Santa Cruz County Behavioral Health

Mental Health Services Act Innovation

Crisis Now Project | FY 24-25 Annual Report

June 2025

RDA CONSULTING

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

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

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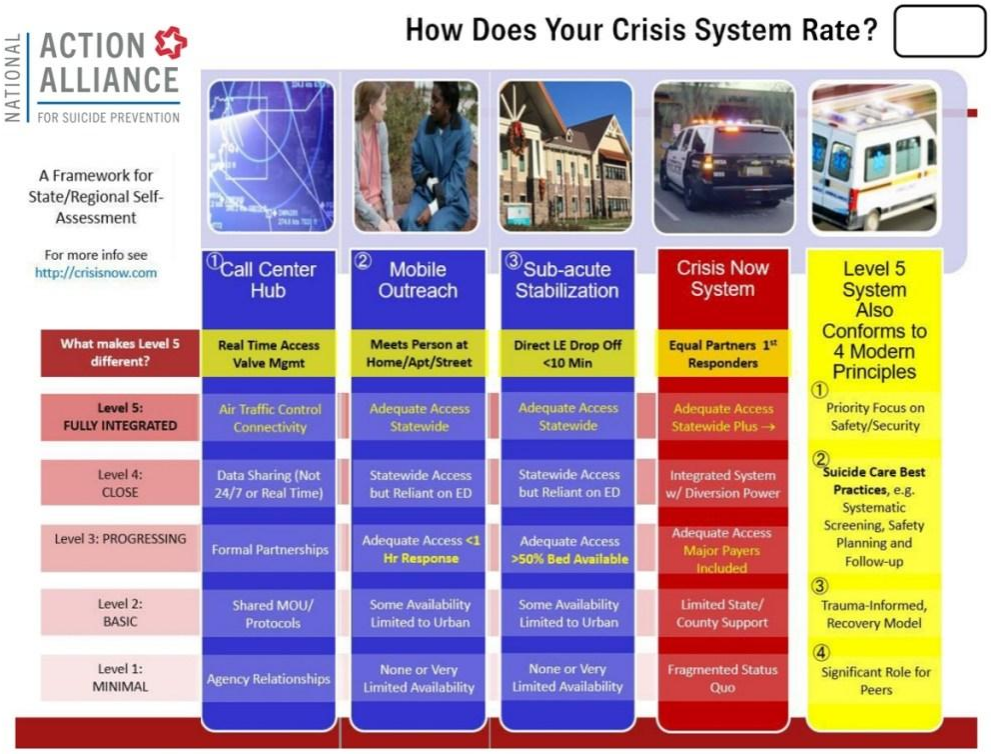
Executive Summary

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

Figure 1. Framework for State/Regional Self-Assessment (Crisis Now)[2]



[1] crisisnow.com

[2] crisisnow.com

Evaluation Overview

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

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

This evaluation employed both qualitative and quantitative data collection methods, including focus groups and a survey with crisis continuum key partners, as well as comprehensive collection of secondary data and records. The evaluation team analyzed these data sources to develop and compare FY23-24 and FY24-25 indicators of SCC Crisis Now project implementation, patient service access, patient service, outcomes, and system-level outcomes.

Key Evaluation Findings

EQ1: Crisis Now Model Implementation

This section highlights FY24-25 of Crisis Now Project implementation, describing the extent to which the model has been implemented and the changes made to the project since FY23-24. It also details key successes and challenges around support for the model, experience of the rollout, knowledge of the system, and collaboration.

In May 2025, RI International conducted a second assessment of Santa Cruz County's crisis continuum and its fidelity to the Crisis Now model. This assessment included a rating for each of the model's components on a scale of one to five, with one indicating "minimally implemented" and five indicating "fully implemented."[3] Below is a high-level summary of this initial fidelity assessment.

[3] For additional Information about the Crisis Now model and assessment tools/methodology, please visit **crisisnow.com** or contact RI International by visiting **riinternational.com**.

Summary

Since their initial Crisis Now Fidelity assessment completed by RI International In 2022, Santa Cruz County has improved their rating from "basic implementation" to "progressing" in two assessment areas: (1) 24/7 Mobile Crisis and (2) Essential Principles & Practice. Although the County has grown in the two remaining assessment categories (High Tech Crisis Call Centers and Crisis Facilities), significant progress has been somewhat hindered by factors outside of the County Behavioral Health Department's direct control (e.g., the construction timeline of the youth crisis facility, technology updates at the 988 call center). In general, there is widespread support for the expanded services within the crisis continuum of care and for the changes made so far, but many partners still express some confusion about how and when to utilize these resources.

Fidelity to Crisis Now Model

Crisis Now Model Component	2025 Fidelity Score from RI Int'l	Key Strength Areas	Key Growth Areas
High Tech Crisis Call Centers	2 out of 5 ***Basic***	• Call center infrastructure is in place In SCC (988 operated by Family Service Agency and a County-run Access Line) • Meets all the fundamental criteria for an effective call center and fulfills most requirements for Level 3 (Progressing)	• Call centers do not yet directly connect to a facility-based crisis provider, they lack access to person-specific health data, and they would benefit from an expanded local presence, data tracking capabilities, and integration with other crisis services
24/7 Mobile Crisis	3 out of 5 ***Progressing***	• SCC operates multiple MCRTs, including Mobile Emergency Response Team for adults (MERT) and youth (MERTY), and Mental Health Liaisons (MHLs) • MCRTs provide quick response times (i.e., within 1 hour), meet patients anywhere, and use systematic suicide screening and safety planning • Meets most requirements for Level 4 (Close)	• At the time of this assessment, MCRTs did not support diversion through services to resolve crisis with a rate over 60%

Crisis Care Facilities	3 out of 5 ***Progressing***	• SCC operates a 12-chair Crisis Stabilization Program (CSP) • CSP served youth, accepted law enforcement drop-offs, utilized trauma-informed and least-restrictive intervention models, and provided crisis chairs at a ratio of at least 4 per 100,000 people	• This assessment identified needs for expanding capacity, improving data integration, and utilizing peers as integral staff members
Essential Principles & Practices	2 out of 5 ***Basic***	• All three key elements above are represented and functioning with some alignment to the Crisis Now model	• This assessment identified needs for strengthening system wide integration real-time data sharing, and integration of peer support specialists as a significant role in all levels of the crisis response system

Key Project Implementation Changes & Ongoing Developments

Crisis Now Model Component	High-Level Finding
High Tech Crisis Call Centers	• Community members can access crisis services by calling the SCC Access Line 24 hours a day. Between 8a-6p, Access Line staff answer calls; after 6pm, Access Line callers are prompted to select the service that best meets their needs, one option of which includes the local 988 crisis line, run by the nonprofit Family Service Agency (FSA). SCC community members may also call 988 directly. • Since the baseline evaluation (covering FY23-24), the local 988 call line has updated their call center technology to determine the general geographic location of the caller. This allows those who possess area codes outside of the county to be connected to the local 988 crisis line instead of the national 988 crisis line, ensuring they can be connected to local mobile crisis services. • The County initially sought to utilize 988 as the primary phone number for accessing crisis services; however, this plan changed because the DHCS requirements (BHIN 23-025) mandated the use of a toll-free phone number and excluded 988 from use.
24/7 Mobile Crisis	• At the time of this report, the County's MCRTs are operating 24/7; however, there are still some field-based staff vacancies (on the MERT and MHL teams). SCCBH anticipates completing additional hiring and staff training

	within six months, at which point 24/7 MCRT operations will be fully staffed and in service.
Crisis Care Facilities	• Pacific Clinics is providing specialty trained youth crisis interventionists for a diversion project in partnership with Watsonville Community Hospital Emergency Department. In July 2023, Telecare stopped providing services to youth at the CSP. In response, the County launched a temporary project at Watsonville Community Hospital Emergency Department. Two staff members are embedded within the emergency department to provide assessments, support, and recommendations for how to proceed with patients daily from 8am-8pm. This project ends June 30, 2025. In the interim (until the Youth Center opens), youth will be directed to the hospital emergency departments. • The County is building a new facility for youth. The County is expecting to open a new facility in Live Oak with 24 beds, including an 8-chair CSP and 16-bed Crisis Residential Program. It is meant to address the current lack of treatment facilities for youth and is expected to open in late 2025.
Essential Principles & Practices	• SCCBH is working to increase its peer support specialist (PSS) capacity in the County. They are actively exploring options that will allow them to hire individuals with lived expertise and ultimately support their training to become certified PSS. • Staff are provided ongoing training in alignment with the Crisis Now model. MHLs provide annual training to law enforcement about how to respond to a person experiencing a behavioral health crisis. Training content includes a review of 5150 criteria, crisis intervention, and de-escalation skills. • The County is continuing to explore opportunities for collaboration across the crisis continuum. In addition to the ongoing crisis continuum meetings, the County is considering plans to partner with non-County entities who provide crisis care. This would include peer-based agencies and community organizations who offer these vital services.

Key Project Successes & Opportunities for Improvement

Area	High-Level Finding	
	Successes	**Opportunities for Improvement**
Support for the Crisis Now Model	There is broad community support for changes to the crisis continuum, especially for the 24/7 mobile crisis coverage. Since the FY23-24 baseline evaluation, SCCBH has continued to conduct community and key partner engagement efforts. Overall, community partners who participated in focus groups had positive impressions of the Crisis Now model.	As there is broad support for the model and this project, no improvement opportunities were identified

Experience of the Rollout	Most crisis care continuum key partners surveyed (19 out of 22) agreed or strongly agreed that the establishment of the mobile crisis team was successful. This is a substantial improvement upon the FY23-24 baseline evaluation findings.	MCRTs are still working through challenges with billing for services, and staffing remains an ongoing challenge across the crisis continuum. MHLs would like to increase the depth of their coverage (i.e., the number of units they have operating at one time). Crisis continuum partners in focus groups would like more practical information about which MCRT to call and when, and the scope of practice for each.
Knowledge of Changes to Crisis Continuum	Most crisis continuum key partners surveyed (19 out of 22) agreed or strongly agreed that they have a solid understanding of the changes to the behavioral health crisis response system, representing a modest increase in agreement from the FY23-24 baseline findings. SCCBH has increased its community outreach and education efforts, including presentations to NAMI, tabling at San Lorenzo Valley High School, and attended numerous events held by community partners.	Focus group participants indicated that their leadership and those closely involved with Crisis Now implementation have the most knowledge of changes to the crisis continuum, but this knowledge has not yet fully been ingrained among many direct care staff. Focus group participants indicated they do not feel they fully understand the differences between the MCRTs, and they do not have informational materials to distribute.
Collaboration	Similar to the FY23-24 baseline year, half of crisis continuum partners agreed or strongly agreed that The County provides spaces for providers to collaborate (9 out of 18). Crisis continuum meetings are generally well attended by partners. SCC BH acknowledges that collaboration is an ongoing process and remains committed to seeking community input and building strong relationships with partners.	Focus group participants feel there is room for improved collaboration. This sentiment was most strongly expressed by focus group participants who represented community partners and consumer advocacy groups. They are eager to contribute to ongoing MCRT training efforts for culturally responsive care and building trust with the community.

EQ2: Indicators of Patient Access to Behavioral Health Crisis Services

This section highlights indicators of patient access to behavioral health crisis services within Santa Cruz County, including key partner perceptions of access to crisis services, as well as characteristics of clients served by MCRTs and CSP admissions during FY24-25.

Summary

During FY24-25, SCC Mobile Crisis Response Teams responded to nearly 1,500 incidents with varying needs and characteristics, and crisis care facilities admitted just over 900 patients. Overall, most crisis continuum partners surveyed feel positively about the ease, availability, and swiftness of the existing MCRTs, representing an improvement from the survey results of FY23-24. Key partners from focus groups also felt that crisis care facility access has improved in several ways.

Patient Access to Crisis Services

Crisis Now Model Component	High-Level Finding
High Tech Crisis Call Centers	• Most crisis continuum partners surveyed agreed that the crisis call lines were user-friendly (13 out of 18) and provided effective service access (11 out of 18), demonstrating improvements from the baseline year. • Focus group participants noted that some consumers and their family or caregivers had difficulty remembering the number to the Access Line and would default to using 911. This issue is expected to be addressed as SCCBH increases the distribution of informational materials.
24/7 Mobile Crisis	• The County's MCRTs, including MERT, MERTY, and MHLs, responded to a total of 1,463 incidents during FY24-25, for a combined average of 163 incidents per month. Most incidents during FY24-25 involved the four MHLs (n=748), followed by MERT (n=481) and MERTY (n=234). • The average number of total monthly MCRT incidents decreased slightly in FY24-25 (163) compared with baseline (210) for the same period. The decrease in call volume is attributed to the loss of one MHL staff member, and several MCRT staff members are on temporary medical leave. • Most MERT and MERTY incidents during FY24-25 were initiated by phone requests for service (78% and 72%, respectively), and most MERT and MERTY incidents reflected initial calls for service (versus follow-up calls) (94% and 87%, respectively). • MCRT incidents occurred in a variety of locations and regions, and teams served clients of varying backgrounds and characteristics. Some of these characteristics changed from FY23-24 to FY24-25 (see table below). • Among crisis continuum partners surveyed, most feel positively about the ease, availability, and swiftness of the existing MCRTs, representing an improvement from the survey results of FY23-24. Notably, bivariate tests of statistical significance indicated that average agreement regarding MCRT ease and availability significantly increased from FY23-24 to FY24-25 (see Evaluation Question 2 Findings for additional information).[4]

[4] This evaluation used independent samples t tests (assuming unequal variances) to assess differences in average item scores between FY23-24 and FY24-25 key partner survey responses. Statistical significance level used was $p<0.05$.

Crisis Care Facilities	• The County's CSP, operated through Telecare, admitted a total of 909 patients during FY24-25, for an average of 101 admissions per month. Most CSP admissions during this period were the result of referrals from MCRTs and SCC Hospital Emergency Departments (EDs) (56%, n=509) or psychiatric holds made by law enforcement officers (LEOs) (32%, n=295), while a minority were voluntary admissions (12%, n=105). The monthly average of voluntary admissions for the FY24-25 evaluation period (n=12) is greater than that of the baseline evaluation year (n=8). This increase could partially be attributed to the CSP's decision to stop automatically placing holds on voluntary admissions. • Crisis continuum partners surveyed were divided about whether the County's facility-based crisis centers, such as Telecare's CSP, are accessible to patients who need their services (4 agreed, 7 disagreed, and 2 were unsure, each out of 18). • System partners who participated in focus groups felt that crisis care facility access has improved in several ways, including improved efficiency stemming from increased communication between hospital and CSP staff, greater acknowledgement of client autonomy with the CSP halting involuntary holds for voluntary admissions, CSP efforts to connect patients to additional services to meet their basic needs, and the forthcoming opening of a new youth crisis facility in 2025.

Key Characteristics of Patients Served Across MCRT Incidents: 2-Year Comparison

	MERT		MERTY		MHL	
	FY23-24 (n=457)	**FY24-25** (n=481)	**FY23-24** (n=272)	**FY24-25** (n=234)	**FY23-24** (n=1,164)	**FY24-25** (n=748)
Age	41% 25-44	42% 25-44	69% 12-17	65% 12-17	43% 25-44	34% 25-44
Gender	52% Male	60% Male	40% Male	47% Male	57% Male	51% Male
Race/Ethnicity	46% White	64% White	30% White	35% White	60% White	45% White
Housing Status	56% Stably Housed	55% Stably Housed	92% Stably Housed	84% Stably Housed	50% Stably Housed	58% Stably Housed
Color Key:	**Orange = % decreased** from FY23-24 to FY24-25		**Blue = % increased** from FY23-24 to FY24-25			

EQ3: Behavioral Health Patient Outcomes

This section highlights indicators of behavioral health patient outcomes in Santa Cruz County, including key partner perceptions of patient crisis dispositions and appropriate level of care placement, as well as the frequency of MCRT-initiated psychiatric holds, SCC hospital emergency department visits, and service referrals during FY24-25.

Summary

Crisis continuum partners agreed that crisis call lines have connected people to appropriate levels of care, MCRTs successfully de-escalate behavioral health crises, crisis centers stabilize patients, and that people are better off because of MCRT services. Hospital staff who participated in focus groups noted that they are receiving far fewer patients on 5150 psychiatric holds who are admitted to their emergency departments (ED) for unnecessary medical clearance. Of the third to half of MCRTs that involved a psychiatric hold assessment in FY24-25, most did not result in a psychiatric hold. MCRTs provided a variety of service referrals to clients during mobile crisis incidents that occurred throughout FY24-25.

