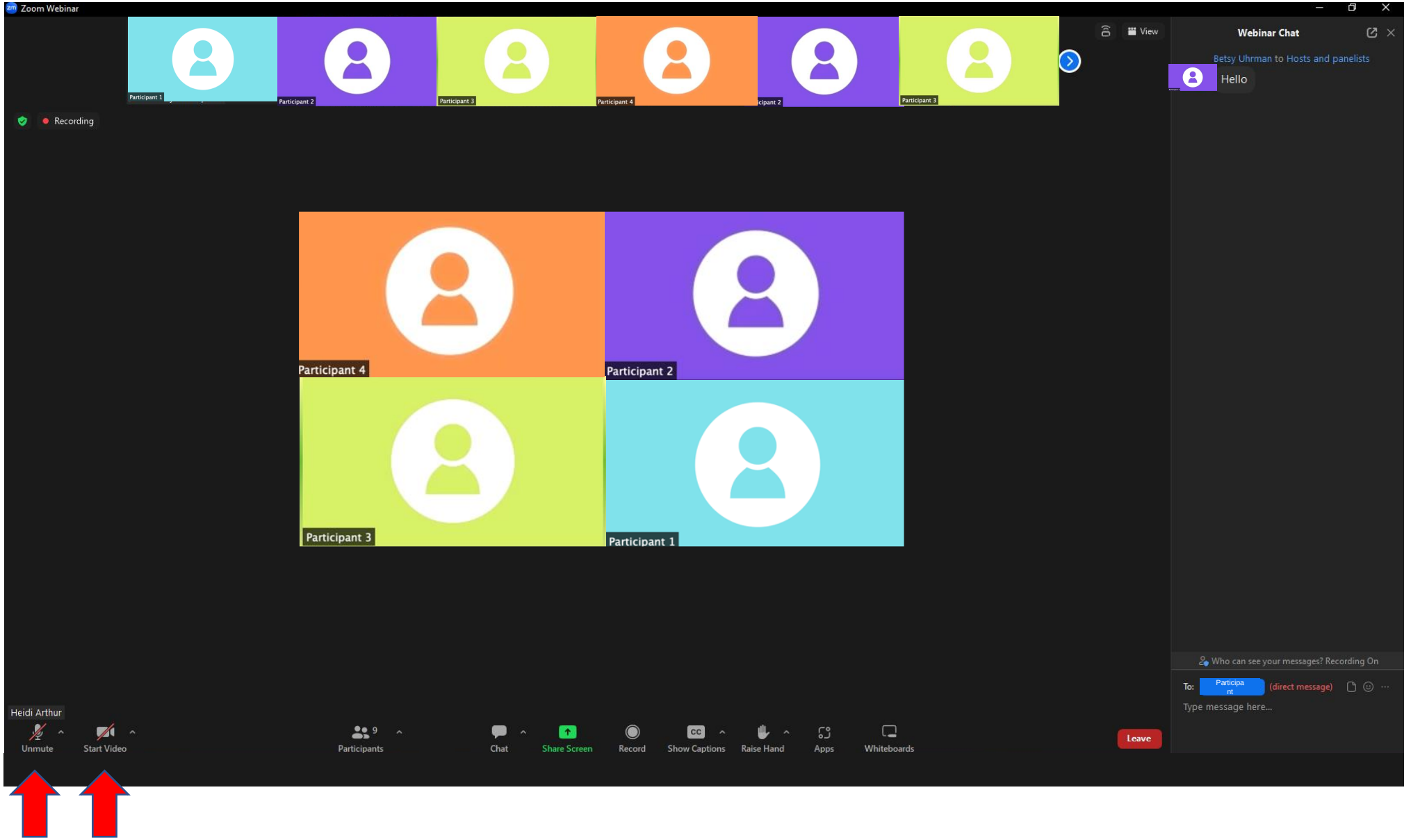
Workgroup 1: Comprehensive Assessment of the Behavioral Health Crisis Services System

Meeting 3
March 19, 2024

Webinar: Panelist View



Webinar View: Attendee

The chat is available for workgroup members.

Note that the chat transcript will be included in the meeting summary, which will be posted on the CalHHS 988 Policy Advisory Group website.

Welcome

Agenda

1. Session Objectives and Introductions (5 mins)
2. Context for Crisis Response/Stabilization Needs (10 mins)
3. Input from Work Group Discussion (60 mins)
4. Public Comment Period (20 mins)
5. Next Steps (5 mins)

Meeting 3 Objectives

Gather input from workgroup members on California…

- Mobile Crisis Response Models
- Models of Person-centered crisis stabilizing facilities and programs
- Potential methods for gathering information (near-term and longer-term)

Policy Advisory Group Members (1)*

- **Amanda Levy**, Deputy Director for Health Policy and Stakeholder Relations, California Department of Managed Health Care (DMHC)
- **Anete Millers**, Director of Regulatory Affairs, California Association of Health Plans (CAHP)
- **Ashley Mills**, Assistant Deputy Director, Community Wellness, California Department of Public Health (CDPH)
- **Bianca Christian**, Associate Therapist, California Coalition for Youth
- **Brenda Grealish**, Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH)
- **Budge Currier**, Assistant Director, Public Safety Communications California Governor's Office of Emergency Services (CalOES)
- **Chad Costello**, Executive Director, California Association of Social Rehabilitation Agencies (CASRA)
- **Christine Stoner-Mertz**, Chief Executive Officer, CA Alliance of Child and Family Services
- **Doug Subers**, Director of Governmental Affairs, California Professional Firefighters
- **Erika Cristo**, Assistant Deputy Director, California Department of Health Care Services (DHCS)
- **Elizabeth Basnett**, Director, California Emergency Medical Services Authority (EMSA)
- **Jana Lord**, Chief Operating Officer, Sycamores
- **Jeff Hebert**, 911 Communications Coordinator, San Diego Sheriff's 911
- **Jennifer Oliphant**, Hope For Tomorrow Program Director, Two Feathers Native American Family Services
- **Jessica Cruz**, Chief Executive Officer, National Alliance on Mental Illness (NAMI) – California
- **John Boyd**, Vice President Behavioral Health and Wellness, Kaiser Permanente, Northern California
- **Kenna Chic**, Former President of Project Lighthouse, California Health Care Foundation
- **Keris Jän Myrick**, Vice President of Partnerships, Inseparable (Mental Health Advocacy and Programs)
- **Kirsten Barlow**, Vice President, Policy, California Hospital Association (CHA)

* Note: 988-Crisis Advisory Group members represent diverse expertise, experience (including lived experience), and diversity of thought. For purposes of this list, only members' professional affiliations are indicated.

Policy Advisory Group Members(2)

- **Lan Nguyen**, Division Manager, Crisis and Suicide Services, County of Santa Clara Behavioral Health Services Department
- **Le Ondra Clark Harvey**, Chief Executive Director, California Council of Community Behavioral Health Agencies (CBHA)
- **Lee Ann Magoski**, Director of Emergency Communications, Monterey County
- **Lei Portugal Calloway**, Certified Medi-Cal Peer Support Specialist, Telecare Orange County
- **Melissa Lawton**, Chief Program Officer, Seneca Family of Agencies
- **Michael Tabak, Lieutenant**, San Mateo County Sheriff's Office
- **Michelle Doty Cabrera**, Executive Director, County Behavioral Health Directors Association (CBHDA)
- **Miguel Serricchio**, Executive Vice President, LSQ Funding Group
- **Nancy Bargmann**, Director, California Department of Developmental Services
- **Peggy Rajski**, Founder and Interim CEO, The Trevor Project
- **Phebe Bell**, Behavioral Health Director, Nevada County
- **Rayshell Chambers**, Commission Member, Mental Health Services Oversight and Accountability Commission
- **Rebecca Bauer-Kahan**, CA State Assemblymember/Author of AB988, State of California, AD 16
- **Rhyan Miller**, Behavioral Health Deputy Director Integrated Programs, Riverside County
- **Robb Layne**, Executive Director, California Association of Alcohol and Drug Program Executive, Inc (CAADPE)
- **Robert Smith**, Chairman, Pala Band of Mission Indians
- **Roberto Herrera**, Deputy Secretary, Veterans Services Division, California Department of Veterans Affairs (CalVet)
- **Ryan Banks**, CEO, Turning Point of Central Valley, Inc.
- **Shari Sinwelski**, Vice President of Crisis Care, Didi Hirsch
- **Sohil Sud**, Director, Children & Youth Behavioral Health Initiative (CYBHI), California Health and Human Services Agency (CalHHS)
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, California Health and Human Services Agency (CalHHS)
- **Susan DeMarois**, Director of California Department of Aging (CDA)
- **Tara Gamboa-Eastman**, Director of Government Affairs, Steinberg Institute
- **Taun Hall**, Executive Director, The Miles Hall Foundation

Comprehensive Assessment Workgroup Members

Co-Chair, Phebe Bell, Nevada County Behavioral Health

Co-Chair, Chad Costello, California Association of Social Rehabilitation Agencies (CASRA)

Aimee Moulin, Department of Emergency Medicine and Department of Psychiatry, UC Davis

Alice Gleghorn, Phoenix House of California

Andrew Holcomb, EMS Administrator, San Francisco

Anete Millers, California Association of Health Plans (CAHP)

Astin Williams, Health Access California

Christina Ramirez, SHIELDS for Families

Corinne Kamerman, California Department of Health Care Services (DHCS)

Don Taylor, Pacific Clinics

Elizabeth Basnett, California Emergency Medical Services Authority (EMSA) (Delegate - Brian Aiello)

Erika Cristo, California Department of Health Care Services (DHCS)

Ivan Bhardwaj, California Department of Health Care Services (DHCS)

Jana Lord, Sycamores

Javon Kemp, Kern Behavioral Health and Recovery Services

Jennifer Oliphant, Two Feathers Native American Family Services

Jessica Jimenez, California Department of Public Health (CDPH)

Jodi Nerrell, Local Mental Health Engagement, Mental Health & Addiction Care, Sutter Health

Kelsey Andrews, Star Vista Center

Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies (CBHA) (Delegate – Courtnie Thomas)

Lishaun Francis, Children NOW

Mark Salazar, Mental Health America (MHA)

Maurice Lee, Center Point, Inc

Miguel Serricchio, LSQ Group, LLC

Scott Perryman, Sacramento Fire Department

Sonia Hwang, California Department of Public Health (CDPH)

Tara Gamboa-Eastman, Steinberg Institute

Tasnim Khan, Western Health Advantage

Taun Hall, The Miles Hall Foundation

Uma Zykfosky, California Behavioral Health Planning Council (CBHPC)

Public Comment Overview

- **All comments—whether written or spoken—will be shared with the Workgroup in the meeting minutes.**
- We will take comments in the order in which we receive sign-ups
- If you are on Zoom and would like to make a public comment, please raise your hand
- Each person will have 2 minute to speak. If you have a condition that may require an accommodation (such as additional speaking time), please notify the project team and we will do our best to provide that accommodation.
- If you would like to make a comment but prefer not to do it in front of a camera or microphone, you may email your written comment to the project email address: AB988Info@chhs.ca.gov

