Trinity counties.**	• Limited information on formalized in-home crisis stabilization programs other than Orange County.

Sources: *CCC-P Glossary
** National Empowerment Center Website

Somewhere to Be: Crisis Stabilization >72 Hours & Step Down

Service Type	Crisis Residential Treatment Services	IOP/PHP/Day Treatment	Supportive Housing
Definition	Therapeutic or rehabilitative services provided in a non-institutional residential setting. CRTS provide structured programs as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. **	Intensive Outpatient Programs (IOPs), prearranged schedule of core services (e.g., individual counseling, group therapy, family psychoeducation and case management). Partial Hospitalization Programs (PHPs), similar to IOPs in terms of services but must provide care for 20 or more hours per week. Day treatment offers similar services but also a multidisciplinary program that includes community meetings, therapy, and skill-building groups.**	Supportive housing is defined as housing with no limit on length of stay, that is occupied by the target population, and that is linked to onsite or offsite services that assist the supportive housing resident in retaining the housing, improving their health status and maximizing their ability to live.
Basic Information	• 31 counties with Social Rehabilitation Programs licensed by DHCS in 2022, 8 of which had CRTs.** • No current Crisis Residential for Children. • BHCIP: 11 Children's Crisis Residential (962 beds/annual slots, $102.6 million).***	• In 2022, only 10 counties in California did not have any intensive outpatient treatment programs.** • In 2022, 29 counties, across 205 facilities, offered SUD partial hospitalization services.** • In 2022, according to data from the SAMHSA BH Treatment Services Locator, only 33 facilities across nine counties had an PHP (1/3 of which were in LA County).**	• In 2023, there were 75,100 total year-round permanent supportive housing bed (up from 65,872 in 2022)**** • Housing support is one of the 14 CalAIM Community Supports • Critical new investment supportive housing via Prop 1

Sources: *California Code §1810.208. Crisis Residential Treatment Service
** DHCS Assessing the Continuum of Care for Behavioral Health Services in California
*** BHCIP Round 5 Data Dashboard
**** HUD 2023 Continuum of Care Housing Inventory

Somewhere to Be: Other Facilities

Service Type	Psychiatric Nursing Facility Services	Mental Health Rehab Center	Psychiatric Health Facilities and State Hospitals
Definition	Skilled nursing facility services that include special treatment program services for mentally disordered persons*	Provides intensive support and rehabilitative services to persons who would have been placed in a state hospital or another mental health facility	Inpatient care for mentally disordered, incompetent, or other persons as described in Division 5 of the Welfare and Institutions Code

Basic Information	• As of June 2024, 1,191 Skilled Nursing Facilities statewide in 57 of 58 counties
	  • 116,057 (listed bed capacity)
	• There were 31 Special Treatment Programs (STP), with 3 defined as Institutions for Mental Diseases (IMD)***
		• As of January 2024, 66 licensed mental health rehab centers and psychiatric health facilities in 31 of 58 Counties*
		  • 33 MHRCs with 26 defined as Institutions for Mental Diseases (IMDs)***
		• BHCIP Funding: 6 being built, 309 beds/slots, $160.6 million
			• As of January 2024, 34 psychiatric health facilities (PHF)in 23 counties ****
			• 5 state hospitals*****
			  • San Luis Obispo (Atascadero = 1,184)
			  • Fresno (Coalinga = 1,286)
			  • Los Angeles(Metro = 826), Napa (1,255), San Bernardino (Patton =1527)
			  • 6,078 beds

Sources: *California Code § CA ADC § 1810.239. Psychiatric Nursing Facility Services.
** Licensed Health Care Facilities, June 2024
*** Data provided by DHCS, January 2024
**** Psychiatric Health Care Facilities
***** Department of State Hospitals (DSH)

Somewhere to Be: Other Facilities (Continued)

Service Type	Substance Use Disorder Recovery Treatment Facilities	Narcotic Treatment Facilities
Definition	All non-medical alcoholism and drug abuse recovery or treatment facilities licensed and/or certified by DHCS	Medication assisted treatment to those persons addicted to opiates NTPs also provide detoxification and/or maintenance treatment services, including medical evaluations and rehabilitative services to help patients become and/or remain productive members of society
What We Know	• 1,781 SUD Recovery Treatment Facilities certified by DHCS*	• 184 Licensed Narcotics Treatment Programs**

Sources: *SUD Treatment Facilities, Accessed June 2024

**Licensed Narcotic Treatment Program Facility Finder, January 2024

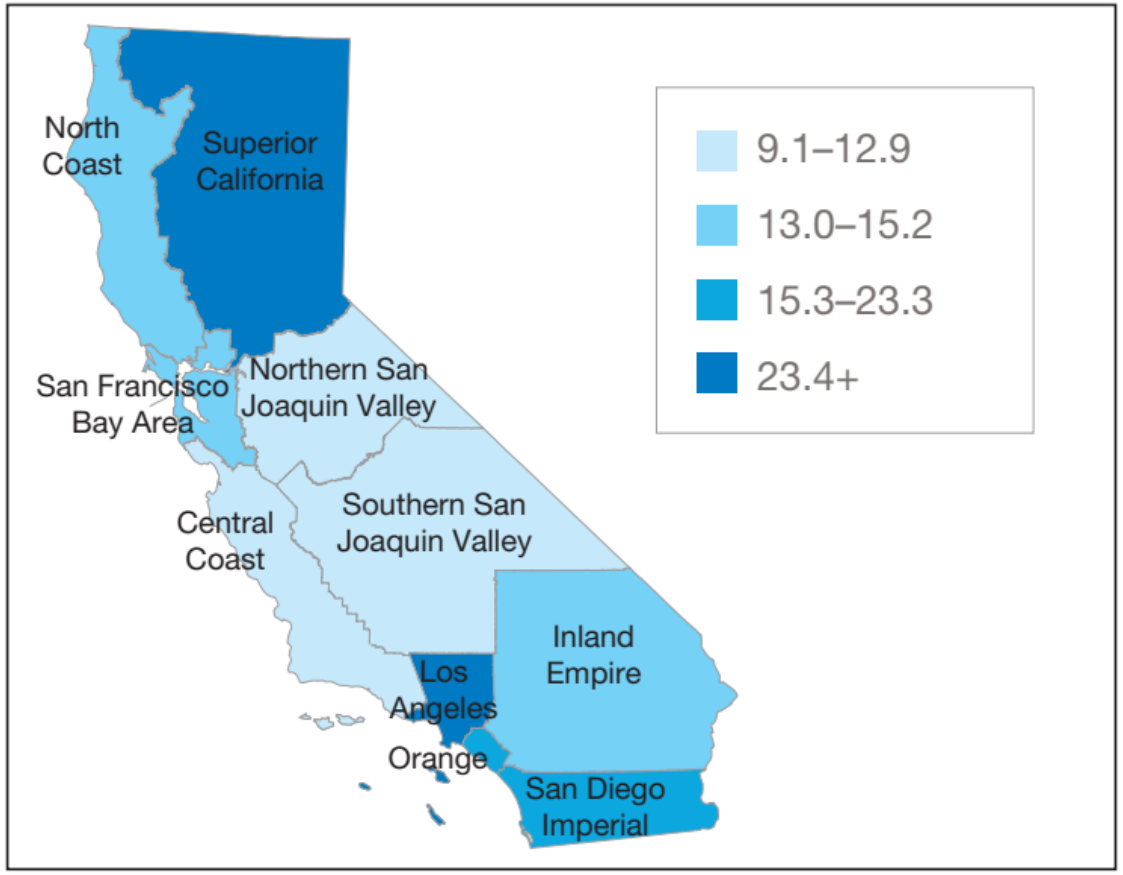
RAND Corporation California Adult Bed Availability Study

- A 2021 RAND study estimated the state's psychiatric bed capacity, needs, and shortfalls for adults across acute, subacute, and community residential care.
  - CA is short approximately 4,767 psychiatric beds (1,971 acute beds and 2,796 subacute beds).
- Acute care targets high-acuity, short-term needs, whereas subacute care centers on longer-term needs. Community residential services focus on lower acuity, longer-term care.
- The study found that:
  - California anticipates 1.7 percent growth in psychiatric bed need from 2021 to 2026.
  - Shortages exist across all three levels of adult care, with significant regional disparities.
  - The northern and southern San Joaquin Valley regions face the largest projected growth in bed need.
  - Hard-to-place populations (e.g., people with dementia, criminal justice involvement, and medical complexities) contribute to bottlenecks in the system.
- Key recommendations from the study included:
  - Prioritizing infrastructure investment in regions with the greatest need
  - Focusing on building or remodeling infrastructure to accommodate hard-to-place populations
  - Actively tracking psychiatric bed capacity, needs, and impacts of investment efforts