Patient Outcomes

Outcome	High-Level Finding
Key partner Perceptions of Crisis Dispositions & Level of Care Placement	• Similar to findings in the baseline year, most FY24-25 crisis continuum partners survey respondents agreed or strongly agreed that the crisis call lines have connected individuals to the appropriate level of care for their needs (11 out of 19), that MCRTs successfully de-escalate behavioral health crises (15 out of 19), that crisis centers stabilize patients (10 out of 19), and that people are better off because of MCRT services (13 out of 19). Most survey respondents were uncertain about whether Crisis Now expansion has reduced unnecessary behavioral health emergency hospitalizations at this time (14 out of 19). • Focus group participants expressed confidence in the CSP's ability to effectively stabilize patients during their stay, stating that most clients get the help they need. However, participants also acknowledged that some clients are forced to utilize the CSP for urgent non-crisis related services, such as shelter and food. According to focus group respondents, approximately a third of clients at the CSP are unhoused, and 25-30% of those unhoused clients are high utilization clients. • Hospital staff who participated in focus groups noted they are receiving far fewer patients on 5150 psychiatric holds who are admitted to their EDs for unnecessary medical clearance. Participants also noted that law enforcement are not issuing as many unnecessary 5150 psychiatric holds (e.g., individuals experiencing psychiatric symptoms but who are not a danger to themselves, others, or gravely disabled) as in previous years.
MCRT-initiated Psychiatric Holds	• Over one third of MERT, MERTY, and MHL incidents involved a psychiatric hold assessment during FY24-25. These proportions for assessments completed exceed those from FY23-24 for MHLs (51% vs. 44%), MERT (37% vs. 14%), and MERTY (43% vs. 21%). • Of the MERT, MERTY, and MHL incidents in which psychiatric hold assessments were completed, most did not result in a written psychiatric hold. These proportions for "no psychiatric hold written" exceed those from FY23-24 for MHLs (70% vs. 67%), MERT (69% vs. 53%), and MERTY (67% vs. 51%).

MCRT-initiated Emergency Department Visits	• For the overwhelming majority of MERT, MERTY, and MHL incidents during FY24-25, clients were not sent or taken to the emergency department at Watsonville Community or Dominican Hospitals. These proportions for "not sent/taken to the ED" are similar to those from FY23-24 for MHLs (91% vs. 85%), MERT (93% vs. 91%), and MERTY (80% vs. 60%).
MCRT-initiated Service Referrals	• MCRTs provided a variety of service referrals to clients during mobile crisis incidents that occurred throughout FY24-25 (see table below). Although close to half of MERT (48%) incidents and one-third of MERTY (39%) incidents involved clients who were already connected to services, both MERT and MERTY responders referred about one-quarter of their incidents to SCCBH and/or other unspecified resources. Although relatively fewer MHL incidents involved clients who were already connected to services (15%), nearly half were referred to SCCBH or other mental health services (46%), and/or other unspecified resources (29%).

Key Service Referrals Made Across FY24-25 MCRT Incidents

Category	MERT (N=481 incidents)		MERTY (N=234 incidents)		MHLs (N=748 incidents)	
	n	%	n	%	n	%
Already Connected to Services	230	48%	91	39%	110	15%
SCCBH or Mental Health	108	22%	64	27%	346	46%
Law Enforcement/MHL	47	10%	14	6%	-	-
Emergency Department	22	5%	18	8%	36	5%
SUD Treatment	26	5%	4	2%	27	4%
Other Unspecified Resources	120	25%	45	19%	216	29%

EQ4: Santa Cruz Behavioral Health System Indicators

This section highlights indicators of Santa Cruz County's Behavioral Health System, including hiring for SCCBH and FSA crisis staff, as well as system-level factors that may be associated with Crisis Now efforts, including hospital emergency department boarding and diversion, as well as EMS (Emergency Medical Services) workload, during FY24-25.

Summary

While there have been some challenges hiring for positions across the crisis continuum, the County has been working to hire staff to support mobile crisis teams. Although hospital emergency department diversion hours have remained stable, key partners believe that boarding and transfer time for patients on a 5150 hold has decreased drastically in FY24-25. EMS data suggests the number of patients experiencing a behavioral health crisis that are transported to SCC hospital emergency departments has decreased substantially since the MCRTs have begun operating 24/7.

SCCBH & FSA Crisis Workforce Snapshot

	MERT	MERTY	MHLs	FSA
Current BH leadership staff	1 manager; 1 supervisor			1 manager; 3 supervisors
Current BH field-based Staff & Vacancies	4 hired; 2 vacancies	4 hired; no vacancies	3 hired; 4 vacancies	12 hired; no vacancies
Core Partner(s)	SCCBH, FSA	SCCBH, Volunteer Center	Sheriff's Office, Watsonville PD, Santa Cruz PD	SCCBH
Coverage	7 days per week, 8am-6pm	7 days per week, 8am-6pm	7 days per week, 8am-6pm	7 days per week; 5pm-8am next day

Hospital Boarding, Emergency Department Diversion, & EMS Workload Indicators

Area	High-Level Finding
Hospital Boarding & Emergency Department Diversion	• During focus groups in 2024, local hospital staff shared that their emergency departments were often overwhelmed by the number of behavioral health patients that they receive and indicated that they aren't always able to provide the most appropriate level of behavioral health care. • When hospital emergency departments have reached critical capacity (i.e., they can no longer safely accept additional patients), the department will go on "diversion". Santa Cruz County emergency department average monthly diversion hours have remained largely consistent, moving from 22.24 hours in FY23-24, to 25.6 hours in FY24-25. Dominican Hospital continues to average much higher diversion hours than Watsonville Community Hospital, which is to be expected, as Dominican Hospital serves a denser population area than Watsonville Community Hospital. • Though diversion trends remain stable, focus group participants shared that boarding and transfer time for patients on a 5150 hold has decreased drastically in this second year of implementation. This is attributed to improved communication between the hospital emergency departments and the CSP, as well as crisis system partners (e.g., law enforcement and EMS) bringing in fewer patients for unnecessary medical clearances. This suggests that ED capacity is no longer as heavily impacted by caring for patients on 5150 holds and are instead managing a higher proportion of medical emergencies that keep them close to full capacity. Decreasing EMS call volume data further supports this potential explanation.
EMS Workload	• During the baseline evaluation period, SCC ambulances transported, on average, 9.48 patients experiencing a behavioral health crisis to SCC hospital emergency departments each day. Since the MCRTs have begun operating 24/7 and received continued referrals, the number of patients

experiencing a behavioral health crisis that are transported to emergency departments has decreased substantially, to 5.28 calls each day.

- The decrease in patients on a 5150 or 5585 hold is also highlighted in the ambulance unit utilization rate (UUR), or the time ambulances are occupied on calls (e.g., responding, treating, transporting). FY24-25 UURs range from 0.41-0.5, approximating SCC's target UUR of 0.4 (associated with a higher quality of patient care).

SCC Behavioral Health-Related Ambulance Calls for Service

	Baseline Evaluation Period FY23-24	Current Evaluation Period FY24-25
Average Daily Total EMS Calls	77.12	72.51
Average Daily MH/BH EMS Calls	9.48	5.28

Introduction

In July 2023, Santa Cruz County Behavioral Health (SCCBH) was awarded three-year Mental Health Services Act (MHSA) Innovation (INN) funding from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to implement their Crisis Now project. All INN projects must be approved by the MHSOAC, and counties are required to submit annual, as well as a final INN Project Report, at the conclusion of the pilot. The MHSA INN funding and the Crisis Now project, along with its FY24-25 evaluation findings, are described in the sections that follow.

MHSA Innovation

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

INNOVATION (INN)

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

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

Address one of the following as its primary purpose:

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

Support innovative approaches by doing one of the following:

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

Project Overview

Project Background

In California, suicide is the 11th leading cause of death.[5] This figure Is even higher for youth, with suicide being the leading cause of death among individuals aged 10-14, the third leading cause of death among individuals aged 15-24, and the fourth leading cause of death among individuals aged 35 and 44.

Despite the acute need for mental health services, most California residents believe there are not enough mental health care workers to serve the needs of residents.[6] In Santa Cruz County (SCC), the need for behavioral health crisis services has continued to increase. According to the regional 988 call center that serves SCC, there was a 93% increase in incoming 988 calls from 2021 to 2022.[7] Unfortunately, the current crisis continuum of care is unable to adequately meet the growing needs of the community. A 2023 community engagement process revealed significant barriers to County crisis service access, including a lack of 24/7 access to mobile crisis response, a significant workforce shortage particularly at the crisis stabilization program (CSP), lack of appropriate services for youth, and lack of appropriate post-crisis services to ensure recovery.[8] In addition, due to lack of appropriate intervention, those experiencing behavioral health crises are often met with delay, detainment, or denial of service in a manner that creates undue burden on the individual, law enforcement, hospital emergency departments, and criminal legal systems.[9]

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

In response, Santa Cruz County is implementing the Crisis Now Innovation Project to strategically plan implementation of the Crisis Now Model. This established multi-

[5] Health, D. of P. (2024). State of Public Health Report. https://www.cdph.ca.gov/Programs/OPP/Pages/State-of-Public-Health-Report.aspx

[6] https://cultureishealth.org/wp-content/uploads/2022/11/CCMHSS-Final-Report.pdf

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

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

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

pronged crisis care model[10] includes high-tech crisis call centers to coordinate immediate crisis response, mobile crisis teams to respond to crises in the community, facility-based crisis centers that help divert individuals from hospital emergency departments and arrests, and a commitment to evidence-based safe care practices (such as trauma-informed care).[11]

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

Project Design

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

[10] crisisnow.com
[11] crisisnow.com

Figure 2. Four Core Elements for Transforming Crisis Services[12]

High-Tech Crisis Call Centers	Mobile Crisis Response Teams	Crisis Care Facilities	Essential Principles & Practices
These programs use technology for real-time coordination across a system of care and leverage data for performance improvement and accountability across systems. At the same time, they provide high touch support to individuals and families in crisis.	Mobile crisis offers outreach and support where people in crisis are located. Programs should include contractually required response times and medical backup.	Facility-based Crisis Centers divert people in crisis away from hospital emergency departments and arrest, booking, and detention, while providing crisis-specific interventions in safe and secure environments.	These must include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to zero suicide or suicide safer care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

Target Population

The Crisis Now project is designed to accept and serve any individual in need of crisis services in Santa Cruz County. The model emphasizes a "no wrong door" approach that accepts all patients without restrictions such as medical clearance, prior authorization, insurance, or level of crisis. Given that nearly half of Americans will experience a mental illness in their lifetime,[13] the potential target population within Santa Cruz County is significant. In SCCBH's MHSA Innovation Plan, RI International estimated that over 6,582 individuals will require acute crisis intervention services each year in Santa Cruz County, with over half of these individuals estimated to require admission to a 23-hour crisis facility with recliners.[14]

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

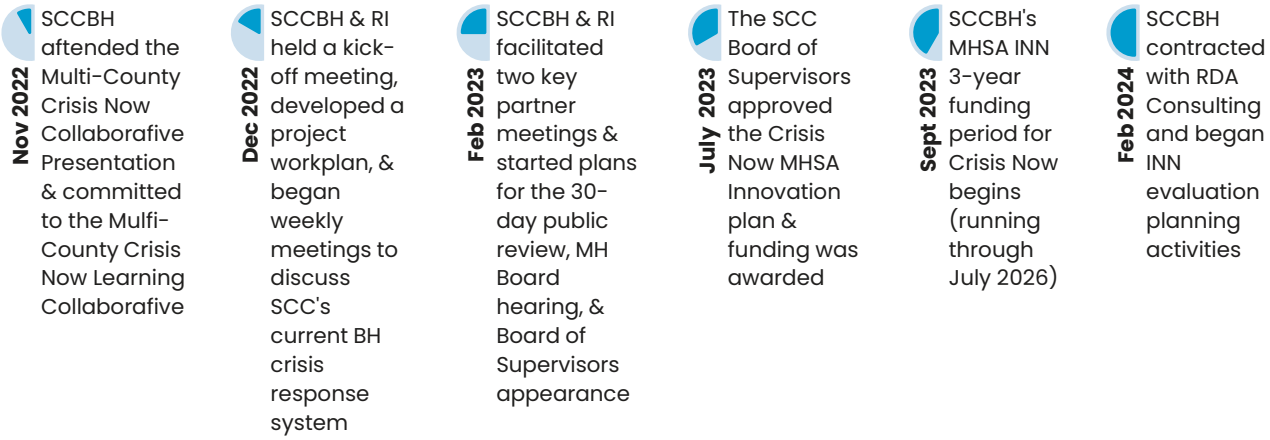
[12] Santa Cruz County Crisis Now Multi-County MHSA Innovation Plan (July, 2023).
[13] National Council for Mental Wellbeing. (2019). *5 surprising mental health statistics*. Retrieved from mentalhealthfirstaid.org/2019/02/5-surprising-mental-health-statistics
[14] Santa Cruz County Crisis Now Multi-County MHSA Innovation Plan (July, 2023).

Project Implementation

Prior to their MHSA Innovation funding, Santa Cruz County Behavioral Health (SSCBH) sought out opportunities to examine and improve their behavioral health crisis response system, beginning in November 2022 with their commitment to the Multi-County Crisis Now Learning Collaborative (see Figure 3) and subsequent proposal of an MHSA INN project aimed at optimizing county's behavioral health crisis response system and align it with the Crisis Now Model. After partnering with RI International (an expert in the Crisis Now Model) to identify gaps and recommendations for implementation of Crisis Now, the County Board of Supervisors approved the Crisis Now MHSA INN plan in July 2023, and funding began in September 2023. SCCBH's Crisis Now innovation project is funded by $5.2 million from the MHSOAC over three years, through July 2026.

As they continued working to identify gaps and recommendations for optimizing changes to SCC's crisis response system into the Fall of 2023, SCCBH contracted with RDA Consulting (RDA) to support MHSA Innovation reporting and evaluation in February 2024. Thereafter, SCCBH collaborated with RDA to plan the evaluation and begin data collection for yearly MHSA INN reports (see Figure 3).

Figure 3. SCC Crisis Now: Administrative Project and MHSA INN Funding Timeline



Both before and since their MHSA funding began in September 2023, SCCBH has made great progress in expanding and optimizing the County's crisis response system to align with the Crisis Now model. This progress, as well as additional baseline evaluation findings, are detailed in the SCCBH's FY23-24 Crisis Now MHSA INN annual evaluation

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

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

report. **Appendix B** depicts a Systems Map of Santa Cruz County's current crisis continuum, with a summary of the key components below.

- **Incident Origin**: Behavioral health crisis incidents are initiated via 911, the SCC Crisis Call Line, and/or the 988 crisis line operated by a local nonprofit, Family Service Agency (FSA).[15]
- **Response Type**: Depending on the incident origin described above and information provided by the caller, a variety of resources may be dispatched to respond. These may include law enforcement, emergency medical services via local fire departments or county wide ambulance services, or one of the county's Mobile Crisis Response Teams (MCRTs), which include: (1) Mental Health Liaisons (MHLs), clinicians who co-respond to behavioral health crises with local law enforcement, (2) Mobile Emergency Response Team (MERT), operated by SCCBH and who respond to adults experiencing behavioral health crises, and (3) Mobile Emergency Response Team for Youth (MERTY), operated by SCCBH and who respond to youth experiencing behavioral health crises.[16]
- **Incident Disposition**: Depending on a variety of factors related to the behavioral health crisis and the patient's needs, crisis dispositions vary and may include on-scene resolution, voluntary transport to a hospital or psychiatric facility, or a psychiatric hold (i.e., 5150/5585).
- **Definitive Care**: Santa Cruz County's definitive care options for behavioral health crises include (1) hospital emergency departments, including Dominican Hospital and Watsonville Community Hospitals, which have 24 beds and 12 beds, respectively, (2) the Crisis Stabilization Program[17] and Psychiatric Health Facility[18], both operated by Telecare, and (3) an out of county psychiatric facility, where patients may go in situations where SCC definitive care options are full.
- **Ongoing Care**: Options for ongoing behavioral health care in Santa Cruz County are varied, and include many community resources (e.g., NAMI, Diversity Center), private and county-based outpatient care (e.g., SCCBH's Walk-in Access centers, Connections Santa Cruz), and long-term inpatient care.

[15] fsa-cc.org
[16] For more information about each of Santa Cruz County's crisis response programs, visit: santacruzhealth.org/HSAHome/HSADivisions/BehavioralHealth/CrisisInterventionTeam(CIT)/MentalHealthEmergency.aspx
[17] telecarecorp.com/santa-cruz-county-csp
[18] telecarecorp.com/santa-cruz-psychiatric-health-facility

Evaluation Overview

In February 2024, SCCBH partnered with RDA Consulting (RDA) to begin a multi-year evaluation of the Crisis Now project, concluding in 2026. The purpose of this evaluation is to: (1) evaluate Crisis Now implementation processes and outcomes; (2) support continuous project improvement efforts; and (3) satisfy and comply with MHSA INN regulatory requirements, including annual and final evaluation reports to the MHSOAC. This second annual report provides evaluation findings for the Crisis Now project for FY24-25 (July 1, 2024-March 31, 2025).

Evaluation Domains and Questions

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

Table 1. SCC Crisis Now Project Evaluation Questions and Domains

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

Data Collection

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

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

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

Data Analysis

To address the previously described evaluation questions, RDA triangulated results from multiple data sources to produce a comprehensive and robust set of evaluation findings.

Separate analytic approaches were used to analyze quantitative and qualitative data. To assess measures from quantitative data sources (e.g., MERT/Y and MHL Workbooks, EMS Records, key partner surveys), RDA used descriptive statistics to calculate basic frequencies and percentages, such as the number of MCRT incidents that took place

during FY24-25, demographics of those who accessed MCRT services, and key partner survey ratings.