Code of Conduct

- Presume positive intentions
- Ask from a place of inquiry
- Be present and stay engaged
- Be brief and brilliant
- Be respectful and courteous

Meeting 3:

- Meeting 2 Summary Highlights
- Context for Crisis Response/Stabilization Needs
- Input from Work Group

Workgroup 2 Meeting Summary (2/28/2024)

- Inventory assessment should focus on **crisis response** (someone to call, someone to respond) and **crisis stabilization** (somewhere to go)
- **System view** is critical to identifying, understanding and address the bottlenecks.
- Explore ways to assess the **needs of individuals in crisis who may not access** the current system or services (e.g., historically marginalized communities).
- **Account for challenges** related to geography, cultural competence, appropriate level of care.
- Explore use of technology and other fields to help BH solve for and **manage system flow and response**.
- Articulate and define the **workforce shortage challenge** and need to address capacity and infrastructure issues.
- Identify **benchmarks/standards for key services** (e.g., 988 crisis centers, mobile crisis response) to understand current gaps and identify pathways to support provider achievement of existing/future standards

Workgroup 1: Assessment of the Behavioral Health Crisis Services System

- Required Recommendation Areas Per AB 988:
  - (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**.
  - (7) Resources and policy changes to address statewide and regional needs in order to meet population needs for behavioral health crisis services

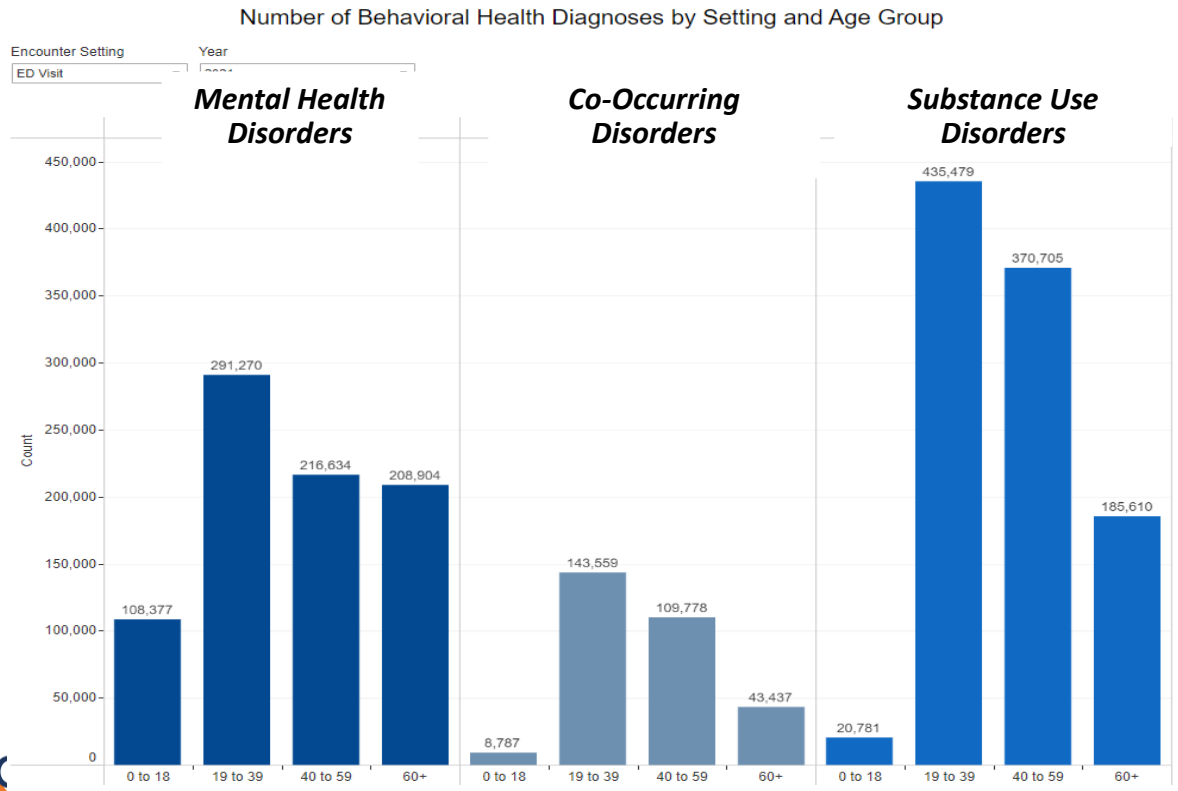
What are the Community Needs?

System Inventory: where else might we look or who might we connect with?

BH-related ED treat-and-release visits

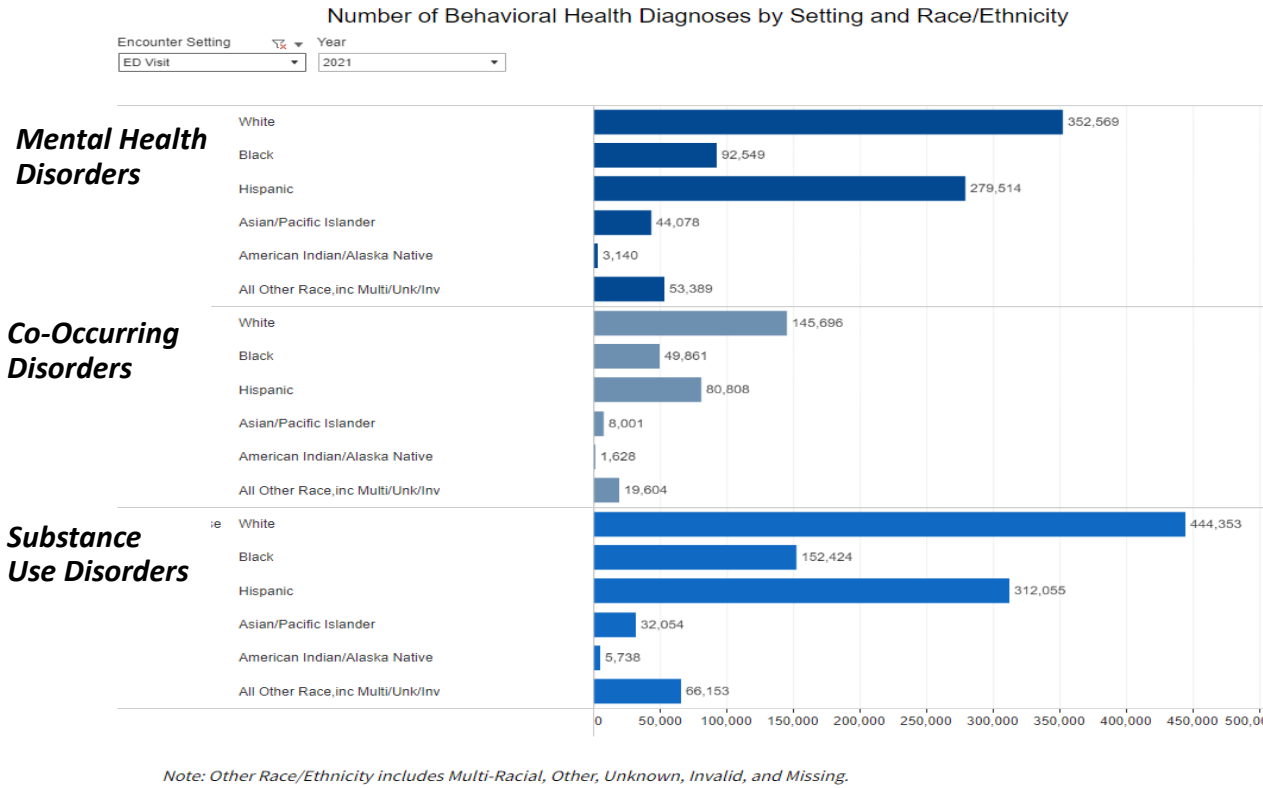
In 2021, patients in California with **behavioral health diagnoses** accounted for **one fifth of all ED visits**

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



Note: Unknown age is not included.

Number of Behavioral Health Diagnosis by Setting and Race/Ethnicity, ED Visits, 2021



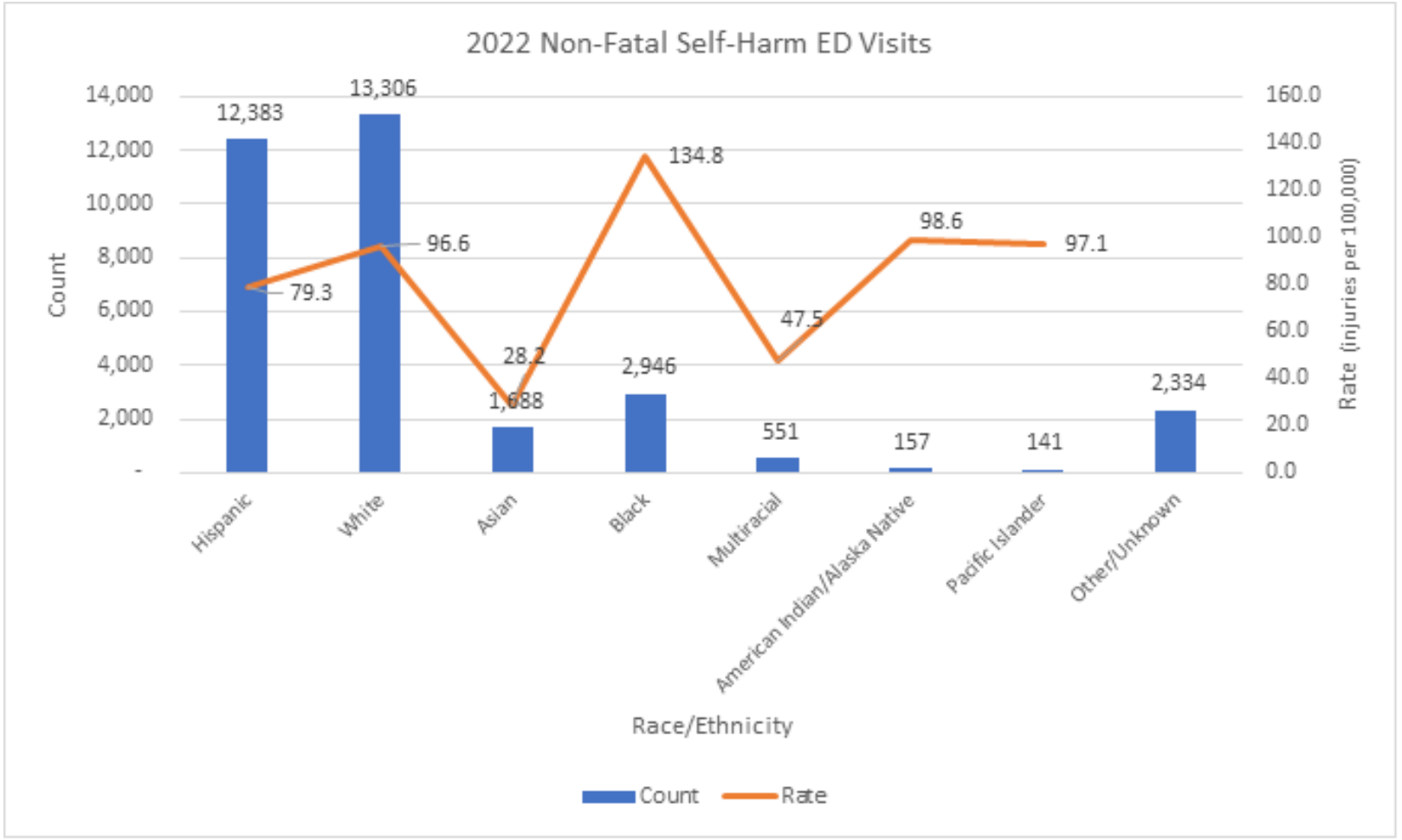
Note: Other Race/Ethnicity includes Multi-Racial, Other, Unknown, Invalid, and Missing.