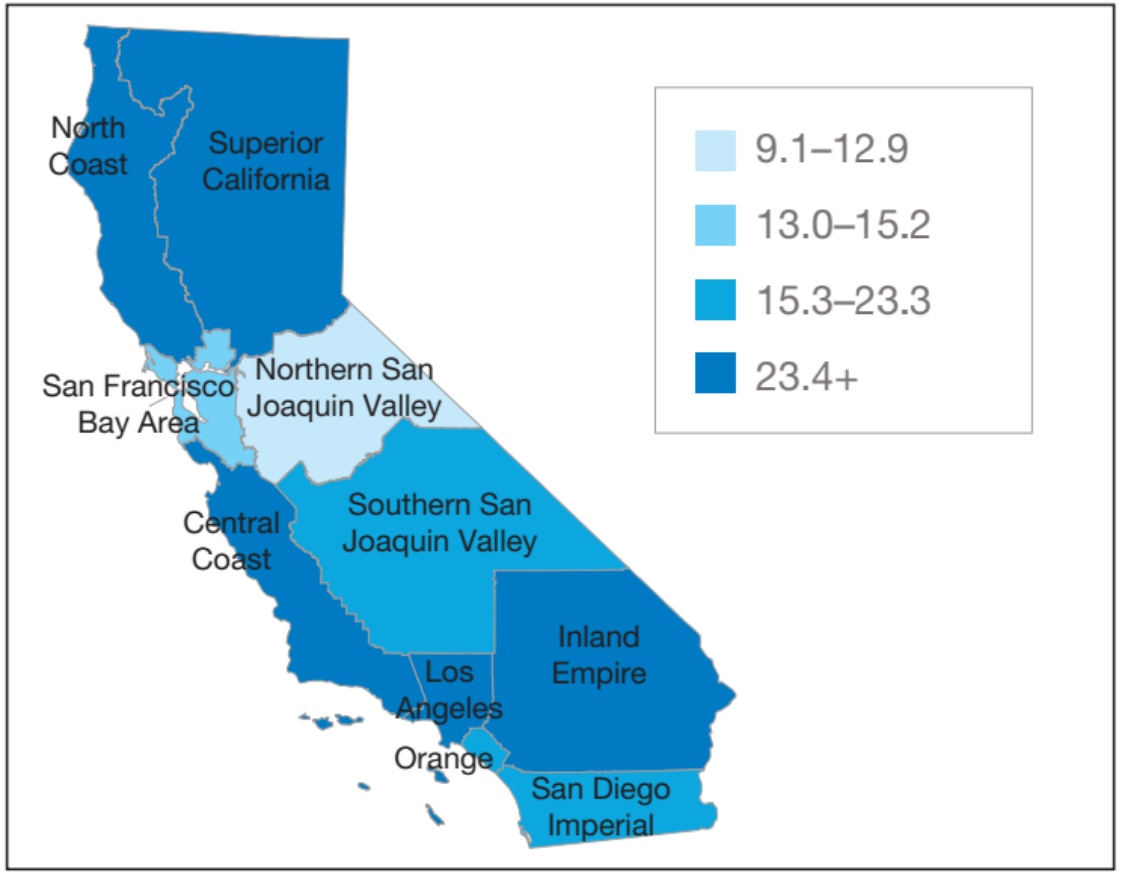
Source: RAND Study, 2021

Adults: Somewhere to Go – Variations in Resources: Acute Level

A. Acute Level: Inpatient Beds per 100,000 Adults, *Excluding* State Hospitals



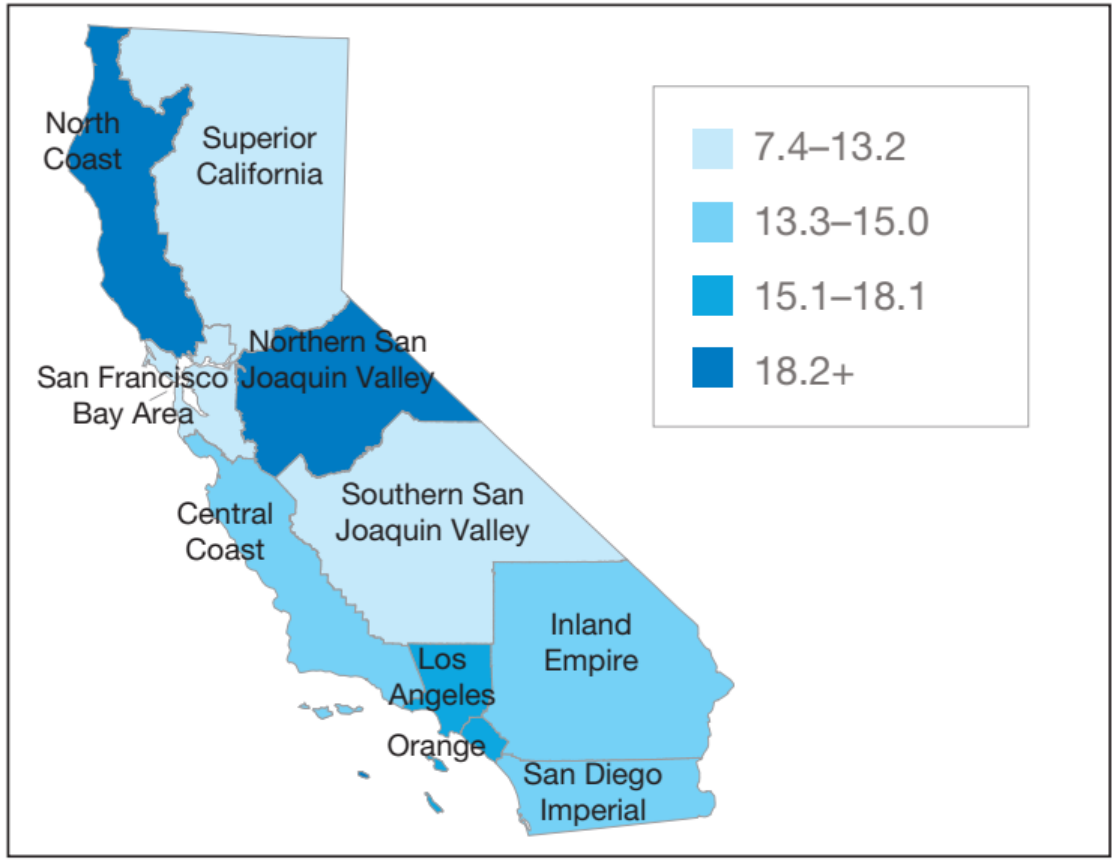
B. Acute Level: Inpatient Beds per 100,000 Adults, *Including* State Hospitals



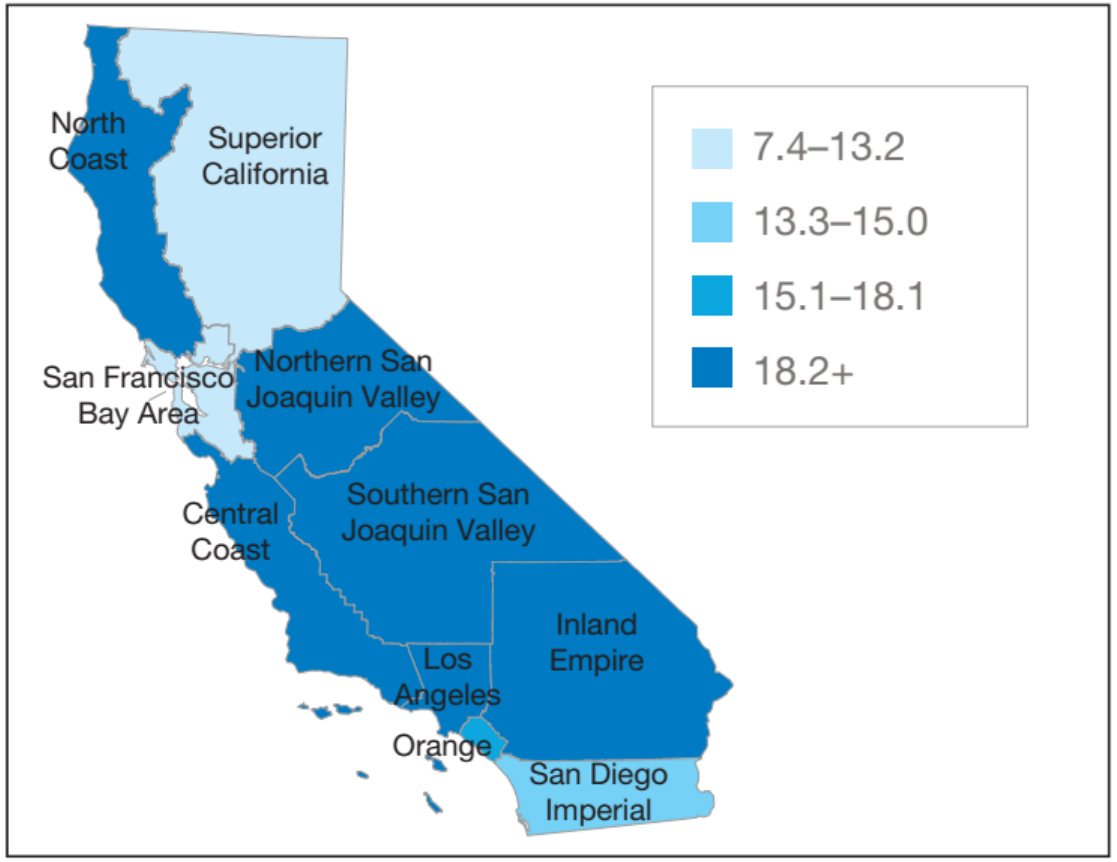
Source: RAND, Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021