Data gathered from the qualitative data sources (e.g., key partner focus groups, meeting and program documentation, qualitative key partner survey responses), were analyzed using a systematic approach. Responses were transcribed, reviewed, and thematically analyzed to identify recurring themes and key takeaways that informed findings relevant to the evaluation questions.

The quantitative and qualitative analytic results were synthesized and interpreted together to develop mixed-method evaluation findings for FY24-25. To further address the evaluation questions, RDA compared FY24-25 findings to the previously reported FY23-24 (baseline) evaluation findings. RDA also engaged SCCBH staff and key partners in discussions around FY24-25 findings, and observed changes from FY23-24 findings, to further contextualize results.

Limitations and Considerations

Data Availability & Measurement: Data for this evaluation was limited to that which was available and retrievable from SCCBH and key partners during the evaluation period (July 1, 2024 - March 31, 2025). Although the FY23-24 (baseline) evaluation period included the entire fiscal year (due to the later report submission deadline), the current FY24-25 annual evaluation period is truncated to allow the evaluation team enough time to gather and evaluate data before the MHSA INN reporting deadline on June 30, 2025.

Although the evaluation team made diligent efforts to secure data reflecting the evaluation period of July 1, 2024-March 31, 2025, some data sources include information from periods closely following this period (e.g., project meeting notes, focus groups, and key partner surveys from April 2025). Additionally, proxy measures were used in some cases where data sources were unavailable (e.g., because data did not exist on the number of crises in which an MCRT was unavailable, this evaluation used the frequency of monthly incidents as one indicator of crisis service access via MCRTs).

Selection & Social Desirability Bias: Focus group and survey data are often subject to selection bias (e.g., self-selection into data collection activities resulting in lack of true participant and community representation), as well as recall or social desirability bias (e.g., inaccurate data provided by respondents due to lack of memory recall or attempts to appear socially desirable). These inherent limitations emphasize the importance of

triangulating multiple quantitative and qualitative data sources where it is possible to maximize validity and reliability of findings.

Causal Relationships: The analytic techniques and methodology proposed for this evaluation cannot establish *causal* relationships between project elements and outcomes. It is important to note that, because the Crisis Now project will exist in the real world (as opposed to a controlled setting), any changes or improvements observed may be due to factors unrelated to the Crisis Now project (e.g., environmental factors for which this evaluation cannot control). Therefore, this evaluation will explore non-causal associations or relationships between the Crisis Now project and observed outcomes.

Evaluation Findings

EQ1: Crisis Now Model Implementation

This section highlights FY24-25 of Crisis Now Project implementation, describing the extent to which the model has been implemented and the changes made to the project since FY23-24. It also details key successes and challenges around support for the model, experience of the rollout, knowledge of the system, and collaboration.

Summary

Since their initial Crisis Now Fidelity assessment completed by RI International In 2022, Santa Cruz County has improved their rating from "basic implementation" to "progressing" in two assessment areas: (1) 24/7 Mobile Crisis and (2) Essential Principles & Practice. Although the County has grown in the two remaining assessment categories (High Tech Crisis Call Centers and Crisis Facilities), significant progress has been somewhat hindered by factors outside of the County Behavioral Health Department's direct control (e.g., the construction timeline of the youth crisis facility, technology updates at the 988 call center). In general, there is widespread support for the expanded services within the crisis continuum of care and for the changes made so far, but many partners still express some confusion about how and when to utilize these resources.

Fidelity to Crisis Now Model

In March 2025, RI International conducted a second assessment of Santa Cruz County's implementation of and fidelity to the Crisis Now model.[19] This assessment culminated in a rating for each of the model's components on a scale of one to five, with one indicating "minimally implemented" and five indicating "fully implemented." Below is a high-level summary of this fidelity assessment. Please see Appendix D for a full breakdown of the Crisis Now Scoring tool for March 2025.

High Tech Crisis Call Centers

2 out of 5

Basic Implementation

In March 2025, RI International scored Santa Cruz County's crisis call center services at a Level 2 out of 5, or as having the "basic" components of the Crisis Now call center hub criteria. Although this score has remained consistent since the initial evaluation in late 2022, there have been significant improvements to the crisis call center operations.

[19] For additional Information about the Crisis Now model and assessment tools/methodology, please visit **crisisnow.com** or contact RI International by visiting **riinternational.com**.

It is important to note that Santa Cruz County has two crisis call centers that work closely together to ensure quality care for community members. The SCC Access Line (also known as the SCC Crisis Call Line) is operated by SCCBH. The 988 crisis line is operated by staff at Family Services Agency (FSA), a local non-profit agency affiliated with the National Suicide Prevention Lifeline. Both the SCC Access Line and the local 988 report prompt answering times, utilize systemic suicide screening and safety planning (C-SRSS) and a trauma-informed recovery model, and effectively deploy mobile crisis response teams.

In justifying this score of Level 2, RI noted that the County's crisis call centers meet most requirements for Level 3, "progressing", with two important exceptions: (1) the call centers do not yet directly connect to a facility-based crisis provider, and (2) the call centers lack access to person-specific health data. Additionally, the crisis call centers would benefit from an expanded local presence (e.g., greater awareness of the resource), data tracking capabilities, and integration with other crisis services.

24/7 Mobile Crisis

3 out of 5

Progressing Implementation

RI International scored Santa Cruz County's mobile crisis response teams (MCRTs) at a Level 3 out of 5, or as "progressing" toward full Crisis Now model fidelity for 24/7 MCRTs. The County operates multiple types of MCRTs, including MERT (Mobile Emergency Response Team, for adults), MERTY (Mobile Emergency Response Team-Youth), MHL (Mental Health Liaison), and FSA mobile crisis teams, each with a slightly different response model. Both MERT and MERTY operate with clinician oversight, are dispatched by the SCC Access Line, and operate during the day shift. MHLs also operate during the day shift but utilize a co-response model in which they are dispatched by 911 concurrently or ride with law enforcement. The FSA mobile crisis team covers both the swing and overnight shifts, with responders who are non-clinical mental health professionals dispatched via the 988 crisis counselors. Between MERT, MERTY, MHL, and FSA, the County now has full 24/7 mobile crisis response coverage. Collectively, all types of mobile crisis response teams are referred to as MCRTs.

RI International found that MCRTs responded to calls within 1 hour throughout the County, received access to real-time electronic health records, used systemic suicide screening and safety planning, and supported diversion through services to help individuals in crisis remain in the community. In fact, SCC MCRTs met all the criteria for a Level 4 score, "close", except for supporting diversion through services to resolve crisis with a rate over 60%.

Several areas were identified for progress toward full Crisis Now model fidelity for this component, including incorporating peer support specialists across the MCRT workforce, coordinating across multiple MCRTs, and aligning more closely with best practices.

Crisis Care Facilities

3 out of 5

Progressing Implementation

RI International scored Santa Cruz County's crisis care facilities at a Level 3 out of 5, or as "progressing". Santa Cruz County has one crisis care facility, the 12-chair Crisis Stabilization Program (CSP), which accepts adults who are enrolled in or eligible to enroll in Medi-Cal. The CSP utilizes a trauma-informed and least-restrictive intervention model and provides crisis chairs at a ratio of at least 4 per 100,000 people in the County.

Several areas were identified for progress toward Crisis Now model fidelity for this component, including expanding capacity, improving data integration, and utilizing peers as integral staff members.

Essential Principles and Practices

3 out of 5

Progressing Implementation

RI International scored Santa Cruz County's alignment with best practices by using the scoring sheets from the previous three categories: (1) high tech crisis call centers, (2) 24/7 mobile crisis, and (3) crisis care facilities. The county's crisis continuum was scored at a Level 3 out of 5 overall, or "progressing" toward full implementation. RI International noted that all three elements of the model are represented and function with some alignment to the Crisis Now model. Key areas for progress include strengthening system wide integration and real-time data sharing and embedding peer support specialists as a significant role in all levels of the crisis response system.

Key Project Implementation Changes & Ongoing Developments

Since the initial baseline assessment of the crisis continuum of care by RDA In FY23-24, Santa Cruz County has made strong progress with Crisis Now implementation.

High Tech Crisis Call Centers

Community members can access crisis services by calling the SCC Access Line 24 hours a day. The Access Line has staff available from 8am to 6pm, during which time staff conduct an assessment and connect callers with appropriate crisis services for their needs, which may include dispatching a MERT/Y unit to their location. After 6pm, Access Line callers are prompted to select the service that best meets their needs. If someone is seeking crisis support, they will select that option and become automatically connected

to the local 988 crisis line. The local 988, run by FSA, will then provide support to the caller over the phone. If the FSA crisis counselor determines that the caller would be best served by in-person support, they dispatch the FSA mobile crisis team. SCC community members may also call 988 directly. Since the baseline evaluation (for FY23-24), the local 988 has updated their call center technology to determine the general geographic location of the caller. This allows those who possess area codes outside of the county to be connected to the local 988 crisis line instead of the national 988 crisis line, ensuring they can be connected to local mobile crisis services.

The County initially sought to utilize 988 as the primary phone number for accessing crisis services; however, this plan changed because the DHCS requirements (BHIN 23-025) mandated the use of a toll-free phone number and excluded 988 from use.

The SCC Access Line and 988 staff plan to utilize the Beacon app for dispatching MCRTs. Both MERT/Y and the Family Services Agency (FSA) mobile crisis team are planning to utilize the Beacon app to dispatch teams into the field. The Beacon app would permit both crisis call centers and MCRTs to see the location of other units, their call status (e.g., on scene, transporting, in-service), dispatch case notes associated with the caller, as well as previous interactions at the same address or phone number. This would allow MCRTs to arrive prepared to best support a community member experiencing a behavioral health crisis.

24/7 Mobile Crisis

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

Crisis Care Facilities

Pacific Clinics is providing specialty trained youth crisis interventionists for a diversion project in partnership with Watsonville Community Hospital Emergency Department. In July 2023, Telecare stopped providing services to youth at the CSP. In response, the County launched a temporary project at Watsonville Community Hospital Emergency Department. Two staff members are embedded within the hospital emergency department to provide assessments, support, and recommendations for how to proceed with patients daily from 8am-8pm. This project ends June 30, 2025. In the interim (until the Youth Center opens), youth will be directed to the hospital emergency departments.

The County is building a new facility for youth. The County is expecting to open a new facility in Live Oak with 24 beds, including an 8-chair CSP and 16-bed Crisis Residential

Program. It is meant to address the current lack of treatment facilities for youth and is expected to open in late 2025.

Essential Principles and Practice

SCCBH is working to increase its peer support specialist capacity in the County. Leadership shared that there is not currently a strong peer culture within direct care roles in the County. They are actively exploring options that will allow them to hire individuals with lived expertise and ultimately support their training to become certified Peer Support Specialists (PSS).

As the County works to build a foundation for integrating PSS roles into various levels of care, the values of the peer recovery movement are exemplified throughout the crisis continuum. In short, the peer recovery movement is centered around "choice and voice".[20] In the context of SCCBH, this includes supporting an individual's autonomy in their own behavioral health care and relying on peers to inform a multi-disciplinary clinical practice. This has shown up in several key ways in the County. First, both the crisis call centers and MCRTs prioritize helping those in crisis remain in the community. Unlike law enforcement, MCRTs can spend more time with clients to listen to their concerns, deescalate, and safety plan. Additionally, FSA Mobile does not have clinician oversight and thus are not empowered to write involuntary psychiatric holds. Though FSA Mobile may call for assistance from a system partner if they do not feel the client can safely remain in the community, having a police-free and clinician-free initial response is a major factor in the extent to which an individual feels safe seeking support.

Second, the CSP has adjusted their practices to not automatically issue 5150 holds for voluntary admissions. This allows clients to have more choice and voice in the progression of their own crisis care and builds trust with the care team.

Third, the SCCBH actively seeks out opportunities to provide information and collaborate with community partners such as community-based organizations and nonprofits that serve those with behavioral health challenges. In addition to community engagement, the SCCBH provides a wide variety of trainings to SCCBH staff, as well as crisis continuum partners such as law enforcement and fire departments.

Staff are provided ongoing training in alignment with the Crisis Now model. MHLs provide annual training to law enforcement about how to respond to a person

[20] National Association of Peer Supporters. (2019). National Practice Guidelines for Peer Specialists and Supervisors. https://www.peersupportworks.org/wp-content/uploads/2021/07/National-Practice-Guidelines-for-Peer-Specialists-and-Supervisors-1.pdf

experiencing a behavioral health crisis. Training content includes a review of 5150 criteria, crisis intervention, and de-escalation skills.

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

Successes and Opportunities for Improvement

Support for the Crisis Now Model

There is broad community support for changes to the crisis continuum, especially for the 24/7 mobile crisis coverage throughout the county. Since the FY23-24 baseline evaluation, SCCBH has continued to conduct community and key partner engagement efforts (to be described further in the following sections). Overall, community partners who participated in focus groups had positive impressions of the Crisis Now model. They particularly appreciate the 24/7 coverage and see the FSA Mobile team as accessible for the most vulnerable populations in the county. Though community partners did request more ongoing collaboration opportunities, as well as informational materials to distribute. Community partners have also expressed their desire to contribute to the development of culturally responsive and trauma-informed training for MCRT staff.

The community partners' support of the Crisis Now model is mirrored among the crisis continuum partners, including law enforcement departments, hospital emergency departments, and fire departments. Both law enforcement and fire departments report improved understanding of the Crisis Now model and increased knowledge of MCRT resources. However, the awareness of both the model and resources, while relatively low overall, is more heavily concentrated at the leadership level. According to law enforcement leadership, police departments who regularly utilize or interact with MHLs are more likely to call for a different MCRT when MHLs are unavailable compared to departments who do not regularly work with MHLs. For departments that do not regularly work with an MHL, they describe some confusion at the direct service level about how and when to request MCRT response. Fire department leadership notes that firefighters would benefit from interactive training on how and when to request an MCRT response.

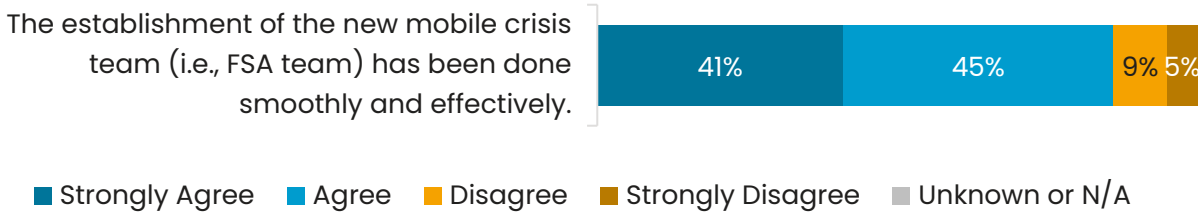
SCC hospital emergency department staff are supportive of the Crisis Now model because it is intended to help individuals in crisis receive the most appropriate level of care. Though they acknowledge that there is little awareness of the specific Crisis Now model among staff, staff are cognizant of the expansion of services and effort to streamline mental and behavioral health care at the county level. Prior to implementation

of the Crisis Now model, hospital emergency department staff described being regularly overwhelmed by the number of patients on 5150 holds because the ED is not designed to meet their needs and uses significant staff resources. Prior to implementation, transfer times for patients on a 5150 hold averaged 10 to 12 hours. Some of these delays were attributed to issues connecting with CSP staff to provide a report prior to transfer of care, as well as difficulty knowing the exact lab tests that CSP would require before accepting a transfer. Now that there is more consistent communication between the hospitals and CSP, transfer times have drastically decreased to 4-5 hours. Focus group participants also highlighted that they are receiving fewer patients on 5150 holds who are brought in for unnecessary medical clearance. Currently, when the EDs receive a patient on a 5150 hold, they more commonly also have a medical concern that needs to be addressed prior to receiving definitive care at a the CSP.

Experience of the Rollout

Now in its second year, most crisis care continuum key partners surveyed (86%) agreed or strongly agreed that the establishment of the mobile crisis team was successful (Figure 4).[21] This is a substantial improvement upon the FY23-24 baseline evaluation findings, where fewer than half of respondents agreed that the rollout had been smooth and effective. Overall, both survey respondents and focus group participants are pleased with the progress that the SCC BH team has made.

Figure 4. Key Partner Perceptions of the Rollout, FY24-25, N=22[22]



Though the rollout experience has improved overall, there remain several ongoing challenges. Internally, MCRTs are still working through challenges with billing for services, and staffing remains an ongoing challenge across the crisis continuum. Staff and community partners shared that many agencies in the crisis continuum have been understaffed for years. The pay for positions within Santa Cruz County is not competitive compared to similar positions in neighboring counties, making it difficult to attract new candidates and retain current staff. While all MCRT teams are staffed to provide 24/7

[21] The key partner survey was completed in April 2025 and yielded 22 respondents, including 10 behavioral health providers (45%), 6 law enforcement officers (27%), 1 emergency/first responder (5%), 2 911 dispatchers (9%), and 3 respondents who identified multiple roles in the crisis care continuum.