White individuals had the highest number of ED visits across BH diagnoses in California.

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

Non-fatal Self-harm ED visits

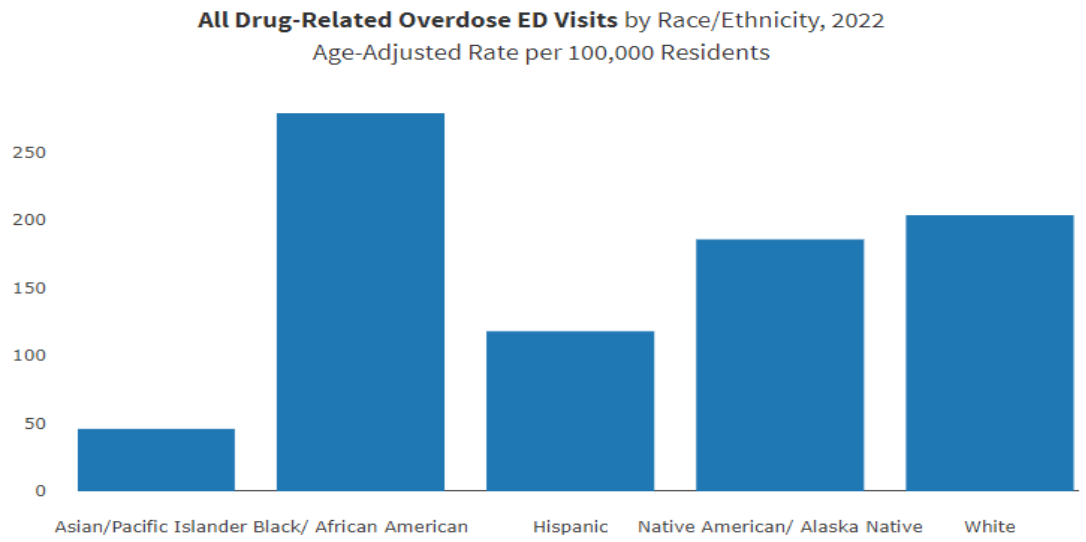
- In 2022, California had a crude rate of non-fatal self-harm ED visits of **85.8 per 100K residents** (33,506 visits), compared to a national rate of 148.2 per 100K individuals in 2021.
- In 2022, **Black/ African Americans** had the **highest crude rate of all non-fatal self-harm ED visits** (134.8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



Source: [California Department of Public Health - California Injury Data Online EpiCenter. 2022]

Drug-related overdose ED visits

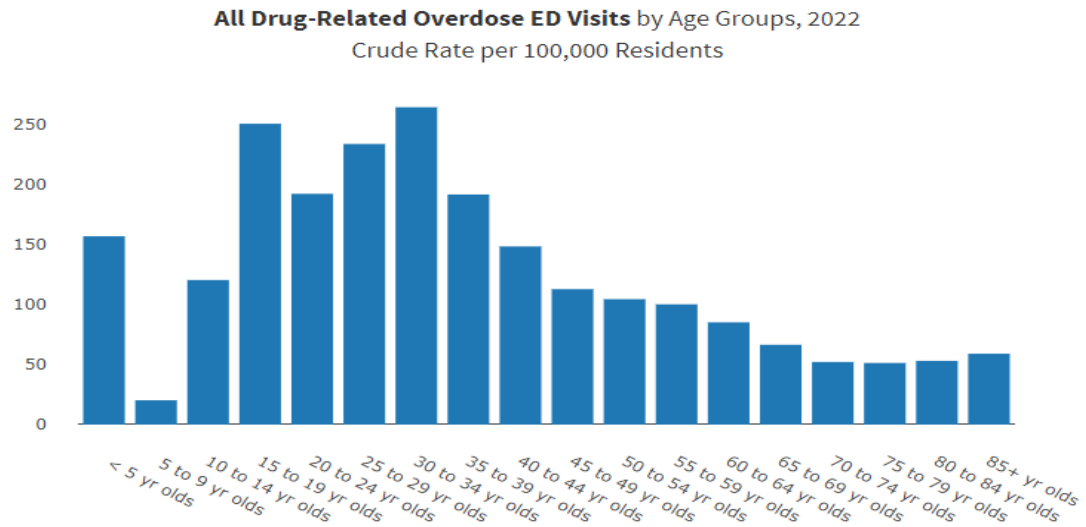
All Drug-Related Overdose ED Visits by Race/Ethnicity, 2022
(Age Adjusted Per 100,000 Residents)



- In 2022, **Black/ African Americans had the highest age-adjusted rate of all drug-related overdose ED visits** (279.19 per 100K 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)



Source: California Overdose Surveillance Dashboard. Prepared by California Department of Public Health (CDPH - Substance and Addiction Prevention Branch (SAPB)

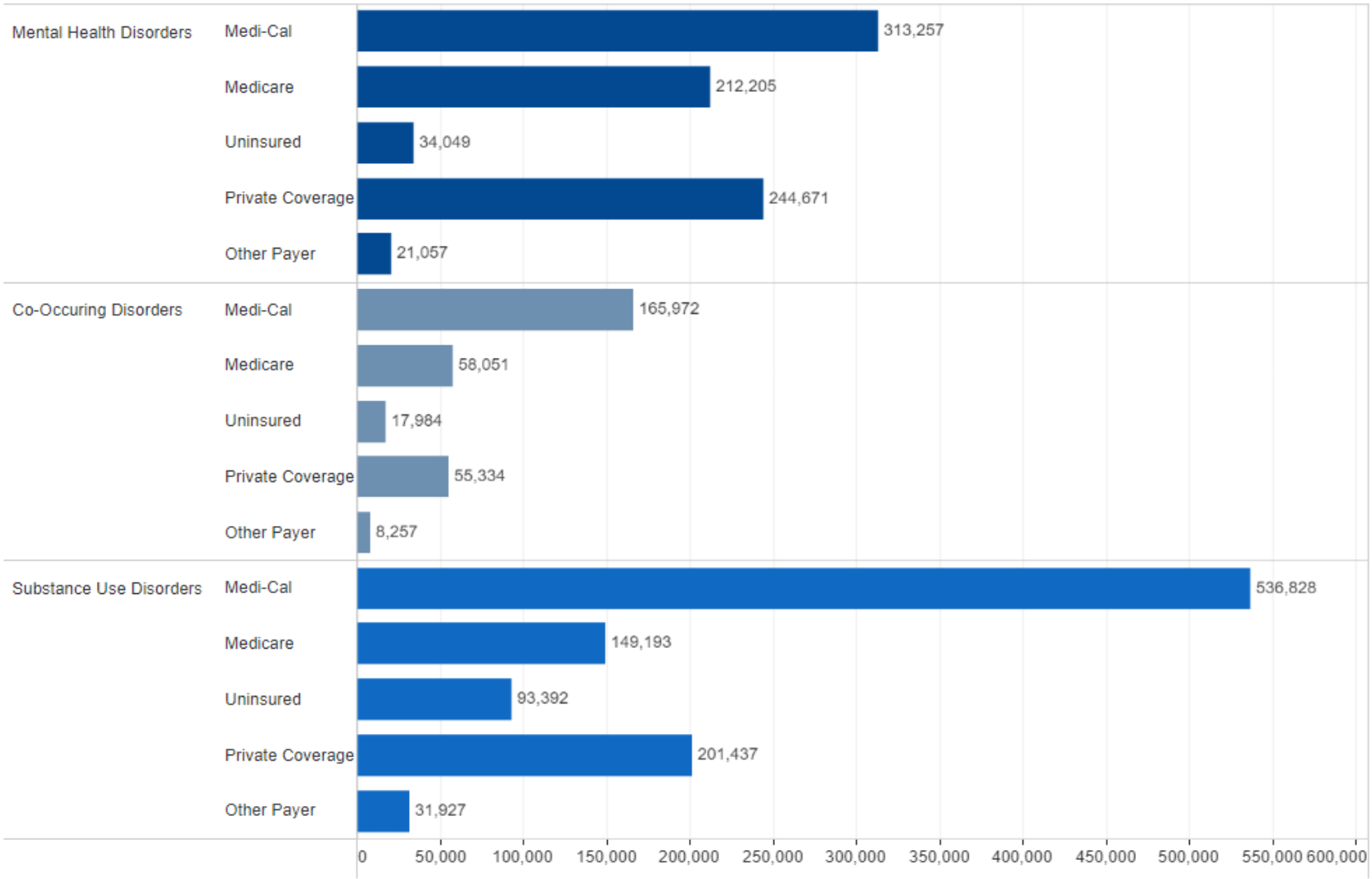
Who pays for BH-related ED services?

In 2021, **Medi-Cal was the most common expected primary payer** for BH-related ED visits

Private coverage covered more mental health disorders than co-occurring or substance use disorders

Uninsured patients were more likely to be treated in the ED for substance use disorders than for mental health or co-occurring disorders.