Adults: Somewhere to Go – Variations in Resources: Sub Acute Level

C. Subacute Level: Inpatient Beds per 100,000 Adults, *Excluding* State Hospitals



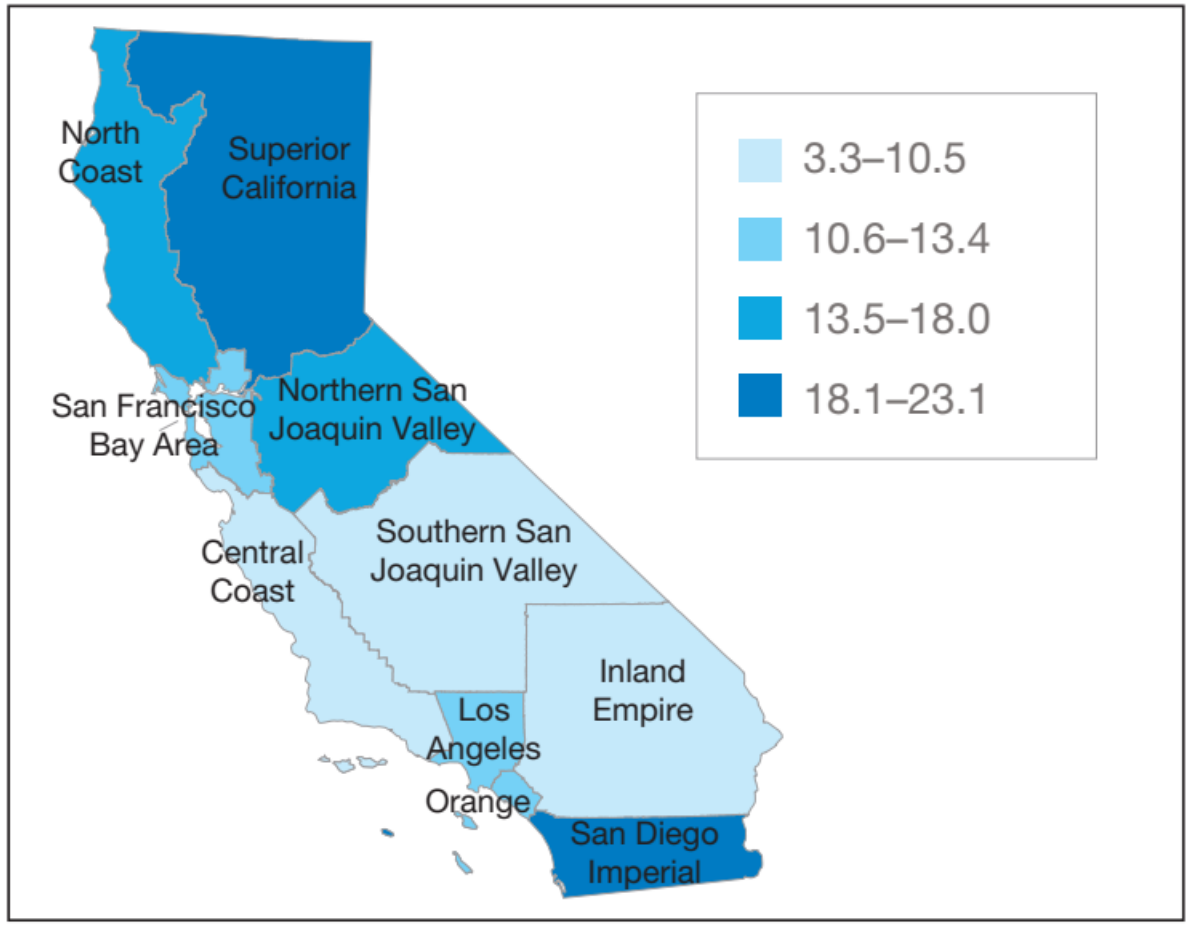
D. Subacute Level: Inpatient Beds per 100,000 Adults, *Including* State Hospitals



Source: RAND, Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021

Adults: Somewhere to Go – Variations in Resources: Community Res. #1

E. Community Residential Level: Beds per 100,000 Adults



Source: [RAND, Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021]

Adults: Somewhere to Go – Variations in Resources: Community Res. #2

- A majority of psychiatric facilities at all levels of care reported an inability to place individuals with:
  - Comorbid dementia or traumatic brain injury
  - Non-ambulatory individuals
  - Those requiring oxygen
  - Those who tested positive for COVID-19
- Individuals involved in the criminal justice system were reportedly difficult to place in community residential settings

Population Characteristics	Acute (%) (n = 20)	Subacute (%) (n = 17)	Community Residential (%) (n = 106)
Co-occurring conditions	-	-	-
Dementia	80.0	64.7	75.5
Traumatic brain injury	65.0	29.4	64.2
Eating disorder	60.0	35.3	44.3
Co-occurring ID	50.0	23.5	24.5
Co-occurring SUD	25.0	5.9	38.7
Co-occurring health issues	40.0	23.5	44.3
Justice system involvement	-	-	-
Arson conviction	25.0	35.3	68.9
Sex offense conviction	25.0	41.2	67.0
Other forensic category[a]	35.0	35.3	54.7
Incompetent to stand trial	40.0	17.7	36.8
History of violence	15.0	11.8	39.6
Murphy's conservatees[b]	25.0	17.7	32.1
Other characteristics	-	-	-
Large size (BMI > 45kg/m^2)	40.0	35.3	28.3
Requiring oxygen	85.0	82.4	69.8
Non-ambulatory	70.0	70.6	71.7
COVID-19 positive	95.0	76.5	68.9
Monolingual, Spanish-speaking	10.0	0.0	16.0
Monolingual, non-English-speaking (other)	10.0	11.8	38.7
Insured by Medi-Cal	15.0	5.9	4.7

Notes: ID = intellectual disability, SUD = substance use disorder

[a] Other forensic category includes forensic cases other than a conviction of arson or sexual assault.

[b] Murphy's conservatees are individuals who have a conservator with the authority to place that individual in a state hospital or psychiatric facility involuntarily

Source: RAND, Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021

Adults: Somewhere to Go – Variations in Resources

Location	*Sacramento*			*Santa Clara*			*Merced, San Joaquin, Stanislaus*		
Psych Beds for Adults	2022 Capacity	Estimated Need	+/-	2022 Capacity	Estimated Need	+/-	2022 Capacity	Estimated Need	+/-
Acute	593	251	342 surplus	304	251	53 surplus	186	156	30 surplus
Subacute	82	335	253 shortage	216	372	150-156 shortage	330	505	175 shortage
Crisis Residential	NA	NA	NA	92	90	2 surplus	NA	NA	NA
Community Residential	262	302	40 shortage	602	525	77 surplus	467	354	113-202 surplus

Sources: RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Sacramento County, California, 2022
RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Santa Clara County, California, 2022
RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in California Merced, San Joaquin, and Stanislaus Counties, 2022

Children and Youth: Somewhere to Go – Variations in Resources

Location	*Sacramento*			*Santa Clara*			*Merced, San Joaquin, Stanislaus*		
Psych Beds for Children	*2022 Capacity*	*Estimated Need*	*Plus/ Minus*	*2022 Capacity*	*Estimated Need*	*Plus/ Minus*	*2022 Capacity*	*Estimated Need*	*Plus/ Minus*
Acute	113	30-34	90 surplus	17	32-72	15-44 **shortage**	26	36-41	Modest shortage
Subacute	0	28-32	28-32 shortage	NA	NA	NA	12	34-39	15 shortage
Community Residential	34	98-164	64-130 shortage	NA	NA	NA	181	116-196	65 bed surplus

SUD Treatment	*Sacramento*			*Santa Clara*			*Merced, San Joaquin, Stanislaus*		
Beds	12	37-58	25-46 shortage	47	25-53	20 surplus	0	43-69	44-69 shortage

Sources: RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Sacramento County, California, 2022
RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Santa Clara County, California, 2022
RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in California Merced, San Joaquin, and Stanislaus Counties, 2022

What We're Learning: Investment through BHCIP #1

Facility Types Funded by BHCIP in Rounds 3, 4, and 5

Inpatient/Residential Facility Types	Total: 95 Residential Facilities	Total: 128 Outpatient Facilities	Outpatient Facility Types
Acute Psychiatric Hospital	8	13	Behavioral Health Integrated Outpatient[5]
Adolescent Residential SUD Treatment Facility[1]	1	7	Behavioral Health Urgent Care/Mental Health Urgent Care
Adolescent Residential SUD Treatment Facility	4	10	Community Mental Health Clinic/Outpatient Clinic
Adult Residential SUD Treatment Facility	10	23	Community Wellness/Youth Prevention Center
Adult Residential SUD Treatment Facility[2]	20	19	Crisis Stabilization Unit (CSU)
Children's Crisis Residential Program (CCRP)	11	1	Hospital-based Outpatient Treatment/Detox
Community Residential Treatment/Social Rehabilitation Program[3]	2	10	Intensive Outpatient Treatment (SUD)
General Acute Care Hospital	1	3	Narcotic Treatment Program (NTP)
Mental Health Rehabilitation Center (MHRC)	5	2	NTP Medication Unit
Mental Health Rehabilitation Center (MHRC)[4]	3	19	Office-based Opioid Treatment
Peer Respite	2	8	Outpatient Treatment for SUD
Perinatal Residential SUD Facility	7	3	Partial Hospitalization Program
Psychiatric Health Facility (PHF)	9	2	School-Linked Health Center
Psychiatric Residential Treatment Facility (PRTF)	1	8	Sobering Center[6]
Recovery Residence/Sober Living Home	2		
Short-Term Residential Therapeutic Program (STRTP)	5		
Social Rehabilitation Program	4		

1 Adolescent Residential SUD Treatment Facility with a DHCS/ASAM Level of Care 3.5 Designation and Withdrawal Management (WM) Designation.
2 Adult Residential SUD Treatment Facility with a DHCS/ASAM Level of Care 3.5 Designation and Withdrawal Management (WM) Designation.
3 Community Residential Treatment/Social Rehabilitation Program with the category of Short-Term Crisis Residential only.
4 Mental Health Rehabilitation Center (MHRC) only with Lanterman-Petris-Short (LPS) Designation.
5 These are mental health and/or SUD outpatient services integrated with community wellness/prevention centers.
6 Funded under the Drug Medi-Cal Organized Delivery System (DMC-ODS) and/or Community Supports.