[22] Data Source: Key Partner Survey

coverage, MHLs would like to increase the depth of their coverage (i.e., the number of units they have operating at one time).

Crisis continuum partners, such as law enforcement agencies and fire departments, who participated in focus groups noted that they do not have a strong sense of the changes that have been made beyond the expansion of MCRT services. Specifically, focus group participants noted that the rollout of information needs to be disseminated in a way that focuses on the practical application of MCRTs; which MCRT to call and when, and the scope of practice for each MCRT. Additionally, knowledge of the Crisis Now model is relatively low among leadership and direct service staff. However, these crisis continuum partners have expressed a desire to be more involved and informed about ongoing changes to the crisis continuum in SCC. SCCBH acknowledges this need and has made continuous efforts to engage crisis and other community partners about the system changes. The lack of clarity for how first responders should engage MCRTs is expected to be further addressed by the development of a brief MCRT protocol memo for law enforcement and fire departments to have on hand.

"It's really unclear and we could really use some concrete across-the-board information. There is a huge gap in understanding the system from our 300 firefighters and 75 AMR staff in terms of how to access these resources and quickly". - Focus Group Participant

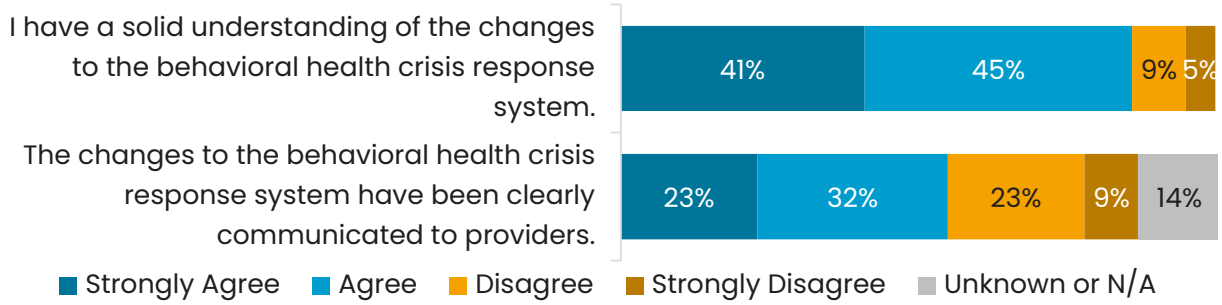
Additionally, some community-based and crisis continuum partners feel that there has not been enough information shared with the community about the services provided by MCRTs. They would like more accessible information to distribute to those who may benefit from MCRT services. One focus group participant highlighted the need to promote awareness of MCRT services in more culturally specific ways. Promotion of MCRTs and the Crisis Now model is available in both English and Spanish. However, more community members may be reached with communication strategies tailored to how they consume information and their age demographic (e.g., geo-targeted social media advertisements for youth).

Knowledge of the Changes to the Crisis Continuum

Most crisis continuum key partners surveyed (86%) agreed or strongly agreed that they have a solid understanding of the changes to the behavioral health crisis response system in Year 2 (Figure 5). This represents a modest increase compared to the baseline evaluation (77%). The County has made efforts to reach key partners and communicate changes. While nearly 1 In 4 key partners (23%) strongly agreed that

communication was clear, close to half (46%) were unaware or dissatisfied with the clarity of communication (Figure 5). These results align with the sentiments shared in the focus groups that leadership and those closely involved with Crisis Now implementation have the most knowledge of changes to the crisis continuum, but this knowledge has not yet fully been ingrained among many direct care staff.

Figure 5. Key Partner Knowledge of the Changes to the Crisis Continuum, FY24-25, N=22[23]



Focus group participants from community-based partners feel that communication about changes has not been clear. Specifically, they do not feel they can accurately describe the resources to clients when they do not fully understand the differences between the MCRTs, and they do not have informational materials to distribute.

Over this evaluation period, the County has increased its community outreach and education efforts. These efforts include presentations to NAMI, tabling at San Lorenzo Valley High School, and attended numerous events held by community partners. Though increasing community and partner knowledge is a gradual process, MCRT leadership is encouraged by improved awareness among law enforcement agencies and the uptick in call for service from community members. Additionally, SCCBH is working to make crisis continuum meeting presentations more interactive and discussion focused to encourage active participation of attendees.

Collaboration

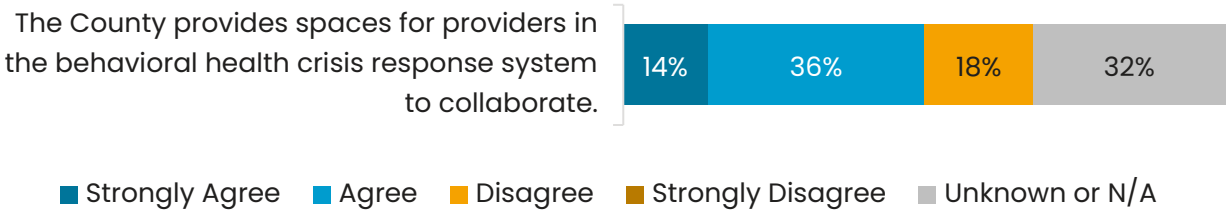
In FY24-25, surveyed crisis continuum key partners continue to have mixed feelings about spaces for collaboration on the new behavioral crisis response system (Figure 6). While monthly crisis continuum meetings are generally well attended, some providers feel there is room for improved collaboration. This sentiment was most strongly expressed by focus group participants who represented community partners and consumer advocacy groups. They are eager to contribute to ongoing MCRT training efforts for culturally responsive care and building trust with the community. Some feel that their outreach to the County falls through the cracks. Additionally, there is room for improvement when it comes to data sharing among continuum partners.

[23] Data Source: Key Partner Survey

SCC BH acknowledges that collaboration is an ongoing process and remains committed to seeking community input and building strong relationships with partners.

"I am very happy with this progress. I know there are lots of good people working at the county that helped make this happen. The biggest issue in my mind is still that the information is not shared widely." -Key Partner Survey Respondent

Figure 6. Key Partner Perceptions of Collaboration, FY24-25, N=18[24]



[24] Data Source: Key Partner Survey

EQ2: Patient Access to Behavioral Health Crisis Services

This section highlights indicators of patient access to behavioral health crisis services within Santa Cruz County as it continues to implement the Crisis Now model, and associated changes in these indicators since FY23-24. Specifically, this section describes crisis continuum partner perceptions of access to crisis call centers, MCRTs, and crisis care facilities in Santa Cruz County, as well as characteristics of clients served by MCRTs and CSP admissions during FY24-25.

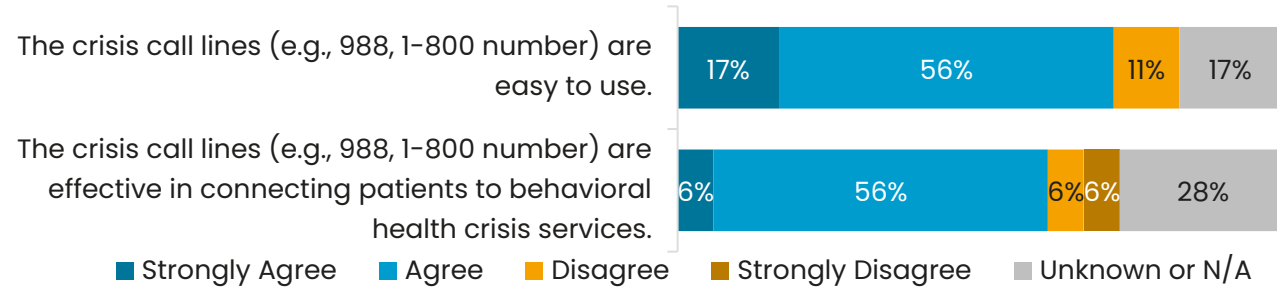
Summary

During FY24-25, SCC Mobile Crisis Response Teams responded to nearly 1,500 incidents with varying needs and characteristics, and crisis care facilities admitted just over 900 patients. Overall, most crisis continuum partners surveyed feel positively about the ease, availability, and swiftness of the existing MCRTs, representing an improvement from the survey results of FY23-24. Key partners from focus groups also felt that crisis care facility access has improved in several ways.

High Tech Crisis Call Centers

In Year 2, a greater proportion of crisis continuum partners surveyed were aware of the crisis call lines, and most agreed that the call lines were user-friendly and provided effective service access (Figure 7). At baseline, one-third (33%) of key partners surveyed could not answer questions about the ease of use and effectiveness of the call lines, compared to 17% and 28% of respondents in FY24-25, respectively. Key partners surveyed in In FY24-25 agreed about the call lines' ease and effectiveness at similar rates to baseline. Focus group participants noted that some consumers and their family or caregivers had difficulty remembering the number to the Access Line and would default to using 911. This issue is expected to be addressed as SCC BH increases the distribution of informational materials.

Figure 7. Key Partner Perceptions of Crisis Call Lines, FY24-25, N=18[25]



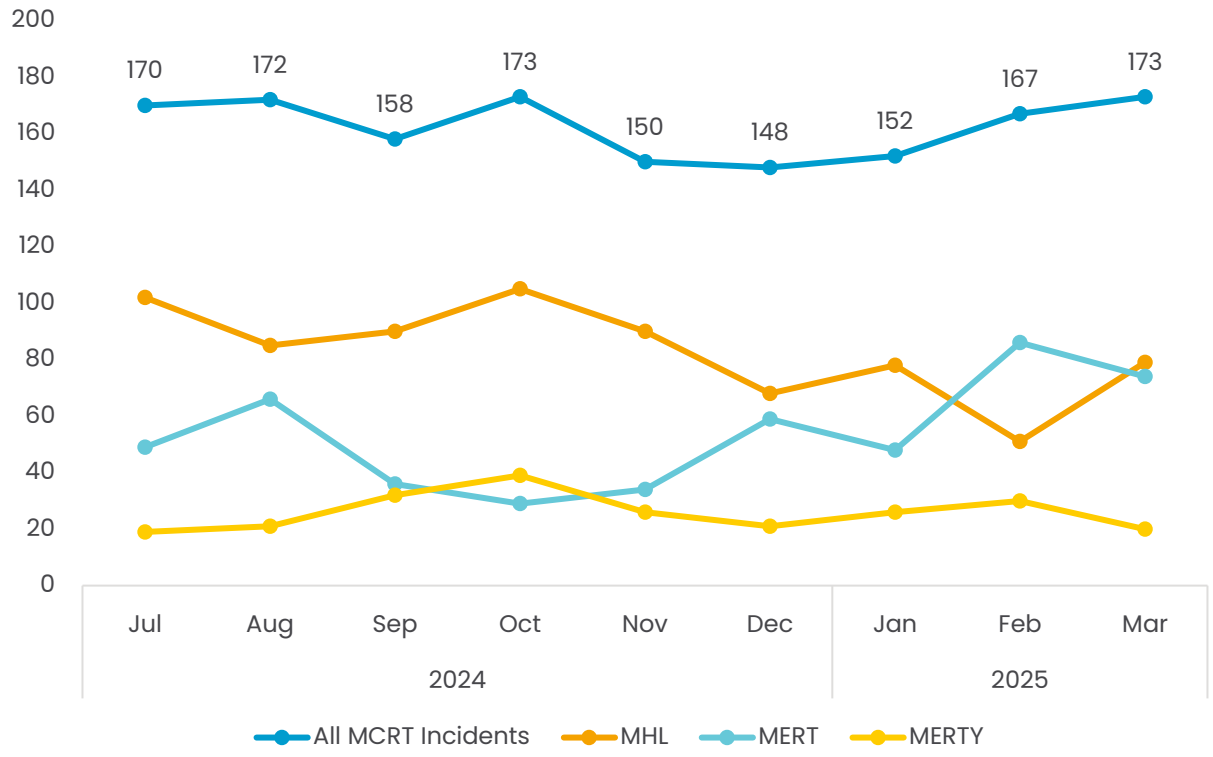
[25] Data Source: Key Partner Survey

24/7 Mobile Crisis

MCRT Incident Characteristics

The County's MCRTs, including MERT, MERTY, and MHLs, responded to a total of 1,463 incidents during FY24-25, for a combined average of 163 incidents per month. Most incidents during this period involved the four MHLs (n=748), followed by MERT (n=481) and MERTY (n=234). The MHLs responded to 83 average incidents per month, while MERT and MERTY responded to 53 and 26 average incidents per month, respectively. Overall, the number of monthly MCRT incidents decreased slightly during the winter holiday period (November - January) and returned to initial levels by February 2025 (see Figure 8). MHL incidents account for approximately half (51%) of all incidents, compared to about two-thirds (67%) during the baseline evaluation period. The average number of total monthly incidents decreased slightly in FY 24-25 (163) compared with baseline (210) for the same period. The decrease in call volume is attributed to the loss of one MHL staff member, and several MCRT staff members are on temporary medical leave.

Figure 8. Monthly MCRT Incidents, FY24-25[26]

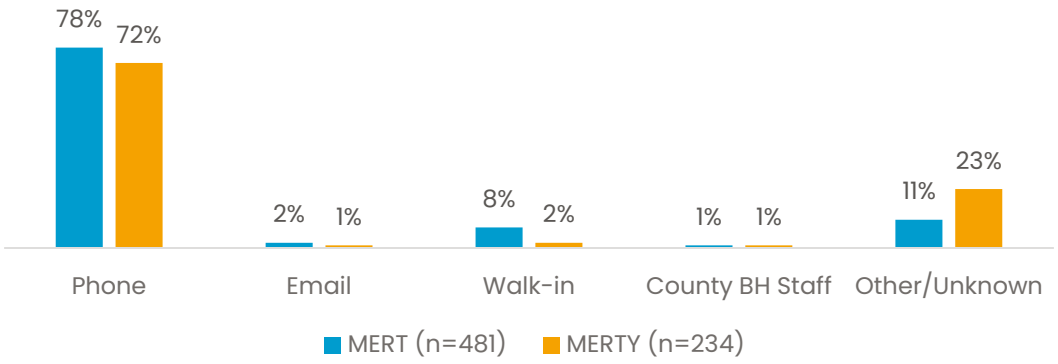


Most MERT and MERTY incidents during FY24-25 were initiated by phone requests for service (78% and 72%, respectively; see Figure 9). Less-frequent service request types included email, walk-in, and initiation by County behavioral health staff. This finding

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

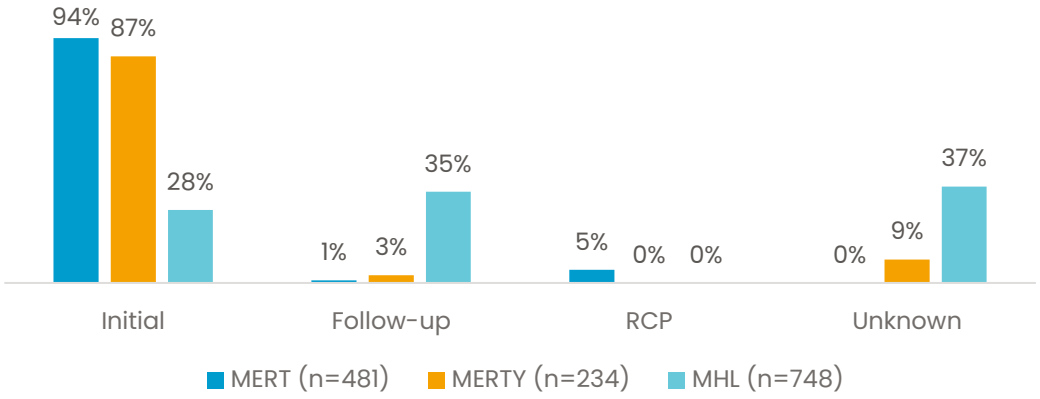
resembles that of FY23-24, except that MERT phone service requests increased (up from 55% in FY23-24) and email service requests decreased (down from 23% in FY23-24) from years 1 to 2.

Figure 9. MCRT Service Request Types, FY24-25[27]



The vast majority of MERT and MERTY incidents during FY24-25 represented initial calls for crisis service (94% and 87%, respectively; see Figure 10). Fewer MERT and MERTY incidents reflected follow-up and "Rapid Connect Program" (RCP)[28] service contacts. In contrast, just 28% and 35% of MHL Incidents represented initial and follow-up calls for service during this period, respectively (note that 37% of MHL incidents were classified as "unknown", or missing information for this measure).

Figure 10. MCRT Service Contact Types, FY24-25[29]



Most MCRT incidents were classified as mental health-related; fewer were alcohol/drug-related. Across all MCRTs, 80% or more of incidents were considered mental health-related (see Figure 11). Although few incidents were considered

[27] Data Source: MERT, MERTY, & MHL Workbooks. Information about service request types were not available for MHLs.
[28] The Rapid Connect Program (RCP) is a program designed to follow-up with individuals leaving hospitals who have previously accessed mobile crisis services.
[29] Data Source: MERT, MERTY, & MHL Workbooks. Information about service contact types were not available for MHLs. Note that "Follow-up" contact types are inclusive of follow-up through the County's Rapid Connect Program (RCP).

alcohol/drug-related across MCRTs (based on available data), MHLs had the highest proportion of incidents classified as such (32%; see Figure 12). These findings (both for mental health- and alcohol/drug-related incidents) mirror those of FY23-24.