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



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

Building 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 BH care
  - CCBHCs
  - Urgent care clinics
  - Transition clinics
  - Bridge clinics
- 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

Post-Crisis Step-Down Services, such as (LT)

- Partial hospitalization
- Supportive housing

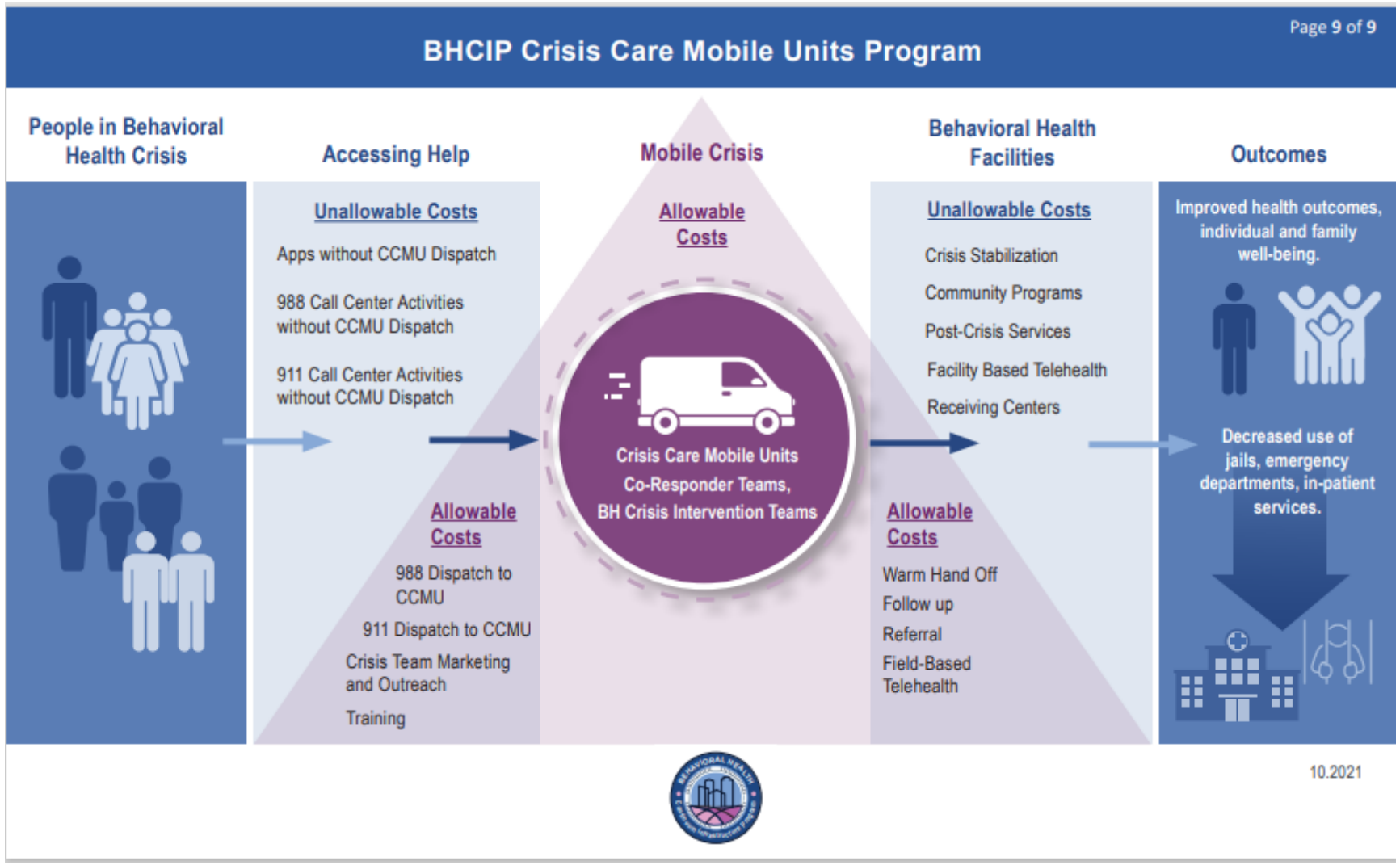
Sobering Center

Sources: SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. September 13th BHTF meeting, DHCS: Existing California Medicaid Policies, proposed Medi-Cal Mobile Crisis Benefit, CalHHS

CalHHS
California Health & Human Services Agency

Crisis Response

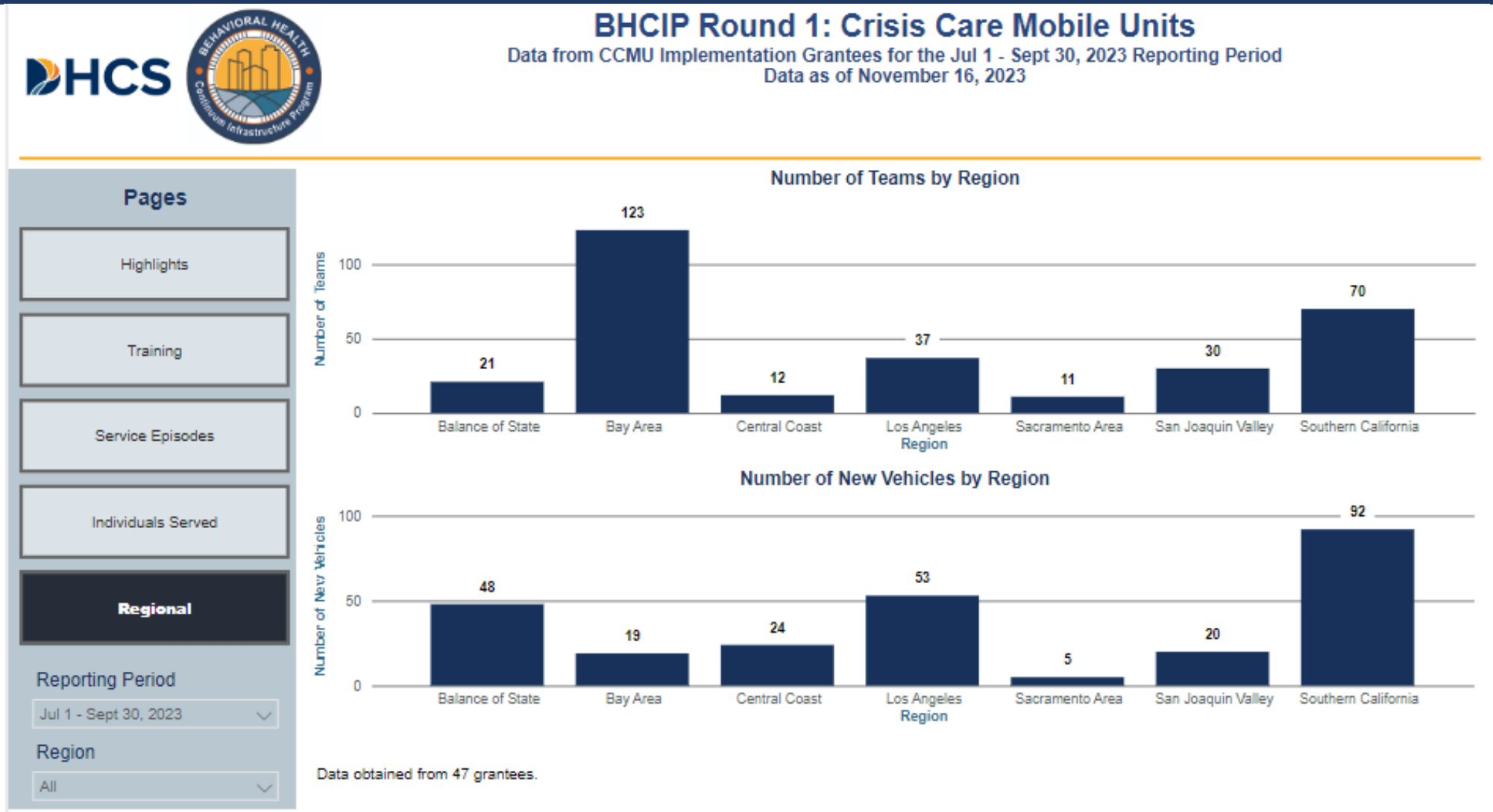
Crisis Care Mobile Units Program Grant



$185 million awarded to 48 BH authorities and 24 tribal entities to create/enhance **390 MCTs**

[Crisis Care Mobile Units Program Funding Fact Sheet (buildingcalhhs.com)]

Distribution of CCMU Teams Across the State



[Round 1 Data Dashboard - BHCIP (buildingcalhhs.com)]

Impact of CCMUs

BHCIP Round 1: Crisis Care Mobile Units

Data from CCMU Implementation Grantees for the Jul 1 - Sept 30, 2023 Reporting Period
Data as of November 16, 2023

73
Total Vehicles Purchased

Pages

- Highlights
- Training
- Service Episodes
- Individuals Served
- Regional

Reporting Period: Jul 1 - Sept 30, 2023

Region: All

304
Total Teams

70.21%
Percent of Grantees Servicing all Zip Codes in their jurisdiction

76.60%*
Percent of Grantees Providing Services

12,848
Unduplicated Individuals Served

Data obtained from 47 grantees.

Number of Grantees by County (includes Planning)

Number of Grantees ● 1 Grantee ● 2 Grantees

*This percentage represents 36 of 47 CCMU Grantees. The remaining grantees are yet to provide services due to workforce/hiring challenges.

[Round 1 Data Dashboard - BHCIP (buildingcalhhs.com)]

Who CCMUs Served

BHCIP Round 1: Crisis Care Mobile Units

Data from CCMU Implementation Grantees for the Jul 1 - Sept 30, 2023 Reporting Period
Data as of November 16, 2023

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)

Pages

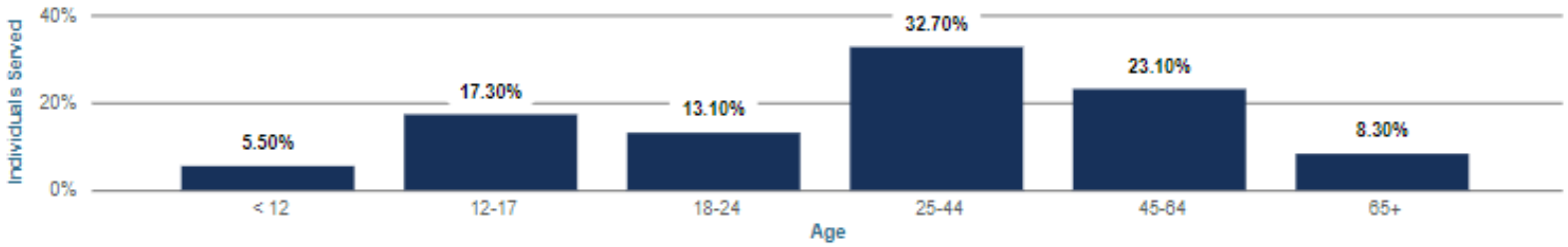
- Highlights
- Training
- Service Episodes
- **Individuals Served**
- Regional

Reporting Period: Jul 1 - Sept 30, 2023

Region: All

Individuals Served by Age

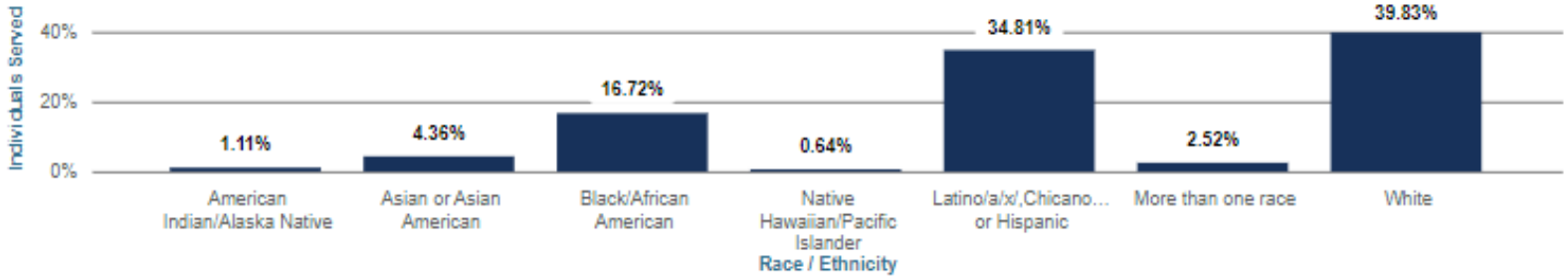
Percentages displayed only represent reported known ages



1083 Individuals of Unknown Age

Individuals Served by Race / Ethnicity

Percentages displayed only represent reported known races/ethnicities



3682 Individuals of Unknown Race/Ethnicity

Data obtained from 47 grantees.