Source: Behavioral Health Continuum Infrastructure Program (BHCIP) Outcomes

What We're Learning: Investment through BHCIP #2

Beds and Annual Outpatient Capacity[1] Funded by BHCIP in Rounds 3, 4, and 5

Inpatient/Residential Facility Types	Total: 2,601	Total: 281,146	Outpatient Capacity
Acute Psychiatric Hospital	295	24,585	Behavioral Health Integrated Outpatient[6]
Adolescent Residential SUD Treatment Facility[2]	8	20,658	Behavioral Health Urgent Care/Mental Health Urgent Care
Adolescent Residential SUD Treatment Facility	80	22,102	Community Mental Health Clinic/Outpatient Clinic
Adult Residential SUD Treatment Facility	405	80,556	Community Wellness/Youth Prevention Center
Adult Residential SUD Treatment Facility[3]	760	66,523	Crisis Stabilization Unit (CSU)
Children's Crisis Residential Program (CCRP)	98	600	Hospital-based Outpatient Treatment/Detox
Community Residential Treatment/Social Rehabilitation Program[4]	30	5,620	Intensive Outpatient Treatment (SUD)
General Acute Care Hospital	42	2,464	Narcotic Treatment Program (NTP)
Mental Health Rehabilitation Center (MHRC)	358	600	NTP Medication Unit
Mental Health Rehabilitation Center (MHRC)[5]	88	29,645	Office-based Opioid Treatment
Peer Respite	22	1,653	Outpatient Treatment for SUD
Perinatal Residential SUD Facility	132	1,305	Partial Hospitalization Program
Psychiatric Health Facility (PHF)	135	146	School-Linked Health Center
Psychiatric Residential Treatment Facility (PRTF)	14	24,689	Sobering Center[7]
Recovery Residence/Sober Living Home	28		
Short-Term Residential Therapeutic Program (STRTP)	42		
Social Rehabilitation Program	64		

1 Individuals served annually in an outpatient setting
2 Adolescent Residential SUD Treatment Facility with a DHCS/ASAM Level of Care 3.5 Designation and Withdrawal Management (WM) Designation.
3 Adult Residential SUD Treatment Facility with a DHCS/ASAM Level of Care 3.5 Designation and Withdrawal Management (WM) Designation.
4 Community Residential Treatment/Social Rehabilitation Program with the category of Short-Term Crisis Residential only.
5 Mental Health Rehabilitation Center (MHRC) only with Lanterman-Petris-Short (LPS) Designation.
6 These are mental health and/or SUD outpatient services integrated with community wellness/prevention centers.
7 Funded under the Drug Medi-Cal Organized Delivery System (DMC-ODS) and/or Community Supports.

Source: Behavioral Health Continuum Infrastructure Program (BHCIP) Outcomes

What We're Learning: Investment through BHCIP #3

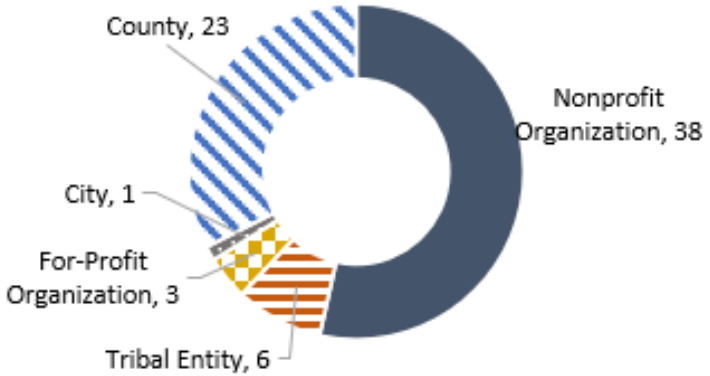
$772 million

The available funding amount in projects that will expand the behavioral health continuum of treatment and service resources in settings that serve Californians ages 25 and younger, including pregnant and postpartum women and their children, and transition-age youth, along with their families.

30 years

The number of years that an entity receiving BHCIP grant funds must operate services in the financed facility for the intended purposes, per the Welfare and Institutions Code Section 5960.15(d).

Number of Awards by Entity Type

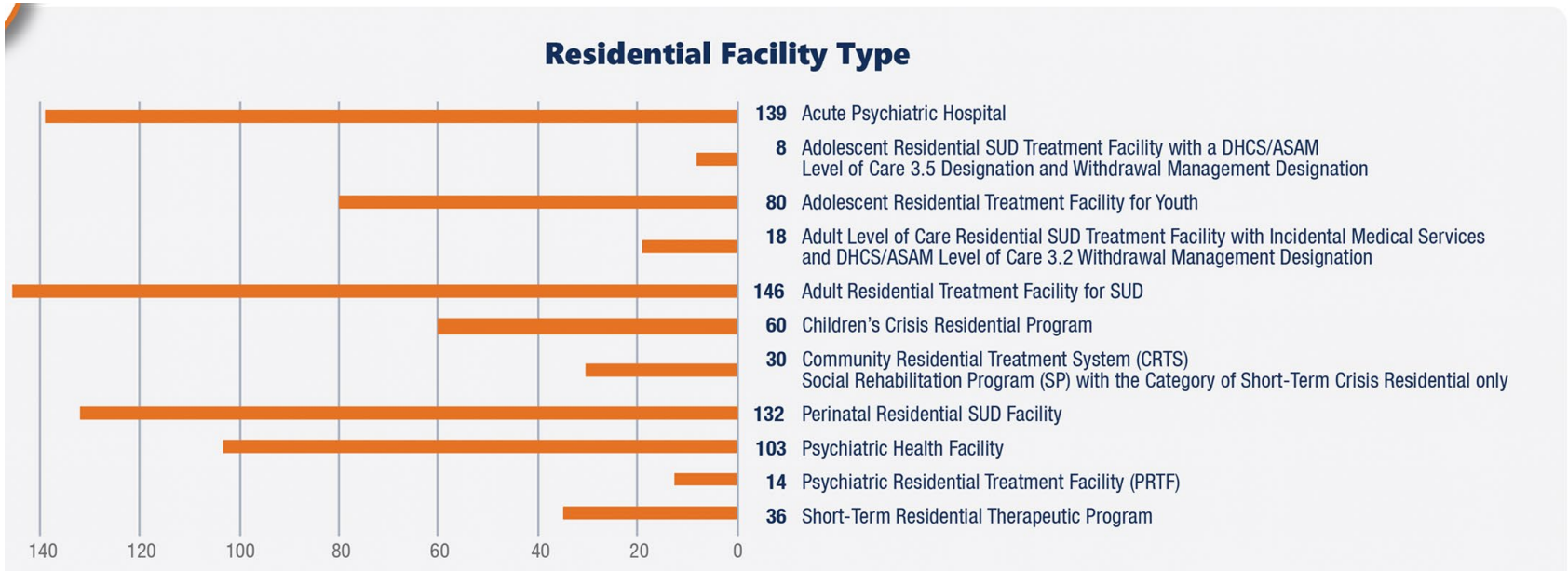


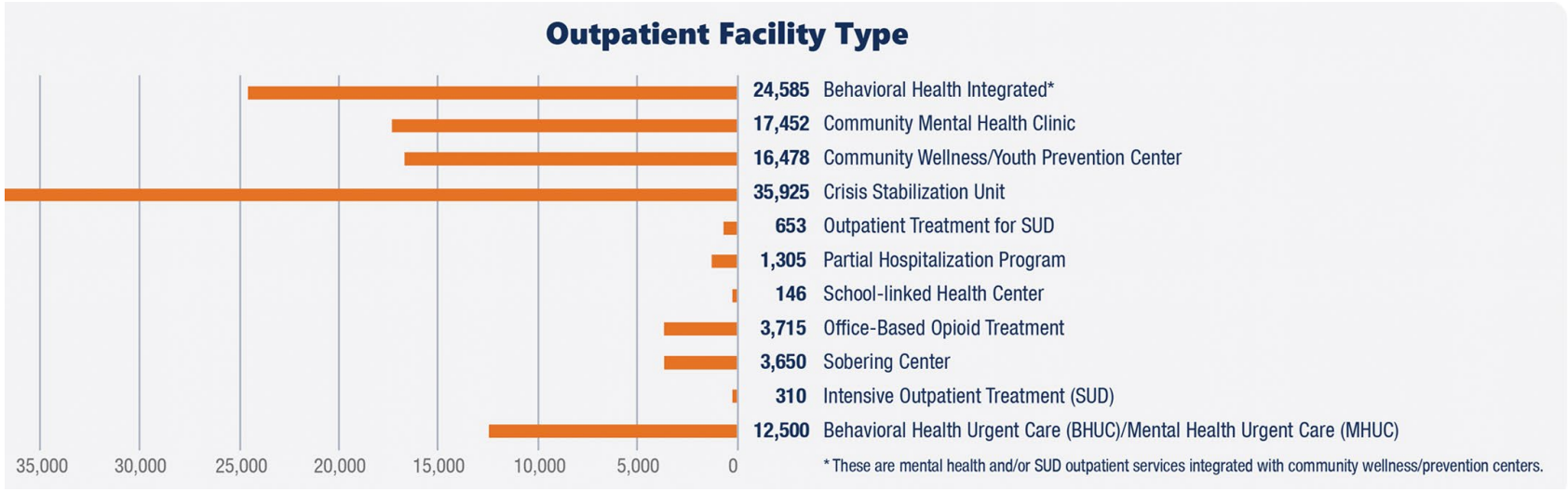
Awardees for BHCIP funds serving Children and Youth include:
counties, cities, tribal entities (including 638s and urban clinics), nonprofit organizations, for-profit organizations, and other for-profit organizations, including private real estate developers, whose project reflect the state's priorities and serve the targeted population.

