CalHHS

Behavioral Health Crisis Care Continuum

PLAN

May 2023

CONTENTS

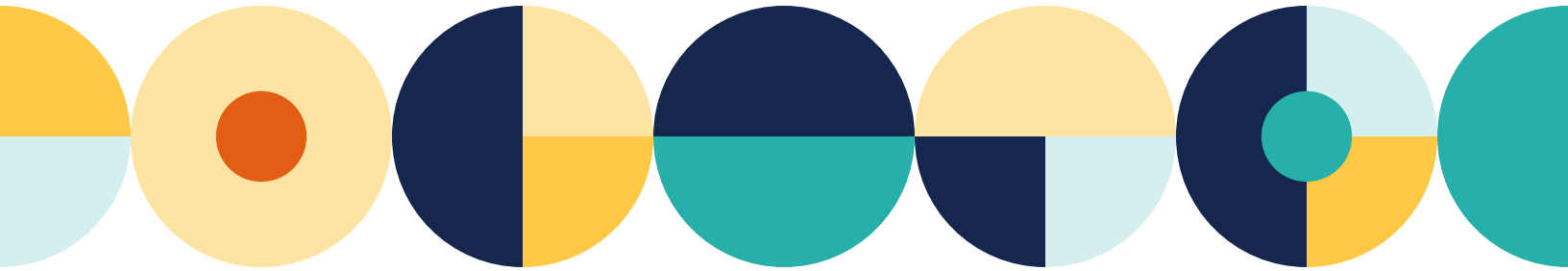
Executive summary

There is significant need for behavioral health crisis care services across the state of California. Recent national and state policy shifts have created opportunities to expand behavioral healthcare services to address gaps in the system, such as designating 988 as the national suicide prevention and crisis hotline.

However, substantial work needs to be done to develop and deliver a robust continuum of crisis care. The California Health and Human Services (CalHHS) agency's Crisis Care Continuum Plan ("Plan") articulates a vision for the future state of behavioral health crisis services in California. The Plan includes crises relating to suicide, mental health, or substance use challenges. The future-state vision described in this Plan is an aspirational but attainable view of what the state's behavioral health crisis care system could look like in the future, when all Californians at risk of – or experiencing – behavioral health crises can access quality care. The intent is to create a system that prevents behavioral health crises and escalation to the point at which higher levels of service are needed. The Plan incorporates inputs from a wide range of leaders across California, summarizes the current state of behavioral health crisis care, describes a statewide vision for the future, and outlines implementation considerations for the current system to serve Californians better.

Currently, California has a county-based behavioral health safety net that coordinates and delivers services to vulnerable Californians.[1] In developing this Plan, numerous challenges are recognized both for stakeholders desiring improved services and for service providers facing increasing demand to deliver the full continuum of crisis care to all Californians, including members of public and private insurance plans.[2] CalHHS aims to address these challenges over time to achieve the future-state crisis care system from prevention to follow-up support, as described in this Plan.

In recent years, several local and statewide efforts have been undertaken to strengthen the behavioral healthcare system, including CalHOPE,[3] a statewide resource for crisis prevention with web-based resources, the CalHOPE warmline, and CalHOPE Connect. The Behavioral Health Continuum Infrastructure Program[4]



1 Discussion with CBHDA

2 Discussions with California Department of Health and Human Services (CalHHS), Department of Health Care Services (DHCS), subject matter experts

3 DHCS, CalHOPE

4 CalHHS, Behavioral Health Continuum Infrastructure Program

(BHCIP) invests state and federal funding to help Californian communities develop new behavioral health facilities or invest in needed mobile crisis infrastructure. At the same time, the state has made a $4.7 billion investment to enhance, expand, and redesign the systems that support behavioral health for children and youth via California's Master Plan for Kids' Mental Health and its core component, the Child and Youth Behavioral Health Initiative(CYBHI).[5] In concert with these efforts to grow service capacity, the state has made investments to strengthen the behavioral health workforce[6] to help Californian communities develop new behavioral health facilities and build up the needed mobile crisis infrastructure. The California Department of Health Care Services (DHCS) has also expanded Medi-Cal coverage for select services provided by community health workers, peer support services, and mobile crisis response. Additionally, through the California Bridge program, the state is expanding the use of behavioral health navigators in emergency departments to connect individuals with substance use disorders to ongoing treatment.[7]

Given that these investments in human and service capacity will take time to materialize, CalHHS engaged with stakeholders and assessed the current landscape to identify near-term opportunities for improved coordination across the crisis continuum, including crisis prevention, response, and stabilization services for suicide, mental health, and substance-use-related crises. Governor Newsom's Behavioral Health Task Force and other stakeholders identified challenges such as workforce and facility capacity constraints, the need for local coordination across systems, different approaches to coverage of crisis care across insurance types, fragmentation across and outside the continuum, a lack of shared statewide data infrastructure, the absence of a common approach to data collection, as well as a lack of consistent standards for quality of care.[8]

To prevent behavioral health crises and deliver high-quality crisis care to Californians in need, CalHHS envisions **a future-state system that is driven by three strategic priorities:**

Build towards consistent access statewide

Across California counties, there are different approaches and resources dedicated to addressing crisis prevention, stabilization, and response, with considerable geographic variation in the availability of services (e.g., county-run warmlines, crisis receiving facilities) and varying approaches to coverage of crisis care across public and private insurance.

Enhance coordination across and outside the continuum

A clear definition of roles and responsibilities is needed so that there is an accountable public entity that can bring the various stakeholders together to establish common goals, protocols, and agreements for effective communication and coordination of services along the continuum of care.

5 California Child and Youth Behavioral Health Initiative, Progress Report, 2023
6 California Department of Healthcare Access and Information (HCAI)
7 DHCS, Assessing the Continuum of Care for Behavioral Health Services in California, 2022
8 See Appendix C for synthesis of stakeholder comments

Design and deliver a high-quality and equitable system for ALL Californians

CalHHS asserts that an understanding of current needs, disparities, and experiences is needed for consistent quality standards and target outcomes with a population-based approach that is inclusive and culturally relevant.[9]

Counties play a critical role as the public behavioral health safety net in the delivery and financing of behavioral health crisis services in California that goes back decades. CalHHS has identified four prototypes for county-level crisis care systems to help guide communities across a range of geographies and populations as they undertake community-level strategic planning. These prototypes (i.e., a full continuum of care, a partial continuum with a focus on rapid crisis response, a partial continuum with a focus on crisis stabilization, and community-defined models) describe examples of local innovation that address behavioral health crises through approaches tailored to community needs and resources.

As CalHHS looks to scale the state's behavioral health crisis system, the Plan examines potential governance structures, provides a broad overview of current and future funding sources, and outlines a high-level overview of California's planning needs over the next few years. In alignment with Governor Newsom's September 2022 signature of the Miles Hall Lifeline Act (AB 988) to expand behavioral health crisis services in California, the Plan provides a foundation for the further detailed implementation planning required by the law.

Additionally, based on preliminary estimates using publicly available data and assumptions, the future-state crisis system may cost approximately $2.5 billion per year at maturity (of which approximately $2.2 billion comprises services potentially reimbursable by third-party payors, e.g., Medi-Cal and commercial insurance) (Exhibit 8).[10] This estimate includes costs for services across the full continuum, including warmlines, hotlines, mobile crisis teams, crisis receiving facilities, sobering centers, and crisis stabilization services. Investments in crisis prevention and effective community-based services are particularly important to control future costs.[11]

Historically, stakeholders report underinvestment in the payment and provision of behavioral health services, which has led to coverage and access challenges as well as capacity constraints for public behavioral health crisis services.[12] The challenges of an underresourced behavioral health system are interrelated and typically amplified in the experiences of historically underserved populations, including BIPOC, LGBTQ+ individuals, individuals with intellectual or developmental disabilities (IDD), older adults, justice-system-impacted youth, and others across all payers.[13] With a comprehensive behavioral health crisis care continuum, it may be easier to respond to individuals experiencing crises at home or in the community. By expanding the capacity and availability of a robust behavioral health crisis continuum, the state may reduce unnecessary mental health and substance-use-related emergency department visits, hospitalizations, and incarceration.[14]

9 Discussions with California Department of Health and Human Services (CalHHS), Department of Health Care Services (DHCS), subject matter experts

10 KFF Health Insurance Coverage of the Total Population 2021, Crisis resource need calculator – Ca, 2023-24, Governor's Budget, Vibrant, SAMHSA

11 Stephenson, A.H., States' Options and Choices in Financing 988 and Crisis Services Systems, Alexandria, VA: National Association of State Mental Health Program Directors, 2022

12 Discussions with CBHDA

13 Kennedy-Satcher Center for Mental Health Equity, Embedding Equity into 988, 2022

14 Crisis Resource Need Calculator

Recent state and federal investments in the crisis care continuum are notable and substantial, and many of these funding sources were one-time or time-limited investments. Several sustainable sources of funding are identified in the Plan (e.g., expanded Medi-Cal coverage for mobile crisis, the 988 State Mental Health and Crisis Services Special Fund, and federal block grant dollars), and according to this analysis, they are not projected to meet the estimated annual need or the needs of the future state crisis system. While AB 988 includes provisions requiring coverage of medically necessary crisis services by third-party payors, the path to widespread insurance reimbursement is not yet clear. This underscores the importance of upstream interventions and preventing crisis to improve outcomes and potential cost avoidance.

To prevent crises and deliver high-quality care to all Californians in a manner that is inclusive and equitable, CalHHS has developed behavioral health work plans that identify implementation considerations across near, medium, and long-term horizons for each of the three aforementioned strategic priorities:

- **Build towards consistent access statewide**

  Assess the current state of care and outline steps to increase capacity, affordability, and range of services to meet diverse needs and increase community awareness.

- **Enhance coordination across and outside the continuum**

  Engage partners at the state and county levels to develop protocols, core quality and training standards, and technology infrastructure, and establish robust formal and informal coordination of care (e.g., across counties, behavioral health service providers, 911/988, hospitals, first responders, public health, public safety, schools).

- **Design a high-quality and equitable system for ALL Californians**

  Develop a comprehensive strategy for data measurement and quality of care that is inclusive of all populations and geographies.

This Plan is intended to start a discussion and elicit feedback on desired outcomes, potential approaches, implementation considerations, and strategies to engage communities across the state. In sharing with the public and consultation with leaders at all levels and as required by AB 988, over the next year or so, CalHHS will create a refined, detailed implementation plan to improve access, coordination, quality, and equity in statewide behavioral health crisis prevention and response.

1

INTRODUCTION

In 2022, 4,164 individuals in California died by suicide.[15] In 2020, one-fifth of all ED visits and one-third of all inpatient hospitalizations in California had a behavioral health diagnosis.[16] Approximately 6% of the ED visits and 3% of inpatient hospitalizations were associated with intentional self-harm, suicidal ideation, and suicide attempts.[17] Between 2019 and 2020, there was a 20% increase in suicide rates among youth aged 10 to 18 in California, notably among Black, Hispanic, and female youth.[18] Nationwide, for example, six in ten female high school students experienced persistent feelings of sadness or hopelessness in 2021 – a 60% rise in the last decade.[19] In the same year, California's rate of ED visits from drug-related overdoses increased to 147 per 100,000 residents, which is the highest it has been since 2015.[20] Recent analyses shared by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicate that the total cost of care for individuals with behavioral health conditions who use emergency departments and inpatient services is roughly two times higher than those who do not.[21]

15 California Violent Death Reporting System, Preliminary Monthly Statewide Violence-Related Death Counts, April, 25 2023.

16 California Department of Health Care Access and Information, Inpatient Hospitalizations and Emergency Department Visits for Patients with a Behavioral Health Diagnosis in California: Patient Demographics

17 Ibid.

18 California Department of Public Health Suicide Prevention Program, California Suicide and Self Harm Trends in 2020

19 Centers for Disease Control and Prevention, Youth Risk Behavior Survey Data Summary & Trends Report, 2011-2021

20 California Overdose Surveillance Dashboard, Any opioid-related overdose deaths, 2021

21 SAMHSA, National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit

Recent national and state policy shifts have led to significant opportunities to expand behavioral healthcare services and address gaps in the crisis care continuum, which have been historically underresourced.[22] In 2020, SAMHSA released national guidelines that highlighted three core components of crisis care: regional crisis call centers, mobile crisis response teams, as well as crisis receiving and stabilizing services.[23] In the same year, Congress passed the National Suicide Hotline Designation Act of 2020, designating 988 as the national suicide prevention and mental health crisis hotline.[24] The transition to 988, which became active in July 2022 across the US, represents an unprecedented opportunity to improve behavioral health crisis prevention, response, and stabilization across the nation. This easy-to-remember three-digit number is a catalyst for change and offers the potential to foster a strengthened infrastructure and promote policies and practices that will allow providers to respond to all behavioral health crises, including suicidality, mental health crises, and substance use disorder crises for all persons across developmental ages.[25] In September 2022, Governor Gavin Newsom signed the Miles Hall Lifeline Act (AB 988) into law to expand services for Californians experiencing a behavioral health crisis.[26]

The shift toward 988 and the related crisis service array has been adopted and expanded in California through both state and local efforts as part of a long-term commitment to transform behavioral healthcare. To date, much has been accomplished to improve access to behavioral health crisis care, even in the context of the COVID-19 pandemic.[27] In addition to federal funding for crisis services (see Section 5, Implementation considerations), California has made the following investments, among others:

- Dedicating $108 million to expand Medi-Cal benefits to include community-based mobile crisis intervention services[28]
- Releasing $205 million for counties and Tribal entities to expand mobile crisis response infrastructure[29]
- Expanding Friendship Line services to increase access to emotional and crisis support for older Californians[30]

22 California Health Care Foundation, A complex case: public mental health delivery and financing in California, July 2013

23 USC-Brookings Schaeffer on Health Policy, Building a sustainable behavioral health crisis continuum, January 6, 2022

24 S. 2661 (116th): National Suicide Hotline Designation Act of 2020

25 Subject matter experts, including former state mental health department leaders (including from California and other states), directors for higher education behavioral health programs, and former leaders of the National Association of State Mental Health Program Directors

26 California Legislative Information, AB 988 Mental Health: 988 Suicide and Crisis Lifeline, 2022

27 Subject matter experts, including former state mental health department leaders (including from California and other states), directors for higher education behavioral health programs, and former leaders of the National Association of State Mental Health Program Directors

28 National Health Law Program, California will expand coverage of Medicaid community-based mobile crisis intervention services, February 3, 2022

29 Crisis Care Mobile Units (CCMU) - Improving California's Infrastructure

30 Office of Governor Gavin Newsom, Governor Newsom announces initiatives to support older Californians during COVID-19 pandemic, April 24, 2020

- Passing the Community Response Initiative to Strengthen Emergency Systems (C.R.I.S.E.S.) Act in 2021 to fund and promote community-based crisis response (see Appendix A)[31]
- Granting $30 million over three years to CalHOPE to provide education, prevention messaging, and connection to resources, including the warmline and CalHOPE support crisis counseling.[32]

Even with these steps, stakeholder and department discussions, and observed practices, there is more work to be done to imagine, plan, and deliver a robust continuum of behavioral health crisis care – starting with crisis prevention – for Californians over the years to come.

With that in mind, the California Health and Human Services (CalHHS) agency developed this Crisis Care Continuum Plan ("Plan") to articulate a vision for the future state of behavioral health crisis care in California. The Plan is grounded in the CalHHS Strategic Priorities.[33] The Plan incorporates inputs from leaders across California, including from state agencies and communities; perspectives from national

Exhibit 1: CalHHS strategic priorities

Create an equitable pandemic recovery

Build a healthy California for all

Integrate health and human services

Improve the lives of the most vulnerable

Advance the well-being of children & youth

Build an Age-Friendly state for all

Source: CalHHS

31 California Legislative Information, Assembly Bill No. 118, 2021
32 California Assembly Budget Subcommittee No. 1 on Health and Human Services, 2021
33 CalHHS, Guiding Principles and Strategic Priorities

organizations, including the Substance Abuse and Mental Health Services Administration (SAMHSA), National Association of State Mental Health Program Directors (NASHMPD), and Centers for Medicare and Medicaid Services (CMS); and approaches taken in other states to develop their crisis care ecosystems.[34]

It provides a high-level summary of the current state of behavioral health crisis care in California, describes the statewide vision for the future, and outlines implementation considerations that will enable the system to better serve the needs of all Californians. This synthesis of the current state is based on publicly available information and data[35] as well as on discussions with state and external stakeholders. It is supposed to provide considerations for communities and is not intended to be a comprehensive assessment of the state of behavioral health services across California.

The future-state vision described in this Plan is an aspirational view of what the state's behavioral health crisis care system could look like in the future, when all Californians at risk of – or experiencing – behavioral health crises can access quality care. The intent is to create a system that builds resiliency and prevents behavioral health crises from escalating to the point at which higher levels of service are needed.

There are numerous challenges today both for stakeholders desiring improved services and for service providers facing increasing demand to deliver the full continuum of crisis care.[36] CalHHS aims to address these challenges over time to fully achieve the future-state crisis care system from prevention to follow-up support, as described in this Plan.

Current challenges with crisis care include:

- **Workforce and facility capacity constraints:** Challenges related to workforce capacity exist across the crisis care continuum and may differ by service and staffing needs. For example, many current mobile crisis response programs do not have dedicated psychiatric support or operate on a 24/7 basis, and counties report difficulties meeting recommended staffing levels at crisis receiving and stabilization facilities, including psychiatric coverage, nurses, therapists, and peers. While the number of psychologists in California is above the national ratio (44.2 per 100,000 residents), the number of psychiatrists in the state is below the national ratio (11.8 per 100,000 residents), with significant regional disparities[37] and shortages projected across the behavioral health workforce by 2028 based on demand forecasts, service utilization, and expected workforce supply.[38]
    - In 2021, 86% of California's county behavioral health agencies reported difficulty recruiting personnel to staff specific programs, including crisis

34 Based on state examples collected by Vibrant and NASMHPD and interviews with subject matter experts, including former state mental health department leaders (including from California and other states), directors for higher education behavioral health programs, and former leaders of the National Association of State Mental Health Program Directors

35 DHCS, Assessing the Continuum of Care for Behavioral Health Services in California, 2022; CalHHS, Governor's Budget Highlights, 2022-23
NOTE: CalHHS recognizes that publicly available datasets may be limited and may not include information on all services, populations, or subpopulations of interest.