[Round 1 Data Dashboard - BHCIP (buildingcalhhs.com)]

Resolution of Mobile Crisis Response

BHCIP Round 1: Crisis Care Mobile Units

Data from CCMU Implementation Grantees for the Jul 1 - Sept 30, 2023 Reporting Period
Data as of November 16, 2023

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)

Pages

- Highlights
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- **Service Episodes**
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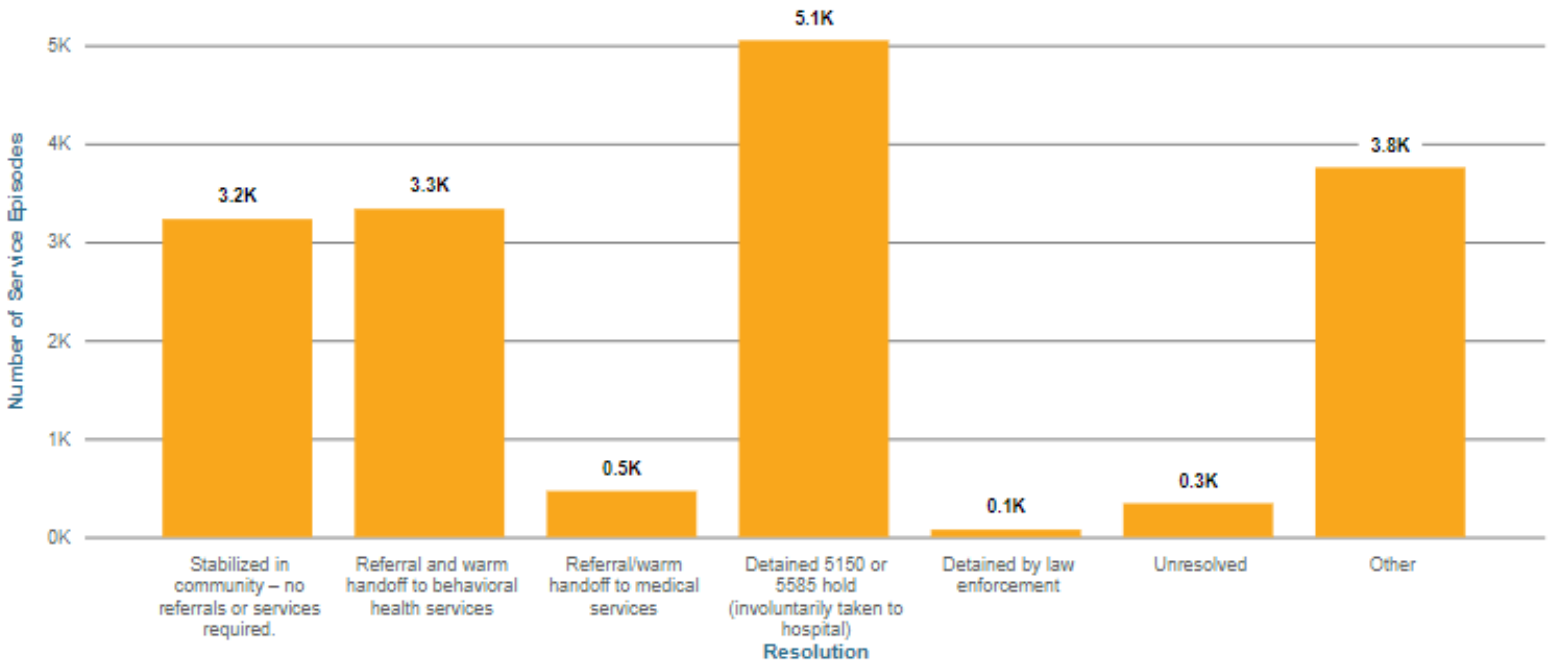
- Regional

Reporting Period: Jul 1 - Sept 30, 2023

Region: All



Data obtained from 47 grantees.

Opportunities to stabilize or divert from involuntary hospitalization

[Round 1 Data Dashboard - BHCIP (buildingcalhhs.com)]

Other Models of Crisis Response: Community Paramedicine

Background:
- 2014: California Office of Statewide Health Planning and Development (OSHPD) approved a Pilot Project by EMSA
- 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
  - Few transferred to ED
    - 1.9% were transferred to an 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 since they did not meet criteria for admission).

**numbers higher if more beds were available or if center could accept private insurance/Medicare*

Alternate Destination – Sobering Center

- Three projects enrolled 2,945 persons between February 2017-September 2020
  - SF: 98.2% treated safety and effectively
    - Few transferred to 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
  - 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

Workgroup Input Needed on Crisis Response

- What else is known about other Models of Crisis Response across California?
  - What are the **different models** (e.g., peers, non-clinicians, CIT trained, BH clinicians, law enforcement)?
  - Who do the mobile crisis response teams partner with across communities?
  - Who pays for these services? Through what funds?

- Where are the opportunities to expand/leverage other workforce to support more robust Mobile Crisis Response?

- How do we get to the unknowns: what are models of crisis response in:
  - Geographically rural or difficult to access areas
  - Underserved populations: children and youth, I/DD, others
  - Historically marginalized communities: AI/AN, migrant communities, others

- Where else might we look or who might we talk with to get more information about mobile crisis response models?

What Else is Known About Other Crisis Response Models

	Examples
Non-Medi-Cal Mobile Response Teams	• Emergency Medical Services (EMS) • EMS + Behavioral Health Clinician • Law enforcement co-response with BH clinician • CIT-trained first responders • Community response teams (peer, non-clinicians, youth) • SF: Local experience, including approved Community Paramedicine program and triage to alternate destinations • LA County: Sycamores partnering with city to provide peer co-response (city funded)W (similar model in Long Beach to West Hollywood model) • LA City, County, Beverly Hills – Advanced provider mobile team • Wellspace – CCBHC, crisis center • Street medicine – utilize EMT and firefighters • Santa Barbara: law enforcement and co-response, also BH peer
Key Community Partnerships	• City-CBO partnerships • Law enforcement (police, sheriff, and other first responders) – requires strong relationships and training (units with CIT training) • Community mental health • Social services • VA • Department of public health • EMS providers • Private ambulance providers
Funding Sources	City, County, Prop 47, MHSA (BH clinicians and peers), PD (officer time), private funding, grant funding, fees for some services Challenge of cost recovery

Targeted Models of Crisis Response for…

	Examples – Notec challenge of transportation – both access and authority	Who/Where to get Information
Geographically rural or difficult to access areas	• Sycamores piloting in Riverside County model similar to W. Hollywood model (peers do first level triage, LPS eval via telehealth)	• BHCIP awardees as models/examples • CARESTAR Foundation pre-hospital care awardees • Final evaluation of SB 82 • Parent groups are sharing information and resources word of mouth (Lishaun can share contact information)
Underserved populations: children and youth, I/DD, others	• Toys and supplies to engage younger populations • Foster youth: Children Now working with several counties to get FURS hotline up and running (FURS does crisis response and 24/7 hotline) • Need for alternative destinations given the shortage of psychiatric beds for youth; more regionally focused models *(Note for Workgroup 3, Integration)*	
Historically marginalized communities: AI/AN, migrant communities, others	• County behavioral health trains **peer employees** that draw staff from particular communities (ncluding those w/lived experience to accompany emergency responders)	

Crisis Stabilization

What We're Learning: Stabilizing Crisis (Somewhere to Go)

Stabilizing Crisis	
Services (24 hours or less) *Crisis Receiving and Stabilization* *BH/MH UCCs* *Sobering Centers* **Up to 72 hours:** *Crisis Stabilization Units* *EmPATH/Psych Emergency Services (PES)* **Other Crisis Supports** *Peer Respite* *In-Home Crisis Stabilization*	**Service (24 hours +)** *Crisis Residential Treatment Services* **Post-Crisis Step-Down Services** • *Partial hospitalization (PHP)* • *Intensive Outpatient (IOP)* • *Day Treatment* • *Supportive housing*

Workgroup Input Needed on Crisis Stabilization Facilities

Models of Person-Centered Crisis Stabilization

Are there other types of crisis stabilization/post crisis step down facilities we should be looking for as part of our assessment?

1. **Non-Licensed Crisis Stabilization Facilities.** Where/how can we find more information about non-licensed programs?

2. **Facilities that serve non Medi-Cal Beneficiaries.** Where/how can we find more information about crisis stabilization services for those with commercial insurance, uninsured, or self-pay?