Number of Children and Youth Awards by Region

Source: Behavioral Health Continuum Infrastructure Program (BHCIP) Outcomes

What We're Learning: Investment through BHCIP





Source: Behavioral Health Continuum Infrastructure Program (BHCIP) Outcomes, 9/2024

V. Challenges and Opportunities to Meeting Needs/Demands

Implementation Challenges/Opportunities Across the Continuum #1

Areas	Challenges	Potential Opportunities Raised by Members
Someone to Call	• Improving the variable awareness and public trust about 988 Crisis Lines • Addressing the lack of state/federal guidance about standards of care and requirements for 988 Crisis Centers • Reducing variation in the capacity of 988 Crisis Centers to address SUDs • Building workforce capacity to meet anticipated future demand; implications for ensuring equitable access to rural and remote communities • Effectively serving/meeting needs of diverse populations and help seekers (e.g., I/DD, SUD, COD, BIPOC, LGBTQIA+, youth, older adults, veterans, individuals with limited English language proficiency, individuals who are deaf and hard of hearing)	• Growing public knowledge and awareness of 988 and building community trust, especially in marginalized communities • Establishing standards to guide protocols for 988 Crisis Call Center operations, including interface with existing crisis warmlines/hotlines • Establishing standards and training requirements around substance use crisis, building on the experience and expertise of the state's 12 crisis centers • Leveraging local resources to support connections with appropriate resources • Partnering with local or other resources to support unique models and needs of these special populations

Source: 988-Crisis Workgroup 1: Comprehensive Assessment: Meeting Dates: January 30, 2024, February 29, 2024, March 19, 2024, April 11, 2024; Intellectual or Developmental Disabilities (IDD); Substance Use Disorder (SUD); Co-occurring Disorder (COD); Black, Indigenous, and People of Color (BIPOC); lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual (LGBTQIA+)

Implementation Challenges/Opportunities Across the Continuum #2

Areas	Challenges	Potential Opportunities Raised by Members
Someone to Come	• Establishing standards of care and requirements for mobile crisis response models across a populous and diverse state • Ensuring sufficient workforce capacity to meet anticipated future demand for mobile response, including equitable access to rural and remote communities • Building community trust, especially in marginalized communities • Effectively serving/meeting the needs of California's diverse populations • Complexity of local integration (e.g., county/city/CBO contracting and collaboration) of crisis response teams) • Reducing Transportation challenges (Reliance on law enforcement and ambulances for transportation related needs) • Implementing mechanisms to support billing for mobile crisis response for individuals who are commercially insured	• Building on Medi-Cal mobile crisis standards/requirements to establish best practices • Building on the Medi-Cal mobile crisis benefit and exploring community-based models and existing or alternative crisis response models (e.g., community paramedicine, EMS, fire, CIT trained law enforcement, etc.) to support 24/7 coverage (especially in rural areas) • Developing local partnerships to create a safe, reliable, accessible, and effective crisis response system that minimizes law enforcement involvement, including peer-based approaches to support on-site resolution and diversion • Building on local innovations and approaches to support system for crisis resolution in the community (including the home) and connections to ongoing care • Establishing funding pathways to support emerging models in paramedicine and alternative destinations, including for transportation • Identifying ways for all payers (including commercial insurance) to contribute to mobile crisis response

Source: 988-Crisis Workgroup 1: Comprehensive Assessment: Meeting Dates: January 30, 2024, February 29, 2024, March 19, 2024, April 11, 2024

Implementation Challenges/Opportunities Across the Continuum #3

Areas	Challenges	Potential Opportunities by Members
A Safe Place To Be	• Developing more accessible Crisis Stabilizing Units and options • Improving slot/bed availability and flow through system • Expanding availability of licensed youth, and senior care settings • Effectively serving/meeting needs of diverse populations, particularly hard-to-place populations • Developing supported and affordable housing and policies to address the intersection of behavioral health crisis and a safe place/home. • Managing the complexity of integration including county/CBO contracting and collaboration	• Creating a provider directory to support crisis responders, consumers and families on where to access crisis stabilizing services • Expanding on step up/down services to mitigate bottle necks in systems including innovations and approaches to support low-barrier engagement options (e.g., sobering centers, peer respite, in home stabilization, etc.) • Growing the number of CSUs and EmPATH programs for individuals in immediate crisis and other investments in residential facilities for children and adults through BHCIP, CYBHI and other grant programs. • Developing options for difficult to place populations (e.g., individuals with complex medical and behavioral health needs, those with certain criminal backgrounds – history of arson, sex offense, disruptive behaviors) • State investments in supported housing for behavioral health and other policies to address the interconnection between housing, homelessness and behavioral health crisis stabilization (e.g., supporting older adults to age in place). • Technical Assistance to support effective braiding of complex funding sources

Source: 988-Crisis Workgroup 1: Comprehensive Assessment: Meeting Dates: January 30, 2024, February 29, 2024, March 19, 2024, April 11, 2024

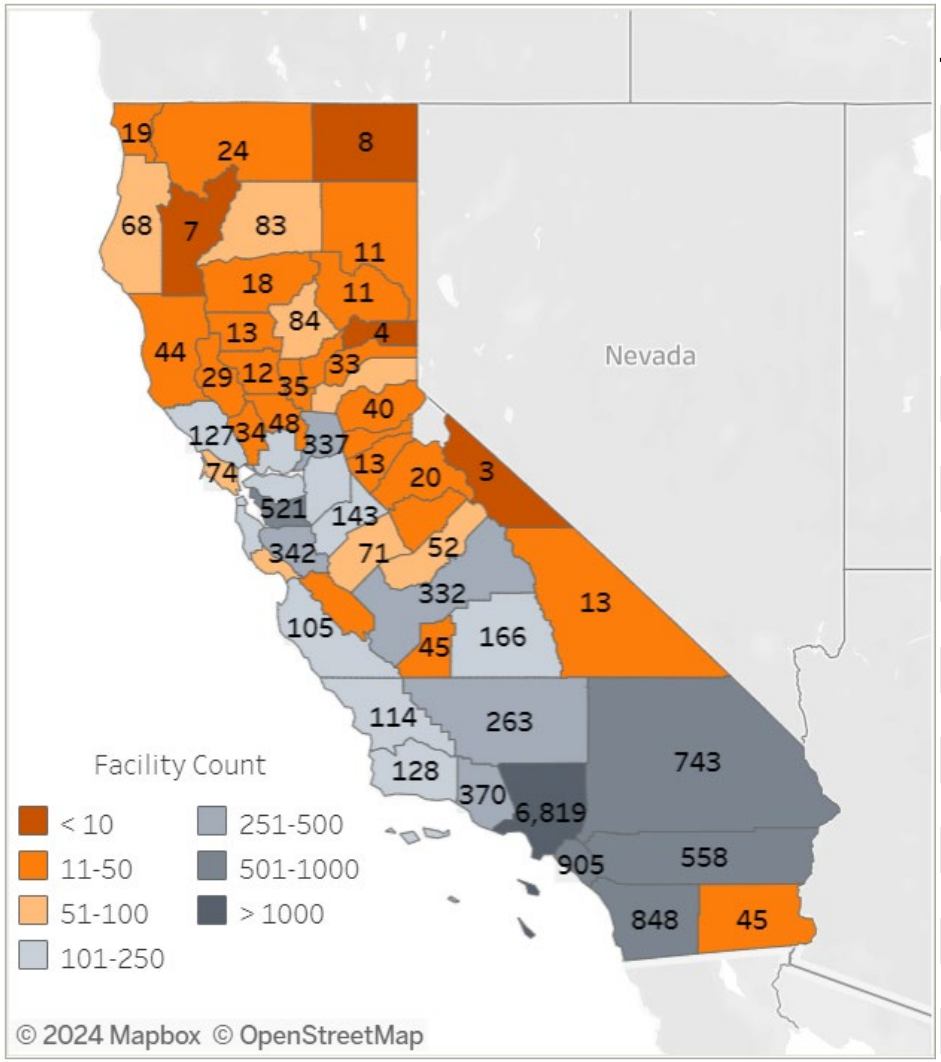
Key Findings for the 988-Crisis Five-Year Implementation Plan

The assessment revealed gaps in California's behavioral health crisis care continuum. Findings most relevant to implementing a comprehensive 988 system include:

1. Many people are not aware of 988, and some people who know about it are apprehensive about using it
2. The numerous "places to contact" before, during, and after a crisis are difficult to track and monitor and vary by community
3. Services offered by California's 988 Crisis Centers vary and sometimes lack formal connection with or knowledge about County and Tribal behavioral health systems and services
4. Population-level disparities exist among some groups and communities who may need tailored services in order to equitably access behavioral health crisis care.
5. In-person community response services are fragmented, and 24/7 mobile crisis response teams that respond to people in crisis are still in development, particularly in rural, remote, and Tribal areas of the state
6. Availability and accessibility of crisis services and facilities that provide a safe place to be during and after an acute crisis vary widely across the state, particularly in rural, remote, and Tribal communities
7. Information on available local resources for 988 Crisis Centers and other crisis responders to connect help seekers with services in the community is inconsistent
8. Data collection and reporting on crisis services vary across the continuum, which makes it difficult to monitor system performance

Appendix: Additional Facility Data

Inventory of All Health Facilities #1



Counts by Facility Type – March 2024

HOME HEALTH AGENCY	3,773
PRIMARY CARE CLINIC	3,058
HOSPICE	2,950
SKILLED NURSING FACILITY	1,190
INTERMEDIATE CARE FACILITY-DD/H/N/CN/IID	1,012
SURGICAL CLINIC	775
CHRONIC DIALYSIS CLINIC	750
GENERAL ACUTE CARE HOSPITAL	430
ADULT DAY HEALTH CARE	323
CONGREGATE LIVING HEALTH FACILITY	253
ACUTE PSYCHIATRIC HOSPITAL	124
REHABILITATION CLINIC	56
OTHER	44
PEDIATRIC DAY HEALTH & RESPITE CARE FACILITY	22
CORRECTIONAL TREATMENT CENTER	21
PSYCHOLOGY CLINIC	21
HOSPICE FACILITY	14
ALTERNATIVE BIRTHING CENTER	10
CHEMICAL DEPENDENCY RECOVERY HOSPITAL	10
INTERMEDIATE CARE FACILITY	8
REFERRAL AGENCY	2
TOTAL	14.846

Source: CHHS Open Data Portal, Current California Healthcare Facility Listing (March 2024)

Inventory of All Health Facilities #2

Licensed Health Facilities	Number Statewide	% of Total	% by Facility Type
Clinic	**2,007**	**19%**	**100%**
Alternative Birthing Center	8	0%	0%
Chronic Dialysis Clinic	655	6%	33%
Community Clinic	1,238	12%	62%
Free Clinic	45	0%	2%
Psychology Clinic	18	0%	1%
Rehabilitation Clinic	11	0%	1%
Surgical Clinic	32	0%	2%
Home Health Agency/Hospice	**6,482**	**62%**	**100%**
Home Health Agency	3,656	35%	56%
Hospice	2,826	27%	44%
Hospital	**536**	**5%**	**100%**
Acute Psychiatric Hospital	40	0%	7%
Chemical Dep. Recovery Hospital	7	0%	1%
General Acute Care Hospital	456	4%	85%
Psychiatric Health Facility	33	0%	6%
Long Term Care Facility	**1,372**	**13%**	**100%**
Congregate Living Health Facility	264	3%	19%
Hospice Facility	14	0%	1%
ICF/Dev. Disabled	9	0%	1%
Skilled Nursing Facility	1,085	10%	79%
Total	10,397	-	-

Source: CHHS Open Data, Licensed Health Facility Listing (accessed April 2, 2024)

Inventory of Crisis Services: Crisis Stabilization Units

County	Number	Percent of Total
Alameda	3	3%
Contra Costa	2	2%
Fresno	2	2%
Humboldt	1	1%
Kern	6	7%
Los Angeles	12	13%
Madera	1	1%
Marin	1	1%
Mariposa	5	5%
Merced	3	3%
Monterey	1	1%
Napa	1	1%
Nevada	1	1%
Orange	3	3%
Riverside	6	7%
Sacramento	4	4%
San Bernardino	4	4%
San Diego	6	7%

County	Number	Percent of Total
San Francisco	4	4%
San Joaquin	1	1%
San Luis Obispo	3	3%
San Mateo	1	1%
Santa Barbara	2	2%
Santa Clara	6	7%
Santa Cruz	1	1%
Shasta	3	3%
Siskiyou	2	2%
Solano	1	1%
Sonoma	1	1%
Stanislaus	1	1%
Tehama	1	1%
Ventura	2	2%
Sutter/Yuba	1	1%
Grand Total	*92*	*100%*

- 92 CSUs in 33 of 58 counties

Sources: Crisis Stabilization Units – DHCS Licensing and Services Division, October 2024
County Population - American Community Survey (ACS); U.S. Census Bureau; 2018-2022 Estimates
Medi-Cal population - DHCS Management Information System/Decision Support System (MIS/DSS); Medi-Cal total enrollment - August 2023

Inventory of Crisis Services: Mental Health Rehab Centers

County	# of MHRCs	Patient Capacity	% of Total Facilities	% of Patient Capacity
Alameda	3	154	9%	7%
Fresno	2	81	6%	4%
Glenn	1	42	3%	2%
Kern	1	55	3%	3%
Los Angeles	3	286	9%	14%
Marin	1	89	3%	4%
Merced	1	98	3%	5%
Napa	1	54	3%	3%
Orange	1	80	3%	4%
Riverside	2	61	6%	3%
Sacramento	1	54	3%	3%
San Diego	4	409	12%	19%
San Francisco	2	101	6%	5%
San Mateo	1	68	3%	3%
Santa Barbara	1	80	3%	4%
Santa Clara	1	100	3%	5%
Santa Cruz	1	99	3%	5%
Solano	1	91	3%	4%
Sutter	3	76	9%	4%
Ventura	2	31	6%	1%
Total	*33*	*2,109*	*100%*	*100%*

- 33 MHRCs across the state
- 20 of 58 counties

DHCS Definition:
24-hour program that provides intensive support and rehabilitative services designed to assist persons aged 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop skills to become self-sufficient and capable of increasing levels of independence and functioning.

Sources: DHCS Website Definition
Data from: CHHS Open Data Portal, Licensed Mental Health Rehabilitation Centers (MHRC) and Psychiatric Health Facilities (PHF), August 2024
Note: Data contains only facilities licensed by the Department of Health Care Services (DHCS)

Inventory of Crisis Services: Psychiatric Health Facilities

County	# of PHFs	Patient Capacity	% of Total Facilities	% of Patient Capacity
Alameda	2	42	6%	7%
Butte	1	16	3%	3%
El Dorado	1	16	3%	3%
Fresno	2	32	6%	5%
Glenn	1	16	3%	3%
Kern	1	16	3%	3%
Los Angeles	4	85	12%	14%
Merced	1	16	3%	3%
Placer	1	16	3%	3%
Riverside	1	16	3%	3%
Sacramento	4	98	12%	16%
San Joaquin	1	16	3%	3%
San Luis Obispo	1	16	3%	3%
Santa Barbara	1	16	3%	3%
Santa Clara	2	40	6%	7%
Santa Cruz	1	16	3%	3%
Shasta	1	16	3%	3%
Solano	1	16	3%	3%
Sonoma	1	16	3%	3%
Stanislaus	1	16	3%	3%
Suter/Yuba	1	16	3%	3%
Sutter	1	16	3%	3%
Tehama	1	16	3%	3%
Yuba	1	16	3%	3%
Total	*33*	*601*	*100%*	*100%*

DHCS Definition: Provide 24-hour inpatient care for mentally disordered, incompetent, or other persons as described in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code. Care includes, but is not limited to, the following basic services: Psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings.

- 33 PHFs across the state
- 25 of 58 counties

Sources: DHCS Website Definition
Data from: CHHS Open Data Portal, Licensed Mental Health Rehabilitation Centers (MHRC) and Psychiatric Health Facilities (PHF), August 2024
Note: Data contains only facilities licensed by the Department of Health Care Services (DHCS)

Inventory of Crisis Services: Social Rehabilitation Programs #1

County	SRP Programs Licensed by DSS (2021)	# of Available Beds Among Social Rehabilitation Programs Affiliated with CA Association of Social Rehabilitation Agencies (2021)			SRP Licensed by DSS (2024)	Number of Beds (2024)
County	**All Facilities**	**Crisis Residential Treatment**	**Long-Term Residential Treatment**	**Transitional Residential Treatment**	***All Facilities***	***All Facilities***
Alameda	8	0	0	0	8	**94**
Butte	2	0	0	0	2	**22**
Contra Costa	5	0	0	0	3	**44**
Eldorado	-	-	-	-	3	**18**
Fresno	4	0	0	0	4	**43**
Humboldt	1	0	0	0	1	**16**
Imperial	1	0	0	0	1	**16**
Kern	2	0	0	0	2	**29**
Los Angeles	34	24	0	0	60	**564**
Marin	1	10	42	0	6	**50**
Mendocino	0	0	0	0	1	**8**
Merced	1	0	0	0	1	**16**
Monterey	3	28	0	1	3	**42**
Napa	2	8	0	1	2	**20**

Sources: DHCS Website Definition
2021 Data from tables provided in Assessing the Continuum of Care for Behavioral Health Services in California Data, Stakeholder Perspectives, and Implications
2024 Data from Certified and Approved Residential Mental Health Programs, April 2024

Note: California licenses transitional and long-term residential settings and crisis residential treatment programs as social rehabilitation programs and does not differentiate among the different settings. 2021 Data provided by California Association of Social Rehabilitation Agencies and may not include complete information from all member organizations.