36 Discussions with CalHHS, DHCS, subject matter experts

37 CHCF, California Health Care Almanac. Mental Health in California: Waiting for Care, July 2022

38 Healthforce Center at UCSF, California's Current and Future Behavioral Health Workforce, February 2018

care programs, and 63% had trouble recruiting certified SUD counselors. Behavioral health workforce challenges are especially pronounced in the Inland Empire and the San Joaquin Valley, which report the lowest ratios of licensed professionals per capita.[39] Within workforce considerations, it is important to note that individuals with lived experience in peer roles are a critical complement to the licensed clinical workforce. In 2021, less than half of the peer workforce felt their pay was consistent with others who do not have lived experience.[40] DHCS has expanded Medi-Cal coverage for select services provided by community health workers[41] and peer support services[42] under Medi-Cal in part which can help address workforce constraints. In addition to challenges with hiring and retention, stakeholders report constraints related to training. For example, some providers may lack training to provide culturally competent care and may have gaps in knowledge of available services.[43]

    - Facility constraints also span across the crisis care continuum. For example, the DHCS "Assessing the Continuum of Care for Behavioral Health Services in California" report noted that, out of 33 counties with crisis stabilization units (CSUs) available, only 16 (48%) have sufficient CSU capacity.[44] In some cases, DHCS reports that CSUs serve people for more than 23 hours due to difficulty in finding appropriate discharge options in the community.[45]

- **Different approaches to coverage across insurance types:** While Medi-Cal provides coverage across the behavioral health crisis care continuum with some gaps in funding for larger facilities that deliver crisis, inpatient, and residential care, coverage and network adequacy for individuals with private insurance varies widely.[46] Individuals with private insurance are more likely to rate their mental health provider network as inadequate compared to their medical provider network, and those with more severe conditions may be more likely to seek care via publicly funded community-based county behavioral health services.[47] Furthermore, for a service to be covered, it must be determined medically necessary by the health plan, and certain services, especially those delivered via paraprofessionals or peers as well as nonclinical services that support crisis prevention, are not typically covered.[48] These challenges are also a focus of the Governor's proposal to modernize California's behavioral health system and provide more housing.[49]

- **Fragmentation across the continuum:** In many California counties, crisis care is siloed with varying levels of integration between services, making care difficult to navigate for community members' providers.[50] For example, in California, the

39 California Behavioral Health Directors Association, Building the Future Behavioral Health Workforce: Needs Assessment February 2023

40 California Behavioral Health Workforce Assessment, 2021

41 DHCS, DHCS Proposal to add Community Health Workers

42 DHCS, Medi-Cal Peer Support Services

43 Behavioral Health Task Force stakeholder reflections, June 14, 2022

44 DHCS, Assessing the Continuum of Care for Behavioral Health Services in California, 2022

45 Ibid.

46 Ibid.

47 Ibid.

48 Department of Managed Health Care, Preliminary Input on the Crisis Continuum for Behavioral Health, shared with CalHHS on October 25, 2022

49 Office of Governor Gavin Newsom, Governor Newsom Proposes Modernization of California's Behavioral Health System and More Mental Health Housing, March 19, 2023

50 DHCS, Assessing the Continuum of Care for Behavioral Health Services in California, 2022

988 Suicide and Crisis Lifeline is answered by 12 independent crisis centers who participate in a national network of more than 200 call centers that juggle several hotlines.[51] However, all 58 counties have behavioral health county access lines which connect beneficiaries with services and in many cases operate as warmlines or hotlines as well. There are also gaps in care transitions across the continuum, for example in referrals to care by hotlines,[52] transitions to stabilization services following an initial crisis,[53] and connections to services following a crisis. There is a need for increased coordination within the behavioral health crisis continuum and with core partners such as law enforcement, emergency medical services, hospitals, community-based partners, schools, and other relevant entities.

- **Lack of shared statewide data infrastructure and approach:** There is a need for data sharing across behavioral health crisis care touchpoints as well as between behavioral and physical healthcare systems. For example, there are currently inconsistent data collection, sharing, and communication processes between different entities involved in crisis care (e.g., crisis care providers, hospital emergency departments, health plans).[54] As a result, there can be challenges in care coordination and in identifying local resources, including for diverse populations to facilitate consistent and equitable community linkages for any Californian needing support.[55] While the state is making strides in defining and implementing state standards for collecting, storing, and sharing health and human services data through the CalHHS Data Exchange Framework, federal requirements for Interoperability, and DHCS requirements as part of its Population Health Management program, there is opportunity to expand this approach more broadly, including for crisis services. As the state strives to make the process of getting behavioral health support as accessible as possible for all Californians, there is also a need to make it easier for them to find and navigate resources.
- **Lack of consistent standards for quality of care:** There is a lack of standardization in care services and experience across the crisis care continuum in the state.[56] Although the guidelines promulgated by the National Suicide Prevention Lifeline have fostered some uniformity,[57] not all 988 crisis centers are set up in a standard way across the state. Access to services and care at emergency rooms can vary widely, including how individuals present to an emergency department (e.g., experience with first responders) and the availability of clinicians trained in behavioral health crisis management.[58] Furthermore, there are no consistent standards for interoperability between crisis hotlines, community-based crisis services, and the public safety answering point (PSAP) system (i.e., 911).[59] Mapping and coming to agreement about what callers can expect when they dial 988 is a crucial component of the build-out of 988 services throughout the state. For mobile crisis, the state can also build on standards laid out within the new Medi-Cal mobile crisis response benefit.[60]

51 NAMI National Warmline Directory, Warmline.org
52 988 Implementation Plan for California – 988 Planning Grants
53 DHCS, Assessing the Continuum of Care for Behavioral Health Services in California, 2022
54 988 Implementation Plan for California – 988 Planning Grants
55 Ibid.
56 Discussions with CalHHS, DHCS, CBHDA, and CalOES
57 National Suicide Prevention Lifeline, Minimum Requirements
58 Discussions with CalHHS, DHCS, CHA
59 Discussions with CalHHS, DHCS, and CalOES
60 DHCS, Medi-Cal Mobile Crisis Services Benefit Implementation, 2022

Stakeholders report they are not always made aware when an individual is in crisis and lack access to information on comorbidities.[61] PSAPs may not have a singular process for suicide risk or other clinical assessments; therefore, a strategy for sharing data across PSAPs and 988 crisis centers might foster better coordination.[62] Lack of standardization extends to the ability to transfer between modalities such as calls, chats, and texts, as well as connections between services (e.g., follow-up care, mobile crisis teams, crisis/emergency receiving facilities). Additional coordination and cross-training between PSAPs and 988 crisis centers may help avert some negative outcomes.[63] Currently, there are some encounters with individuals with mental illness that are met with a law enforcement response by default; enhanced 911/988 coordination may support a stronger public health response for situations where a community-based response might be more appropriate.[64]

For underserved populations, challenges with quality and consistency of crisis services are interrelated and often amplified. BIPOC, LGBTQ+, veterans, Tribes, individuals with intellectual and/or developmental disabilities (IDD), older adults, justice-system-impacted youth, and others may be at elevated risk for behavioral health crisis, experience discrimination and prejudice, and have unique cultural and/or linguistic needs.[65] For example,

The Voices of Lived Experience

CalHHS conducted listening sessions with the Behavioral Health Task Force members and individuals with lived experience in October 2022 to better understand challenges and opportunities in the current system. Throughout this Plan, the voices of people with lived and living experience with behavioral health crises will highlight the challenges across the continuum and the need for essential behavioral health crisis care services. The example below sheds some light on the consequences of capacity constraints, fragmentation and lack of consistent standards on the experience of system-impacted youth:

A former probation department employee described cases in which children were jailed because of minor offenses such as vandalism that they committed while in crisis. The juvenile hall did not have the mental health resources to serve these youth experiencing crises and would often have to call mobile crisis teams for support. However, the mobile crisis team lacked capacity to serve everyone in need in the county so children would wait in a jail cell in crisis until the crisis team arrived.

Source: Behavioral Health Task Force listening session, October 2022

61 BHTF stakeholder reflections, June 14, 2022

62 SAMHSA's GAINS Center California SWOT Analysis for California

63 Technical Assistance Collaborative, Implementation of the 988 Hotline: A Framework for State and Local Systems Planning, October 2021

64 SAMHSA, Executive Order Safe Policing for Safe Communities: Addressing Mental Health, Homelessness, and Addiction Report

65 Kennedy-Satcher Center for Mental Health Equity, Embedding Equity into 988, 2022

rates of suicide among Black youth have risen dramatically in the last decade and, in 2020, the rate of suicide among Black youth in California was nearly double the rate of other children[66]. In addition, patterns of suicidal behavior may differ across populations. For example, some Black male youth may be more likely than other youth to attempt suicide impulsively, without prior ideation.[67] Given the diverse ways in which youth and other populations experience elevated risk, a high-quality crisis care system may look to develop culturally responsive efforts to prevent crisis (e.g., Gathering of Native Americans, Family Acceptance Project) or services designed to meet the needs of specific populations (e.g., Press 1 option on 988 for Spanish language, Veterans Crisis Line and Press 2 option on 988, Trevor Lifeline and new Press 3 option on 988).[68,69]

The experiences and challenges described here vary widely by community and population. For the crisis care continuum to be more comprehensive, it will need to strive for both standardization of quality, access, and expectations while allowing variation in approach driven by population health needs rather than funding or coverage gaps.[70] This Plan, which provides a vision for the state's future crisis care system, is intended to provide all Californian communities with guidance as they build out their service array. These services should be inclusive of populations that may be particularly impacted by challenges with crisis care delivery, including BIPOC, LGBTQ+, Tribes, individuals with intellectual and/or IDD, veterans, and others, as California works toward designing and delivering a high-quality and equitable behavioral healthcare system for all Californians.

66 California Department of Public Health, Suicide in California – data trends in 2020, COVID impact, and prevention strategies, 2021

67 Suicide Rates Rise in a Generation of Black Youth, Scientific American, 2022

68 CDC, 2020

69 CDC, 2022

70 Discussions with DHCS

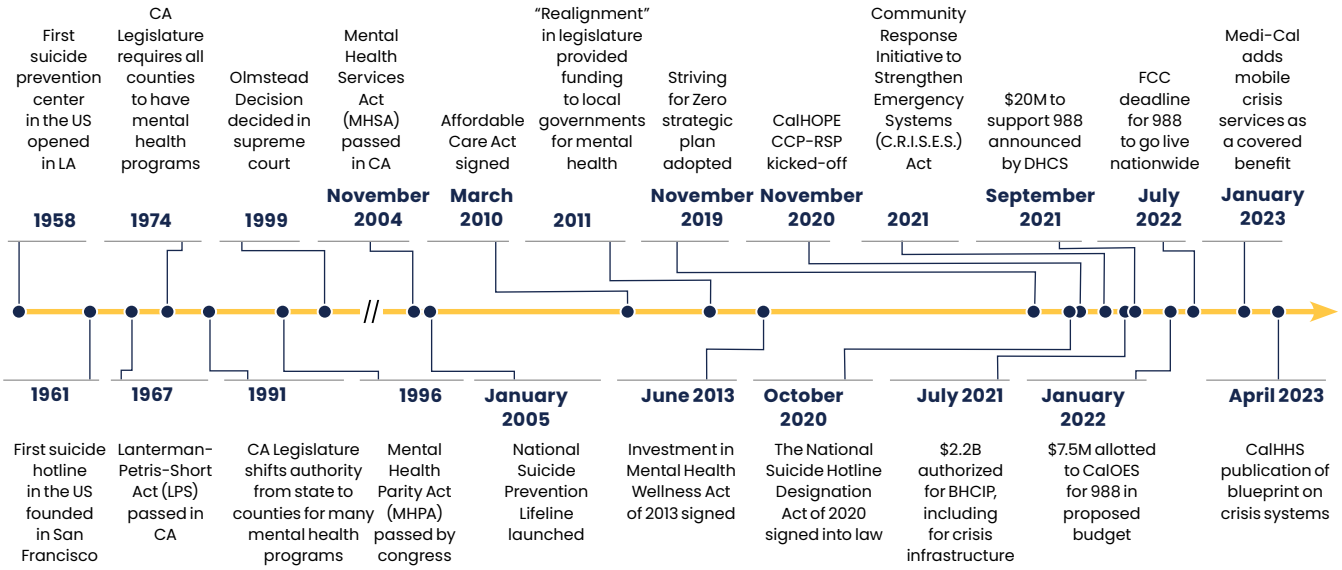
2

OVERVIEW OF CALIFORNIA'S CURRENT BEHAVIORAL HEALTH CRISIS CARE SYSTEM

California's behavioral health crisis response system has been evolving since 1958 when the nation's first suicide prevention center opened in Los Angeles County.[71] Over the last 70 years, there has been significant activity at the state and local levels.

71 Brief History of Suicide Prevention in the United States - 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action

Exhibit 2: Timeline of select milestones for California's behavioral health crisis care system



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, DHCS Fact Sheet – all sources accessed prior to April 12, 2023*

In response to the public health emergency, California further invested in crisis services, particularly crisis prevention. CalHOPE, originally funded through Federal Emergency Management Agency (FEMA) grants and developed and administered in partnership with county behavioral health agencies, has evolved into a statewide resource for crisis prevention with services such as web-based resources, the CalHOPE warmline, and CalHOPE Connect.[72] The state also partnered with the Institute on Aging to expand the Friendship Line, a warmline and hotline for older adults.[73] In 2023, California has twelve 988 crisis centers affiliated with the National Suicide Prevention Lifeline (NSPL) and more than 85 state and local hotlines and warmlines.[74]

California's 988 crisis call centers have an in-state call answer rate of approximately 85 to 90%,[75] operate 24/7/365, maintain and train a volunteer workforce, employ clinicians and trained staff to oversee operations, and adhere to NSPL standards,[76] which meets initial goals set by SAMHSA in its five-year vision for 988[77] and is consistent with National Guidelines for Behavioral Health Crisis Care.[78]

For crisis prevention related to substance use, there has also been state and local innovation with harm reduction programs:

- The Recovery Incentives program is a contingency management pilot program

72 DHCS discussions

73 Institute on Aging, California Department on Aging

74 California All: Resources for emotional support and well-being (retrieved January 2023; DHCS discussions

75 Vibrant, State-based Monthly Report for California, 2022

76 988 Implementation Plan for California – 988 Planning Grants; SAMHSA, National Guidelines for Behavioral Health Crisis Care, 2020

77 Horizon 1, Crisis centers: 90%+ of all 988 contacts answered in-state by 2023

78 988 Implementation Plan for California – 988 Planning Grants; SAMHSA, National Guidelines for Behavioral Health Crisis Care, 2020

for Medi-Cal members experiencing a stimulant use disorder. Eligible individuals can enroll in a structured 24-week recovery course where gift cards are used as motivational incentives to reduce the use of stimulants; participants can also receive six or more months of additional recovery support services.[79]

- To support overdose prevention efforts, as of June 2022, DHCS had approved low-barrier naloxone distribution projects. Since October 2018, the Naloxone Distribution Project has distributed more than 2.2 million units, resulting in more than 140,000 overdose reversals.[80]
- The San Diego Prescription Drug Abuse Task Force (PDATF) is a countywide public education initiative to decrease the harms associated with the misuse of prescription drugs in San Diego County. To combat opioid overdoses in San Diego, PDATF created an information resource on fentanyl testing, fentanyl drug tests, and other toolkits to help Californians become better informed regarding synthetic opioids.[81]
- Since 2019, FentCheck has distributed thousands of fentanyl test strips per week to over 50 retail and other commercial venues across the country, including in the San Francisco Bay Area and New York City. This harm reduction organization also makes NARCAN and NARCAN training available to staff at venues around the US to help prevent crises related to opioid overdose.[82]

Outside of crisis prevention, there are different approaches to behavioral health crisis care service delivery across communities, and there is geographic variation in the availability of services across the continuum. The state has been investing in building capacity to enhance the current system, particularly in resources to respond to and stabilize behavioral health crises including:

- **Behavioral Health Continuum Infrastructure Program (BHCIP):** Authorized in 2021, BHCIP provides $2.2 billion to award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources in settings that serve Medicaid beneficiaries. A substantial portion of the BHCIP funding will prepare the state for the implementation of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration waiver.[83] There were six rounds of requests for applications, which included a mobile crisis round as well as a crisis and behavioral health continuum infrastructure round.[84]
- **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH- CONNECT) Demonstration Waiver:** This waiver would complement and amplify the state's existing initiatives to build out the behavioral health continuum of care in the community. This builds on: The CARE Act, Behavioral Health Bridge Housing, Children and Youth Behavioral Health Initiative, Contingency Management as a Medi-Cal benefit, Peer Support Services, the CalAIM Justice-Involved initiative, Behavioral Health Payment Reform, No Wrong Door, Adult and Youth Screening and Transition Tools, Documentation Redesign, Behavioral Health

79 DHCS, Recovery Incentives Program: California's Contingency Management Benefit
80 Data – California MAT Expansion Project
81 San Diego County: PDATF
82 CNBC, America's deadliest drug: Could fentanyl test strips help save lives? May 10, 2022
83 DCHS, California Behavioral Health Community-Based Continuum Demonstration
84 DCHS and CDSS Behavioral Health Continuum Infrastructure Program

Administrative Integration, Administrative Integration, streamlined Specialty Mental Health Services access criteria, Psychiatric Residential Treatment Facilities, Behavioral Health Integration Incentives Program, Housing and Homelessness Incentive Program, Student Behavioral Health Incentive Program, Enhanced Care Management and Community Supports under CalAIM, and new behavioral health crisis services in Medi-Cal.[85] The BH-CONNECT will expand behavioral health services for Medi-Cal beneficiaries living with serious mental illness and serious emotional disturbance – with a focus on children and youth, people experiencing homelessness, and justice-involved individuals.[86] California has proposed $6.1 billion ($314 million General Fund, $175 million Mental Health Services Fund, $2.1 billion Medi-Cal County Behavioral Health Fund, and $3.5 billion federal funds) over five years to implement BH-CONNECT. [87]

- **California's Children and Youth Behavioral Health Initiative (CYBHI):** This initiative incorporates a $4.6 billion investment following a five-year timeline and intends to transform California's behavioral health system into an innovative ecosystem where all children and youth from birth to age 25 have access to services for emerging and existing behavioral health needs, regardless of their health payer. With the effort led by the California Health and Human Services Agency, in partnership with other state departments, there are significant efforts to advance the adoption of evidence-based models of care, strengthen the behavioral health workforce, and increase access to information and resources online and across systems such as schools and primary care.[88]
- **State Plan Amendment for Medi-Cal mobile crisis intervention services:** Through funding from the American Rescue Plan Act of 2021 (ARPA), the Department for Health Care Services (DHCS) submitted a State Plan Amendment to add qualifying community-based mobile crisis intervention services ("mobile crisis services") as a new Medi-Cal benefit, effective in January 2023.[89]

85 DHCS
86 CalAIM, California Behavioral Health Community-based Continuum Demonstration
87 CalHHS, Governor's Budget Highlights
88 CalHHS
89 DHCS, Mobile Crisis Services

3

FUTURE-STATE VISION FOR CALIFORNIA'S BEHAVIORAL HEALTH CRISIS CARE SYSTEM

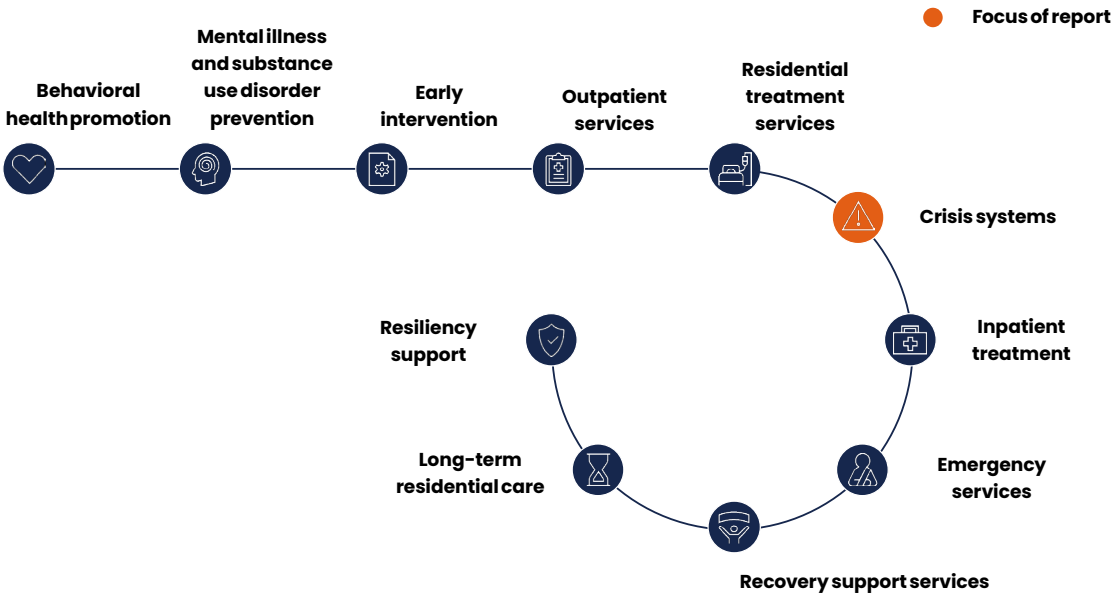
Just as 911 connects callers to "out-of-hospital" care that is linked to the healthcare system, 988 has the potential to become a bridge to "out-of-hospital" care linked to the behavioral health system. The behavioral health continuum of crisis care includes the spectrum of prevention, response, and stabilization services for suicide, mental health, and substance-use-related crises. To the extent people in crisis have access to "out-of-hospital" options in the community, reliance on more expensive and acute levels of care, such as emergency departments and inpatient psychiatric beds, is likely to decrease.[90]

90 DHCS, Assessing the Continuum of Care for Behavioral Health Services in California

In the 2017 NASMHPD paper "Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care", there was a call to attention for state and local government leaders to shift from focusing only on inpatient psychiatric beds as a single solution to address the behavioral health needs of the population.[91] The American Psychiatric Association recently published a similar report on psychiatric bed need,[92] recognizing interdependencies among the broader ecosystem of prevention services, crisis services, stabilization, and more intensive forms of treatment. Moreover, a RAND report commissioned by CALMHSA found that California faces a projected 1.7% growth in its psychiatric bed need from 2021 to 2026 and faces a shortage of approximately 3,000 community residential beds.[93] To the degree the continuum works well, communities and health systems could offset the need for acute or institutional care.