3. **Facilities for Underserved or Specialized Populations.** For example, Children/Youth, I/DD, others…

What We're Learning: Crisis Stabilization 24-72 Hours (1)

	Crisis Stabilization Units	EmPATH/Psych Emergency Services (PES)
Definition	Provide BH services on an urgent basis for less than 23 hours. Designed for those with BH condition that requires timelier response than regularly scheduled visit, but that do not require evaluation and stabilization in an ED. Those who require additional tx an observation can be referred to Crisis Residential Services (BHCCP)	The Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) is a specialized hospital-based emergency department or outpatient medical observation unit dedicated to mental health emergencies (CHA PowerPoint)
What We Know	• 63 total licensed Crisis Stabilization facilities • 24 of the 58 counties as of August 2023 • 2022 BHCCCP: Only 16 (48%) had sufficient CSU capacity	• 4 programs that meet the standard definitions • 3 Psychiatric Emergency Services that have design philosophy • 12 currently in development
What else should we know?	• # of crisis residential beds statewide (serve as step down AND diverting going to CSU) • County discharge data from hospitals • # Commercial insurance plans paying for crisis stabilization • timely follow up to hospital admissions is in EQRO reports • Admin/documentation burden as barriers to increased supply • # of CSUs that had closed their doors and reasons for why that occurred • How effective beds are compared to respites/alternative settings. • From LeOndra: Bus Test Express is a transportation company that retrofits buses to provide mobile crisis and has some options that could be utilized as a CSU	• Get list of EmPATH rom Kirsten (via Scott Zeller)

What We're Learning: Crisis Stabilization 24-72 Hours (2)

	Sobering Centers	Crisis Receiving and Stabilization	BH 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 (CCC-P Glossary)	Provide short-term (under 24 hours) observation and crisis stabilization services in a home-like, nonhospital environment (CCC-P Glossary)	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
What We Know	As of Nov. 2020… • only 10 operating in CA • 6-8 were planned	• Variety of community defined models operating across the state	• Found across the state, including Santa Clara County, Los Angeles County, Riverside, San Diego, Orange County, others
What else should we know?	Ques. about feasibility of funding model • Santa Barbara County added as sobering center • Funding: MCPs under Community Supports (member-specific), counties (non-MCP members who are Medi-Cal eligible), Prop 47 • 2021 CHCF report: https://www.chcf.org/publication/sobering-centers-explained/		• Sacramento County/Turning Point has a Mental Health ER available for crises • Placer County MHUCC called LOTUS (opened 1/5 years ago) • Funded through Medi-Cal and MHSA *Note: County websites outline what they offer vis a vis crisis stabilization*

What We're Learning: Crisis Stabilization Other Crisis Supports

	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 are capable of remaining safely in the community and out of the hospital with appropriate support
What We Know	• As of 2021, California had five, including in Los Angeles and the Bay Area	• Limited information on formalized in-home crisis stabilization programs other than Orange County
What else should we know?	• Peer respite listing from National Empowerment Center: https://power2u.org/directory-of-peer-respites/ • Partnership HP contracts for BH Respite beds under Community Supports, in Solano Co which is utilized as a step down from CSU/EDs and mobile crisis drop offs. • (For family: NAMI programs/resources (funded through state and county funds))	

What We're Learning: Crisis Stabilization > 72 Hours and Step Down (1)

	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 offer 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.
What We Know	31 counties with Social Rehabilitation Programs licensed by DHCS in 2022; 8 of which had CRTs		

What We're Learning: Crisis Stabilization > 72 Hours and Step Down (2)

	Crisis Residential Treatment Services	IOP/ PHP/ Day Treatment	Supportive Housing
What else should we know?			

- Also: In-home and family caregiver support (come over, provide additional resources, support medication management, etc.). Don't have models of follow-up care for BH in the same way we do for other needs
- Co-response teams can do post crisis visits
- Missing licensing category, "Folks get stuck in ERs because they can't be medically cleared into A, B or C."

Public Comment Period

Public Comment Guidelines

- **All comments—whether written or spoken—will be shared with the Workgroup in the meeting minutes.**
- If you prefer, you may email your written comment to the project email address: AB988Info@chhs.ca.gov
- Each speaker is allocated 2 minutes to speak unless adjusted by the meeting facilitator.
- A speaker may not share or relinquish any remaining time they have not used to another speaker.
- Speakers may share one time during the public comment period.
- If time in the agenda remains after all individuals who signed up to speak have been called, the facilitator may invite other members of the public to raise their hand to speak. The facilitator will call individuals in the order they raise their hand.
- Speakers shall be civil and courteous in their language and presentation. Insults, profanity, use of vulgar language, or gestures or other inappropriate behavior are not allowed.
- Speakers should not ask questions of Workgroup members or ask Workgroup members to respond to their comments directly.

Public Comment Sign-Ups

1.

Action Items and Next Steps

Action Items and Next Steps

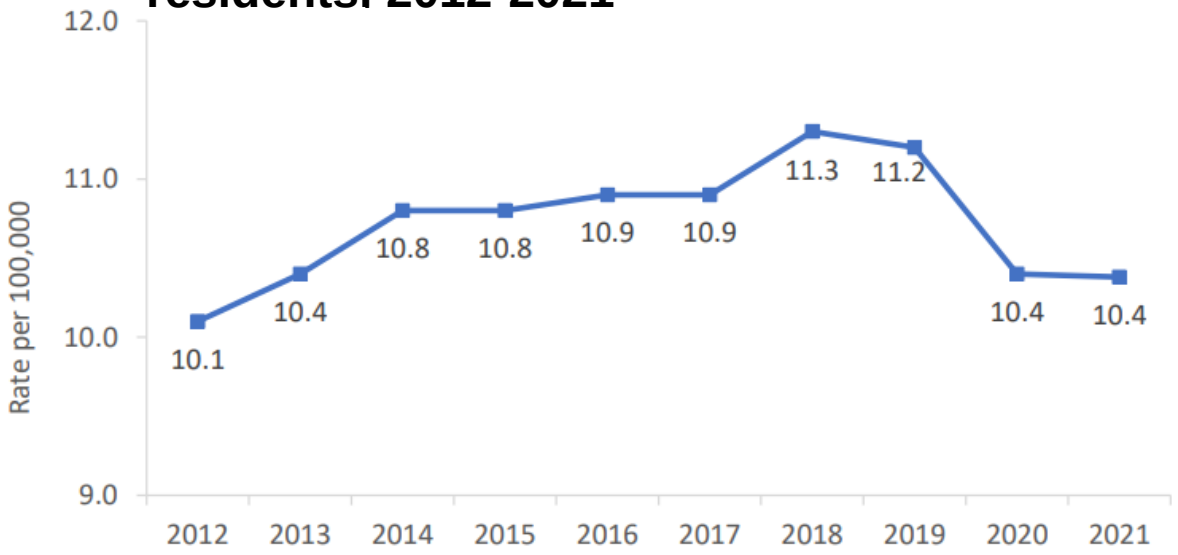
- All information from today's meeting will be posted on the CalHHS website on the 988-Policy Advisory Groups webpage: Link to Website for CalHHS 998 Crisis Policy
- **Next Meeting of the Workgroup: April 11, 1-3 PM Pacific**

Adjourn

Extra slides moved down from above

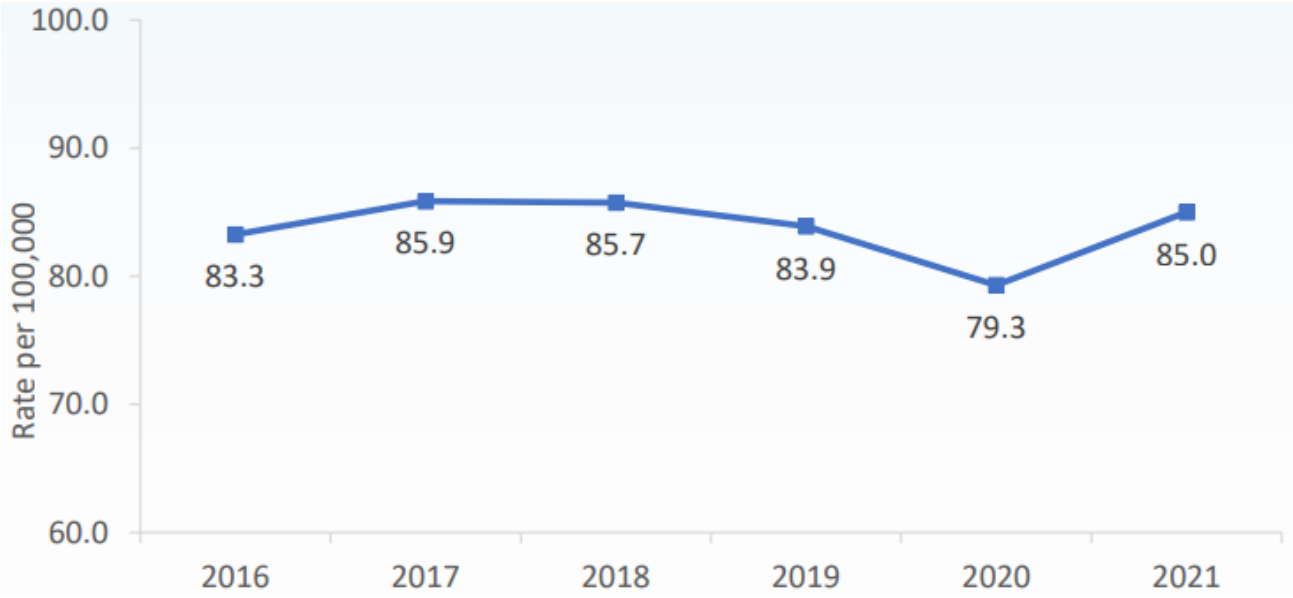
Some of What We're Learning: Indicators of BH Crisis

Figure 1. **Suicide Rates (per 100,000) Among CA residents. 2012-2021**



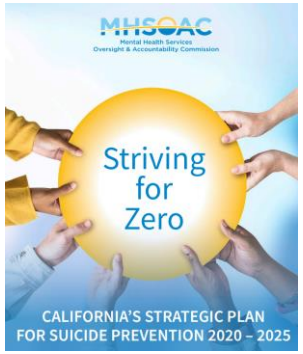
Although suicide rates in California remained the same between 2020 to 2021, self-harm ED visit rates in California increased during the same time period

Figure 2. **Self-Harm ED Visit Rates (per 100,000) Among CA residents, 2016-2021**



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

Some What We're Learning: Preventing Crisis



CDPH Reported Challenges to Prevention Efforts

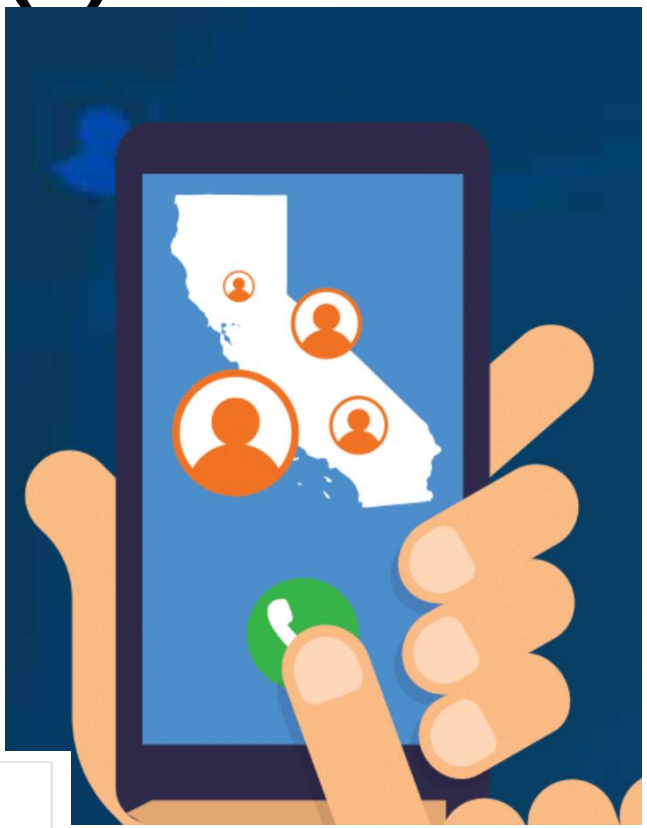
- Public confusion over 988 rollout
- Timely access to local-level data
- Stakeholder coordination and communication
- Limited resources and infrastructure
- Staff turnover and leadership challenges
- Stigma surrounding mental health and suicide
- Parent engagement in youth suicide prevention
- Integrating suicide prevention screening 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, differences in systems across counties)

