Behavioral Health Crisis Care Continuum Planning

STEPHANIE WELCH, DEPUTY SECRETARY OF BEHAVIORAL HEALTH
CALIFORNIA HEALTH & HUMAN SERVICES AGENCY

August 31, 2022
VIRTUAL MEETING PROTOCOLS

Thank you for joining us today for this informational Lunch & Learn!

- This meeting is being recorded and will be available for viewing post meeting
- American Sign Language interpretation is provided in pinned video
- Live captioning link is provided in chat

Please note: This is an informational session only and there will not be a Q&A. We will have a follow-up discussion on this topic at the September 13th BHTF meeting.
WELCOME & OVERVIEW
Behavioral Health Task Force – Lunch and Learn Goals

• Recap the overview of the current state of behavioral health investments in California – including crisis care services, and share about the CalHHS planning process to address the gaps the current crisis care continuum

• Share preliminary insights and themes from the initial understanding of the current state of crisis care services in California and potential approach to statewide baseline service model

• Review BHTF engagement on this topic / Share initial overview of the BHTF meeting on September 13th including the opportunity to share additional resources and information not currently included in synthesis
Overview: Current State of Behavioral Health Investments – Including Crisis Care in California
Systemic Change to Behavioral Health Care

The growing need for crisis services has signaled to California leadership that our behavioral health care system deserves much-needed investment and systemic change.

This Administration, similar to the leadership demonstrated in the Legislature, is deeply committed to transforming the Behavioral Health Care System.

Transforming the behavioral health system will ultimately create generational change so ALL Californians have access to high quality, culturally responsive and easily accessible behavioral health care.

Critical investment is needed to build new behavioral health capacity and reduce fragmentation in the behavioral health system - both for mental health and substance use disorders. Much of this is driven by decades of stigma, where behavioral health was not considered a core component of the health system.
Key Initiatives Underway

California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Efforts

California Advancing and Innovating Medi-Cal and Providing Access and Transforming Health (PATH)

Behavioral Health Continuum Infrastructure Program and Community Care Expansion Fund

Behavioral Health Bridge Housing

Children and Youth Behavioral Health Initiative

Community-Based Alternatives to State Hospitalization and Incarceration

Healthy CA Workforce for ALL – Care Economy Investments

Medi-Cal Community-Based Mobile Crisis Services

Extension of CalHOPE a crisis counseling assistance and training program

Opioid Response Efforts – MAT Expansion, Provider Training, Youth Fentanyl Prevention, etc.

Mental Health Parity Enforcement
CalHHS Role – Coordination and Connections

CalHHS is developing a plan to support connections between prevention efforts like hotlines and peer support services, 9-8-8 mental health crisis call centers, and mobile crisis response at the local level

• Building off of existing planning efforts, CalHHS is developing a blueprint with an implementation roadmap to be completed by the end of 2022

• Currently seeking stakeholder input from diverse perspectives on the behavioral health crisis system, including state agencies, local jurisdictions, providers, consumers, caregivers, and family members, with a particular focus on individuals from underserved communities, communities of color, LGBTQ+, and youth

• Behavioral Health Taskforce (BHTF) will provide a forum for vetting and disseminating draft materials

Source: CalHHS, Discussion materials from Commission on Emergency Medical Services Quarterly Meeting June 15, 2022
CalHHS Role – Crisis Care Continuum Blueprint and Roadmap

Plan Components

• Identify the state-wide vision for full set of services for individuals experiencing crisis (interactions among 988, 911, Medi-Cal mobile crisis response, crisis receiving facilities, long term crisis residential services)

• Articulate state-wide minimum standards and metrics

• Define models / prototypes of how state-wide services could be implemented locally, recognizing different models will be needed in different counties/communities

• Provide a high-level view of resources required, or current investments that could be used, to support implementation of a robust crisis care response system

• Outline a governance model to support future implementation

• Identify approaches to reach major milestones (“the how to”), including what would be needed in terms of legislative authority, funding and approximate timing – a roadmap over several years of capacity building efforts