The overarching continuum of behavioral health services (including but not limited to crisis care) starts taking shape when behavioral health promotion, targeted prevention services, access to outpatient care, and interventions for existing behavioral health needs are available and well coordinated. This continuum is only complete when connected to more intensive services that can be accessed when medically necessary, and from which people will exit and return to the community where recovery and resiliency support will be critical. This idea of a "continuum of care" applies broadly to all levels of care but can be specifically examined from the lens of a complete crisis system.

Exhibit 3: The behavioral health continuum of care



Source: McKinsey Health Institute .Note: This framework represents the behavioral health system on a continuum of need (from health promotion/illness prevention to chronic illness treatment and support). This framework is not intended to represent an individual's care journey.

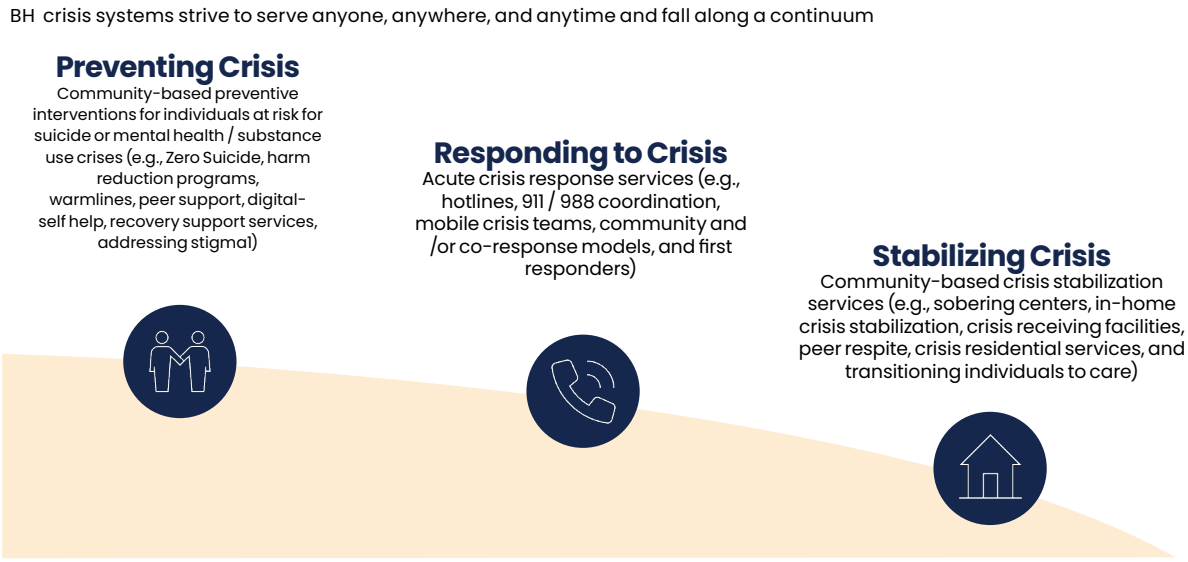
91 Pinals, D., Fuller, D., NASMHPD, Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care, October 2017

92 American Psychiatric Association, The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions, May 2022

93 The Rand Corporation, Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021

The Plan's future-state vision is focused on California's behavioral health crisis care system and how it has been and will be further developed so that its individual components can prevent, respond to, and stabilize individuals in crisis – including transitions to ongoing care.

Exhibit 4: Components of California's crisis systems



Source: CalHHS

There are three strategic priorities to the future-state crisis system. To deliver on the promise of the state's crisis care vision, the future-state design must be grounded in these strategic priorities.

Strategic Priority 1: Build toward consistent access statewide

In California today, the availability of behavioral health crisis services can be improved,[94] and according to stakeholders is due to underinvestment in workforce, quality standards, data infrastructure, cross-system coordination, and insurance coverage.[95] While Californian communities have led the nation with their innovative approaches to crisis care for decades, there remains tremendous variation in availability, access, and quality of crisis services across communities. While some counties have been able to develop a robust system approach, others must still rely on traditional emergency systems (e.g., PSAPS, first responders, emergency departments).[96]

According to DHCS, as of January 2022, 44 counties operate mobile crisis teams, 33 counties have crisis stabilization units, and 28 counties have crisis residential treatment programs. Many of the counties that operate crisis services report that

94 DHCS, Behavioral Health Assessment Report, 2022

95 Discussions with CalHHS, DHCS, and other state agencies and community stakeholders (including during the Behavioral Health Task Force meeting, September 13, 2022)

96 DHCS, Behavioral Health Assessment Report, 2022

they do not have sufficient capacity.[97] More county and region-specific data can be found in the DHCS's 2022 report "Assessing the Continuum of Care for Behavioral Health Services in California." Through the implementation of the new Medi-Cal mobile crisis response benefit in 2023, all counties will cover mobile crisis response services consistent with federal and state guidance.

As a result of this variation in available crisis response options, individuals in crisis and their families may receive drastically different responses in their time of greatest need. For example, a mother calls for help for her agitated adult son experiencing psychosis and thoughts of suicide. In one county, she might speak to a trained crisis counselor who works with the county to send a mobile crisis team to the home. A social worker and peer support specialist arrive promptly, de-escalate the situation, and establish a plan for in-home crisis stabilization. In another county, there is only one available mobile team so the mother and son could wait for hours. Finally, the son runs from the home without shoes or a phone, frightened, and at risk of being injured, victimized, or arrested. Examined from a diversity and equity lens, varied responses may negatively and disproportionately impact certain populations such as persons of color, marginalized communities, those with disabilities, and others.[98]

There are also gaps in coverage across insurance types. California's Mental Health Parity Act, as amended in 2020, requires commercial health plans to cover the full spectrum of medically necessary treatment across settings.[99] However, providers report inconsistencies in commercial insurance reimbursements,[100] and some types of commercial insurance are only regulated at the federal level.[101] Medi-Cal covers crisis intervention/response, crisis stabilization, and crisis residential treatment services.[102] According to DHCS, some gaps in coverage remain (e.g., current reimbursements do not cover full cost of mobile crisis services, and enrollees often exceed the permitted reimbursement time for CSUs).[103]

CalHHS envisions a future-state system that provides an array of essential crisis services and baseline service levels across crisis prevention, response, and stabilization to all Californians in need. This array of essential crisis services describes the baseline in the future state, recognizing that specific populations, including children, youth, and older adults, may need additional services based on characteristics or needs. Each county will design and operate its crisis care model to best meet the needs of its population. Services included as essential were defined based on input from state and community stakeholders as well as on the assessment of currently covered services under Medi-Cal and commercial insurance products.[104]

The vision for the future state includes a system in which services across the care continuum (Exhibit 5) are provided in culturally and linguistically appropriate ways and delivered through person- and family-centered approaches.[105] This includes meeting

97 Ibid.

98 DHCS, Assessing the Continuum of Care for Behavioral Health Services in California

99 California Department of Managed Health Care (DMHC)

100 Interview with CBHDA, October 6, 2022; interview with CBHA, September 12, 2022; BHTF stakeholder reflections, June 14, 2022

101 Interview with representatives from DMHC, October 17, 2022

102 DHCS, Existing California Medicaid Policies

103 DHCS, Behavioral Health Assessment Report, 2022

104 Discussions with CalHHS, DHCS, and other state agencies and community stakeholders (including during the Behavioral Health Task Force meeting, September 13, 2022

105 Discussions with CalHHS and CDPH, October 26, 2022

people where they are by ensuring various forms of access, including opportunities to provide digital access and special considerations for individuals with intellectual or developmental disabilities. This also includes ensuring that first responders, including emergency medical services (EMS) and public safety responders, are trained in understanding trauma and applying a trauma-informed approach. While there are situations that necessitate direct first-responder involvement, many times public safety or EMS are engaged in lower-acuity circumstances because community-based crisis response is not available.[106] While developing the capacity to offer least restrictive responses to crisis, public safety partners play a role in crisis response and it is necessary for these partners to receive the necessary tools and training to improve practices.[107] Essential preventive crisis care services do not describe and are not intended to replace primary prevention activities that incorporate a life course approach for individuals at risk for or recovering from a behavioral health crisis, such as access to coping skills/stress management strategies, positive psychology classes, and parenting classes.[108]

Exhibit 5: Essential behavioral health crisis care services

Preventing Crisis

1. **Digital apothecary (e.g., CYBHI digital platform, CalHOPE digital tool)**
2. **Community-based behavioral health services, such as**
   - Community-based social services
   - School-based and school-linked services
   - Primary care clinics and FQHCs
   - Peer support
   - Community health workers (Promotoras)
   - Harm reduction
   - Medication for Addiction Treatment (MAT)
   - Social determinants of health supports
   - Recovery services
3. **Peer-based warmlines**

Responding to Crisis

1. **Hotlines**
   - Operate 24/7/365
   - Answer all calls (or coordinate back-up)
   - Offer text / chat capabilities
   - Be staffed with clinicians overseeing clinical triage
2. **Mobile crisis services**
   - Operate 24/7/365
   - Staffed by multdisciplinary team meeting training, conduct, and capability standards
   - Respond where a person is in the community
   - Include licensed and/or credentialed clinicians

Stabilizing Crisis

1. **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 may 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
   - Support assessment of basic physical health needs
2. **Peer respite**
3. **In-home crisis stabilization**
4. **Crisis residential treatment services**
   - Operate 24/7/365
5. **Post-crisis step-down services, such as**
   - Partial hospitalization
   - Supportive housing
6. **Sobering centers**

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

The state recognizes that consistent and comprehensive community-level access to this base array of essential crisis services will take time to develop and will require a holistic approach that varies by community. Given the significant diversity across and between communities in California, this plan offers a prototype approach that lifts up existing examples of local innovations that address crisis care needs through different approaches (see Section 4). The initial approach to implementation is described in Section 5 (Implementation considerations and roadmap).

106 Office of the Surgeon General: Preliminary Input on the Crisis Continuum for Behavioral Health, shared with CalHHS, October 27, 2022

107 NASMHPD, Lending Hands: Improving Partnerships and Coordinated Practices between Behavioral Health, Police, and other First Responders

108 Discussions with CalHHS and CDPH, October 26, 2022

The Voices of Lived Experience

One individual described being admitted to the hospital for suicidal thoughts related to severe depression and anxiety. Although she received the care she needed while in the hospital, she was discharged without extended care or follow-up because the clinical staff was unable to get insurance approval. She became suicidal again and called the suicide hotline. The next day, she was able to get an appointment with a therapist.

A grandfather discussed his grandson who has schizophrenia and anxiety. When previously seen in an ED, he became anxious while awaiting a bed. He responded aggressively when attempts were made to keep him from leaving and, ultimately, he was charged with battery. He later went to a crisis stabilization unit for care, where he received prompt treatment and did not require hospitalization.

Source: Behavioral Health Task Force listening session, October 2022

Strategic Priority 2: Enhance coordination across and outside the continuum

Behavioral health crisis care service delivery may require action from different stakeholders and implementers across the behavioral health continuum, requiring thoughtful and systemic coordination. Points of transition (Exhibit 6) are particularly important when coordinating behavioral health crisis care given the urgent need and elevated risk facing individuals in crisis. Delays in accessing support, missed connections, or failure to route an individual to appropriate care could have serious and potentially fatal consequences.[109]

The crisis care system comprises three main functions: preventing, responding to,

The Voices of Lived Experience

One parent shared that her child was refused admission to an inpatient facility where they had previously been treated because the facility was prioritizing new admissions due to a shortage of treatment beds. Unable to access care, the episode ultimately resulted in a self-harm incident in the home.

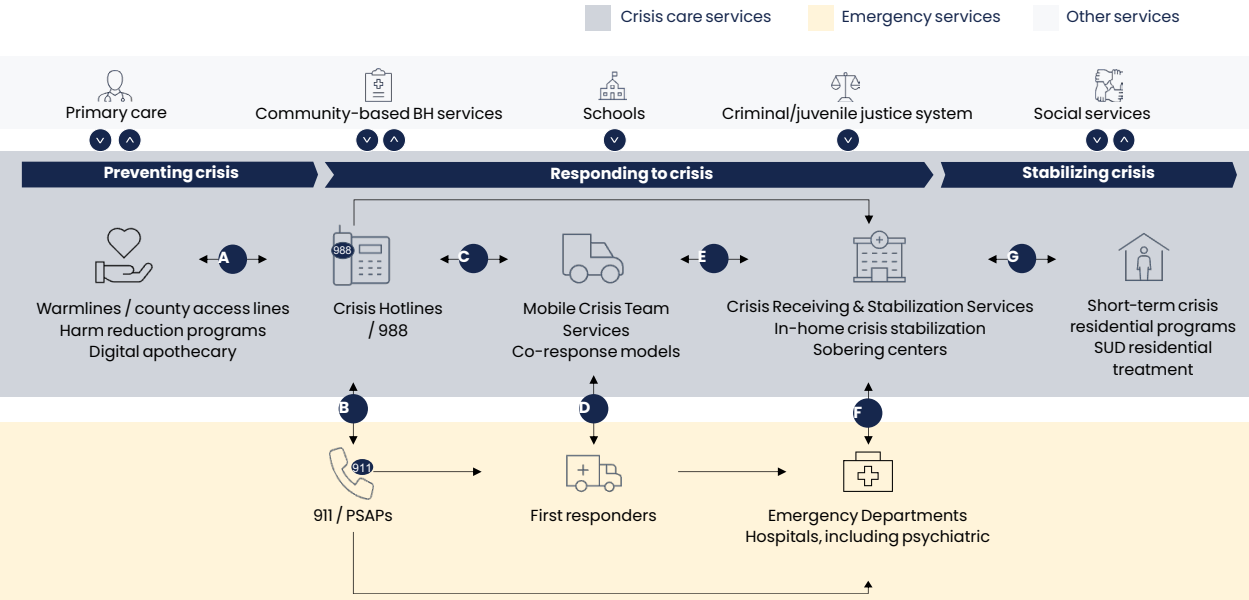
Source: Behavioral Health Task Force listening session, October 2022

109 Subject matter experts, including former state mental health department leaders (including from California and other states), directors for higher education behavioral health programs, and former leaders of the National Association of State Mental Health Program Directors

and stabilizing suicidal, mental health, and substance use crises.[110] In addition to the key transitions described in this section, it is important to note that one effective tool for upstream prevention may be access to a "digital apothecary" (e.g., CYBHI digital platform, CalHOPE Connect[111]) that can decrease the stigma associated with accessing behavioral health services and make it easier for Californians to engage in care across the continuum.[112]

Across the behavioral health crisis care continuum, there are five key points of coordination:

Exhibit 6: Transitions in crisis systems – nonexhaustive examples



Source: 988 Implementation Guidance Playbooks, SAMHSA National Guidelines for Crisis Care, DHCS, CalHHS, expert interviews

A. From warmlines/county access lines to hotlines/988: Each of California's 85+ warmlines and county access lines individually initiate warm handoffs to crisis hotlines if crisis counseling is required by an individual caller. Currently there is no formal state-level guidance or standard for emergency transfers, resulting in different approaches taken across warmlines.[113] CalHHS asserts there is an opportunity to establish standard protocols for warm handoffs; CalHOPE has begun this work by standardizing its operations as a warmline.[114] Standardization may also be helpful to increase warmline access and availability. Standard protocols could also be applied to county-operated and/or funded 24/7 access lines (although in some cases, county access lines also operate as crisis hotlines). In addition, California residents have access to both 311[115] (which provides options to connect to a wide variety of nonemergency services) and

110 Discussions with CalHHS, informed by SAMHSA National Guidelines

111 CalHOPE Connect

112 The Conversation, From recognition to transformation: How digital technology can reduce mental illness stigma, January 2020

113 Discussions with DHCS

114 Ibid.

115 LACity.gov: MyLA 311

211[116] (which provides information about and access to social services such as food, housing, job training, after-school programs). These lines may be overwhelmed, resulting in delayed responses and individuals turning to hotlines when not in crisis.