Figure 11. Mental Health-Related MCRT Incidents, FY24-25[30]

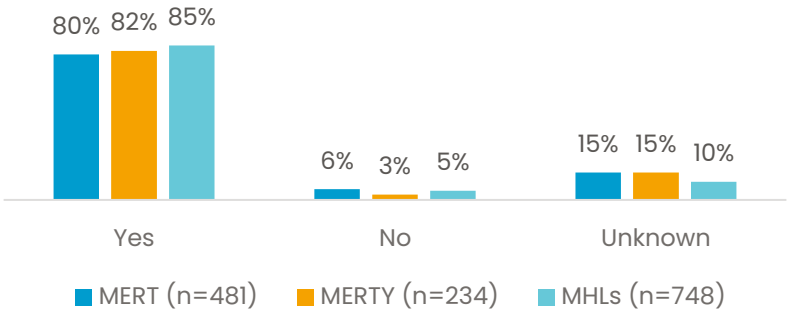
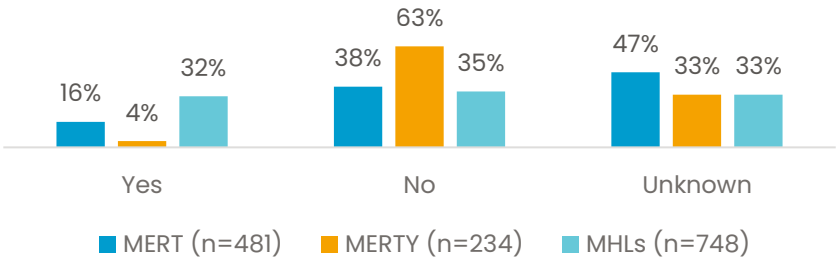


Figure 12. Alcohol/Drug-Related MCRT Incidents, FY24-25[31]



MCRT incidents occurred in a variety of locations and regions during FY24-25. Most MERT incidents took place over the phone (45%), at home (16%), or in the field (18%) and in the North County region (78%) (see Figures 13 and 14). MERTY incidents most commonly took place at a hospital emergency department (25%), over the phone (23%), or at school (21%) and were fairly split between North (45%) and South (46%) County regions. Due to differences in workbook tracking, less location information was available for MHL incidents; however, at least a third of MHL incidents took place over the phone (34%), and in the South County region (34%). In FY24-25, a larger proportion of MERTY and MHL incidents took place In South County compared to FY23-24 (each increased approximately 10% from year 1 to 2). The regional proportions of MERTY incidents remained similar from year 1 to 2.

[30] Data Source: MERT, MERTY, & MHL Workbooks.
[31] Data Source: MERT, MERTY, & MHL Workbooks.

Figure 13. MCRT Incident Location Type, FY24-25[32]

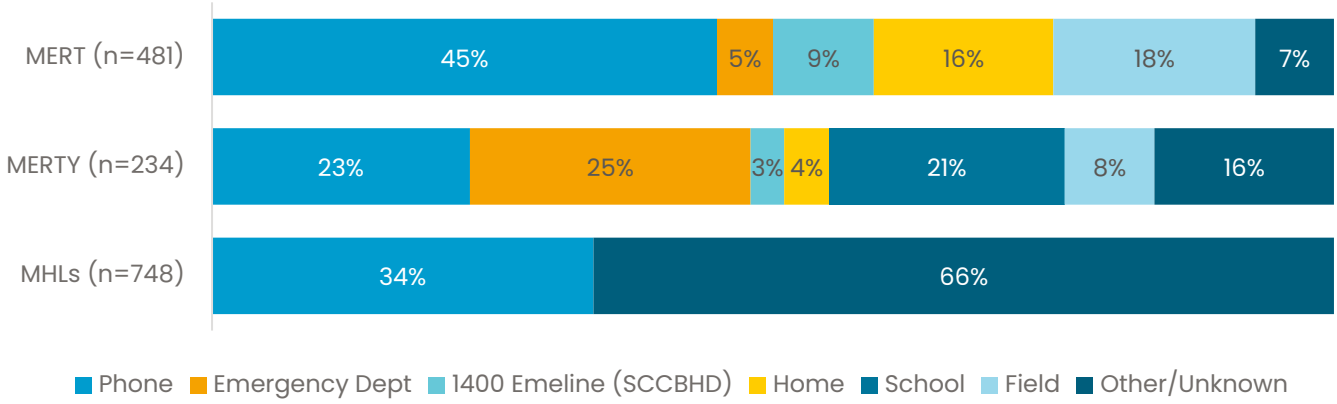
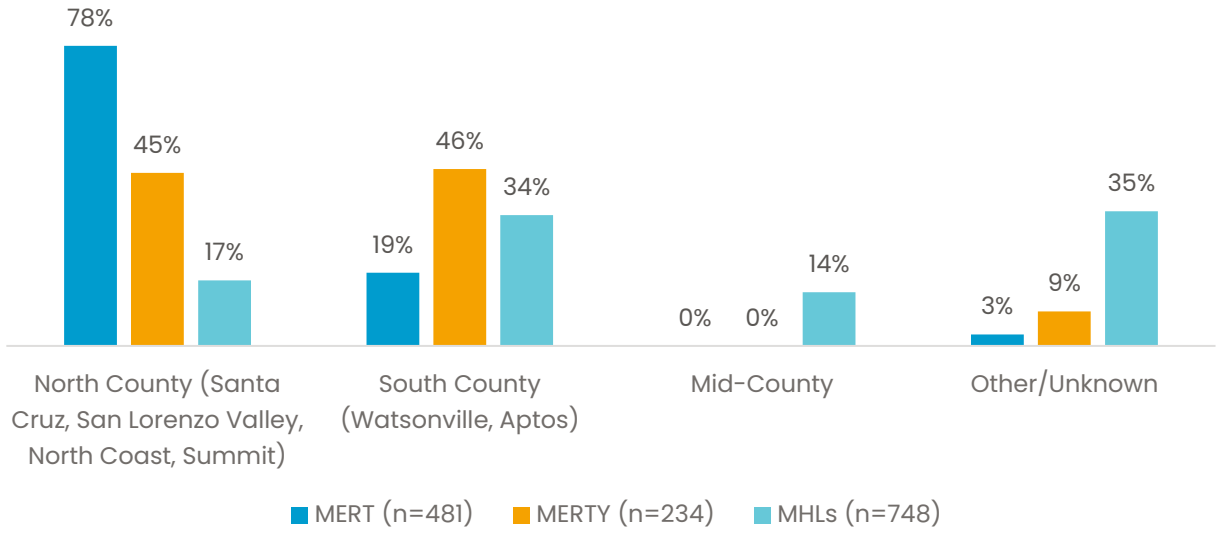


Figure 14. MCRT Incident Region, FY24-25[33]



Characteristics of Clients Served Across MCRT Incidents

The MCRTs served clients of varying backgrounds and characteristics (see Table 3). Most MERT and MHL incidents involved clients between 25-64 years old (71% and 55%, respectively), while the majority of MERTY incidents involved youth under the age of 18 (80%). Most MERT incidents involved male clients (60%), approximately half of MHL and MERTY incidents involved male clients (51% and 47%, respectively). In line with 2024 census data for Santa Cruz County[34], most MERT, MERTY, and MHL incidents involved clients who identified as White (64%, 35%, and 45%, respectively) or Hispanic/Latinx (10%, 35%, and 35%, respectively). The vast majority of MERT, MERTY, and MHL incidents involved clients whose primary language was English (91%, 87%, and 87%, respectively). Additionally, although the

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

majority of all MCRT incidents involved clients who were stably housed at the time, nearly a quarter of MERT and MHL incidents involved unhoused clients (22% and 19%, respectively).

Table 3. Characteristics of Clients Served Across MCRT Incidents, FY24-25[35]

Category*	MERT (n=481 incidents)		MERTY (n=234 incidents)		MHLs (n=748 incidents)	
	n	%	n	%	n	%
Age						
Under 18 years	41	9%	188	80%	56	7%
18-24 years			26	11%	82	11%
25-44 years	203	42%	0	0%	258	34%
45-64 years	138	29%	0	0%	153	20%
65+ years	77	16%	20	8%	141	19%
Unknown	22	5%			58	8%
Gender						
Male	290	60%	109	47%	378	51%
Female	191	40%	96	41%	370	49%
Another Gender or Unknown			29	12%		
Race/Ethnicity						
White	307	64%	81	35%	334	45%
Hispanic/Latinx	50	10%	83	35%	265	35%
Another Race/Ethnicity	27	6%	22	8%	37	5%
Unknown	97	20%	48	21%	112	15%
Primary Language						
English	440	91%	203	87%	651	87%
Another Language or Unknown	41	9%	31	13%	97	13%
Housing Status						
Stably Housed	265	55%	196	84%	433	58%
Unhoused: Shelter or Streets	107	22%	38	16%	144	19%
Risk of Homelessness	38	8%			70	9%
Another Status	37	8%			101	13%
Unknown	34	7%				

*Note that the frequencies and proportions for some categories that represented groups of individuals between 1-11 have been collapsed. This practice complies with DHCS public reporting guidelines for masking personal information representing groups or subgroups of 1-11 individuals, in order to reduce the risk of potential disclosure of personal information (see also California Civil Code 1798.24). For more information on this practice, please refer to the following guidance: **https://www.dhcs.ca.gov/dataandstats/Pages/PublicReportingGuidelines.aspx**.

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

Some characteristics of clients served across MCRT incidents changed from FY 23-24 to FY 24-25 (see Table 4). Notably, for MERT, the proportion of incidents involving White adults increased by 18% (from 46% to 64%). For MERTY, the proportion of incidents involving youth who were stably housed decreased 8% (from 92% to 84%), though the majority were stably housed in both years. For MHLs, the proportion of incidents involving White adults decreased 15% from FY 23-34 to FY 24-25 (from 60% to 45%).

Table 4. Characteristics of Clients Served Across MCRT Incidents: 2-Year Comparison[36]

	MERT		MERTY		MHL	
Client Characteristics	**FY23-24** (n=457)	**FY24-25** (n=481)	**FY23-24** (n=272)	**FY24-25** (n=234)	**FY23-24** (n=1,164)	**FY24-25** (n=748)
Age	41% 25-44	42% 25-44	69% 12-17	65% 12-17	43% 25-44	34% 25-44
Gender	52% Male	60% Male	40% Male	47% Male	57% Male	51% Male
Race/Ethnicity	46% White	64% White	30% White	35% White	60% White	45% White
Housing Status	56% Stably Housed	55% Stably Housed	92% Stably Housed	84% Stably Housed	50% Stably Housed	58% Stably Housed
Color Key:	**Orange = % decreased** from FY23-24 to FY24-25		**Blue = % increased** from FY23-24 to FY24-25			

Key Partner Perceptions of MCRT Access

Among crisis continuum partners surveyed, most feel positively about the ease, availability, and swiftness of the existing MCRTs (Figure 15). This represents an improvement from the survey results of FY23-24, where 66-75% of respondents felt they could not comment or did not agree with the statements about the ease, availability, and swiftness of the MCRTs. **Notably, bivariate tests of statistical significance Indicated that average agreement regarding MCRT ease and availability *significantly increased* from FY23-24 to FY24-25.**[37] Specifically, average agreement with MCRT ease of access *and* availability both increased from a score of 2.4 ("Disagree") in FY23-24 (n=9 respondents for items) to a score of 3 ("Agree") in FY24-25 (n=15 survey respondents for items)[38]

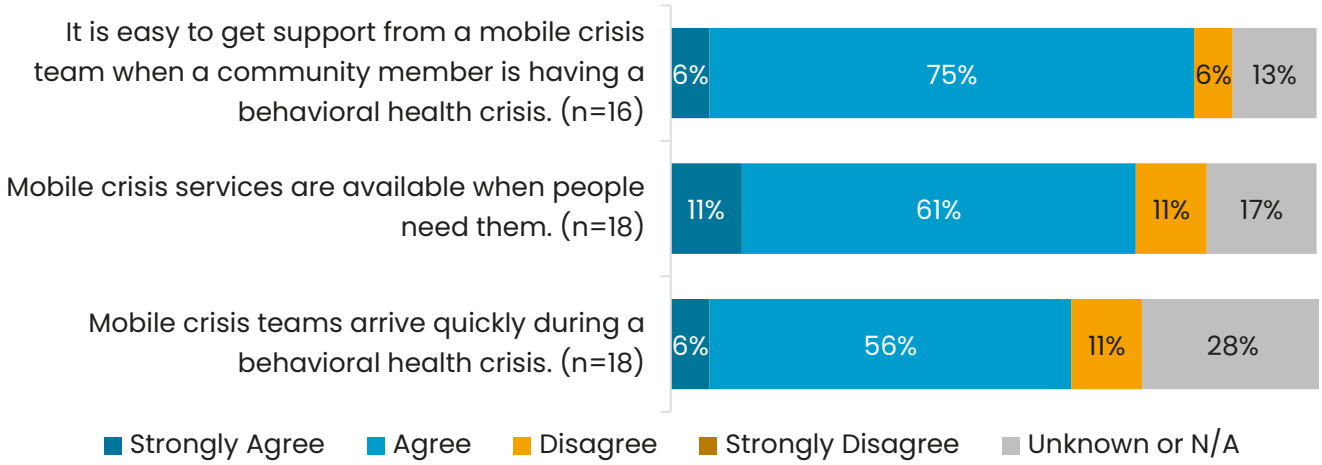
Survey respondents and focus group participants expressed excitement about the expanded 24/7 MCRT availability, a longtime goal of many community members. Additionally, MERTY has a particularly positive reputation within the community. Overall,

[36] Data Source: MERT, MERTY, & MHL Workbooks. Note that client characteristics are presented at the MCRT incident-level (i.e., clients may be duplicated across incidents).
[37] This evaluation used independent samples t tests (assuming unequal variances) to assess differences in average item scores between FY23-24 and FY24-25 key partner survey responses. Statistical significance level used was $p<0.05$.
[38] Survey items used the following Likert scale scoring categories for comparing average scores: 1=Strongly Disagree, 2=Disagree, 3=Agree, and 4=Strongly Agree

focus group respondents feel that MCRT utilization and trust among system partners is gradually improving.

"MERTY has a positive image and reputation, that MERTY is special and attentive and will take their time." - Focus Group Participant

Figure 15. Key Partner Perceptions of MCRTs, FY24-25[39]



Survey respondents and focus group participants identified several areas for growth, including clearly defining the MCRTs scope of practice, and successfully connecting with clients for a follow-up. Because each MCRT operates slightly differently, there is some confusion among potential consumers and system partners about who is the most appropriate resource to reach out to. Additionally, a substantial portion of the client population (particularly for MHLs) are unhoused, rendering It difficult to locate the client for a follow-up via phone or provider connection.

Crisis Care Facilities

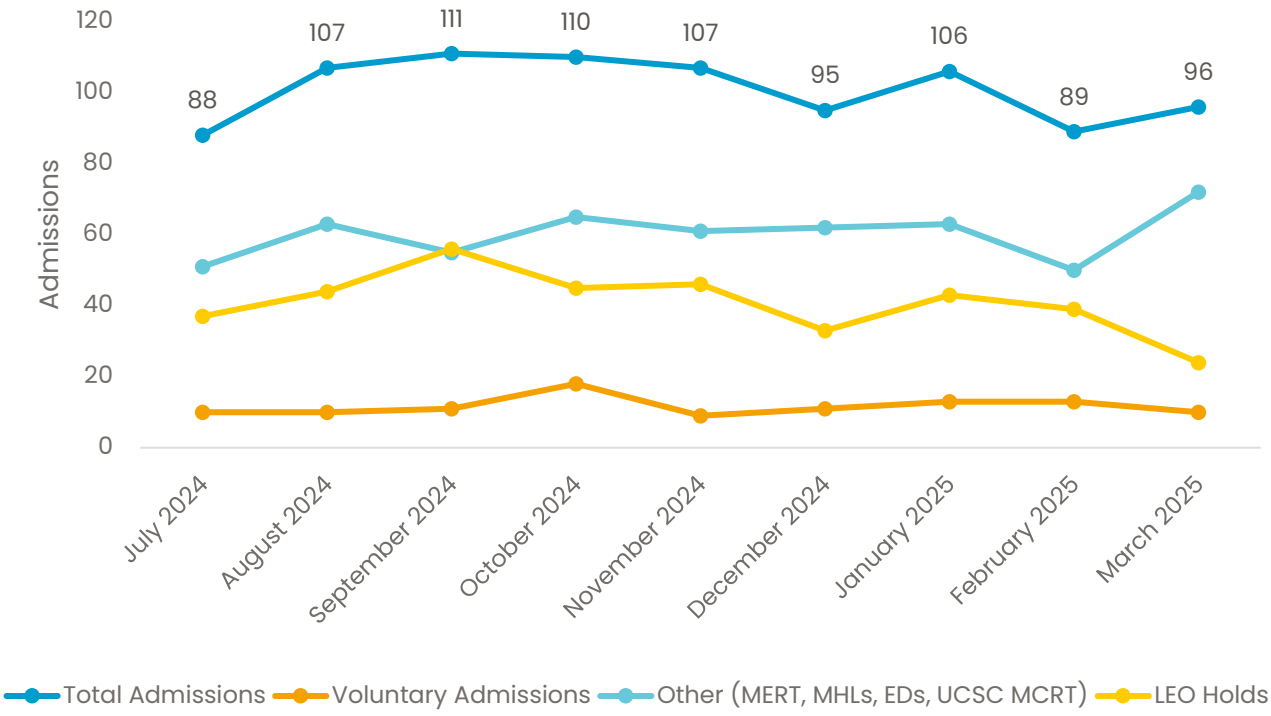
CSP Admissions

The County's CSP, operated through Telecare, admitted a total of 909 patients during FY24-25, for an average of 101 admissions per month. Most CSP admissions during this period were the result of referrals from MCRTs and SCC Hospital Emergency Departments (EDs) (56%, n=509) or psychiatric holds made by law enforcement officers (LEOs) (32%, n=295), while a minority were voluntary admissions (12%, n=105). The monthly average of voluntary admissions for this evaluation period (n=12) is greater than that of the baseline

[39] Data Source: Key Partner Survey

evaluation year (n=8). This increase could partially be attributed to the CSP's decision to stop automatically placing holds on voluntary admissions.