Source: CalHHS, Discussion materials from Commission on Emergency Medical Services Quarterly Meeting June 15, 2022
Components of crisis systems

**BH crisis systems are for anyone, anywhere and anytime and fall along a continuum:**

**Preventing Crisis**  
Community-based preventive interventions for individuals at risk for suicide or mental health / substance use crises (e.g., Zero Suicide, harm reduction programs, warmlines, peer support, recovery support services)

**Responding to Crisis**  
Acute crisis response services, including hotlines, 911 diversion, mobile crisis teams, social service response, and co-response models

**Crisis Stabilization**  
Community-based crisis stabilization services, including in-home crisis stabilization, crisis receiving facilities, peer respite, and crisis residential services

Source: Discussions with CalHHS team
Components of crisis systems – Non-exhaustive examples

Preventing Crisis

- **Warmlines**: Free call/text/chat services that offer early intervention and emotional support that can build resilience and prevent crises, often peer-run

- **Harm reduction programs**: Programs to mitigate the impacts of behavior associated with alcohol and other substance use (e.g., overdose prevention programs)

Crisis continuum care plan will build on in-flight stigma reduction and other programs focused on whole-person care contributing to primary prevention of crisis

Responding to Crisis

- **Hotlines**: Accessible crisis call center that is equipped to support people in crisis and connect individuals to needed care

- **911 / 988 coordination**: Connecting function for when someone contacts 911 due to a behavioral health crisis or other health or social service need

- **Mobile Crisis Team Services**: Community-based mobile units for people in crisis at home or a location in the community

- **Co-response models**: Integrated teams of law enforcement and behavioral health professionals respond to suicide, mental health or substance use emergencies

Stabilizing Crisis

- **Crisis Receiving & Stabilization Services**: Offer the community no-wrong-door rapid access to in person crisis care

- **Short-term crisis residential programs**: Provide in-person 24-hour crisis care with option for multi-day stays, including crisis respite services

- **In-home crisis stabilization**: Short-term, intensive in-home services to individuals who have been assessed to be at high-risk

- **Sobering centers**: Locations for individuals waiting for the effects of alcohol or drug intoxication to wear off while being monitored for underlying medical conditions or injury

Sources: SAMHSA Suicide prevention, SAMHSA Find help, SAMHSA national guidelines, SAMHSA executive order, NAMI website, Vibrant website, California Treasurer’s Office, MHSOAC Striving for Zero, Orange County Health Care Agency, CSG Justice Center
Preliminary insights:

1. Current state of crisis care services
2. Collation and comparison to national best practices
3. Potential approach to future state minimum standards
1: Preliminary takeaways of the current state of crisis care in California

- There have been many local and state-wide efforts related to crisis care; however, there is room for improved coordination between crisis prevention, response, stabilization\(^1\)

- Across CA counties, there are different approaches to crisis prevention, stabilization, and response with considerable geographic variation in the availability of services,\(^2\) particularly county-run warmlines\(^3\)

- Focusing on 988, California appears to meet readiness standards within the Lifeline Network-affiliated contact centers;\(^4\) however, there may be opportunities to ensure coordination and readiness across the broader network of call lines\(^5\)

1. Based on the DHCS Assessing the Continuum of Care for Behavioral Health Services in California, 988 Implementation Plan for California – 988 Planning Grants, SAMHSA’s Gains Center California SWOT Analysis, and participant reflections from the June 14 BHTF Meeting
2. Based on services offered by county as outlined in the DHCS Assessing the Continuum of Care for Behavioral Health Services in California and the 988 Implementation Plan for California – 988 Planning Grants
3. Only 6 county/local warmlines listed in the following National warmline directories: NAMI National Warmline Directory, Warmline.org; however, all 58 counties have crisis lines
4. Readiness metrics outlined in NASMHPD 988 Convening Playbook: States, Territories, and Tribes; insights on California from DHCS Assessing the Continuum of Care for Behavioral Health Services in California, 988 Implementation Plan for California – 988 Planning Grants, & reflections from the June 14 BHTF Meeting
1: Timeline of select milestones in California