B. Hotlines to 911/emergency services: CalHHS maintains that crisis systems must coordinate with traditional emergency systems due to some communities not having an adequate alternative to traditional emergency services, and there are certain circumstances (e.g., self-harm, overdosing) where emergency personnel is essential. 911/988 interoperability is a central element of ensuring timely crisis response. Some county-operated hotlines are currently co-located with 911, which facilitates coordination across these two transition points. The approach to coordination may be further informed by national guidance documents and examples from California and other states:

- For the technical process of 911/988 call transfer: The state may consider a range of options which vary in difficulty to execute, impact on call experience, and ease of integration with the Lifeline Network.[117] Didi Hirsch Mental Health Services and Los Angeles Police Department, for example, have established a partnership that allows them to divert 20 to 30 911 calls per week.[118]
- For data and information sharing: The state may consider establishing protocols and trainings to facilitate the sharing of critical incident and caller information (in line with National Emergency Number Association [NENA] standards) as well as data sharing (following the example of states like Arizona).[119]

C. Hotlines to mobile crisis response: Mobile crisis teams are largely operated and initiated by county-run hotlines in the state. California's SAMHSA 988 Planning Grant details current gaps in referrals from hotlines.[120] CalHHS is exploring opportunities to address gaps by establishing standards for protocols for triage processes, safety considerations, and public safety engagement, incentivizing partnerships (such as partnerships between the 988 crisis centers and county-operated mobile crisis teams) and exploring approaches for location-tracking technology.[121]

D. Mobile crisis teams to first responders/emergency services: Along with behavioral health crisis responders, first responders (e.g., public safety, EMS) play a role in crisis response. As such, it is necessary for first responders to receive the necessary tools and training to improve practices while still developing least restrictive responses to crisis. Moreover, mobile crisis responses have evolved to include numerous models of interdisciplinary response that will require increased coordination as sometimes response will include EMS, behavioral health, and public safety. In determining processes and protocols for partnerships, mobile crisis teams and first responders can consider factors such as medical clearance protocols, less restrictive transportation

116 211CA.org

117 NASMHPD, 988 Convening Playbook: Public Safety Answering Points (PSAPs)

118 Didi Hirsch Mental Health Services, "988 is an urgently needed national lifeline for mental health support, but will it be ready?" April 21, 2022

119 NASMHPD, 988 Convening Playbook: Public Safety Answering Points (PSAPs)

120 988 Implementation Plan for California – 988 Planning Grant

121 Synthesis of notes from Behavioral Health Task Force meeting, June 14, 2022

options, and no-wrong-door protocols.[122]

E. Mobile crisis response to crisis receiving and stabilization services: According to one study of the Arizona Crisis Now model, evaluators found that of all crisis line calls received, only 20% require a dispatch of mobile crisis teams, public safety, or emergency medical services.[123] Of these, 30% require transport to a higher level of care to help respond to or stabilize crisis. California's crisis continuum therefore must anticipate the demand for crisis receiving services through appropriate allocation of funding and regional distribution of the crisis receiving centers to support transitions from mobile crisis response teams.[124] In addition, for those 80% of crises that can be resolved at home, many will require stabilization services, which can be built into the continuum with typical 30- to 60-day periods of follow-up services to the individual in crisis.[125] It should be noted that the success of such models depends on their financial sustainability. Models of reimbursement that consider the needs of all Californians will be critical to ensuring their ability to deliver quality services over time.[126]

F. Emergency services to crisis receiving and stabilization services: Current challenges relating to the connection from emergency services to crisis receiving and stabilization services include approval and coordination requirements for transfers, limited transportation options for transfers, and situations of reliance on emergency departments for BH support across first responders and providers. One successful program has been the CalBridge Health Navigator which trains ED-based navigators to expand access to substance use and mental health services.[127] Based on input from the California Hospital Association, the state can expand the existing use of care navigators (particularly for frequent users of ED/inpatient hospital services), provide real-time information on potential capacity available in crisis receiving facilities to support seamless transfers of individuals, and reassess transfer requirements and processes across the state.[128]

G. Crisis receiving and stabilizing services to short-term residential treatment centers: Crisis receiving and stabilizing services often serve people for more than 23 hours when the appropriate level of care is unavailable due to insufficient capacity to take new referrals, eligibility requirements, or other factors. When crisis receiving facilities have limited options for discharging clients to short-term residential treatment or sobering centers, crisis residential programs, SUD residential treatment, or other community-based sites of care, the crisis receiving facilities are forced to extend stays beyond 23 hours.[129]

H. Acute sites of care to outpatient and recovery support services: National analyses indicate that fewer than one out of three young people with commercial insurance gets recommended follow-up care within seven days after an acute psychiatric ER

122 NASMHPD, Lending Hands: Improving Partnerships and Coordinated Practices between Behavioral Health, Police, and other First Responders

123 SAMHSA, 988 Appropriations report; Arizona Complete Health FY2019 data review

124 SAMHSA, 988 Appropriations report; Arizona Complete Health FY2019 data review

125 Ibid.

126 Discussions with CBHDA, February 2023

127 DHCS, DHCS Awards Nearly $10 Million to Emergency Departments to Help Address Overdose Deaths and Broader Mental Health Crisis, July 2022

128 California Hospital Association, Preliminary Input on the Crisis Continuum for Behavioral Health, shared with CalHHS, October 20, 2022

129 DHCS, Behavioral Health Assessment Report, 2022

visit.[130] Yet it is known that people seen in emergency departments for self-injury, regardless of their intent to die, are 30 times more likely to die by suicide than people who do not self-injure,[131] which highlights the need for services and support for individuals following a behavioral health crisis. For veterans, one study showed that the suicide risk may be elevated during the first three months following the discharge from a psychiatric hospital.[132] In another study among Medicaid enrollees with opioid use disorder, follow-up care seven days after an ED visit was protective against fatal or nonfatal overdose within six months.[133] In California, programs like the Emergency Department Follow-up program reach out to people at risk who are nearing discharge from hospital settings within 24 hours, delivering follow-up services that include emotional support, risk assessment, safety planning, and monitoring.[134] For individuals who have experienced an overdose, peer services have been shown to be effective in reducing subsequent risk.[135]

To facilitate coordination within the crisis care continuum, the state can:

- Identify crisis care journeys and key transition points with input from community stakeholders
- Articulate objectives for how each coordination point can operate
- Disseminate standards and protocols to crisis care providers across the state
- Identify and support the underlying infrastructure and technology required to facilitate coordination
- Facilitate formal and informal relationships that reflect the level of care coordination required

There are also connections between crisis services and entities outside of the continuum. CalHHS suggests the state prioritize coordination across five potential partners: primary care, community behavioral health, schools, the criminal and juvenile justice systems, and social services, with special considerations for special populations (i.e., intellectual and developmental disabilities, tribal communities, veterans). In addition to leveraging similar strategies to improve coordination within the continuum, California can build on existing programs and reference examples from across the country to develop a crisis system that is fully integrated into other systems and services.

- **Primary care:** Primary care can serve as one key entry point for crisis services through screening for behavioral health (sometimes through telehealth) and providing initial referrals and connections to receive support for a potential or

130 Psychiatry Online

131 Cooper, J., Kapur, N., Webb, R., Lawlor, M., Guthrie, E., Mackway-Jones, K., & Appleby, L., Suicide after deliberate self-harm: A 4-year cohort study, The American Journal of Psychiatry, 162, 297–303, 2005

132 Valenstein, M., Kim, H.M., & Ganoczy, D., et al., Higher-risk periods for suicide among VA patients receiving depression treatment: prioritizing suicide prevention efforts. Journal of Affective Disorders, 112(1-3), 50–58, 2009

133 Medicaid Outcomes Distributed Research Network, Follow-up after ED visits for opioid use disorder: Do they reduce future overdoses?

134 MHSOAC, Striving for Zero. California's strategic plan for suicide prevention 2020-2025

135 BMJ Open, Randomised clinical trial of an emergency department-based peer recovery support intervention to increase treatment uptake and reduce recurrent overdose among individuals at high risk for opioid overdose: study protocol for the navigator trial, 2019

immediate behavioral health crisis. The state may build on programs like ACEs Aware (a first-in-the-nation effort to screen patients for Adverse Childhood Experiences), the DHCS Screening and Brief Intervention (SBI) Toolkit,[136] and existing protocols under the DHCS Screening Behavioral Health Counseling Interventions in Primary Care[137] to expand processes for alcohol and drug screenings, treatment, and referrals, and support integration of physical and behavioral health (e.g., through multidisciplinary medical and behavioral healthcare teams) even outside of crisis care.[138] This integration can enhance opportunities for crisis prevention and handoff from crisis services to a medical home or treatment hub where the individual can access ongoing community-based care. Integration would require training so that primary care providers have awareness of the crisis care continuum and know how to manage behavioral health crises.

- **Community behavioral health:** Continuity of care across the broader behavioral healthcare continuum involves coordination with community-based behavioral health services. As noted in the Roadmap to the Ideal Crisis System, state and local leaders, peers, and community providers play important roles in facilitating partnerships between behavioral health providers and crisis services, exploring technology to enable more rapid and facile scheduling of outpatient services, and establishing protocols for referrals and access to community-based behavioral health services.[139]

- **Schools:** 50% of mental health problems emerge before children are 14 years old,[140] and children and youth spend the majority of their day in K-12 educational settings. Furthermore, 25% of high school students seriously considered attempting suicide in the last year;[141] and college-aged youth – young people 18 to 25 years of age – have the highest rates of serious mental illness and substance use disorder of any age group.[142] Therefore, it is important to leverage and strengthen school-based staff and systems including in colleges and universities.[143] California has already made strides to integrate behavioral health into schools, such as through the Children and Youth Behavioral Health Initiative (CYBHI).[144] To further build out connections to schools, the state can establish protocols for referral, assessment, and coordination of school and community behavioral health and crisis services, offer trainings to employees on supporting student behavioral health, and support standards that enable mobile crisis intervention in school settings (such as in Solano County where they have a school-based mobile crisis services).[145] Behavioral health professionals can share services available for students at risk (e.g., Katie A. Services) that aim to improve youth's coping skills and functioning for success including through individual therapy, psychiatric services, and medication management, when needed.[146] It is also important to create more awareness

136 DHCS, Screening and Brief Intervention for Variable Settings and Populations

137 DHCS, All Plan Letter, October 27, 2017

138 The Commonwealth Fund

139 SAMHSA National Guidelines; National Council for Mental Wellbeing, Roadmap to the Ideal Crisis System

140 Office of Youth and Community Restoration, Preliminary Input on the Crisis Continuum for Behavioral Health, shared with CalHHS on October 25, 2022

141 Centers for Disease Control and Prevention, Youth Risk Behavior Survey Data Summary & Trends Report, 2011-2021

142 SAMHSA, 2021 NSDUH Annual National Report, 2023

143 Office of the Surgeon General: Preliminary Input on the Crisis Continuum for Behavioral Health, shared with CalHHS, October 27, 2022

144 California Department of Education; CalHHS

145 National Institute of Justice; NASMHPD; Solano County

146 Office of Youth and Community Restoration, Preliminary Input on the Crisis Continuum for Behavioral Health, shared with CalHHS, October 25, 2022

among educators in higher education. The need for mental health and substance use services among 18- to 25-year-olds is increasing. For example, in 2020 and 2021, over 60% of students met criteria for one or more mental health problems – a nearly 50% increase from 2013. American Indian/Alaskan Native students experienced the largest increases in depression, anxiety, suicidal ideation, and meeting criteria for one or more mental health problems, including substance misuse.[147]

- **Adult and juvenile justice systems:** There have been numerous efforts to integrate behavioral health into the justice systems in California. For example, the state has issued grants to communities through DSH to divert individuals with serious mental illness from criminal justice systems, as well as through the Board of State and Community Corrections which administers the US Department of Justice Edward Byrne Memorial Justice Assistance Grant to support behavioral health services and crisis intervention teams related to justice efforts.[148] Additionally, through the CalAIM Justice-Involved Initiative, the state will provide targeted Medi-Cal services to eligible individuals while they are incarcerated during a 90-day period prior to their release to support continuity of coverage and services, including for behavioral health services, as individuals reenter the community after incarceration.[149]

  To strengthen connections between crisis systems and the criminal and juvenile justice systems and help maximize the opportunity for individuals to move toward treatment and away from justice involvement, the state can facilitate partnerships through commissions and task forces, offer cross-trainings on identifying and responding to behavioral health crises, and promote access to crisis services. This includes providing overdose prevention services to individuals upon release from jail/prison, creating clearer roles and delineations between law enforcement and behavior health professionals, connecting juvenile-justice-involved youth to mental health navigators, and ensuring standards that promote criminal/juvenile justice system diversion.[150] For example, in San Bernardino County, the Community Service and Reentry Division (CSRD) provides rehabilitation, education, support, and advocacy services for the county's vulnerable and hard-to-serve populations. These include the incarcerated population, those reentering the community from the county correctional system, and those experiencing homelessness and untreated/undertreated mental illness. The division's deputies, social workers, counselors, educators, and advocates connect people with resources to address substance use disorders, unresolved trauma, adverse childhood experiences, and other challenges to prevent crises and further justice system involvement.[151]

- **Social services:** Social services can include food, housing, and foster care, among other forms of support. California has already taken steps to support individuals with certain undiagnosed and/or untreated behavioral health diagnoses who may be experiencing homelessness through the passage of the Community Assistance, Recovery and Empowerment (CARE) Act in 2022, which provides individualized

147 ScienceDirect, Trends in college student mental health and help-seeking by race/ethnicity: Findings from the national healthy minds study, 2013–2021, 2022

148 California Board of State and Community Corrections, JAG 2022

149 DCHS, CalAIM Justice-Involved Initiative

150 NASMHPD, Law enforcement and crisis services: past lessons for new partnerships and the future of 988, September 2021; discussions with the Council on Criminal Justice and Behavioral Health (CCJBH), September 2022; Office of Youth and Community Restoration: Preliminary Input on the Crisis Continuum for Behavioral Health, shared with CalHHS, October 25, 2022

151 San Bernardino County Sheriff's Department

behavioral healthcare plans, including stabilization services.[152] The state may also build on programs such as the Family Urgent Response System (FURS), which offers county-based crisis services specifically for current or former foster youth and their caregivers in need of crisis services, including a hotline and a Mobile Response Team trained to assist in resolving behavioral health issues and connecting to local services and support.[153] Additionally, the state may play a role in facilitating partnerships to coordinate between warmlines/hotlines and social services, establishing protocols to connect individuals with social services, and offering trainings for crisis providers on the intersections between crisis systems and social services.[154]

The Voices of Lived Experience

One mother told the story of her son who was dishonorably discharged from the army for misconduct after two years because he had been drinking heavily and exhibited altered behavior. Once he left the army, her son struggled to stabilize and ended up homeless, arrested, spending time in prison, and addicted to illicit drugs. The mother noted that her son, who is a Veteran, is often seen as a criminal rather than a person who needs mental health services. She took it upon herself to become his advocate and learned about available services, accompanied him to court, and helped him get his Veterans benefits. She noted that the VA does not have its own mobile crisis team so they still rely on the county for mobile crisis which is not available 24/7. The San Diego psychiatric response team has been helpful as they have peer supports at every level. She noted that sometimes it is difficult to get care for an adult child when they are not able to care for themselves.

Source: Behavioral Health Task Force listening session, October 2022

152 CalHHS, Community Assistance, Recovery and Empowerment Act; CalHHS Funding Backgrounder: California's Behavioral Health Approach and Funding

153California Department of Social Services, Family Urgent Response System (FURS) Youth Resources; discussions with the California Alliance for Children and Families, October 2022

154 Subject matter experts, including former state mental health department leaders (including from California and other states), directors for higher education behavioral health programs, and former leaders of the National Association of State Mental Health Program Directors leader

Strategic Priority 3: Design and deliver a high-quality and equitable system for Californians

CalHHS believes that building a comprehensive crisis system that serves Californians requires an understanding of current needs, disparities and experiences, and a population-based approach. Behavioral health and crisis care should be addressed in a cultural context, especially for populations that may have seen greater need or have been historically underserved.[155] Each population will have its own needs due to different underlying drivers.

The National Association of State Mental Health Program Directors' "988 Convening Playbook: States, Territories, and Tribes"[156] highlights several populations of focus,[157] which the state will build on as it designs its detailed implementation plan:

- **LGBTQ+ youth** are more than four times more likely to attempt suicide than non-LGBTQ+ peers.[158]
- **Individuals with intellectual and/or developmental disabilities (IDD)** have more varied and complex needs across behavioral and physical health when compared to the general population[159] and are at increased risk of having a co-occurring mental health disorder. Individuals with IDD often encounter ableist attitudes which devalue the potential of those with disabilities and commonly encounter mental health practitioners who may dismiss them as unlikely to benefit from therapeutic interventions.[160]
- **Individuals who are deaf or hard of hearing** may experience access challenges to crisis resources that are phone based.[161]
- **Veterans**, who historically have a higher rate of suicide[162] than the general population,[163] may experience a lack of cultural understanding from crisis center operators untrained in the military context. In 2020, 26.2% of veterans in the US had a mental illness and/or substance use disorder.[164] There may also be additional considerations for specific veteran groups; older veterans, for example, might experience increased health risks and financial challenges.[165]
- **American Indian/Alaska Native and other native populations** have seen the highest increase in age-adjusted suicide rates from 2011 to 2020[166] with access to crisis care constrained by insufficient health insurance coverage or poor access to crisis care on tribal lands.[167] This population, which includes Urban Indians, may also

155 NASMHPD, 988 Convening Playbook: States Territories and Tribes
156 Ibid.
157 NASMHPD, Crisis Services: Addressing Unique Needs of Diverse Populations
158 The Trevor Project, Facts About LGBTQ Youth Suicide
159 NASMHPD, Crisis Services: Addressing Unique Needs of Diverse Populations
160 National Alliance on Mental Illness, People with Disabilities; California Department of Developmental Services, Special Considerations for California's Crisis Care Continuum Plan: Intellectual and Developmental Disabilities, shared with CalHHS, October 26, 2022
161 NASMHPD, Crisis Services: Addressing Unique Needs of Diverse Populations
162 National Library of Medicine, Veteran and Military Mental Health Issues, 2022
163 National Institute of Mental Health, Major depression
164 SAMHSA, 2020 National Survey on Drug Use and Health: Veteran Adults, 2022
165 US Department of Veterans Affairs, Older Veteran Behavioral Health Resource Inventory, 2023
166 Suicide Prevention Resource Center
167 NASMHPD, 988 Convening Playbook: States Territories and Tribes

experience lack of cultural understanding by call center staff untrained in cultural practices.[168]

- Individuals with specific language needs may experience difficulties accessing crisis services due to varied availability across crisis centers.[169] California has historically been a leader in language access for crisis services, having played a crucial role in developing Spanish language capacity and translation capabilities for the nation's National Suicide Prevention Lifeline network,[170] but more can be done to support access across multiple languages.
- Older adults may see greater rates of co-occurring conditions of complex behavioral and physical health needs that crisis providers are not well equipped to support,[171] but first responders are not always trained or informed of resources to address the unique needs of older adults.[172]
- System-impacted youth may have a higher prevalence of behavioral health needs compared to youth who are not within the system. Up to 70% of youth involved with the juvenile justice system have a diagnosable mental health problem,[173] and up to 80% of children in foster care have emotional and behavioral health problems[174] but oftentimes experience fragmentation in care, including "bouncing" between the separate systems for managing mental health and substance use disorders within the justice system.[175]
- Black, indigenous, and people of color (BIPOC) experience disparities in access to healthcare resources and outcomes which may contribute to and sustain racial inequities in mental healthcare.[176] For example, in its November 2020 report on "Mental Health Disparities by Race and Ethnicity for Adults in Medi-Cal", the California Pan-Ethnic Health Network (CPEHN) found that Latinx, Asian, and Pacific Islander Medi-Cal enrollees have the lowest rates

The Voices of Lived Experience

One Black woman described a traumatic experience with a gun-related death in the family. When she sought behavioral health care through her place of employment, she was assigned a white crisis counselor who assumed the death was gang-related. It was only after several attempts with several more therapists that she was able to find a therapist who was able to appropriately diagnose and treat her symptoms.