Figure 16. Monthly SCC CSP Admissions, FY24-25[40]



Key Partner Perceptions of CSP Access and Overall Behavioral Health Crisis Services

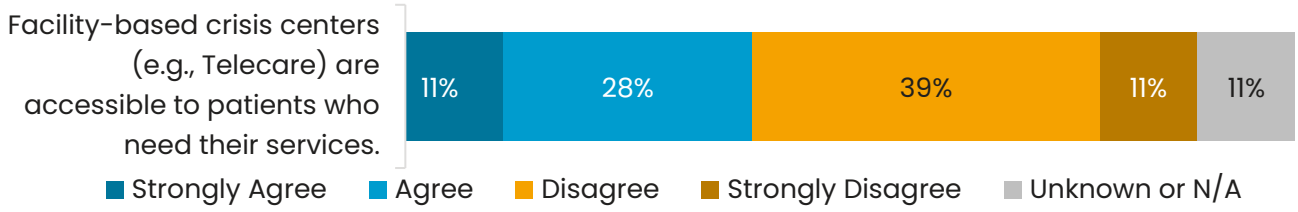
Crisis continuum partners surveyed were divided about whether the County's facility-based crisis centers, such as Telecare's CSP, are accessible to patients who need their services (Figure 17). System partners who participated in focus groups felt that access has improved in several ways. First, transfers from the hospital emergency department are far more efficient due to improved active communication between hospital and CSP staff. Second, the CSP has stopped issuing involuntary holds for voluntary admissions. This practice was previously intended to ensure a client would not leave care prior to receiving services. However, this practice was adjusted to better acknowledge a client's autonomy in their own care and maintain a strong rapport with the client. Third, CSP staff are working to address the broader needs of their client community, many of whom are unhoused. This involves connecting them to additional services and resources to help meet their basic needs. Lastly, the youth crisis facility is anticipated to open in late 2025, allowing youth to receive care closer to home instead of being transferred out of county or being treated at the Youth Diversion Project at Watsonville Community Hospital Emergency Department.

[40] Data Source: CSP Database

Despite these prior and forthcoming improvements, there remains room for growth in improving crisis facility access for SCC community members. Some community partners highlighted that those who rely on the CSP for meeting basic needs (e.g., shelter, food, hygiene) must do so because there are not enough sub-acute facilities or services to help them gain traction in their recovery. Focus group participants note that a sobering center and crisis step-down facilities would be beneficial.

"We're doing better with voluntary clients; we don't have to write a [5150] hold. Once MERT explains everything, we'll be doing well with those clients…We used to have that mindset here too, of needing to be on a [5150] hold to be in the CSP. But we're moving towards voluntary. The majority of clients are getting the help they need here". -Focus Group Participant

Figure 17. Key Partner Perceptions of CSPs, FY24-25, N=18[41]

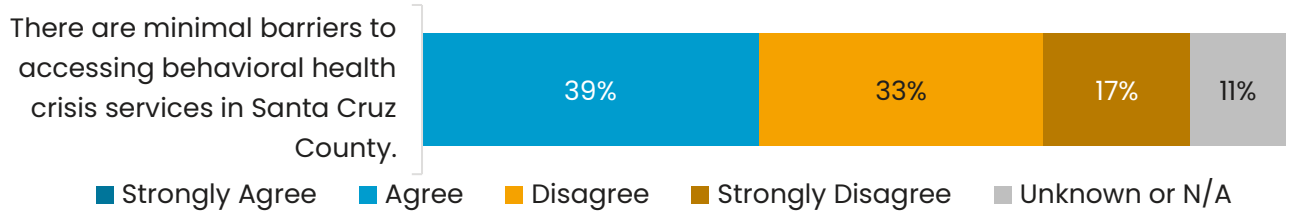


Among crisis continuum partners surveyed, half disagreed or strongly disagreed that there are minimal barriers to behavioral health crisis service access in Santa Cruz County (50%; see Figure 18). This finding has remained consistent with the baseline evaluation. One potential explanation is that both the CSP and the MCRTs are mandated to serve Medi-Cal recipients. While MCRTs are payor source blind in how they administer services, the majority of their clients are either eligible for or already enrolled in Medi-Cal. However, the CSP does not accept private insurance, making it difficult for those who do not receive Medi-Cal or are not eligible for Medi-Cal to receive facility-based crisis care without having to go out of the county. Additional barriers include stigma around receiving facility-based care, previous negative experiences with the crisis system or involuntary holds, and limited capacity of crisis care facilities (however, since the CSP has shifted to serving only adults, it has drastically reduced the frequency with which it must temporarily stop accepting new clients due to staff capacity). It is expected that, with

[41] Data Source: Key Partner Survey

enough time and promotion of new practices, the community trust in facility-based crisis care will improve.

Figure 18. Key Partner Perceptions of Barriers to Crisis Service Access, FY24-25, N=18[42]



EQ3: Behavioral Health Patient Outcomes

This section highlights indicators of behavioral health patient outcomes in Santa Cruz County as Crisis Now continues its implementation, and associated changes in these indicators since FY23-24. Specifically, this section describes crisis continuum partner perceptions of patient crisis dispositions and appropriate level of care placement, as well as the frequency of MCRT-initiated psychiatric holds, hospital emergency department visits, and service referrals, during FY24-25.

Summary

Crisis continuum partners agreed that crisis call lines have connected people to appropriate levels of care, MCRTs successfully de-escalate behavioral health crises, crisis centers stabilize patients, and that people are better off because of MCRT services. Hospital staff who participated in focus groups noted that they are receiving far fewer patients on 5150 psychiatric holds who are admitted to their hospital emergency departments (ED) for unnecessary medical clearance. Of the third to half of MCRTs that involved a psychiatric hold assessment in FY24-25, most did not result in a psychiatric hold. MCRTs provided a variety of service referrals to clients during mobile crisis incidents that occurred throughout FY24-25.

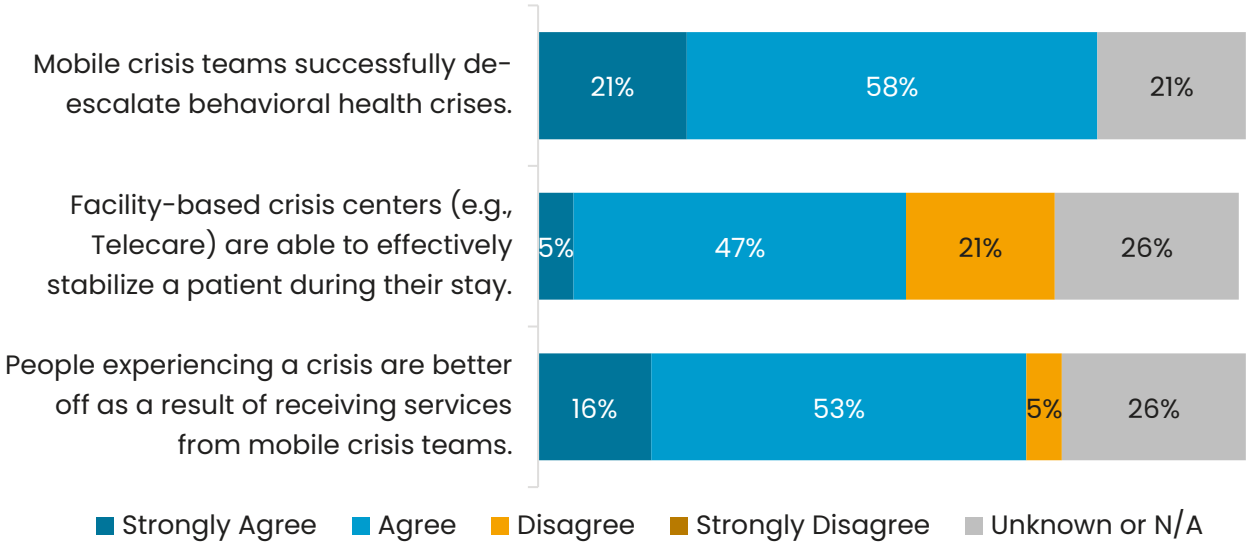
Key Partner Perceptions of Crisis Dispositions

Most crisis continuum partner survey respondents agreed or strongly agreed that MCRTs successfully de-escalate behavioral health crises (79%)**, that crisis centers stabilize patients** (52%)**, and that people are better off because of MCRT services** (69%; see Figure 19). These results are similar to those from the FY23-24 key partner survey. Focus group participants expressed similar confidence in the MCRTs' and the CSP's abilities to successfully manage behavioral health clients. Community-based

[42] Data Source: Key Partner Survey

organization staff shared that having crisis response options that are free from law enforcement represents a significant improvement from the past, where law enforcement is traditionally present or involved in behavioral health crisis response. However, key partners also acknowledged that MCRT responders should remain cognizant of the potential perception among clients that the MCRTs are directly connected to (or working in close partnership with) law enforcement. For individuals experiencing behavioral health crises, it is not always clear that MCRTs and law enforcement are different entities on scene.

Figure 19. Key Partner Perceptions of MCRT & Crisis Care Facility Effectiveness, FY23-24, N=19[43]



Law enforcement focus group attendees said that they rely on MERT, MERTY, or FSA Mobile when an MHL is not available or on duty. They attributed their positive experiences with MHLs to their increased confidence in other MCRTs' de-escalation and assessment skills during behavioral health crises. However, some focus group participants whose departments do not work with MHLs acknowledged that their staff are hesitant to request an MCRT response. While law enforcement leadership continues to encourage officers and deputies to utilize MCRTs, they acknowledge that it takes a long time to shift the culture towards trusting another entity to take over care of an individual in crisis.

Focus group participants expressed confidence in the CSP's ability to effectively stabilize patients during their stay, stating that most clients get the help they need. However, participants also acknowledged that some clients are forced to utilize the CSP for urgent non-crisis related services, such as shelter and food. According to focus group

[43] Data Source: Key Partner Survey

respondents, approximately a third of clients at the CSP are unhoused, and 25-30% of those unhoused clients are high utilization clients.

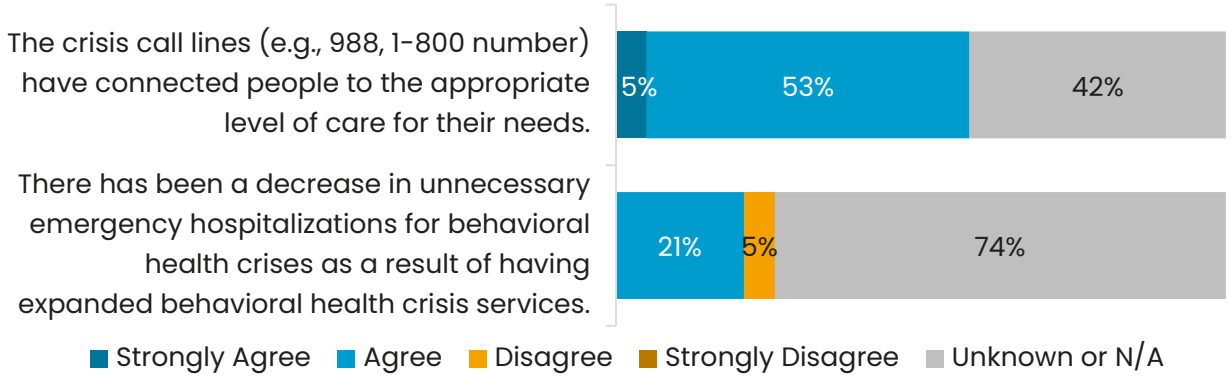
The vast majority of survey respondents and focus group participants felt that community members are better off as a result of receiving services from MCRTs. Focus group participants saw benefit in the variety of MCRT response models available, strong linkages to services, and the prioritization of helping those in crisis remain safely in the community. MCRTs regularly follow up with clients after the initial crisis to ensure their needs are being met and their immediate concerns are addressed. Unfortunately, it is quite challenging to follow up with clients who are unhoused, because they often lack consistent access to a phone and do not usually stay in one location very long.

"People need to be heard sometimes, and that's not the focus of LEO – which is fine. But for us, folks are glad that there are people to listen and respond without the fear of arrest. People can have someone to listen to them and share resources in the community based on their needs."
-Focus Group Participant

Key Partner Perceptions of Appropriate Level of Care Placement

Crisis continuum partner perceptions of whether or not clients are placed in the appropriate level of care has remained steady among survey respondents. Most survey respondents agreed or strongly agreed that the crisis call lines have connected individuals to the appropriate level of care for their needs (58%). In contrast, the majority of respondents disagreed (5%) or were uncertain (74%) in response to the statement that the Crisis Now expansion has reduced unnecessary hospital emergency department hospitalizations. These findings may be expected, given that many of the survey respondents represent behavioral health care workers as opposed to hospital staff (and therefore may be unaware of changes in patient needs in the emergency department).

Figure 20. Key Partner Perceptions of Level of Care Outcomes, FY25-25, N=19[44]



Conversely, hospital staff who participated in focus groups noted that they are receiving far fewer patients on 5150 psychiatric holds who are admitted to their emergency departments (ED) for unnecessary medical clearance. Additionally, participants noted that law enforcement are not issuing as many unnecessary 5150 psychiatric holds (e.g., individuals experiencing psychiatric symptoms but who are not a danger to themselves, others, or gravely disabled) as in previous years. According to one focus group participant, the demand for psychiatric care within their ED has decreased so substantially that they have not needed to use their telepsychiatry services in approximately six months. For the few patients on 5150 holds who are admitted to the ED for medical clearance, ED staff found that they typically also have complex medical needs that are most appropriately treated in the ED.

MCRT-Initiated Psychiatric Holds

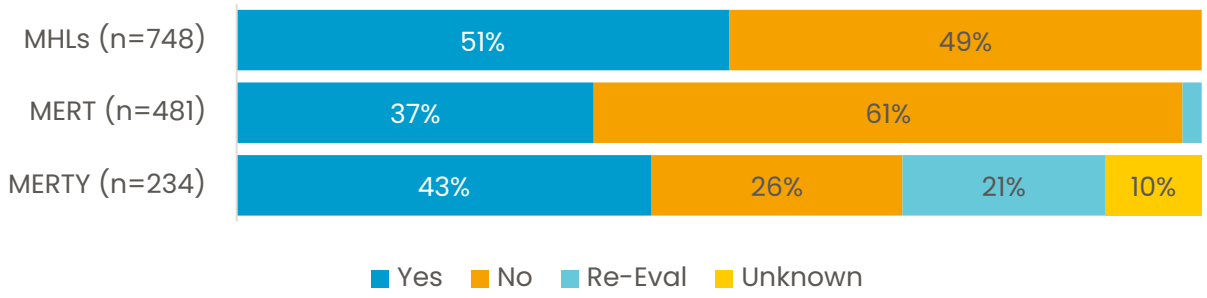
Psychiatric "5150" holds (i.e., "5150" holds for adults and "5585" holds for youth) are a type of involuntary behavioral health disposition for individuals whose behavioral health disorder renders them a danger to others, to themselves, or gravely disabled.[45] The primary goal of a psychiatric hold is to mitigate the risk of harm to self or others and provide behavioral health support, for up to 72 hours, to stabilize an individual in crisis.

Over one third of MERT, MERTY, and MHL incidents involved a psychiatric hold assessment during FY24-25 (37-51%; see Figure 21). These proportions for assessments completed exceed those from FY23-24 for MHLs (51% vs. 44%), MERT (37% vs. 14%), and MERTY (43% vs. 21%).