- First suicide prevention center in the US opened in LA (1958)
- Mental Health Services Act (MHSA) passed in CA (1974)
- First suicide hotline in the US founded in San Francisco (1961)
- CA Legislature requires all counties to have mental health programs (1958)
- National Suicide Prevention Lifeline launched (January 2005)
- Affordable Care Act signed (March 2010)
- Mental Health Association of San Francisco Peer-Run Warm Line began (October 2010)
- The National Suicide Hotline Designation Act of 2020 signed into law (October 2020)
- Mental Health Services Act (MHSA) passed in CA (November 2004)
- Affordable Care Act signed (March 2010)
- Prevention and Early Intervention (PEI) Program launches (November 2011)
- Striving for Zero strategic plan adopted (November 2019)
- Striving for Zero strategic plan adopted (November 2019)
- California HOPE CCP-RSP kicked-off (November 2020)
- $20M to support 988 announced by DHCS (September 2021)
- FCC deadline for 988 to go live nationwide (July 2022)
- First suicide hotline in the US founded in San Francisco (1961)
- Mental Health Association of San Francisco Peer-Run Warm Line began (October 2010)
- Mental Health Services Act (MHSA) passed in CA (November 2004)
- Affordable Care Act signed (March 2010)
- Prevention and Early Intervention (PEI) Program launches (November 2011)
- Striving for Zero strategic plan adopted (November 2019)
- Striving for Zero strategic plan adopted (November 2019)
- California HOPE CCP-RSP kicked-off (November 2020)
- $20M to support 988 announced by DHCS (September 2021)
- FCC deadline for 988 to go live nationwide (July 2022)

Source: Suicide Prevention Lifeline, California State Treasurer, MHSOAC, SAMHSA, CalHOPE, DHCS, California Legislative Information, Cal OES, DHCS, CalHHS, FCC, healthcare.gov, DHCS, New York Times, National Library of Medicine, MHAOSF, LA County; RAND.org
# 1: Opportunities for improved transitions across levels of crisis care

<table>
<thead>
<tr>
<th>Preventing Crisis</th>
<th>Responding to Crisis</th>
<th>Stabilizing Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No unified database of statewide &amp; local resources for use by call lines¹</td>
<td>• Disconnects in policies for crisis hotlines and the PSAP system according to CA SWOT analysis³</td>
<td>• Lack of available stabilization services following an initial crisis according to DHCS⁴</td>
</tr>
<tr>
<td>• Opportunities to coordinate between 81+ county / local crisis &amp; warm lines¹²</td>
<td>– No current policy on interoperability between 911 and 988³</td>
<td>• CSUs serve people &gt; 23 hours due to capacity constraints in other services according to DHCS⁴</td>
</tr>
<tr>
<td></td>
<td>– Each PSAP has own process for suicide risk assessment³</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Gaps in referrals to care from hotlines according to 988 Planning Grants</td>
<td></td>
</tr>
</tbody>
</table>

¹. 988 Implementation Plan for California – 988 Planning Grants
². 81+ county / local crisis & warm lines based on crisis line directory from California (excluding call lines that are part of the NSPL network) and collating existing county / local warmlines based the following National warmline directories: NAMI National Warmline Directory, Warmline.org
³. SAMHSA’s Gains Center California SWOT Analysis for California
⁴. DHCS Assessing the Continuum of Care for Behavioral Health Services in California
1: Availability & sufficiency of crisis services by county

Notes about approach to estimation (from the DHCS 2022 report Assessing the Continuum of Care for Behavioral Health Services in California)

• Estimates of county-level demand for crisis care services are based on population average demand for in-person crisis episodes, which do not adjust for
  – Differences across sub-populations and geographies
  – Variation over time (including trends driven by the COVID-19 pandemic)