Source: Behavioral Health Task Force listening session, October 2022

168 Discussion with the California Consortium for Urban Indian Health, October 2022

169 NASMHPD, Crisis Services: Addressing Unique Needs of Diverse Populations

170 The Rand Corporation, Suicide Prevention Hotlines in California: Diversity in Services, Structure, and Organization and the Potential Challenges Ahead, 2016

171 NASMHPD, Crisis Services: Addressing Unique Needs of Diverse Populations

172 Discussion with the California Department of Aging, October 2022

173 OJJDP, Intersection between Mental Health and the Juvenile Justice System, 2017

174 California State Assembly Committee on Human Services & Assembly Select Committee on Foster Care, Joint Informational Hearing, October 2018; Mental Health Needs of Foster Youth, presentation by Wendy Smith, PhD, LCSW, University of Southern California

175 Discussion with Council on Criminal Justice and Behavioral Health, September 2022

176 NASMHPD, Crisis Services: Addressing Unique Needs of Diverse Populations

of access[177] of all racial and ethnic groups and are less likely to have continued engagement with behavioral health services across both managed care and county specialty plans.[178] Earlier sustained engagement for Black, Latinx, and API Medi-Cal beneficiaries in Medi-Cal could also prevent the need for additional specialty services.

Potential approaches to embed equity into crisis care should start with efforts to::

- Understand the historical trauma and cultural divide that has created distrust in current systems[179]
- Assess crisis intervention outcomes and how they vary between groups within a region[180]
- Assess social and economic conditions of these populations that impact physical and behavioral health[181]
- Develop and use equity-based datasets that help identify effective solutions[182]
- Integrate health equity into crisis systems using proven tools and frameworks[183]
- Incorporate equity into ongoing measurement and accountability measures[184]

For example, the Long Beach Department of Health and Human Services leveraged the Government Alliance on Racial Equity (GARE) framework along with their work to provide trauma-based care and lead efforts on mental health diversion from incarceration.[185] Another example of taking an equity-minded approach to behavioral health is the START teams program focused on serving individuals with IDD. The Department of Developmental Services has funded the development of Systemic, Therapeutic, Assessment, Resources and Treatment (START) teams[186] which is a model of preventative crisis services for individuals with IDD and mental health service needs.[187] The START program provides person-centered, trauma-informed, evidence-based, and positive support for individuals with IDD ages six and older.

The state will develop its own detailed approach so that the specific needs of Californians are being addressed. It can build on efforts such as the California Reducing Disparities Project (CRDP) which seeks to identify mental health solutions, including crisis care solutions, for historically unserved and underserved

177 Access rate is the percentage of people eligible for a Medi-Cal mental health service who receive one or more such services in a given time period. See CHCF, Mental Health Disparities by Race and Ethnicity for Adults in Medi-Cal, 2020

178 Mental Health Disparities by Race and Ethnicity for Adults in Medi-Cal

179 NASMHPD, 988 Convening Playbook: States Territories and Tribes

180 Ibid.

181 Discussion with California Department of Social Services in September 2022; NASMHPD, 988 Convening Playbook: States Territories and Tribes

182 Discussion with California Department of Public Health in July 2022; 988 Convening Playbook: States Territories and Tribes

183 NASMHPD, 988 Convening Playbook: States Territories and Tribes

184 Discussion with the Mental Health Oversight and Accountability Commission, October 2022

185 Government Alliance on Race & Equity, Long Beach, California

186Department of Developmental Services, START Program, April 2022

187 National Center for Start Services Institute on Disability/UCED University of New Hampshire(n.d.), START, retrieved August 2, 2022

communities.[188] Through consulting with stakeholders and examining other state and national approaches to infuse equity into the crisis care continuum, CalHHS will develop a data and quality of care strategy so that access, outcomes, and experience are measured at the population and community levels as further described in Section 5 (Implementation considerations).

188 California Department of Public Health – California Reducing Disparities Project

4

COMMUNITY-LEVEL CONSIDERATIONS

There is significant geographic, population, and economic diversity across and between communities in California, which may require a range of community-level approaches to address behavioral health crisis care needs, as well as approaches that are integrated across communities, such as exposure to a digital apothecary. County behavioral health services anchor behavioral health crisis services throughout the state and have significant experience providing and implementing crisis services. This Plan, which provides a vision for the state's future behavioral health crisis care system, is intended to provide all California communities with considerations as they build out their service array and coordination across the system. Given the unique strengths and differences among California's diverse communities, the Plan recognizes the importance of designing the system at the community level and reinforcing mechanisms for local planning to serve the needs of its residents best and highlights select examples of local innovation below. Additional aspects of local planning that are key to designing local systems that effectively serve communities may include:

- Conducting assessments of system policies, resources, and practices via qualitative and quantitative data
- Identifying needs, gaps, challenges, and opportunities to optimize resources
- Providing expertise on evidence-based and best practices in behavioral health, healthcare, and affordable social services, particularly the needs of the local communities
- Developing policy documents and financial proposals, including Medicaid waivers and state plan amends collaboratively with state partners
- Formulating strategic recommendations to facilitate systems change[189]

To develop the future-state behavioral health crisis care system, CalHHS is lifting up examples of prototypes to help guide communities across a range of geographies and populations as they undertake community-level strategic planning. These prototypes describe existing examples of local innovation that address crisis care needs through different approaches.

As stated above, across California's communities, including at the county level, there are different approaches to crisis care service delivery and geographic variation in the availability of services across the continuum. For example, counties already have the full continuum of crisis response and stabilization services, including mobile crisis models and collaborations with emergency systems (e.g., EMS/first responders, hospitals, emergency departments). Other localities are growing their mobile crisis response system yet already have substantial peer involvement across the board, partner with local harm reduction programs, or integrate technology in novel ways. Each community will need to design a system to best serve its unique needs, potentially with a few considerations based on community characteristics:[190]

- **Population size:** Whether a community's population is considered large (more than 1 million residents), medium (between 300,000 and 1 million residents), small (between 25,000 and 300,000 results), or frontier (fewer than 25,000 residents) may determine the total system capacity required, how centralized the crisis care system should be, and what settings and services may best serve its needs.[191]
- **Existing crisis care infrastructure capacity**: A community's existing infrastructure, including existing capacity across crisis prevention, response, and stabilization, may determine its near-term strategy as well as its longer-term future-state vision.
- **Landscape:** The urbanity (i.e., urban, rural) of a community and the density of its residents may determine the appropriate approaches to deployment in-person crisis response (e.g., mobile crisis teams) and the relative need across facility-based and at-home stabilizing services. For example, crisis continuums for sparsely populated rural regions within and across counties may look different than more densely populated areas of the state.

189 The Technical Assistance Collaborative, State and local systems design
190 Discussions with County Behavioral Health Directors Association, August and September 2022, counties.org
191 Counties.org

In addition to the community characteristics listed above, counties may also consider their specific context relating to crisis services, including the availability of SUD and other behavioral health services, and the existing role of 988 and warmlines. Counties may also engage existing and potential partners (e.g., first responders, hospitals) when assessing what models of crisis services would work best for the community.

Community prototypes were identified by analyzing communities at the county level by population size, urbanity (i.e., urban, rural, suburban), and existing crisis care infrastructure. Four prototypes largely describe the range of approaches that communities can take to design their crisis care systems:

Full continuum of care: Fully integrated crisis care continuum for responding to and stabilizing crises, with infrastructure that has the capacity to serve the intent of each setting specifically. Roughly a third of counties (21 of 58) already have aspects of the full crisis care continuum, including the complete range of mobile crisis teams, crisis stabilization units, and crisis residential treatment programs.[192]

Example: San Francisco's crisis system covers the entire continuum of care. Services include homeless outreach teams (SFHOT) providing case management and a stabilization plan for individuals experiencing homelessness;[193] a street crisis response team that provides immediate, trauma-informed care to people experiencing a substance use or mental health crisis; a mental health urgent care center; and a range of facility-based treatment options based on acuity and level of care needed, including psychiatric respite care and a drug sobering center. An office of coordinated care assigns case managers to individuals to ensure appropriate linkages in care.[194]

Partial continuum, focusing on rapid crisis response: A crisis care system with a greater capacity to deploy fast crisis in-person response (e.g., with mobile crisis teams) than to deliver stabilization services, particularly in facility-based settings. Communities with this prototype may use alternative evidence-based and community-defined approaches for stabilizing crises, such as in-home crisis stabilization services and peer respite.

Example: Mariposa County's crisis system is an example of a partial continuum, focusing on rapid crisis response. The County developed the Triage Response Assessment of Crisis (TRAC) team that responds to crises and precrisis in the community, jail, schools, hospitals, and other areas as needed 24/7. The team comprises a daytime supervisor, two crisis workers, a nighttime supervisor, and two rotating on-call crisis workers.[195] Mariposa contracts with Merced County to provide crisis stabilization services.[196]

192 DHCS, Assessing the Continuum of Care for Behavioral Health Services in California

193 San Francisco Department of Homelessness and Supportive Housing, Homeless Outreach Team

194 Street Crisis Response Team Issue Brief, Mental Health San Francisco Implementation Working Group, February 2021; Behavioral Health Services and Mental Health SF: San Francisco Mental Health Commission Presentation, July 6, 2021

195 Mental Health Services Oversight & Accountability, Mariposa County Triage Grant

196 Mariposa County, Human Services/Behavioral Health & Recovery Services

Partial continuum, focusing on crisis-stabilizing services: A crisis care system with a greater capacity to stabilize crises in facility-based settings (including crisis-stabilizing units and short-term residential treatment centers) than to deploy mobile crisis in-person responses. Communities with this prototype may use alternative evidence-based and community-defined approaches to responding to crisis, such as co-response models involving collaboration with public safety and/or technology. The use of virtual behavioral health support extends the range of practice of responders for their community-based responses. This may help minimize unneeded facility-based care while providing access to crisis stabilization units when clinically appropriate.

Example: Nevada County's crisis system is an example of a partial continuum, focusing on crisis-stabilizing services. Services include a 24/7 crisis hotline and a four-bed CSU. An ED/hospital-based crisis team evaluates and supports individuals, including referrals to contracted, out-of-county hospitals for inpatient treatment services. A mobile crisis team, staffed four days per week, is piloted with Nevada County Sheriff's Office, Nevada County Behavioral Health, and Sierra Mental Wellness Group.[197]

Community-defined models: Localities may design a crisis care system that does not rely on mobile crisis response or crisis-stabilizing facilities but uses community-defined models to respond to and stabilize crises. Communities may choose, for example, to use co-response models, community paramedicine programs, and/or virtual behavioral health support models to respond to crises and provide in-home crisis stabilization or peer respite to stabilize crises.

Example: Stanislaus County is an example of a community-defined model of crisis care. In response to 911 calls, community paramedics have partnered with their county behavioral health agency to dispatch trained EMS personnel to evaluate patients with potential mental health needs in the field and, when clinically appropriate, assist with the transfer to a mental health crisis center as opposed to an emergency room. The program has resulted in safe transfers to crisis centers rather than EDs and faster times for mental health assessments for patients.[198]

197 Nevada County Mental Health Crisis

198 California Health Care Foundation, California's Community Paramedicine Pilot Projects: Alternate Destination – Mental Health, April 2018

5

IMPLEMENTATION CONSIDERATIONS AND ROAD MAP AHEAD

In September 2022, Governor Gavin Newsom signed the Miles Hall Lifeline Act (AB 988) into law as one of many recent steps to ensuring and expanding services for Californians experiencing a behavioral health crisis. CalHHS has been tasked with developing a detailed five-year implementation plan to achieve the future-state vision for California's behavioral health crisis care continuum by 2024.[199] A robust governance structure will be needed to support ownership and accountability to define and execute the state's implementation plan. In addition, a sustainability plan will be needed to support the future crisis care system.

At the federal level, the Centers for Medicare and Medicaid Services (CMS) will continue to set standards and support select components of crisis care for Medicaid and Medicare enrollees. SAMHSA will continue to play a role as a convenor and source of formula and discretionary grant funding, with a five percent set-aside in the Community Mental Health Services Block Grant and discretionary funding

199 AB 988 Mental Health: 988 Suicide and Crisis Lifeline

opportunities for states and 988 call centers dedicated to strengthening the Lifeline network and building out the crisis care continuum.

AB 988 includes a high-level governance structure at the state level, which describes the inclusion of CalHHS and CalOES.

Funding for the behavioral health crisis care continuum

AB 988, enacted in September 2022, provides a framework and funding mechanism for the 988 Suicide Prevention Lifeline in California, including:[200]

- Establishing a 988 surcharge for the 2023 and 2024 calendar years at $0.08 per access line per month and for years beginning January 1, 2025, at an amount based on a specified formula, but not greater than $0.30 per access line per month
- Requiring health plan and insurer coverage of 988 center and mobile crisis services when medically necessary and without prior authorization

Additional funding commitments support the implementation and ongoing costs for the Lifeline:[201]

- In 2021, the Governor committed $20 million for the 988 launch, investments for mobile crisis teams, and crisis receiving and stabilization. The 2022 budget established mobile crisis services as a Medi-Cal benefit, effective January 1, 2023, along with funding for 911 interoperability and a statewide 988 planning effort.
- The Budget Act of 2022 includes a $7.5 million general fund ($6 million ongoing) for CalOES to advance implementation of the 988 call system and to support call handling equipment so that existing crisis hotline centers have the needed resources to process additional 988 calls as well as coordinate and transfer calls with no loss of information between the 988 and 911 systems.

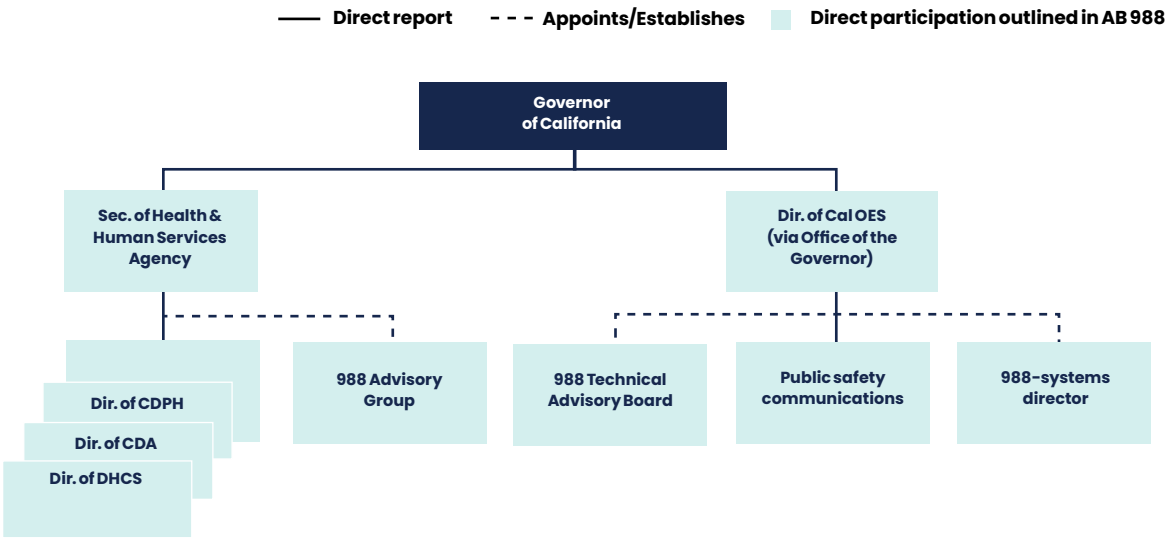
Between the Budget Act of 2021 and 2022, DHCS has dedicated nearly $30 million toward building the capacity of California's 988 crisis centers.

200 Discussions with CalHHS

201 Discussions with CalHHS and Steinberg Institute, Our Legislation

Exhibit 7: AB 988 high-level synthesis of preliminary roles and responsibilities

Preliminary synthesis of roles and responsibilities based on draft AB 988



Source: AB 988 Mental health: 988 Suicide and Crisis Lifeline law

The bill's framework for organizational structure helps jump-start the direction that California can take in developing the complex and cross-cutting enterprise of behavioral health crisis services. With this as an initial scheme, CalHHS will begin drafting roles and responsibilities for CalHHS and CalOES, including how they interact with newly established advisory boards. Specifically, dotted line influence (or direct oversight) and accountability for budgets and outcomes will be delineated across specific tasks and functions. Furthermore, across advisory board meetings, the state will identify specific advisory body facilitators for agenda setting, meeting cadence scheduling, and internal rules of order for decision-making. The state will also develop bidirectional feedback loops across advisory bodies and communication strategies across all stakeholders. Community- or county-level roles will be further specified as the overall governance model is designed.

Based on CHHS preliminary point-in-time estimates, the future-state crisis system, at maturity, may cost an estimated $2.5 billion annually (of which about $2.2 billion comprises potentially covered services) to fund warmlines, 988 crisis call centers, and other hotlines, mobile crisis teams, crisis receiving and stabilization services, and short-term crisis residential programs. Per the analysis, the majority of costs are expected to result from stabilizing crisis services. The anticipated benefit of the proposed upstream investment in prevention and community-based care is averted costs through the reduced emergency department or inpatient care and reduced reliance on first responders instead of healthcare providers.[202] These estimated costs are subject to further refinement based on future discussions and an analysis of existing and future funding needs.

202 RI International, Crisis Now Calculator

The CHHS point-in-time estimated cost was calculated through various publicly available sources of information in a three-step process and is subject to further refinement based on future discussions and an analysis of existing and future funding needs. The CalHHS determined which crisis-related services were potentially reimbursable, as indicated by existing Medi-Cal policies, and applied the distribution by provider type as reported in this Kaiser Family Foundation analysis (e.g., 7.5% of California residents are not covered by insurance, 23.7% is potentially covered by Medi-Cal, 54.4% is potentially covered through parity, and 14.4% is potentially covered through Medicare or Military insurance).[203] Then, CalHHS compiled the dollar value cost for California through multiple sources, the total number of each bar in Exhibit 8.

To estimate the cost of warmlines, CalHHS deferred to the state general fund and Mental Health Services Fund allocations of $45 million for CalHOPE, general fund allocations of $2 million for the Friendship Line, and $30 million for Family Urgent Response System in FY 2023/2024.[204] In addition, county behavioral health agencies use a mix of county behavioral health realignment and MHSA funding to fund county warmlines and crisis lines, which are not included in the estimates provided in this report. To estimate the cost of hotlines, CalHHS used estimations from Vibrant Emotional Health for cost per contact ($79)[205] by the projected contact volume (3.3 million and 17,000 for CalYouth hotlines) in CA at maturity (i.e., about five years).[206] Lastly, to estimate the cost of mobile crisis teams, crisis receiving and stabilization services, and short-term crisis residential programs, CalHHS used estimates from the Crisis Now Resource Needs Calculator created by RI International and the McKinsey Health Institute.[207] The calculator predicts potential healthcare costs associated with delivering care for all individuals requiring in-person behavioral health crisis care across a number of scenarios. Once finalized, CalHHS multiplied the total cost for each service by the percentages of the California residents that are insured and uninsured to create the individual breakdown within each bar. While this approach can provide the state with a high-level understanding of the potential point-in-time estimated costs to operate a robust crisis system, further analysis is needed to develop a detailed projection of both capital and operational costs, inclusive of investments beyond what is outlined above (e.g., costs for 988 call centers to meet projected demand, costs to implement and maintain mobile crisis dispatch systems, costs to train relevant stakeholders on crisis systems and processes, and detailed considerations into covered services by insurance type).