[44] Data Source: Key Partner Survey

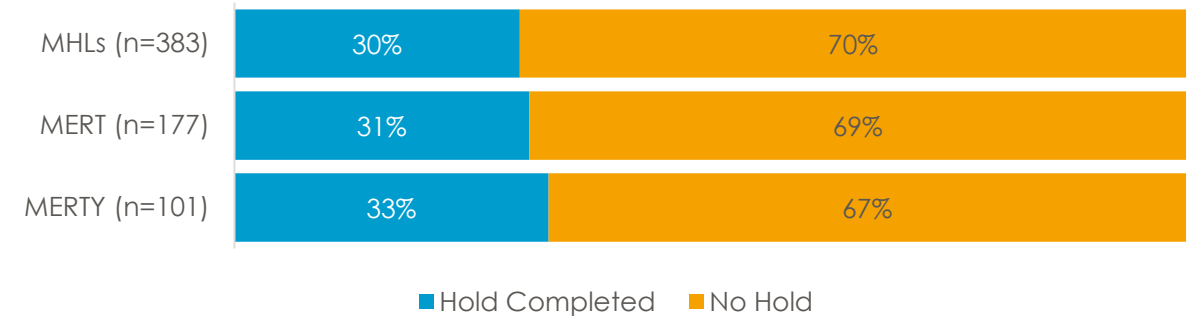
[45] California Legislative Information. (n.d.). *Code section*. California Code, WIC 5150. leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5150

Figure 21. Proportion of MCRT Incidents with Psychiatric Hold Assessments, FY24-25[46]



Of the MERT, MERTY, and MHL incidents in which psychiatric hold assessments were completed, most did *not* result in a written psychiatric hold (67-70%; see Figure 22). These proportions for "no psychiatric hold written" exceed those from FY23-24 for MHLs (70% vs. 67%), MERT (69% vs. 53%), and MERTY (67% vs. 51%).

Figure 22. Proportion of MCRT Incidents where Psychiatric Hold Assessments Resulted in Psychiatric Holds, FY24-25[47]

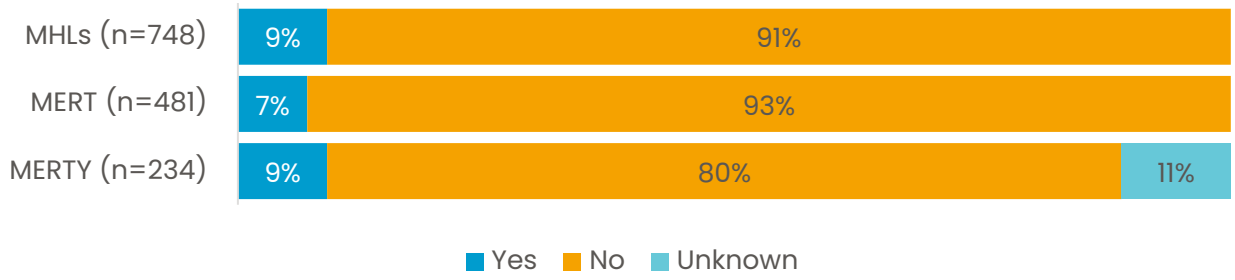


MCRT-Initiated Hospital Emergency Department Visits

For the overwhelming majority of MERT, MERTY, and MHL incidents during FY24-25, clients were *not* sent or taken to the emergency department at Watsonville Community or Dominican Hospitals (80-93%; see Figure 23). These proportions for "not sent/taken to the ED" are similar to those from FY23-24 for MHLs (91% vs. 85%), MERT (93% vs. 91%), and MERTY (80% vs. 60%).

[46] Data Source: MERT, MERTY, & MHL Workbooks
[47] Data Source: MERT, MERTY, & MHL Workbooks

Figure 23. Proportion of MCRT Incidents where Clients were Sent/Taken to a Hospital Emergency Department, FY24-25[48]



MCRT-Initiated Service Referrals

MCRTs provided a variety of service referrals to clients during mobile crisis incidents that occurred throughout FY24-25 (see Table 5). Although close to half of MERT (48%) incidents and one-third of MERTY (39%) incidents involved clients who were already connected to services, both MERT and MERTY responders referred about one-quarter of their incidents to SCCBH and/or other unspecified resources. Although relatively fewer MHL incidents involved clients who were already connected to services (15%), nearly half were referred to SCCBH or other mental health services (46%), and/or other unspecified resources (29%).

Table 5. Key Service Referrals Made Across MCRT Incidents, FY24-25[49]

Category	MERT (N=481 incidents)		MERTY (N=234 incidents)		MHLs (N=748 incidents)	
	n	%	n	%	n	%
Already Connected to Services	230	48%	91	39%	110	15%
SCCBH or Mental Health	108	22%	64	27%	346	46%
Law Enforcement/MHL	47	10%	14	6%	-	-
Emergency Department	22	5%	18	8%	36	5%
SUD Treatment	26	5%	4	2%	27	4%
Homeless Services	13	3%	1	<1%	38	5%
Private Insurance	15	3%	20	9%	-	-
Primary Care Provider	11	2%	4	2%	-	-
School Counseling	0	0%	18	8%	-	-
Independent Therapy	6	1%	8	3%	-	-
Other Unspecified Resources	120	25%	45	19%	216	29%

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

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

EQ4: Santa Cruz Behavioral Health System Indicators

This section highlights indicators of Santa Cruz County's Behavioral Health System as Crisis Now continues its implementation, and associated changes in these indicators since FY23-24. Specifically, this section describes the workforce development for SCCBH and FSA staff, as well as crisis continuum partner impressions and secondary administrative data on other system-level factors that may be associated with Crisis Now efforts, including hospital emergency department boarding and diversion, and ambulance calls with a behavioral health component during FY24-25.

Summary

While there have been some challenges hiring for positions across the crisis continuum, the County has been working to hire staff to support mobile crisis teams. Although hospital emergency department diversion hours have remained stable, key partners believe that boarding and transfer time for patients on a 5150 hold has decreased drastically in FY24-25. EMS data suggests the number of patients experiencing a behavioral health crisis that are transported to hospital emergency departments has decreased substantially since the MCRTs have begun operating 24/7.

Workforce Development

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

To provide 24/7 mobile crisis coverage as part of adherence to the Crisis Now model, SCCBH and FSA are currently working to hire and train staff (see Figure 24 for the intended teams and coverage periods). Currently, MERTY and FSA are fully staffed for their respective coverage shifts (i.e., day shift for MERTY; swing and night shifts for FSA). The MERT and MHLs are still working to hire additional staff at the time of this report (see Table 6).

Figure 24. Mobile Crisis Response: 24-hour Coverage Periods, FY24-25[50]

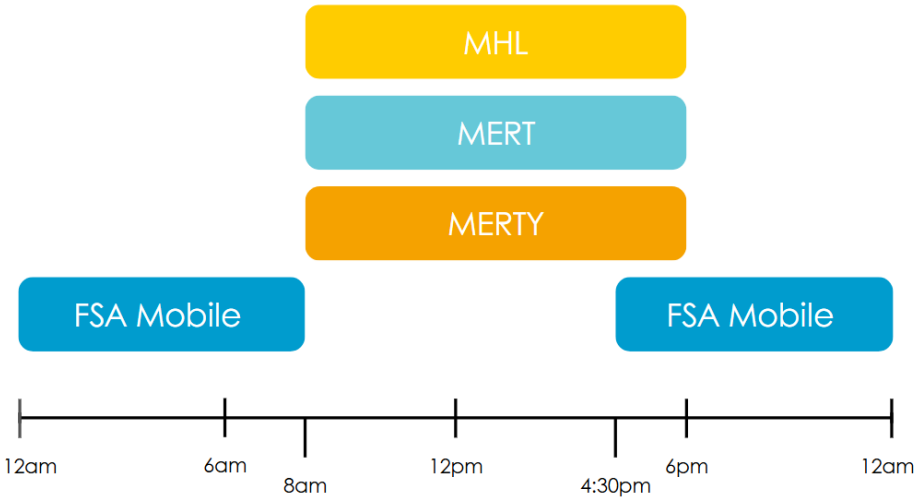


Table 6. MCRT Workforce Snapshot, Spring 2025[51]

	MERT	MERTY	MHLs	FSA
Current BH leadership staff	1 manager; 1 supervisor			1 manager; 3 supervisors
Current BH field-based Staff & Vacancies	4 hired; 2 vacancies	4 hired; no vacancies	3 hired; 4 vacancies	12 hired; no vacancies
Core Partner(s)	SCCBH, FSA	SCCBH, Volunteer Center	Sheriff's Office, Watsonville PD, Santa Cruz PD	SCCBH
Deployment	North & South Counties	North & South Counties	North & South Counties	North & South Counties
Coverage	7 days per week, 8am-6pm	7 days per week, 8am-6pm	7 days per week, 8am-6pm	7 days per week; 5pm-8am next day

Hospital Emergency Department Boarding and Diversion & EMS Workload

In its initial proposal for MHSA Innovation funding, SCCBH cited boarding[52] of behavioral health patients in hospital emergency departments as a significant stressor on the health of the overall system. During focus groups conducted during the baseline (FY23-24) evaluation, local hospital staff shared that their **emergency departments were often**

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

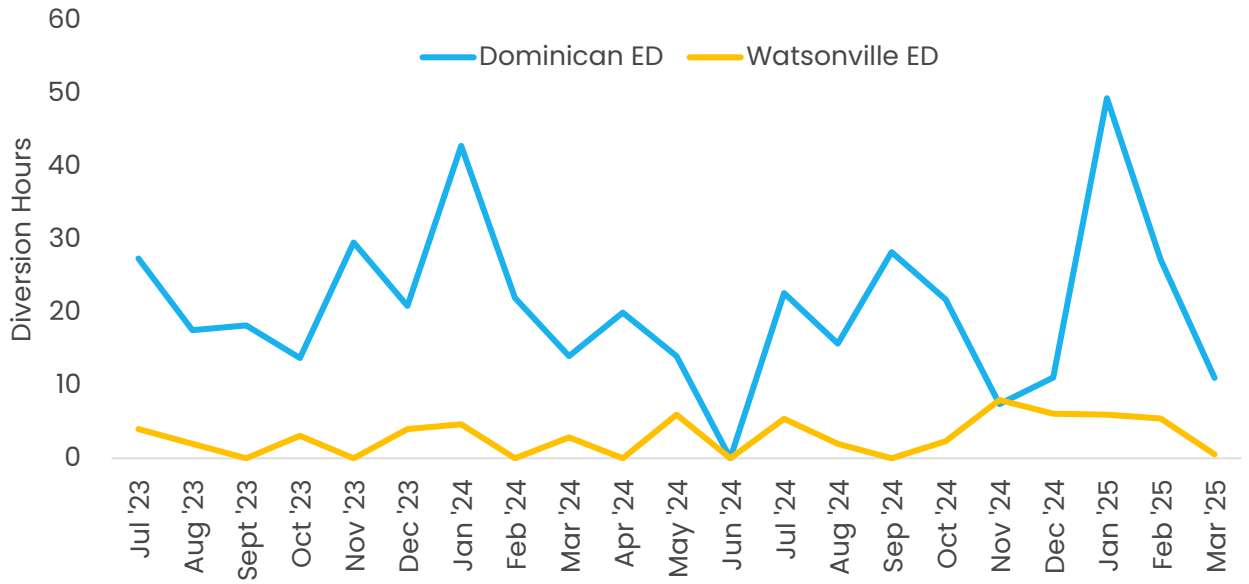
overwhelmed by the number of behavioral health patients that they receive. One baseline assessment focus group participant noted that "even freeing up a *single* hospital bed would help the entire system". Because the emergency departments in SCC hospitals have a limited number of beds for adults and youth (including 24 at Dominican Hospital and 12 at Watsonville Community Hospital), admission of patients on psychiatric holds or who have other behavioral health needs without an urgent medical concern strains emergency department capacity.

> *"There have been times in the past where we felt law enforcement initiated unnecessary 5150s. Those have decreased, last month we only had one [5150] come in with law enforcement." - Hospital Based Focus Group Participant*

The strain that boarding creates for emergency departments can also impact the larger emergency health system. When emergency departments have reached critical capacity (i.e., they can no longer safely accept additional patients), the department will go on "diversion". Ambulances cannot transport patients to emergency departments on diversion; they must transport patients to the next closest and most appropriate emergency department, which may be across the County or outside of County limits. This may increase ambulance transport times, delaying definitive care for patients. Increased travel time to return to their service area also keeps ambulances out of service for longer periods, decreasing EMS availability and increasing response times.

Santa Cruz County hospital emergency department average monthly diversion hours remained largely consistent, moving from 22.24 hours in FY23-24, to 25.6 hours in FY24-25. Additionally, Dominican Hospital continues to average much higher diversion hours than Watsonville Community Hospital (see Figure 25). This is to be expected, as Dominican Hospital serves a denser population area than Watsonville Community Hospital. Though diversion trends remain stable, focus group participants shared that boarding and transfer time for patients on a 5150 hold has decreased drastically in Year 2 of implementation. This is attributed to improved communication between the emergency departments and the CSP, as well as crisis system partners (e.g., law enforcement and EMS) bringing in fewer patients for unnecessary medical clearances. This suggests that ED capacity is no longer as heavily impacted by caring for patients on 5150 holds and are instead managing a higher proportion of medical emergencies that keep them close to full capacity. In other words, the capacity created by diverting individuals in crisis to the most appropriate level of care (e.g., CSP, remaining in the community) may have been filled by patients with medical concerns. Decreasing EMS call volume data further supports this potential explanation.

Figure 25. Monthly SCC Hospital ED Diversion Hours, FY24-25[53]



During the baseline evaluation period, SCC ambulances transported, on average, 9.48 patients experiencing a behavioral health crisis to SCC hospital emergency departments each day. Since the MCRTs have begun operating 24/7 and received continued referrals, the number of patients experiencing a behavioral health crisis that are transported to SCC hospital emergency departments has decreased substantially, to 5.28 calls each day (see Table 7). The mental and behavioral health calls were isolated from the EMS total call volume by selecting calls in which behavioral health/psychiatric crisis, overdose/poisoning/ingestion, agitated delirium, and alcohol intoxication were the "provider impressions" documented in patient care reports. EMS data indicate that mental and behavioral health calls comprised 12.37% of EMS total call volume during the baseline (FY23-24) evaluation year. During this evaluation period, mental and behavioral health calls made up 7.28% of EMS total call volume.

Table 7. SCC Behavioral Health-Related Ambulance Calls for Service[54]

	Baseline Evaluation Period FY23-24	Current Evaluation Period FY24-25
Average Daily Total EMS Calls	77.12	72.51
Average Daily MH/BH EMS Calls	9.48	5.28

[53] Data Source: EMS Records
[54] Data Source: EMS Records

The decrease in patients on a 5150 or 5585 hold is also highlighted in the ambulance unit utilization rate (UUR), or the time ambulances are occupied on calls (e.g., responding, treating, transporting). The UUR is a measure of ambulance workload, which may be affected by the County's adoption of the Crisis Now model. For the purposes of this evaluation, the UUR is calculated by dividing the average number of calls for service by the total unit hours within a 24-hour period. On average, there are eight ambulances in service during the day shifts and five ambulances in service for night shifts, totaling 156 unit hours to cover Santa Cruz County. When comparing the baseline evaluation UUR with the current evaluation period, there are modest (but encouraging) decreases in UUR (see Table 8). Target UURs vary between types of ambulance services, with 911 services aiming for a UUR between 0.3 and 0.5 to ensure there are enough available ambulances to respond to emergencies.[55] A lower UUR is also essential to mitigate provider fatigue and medical errors. Per EMS leadership, Santa Cruz County is aiming for a UUR of 0.4, a workload level which is associated with a higher quality of patient care.

Table 8. SCC Emergency Medical Services Unit Utilization Rate[56]

	Baseline Evaluation Period July 2023 - June 2024	Current Evaluation Period July 2024 - March 2024
24 Hour UUR	.49	.46
Day Shift UUR	.52	.50
Night Shift UUR	.44	.41

During the baseline evaluation period, the evaluation team expected that MCRTs would take a larger share of behavioral health related calls as they increase the depth and breadth of their coverage. This expectation was supported by both the decrease in MH/BH EMS call volume, the improved UUR, and the improved medical clearance and transfer times from the ED to the CSP. Overall, the ongoing Crisis Now implementation efforts have resulted in improved health of the crisis continuum of care. Additionally, these improvements are expected to continue as crisis continuum partners, community partners, and the public increase their awareness of MCRT services.