Inventory of Crisis Services: Social Rehabilitation Programs #2

County	SRP Programs Licensed by DSS (2021)	# of Available Beds Among Social Rehabilitation Programs Affiliated with CA Association of Social Rehabilitation Agencies (2021)			SRP Licensed by DSS (2024)	Number of Beds (2024)
County	**All Facilities**	**Crisis Residential Treatment**	**Long-Term Residential Treatment**	**Transitional Residential Treatment**	***All Facilities***	***All Facilities***
Nevada	1	0	0	0	1	**16**
Orange	39	0	0	0	62	**390**
Placer	1	0	0	0	2	**20**
Riverside	6	0	0	0	13	**117**
Sacramento	9	45	0	0	8	**102**
San Bernardino	12	0	0	0	14	**154**
San Diego	15	0	0	0	20	**201**
San Francisco	17	48	0	13	17	**198**
San Joaquin	5	0	0	0	5	**66**
San Luis Obispo	1	0	0	1	1	**12**
San Mateo	5	16	0	2	4	**53**

Sources: DHCS Website Definition
2021 Data from tables provided in Assessing the Continuum of Care for Behavioral Health Services in California Data, Stakeholder Perspectives, and Implications
2024 Data from Certified and Approved Residential Mental Health Programs, April 2024

Note: California licenses transitional and long-term residential settings and crisis residential treatment programs as social rehabilitation programs and does not differentiate among the different settings. 2021 Data provided by California Association of Social Rehabilitation Agencies and may not include complete information from all member organizations.

Inventory of Crisis Services: Social Rehabilitation Programs #3

County	SRP Programs Licensed by DSS (2021)	# of Available Beds Among Social Rehabilitation Programs Affiliated with CA Association of Social Rehabilitation Agencies (2021)			SRP Licensed by DSS (2024)	Number of Beds (2024)
County	**All Facilities**	**Crisis Residential Treatment**	**Long-Term Residential Treatment**	**Transitional Residential Treatment**	***All Facilities***	***All Facilities***
Santa Barbara	4	0	0	0	4	**44**
Santa Clara	9	62	45	0	10	**139**
Santa Cruz	3	0	0	0	3	**38**
Shasta	2	0	0	0	2	**29**
Solano	2	0	0	0	2	**22**
Sonoma	6	20	0	1	5	**50**
Tulare	-	-	-	0	1	**16**
Ventura	7	0	0	0	16	**142**
Yolo	2	0	0	0	2	**24**
Total	***210***	**-**	**-**	**-**	***289***	***2815***

- 289 SRPs across the state, including 2,815 beds
- 35 of 58 counties
- Net increase of 79 SRP facilities from 2021 to 2024

Sources: DHCS Website Definition
2021 Data from tables provided in Assessing the Continuum of Care for Behavioral Health Services in California Data, Stakeholder Perspectives, and Implications
2024 Data from Certified and Approved Residential Mental Health Programs, April 2024

Note: California licenses transitional and long-term residential settings and crisis residential treatment programs as social rehabilitation programs and does not differentiate among the different settings. 2021 Data provided by California Association of Social Rehabilitation Agencies and may not include complete information from all member organizations.

Inventory of Crisis Services: Special Treatment Programs (STP)

County	Special Treatment Programs	# of Beds
Alameda	2	149
Fresno	1	44
Los Angeles	10	1093
Merced	2	154
Orange	3	221
Placer	1	48
Riverside	2	228
San Bernardino	3	224
San Diego	2	97
San Joaquin	1	72
Santa Clara	1	116
Shasta	1	99
Sonoma	1	58
Stanislaus	1	76
Total	*31*	*2,679*

Special Treatment Programs

Special Treatment Programs (STPs) are licensed by the Department of Public Health as a skilled nursing facility (SNF) that has opted to have a mental health program approved by DHCS. STPs provide mental health services for patients who have a diagnosed chronic psychiatric impairment and whose adaptive functioning is moderately impaired (§ 72443-72475).

- 31 STPs, including 2,679 beds
- 14 of 58 counties

Sources: § 72443-72475. Special Treatment Program Service Unit
2024 Data from Certified and Approved Residential Mental Health Programs, April 2024

Children's: Short-Term Residential Therapeutic Program #1

County	STRTP Facility	# of Beds	Percent of Facilities	Percent of Beds
Alameda	8	62	2%	2%
Alpine	2	12	1%	0%
Butte	2	12	1%	0%
Calaveras	1	16	0%	1%
Contra Costa	11	68	3%	3%
El Dorado	3	18	1%	1%
Fresno	31	200	10%	8%
Imperial	2	12	1%	0%
Kern	25	156	8%	6%
Kern	1	6	0%	0%
Kings	1	6	0%	0%
Lassen	1	10	0%	0%
Los Angeles*	55	430	17%	17%
Madera	2	22	1%	1%

Short-Term Residential Therapeutic Programs (STRTPs) are licensed by the California Department of Social Services, and approved by the Department of Health Care Services, to provide an integrated program of specialized and intensive care and supervision, services and supports, specialty mental health services, mental health treatment, and short-term, 24-hour care and supervision to children.

Note: Two licensed CTF programs in Los Angeles
2024 Data from Certified and Approved Residential Mental Health Programs, April 2024

Children's: Short-Term Residential Therapeutic Program #2

County	STRTP Facility	# of Beds	Percent of Facilities	Percent of Beds
Marin	1	6	0%	0%
Mariposa	1	6	0%	0%
Mendocino	2	6	1%	0%
Merced	3	20	1%	1%
Monterey	2	12	1%	0%
Nevada	1	6	0%	0%
Orange	18	144	6%	6%
Placer	2	12	1%	0%
Riverside	31	289	10%	12%
Sacramento	16	110	5%	4%
San Bernardino	34	240	10%	10%
San Diego	16	202	5%	8%

Note: Two licensed CTF programs in Los Angeles
2024 Data from Certified and Approved Residential Mental Health Programs, April 2024

Children's: Short-Term Residential Therapeutic Program #3

County	STRTP Facility	# of Beds	Percent of Facilities	Percent of Beds
San Francisco	2	16	1%	1%
San Joaquin	2	22	1%	1%
San Luis Obispo	1	6	0%	0%
San Mateo	2	24	1%	1%
Santa Barbara	4	36	1%	1%
Santa Clara	2	12	1%	0%
Santa Cruz	2	12	1%	0%
Shasta	3	18	1%	1%
Solano	3	18	1%	1%
Sonoma	8	53	2%	2%
Stanislaus	13	98	4%	4%
Tulare	3	28	1%	1%
Ventura	7	50	2%	2%
Yolo	2	12	1%	0%
Grand Total	*326*	*2488*	*NA*	*NA*

Note: Two licensed CTF programs in Los Angeles
2024 Data from Certified and Approved Residential Mental Health Programs, April 2024

Inventory of Crisis Services: SUD Recovery Treatment Facilities #1

County	DPH	DSS	NON	NON-DETOX	RES	RES-DETOX	Total
Alameda County	-	2	13	-	13	2	30
Amador County	-	-	-	-	-	1	1
Butte County	-	-	6	-	2	1	9
Calaveras County	-	-	-	-	1	3	4
Contra Costa County	-	-	5	1	7	5	18
El Dorado County	-	-	4	-	3	1	8
Fresno County	-	-	16	1	2	13	32
Glenn County	-	-	1	-	-	-	1
Humboldt County	-	-	1	-	1	3	5
Imperial County	-	-	2	-	-	1	3
Inyo County	-	-	2	-	-	-	2
Kern County	-	-	8	1	3	2	14
Kings County	-	-	4	-	-	3	7
Lake County	-	-	3	-	2	-	5
Los Angeles	-	-	1	1	-	2	4
Los Angeles County	3	3	232	33	49	248	568
Marin County	-	2	9	1	-	14	26
Mariposa County	-	-	1	-	-	-	1
Mendocino County	-	-	5	-	-	1	6
Merced County	-	-	3	-	2	-	5

1,781 facilities in 50 of 58 counties

SUD Recovery Treatment Facilities, April 2024

Inventory of Crisis Services: SUD Recovery Treatment Facilities #2

County	DPH	DSS	NON	NON-DETOX	RES	RES-DETOX	Total
Monterey County	-	-	8	-	1	4	13
Napa County	-	-	2	-	-	1	3
Nevada County	-	-	2	-	-	2	4
Orange County	-	13	111	5	26	180	335
Placer County	-	-	10	-	2	7	19
Riverside County	-	1	38	2	9	58	108
Sacramento County	-	-	24	1	8	14	47
San Benito County	-	-	2	-	-	3	5
San Bernardino County	-	-	32	-	3	17	52
San Diego County	-	2	82	5	21	39	149
San Francisco County	-	-	15	-	8	6	29
San Joaquin County	-	-	7	-	3	3	13
San Luis Obispo County	-	-	3	2	2	3	10
San Mateo County	-	-	10	-	8	3	21
Santa Barbara County	-	-	15	-	4	8	27
Santa Clara County	-	2	17	-	3	9	31
Santa Cruz County	-	1	8	-	4	6	19
Shasta County	-	-	6	-	2	1	9
Siskiyou County	-	-	2	-	-	-	2
Solano County	-	-	4	-	4	3	11