As of 2023, CalHHS estimates the state has made over $2 billion[208] in investments for behavioral health crisis services, with the majority of the investments coming from the $1.4 billion investment budgeted over five years to add qualifying community-based mobile crisis intervention services as a Medi-Cal-covered benefit. Other sources of funding[209] include:

203 For services potentially covered by insurance (as indicated by existing Medi-Cal policies), applied the distribution of coverage by provider type as analyzed by Kaiser Family Foundation (retrieved in January 2023)

204 State of California 2023-24 Governor's Budget

205 Vibrant

206 Based on the Moderate Scenario five-year projections from Vibrant (which was adopted by SAMHSA), extrapolated for the hotline network based on the assumption for crisis center diversions (~80%) and SAMHSA estimates for 911 call diversion under a moderate growth scenario; applied the distribution of national calls originating in California from August 2022 projections from Vibrant includes estimate for CalYouth Teen hotlines (average annual calls at 17,000 multiplied by the cost per contact estimation from Vibrant at $79/contact)

207 Crisis resource need calculator

208 Includes federal match for Medi-Cal expenditures

209 Published CalHHS budget summaries from FY 2020/2021, 2021/2022, 2022/2023

- $685 million granted to support and expand behavioral health mobile crisis and noncrisis services and develop crisis and behavioral health continuum infrastructure
- $30 million granted over three years to CalHOPE, in addition to $13 million for base operations
- $20 million granted by SAMHSA to DHCS to build call center capacity for 988 implementation
- $14.5 million granted by SAMHSA to DHCS for communities to enhance call center readiness
- $7.5 million granted in FY 2022/2023, with $6 million ongoing, to support equipment for transferring calls between the 988 National Suicide Prevention Lifeline and the 911 system
- $4 million provided per year by the Mental Health Services Act state administration funding

In addition to the funding allocations defined above, counties may invest in their crisis systems through county behavioral health realignment funding[210] and the Mental Health Services Act.[211]

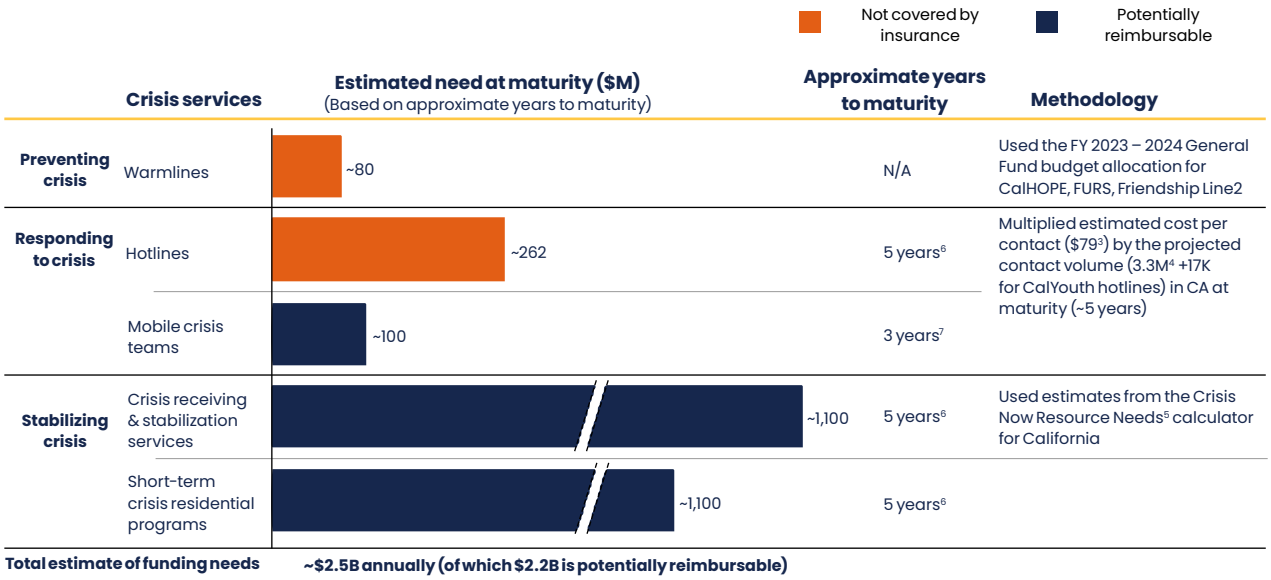
While California has significantly invested in behavioral health crisis services, the path to long-term and sustainable funding remains unclear. Currently, the state has identified approximately $1.4 billion for mobile crisis intervention services as a Medi-Cal-covered benefit, which can be used over the next five years to support the Plan. However, the enhanced federal matching funds of the benefit is time-limited and the ongoing federal matching funds level may differ. Other key sources of sustainable funding include Medi-Cal (including BH-CONNECT funding, which DHCS plans to submit),[212] commercial insurance, 988-surchage fees, and federal block grants.

The funding difference between recurring costs and multiyear funds requires additional analysis of the Plan's sustainability.

210 California Legislative Analyst's Office, 2011 Realignment
211 DHCS, Mental Health Services Act
212 DHCS, The California Behavioral Health Community-Based Demonstration External Concept Paper

Exhibit 8: Estimated funding sources for the California Crisis Care Continuum

High level estimate of potential funding needs (based on publicly available data)



	Crisis services	Estimated need at maturity ($M) (Based on approximate years to maturity)	Approximate years to maturity	Methodology
Preventing crisis	Warmlines	~80	N/A	Used the FY 2023 – 2024 General Fund budget allocation for CalHOPE, FURS, Friendship Line2
Responding to crisis	Hotlines	~262	5 years[6]	Multiplied estimated cost per contact ($79[3]) by the projected contact volume (3.3M[4] +17K for CalYouth hotlines) in CA at maturity (~5 years)
	Mobile crisis teams	~100	3 years[7]	
Stabilizing crisis	Crisis receiving & stabilization services	~1,100	5 years[6]	Used estimates from the Crisis Now Resource Needs[5] calculator for California
	Short-term crisis residential programs	~1,100	5 years[6]	
Total estimate of funding needs		**~$2.5B annually (of which $2.2B is potentially reimbursable)**		

Most crisis care components include care coordination. The crisis system is dynamic, and funding estimates might change as demand for crisis services continue to develop.

Source: KFF Health Insurance Coverage of the Total Population 2021; crisis resource need calculator; 2023-2024 Governor's Budget; Vibrant; SAMHSA

CalHHS must develop plans addressing several implementation considerations to achieve the three strategic priorities. The below initial roadmap outlines approaches to address implementation considerations that CalHHS believes to be fundamental to progress toward the strategic priorities. CalHHS recognizes that this initial list of considerations is not exhaustive, and additional considerations will arise during implementation. Implementation has already begun due to the launch of 988 and the existing work done to build up the digital apothecary and warmlines, which will hopefully mitigate the need for 988.

Exhibit 9: CalHHS crisis care continuum plan

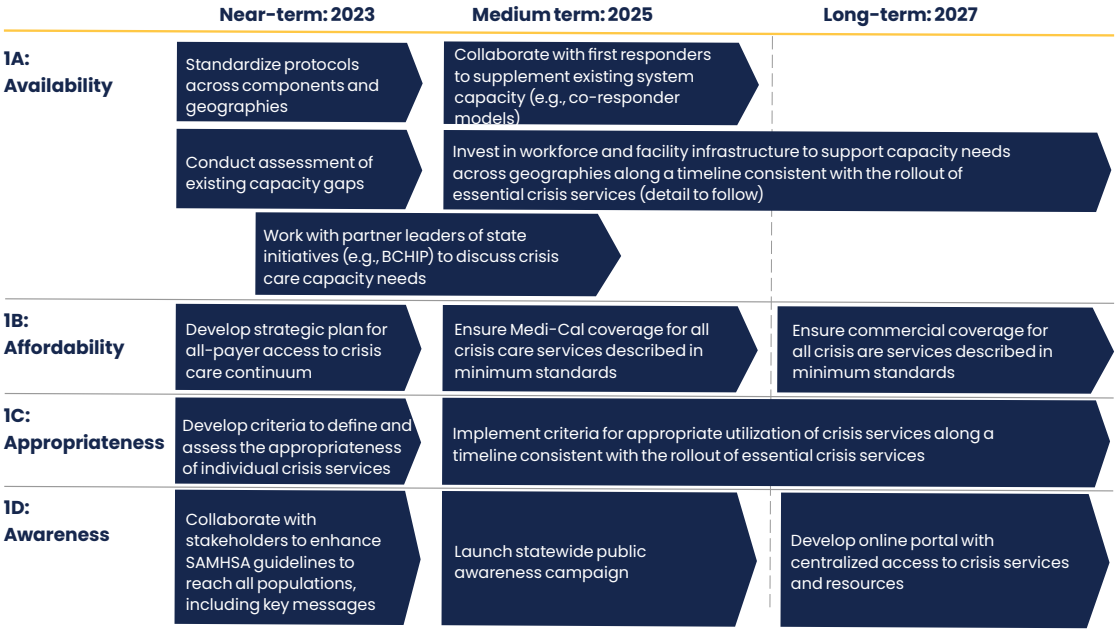
Strategic priorities and implementation considerations

Strategic priorities	Considerations for implementation
1 **Build towards consistent access statewide**	A Availability: Enhance system capacity across the care continuum B Affordability: Ensure continuity of care through coverage across all payors C Appropiatness: Ensure services meet the needs of diverse populations D Awareness: Educate communities on how to prevent, respond and stabilize crises
2 **Enhance coordination across and outside the continuum**	A Technology infrastructure: Identify and develop technology infrastructure to enable system-wide interoperability B Partnerships: Ensure robust formal and informal partnerships across components of the crisis care continuum and related systems
3 **Design and deliver a high quality and equitable system for ALL Californians**	A Measurement strategy: Develop a measurement strategy that is inclusive of populations and geographies B Quality of care & equity strategy: Develop a quality of care crisis services strategy, including an equity-focused measurement framework

Source: CalHHS

CalHHS plans to address the implementation considerations for each of the Plan's strategic priorities across near-, medium-, and long-term time horizons.

Exhibit 10: Potential implementation roadmap for California – Strategic Priority 1: Support a consistent minimum level of access statewide



Source: CalHHS

1A. Availability: Enhance system capacity across the care continuum

To aspire toward consistent access statewide, California can prioritize ensuring sufficient capacity within crisis services.[213] Based on approaches from other states and national guidelines, the state may consider several approaches to increasing system capacity over time:[214]

- **Near term:** Increasing access and enhancing the quality of care of existing crisis infrastructure
- **Medium term:** Expanding linkages within the crisis care infrastructure of communities through stronger collaborations with existing providers
- **Long term:** Increasing the crisis care workforce and infrastructure through investments in workforce and facility capacity building

To increase capacity in the near term, the state may consider supporting evidence-based solutions to improve access and enhance quality within the current crisis infrastructure, such as standardizing processes and protocols like response protocols involving PSAPs and EMS,[215] analyzing data to inform staffing and process decisions, and using telehealth innovations to increase the reach of individual mental healthcare professions.[216] The state can build off existing telehealth programs, such as in Sonoma County, where a Federally Qualified Health Center established virtual care services at its community health centers, supported by funding from the California Health Care Foundation. Given the limited access to broadband, several of the visits were initially conducted by telephone; however, through increased partnerships with broadband access points in the community (e.g., libraries, schools, and fire stations), video visits increased, and patient no-shows were reduced.[217]

213 SAMHSA National Guidelines for Crisis Care

214 Subject matter experts, including former state mental health department leaders (including from California and other states), directors for higher education behavioral health programs, and former leaders of the National Association of State Mental Health Program Directors

215 Discussions with EMSA, September 2022

216 NASMHPD, 988 Implementation Guidance Playbooks

217 California Health Care Foundation, New Technology is Transforming Care in California's Safety Net, May 2022

Exhibit 11: Example evidence-based solutions to increase access and enhance quality

	Evidence-based approaches		Proposed solution	Potential state-wide approaches
Standardizing processes and protocols	Standardize processes for assessments and intervention for medical conditions		Chickasaw Nation standardized processes for screening & suicide risk assessment	Establish standard processes that can be applied state-wide
	Structure protocols that enable the most credentialed clinicians have capacity for higher-acuity cases	connections Arizona	Connections supports team members to "work at the top of their license"	Offer trainings to providers on developing an organization-wide culture
Analyzing data to inform staffing & process decisions	Formally apply quality improvement technology	988 Convening Playbook	The 988 Playbook suggests LEAN & plan-do-check-act cycles	Offer trainings related to quality improvement technologies
	Use dashboard tracking tools to evaluate case-level and system-level outcomes	connections Arizona	Connections improved dashboard tracking tools as part of Lean Six Sigma approach to quality improvement	Provide grants to support the development of dashboards; require data tracking of providers
	Use data to estimate staffing needs and reflect working hours accordingly; promote working models that enable staffing flexibility	DCF	CT supports providers in accessing staffing data and have flexibility to adjust staffing during peak times	Require data tracking of providers; offer staffing strategy consultations to individual organizations
Using telehealth innovations	Utilize telehealth in alignment with SAMHSA best practices		TBD	Provide grants to support telehealth infrastructure

Source: NASMHPD, 988 Implementation Guidance Playbooks; SAMHSA National Guidelines for Crisis Care; Chickasaw Nation: Mental Health; Connections Health Solutions; Connecticut State Department of Mental Health and Addiction Services; expert interviews

Additionally, in the medium term, the state may consider increasing collaborations with first responders (e.g., EMS and public safety) and hospital systems, particularly in communities with more acute access challenges. For example, in some California communities, EMS triages individuals experiencing a behavioral health crisis to crisis receiving and stabilizing centers instead of emergency departments.[218] The state may also collaborate with counties to provide more robust and expansive Lanterman-Petris-Short (LPS) designation training to ED staff to permit them to write or release 72-hour holds.[219] By using first responder transportation systems, strengthening co-response models, and engaging with hospitals/EDs, the state can help communities prepare to meet the demand for crisis services.[220]

In the long term, the state can develop strategic approaches to build out the crisis workforce (e.g., by increasing the clinical workforce and expanding opportunities for peer involvement) and augment crisis infrastructure, including mobile crisis and physical crisis infrastructure.[221] For example, the state may expand existing programs, such as bridge navigators in EDs to behavioral health.[222] Investments in capacity building (see Appendix A for examples) can parallel the rollout of essential crisis services across the state.

218 Discussions with EMSA in September 2022 and Steinberg Institute in October 2022

219 California Hospital Association, Preliminary Input on the Crisis Continuum for Behavioral Health, shared with CalHHS on October 20, 2022

220 SAMHSA National Guidelines for Crisis Care

221 NASMHPD, 988 Implementation Guidance Playbooks

222 Discussions with CBHDA, July 2022

1B. Affordability: Support continuity of care through coverage across insurance types

So that all Californians have affordable access to crisis care, the state can work to provide coverage across the crisis care continuum for Medi-Cal populations as well as ensure flexibility within the system to address the needs of all Californians regardless of insurance access or coverage. Under AB 988, all healthcare service plans and insurers are required to provide coverage for medically necessary behavioral health crisis services, including services provided by a 988 center or mobile crisis team, regardless of network inclusion and without prior authorization.[223] It is the goal of CalHHS to work across types of insurance, including Medi-Cal and commercial health plans, to increase coverage of behavioral health services across the crisis care continuum, so that access to the crisis system is not determined by an individual's coverage status, including for those who are not insured.

The state can first look to enhance coverage of the population insured through Medi-Cal to include all essential crisis services. To do this, California can look to examples from other states:[224]

- **Washington, D.C.** increased the availability of call centers, mobile crisis units, outpatient services, and inpatient services in its 1115 demonstration, which is federal funding for innovative approaches to care not normally covered under Medicaid.[225]
- **Maryland's** 1915(i) program, which provides home and community-based services, serves seniors and people with disabilities and includes 24/7 mobile crisis services.[226]
- **Massachusetts** covers mobile crisis services for children as covered rehabilitative services in a state plan amendment under Early and Periodic Screening, Diagnostic and Treatment (EPSDT), a benefit that provides comprehensive and preventive healthcare services for children under the age of 21.[227]

Subsequently, to support coverage of the population covered by commercial insurers, the 988 Convening Playbook[228] suggests that states may explore how to standardize billing codes, utilize existing parity laws, ensure commercial insurers are familiar with crisis services, facilitate convenings of insurers and state actors, and provide an inventory of the crisis services offered in the state and the benefits of comprehensive crisis services. California can also look to states like Massachusetts and Arizona, which regularly meet with their respective insurance divisions to discuss parity opportunities.[229]

223 California Legislative Information, Assembly Bill No. 118

224 NASMHPD, 988 Convening Playbook: States, Territories, and Tribes

225 Centers for Medicare & Medicaid Services, Washington, DC's 1115 demonstration approval letter, December 19, 2019

226 Maryland Department of Health, 1915(i) State plan home and community-based services administration and operation

227 Massachusetts State Plan Amendment (TN #08-004), effective April 1, 2009 (accessed February 2022)

228 NASMHPD, 988 Convening Playbook: Lifeline Contact Centers

229 Subject matter experts, including former state mental health department leaders (including from California and other states), directors for higher education behavioral health programs, and former leaders of the National Association of State Mental Health Program Directors

1C. Appropriateness: Provide services that meet the needs of diverse populations

So that individuals receive the appropriate level of care, the state will consider which instruments will be most effective across age groups within the crisis care continuum to determine the need for particular services. It is the expectation that local communities would implement consistent evidence-driven standards for assessing the level of care, such as Level of Care Utilization System (LOCUS), Adult Needs and Strengths Assessment (ANSA), Child and Adolescent Needs and Strengths (CANS), and Milestones of Recovery Scale (MORS). Counties are already employing these tools to assess the appropriateness of the level of care individuals receive.[230] For example, San Diego County provides training and support to clinicians on using several of these tools and their collection through the Mental Health Outcomes Management System (mHOMS).[231] As communities continue to build out these crisis care tools, stakeholders' input will be important before adopting any instrument to support its usability, feasibility, and reliability to address the questions set forth in the crisis response (see Exhibit 12 for an example of LOCUS).[232]

230 Discussions with DHCS

231 University of California, San Diego Health Services Research Center, San Diego County Adult Outcome Measures: Outcome Measures Manual, May 2016

232 SAMHSA National Guidelines for Crisis Care

Exhibit 12: Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)

Level	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Description	Recovery maintenance and health management	Low-intensity community-based services	High-intensity community-based services	Medically monitored non-residential services	Medically monitored residential services	Medically managed residential services
Optimal referral path as defined by SAMHSA	Evaluation by crisis mobile team with referral to care as needed				Referral to crisis receiving and stabilization facility	Direct referral to acute hospital

Source: American Academy of Community Psychiatry; SAMHSA National Guidelines for Crisis Care

CalHHS asserts that crisis care services must also be appropriate for all Californians regardless of demographic factors such as age, language, or ability. This involves tailoring services to be accessible for populations with specific needs, such as:

- Adapting Lifeline Network membership processes to incorporate organizations providing specialized services for LGBTQ+ youth (e.g., the Trevor Project)
- Establishing no-wrong-door policies for those with IDD experiencing a behavioral health crisis in need of facility-based care
- Coordinating crisis responses with Tribal Health Authorities
- Partnering with veteran serving organizations to support culturally competent and appropriate crisis responses to service members, veterans, and their families in the community
- Establishing resources necessary to provide crisis contact services for individuals who are deaf or hard of hearing (e.g., ASL-fluent counselors, video technology)
- Building a crisis workforce that reflects the diversity of the population served

1D. Awareness: Educate communities on how to prevent, respond, and stabilize crises

Public awareness is a requisite to ensuring access. The 988 Convening Playbook: States, Territories, and Tribes suggests an engagement strategy to develop key messages for specific audiences.[233] California is also coordinating with local efforts focused on behavioral-health-focused public awareness, including under CYBHI, which includes the CDPH-led Public Awareness Campaign addressing mental health stigma and OSG-led ACEs, the Toxic Stress Public Awareness Campaign,[234] and First 5's Public Awareness campaign focusing on stress and brain health.[235]

233 NASMHPD, 988 Convening Playbook: States, Territories, and Tribes
234 Children and Youth Behavioral Health Initiative 101
235 First 5 LA: First 5 LA launches innovative public awareness campaign to support parents and caregivers

To educate communities on how to prevent, respond to, and stabilize crises, there are two primary audiences:

- **Partners**, includes state agencies, crisis services organizations, and nonprofits: Communication with partners may focus on describing how the future crisis care system works, how it fits within the broader crisis service ecosystem, and each partner's role in its operations
- **Community members**, includes individuals who may be in crisis and/or recovery or who may refer others to the crisis services, as well as families, faith-based leaders, specific population interest groups, and all Californians: Communication with community members may be adjusted based on the timing, availability, and capacity of various services. In addition, it will be important for communications specialists to ensure that messaging is not misleading or confusing. **To that end, the 988 Convening Playbook for States, Territories, and Tribes highlights a few indicators for system readiness before launching a public awareness campaign:**[236]
    - *Sufficient capacity at California's twelve 988 crisis centers to meet the anticipated demand*: While the call centers are largely able to meet existing demand as reflected by approximately 85 to 90% in-state call answer rate,[237] according to a projections report, within five years of 988 implementation, the total call/chat/text volume nationwide could increase by 13 million annual contacts, requiring significant increases in staffing, volunteer recruitment, and training efforts at 988 crisis centers.[238]
    - *Connections and linkages established between 988 crisis centers and mobile crisis teams or other rescue units support access to the right level of care as needed*: There is currently no shared data infrastructure, and as such, it can be difficult for Californians and entities within the crisis system to find appropriate local resources to facilitate consistent and equitable community linkages for individuals needing support after contacting 988. Thoughtful community partnerships can help facilitate linkages and foster coordination across local resources, including 211 and 311[239] so that the responsibility of finding and navigating resources does not fall on the individual in crisis.
    - *Sufficient behavioral health workforce capacity to respond to crisis episodes that develop and need services beyond 988 crisis centers and mobile response*: There are significant regional disparities in behavioral health workforce availability across California,[240] and shortages are projected by 2028 based on demand forecasts, service utilization, and expected workforce supply.[241]

The roadmap builds toward the full suite of essential crisis services over time, with some services such as warmlines and hotlines potentially being available consistently as soon as 2024.