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

Appendices

Appendix A

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

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

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

Mobile Crisis Response Teams: *Someone to Respond*

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

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

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

Additionally, MCRT teams should have the capacity to:

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

Crisis Care Facilities: *Somewhere to Go*

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

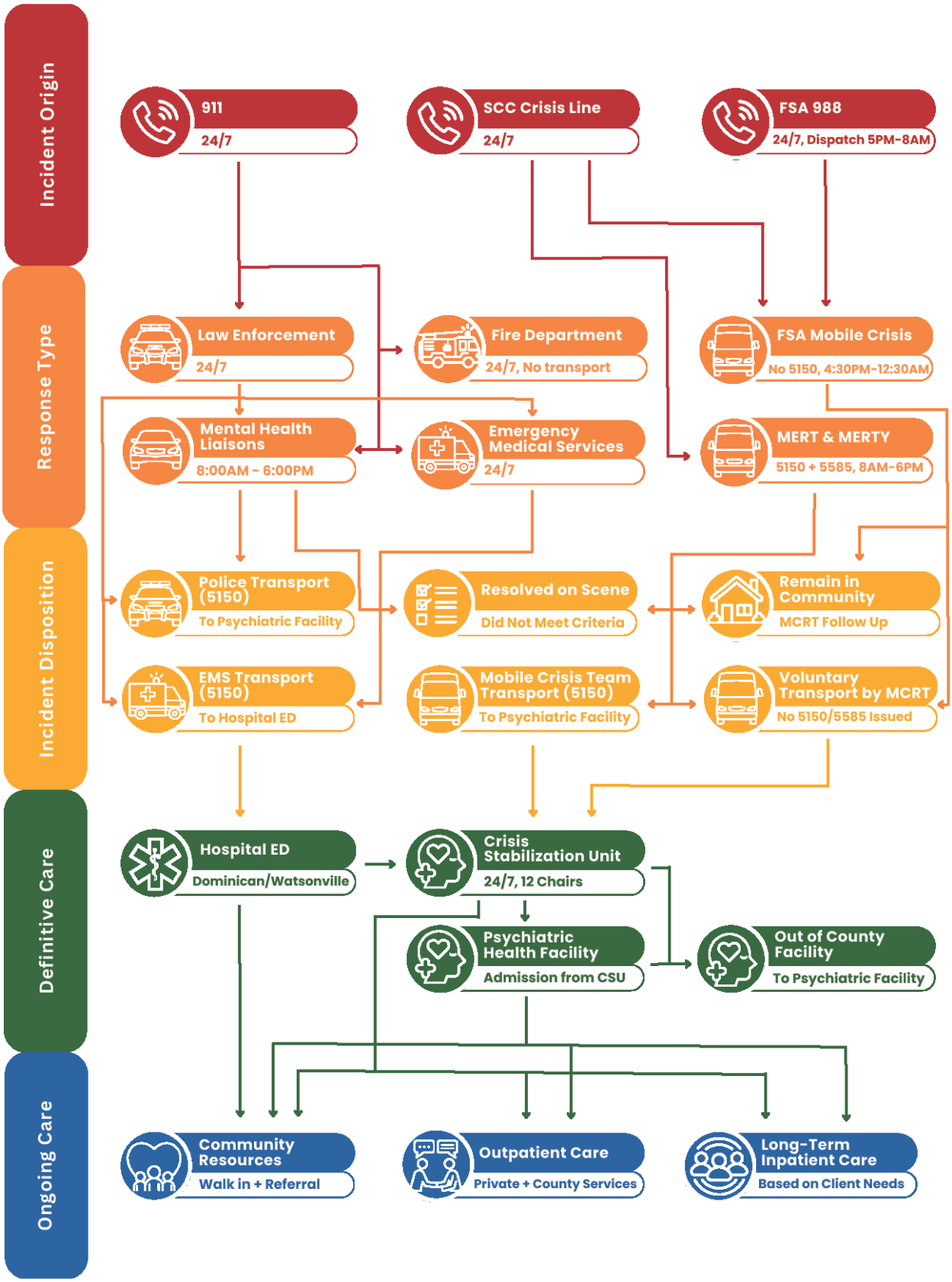
Crisis facilities provide the following services:

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

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

Appendix B

Santa Cruz County Crisis Now Systems Map



Appendix C

Data Sources and Collection Tools

Key Partner Focus Groups & Interviews. As part of the initial discovery for this evaluation, RDA completed 7 focus groups with a total of 25 crisis continuum partners in April 2025, including leaders from field-based mental health frontline agencies (i.e., MCRTs), location-based mental health frontline agencies (i.e., SCCBH, CSP), medical first responders (i.e., EMS, hospitals), local law enforcement, and community advisory and direct care partners. All focus groups took place virtually via zoom. Each focus group was designed to gather unique insights from each group based on their position within the Crisis Now continuum. Focus groups involved discussions of Crisis Now project processes and implementation thus far, including changes made over time, as well as early perspectives on Crisis Now patient access and outcomes. Key partner focus group data were used to inform findings for evaluation questions 1-4. Due to their positions within the County, staff were not permitted to receive gift cards for their participation.

Key Partner Survey. In partnership with SCCBH, RDA developed and administered a voluntary electronic survey to collect crisis continuum partner insights about Crisis Now implementation progress, perceptions of crisis service access within SCC, as well as early impressions of impact for participants and the community. The survey was sent to key partners identified through SCCBH's crisis continuum partner listserv. The key partner survey was completed in April 2025 and yielded 22 respondents, including 10 behavioral health providers (45%), 6 law enforcement officers (27%), 1 emergency/first responder (5%), 2 911 dispatchers (9%), and 3 respondents who identified multiple roles in the crisis care continuum. Due to their positions within the County, staff were not permitted to receive gift cards for their participation.

Crisis Now Fidelity Assessments. RDA used secondary assessment findings regarding SCCBH's fidelity to the Crisis Now model to further inform the findings in this evaluation. SCCBH contracted with RI International and completed an assessment of Crisis Now fidelity in Spring 2025. The results of the assessment were used to inform findings for evaluation question 1.

Project Meeting Notes. Each month since contracting with RDA in February 2024, SCCBH staff attend virtual monthly meetings with RDA to identify and discuss project implementation, updates, successes, challenges, and evaluation activities/progress. The written notes from each of these meetings (July 1, 2024 - March31, 2025) were used to inform findings for evaluation questions 1-4.

CSP Data Sheet. RDA used secondary data from SCCBH's Adult Crisis Stabilization Program (CSP) data sheet to inform findings for evaluation question 2. This data sheet consisted of aggregate data on the total number of psychiatric holds the CSP received between July 2024 and March 2025, including the origin of the psychiatric hold and whether or not it was voluntary.

SCCBH Community Engagement Tracker. RDA used secondary data from SCCBH's Community Engagement Tracker to inform analysis and findings for evaluation question 1. This tracker serves as a running list of all trainings and community engagement activities SCCBH has facilitated or engaged in on behalf of the Crisis Now project.

MERT, MERTY, and MHL Workbooks. RDA used Crisis Now participant data from SCCBH's existing crisis MERT, MERTY, and MHL workbooks to inform findings for evaluation questions 2 and 3. These workbooks consisted of incident-level data for MERT, MERTY, and MHL incidents that took place anytime between July 1, 2024-March 31, 2025. Information provided within the workbooks included: client demographics, descriptive information about the crisis incident, and service referrals.

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

EMS Records. RDA used aggregate data from SCC EMS to further inform findings for evaluation question 4 regarding system-level outcomes. These records consisted of aggregate data on hospital emergency department diversion hours and ambulance call volume data from 2019 through 2025.

Appendix D

RI International Crisis Now Scoring Tool

Crisis Now Scoring Tool (Call Center Hub)				
Level 1 (Minimal)	**Level 2 (Basic)**	**Level 3 (Progressing)**	**Level 4 (Close)**	**Level 5 (Full)**
Call Center Exists	**Meets Level 1 Criteria**	**Meets Level 2 Criteria**	Meets Level 3 Criteria	Meets Level 4 Criteria
24/7 Call Center in Place to Receive BH Crisis Calls	**Locally operated 24/7 Call Center in Place to Receive Calls**	**Hub for Effective Deployment of Mobile Teams**	Formal Data Sharing in Place Between Crisis Providers	Integrated Data that Offers Real-Time Air Traffic Control (Valve Management) Functioning
Answer Calls Within 30 Seconds	**Answer Calls Within 25 Seconds**	**Answer Calls Within 20 Seconds**	**Answer Calls Within 15 Seconds**	GPS-Enabled Mobile Team Dispatch by Crisis Line
Cold Referral to Community Resources or Better Connection to Care	**Warm Hand-off to BH Crisis Providers**	Directly Connects to Facility-Based Crisis Providers	Coordinates Access to Available Crisis Beds	Shared Bed Inventory and Connection to Available Crisis and Acute Beds
Meets NSPL Standards and Participates in National Network	**Staff Trained in Zero Suicide / Suicide Safer Care and BH Services**	**URAC Call Center or Similar Accreditation**	Single Point of Crisis Contact for the Region	24/7 Outpatient Scheduling with Same Day Appointment Availability
	Call Abandonment Rate Under 20%	**Call Abandonment Rate Under 15%**	Call Abandonment Rate Under 10%	Call Abandonment Rate Under 5%

	Shared MOUs / Protocols with Crisis Providers	Some Call Center Access to Person-Specific Health Data	Some Access to Person Specific Data for All Crisis Providers	Real-Time Performance Outcomes Dashboards Throughout Crisis System
	Priority Focus on Safety / Security	**Some Peer Staffing within Call Center**	Shares Documentation of Crisis with Providers	Shared Status Disposition of Intensive Referrals
			Peer Option Made Available to All Callers Based on Need	Trauma-Informed Recovery Model Applied
			Systematic Suicide Screening and Safety Planning	**Suicide Care Best Practices That Include Follow-up Support**
				Full Implementation of all 4 Crisis Now Modern Principles (Required)
Assessed Level = 2	**Justification of Rating**: The Call Center infrastructure is in place and meets all the fundamental criteria for an effective call center (Level 2 - Basic) and fulfills most requirements for Level 3 (Progressing), except for 'Directly connecting to a Facility-Based Crisis Provider' and 'Some Call Center Access to Person-Specific Health Data.' The call center lacks local presence, data tracking, and advanced integration with other crisis services. California has 12 active Lifeline Centers. Santa Cruz County contracts with a third-party community agency that operates as a Lifeline Center, providing services to Santa Cruz and two neighboring counties.			

Crisis Now Scoring Tool (Mobile Crisis Service)				
Level 1 (Minimal)	**Level 2 (Basic)**	**Level 3 (Progressing)**	**Level 4 (Close)**	**Level 5 (Full)**
Mobile Teams are in Place for Part of the Region	**Meets Level 1 Criteria**	**Meets Level 2 Criteria**	**Meets Level 3 Criteria**	Meets Level 4 Criteria
Mobile Teams are Operating at Least 8 hours Per Day in at least part of the region	**Mobile Teams are Available Throughout the Region at Least 8 hours Per Day**	**Mobile Teams are Available Throughout the Region at Least 16 hours Per Day**	**Formal Data Sharing in Place Between Mobile Teams and All Crisis Providers**	Real-Time Performance Outcomes Dashboards Throughout Crisis System (in process)
Mobile Teams Respond to Calls Within 2 Hours Where in Operation	**Mobile Teams Respond to Calls Within 2 Hours Throughout the Region**	**Mobile Teams Respond to Calls Within 1.5 Hours Throughout the Region**	**Mobile Teams Respond to Calls Within 1 Hour Throughout the Region**	GPS-Enabled Mobile Team Dispatch by Crisis Line (in process)
Mobile Teams Complete Community-Based Assessments	**Mobile Team Assessments include All Essential Crisis Now Defined Elements**	**Directly Connect to Facility-Based Crisis Providers as Needed**	Support Diversion Through Services to Resolve Crisis with Rate Over 60%	Support Diversion Through Services to Resolve Crisis with Rate Over 75%
Mobile Teams Connect to Additional Crisis Services as Needed	**Staff Trained in Zero Suicide / Suicide Safer Care and BH Services**	**Some Mobile Team Access to Person Specific Health Data**	**Mobile Teams Receive Electronic Access to Some Health Information**	All Mobile Teams Include Peers
	Shared MOUs / Protocols with Call Center Hub	**Shared MOUs / Protocols with Call Center and Crisis**	**Shares Documentation of Crisis with Providers**	Shared Status Disposition of Intensive Referrals

		Facility-Based Providers		
	Priority Focus on Safety / Security	**Trauma-Informed Recovery Model Applied**	**Some Peer Staffing within Mobile Teams**	**Meets Person Wherever They Are - Home/Park/ Street / Shelter etc.**
			Systematic Suicide Screening and Safety Planning	**Real-Time Access to Electronic Health Records**
				Suicide Care Best Practices That Include Follow-up Support
				Full Implementation of all 4 Crisis Now Modern Principles (Required)
Assessed Level = 3	**Justification of Rating:** Mobile crisis services are progressing, with strong foundational elements and community-based response. Mobile Crisis Services is currently at Level 3 (Progressing) and fulfills most requirements for Level 4 (Close), except for one item: 'Support Diversion Through Services to Resolve Crisis with a Rate Over 60%.' MCT services need improvement in data integration, formal evaluation, and peer involvement to reach higher levels. The county provides mobile crisis response, which has been recognized as valuable by many partnering agencies and community members. The composition of response teams varies, and not all teams include peers or individuals with lived experience. Santa Cruz County has several elements of Level 5 either completed or in progress.			

Crisis Now Scoring Tool (Crisis Receiving Center)				
Level 1 (Minimal)	**Level 2 (Basic)**	**Level 3 (Progressing)**	**Level 4 (Close)**	**Level 5 (Full)**
Sub-Acute Stabilization is in Place for Part of the Region	**Meets Level 1 Criteria**	**Meets Level 2 Criteria**	Meets Level 3 Criteria	Meets Level 4 Criteria
Have 24/7 Access to Psychiatrists or Master's Level Clinicians	**Some Form of Facility-Based Crisis is Available Throughout the Region**	**Crisis Beds / Chairs Available at a Ratio of at Least 3 per 100,000 Census**	Formal Data Sharing with Sub-Acute Stabilization and All Crisis Providers	Real-Time Performance Outcomes Dashboards Throughout Crisis System
In Counties with Sub-Acute Stabilization, at Least 1 Bed / Chair per 100,000 Census	**Crisis Beds / Chairs Available at a Ratio of at Least 2 per 100,000 Census**	**Offers Crisis Stabilization / Observation Chairs as well as Sub-Acute / Residential**	Crisis Beds / Chairs Available at a Ratio of at Least 4 per 100,000 Census	Crisis Beds / Chairs Available at a Ratio of at Least 5 per 100,000 Census
	Shared MOUs / Protocols with Other Crisis Providers	Multiple Providers Offering Facility-Based Crisis Services	Support Diversion From Acute Inpatient at Rate Over 60%	Support Diversion From Acute Inpatient at Rate Over 70%
	Staff Trained in Zero Suicide / Suicide Safer Care and BH Services	**Some Crisis Facility Access to Person Specific Health Data**	**Incorporates Crisis Respite Services into the Facility-Based Crisis Continuum**	No Refusal to First Responder Drop offs as Primary Service Location
	Priority Focus on Safety / Security	**Trauma-Informed Recovery Model Applied**	Operates in a Home-Like Environment	Bed Inventory and Referral Centralized Through Crisis Line

		Direct Law Enforcement Drop-Offs Accepted	**Systematic Suicide Screening and Safety Planning**	Suicide Care Best Practices That Include Follow-up Support
		Least Restrictive Intervention and No Force First Model	**Some Peer Staffing within the Crisis Facility**	Utilize Peers as Integral Staff Members
			Sub-Acute Stabilization Receive Electronic Access to Some Health Information	Shared Status Disposition of Intensive Referrals
			Shares Documentation of Crisis with Providers	Law Enforcement Drop-Off Time Less Than 10 Minutes
				Full Implementation of all 4 Crisis Now Modern Principles (Required)
Assessed Level = 3	**Justification of Rating:** The Crisis Receiving Services infrastructure is well-established, meeting all fundamental criteria for an effective facility-based crisis center at Level 2 (Basic). It also fulfills most requirements for Level 3 (Progressing), though Santa Cruz County relies on a single crisis facility agency as its primary provider. Facility-based services are well-established and meet many of the Crisis Now standards, with room to grow in capacity, data integration, and peer involvement.			

Crisis Now Scoring Tool (Crisis Now System)				
Level 1 (Minimal)	**Level 2 (Basic)**	**Level 3 (Progressing)**	**Level 4 (Close)**	**Level 5 (Full)**
System Includes at Least Level 1 Implementation in All Areas of Crisis Now	**System Includes at Least Level 2 Implementation in All Areas of Crisis Now**	**Meets Level 2 Criteria**	System Includes at Least Level 3 Implementation in All Areas of Crisis Now	System Includes at Least Level 3 Implementation in All Areas of Crisis Now
Some Implementation of at Least 2 Crisis Now Modern Principles	**Some Implementation of at Least 3 Crisis Now Modern Principles**	**Some Implementation of all 4 Crisis Now Modern Principles**	Substantial Implementation of all 4 Crisis Now Modern Principles	Full Implementation of all 4 Crisis Now Modern Principles
The 4 Crisis Now Modern Principles Are:	**1 -** Priority Focus on Safety / Security	**2 -** Suicide Care Best Practices (Systematic Screening, Safety Planning and Follow-Up)	**3 -** Trauma-Informed Recovery Model	**4 -** Significant Role of Peers
Assessed Level = 2	**Justification of Rating**: The Call Center infrastructure is in place and meets all the fundamental criteria for an effective call center (Level 2 - Basic) and fulfills most requirements for Level 3 (Progressing), except for 'Directly connecting to a Facility-Based Crisis Provider' and 'Some Call Center Access to Person-Specific Health Data.' The call center lacks local presence, data tracking, and advanced integration with other crisis services. California has 12 active Lifeline Centers. Santa Cruz County contracts with a third-party community agency that operates as a Lifeline Center, providing services to Santa Cruz and two neighboring counties.			