988-Related Suggestions

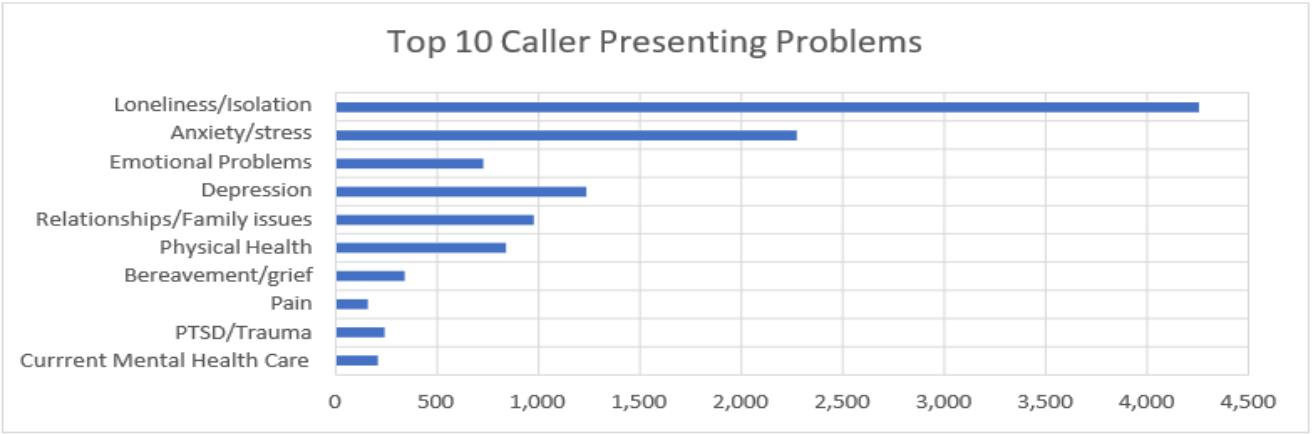
- helping to normalize 988 via widespread and targeted marketing
- dedicated funding, resources, and support to effectively promote 988

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

Some of What We're Learning: Warm Lines (1)



- 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% citing other gender identity.
  - 75% of callers identified as heterosexual and 25% as LGBTQIA.
  - Caucasian is the largest category of callers by ethnicity followed by Latino, Black, Asian /Pacific Islander.
  - Callers predominately identified as living alone and single.



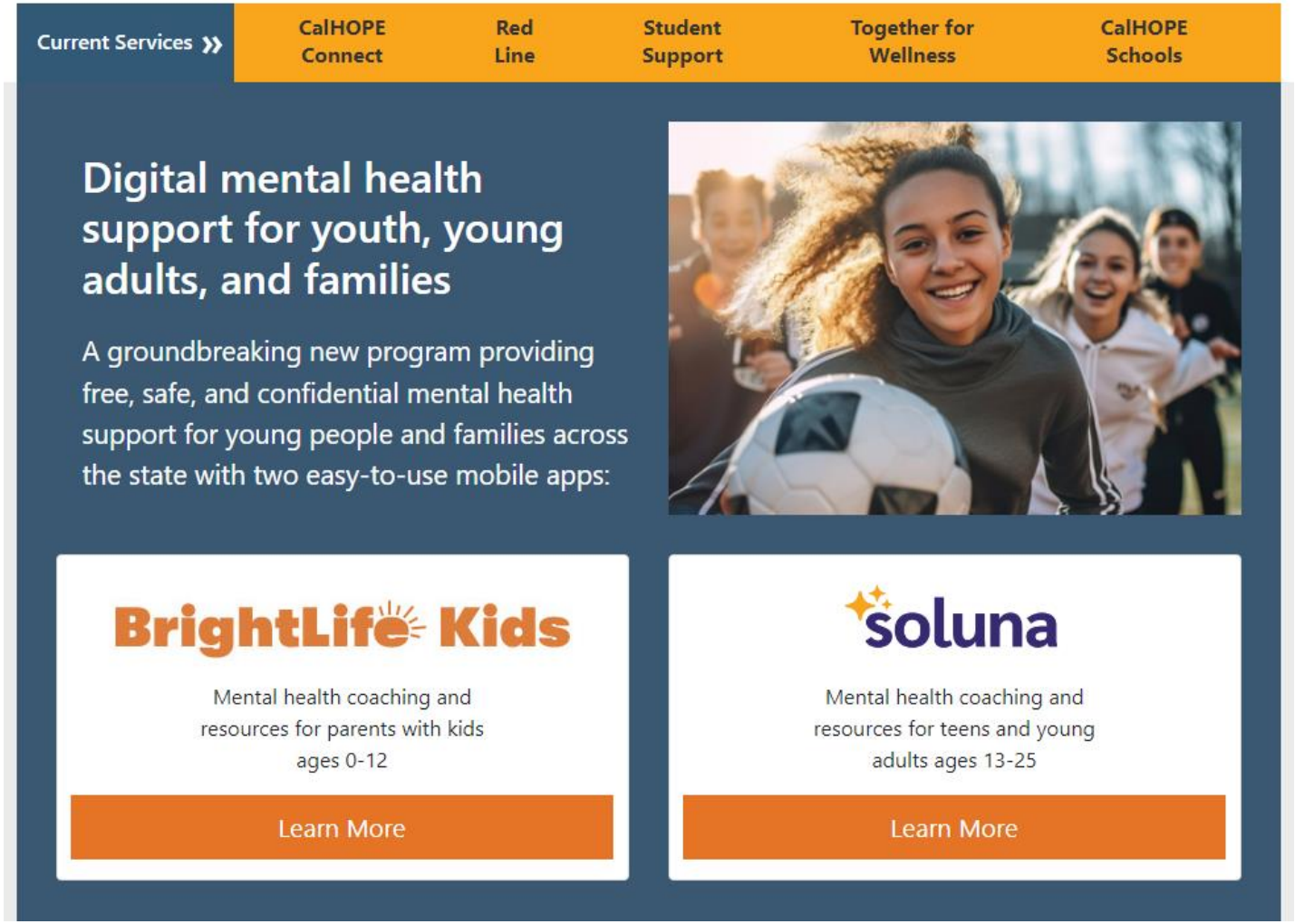
Internal Data provided by MHASF "Friendship Line Snapshot"

Some of What We're Learning: Warm Lines (2)

- 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.
- More data to be provided as part of the Comp Assessment

Sources: Information provided y MHASF "Friendship Line Snapshot"

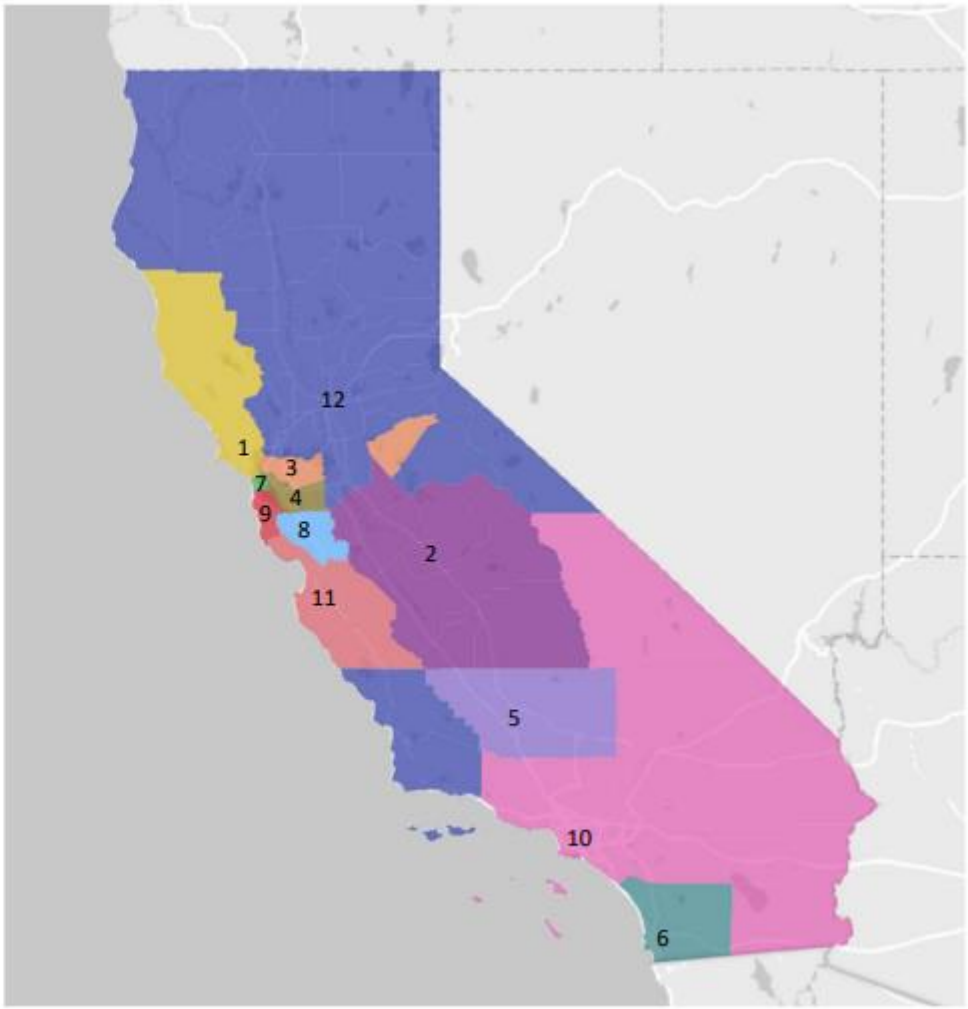
Some of What We're Learning: Digital Tools



What We're Learning: Responding to Crisis (1)

Current California Crisis Centers

1	Buckelew Suicide Prevention Program
2	Central Valley Suicide Prevention Hotline – Kings View
3	Contra Costa Crisis Center
4	Crisis Support Services of Alameda County
5	Kern Behavioral Health & Recovery Services Hotline
6	Optum
7	San Francisco Suicide Prevention Felton Institute
8	Santa Clara County Suicide and Crisis Services
9	StarVista
10	Suicide Prevention Center - Didi Hirsch Mental Health Services
11	Suicide Prevention Service of the Central Coast
12	WellSpace Health