236 NASMHPD, 988 Convening Playbook: States, Territories, and Tribes

237 State-based Monthly Report for California – December 2022; Vibrant, 2022

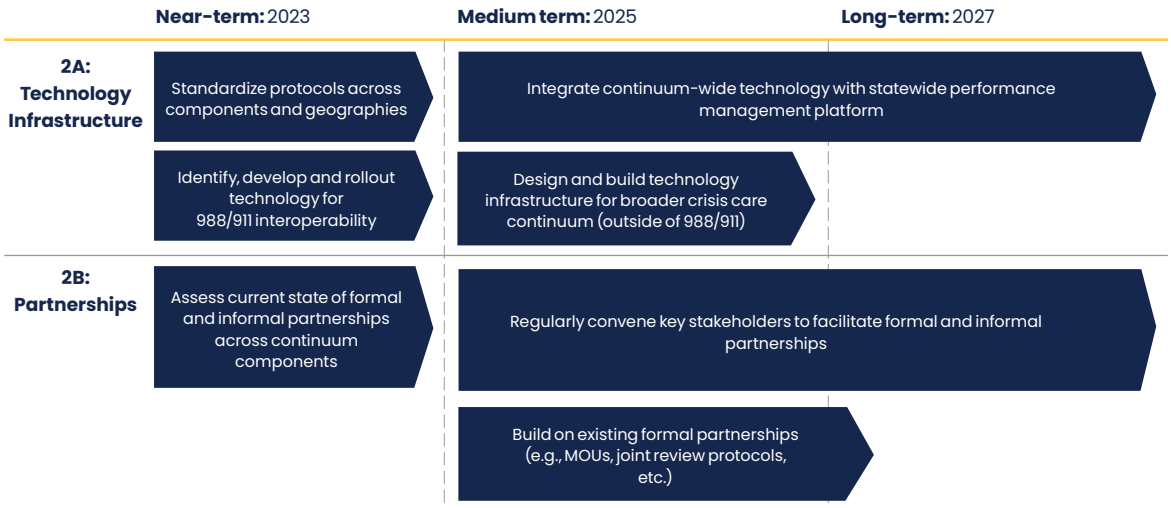
238 988 Implementation Plan for California – 988 Planning Grants

239 Ibid.

240 California Health Care Foundation, California Health Care Almanac, July 2022, Mental Health in California: Waiting for Care

241 Healthforce Center at UCSF, California's Current and Future Behavioral Health Workforce, February 2018

Exhibit 13: Potential implementation roadmap – Strategic Priority 2: Enhance coordination across and outside of the continuum



Source: CalHHS

2A. Technology infrastructure: Identify and develop technology infrastructure to enable systemwide interoperability

Technology infrastructure is crucial to ensuring the coordination of the crisis system. Selecting a 988 technology platform is a core decision for the state's underlying crisis technology infrastructure. Per SAMHSA specifications, this platform must facilitate connections to 911, maintain a call routing system to effectively link callers to the most appropriate call centers available, and implement a unified communications platform to suppport networkwide phone/chat/text interoperability and real-time monitoring and management of service connectivity and performance data.[242]

California had two options regarding its technology platform: (1) adopt the Unified Vibrant Platform (described in the figure below) and (2) build another platform that is compatible with the Unified Vibrant Platform.[243]

242 SAMHSA SM-21-005 Grant Award
243 988 Implementation Plan for California

Exhibit 14: Unified Vibrant Platform functionality

Vibrant is developing a unified tech platform that is interoperable within/across crisis & emergency systems & 988; states & contact centers may choose to adopt

Unified Vibrant Platform Functionality

Component	Description	Expected functions by Nov '22	Potential future functions
Omnichannel Contact Center System (CCM)	A computer-based system that provides call and contact routing & linking	Automatic call distribution (ACD) and skills-based routing Geo-location-based routing (pending FCC approval)	MCT dispatching
Customer Relationship Management system (CRM)	A central system where the state / contact centers can store contact data, track contact interactions, and share information	Call reports Follow-up Medicaid billing preparedness Resource database MCT database	Bed registries
Additional functions / systems	Supplementary functionality, including integration with outside data systems	Centralized Identity and Access Management (IAM)	Alternate lines of business

Implementation/ launch timelines

- **January 2022:** CA Crisis Center Leadership began engaging in Unified Platform Advisory Committee (UPAC)
- **Q4 2022:** The Vibrant Unified Platform is expected to go live
- **2023:** Vibrant Unified Platform is planned for expanded rollout

Source: SAMHSA and NASMHPD 988 Implementation Guidance for States, Territories, and Tribes; 988 Implementation Plan for California

State leaders aligned on building an independent platform for California and selected Next Generation Advanced (NGA) NG Trunk as the vendor.[244] 988 crisis centers and CalOES are working with NGA NG Trunk to develop a platform to meet the needs of California and to interface with national data collection systems.[245]

In addition to this fundamental choice of technology platform, other technological enhancements for later consideration can improve coordination, including mobile crisis dispatch and bed registries.[246] However, the utility of bed registries varies, and further research on the effectiveness can depend on the state context.[247] The state can look to examples nationwide (such as in Georgia or Arizona[248]) and within California (e.g., Los Angeles is developing mobile crisis dispatch technology[249]) to identify effective technological models.

2B. Partnerships: Support robust formal and informal partnerships across components of the crisis care continuum and related systems

Coordination within crisis systems requires partnerships between operators of crisis care services and other entities that interact with the crisis system. Partnerships among crisis service operators, including call centers, can improve system effectiveness across each component of the crisis care continuum, from prevention (e.g., warmlines, peer support) to crisis response (e.g., hotlines) to stabilizing crisis (e.g.,

244 Next Generation Advanced: NGA911.com
245 Written correspondence with DHCS, October 18, 2022
246 SAMHSA National Guidelines
247 NRI Psychiatric Bed Registries Report
248 NASMHPD, 988 Convening Playbook: States, Territories, and Tribes
249 Interview with Didi Hirsch, September 14, 2022

emergency departments), through enabling alignment of individuals to appropriate care, improving coordination, and facilitating cross-entity decisions. In a formal partnership, entities can codify processes and points of connection.[250] State agencies may be able to help facilitate partnerships by convening operators, incentivizing formal and informal partnerships, and outlining the crisis care operator landscape.[251]

For example, Orange County has worked with public and private partners to develop a comprehensive system for mental health that will help individuals access treatment regardless of whether they are insured. Nonprofit organizations, county government, faith leaders, hospitals, insurance companies, mental health advocates, and law enforcement agencies pooled funding to create the Be Well OC Regional Mental Health and Wellness Hub in Orange. The $40 million facility houses a variety of services, such as short- and long-term mental health treatment, crisis stabilization units, and substance use disorder treatment programs.[252]

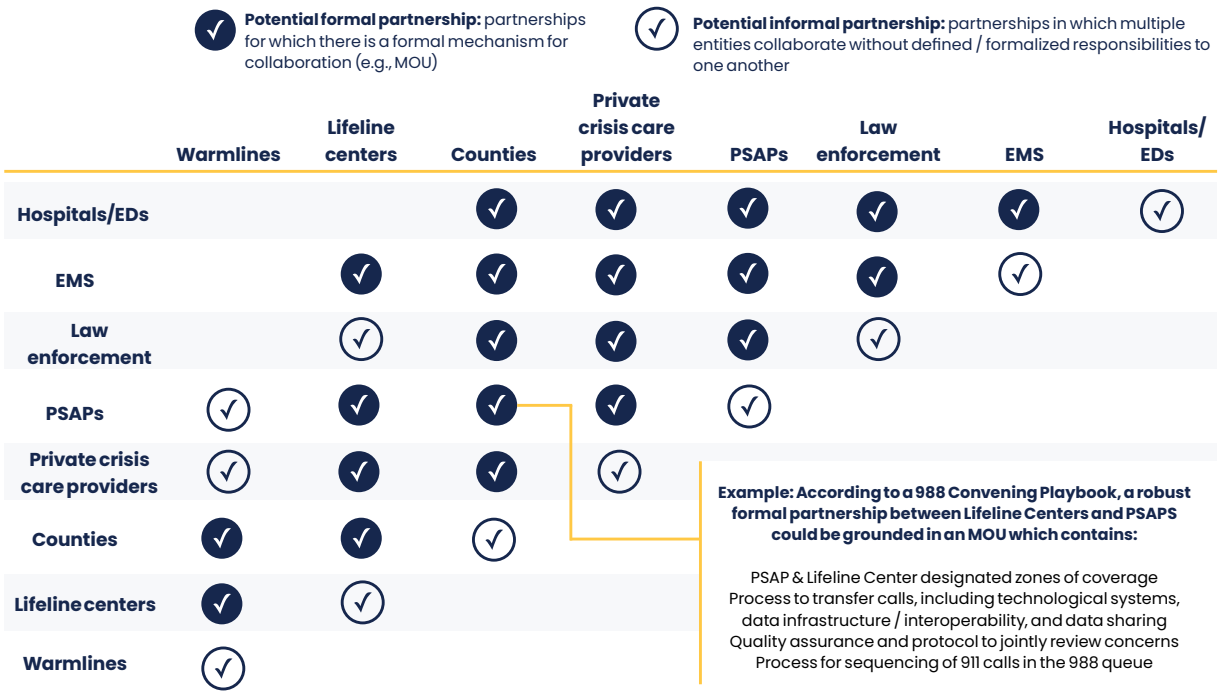
250 NASMHPD, 988 Implementation Guidance Playbooks

251 Subject matter experts, including former state mental health department leaders (including from California and other states), directors for higher education behavioral health programs, and former leaders of the National Association of State Mental Health Program Directors

252 Public-private partnerships bring mental health crisis care to uninsured

Within the California crisis system, there are opportunities for informal and formal partnerships across eight key operators:

Exhibit 15: Potential partnerships within crisis systems



Source: 988 Implementation Guidance Playbooks; SAMHSA National Guidelines; expert interviews

National guidance documents, including the SAMHSA National Guidelines and the 988 Implementation Guidance Playbooks, outline several "best practices," including enlisting "bridge builders" to support individuals who can "translate" among different stakeholder groups, articulating the mission of the partnership, identifying a single point of contact. Formal partnerships can include establishing regular and continuous meetings, finding funding for shared resources (e.g., training programs), and establishing formal contracts.[253] Efforts like the California Reducing Disparities Project (CRDP) may leverage multiple strategies, including formal and informal partnerships, to inform statewide policy identifying crisis solutions for historically unserved and underserved communities.[254]

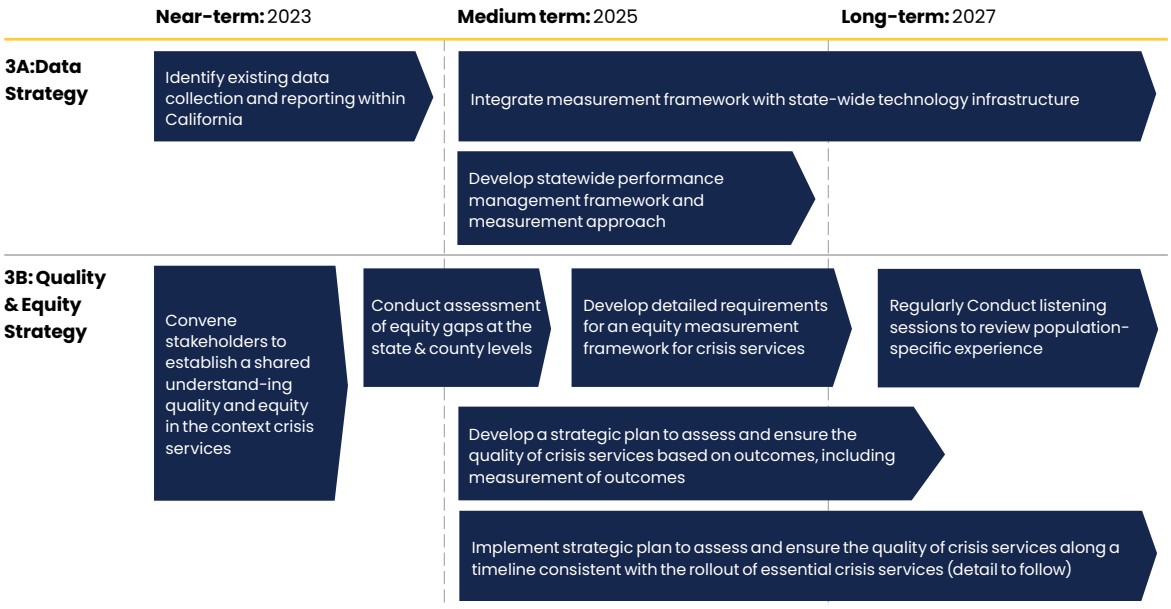
253 NASMHPD, 988 Convening Playbook (PSAPs)
254 California Department of Public Health – California Reducing Disparities Project

The state can also look to examples from counties[255] and from other states[256] on how to implement partnerships between crisis providers:

- In Yuba County, behavioral health county staff are embedded and available 24/7 in a large hospital ED to coordinate patient care
- In San Joaquin County, a large hospital ED coordinates with an adjacent CSU to transfer patients after medical evaluation and provide intermediary psychiatric care
- Behavioral Health Link, a crisis services provider and operator of the statewide Georgia Crisis and Access Line:
    - Employs staff as local liaisons to maintain local networks of crisis stakeholders
    - Holds regular meetings with hospitals, schools, jails, and PSAPs
    - In Southern Arizona, a crisis line has been serving as the convening partner that connects all the stakeholders in the crisis system
    - Nevada established a 988/911 Interoperability Workgroup that meets monthly

Similar approaches can be utilized to facilitate partnerships between crisis service operators and other entities in the community, including community-based organizations and noncrisis systems/services (e.g., primary care providers, schools, social service providers).

Exhibit 16: Potential implementation roadmap – Strategic Priority 3: Design and deliver a high-quality and equitable system for Californians



Source: CalHHS

255 California Hospital Association: Preliminary Input on the Crisis Continuum for Behavioral Health, shared with CalHHS, October 20, 2022

256 NASMHPD, 988 Convening Playbook (PSAPs)

3A. Measurement strategy: Develop a measurement strategy that is inclusive of populations and geographies

Measurement approach and data infrastructure are essential tools for monitoring, managing, and improving crisis performance, including assessing and addressing potential disparities in care or outcomes for population groups. Through a comprehensive measurement strategy and approach, the state can define and measure progress against objectives for the crisis system, hold providers and counties accountable for meeting standards set by the state, and identify where additional state support could be needed.[257]

A comprehensive measurement strategy for crisis services can include the following components:[258]

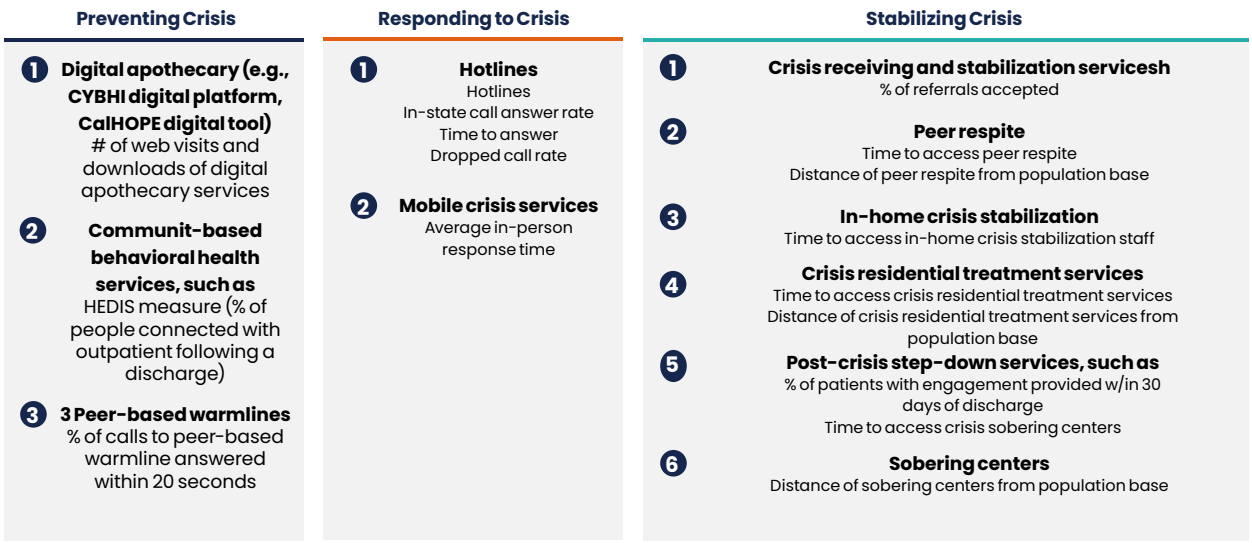
- Standard definitions and practices on data to collect and share
- Building or adapting processes and systems for data collection or sharing
- Interfaces to view, translate, and track data
- Approaches for analyzing data with an equity lens (e.g., wherever possible, disaggregating by ethnic subgroup)

From a sequencing perspective, the state could first define the key metrics to measure, including key performance indicators to track over time. Then, California could assess the existing data infrastructure (e.g., the ongoing population health management project within DHCS[259]), including surveying the data that is already collected and reported (e.g., through CalAIM). Based on this assessment, the state could then determine what additional enhancements to the data infrastructure would be required.[260]

The state can prioritize tracking metrics aligned to the essential crisis services (Exhibit 17).