• Estimations for county-level supply of crisis services are based on a survey of county behavioral health directors and DHCS licensure data, as included in 2022 DHCS report

Sources: DHCS Assessing the Continuum of Care for Behavioral Health Services in California
1: Availability & sufficiency of crisis services by county

**Number of Mobile Crisis Teams by county**
Relative to projections from the Crisis Now Model

Number of Mobile Crisis Teams According to Crisis Now Calculator
- "Sufficient" mobile crisis teams available
- Not enough mobile crisis teams available
- No mobile crisis teams available

**Number of Crisis Stabilization Units by county**
Relative to projections from the Crisis Now Model

Number of CSU Slots According to Crisis Now Calculator
- "Sufficient" CSU slots available
- Not enough CSU slots available
- No CSU slots available

**Presence of Crisis Residential Treatment Programs by county**

Counts with Operational Crisis Residential Treatment Programs
- Yes
- Not yet, in planning
- No

37 of 44 counties with mobile crisis teams have "sufficient" intervention capacity
16 of 33 counties with Crisis stabilization units have "sufficient" crisis stabilization capacity
9 of 28 counties with CRTPs reported sufficient crisis residential treatment capacity

1. County-reported resource levels meet or exceed NASMHPD Crisis Resource Need Calculator recommended county level resource allocations (as reported by DHCS)
2. Counties that reported operating Crisis Residential Treatment Programs and did not report requiring additional residential treatment capacity

Sources: DHCS Assessing the Continuum of Care for Behavioral Health Services in California
## 1: Landscape of hotlines & warmlines available to Californians

### Scope

<table>
<thead>
<tr>
<th>Warmlines</th>
<th>Hotlines</th>
</tr>
</thead>
</table>
| **National** | • 8+ major national warmlines, including the TeenLine  
• Largely operated by non-profits with private funding  
• Volume ranges from 10k – 75k+ conversations annually by line | • 5+ major national hotlines, including the NSPL which operates via 13 Lifeline Centers in CA  
• Operated and funded by mix of non-profit, for-profit, and federal gov. entities  
• Volume ranges from 150k – 2.4M national crisis contacts / calls annually by line |
| **State-wide** | • 2+ state-wide warmlines, including  
• Operated by gov / non-profit entities; funded by federal (e.g., CCP), state, and private sources  
• Annual call volume ranges from 20k – 60k by line | • 3+ statewide hotlines, including the Friendship Line (which operates as both a crisis line and a warmline), the CA Youth Crisis Line, DSS Parent & Youth Helpline  
• Operated by a non-profit organizations and funded by State of CA as well as private donors  
• Annual call volume ranges from 15k – 300k by line |
| **County / local** | • 6+ county / local warmlines  
• Operated by county governments and non-profits; funded through public (e.g., MHSA) and private sources  
• Annual call volume can be up to 100k+ in certain counties | • 75+ county / local crisis lines  
• Most lines run by counties and other operate as non-profits; some lines re-direct calls to lifeline centers  
• Annual call volume can be up to 55k+ in certain counties |

### Sources:
1: Readiness for 988 within California’s Lifeline network

The 13 CA Lifeline Centers largely meet 988 readiness metrics outlined in the NASMHPD self-assessment\(^1\)

- CA Lifeline Centers have an in-state call answer rate\(^2\) of \(\sim 85\%-90\%\), with some variation across counties\(^3\)
- 12 of 13 Lifeline Centers operate 24/7/365; Yolo County to become 24/7/365 by July 2022 (launch of 988)\(^4\)
- 2 of 13 Lifeline Centers offer text/chat capabilities through Lifeline\(^5\)
  - Plan set for 80% chat/text in-state answer rate by 2023\(^5\)
  - 7 Lifeline Centers offer text or chat locally\(^5\)

Efforts underway within the CA Lifeline network to prepare for projected increases in call volume\(^6\)