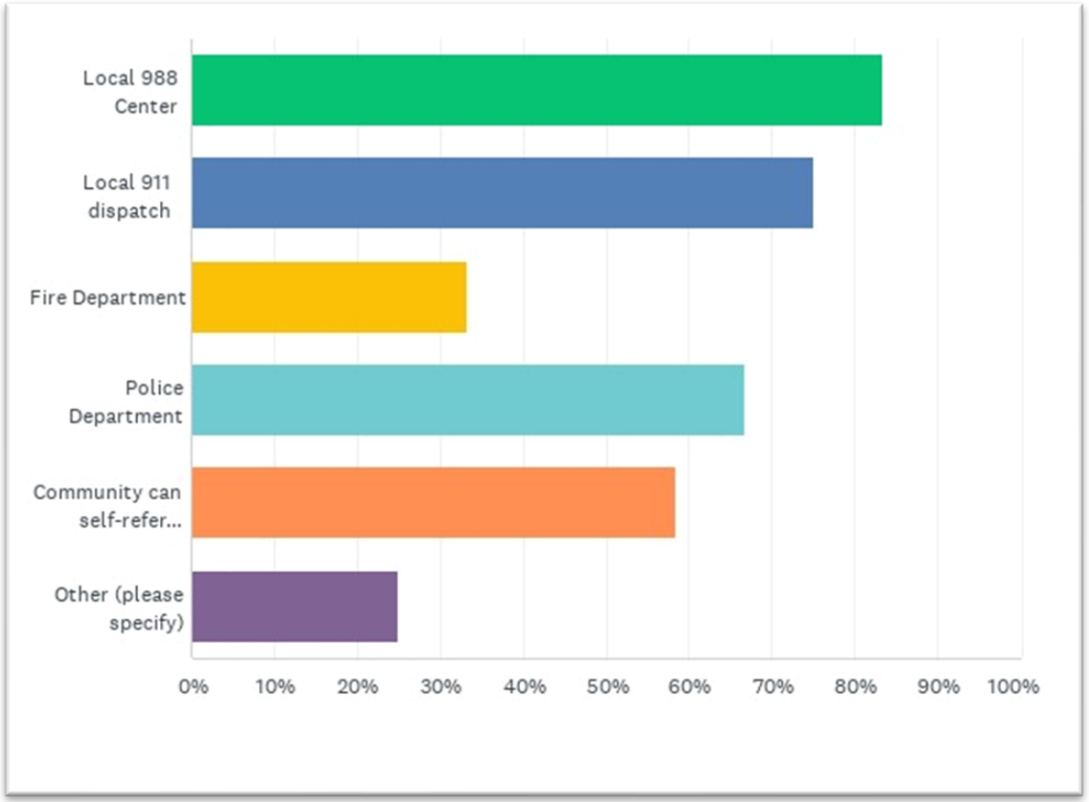
What We're Learning: Responding to Crisis (2)

California Crisis Centers

Mobile Crisis and California 988 Crisis Centers….

- 2 of the 11 centers are able to directly dispatch mobile crisis teams
- 11 of the 12 centers do warm handoffs
- Assessment and triage protocols vary across centers
- 8 of the 12 centers say they have an established training for how and when to engage mobile crisis
- 4 of the 12 centers say they have youth specific mobile crisis teams in the area, with one of the 4 having its own criteria for dispatch
- 7 of the 12 centers say they have ongoing relationships with MCTS (beyond MOUs); 4 did not and one was unsure

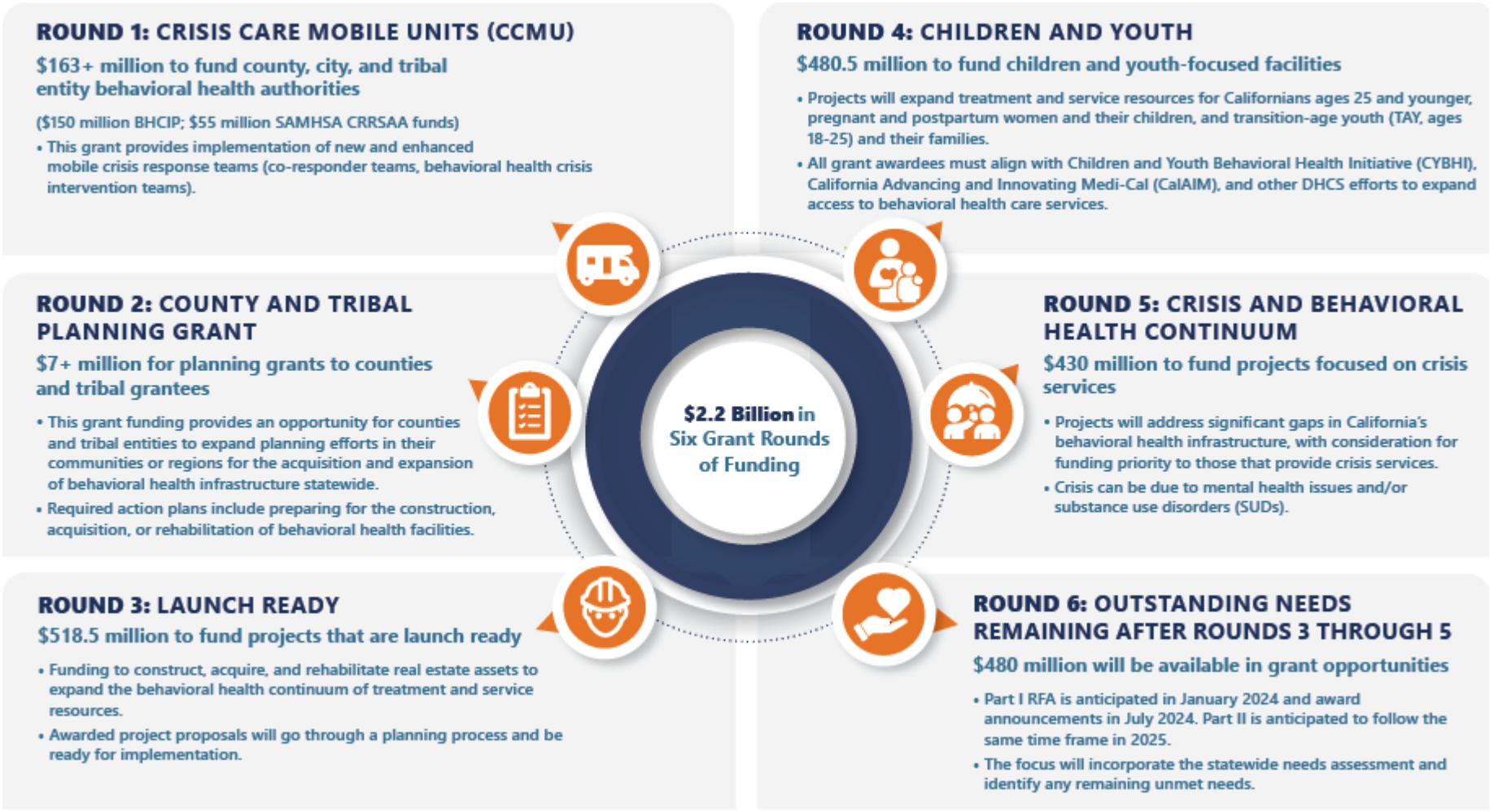
Ways that MCT can be accessed by community members



Didi Hirsch, "Mobile Crisis Survey Results: Mobile Crisis Workshop," October 9, 2023

What We're Learning: State Investments in Mobile Crisis

Intent: Crisis Centers and CCMU services integration to establish crisis continuum of care



Behavioral Health Continuum Infrastructure Program (BHCIP) Overview, DHCS, June 2023

What We're Learning: Workforce Challenges

Composition of California's Safety Net Mental Health Workforce, 2020

Occupation(s)	Number	Percentage
Other Qualified Providers	8,441	30%
LMFTs and AMFTs	6,810	24%
LCSWs and ASWs	4,763	17%
Mental Health Rehabilitation Specialists	2,744	10%
Psychiatrists and other Physicians	1,651	6%
Peer Providers	1,170	4%
Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs)	903	3%
Psychologists	727	3%
Advanced Practice RNs and Physician Assistants	489	2%
Licensed Professional Clinical Counselors (LPCCs) and Associate Professional Clinical Counselors (APCCs)	444	2%
Psychiatric Technicians	218	1%
Occupational Therapists	58	0.2%
Pharmacists	22	0.1%
Total	28,440	

Source: Mental Health Plan NACT reports, 2020.

Excerpted from: UCSF, Healthforce Center, "Building the Future Behavioral Health Workforce: Needs Assessment," February 2023

What We're Learning: Medi-Cal SMHS Utilization (1)

2022-2023	Adult Crisis Residential Services (CRS)	Adult Residential Treatment Services	Crisis Intervention	Crisis Stabilization	Day Rehabilitation (Half-Day & Full-Day)	Day Treatment Intensive (Half-Day & Full-Day)	Intensive Care Coordination	Intensive Home Based Services
Number of clients	7756	1,341	48,091	50,977	71	128		
Number of days/Hours	15.78	153,645	11,250,504	1,341,428 (Number of Hours)	13,060	12,748		
Days per client	179,655	114.57	234	26.31	183.94	99.59		

What We're Learning: Medi-Cal SMHS Utilization (2)

2022-2023	Medication Support Services	Community-Based Mobile Crisis Intervention Services	Peer Support Services	Psychiatric Health Facility (PHF) Services	Psychiatric Inpatient Hospital Services	Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC	Targeted Case Management	Therapeutic Behavioral Services	Therapeutic Foster Care	Mental Health Services
Number of clients	232,908*			4,592	6,959		137,015	241,134		
Number of days/Hours	74,383,165*			72,451	86,422		64,026,824	207,522,538		
Days per client	74,383,165*			15.78	12.42		467	861		
				SD/MC - SMA (Also # for FFS/MC)				Therapy and Other Services Activities		

What We're Learning: A Place to Go - Moderate Acuity

	Skilled Nursing	Crisis Residential Treatment Program	Mental Health Rehab
Total Number of Facilities	1191 Skilled Nursing Facilities		66 Licensed mental health rehab centers and psychiatric health facilities
County/County Coverage	57 of 58 counties		31 of 58 Counties
Capacity	116,057 (listed capacity)		
Other Notes			

What We're Learning: A Place to Go - Acute Inpatient

	Psychiatric Health Facility	Other Acute Inpatient
Total Number of Facilities	119 acute psych hospitals	5 state hospitals
County/County Coverage	27 of 58 counties	San Luis Obispo (Atascadero = 1,184) Fresno (Coalinga = 1,286) Los Angeles(Metro = 826), Napa (1,255), San Bernardino (Patton =1527)
Capacity	8,566 Beds	6,078 beds

https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx

What We're Learning: A Place to Go - Community Residential

	Enriched Residential Treatment	Enhanced/ Augmented Board and Care	Enhanced Residential Rehab Centers	Other Community Residential
Total Number of Facilities				648 certified and approved residential mental health programs -326 Short Term Residential Therapeutic Programs -320 Social Rehab Programs -2 Community Treatment Facilities (CTF)
County/County Coverage				
Capacity				
Other Notes				