SUD Recovery Treatment Facilities, April 2024

Inventory of Crisis Services: SUD Recovery Treatment Facilities #3

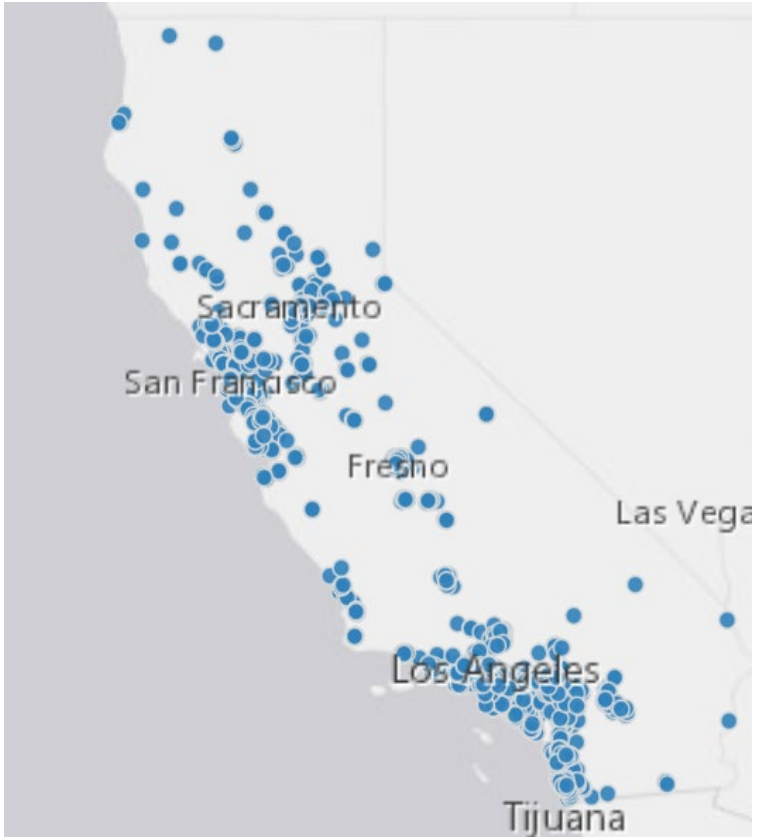
County	DPH	DSS	NON	NON-DETOX	RES	RES-DETOX	Total
Sonoma	-	1	-	-	-	-	1
Sonoma County	-	13	8	-	3	4	28
Stanislaus County	-	2	6	-	2	3	13
Sutter County	-	-	2	-	1	1	4
Tehama County	-	-	-	-	1	-	1
Tulare County	-	-	8	-	5	3	16
Tuolumne County	-	-	-	-	-	1	1
Ventura County	-	4	26	1	-	23	54
Yolo County	-	-	1	-	2	-	3
Yuba County	-	-	1	-	1	2	4
Grand Total	*3*	*46*	*766*	*54*	*208*	*704*	*1781*

SUD Recovery Treatment Facilities, April 2024

Somewhere to Go – SUD

Licensed Narcotic Treatment Program Facilities

Recovery Treatment Facilities



Sources: Narcotic Treatment Facility Finder; SUD Recovery Treatment Facilities

Children and Youth: Somewhere to Go – 24 Hour Residential Care #1

COUNTY	COMMUNITY CRISIS HOMES	COMMUNITY TREATMENT FACILITY	CRISIS NURSERY	ENHANCED BEHAVIORAL SUPPORTS HOME - GH	GROUP HOME	SHORT TERM RESIDENTIAL THERAPEUTIC PROGRAM	SMALL FAMILY HOME	TEMPORARY SHELTER CARE FACILITY	TRANS-ITIONAL HOUSING PLACEMENT PROGRAM	TRANS-ITIONAL SHELTER CARE FACILITY	YOUTH HOMELESSNESS PREVENTION CENTER - GH	*Grand Total*
ALAMEDA	-	-	-	-	14	11	2	-	11	-	-	*38*
ALPINE	-	-	-	-	-	2	-	-	-	-	-	*2*
BUTTE	-	-	-	-	-	2	-	-	3	-	-	*5*
CALAVERAS	-	-	-	-	-	3	-	-	-	-	-	*3*
CONTRA COSTA	1	-	1	-	22	16	10	-	3	2	-	*55*
DEL NORTE	-	-	-	-	-	-	-	-	-	-	-	*0*
EL DORADO	-	-	-	-	6	3	-	-	-	-	-	*9*
FRESNO	-	-	-	1	9	33	1	-	4	1	-	*49*
HUMBOLDT	-	-	-	-	1	1	-	-	2	-	-	*4*
IMPERIAL	-	-	-	-	-	2	-	1	-	-	-	*3*
KERN	-	-	-	1	11	26	4	1	4	-	-	*47*
KINGS	-	-	-	-	-	1	-	-	-	-	-	*1*
LAKE	-	-	-	-	1	-	1	-	-	-	-	*2*
LASSEN	-	-	-	-	-	1	-	-	1	-	-	*2*
LOS ANGELES	1	2	-	3	89	52	32	7	18	-	1	*205*
MADERA	-	-	-	-	1	2	-	-	-	-	-	*3*
MARIN	-	-	-	-	7	2	-	-	1	-	-	*10*
MARIPOSA	-	-	-	-	-	1	-	-	1	-	-	*2*

Source: CDSS Data: 24 Hour Residential Care for Children as of December 15, 2024. GH = Group Home. See Glossary for additional information. Note: the data includes only licensed facility counts; counties with no CDSS licensed facilities are not included. Data is updated weekly and available at the Care Facility Search.

Children and Youth: Somewhere to Go – 24 Hour Residential Care #2

COUNTY	COMMUNITY CRISIS HOMES	COMMUNITY TREATMENT FACILITY	CRISIS NURSERY	ENHANCED BEHAVIORAL SUPPORTS HOME - GH	GROUP HOME	SHORT TERM RESIDENTIAL THERAPEUTIC PROGRAM	SMALL FAMILY HOME	TEMPORARY SHELTER CARE FACILITY	TRANS-ITIONAL HOUSING PLACEMENT PROGRAM	TRANS-ITIONAL SHELTER CARE FACILITY	YOUTH HOMELESSNESS PREVENTION CENTER - GH	Grand Total
MENDOCINO	-	-	-	-	2	1	1	-	1	-	-	*5*
MERCED	-	-	-	-	-	3	-	-	2	-	-	*5*
MONTEREY	-	-	-	-	-	1	-	-	1	1	-	*3*
NAPA	-	-	-	-	1	-	1	-	-	-	-	*2*
NEVADA	-	-	1	-	1	-	-	-	1	-	-	*3*
ORANGE	1	-	-	-	32	17	8	1	4	-	4	*67*
PLACER	-	-	-	-	5	2	6	-	1	-	-	*14*
RIVERSIDE	-	-	-	1	12	33	73	-	7	1	-	*127*
SACRAMENTO	1	-	2	2	16	15	5	5	5	-	1	*52*
SAN BERNARDINO	-	-	-	-	8	41	53	-	6	-	3	*111*
SAN DIEGO	1	-	-	2	32	16	11	1	10	-	1	*74*
SAN FRANCISCO	-	-	-	-	1	2	-	-	1	-	2	*6*
SAN JOAQUIN	1	-	-	1	13	2	9	1	3	-	-	*30*
SAN LUIS OBISPO	-	-	-	-	4	1	1	-	1	-	-	*7*
SAN MATEO	-	-	-	-	4	2	-	1	-	-	-	*7*

Source: CDSS Data: 24 Hour Residential Care for Children as of December 15, 2024. GH = Group Home. See Glossary for additional information. Note: the data includes only licensed facility counts; counties with no CDSS licensed facilities are not included. Data is updated weekly and available at the Care Facility Search.

Children and Youth: Somewhere to Go – 24 Hour Residential Care #3

COUNTY	COMMUNITY CRISIS HOMES	COMMUNITY TREATMENT FACILITY	CRISIS NURSERY	ENHANCED BEHAVIORAL SUPPORTS HOME - GH	GROUP HOME	SHORT TERM RESIDENTIAL THERAPEUTIC PROGRAM	SMALL FAMILY HOME	TEMPORARY SHELTER CARE FACILITY	TRANS-ITIONAL HOUSING PLACEMENT PROGRAM	TRANS-ITIONAL SHELTER CARE FACILITY	YOUTH HOMELESSNESS PREVENTION CENTER - GH	*Grand Total*
SANTA BARBARA	-	-	-	-	2	5	-	-	1	-	1	*9*
SANTA CLARA	-	-	-	1	10	-	-	-	3	4	1	*19*
SANTA CRUZ	-	-	-	2	1	2	-	-	2	-	-	*7*
SHASTA	-	-	-	-	4	3	1	-	2	-	-	*10*
SOLANO	1	-	-	2	3	4	1	-	4	-	-	*15*
SONOMA	-	-	-	-	14	8	-	1	2	-	-	*25*
STANISLAUS	-	-	-	-	3	10	1	-	3	-	1	*18*
SUTTER	-	-	-	-	-	-	-	-	2	-	-	*2*
TEHAMA	-	-	-	-	1	-	-	-	1	-	-	*2*
TULARE	1	-	-	-	1	4	-	-	4	-	-	*10*
VENTURA	-	-	-	-	12	7	2	-	4	-	-	*25*
YOLO	-	-	1	-	-	-	-	-	-	-	-	*1*
YUBA	-	-	-	-	-	-	1	-	-	-	-	*1*
Grand Total	*8*	*2*	*5*	*16*	*343*	*337*	*224*	*19*	*119*	*9*	*15*	*1097*

Source: CDSS Data: 24 Hour Residential Care for Children as of December 15, 2024. GH = Group Home. See Glossary for additional information. Note: the data includes only licensed facility counts; counties with no CDSS licensed facilities are not included. Data is updated weekly and available at the Care Facility Search.