- Assessment of network volume, coverage, and gaps planned for 6 months following launch of 988
- Applications submitted from 3 additional California contact centers to join the Lifeline network
- Process initiated to select a unified training platform
- \$20M from DHCS awarded for capacity & infrastructure, including \$8.5M in FY 22-23 for crisis line capacity
- \$\sim \$5M technology budget granted to CalOES
- \$14.4M SAMHSA grant application submitted

Beyond the Lifeline Centers, open questions remain for how 988 will integrate into the broader network of hotlines & warmlines available to Californians\(^2\)

---

1. NASMHPD 988 operational readiness self-assessment for states, territories, and tribes: performance against all criteria noted as “Criteria identified as priorities for July 2022” based on the State of California 988 Implementation Plan
2. The percentage of calls originating in California answered by a call center located in California
3. NASMHPD defines meeting self-assessment criteria as 90% in-state call answer rate
4. NASMHPD defines meeting self-assessment criteria as 24/7 primary coverage for Lifeline calls
5. NASMHPD defines meeting self-assessment criteria as 1+ Lifeline contact center currently has chat/text capabilities, capacity to handle at least 50 percent of chats/texts by July 2022 and 80 percent of chats/texts by July 2023, and state/territory-wide 24/7 primary coverage for chats/texts
6. Efforts listed in the section “Expand and Sustain Center Capacity to Maintain Target In-State/Territory Answer Rates for Current and Projected Call, Text, and Chat Volume” section in the State of California 988 Implementation Plan, or funding-related efforts listed in the “Overall Background and Context” section of the State of California 988 Implementation Plan

Source: 988 Implementation Plan for California, NASMHPD 988 operational readiness self-assessment for states, territories, and tribes
1: CalHOPE: High-level description and preliminary perspectives on opportunities

**Background on CalHOPE**

Started in response to the COVID-19 Pandemic, CalHOPE has evolved into a state-wide resource for crisis prevention more broadly; key services include CalHOPE warm line and CalHOPE Connect (chat).

**Operations**
- Run by the California Department of Health Care Services
  - 30 community-based organizations as partners
  - 400+ peer crisis counselors

**Funding**
- FEMA grants supporting CalHOPE ended May 2022
  - $80M in 2022-23 General Fund
  - $40M in 2023-24 General Fund
  - $45M for CalHOPE Student Support in 2021-22 budget

**Impact**
- 5,100 calls from Jan – May 2022
- 33,500 chats from Jan – May 2022

**Integration with other call lines in CA**

**Context**
- CalHOPE offers outreach, counseling, and support services to those at risk of experiencing a behavioral health crisis
- If acute crisis care is required, CalHOPE initiates a warm handoff to a hotline (e.g., 988)

**Opportunities**
- Establish clear standards governing hand-offs between CalHOPE & hotlines (e.g., 988) or 911

**Hotlines (e.g., 988)**
- There are other local warmlines serving a similar role as CalHOPE (i.e., pre-clinical crisis prevention)
  - Establish common standards for warmline operations
  - Improve communication among warmlines

**Warmlines**

Source: CalHHS Revised Budget Highlights, interviews on 7/19/22 and 7/21/22 with DHCS, CalHOPE, Legislative Analyst's Office
Approach for synthesizing national guidance documents from SAMHSA and national leaders

- **SAMHSA National Guidelines**\(^1\) outlined:
  - **Minimum expectations**: baseline requirements as listed in the SAMHSA National Guidelines (for select continuum components); includes performing all **essential functions** outlined by SAMHSA for each service
  - **Best practices**: actions accepted as "gold standard" in addition to meeting minimum expectations, including **cross-cutting enablers** for excellent crisis care from SAMHSA

- All other practices from other sources\(^2\) are classified in this document as **example recommendations from national guidance documents**

Approach for reviewing California’s crisis system against synthesized national standards

Based on **public sources and preliminary stakeholder feedback**, relative to national standards, crisis care in California can be defined as:

- **Beginning**: Work in this area has not yet started
- **Emerging**: Work in this area is underway but not yet complete
- **Solidified**: Objectives in this area are fully or almost fully met

This review is based on publicly available sources and CalHHS has not yet vetted the analysis with stakeholders

---

\(^1\) SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit

\(^2\) SAMHSA Harm Reduction, National Harm Reduction Coalition, NASMHPD 988 Convening Playbook, SAMHSA & NASMHPD 988 Implementation Guidance for States, Territories & Tribes, Vibrant, Council of State Governments Justice Center, Crisis Residential Association
2: Preliminary takeaways of California’s performance against national standards for crisis systems

Based on synthesis of 7 public national guidance documents, 4 external sources on crisis services in CA, and preliminary stakeholder interviews

- Existing national guidance documents primarily focus on responding to and stabilizing crises;\(^1\) CA may consider prioritizing preventing crises in the context of ongoing public health initiatives in the area

- When compared to national guidance documents for responding to and stabilizing crises, CA meets expectations for hotlines;\(^2\) however, there are inconsistencies for other crisis services operated at the county-level\(^3\)

---

1. Based on national guidance documents from SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, SAMHSA Harm Reduction, National Harm Reduction Coalition, SAMHSA & NASMHPD 988 Implementation Guidance for States, Territories & Tribes, Vibrant, Council of State Governments Justice Center, Crisis Residential Association

2. National Standards from SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit & additional national guidance documents from Vibrant & NASMHPD; current state analysis based on the 13 Lifeline Centers affiliated with NSPL based on the DHCS BH assessment, 988 Implementation Plan for California – 988 Planning Grants, NSPL offerings, and June 14 BHTF meeting reflections

3. National Standards from SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit & additional national guidance documents from Vibrant & NASMHPD; current state analysis based on the DHCS BH Assessment, as well as the 988 Implementation Plan for California – 988 Planning Grants and June 14 BHTF meeting reflections
## 2: Overview of national guidance documents in review

<table>
<thead>
<tr>
<th>Minimum expectations from SAMHSA</th>
<th>Preventing Crisis</th>
<th>Responding to Crisis</th>
<th>Stabilizing Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warmlines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harm reduction programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hotlines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>911 / 988 coordination</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mobile crisis team services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-response models</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Receiving &amp; Stabilization Services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Short-term crisis residential programs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>In home crisis stabilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sobering centers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Example recommendations from national guidance documents

- Preventing Crisis: ✓
- Responding to Crisis: ✓
- Stabilizing Crisis: ✓

---

1. Not included in analysis since there is not a clear, nationally recognized guidance document.

### 2: Overview of crisis care components in CA relative to national guidance

<table>
<thead>
<tr>
<th>Preventing Crisis</th>
<th>Responding to Crisis</th>
<th>Stabilizing Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warmlines</td>
<td>Hotlines(^1)</td>
<td>Crisis Receiving &amp; Stabilization Services(^3)</td>
</tr>
<tr>
<td>Harms reduction programs</td>
<td>911 / 988 coordination</td>
<td>Short-term crisis residential programs</td>
</tr>
<tr>
<td></td>
<td>Mobile crisis team services(^2)</td>
<td>In home crisis stabilization</td>
</tr>
<tr>
<td></td>
<td>Co-response models</td>
<td>Sobering centers(^4)</td>
</tr>
</tbody>
</table>

#### Availability
- Preventing Crisis: Not included in analysis\(^5\)
- Responding to Crisis: Not included in analysis\(^5\)
- Stabilizing Crisis: Not included in analysis\(^5\)

#### Standard of care
- Preventing Crisis: More information needed
- Responding to Crisis: More information needed
- Stabilizing Crisis: More information needed

#### Coordination
- Preventing Crisis: Beginning - Work in this area has not yet started
- Responding to Crisis: Solidified - Objectives in this area are fully or almost fully met
- Stabilizing Crisis: More information needed