257 NASMHPD, 988 Convening Playbook: States, Territories, and Tribes
258 NASMHPD, 988 Convening Playbook: States, Territories, and Tribes
259 DHCS CalAIM Population Health Management Initiative
260 Discussion with the Mental Health Services Oversight and Accountability Commission (MHSOAC)

Exhibit 17: Potential metrics corresponding to draft essential crisis services



Source: SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit; NASHMPHD 988 Convening Playbooks; expert interviews

Collecting demographic information allows the state to disaggregate data on the above metrics. While demographic information is voluntary, the state has achieved high completion rates and has more complete demographic data than most states.[261]

California can look to examples within and outside the state to inform its measurement strategy. Within California, for example, the 2022 DHCS Comprehensive Quality Strategy (CQS) defines measurable goals and tracks improvement across all Medi-Cal managed care (MCMC) and can serve as a foundation for a crisis-care-focused quality strategy for the state. The CQS delivery systems, which are shared back with MCMCs to improve care coordination, may also inform how the crisis care system approaches protocols so that coordination supports quality of care. The CQS will also include a set of priority clinical outcome metrics to serve as health equity metrics and be stratified by race and ethnicity to inform disparity reduction efforts.[262] Other states are also developing innovations across data infrastructure and performance management approaches, such as Tennessee's Department of Mental Health and Substance Abuse Services' collaboration with providers to monitor and manage crisis care performance through data dashboards so that individuals receive timely and quality care,[263] as well as Florida's Data Access and Collaboration on Treatment Alternatives program.[264]

261 DHCS
262 Department of Health Care Services Comprehensive Quality Strategy 2022
263 NASMHPD, 988 Convening Playbook: States, Territories, and Tribes
264 NASMHPD, 988 Convening Playbook: Mental Health and Substance Use Disorder Providers

3B. Quality of care and equity strategy: Develop a quality of care standard for crisis services strategy, including an equity-focused measurement framework

Given the integral role of equity in the mission of CalHHS, developing a quality of care and equity strategy is crucial to implementing the Plan.

To support quality care and equity within crisis services, the state may qualitatively and quantitively measure and track how individual populations engage with crisis services.[265] The 988 Convening Playbook lays out seven potential populations of focus: LGBTQ+ youth, individuals with intellectual and/or developmental disabilities (IDD), individuals who are deaf or hard of hearing, veterans, tribal members and other native populations, individuals with specific language needs, older adults, and youth involved with the juvenile justice system.[266] In addition, this focus on specific groups will require analyses across intersecting issues, including race, rural versus urban residence, and socioeconomic status.

The state may build on existing equity efforts to address behavioral health disparities among these focus populations, including through the Community Mental Health Equity Project (CMHEP). The CMHEP is a collaboration between the CDPH Office of Health Equity and DHCS Medi-Cal Behavioral Health Division, which aims to improve access to culturally and linguistically relevant behavioral health services through contracts between county behavioral health plans and community-based organizations (CBOs), 34 of which have received grants across the state and have expertise in community-defined practices for specific, underserved populations.[267]

The state may also consider building its equity framework regarding assessment tools such as the American Association for Community Psychiatry (AACP) Self-Assessment for Modification of Anti-Racism Tool. Building on existing tools from AACP, components of an equity measurement framework could include tracking of:

- **Hiring, recruitment, retention, and promotion:** Identifying and addressing disparities in the workforce and ensuring that workforce-related processes reflect values of equity in employment opportunity
- **Clinical care:** Identifying and addressing disparities in access to care, engagement in care, and quality of diagnosis and treatment
- **Workplace culture: Assessing the systems' ability to create a safe space for crisis staff, clients, and families**
- **Community advocacy:** Assessing the performance of the community service system in preventing racial disparities in outcomes
- **Population health outcomes/evaluation:** Identifying and addressing disparities in the functional and clinical outcomes of treatment at the individual and population levels[268]

265 Subject matter experts, including former state mental health department leaders (including from California and other states), directors for higher education behavioral health programs, and former leaders of the National Association of State Mental Health Program Directors

266 NASMHPD, 988 Convening Playbook: States, Territories, and Tribes

267 DHCS Efforts to Reduce Disparities in Behavioral Health

268 American Association for Community Psychiatry (AACP) Self-Assessment for Modification of Anti-Racism Tool

CalHHS is committed to routinely engaging with different population groups, including persons with lived experience, around their interactions with crisis services, and opportunities to improve. The California Reducing Disparities Project (CRDP) described earlier regularly convenes individual organizations representing five populations (African Americans, Asians and Pacific Islanders, Latinos, LGBTQ, and Native Americans) with other statewide associations such as the Mental Health Services Oversight and Accountability Commission (MHSOAC), the California Mental Health Directors Association (CMHDA), and the California Mental Health Planning Council (CMHPC) to discuss policy for crisis solutions for historically unserved and underserved communities.[269] Additionally, given the unique role of Tribes as Sovereign Nations, increased engagement and a tailored plan will be needed so that crisis systems can meet their needs in an inclusive, equitable, and collaborative way.[270]

269 California Department of Public Health – California Reducing Disparities Project

270 Subject matter experts, including former state mental health department leaders (including from California and other states), directors for higher education behavioral health programs, and former leaders of the National Association of State Mental Health Program Directors

6

CONCLUSION

This California Crisis Continuum Plan aims to start a discussion on specific details, elicit feedback on implementation considerations, and enlist support across a broad set of stakeholders to advance crisis care in all communities across the state. Over the next 18 months, as part of AB 988, CalHHS will gather data, consult with experts, and conduct statewide stakeholder engagement to get a more granular view of opportunities and challenges to transforming behavioral health crisis care in the state. Through that process, a detailed plan will emerge to implement the state's vision for a crisis care continuum that provides Californians with access to consistent, high-quality, equitable, and accessible resources that prevent, respond to, and help stabilize suicide, mental health, or substance use crises. This implementation plan will include perspectives on how to effectively finance and deliver transitions to appropriate care post-crisis, including how best to use communication strategies targeting the public to support positive outcomes.

7

APPENDIX

A. Selected California state investments in behavioral health crisis care

Investment	Description
CARE Act	• Community Assistance, Recovery, and Empowerment (CARE) Act is "intended to get Californians in crisis off the streets and into housing, treatment, and care" • $64.7 million in SY 2022/2023 to counties in the current year for start-up and implementation funds • The Administration continues to work with Judicial Council and counties to estimate costs associated with this new court process, including administrative costs for counties
Behavioral Health Continuum Infrastructure Program	• $2.2 billion to support competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources
Community Care Expansion Program	• $805 million for acquisition, construction, and rehabilitation to preserve and expand adult and senior care facilities that serve SSI/SSP and Cash Assistance Program for Immigrants • This program supports seniors and adults who are at risk of or experiencing homelessness, including those who have behavioral health conditions • It expands the state's housing and care continuum, facilitating better treatment outcomes and preventing the cycle of homelessness or unnecessary institutionalization
Behavioral Health Bridge Housing Program	• $1.5 billion to address the immediate housing and treatment needs of people experiencing unsheltered homelessness with severe behavioral health conditions by providing time-limited operational supports in various bridge housing settings, including assisted-living settings
Children and Youth Behavioral Health initiative	• $4.7 billion (including $480.5 million in the Behavioral Health Continuum Infrastructure Program described above, targeted to individuals 25 years of age and younger) to help transform the state's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs

Investment	Description
Opioid Settlements Funds	• $127.8 million to support opioid abatement programs, including, but not limited to, distribution of naloxone to homeless service providers, operation of a web-based statewide addiction treatment locator platform, support of vocational rehabilitation employment services, provider training on opioid treatment, and education and outreach campaigns
CA MAT Expansion Project	• $101 million in funding to support the Medication Assisted Treatment (MAT) Expansion Project in further reducing overdose and death related to opioid misuse by expanding the Naloxone Distribution Project, supporting 100 new MAT access points statewide, expanding MAT in county jails, and increasing MAT services within state-licensed facilities
Behavioral Health Crisis Continuum	• $20 million in one-time federal funds in 2021/2022 to expand capacity to the 12 accredited crisis call centers in California • In 2022, the California Health and Human Services Agency is starting a planning process to develop a clear strategy for how all components of the behavioral health crisis continuum interact, including connections between prevention efforts like warmlines and peer support services, 988 mental health crisis call centers, and mobile crisis response at the local level
Medi-Cal Mobile Crisis Benefit	• $1.4 billion to add qualifying community-based mobile crisis intervention services as a Medi-Cal-covered benefit available to eligible Medi-Cal beneficiaries exclusively through the Medi-Cal behavioral health delivery system • Qualifying community-based mobile crisis intervention services will be available 24 hours a day, seven days a week, and provided by a multidisciplinary mobile crisis team to Medi-Cal beneficiaries in the community
Crisis Care Mobile Units (CCMU) grants	• $205 million to California counties, city behavioral health agencies, joint groups of countries and/or city behavioral health agencies, and tribal entities for mobile crisis response services • These could include needs assessments for mobile crisis programs and implementation grants to develop new or expanded CCMU programs

Investment	Description
CalAIM Providing Access and Transforming Health (PATH) initiative	• CalAIM includes initiatives to improve behavioral health, strengthen the behavioral health continuum, and streamline access to services • $1.85 billion over five years to build up the capacity and infrastructure of community partners, including public hospitals, community-based organizations, county agencies, and others, enabling them to scale up services provided to Medi-Cal beneficiaries • The program supports resources such as additional staff, a billing system, and data exchange capabilities

Source: California DHCS Program Updates; California DCHS CalAIM Providing Access and Transforming Health Initiative; Office of the California Surgeon General Feedback on the CalHHS Crisis Care Continuum Plan, shared with CalHHS on October 26, 2022

B. Behavioral Health Task Force comment synthesis

Behavioral Health Task Force: Themes and discussion highlights

Theme	Discussion highlights
Breaking down siloes	• Create bridge services to build connections all along the currently fragmented continuum of care • Align crisis services across funding streams and payers with a no-wrong-door approach • Integrate across programs and services, including data sharing • Take a public health approach to prevention and upstream response • Clarify roles and responsibilities and increase transparency • Enhance the role of hospitals
Equitable and culturally appropriate care	• Be transparent about the equity lens • Provide non-traumatizing, anti-racist crisis response options for BIPOC, LGBTQ+, and other communities in crisis • Strengthen community-based care • Increase offerings for culturally and linguistically appropriate care • Train providers and integrate community practices into learning models

Theme	Discussion highlights	
Access, barriers, and community-based care	• Access	• Address fragmentation between delivery systems and payers • Create pathways for real-time linkages to services
	• Barriers	• There are gaps in knowledge about signs and symptoms of mental health needs and information about resources • The 24-hour limitation for crisis stabilization services is a structural barrier • Economic issues, food insecurity, and the digital divide are important barriers that disproportionately impact Black and Brown communities
	• Community-based care	• Improve local access to at least a minimal level of care • Support crisis response services as part of community centers and mutual aid efforts • Integrate wraparound services into the broader care model, with known team members providing crisis services • Create pathways beyond emergency departments and jails
Capacity and workforce	• Reconsider staffing regulations to enable more robust service models, ease of securing appointments, and making appropriate placements • Enhance provider pipeline through planned investments in short-term solutions and long-term training and development • Address retention and pathways through financial and non-remunerative measures • Support CBOS and others in ensuring the workforce is adequately competent and culturally and linguistically trained to address community mental health crises, including for the most acute and complex individuals	
Transparency and data	• Use data to prioritize and focus resources • Develop statewide resources and standardization of processes	

Theme	Discussion highlights
Funding and payers	• Invest additionally in crisis response options that are non-traumatizing to support 24/7 crisis services and to expand acute crisis, inpatient, and post-discharge services • Streamline funding for related services to decrease care delivery divisions and siloes (e.g., address lack of private insurance payment for services) • Consider additional funding opportunities (e.g., FMAP reimbursement for crisis response, Medicare to extend Medi-Cal for other purposes, shared savings mechanisms to fund alternatives to law enforcement, and ED-based crisis response)
Children, youth, and families	• Modify services to account for differences between adult and child needs • Ensure cultural and linguistic appropriateness of services to ensure engagement resonates with children and their families and meets their needs • Start prevention in early childhood • Support parents and caregivers • Close the gap in resources in educational environments
Legal and licensing	• Consider the CSU licensing category within CDPH • Revisit facility licensing requirements to ensure workability (e.g., staff requirements, the licensing process, and timelines)
Crisis and prevention	• Improve screening • Expand diversion programs, including navigation support to utilize services and early identification to prevent high-level decompensation
Crisis response	• Build on existing models
Crisis stabilization	• Consider having mobile response stabilization services as part of the Crisis Care Continuum
Other	• Consider that words may mean different things in different spaces (e.g., the word "peer") and impact resource access and services utilization • Consider opportunities to better serve individuals found incompetent to stand trial

C. Stakeholder comment synthesis

Stakeholder conversations: Themes and discussion highlights

Theme	Discussion highlights	
Breaking down siloes	• Explicit state guidance on how to integrate into a broader state system, including 988, could benefit local communities in building their crisis systems and technologies (e.g., responsibilities, timeline, frameworks, balancing county ownership versus statewide integrated system) • The state may want to develop a statewide approach to integration of technology systems • A visualization of referral processes across different levels of the crisis continuum could help coordination among crisis care providers, crisis services, and emergency services; a similar visualization across the behavioral health continuum could also help	
Equitable and culturally appropriate care	• Increased efforts are needed to meet people where they are, e.g., expanding linguistic capabilities to include individuals who are deaf or hard of hearing, supporting system-involved individuals, and expanding navigability for Tribal members and Indian Health Services • Individuals with lived experience could help align definitions relating to crisis services of all levels across stakeholders • Communities of color, in particular, may benefit from increased awareness of entry points into the behavioral health continuum of care ex-crisis	
Access, barriers, and community-based care	• Access	• Rural communities face access challenges, especially with ambulances and transportation
	• Barriers	• Increased literacy around mental health crises, e.g., players and resources, is critical for helping counties easily understand available resources and navigate individuals appropriately
		• Greater integration with primary care and more referrals to community-based behavioral health services can increase prevention • CBOs could benefit from greater state recognition and resources

Theme	Discussion highlights
Capacity and workforce	• Constrained capacity due to staffing limitations could be addressed partly through measures such as pay scale revisions, updating regulation of staffing patterns for some crisis services, and revisiting provider certification requirements • Workforce capacity and individuals in crisis could benefit from appropriately resourced peer-based services
Transparency and data	• Clear, up-to-date information on crisis-related data points across the state could benefit the state, local partners, and the general public
Funding and payers	• Clarity on and enforcement of crisis services billing and reimbursement mandates could help keep service providers operating (e.g., many counties providing mobile crisis team response are not reimbursed by payers) and reduce individuals' out-of-pocket spend • Inconsistencies with coding and billing for crisis services lead to payment challenges and gaps within claims data • Incentivizing counties and local departments to bring siloed funding resources together, e.g., regionally, could produce scaled benefits • Stakeholders should consider steady funding sources for alternatives to mobile crisis response
Children, youth, and families	• Schools would benefit from having minimum levels of behavioral health professionals, e.g., counselors and behavioral health coaches • Varied coordination exists between schools and county behavioral health services • Schools need alternative de-escalation processes and resources when 988 may not be the right default approach, e.g., school policies for substance use could focus more on harm reduction versus defaulting to disciplinary measures due to substance use
Substance use disorders	• More attention could be spent on addressing SUD, e.g., acknowledging the benefits of sobering centers and ensuring that professionals answering calls at crisis centers are training on addressing SUD-related crises and needs
Crisis and prevention	• Innovative upstream efforts could benefit the entire crisis system, e.g., expanding the use of behavioral health bridge navigators

Theme	Discussion highlights
Crisis response	• Clearer definition of roles and responsibilities among crisis care providers, crisis services, and emergency services, including how players should intersect, collaborate, and coordinate, could improve efficiency and outcomes
Crisis stabilization	• Use of crisis stabilization services outside CSUs, such as peer respite, home respite, outpatient services, and crisis residential services, are essential in stabilizing crises and should be delivered in a way that is more seamless across settings to provide continuity of care • Individuals could benefit from increased guidance on post-hospital and post-crisis support
Other	• Law enforcement should address crises thoughtfully, e.g., EMS should be activated before law enforcement as a last resort • Sustainable recovery-oriented efforts should consider social needs such as employment opportunities • Performance management and accountability should include feedback from residents

D Glossary

Term	Definition
Behavioral health	• A vital part of a person's overall health includes emotional, psychological, and social well-being. Conditions that may impact behavioral health include mental illnesses, substance use disorders, and co-occurring mental and substance use disorders
Behavioral health crisis	• Any event or situation associated with an actual or potential disruption of stability and safety as a result of behavioral health issues or condition
Behavioral health workforce	• A workforce that includes primary care clinicians, behavioral health professionals, paraprofessionals, and first responders
Community-based care	• Person-centered care delivered in the home and community
Community-based organizations	• Public or private not-for-profit resource hubs that provide specific services to the community or targeted populations within the community
County access lines	• All county mental health departments have 24/7 access lines for residents seeking assistance in a crisis and accessing local mental health programs
Crisis care	• A range of services for individuals experiencing an acute mental and/or substance use disorder crisis
Crisis receiving and stabilization services	• Provide short-term (under 24 hours) observation and crisis stabilization services in a home-like, nonhospital environment
Crisis residential programs	• Provide in-person 24-hour crisis care with the option for multiday stays
Digital apothecary	• An online repository of evidence-based digital interventions
Inpatient services	• Services are provided in a hospital or other inpatient facility where patients are admitted and spend at least one night
Mobile crisis teams	• Community-based support where people in crisis are either at home or at a location in the community
No-wrong-door policy	• The no-wrong-door policy ensures that Medi-Cal beneficiaries receive mental health services without delay, regardless of where they initially seek care. They can continue to see the provider with whom they have built a trusted relationship
Outpatient services	• Any healthcare consultation, procedure, treatment, or other service that is administered without an overnight stay in a hospital or medical facility

Population-based approach	• Inclusive and culturally relevant care that accounts for the needs, disparities, and experiences of a population
Short-term residential care	• Provide in-person 24-hour crisis care with the option for multiday stays
Respite care	• Voluntary, short-term residential programs, often operated by peers
Sobering center	• 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
Trauma-informed care	• Services or care are based on the knowledge and understanding of trauma and its far-reaching implications
Warmline	• A service, often peer-run, that offers callers emotional support
988	• 988 is the three-digit dialing code that will route callers to the National Suicide Prevention Lifeline and is now active across the United States

Source: 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; SAMHSA Advisory; NAMI Navigating a Mental Health Care Crisis; California Department of Health Care Access and Information; Centers for Medicare and Medicaid Services; US Department of Health and Human Services; Department of Health Care Services