#### Technology
- Preventing Crisis: N / A
- Responding to Crisis: N / A
- Stabilizing Crisis: N / A

---

1. Current state analysis based on the 13 Lifeline Centers affiliated with NSPL based on the DHCS BH assessment, 988 Implementation Plan for California – 988 Planning Grants, NSPL offerings, and June 14 BHTF meeting reflections
2. Current state analysis based on county resources as reported in the DHCS BH Assessment, as well as the 988 Implementation Plan for California – 988 Planning Grants and June 14 BHTF meeting reflections
3. Current state analysis based on county resources as reported in the DHCS BH Assessment
4. Current state analysis based on synthesis from the California Health Care Foundation, which states: “most California sobering centers share [these] key best practices that sustain and support their work”
5. Not included in analysis since there is not a clear, nationally recognized guidance document

---

**Sources:** SAMHSA Harm Reduction, National Harm Reduction Coalition, SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, NASMHPD 988 Convening Playbook, SAMHSA & NASMHPD 988 Implementation Guidance for States, Territories & Tribes, Vibrant, Council of State Governments Justice Center, Crisis Residential Association.
3: Potential approach to establishing future state minimum standards

The approach below is informed by national guidelines from SAMHSA and expert interviews.

**Future state minimum standards may address objectives of each component** (e.g., prevention, response, stabilization) regardless of specific service or setting being used to meet the standard.

### Preventing Crisis

- Access to peer-based warmlines
- Access to community-based behavioral health services, such as:
  - Community-based social services
  - School-based and school-linked services
  - Primary care clinics and FQHCs
  - Outpatient BH care (e.g., CCBHCs, urgent care clinics, transition clinics, bridge clinics)
  - Peer support
  - Harm reduction
- Exposure to digital apothecary (e.g., CYBHI digital platform, CalHOPE digital tool)

### Responding to Crisis

- Real-time coordination of crisis and outgoing services
- Linked, flexible services specific to crisis response
- Triage/screening & initial assessment, including explicit screening for suicidality
- Counseling throughout the encounter and intervene to de-escalate the crisis
- Family and individual psycho-education
- Exposure to peer support and family support
- Coordination with medical and behavioral health services
- Crisis planning and follow-up

### Stabilizing Crisis

- Evaluation of needs and strengths
- Continued monitoring of care
- Crisis service discharge planning
- Linkage to ongoing care

---

**Baseline standards for the crisis care continuum plan assume access to services in the broader behavioral health ecosystem addressing primary prevention of crisis and routine treatment of mental and substance use disorders**

---

1. Based on the "Essential Functions" described for individual crisis care continuum components included in the SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit.

**Sources:** [SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit](#)
Recap: BHTF engagement to date and upcoming

May Lunch & Learn
- Introduce the Crisis Care Continuum effort to the BH Task Force

Tuesday, June 14th
- Introduce the Crisis Care Continuum effort to the BH Task Force
- Hear from members on related efforts through “Lightning talks”
- Gather inputs on gaps and opportunities in crisis care through breakout sessions

Tuesday, September 13
- Review progress to date
- Gather feedback from BH Task Force members on potential gaps in initial understanding of current crisis care landscape and preliminary approach to future state minimum service levels

October and Beyond
- Engagement opportunities to focus on population- and service-specific needs and gather feedback on major elements of the Blueprint.

Sources: Discussions with CalHHS and CSUS
Next Behavioral Health Task Force Meeting

• September 13, 2022, 10am – 3pm
  10:00 am - 12:30 pm | Crisis Care Continuum Plan
  12:30 pm - 1:00 pm | Lunch Break
  1:00 pm - 3:00 pm | Children and Youth Behavioral Health Initiative

• Email BehavioralHealthTaskForce@chhs.ca.gov to sign up for the BHTF listserv and send any questions/comments
Thank you!

For resources and more information regarding our behavioral health initiatives:

- CalHHS Crisis Care Continuum – Plan webpage
- Behavioral Health Task Force webpage